

**MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH (MDPH)
POSTPARTUM (PPD) DEPRESSION SCREENING TOOL GRID - 2015**

Screening tool	Additional Information ⁱ	Validity ⁱⁱ , Cut-offs ⁱⁱⁱ	Availability/Other information
BDI-II: Beck Depression Inventory (revised)	<ul style="list-style-type: none"> • self-admin • 21 items • 5 mins 	<ul style="list-style-type: none"> • BDI-II: Cutoff: 20 (MDD) Sensitivity 56-57%, Specificity: 97-100% 	<p>http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8018-370</p> <ul style="list-style-type: none"> • \$125 for manual and 25 record forms • available in Spanish • 5th - 6th grade reading level • includes assessment of certain somatic symptoms of depression which may overlap with normal postpartum experience
BDI-FS (formerly BDI-PC)	<ul style="list-style-type: none"> • self-admin • 7 items • < 5 mins 		<p>http://psychcorp.pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=015-8019-415</p> <ul style="list-style-type: none"> • \$102 for manual and 50 record forms
CES-D: Center for Epidemiological Studies Depression Scale	<ul style="list-style-type: none"> • self-admin • 20 items • about 5 mins 	<ul style="list-style-type: none"> • Cutoff: 16 • Sensitivity: 60% • Specificity: 90% 	<p>http://cooccurring.org/public/document/ces-d.pdf http://cooccurring.org/public/document/usingmeasures.pdf</p> <ul style="list-style-type: none"> • free • available in over 40 languages including Spanish, French, Russian and Chinese
EPDS: Edinburgh Postnatal Depression Scale^{iv}	<ul style="list-style-type: none"> • self-admin • 10 items • about 5 mins 	<ul style="list-style-type: none"> • Cutoff: 8.5-15 (MDD)—9 is recommended by EPDS toolkit; 2005 AHRQ review suggests ≥13 which is the most commonly used cut-off score • Sensitivity: 59-100% • Specificity: 49-100% 	<p>http://www2.aap.org/sections/scan/practicingsafety/toolkit_resources/module2/epds.pdf</p> <ul style="list-style-type: none"> • free • available in over 35 languages including Spanish, Portuguese, French, and Khmer • 3rd - 6th grade reading level • substitution of 3 item EPDS anxiety subscale proposed^v • developed by Cox et al in 1987; purposefully excludes somatic symptoms except for one item measuring sleep difficulties^{vi}

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PDSS: Postpartum Depression Screening Scale	<ul style="list-style-type: none"> • self-admin • 35 items • 5-10 mins 	<ul style="list-style-type: none"> • Cutoff: 60 (MnDD), 80 (MDD) • Sensitivity: 91-94% • Specificity: 72-98% 	<p>http://www.wpspublish.com/store/p/2902/postpartum-depression-screening-scale-pdss</p> <ul style="list-style-type: none"> • \$85 for kit: 25 AutoScore test forms and scoring manual • available in Spanish • 3rd – 7th grade reading level • explores “7 domains” of PPD
PHQ-9: Patient Health Questionnaire-9	<ul style="list-style-type: none"> • self-admin • 9 items • 5-10 mins 	<ul style="list-style-type: none"> • Cutoff typically ≥ 10^{vii} • Sensitivity: 75% • Specificity: 90% 	<p>http://www.phqscreeners.com/select-screener</p> <ul style="list-style-type: none"> • free • available in Spanish • staff- or self-scored <p>Multipurpose instrument used for screening, diagnosing, monitoring and measuring the severity of depression</p>

On a periodic basis, MDPH will conduct a literature search to determine if any newly validated screening tools could be considered for inclusion in the MDPH list of approved PPD Screening Tools. In addition, MDPH will consider any written requests for consideration of a validated PPD screening tool for inclusion in the MDPH list of approved PPD Screening Tools. If you are interested in submitting a request for consideration, please submit your request in writing along with the screening tool and any relevant clinical publications to ppd.regulations@state.ma.us. Do not consider your proposed request for consideration to be accepted by MDPH unless you receive express written approval for the consideration by MDPH.

ⁱNIHCM Foundation June 2010 Issue Brief: *Identifying and Treating Maternal Depression: Strategies & Considerations for Health Plans*, p 12.

ⁱⁱ Unless otherwise specified, sensitivity and specificity values obtained from: ACOG Committee Opinion Number 453, February 2010, “Screening for Depression During and After Pregnancy,” Vol. 115, No. 2, Part 1, pp 394-5.

ⁱⁱⁱ Unless otherwise specified, cutoff scores shown are from a 2005 review on PPD screening instruments (Boyd RC, Le HN, Somberg R. (2005) Review of screening instruments for postpartum depression. *Arch Womens Ment Health* 8: 141-153.) Cutoff scores are likely to differ in their utility with various populations— for example, one study found that among low-income, predominantly black, young urban mothers attending well-child visits, “optimal cutoff scores for the BDI-II (≥ 14 for Major Depressive Disorder (MDD) and ≥ 11 for MDD/Minor Depressive Disorder (MnDD)) and EPDS (≥ 9 for MDD and ≥ 7 for MDD/MnDD) were lower than currently recommended. For the PDSS, the optimal cutoff score was consistent with current guidelines for MDD (≥ 80) but *higher* than recommended for MDD/MnDD (≥ 77 .)” (Chaudron LH, Szilagyi PG, Tang W, Anson E, Talbot NL, Wadkins HIM, Tu X, Wisner KL. (2010) Accuracy of Depression Screening Tools for Identifying Postpartum Depression Among Urban Mothers. *Pediatrics* 125, 3:e609-e617.) Lower cutoff scores will increase sensitivity at the expense of specificity, while higher scores will correspondingly risk missing some depressed women but yield higher specificity. Clinical judgment is an essential complement to any screening tool score.

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^{iv} The EPDS is currently the most widely studied and widely translated PPD screening instrument; the most recent systematic review of studies validating the EPDS was published in 2009. In this review, they found marked heterogeneity between different studies with widely ranging sensitivities, specificities, and likelihood ratios. They concluded “the results of different studies may not be directly comparable and the EPDS may not be an equally valid screening tool across all settings and contexts...differences in methodology of the included studies are likely to account for the variation in results.” (Gibson J, McKenzie McHarg K, Shakespeare J, Price J, Gray R. (2009) A systematic review of studies validation the Edinburgh Postnatal Depression Scale in antepartum and postpartum women. *Acta Psychiatr Scand*; 119: 350-364.)

^v In sample of ethnically diverse, adolescent mothers, the EPDS-3 (anxiety subscale) had sensitivity of 95% and specificity of 80% for the full 10 item EPDS score ≥ 10 . (Kabir, K, Sheeder, J, Kelly, LS. (2008) Identifying Postpartum Depression: Are 3 Questions as Good as 10? *Pediatrics*;122; e696-e702.)

^{vi} Lawrie et al modified this EPDS item about sleep disturbance, which potentially overlaps with the normal postpartum experience, by adding the phrase, “not due to the baby.” (Lawrie TA, Hofmeyr 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: 1340-1344.)

^{vii} Scores of 5-9 on the PHQ-9 variously categorized as “watchful waiting” (and reevaluation) vs. part of “normal” category. For further discussion, see: Yawn BP, Pace W, Wollan PC, Bertram S, Kurland M, Graham D, Dietrich A. (2009) Concordance of Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire (PHQ-9) to Assess Increased Risk of Depression among Postpartum Women. *JABFM* 22,5: 483-491. Current “best practice guideline” said to be “brief, on-site clinical assessment” for women scoring above 5.

Developed by Alison Porter, Preventive Medicine Resident. Special thanks to Beth Buxton, Claudia Catalano, and Laura Miller for their assistance in creating this grid.