4.3 Screening tools

The Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a set of questions used to assess whether or not a woman may be suffering from depression or anxiety, or both. It can be used antenatally and postnatally. It is one of the most widely accepted tools in the world. It has been validated through research in many different cultures and countries.

Definition: validated

A tool that has been *validated* when that the tool has been tested against a diagnostic 'gold standard' assessment, and proven to be an adequate screening tool for assessing depression and anxiety.

Note

The version of the EPDS provided here has been adapted for use in South Africa, and specifically for use in a Midwife Obstetric Unit in Cape Town. It is based on the work of: Cox JL, Holden JM & Sagovsky R (1987) Detection of postnatal depression, development of the 10 item postnatal depression scale. British Journal of Psychiatry. 150: 782-6.

Health workers may use this questionnaire but only if it is copied and used in full. **Do not use the copy on the next page.** Rather, copy the questionnaires **without scores** in the Resources section at the end of this handbook.

The Edinburgh Postnatal Depression Scale

My feelings now that I am pregnant or have had a baby.

As you are pregnant or have had a baby, we would like to know how you are feeling. It may help us in choosing the best care for your needs. The information you provide us will be kept private and confidential.

There is a choice of four answers for each question. Please circle the one that comes closest to how you have felt *in the past seven days*, not just how you feel today.

[SCORES ON RIGHT HAND SIDE]

In the past seven days:

1. I have been able to see the funny side of things:

As much as I always could	[0]
Not quite so much now	[1]
Definitely not so much now	[2]
Not at all	[3]

2. I have looked forward with enjoyment to things:

As much as I ever did	[0]
A little less than I used to	[1]
Much less than I used to	[2]
Hardly at all	[3]

3. I have blamed myself when things went wrong, and it wasn't my fault:

Yes, most of the time	[3]
Yes, some of the time	[2]
Not very much	[1]
No, never	[0]

4. I have been worried and I don't know why:

No, not at all	[0]
Hardly ever	[1]
Yes, sometimes	[2]
Yes, very much	[3]

5. I have felt scared or panicky and I don't know why:

Yes, quite a lot	[3]
Yes, sometimes	[2]
No, not much	[1]
No, not at all	[0]

6. I have had difficulty in coping with things:

Yes, most of the time I haven't been managing at all	[3]
Yes, sometimes I haven't been managing as well as usual	[2]
No, most of the time I have managed quite well	[1]
No, I have been managing as well as ever	[0]

7. I have been so unhappy I have had difficulty sleeping:

Yes, most of the time	[3]
Yes, sometimes	[2]
Not very much	[1]
No, not at all	[0]

8. I have felt sad and miserable:

Yes, most of the time	[3]
Yes, quite a lot	[2]
Not very much	[1]
No, not at all	[0]

9. I have been so unhappy that I have been crying:

Yes, most of the time	[3]
Yes, quite a lot	[2]
Only sometimes	[1]
No, never	[0]

10. I have thought of harming myself or ending my life:

Yes, quite a lot	[3]
Sometimes	[2]
Hardly ever	[1]
Never	[0]

Step 1: Ask the mother the questions or leave her to complete the questionnaire on her own

Make sure that she has ticked all the questions. The EPDS questionnaire is made up of ten multiple-choice questions. These questions ask the mother about how she has felt in the last seven days. Each question has four possible answers. These answers are given score values, from 0 to 3. The scores indicate how strongly the mother was feeling about something. A higher score indicates a more serious symptom.

Step 2: Some questions might require double-checking

Question 7: 'I have been so unhappy I have had difficulty sleeping.'

Check if the mother is having difficulty sleeping because of her feelings, or because of being physically uncomfortable due to the pregnancy.

Question 10: 'I have thought of harming myself or ending my life.'

If the mother gives an answer with a score of 1, 2 or 3 on this question, you must ask her further questions to determine if she is suicidal.

Step 3: Scoring

After the client has completed the questionnaire, score her answers. The example of the EPDS given on the previous two pages includes scores. Note how the ordering of highest or lowest score is not the same for each question. Add up each of the scores the mother got for the ten questions. The TOTAL score is important.

Step 4: Add up the scores

If TOTAL score is:

- **Below 10**
  = the mother is probably fine and does not need to be referred
- **Above 10**
  = she is at risk of depression and anxiety and may need to be referred
- **13 and above**
  = the women needs to be referred

If the mother has previously attempted suicide, or has a thought-out plan for how she may harm herself, you need to refer her **URGENTLY.**

It does not matter what her overall score is.

The Risk Factor Assessment (RFA)

This questionnaire was developed by the PMHP team in Cape Town. While the EPDS screens for symptoms of maternal mental illness, this questionnaire assesses the risk factors for mental illness.

This is a screening tool which is quick and easy to use in busy settings. It is important to note that this tool has **not yet been validated** like the EPDS. However, it has been developed based on international research and on the PMHP experience with women during the perinatal period. The PMHP is conducting a study to find out if this is a valid tool to use. Research shows that it is better to screen for both mood symptoms and risk factors. We have found it very helpful to combine the EPDS with the RFA tool, although this may take too long for some settings.

The Risk Factor Assessment (RFA)

My situation now that I am pregnant/have had a baby.

We are interested to find out how your situation is in your pregnancy/now that you have had your baby. This questionnaire may help us suggest extra care for you if necessary. Your answers will be kept confidential. Please answer either **yes** or **no** to the following questions. **Tick the box.**

Question	Yes	No
1. I feel pleased about being pregnant/having had a baby.	Yes	No
2. I have had some very difficult things happen to me in the last year (e.g. losing someone close to me, losing my job, leaving home etc.)	Yes	No
3. My husband/boyfriend and I are still together.	Yes	No
4. I feel my husband/boyfriend cares about me (say 'no' if you are not with him anymore).	Yes	No
5. My husband/boyfriend or someone else in the household is sometimes violent towards me.	Yes	No
6. My family and friends care about how I feel.	Yes	No
7. I have experienced some kind of abuse in the past (e.g. physical, emotional, sexual, rape).	Yes	No
8. My family and friends help me in practical ways.	Yes	No
9. On the whole, I have a good relationship with my own mother (indicate 'no' if your mother has passed away).	Yes	No
10. I have experienced one of the following in the past: miscarriage, abortion, stillbirth, or the death of a child anytime after birth.	Yes	No
11. I have had serious depression, panic attacks or problems with anxiety before.	Yes	No

Step 1: Ask the mother the questions or leave her to complete it on her own

Make sure that she has ticked all the questions.

Step 2: Scoring

Questions 1, 3, 4, 6, 8 and 9

- **NO** answers to these questions indicate the woman is at risk
- give a score of 1 for each of these questions if the answer is NO
- **YES** answers to these questions indicate low risk
- give a score of 0 for each of these questions if the answer is 'yes'.

Questions 2, 5, 7, 10 and 11

- **YES** answers to these questions indicate the woman is at risk
- give a score of 1 for each of these questions if the answer is YES
- **NO** answers to these questions indicate low risk
- give a score of 0 for each of these questions if the answer is NO

Question	Yes	No
1	0	1
2	1	0
3	0	1
4	0	1
5	1	0
6	0	1
7	1	0
8	0	1
9	0	1
10	1	0
11	1	0

Step 3: Add up the scores

Based on the scoring instructions, add up the scores. Use the table to the left as a guide by counting the answers in the shaded areas. If a woman's total score is **3 or above** she needs to be referred to a counsellor.

Because this assessment identifies serious risk factors, **a referral is needed with a score of 3 or above, no matter what the mother's EPDS score is.**

The 5-item Short Risk Factor Screen

This shorter risk factor screening tool was developed in 2007 by the PMHP, **but it has not been validated.**

Information was collected from about 1000 women who had completed the EPDS and the 11-item RFA. By analysing the RFA against the EPDS, 5 questions were identified which could predict if a woman was at risk of mental illness. A research study is being done to try and validate this new short tool.

Question	Yes	No
1. Have you had some very **difficult** things happen in the last year?	Yes	No
2. Are you pleased about this pregnancy or now that you have had your baby?	Yes	No
3. Is your partner supportive?	Yes	No
4. Have you had problems with things like depression, anxiety or panic attacks before?	Yes	No
5. Is your partner or someone at home sometimes violent towards you?	Yes	No

For total, add the answers according to the shaded areas in the table above.

TOTAL: _____ / 5

Other risk? Yes / No

_____

_____

Action

_____

_____

Step 1: You may ask the mother the questions or leave her to complete the form on her own.

If a mother is finding it difficult to answer the questions, you may need to explain each one. Some examples are outlined here.

1. Have you had some very difficult things happen in the last year? For example:

- Losing someone close
- Losing a job, or a partner losing a job
- Moving home
- Illness in the home
- Divorce
- Being a victim of crime

2. Are you pleased about this pregnancy / now that you have had your baby?

- If still pregnant, this question refers to the current time, not how she may have felt when she found out she was pregnant.
- If the mother has already had her baby (postnatal), ask her the second part of this question: 'Are you pleased now that you have had your baby?'

3. Is your partner supportive?

Does the woman's partner provide the following type of support:

- Emotional: cares about her and/or the baby
- Financial: contributes money
- Practical: helps out at home

4. Have you had problems with things like depression, anxiety or panic attacks before?

Find out if the mother has had or has any significant history of mental illness where her symptoms:

- Required treatment (of any kind)
- Affected functioning at work or at home
- Caused her to take drugs or alcohol 'to cope'
- Affected her ability to care for herself or her family
- Lasted 6 months or longer

5. Is your partner or someone at home sometimes violent towards you?

This question refers to anyone, not just the mother's partner. It includes threats of violence.

Step 2: Add up the scores

- Give 1 point for each answer in the shaded boxes.
- 1 or above = risk for mental illness, the woman may need to be referred.

Note

If your unit has few resources for referral, perhaps raise the cut-off score and use 2/5 or 3/5.

Step 3: Other risks

Make a note of other risk factors such as adolescent pregnancy, refugee status, HIV status etc. See **Section 1.1** for a list of other risk factors.

4.4 Summary

- Screening can be an efficient way for busy health workers to identify women who are likely to suffer from a mental illness or who are at risk of developing a mental illness.
- Making screening a routine part of pregnancy care makes it more acceptable for mothers and health workers.
- Routine screening allows for many vulnerable mothers to be referred to other services and to have access to supportive care.
- Practical tips can make screening easier and more effective.

References

The information in this chapter draws from the following articles:

Cox JL, Chapman G, Murray D, Jones P (1996) Validation of the Edinburgh Postnatal Depression Scale (EPDS) in non-postnatal women. *Journal of Affective Disorders.* 39(3): 185-189.

Lawrie TA, Hofmeyer GJ, de Jager M, Berk M (1998) Validation of the Edinburgh Postnatal Depression Scale on a Cohort of South African Women. *South African Medical Journal.* 88(10): 1340-1344.