Maternal Depression Screening Procedure

Early Learning
psesd
excellence & equity in education
Puget Sound Educational Service District

Purpose
This explains how and when to administer and score the screening.

Guidance
Edinburgh Postnatal Depression Scale (EPDS)
Taken from the British Journal of Psychiatry
June, 1987, Vol. 150 by J.L. Cox, J.M. Holden, R. Sagovsky

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item self-report screening tool that measures the severity of depression symptoms in women during the perinatal period.

Studies have shown that postnatal depression affects at least 10% of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long term effects on the family.

The validation study showed that mothers who scored above threshold 92.3% were 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* and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Procedure
1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
4. After the mother completes the questionnaire a conversation with the mother should occur.
5. The home visitor and the mother should look at the questions together and discuss any concerns the mother has about how she is feeling.

How to Score
Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptoms. Items marked with an asterisk are reverse scored (i.e. 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. A score of 12+ indicates the likelihood of depression, but not the severity. It is not meant to replace clinical judgment. If the total score is 12 or more, further discussion with the mother should occur. Staff may offer resources and/or referrals as appropriate.

Scores of 1 or higher on question #10 (suicide ideation) requires immediate consultation with the home visitor's supervisor and the mental health coordinator for follow up.

When
Within third trimester and at six weeks postpartum. Additional screening can be done at anytime.