FAQs

by Dr. Angela Bowen:

Edinburgh Postnatal Depression Scale (EPDS) Cox, Holden & Sagovsky (1987)
WAST II - Women Abuse Screening Tool II Brown, Lent, Schmidt, Sas (2000)
T-ACE Screening Tool (Alcohol) Chang, Fisher, Hornstein & Orav (2010)

Q. Who is currently using this form?
A. Has only now been released with the revised prenatal form

Q. Has the revised tool been validated with the changes OR are the two sections added been validated previously?
A. Yes, these are all validated scales.

Q. Does the EPDS remain valid with the other screens on the same form?
A. The EPDS is not affected, and the two other screens are stand-alone tools. They have been administered together in clinical and research settings

Q. Are the other screens validated for self-administration?
A. Yes.

Q. The current EPDS is translated into a number of other languages which is really helpful. Is the revised tool also available and validated in these other languages or will it be?
A. Sorry, the other tools are only in English from what we can find.

Q. Has the revised tool been reviewed in relation to being culturally sensitive?
A. These screens have been used in one First Nations Community as a combination for many years, they have been used in research settings and maternal mental health programs for a number of years. The EPDS has been validated in Regina First Nations postpartum women.

Q. Is screening for violence/alcohol at time of EPDS the right time for this service? While these are important screens, there are others equally important with PPD such as, for example, social support screening. Would it not make more sense that once a person is identified as at risk for PPD, they be referred to a mental health professional/counsellor who can then do a thorough assessment using all screenings appropriate to the client's situation?
A. It is exactly the right time. These issues are often found together, dual diagnosis, but all are interrelated and harmful to the mother and baby if undetected or untreated. In a study in Saskatoon, we found that 30% of breastfeeding women in socially affluent neighbourhoods were drinking regularly at three months postpartum, a big surprise to us.

Q. I question the box that says women should be automatically connected to a safe house or to HealthLine based on their answers on the WAST II. PPD is much different than abuse in the sense that abuse is an issue of power and control and PPD is not.

A. There is high correlation with abuse and depression and substance abuse. Women living in abusive relationships often struggle with depressive symptoms and substance use.

Q. Based on my education and experience, one of the most important things when dealing with female victims of violence is that they have the autonomy to decide how they want to proceed.

A. Making women aware of their options (e.g., a women's shelter) is prudent after identifying potential problems, not all women know the system, and a giving them information is paramount. We know that women do not easily admit that they are in an abusive situation, the WAST II is a good proxy for problems in the relationship without asking if the woman is being abused, as often is the question, and she isn't comfortable answering it.

Q. Autonomy helps women to regain their sense of agency, which is taken from them in abuse. A preference would be for a woman to be seen by a counsellor who can spell out all her potential options and then allow her to make the best decision for herself about how she wants to proceed.

A. There can be a long wait for such counselling, particularly for rural and remote women.

Q. The statement that the woman must be connected to a safe house or HealthLine is very narrow in the scope of potential resources available to her, and I think that automatically connecting her to a service she does not want or may not be ready for has the potential to do more harm than good.

A. As former chair of a shelter, women know about them long before they take advantage of the service, the sooner we familiarize women with them the better. The Maternal Wellness line can help with this as well. She doesn't have to accept any referral she doesn't want to receive, clients always have an option to refuse.

Q. There are concerns with asking very personal questions of people with whom we may be complete strangers, little time to develop a relationship with them, may never see again and have little to no time to address their concerns if disclosed in many environments under which the tool is used. Are the additional questions most appropriate for the initial screen or more appropriate being managed by the person/agency that is consulted? Often these screens are being administered at baby clinic appointments with several other priority tasks to complete in the same 20-30 minutes.

A. This is exactly why we have universal screening, there is not enough time to get indepth assessment on these very important aspects of maternal health. Screens have been shown (also in socially vulnerable women) to open the door to communication. Women have told us repeatedly that they want to be asked about their emotional and mental wellbeing, not just physical or baby's health. If there are

problems and you are a Public Health Nurse, you can contact the HealthLine's Maternal Wellness Program with inquiries along with referrals.

Q. There was mention in your report of an "environmental scan" being completed. We were unclear if that included members of the public – non health related persons. Their knowledge of resources may be very different than those we list, but their knowledge is a very valuable piece.

A. Agreed. We were hoping to get funding for a postdoctoral student to do the public portion of this, this didn't come through and there is no funding for the work.

Q. There is no doubt screening tools generally have value, but administering the tool with no ability to develop a rapport with the person is concerning. It would be different if they approach us – but that is not the case with how the tool is being used for the most part in Saskatchewan.

A. There is no reason that there is no follow-up with individuals in your care, such as the HealthLine's Maternal Wellness Program or Family Doctor or Mental Health Services. This situation is similar to a Family Doctor referring their patient with physical concerns to a specialist.

Universal Screening is essential to capture these issues that are often undetected due to stigma, lack of awareness, or lack of interest on the part of the care provider.