Edinburgh Postnatal Depression Scale (EPDS)

Your Name: _____ **Date Of Birth:** _____

Baby's Due Date Or Date Of Birth: _____ **Phone Number:** _____

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.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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

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

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:
   - ☐ Yes, very often
   - ☐ Yes, sometimes
   - ☐ Hardly ever
   - ☐ No, not at all

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

6. Things have been getting on top of me:
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ 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

SCORE: _____

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.

Instructions for using the Edinburgh Postnatal Depression Scale:

This scale is validated during pregnancy and the first year postpartum and can be provided to both pregnant and postpartum mothers for assessment. It is publicly available and validated in multiple languages which you can find online as needed.

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. The mother should complete the scale herself, unless she has limited English and cannot complete the scale in her native language, or has difficulty with reading.
4. **Always look at item 10 (suicidal ideation) before the mother leaves the office.**

Scoring

In this adapted version, all items are reverse scored, with the top box scored as a 3 and the bottom box scored as 0. Maximum score is 30.

Example scoring:

1. I have been able to laugh and see the funny side of things:
   - ☐ Not at all **(3 pts)**
   - ☒ Definitely not so much now **(2 pts)** **Respondent's score on this item = 2**
   - ☐ Not quite as much now **(1 pt)**
   - ☐ As much as I always could **(0 pts)**

Score	Interpretation	Recommended Clinician Action
0-9	Scores on the higher end of this range (~7-9) may indicate the presence of symptoms of distress that are less likely to interfere with day to day ability to function at home or at work.	Repeat scale at next appointment. In some cases, if these scores persist at higher end for two or more weeks, referral to a trained mental health professional for evaluation may be appropriate.
10+	Scores in this range indicate the likely presence of clinical depression (sensitivity, 85%; specificity, 84%), anxiety, or other psychiatric disorders.	Refer to a trained mental health professional for evaluation and treatment.
Item 10	Positive response on item 10 indicates presence of suicidal ideation.	Any respondent who scores 1, 2, or 3 on item 10 should be screened for suicide risk level before leaving the office. You may wish to use the attached Columbia Suicide Severity Rating Scale or SAFE-T card as guides. Follow your organization's suicide prevention policy or the example guidelines below.

Adapted by Reichenbacker, O. L. (2022)

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.

	Resources Available	Contact Information
Postpartum Support Virginia	Numerous resources to connect parents with mental healthcare and support during pregnancy and postpartum including: • Care coordination to get patients connected with mental health services. • Funding for perinatal mental healthcare and other support services and medical items (e.g. breast pumps, PP doulas) • Warmline for urgent mental health needs	Postpartumva.org Warmline: (703) 829-7152
Postpartum Support International	• Online and phone support groups for patients. • Directory of perinatal mental health providers and therapists • Professional consult line for perinatal mental health cases • Helpline for general perinatal mental health support.	Postpartum.net Helpline: 1-800-944-4773 (call or text)
National Maternal Mental Health Hotline	24/7, free, confidential support before, during, and after pregnancy Including: • Phone or text access to professional counselors • Response within a few minutes, 24 hours a day, 7 days a week • Referrals to local and telehealth providers and support groups	1-833-TLC-MAMA (1-833-852-6262)
MothertoBaby	Organization of Teratology Information Specialists resource site • Providers and patients can text, chat, or call to receive comprehensive information regarding medications in pregnancy and lactation.	Mothertobaby.org Talk with an expert: (866) 626-6847
MGH Center for Women's Mental Health	Reproductive Psychiatry Resource and Information Center: • Comprehensive summary analysis articles for both individual medications and groups of medications, email digest available	Womensmentalhealth.org
Brookside Psychiatric Specialists	Psychiatry services including: • Medication management with psychotherapy for Virginia patients who are pregnant or postpartum. • Other reproductive psychiatry services available (menstruation or perimenopause related concerns), care for dads and non-gestational parents.	www.brooksidepsych.com (757) 453-1256

SUICIDE RISK ASSESSMENT AND PREVENTION GUIDELINES – PRIMARY CARE

The following guidelines are adapted from those provided on the SAFE-T card and in the SAFE-T protocol.

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."

From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

Risk Level	Risk/Protective Factors	Suicidality	Possible Interventions
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt, or persistent ideation with strong intent, or suicide rehearsal	Inpatient admission generally indicated unless a significant change reduces risk. ☐ **Initiate local psychiatric admission process - send to ER or call emergency services and ask for CIT (crisis intervention team) officers who are trained to manage mental health crises.** ☐ **Stay with patient until transfer to higher level of care is complete.** ☐ **Follow-up and document outcome of emergency psychiatric evaluation.**
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Inpatient admission may be necessary in some cases depending on risk factors. Otherwise, develop a safety plan and refer for outpatient treatment. ☐ **Develop Safety Plan - directly address suicide risk, implementing suicide prevention strategies** ☐ **Give emergency/crisis numbers (e.g. NAMI Crisis Resource List for your area) and help patient understand how/when to use these resources.** ☐ **Outpatient referral to a trained mental health professional for evaluation and treatment**
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers ☐ **Give emergency/crisis numbers (e.g. NAMI Crisis Resource List for your area) and help patient understand how/when to use these resources.** ☐ **Outpatient referral to a trained mental health professional for evaluation and treatment**

RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

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SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1

IDENTIFY RISK FACTORS

Note those that can be modified to reduce risk

2

IDENTIFY PROTECTIVE FACTORS

Note those that can be enhanced

3

CONDUCT SUICIDE INQUIRY

Suicidal thoughts, plans, behavior, and intent

4

DETERMINE RISK LEVEL/INTERVENTION

Determine risk. Choose appropriate intervention to address and reduce risk

5

DOCUMENT

Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live

* *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition

* *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime**	
	Past 3 Months	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions