Overview of Screening/Assessment Instruments for Depressive Symptoms Screening

Benchmark Measure 3: Depression Screening
Benchmark Measure 17: Completed Depression Referrals

Edinburgh Postnatal Depression Scale (EPDS)

Source/More Information: http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

Purpose/Features: Self-report checklist to measure and assess risk for maternal perinatal depression. Women rate the degree to which they are experiencing depressive symptoms within the past week.

Admin Time: 10 items; About 5-10 min. to complete

Scoring: about 5 min.; responses scored from 0-3; items are totaled for overall score

Training: Not necessary to use the instrument

Languages: English and Spanish forms are included within this toolkit. The EPDS has been translated into numerous languages. The following document contains further information and copies of translated versions - http://www.dchealthcheck.net/documents/10-2015-EPDS-Translations.pdf. Some have undergone statistical validation while others have not. Before using another translated version that has not been validated, please seek consultation from Debbie Richardson, your local MIECHV mental health consultant, and/or interpreter.

Cost: None

EDINBURGH POSTNATAL DEPRESSION SCALE

Participant ID#: ________________________ **Date Completed:** _____/______/______

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past 7 days…

1. **I have been able to laugh and see the funny side of things**
   - O As much as I always could
   - O Not quite so much now
   - O Definitely not so much now
   - O Not at all

2. **I have looked forward with enjoyment to things**
   - O As much as I ever did
   - O Rather less than I used to
   - O Definitely less than I used to
   - O Hardly at all

3. ***I have blamed myself unnecessarily when things went wrong**
   - O Yes, most of the time
   - O Yes, some of the time
   - O Not very often
   - O No, never

4. **I have been anxious or worried for no good reason**
   - O No, not at all
   - O Hardly ever
   - O Yes, sometimes
   - O Yes, very often

5. ***I have felt scared or panicky for no good reason**
   - O Yes, quite a lot
   - O Yes, sometimes
   - O No, not much
   - O No, not at all

6. ***Things have been getting on top of me**
   - O Yes, most of the time I haven't been able to cope at all
   - O Yes, sometimes I haven't been coping as well as usual
   - O No, most of the time I have coped quite well
   - O No, I have been coping as well as ever

7. ***I have been so unhappy that I have had difficulty sleeping**
   - O Yes, most of the time
   - O Yes, quite often
   - O Not very often
   - O No, not at all

8. ***I have felt sad or miserable**
   - O Yes, most of the time
   - O Yes, quite often
   - O Not very often
   - O No, not at all

9. ***I have been so unhappy that I have been crying**
   - O Yes, most of the time
   - O Yes, quite often
   - O Only occasionally
   - O No, never

10. ***The thought of harming myself has occurred to me**
    - O Yes, quite often
    - O Sometimes
    - O Hardly ever
    - O Never

EDINBURGH POSTNATAL DEPRESSION SCALE (Spanish Version)
Kansas MIECHV

 # de Identificación de Participante:_________________ Fecha de encuesta:____/_____/____

Como usted ha tenido un bebé recientemente, nos gustaría conocer cómo se siente ahora. Por favor, SUBRAYE la respuesta que encuentre más adecuanda a cómo se ha sentido durante la semana pasada.

En los pasados 7 dias…

1. **He sido capaz de reírme y ver el lado divertido de las cosas**
   - O Igual que siempre
   - O Ahora, no tanto como siempre
   - O Ahora, mucho menos
   - O No, nada en absoluto

2. **He mirado las cosas con ilusión**
   - O Igual que siempre
   - O Algo menos de lo que es habitual en mí
   - O Bastante menos de lo que es habitual en mí
   - O Mucho menos que antes

3. ***Me he culpado innecesariamente cuando las cosas han salido mal**
   - O Sí, la mayor parte del tiempo
   - O Sí, a veces
   - O No muy a menudo
   - O No, en ningún momento

4. **Me he sentido nerviosa o preocupada sin tener motivo**
   - O No, en ningún momento
   - O Casi nunca
   - O Sí, algunas veces
   - O Sí con mucha frecuencia

5. ***He sentido miedo o he estado asustada sin motivo**
   - O Sí, bastante
   - O Sí, a veces
   - O No, no mucho
   - O No, en absoluto

6. ***Las cosas me han agobiado**
   - O Sí, la mayoría de las veces no he sido capaz de afrontarlas
   - O Sí, a veces no he sido capaz de afrontarlas tan bien como siempre
   - O No, la mayor parte de las veces las he afrontado bastante bien
   - O No, he afrontado las cosas tan bien como siempre

7. ***Me he sentido tan infeliz que he tenido dificultades para dormir**
   - O Sí, la mayor parte del tiempo
   - O Sí, a veces
   - O No muy a menudo
   - O No, en ningún momento

8. ***Me he sentido triste o desgraciada**
   - O Sí, la mayor parte del tiempo
   - O Sí, bastante a menudo
   - O No con mucha frecuencia
   - O No, en ningún momento

9. ***Me he sentido tan infeliz que he estado llorando**
   - O Sí, la mayor parte del tiempo
   - O Sí, bastante a menudo
   - O Sólo en alguna ocasión
   - O No, en ningún momento

10. ***He tenido pensamientos de hacerme daño**
    - O Sí, bastante a menudo
    - O A veces
    - O Casi nunca
    - O En ningún momento

EPDS[1] Instructions and Scoring

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199