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| **Edinburgh Postnatal Depression Scale (EPDS)**  (Please note: The Edinburgh Postnatal Depression Scale is 1 page) |

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| **Purpose:**  The purpose of this form is to screen for perinatal depression. Postpartum depression is the most common complication of childbearing. The research literature indicates that the incidence may be as high as 17%-18%.[[1]](#footnote-1) The Edinburgh Postnatal Depression Scale (EPDS) is a 10-question self-rating scale that has been proven to be an efficient and effective way of identifying women at risk for perinatal/postnatal depression.[[2]](#footnote-2) Without treatment, perinatal depression affects all aspects of a woman’s health and that of her baby. It can be a factor leading to low birth weight, compromised mother-infant interaction, and behavioural/cognitive impairment in early preschool years. The most tragic consequences of perinatal depression are maternal suicide and infanticide. NFP Nurse Home Visitors (NHVs) may be the first point of contact for women experiencing perinatal depression. The use of a reliable screening instrument is intended to supplement the NHV’s clinical judgment and assist with decision making about the client’s care. Its use provides women with the opportunity to discuss their feelings and enables the nurse home visitor to discreetly raise the issue of potential perinatal depression with the client. The instrument is easy to administer, and most mothers easily complete the scale in less than 5 minutes.  High scores do not themselves confirm a depressive illness, and similarly, some women who score below a set threshold might be depressed. The EPDS does not provide a clinical diagnosis of depression and should not be used as a substitute for full psychiatric/mental health assessment and clinical judgment. The EPDS cannot be used to predict whether or not a respondent will experience depression in the future - it can only be used to determine current mood- within the past seven days. The EPDS will not detect mothers with anxiety neuroses, phobias or personality disorders. The EPDS Score is designed to assist, not replace, clinical/professional judgment. Since the Patient Health Questionnaire-9 is a mandatory component of STAR, agencies/societies may elect not to use the Edinburgh.  **General Guidelines:**   * This form is completed 3 times: Pregnancy 36 Weeks, Infancy 6-8 weeks, and Infancy 4-6 months and as needed * If the client has a high EPDS prenatally, or indicates/exhibits any early signs of postpartum depression, the EPDS should be done prior to 6-8 weeks.   **Definitions/Directions for Completing Form**   * The mother should complete the scale herself, unless she has limited English or has difficulty with reading. * The mother is asked to put an “X” beside the response that comes closest to how she has been feeling in the previous 7 days. * All ten items must be completed. * Good clinical care also involves asking if the mother has fears about hurting the baby or fears of the baby coming to harm.   **Scoring:**   * Questions 1, 2 and 4 are scored 0, 1, 2 or 3 with top box scored as a 0 and the bottom box scored as 3. * Questions 3, 5-10 are reverse scored, with the top box being scored as a 3 and the bottom box scored as 0. * Individual items are totaled to give an overall score. * Guidance for action and interpretation of the client’s EPDS score is found on the next page   **Translations:**   * Translations of the EPDS into several different languages are available on Perinatal Services BC website:   <http://www.perinatalservicesbc.ca/ForHealthcareProviders/Resources/ProfessionalToolbox/EPDSScale/default.htm> |

**Guidance for action and interpretation of Edinburgh Postnatal Depression Scale (EPDS) score**

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| **EPDS Score** | **Interpretation** | **Action** |
| 0-9 | Depression not likely | * Scores in this range may indicate the presence of some symptoms of distress that may be short-lived and are less likely to interfere with day to day ability to function at home, work, or school. * If these symptoms have persisted more than a week or two further enquiry is warranted. |
| 10-12 | Depression possible | * Scores within this range indicate presence of symptoms of distress that may be discomforting. * Repeat the EDS in 2 weeks’ time and continue monitoring * If the scores increase to above 12, assess further and consider referral as needed. * NHV assesses with the client any needs for additional support and offers additional information/education * Consider referral to primary care provider (PCP). |
| 13 and higher  (positive screen) | Fairly high possibility  of depression | * Women with scores above 12 require further assessment and appropriate management as the likelihood of depression is high. * Refer to PCP and/or mental health specialist for diagnostic assessment and treatment * NHV works with the client and community health professionals to develop a collaborative plan of care |
| Positive score  (1, 2 or 3) on  question #10  (suicidality risk) |  | * Immediate discussion required. * Refer to PCP ± mental health specialist or emergency resource for further assessment and intervention as appropriate. * Urgency of referral will depend on several factors including: whether the suicidal ideation is accompanied by a plan, whether there has been a history of suicide attempts, whether symptoms of a psychotic disorder are present and/or there is concern about harm to the baby. |

Adapted from:

<http://www.perinatalservicesbc.ca/NR/rdonlyres/895522A4-933C-4F0C-B980-EA2B5958692F/0/EPDSScoringGuide_March2015.pdf>

and

<http://www.blackdoginstitute.org.au/docs/CliniciansdownloadableEdinburgh.pdf>

**Note: NHVs should follow their agency policies and procedures regarding referral and coordination of care for clients who screen positive or those who are in need of mental health evaluation/assessment based on the nurse’s clinical judgment.**

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| **Client Name:** |

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| **Client ID:** |  | **Nurse ID:** |  | **Date:** |

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| **Check one:** | * Pregnancy 36 Weeks | * Infancy 6-8 weeks | * Infancy 4-6 months |

As you are having a baby, we would like to know how you are feeling. Please mark an “X” beside the answer which comes closest to how you have felt in the **past 7 days** – not just how you feel today.

**In the past 7 days:**

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| 1. I have been able to laugh and see the funny side of things  \_\_\_ As much as I always could  \_\_\_ Not quite so much now  \_\_\_ Definitely not so much now  \_\_\_ Not at all  2. I have looked forward with enjoyment to things  \_\_\_ As much as I ever did 0  \_\_\_ Rather less than I used to 1  \_\_\_ Definitely less than I used to 2  \_\_\_ Hardly at all 3  3. I have blamed myself unnecessarily when things went wrong  \_\_\_ Yes, most of the time  \_\_\_ Yes, some of the time  \_\_\_ Not very often  \_\_\_ No, never  4. I have been anxious or worried for no good reason  \_\_\_ No, not at all  \_\_\_ Hardly ever  \_\_\_ Yes, sometimes  \_\_\_ Yes, very often  5. I have felt scared or panicky for no very good reason  \_\_\_ Yes, quite a lot  \_\_\_ Yes, sometimes  \_\_\_ No, not much  \_\_\_ No, not at all | 0  1  2  3  0  1  2  3  3  2  1  0  0  1  2  3  3  2  1  0 | 6. Things have been getting on top of me  \_\_\_ Yes, most of the time I haven’t been able to cope  \_\_\_ Yes, sometimes I haven’t been coping as well as usual  \_\_\_ No, most of the time I have coped quite well  \_\_\_ No, I have been coping as well as ever  7. I have been so unhappy that I have had difficulty sleeping  \_\_\_ Yes, most of the time  \_\_\_ Yes, sometimes  \_\_\_ Not very often  \_\_\_ No, not at all  8. I have felt sad or miserable  \_\_\_ Yes, most of the time  \_\_\_ Yes, quite often  \_\_\_ Not very often  \_\_\_ No, not at all  9. I have been so unhappy that I have been crying  \_\_\_ Yes, most of the time  \_\_\_ Yes, quite often  \_\_\_ Only occasionally  \_\_\_ No, never  10. The thought of harming myself has occurred to me  \_\_\_ Yes, quite often  \_\_\_ Sometimes  \_\_\_ Hardly ever  \_\_\_ Never | 3  2  1  0  3  2  1  0  3  2  1  0  3  2  1  0  3  2  1  0 |

1. Josefsson A, Berg G, Nordin C, Sydsjö G. Prevalence of depressive symptoms in late pregnancy and postpartum. Acta Obstet Gynecol Scand. 2001;80(3):251-5. [↑](#footnote-ref-1)
2. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry, 1987;150:782-6. [↑](#footnote-ref-2)