Identifying Barriers: Interpreting the Edinburgh Postpartum Depression Scale for Refugees

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Abstract

Introduction: Depression screeners are helpful tools in Health Care Workers at the Clinton Family Clinic's Women's Center show concern of the efficacy of the Edinburgh Postpartum Depression Screener (EPDS) when administered to their refugee patients. The idea behind this study is to investigate potential barriers in translating the screener to non-English speaking refugee patients that may lead to false positive or false negative scoring.

Methods: In efforts to measure barriers, concerns, and feedback, two surveys were developed; one of which was used to gauge Health care workers' concerns of the EPDS with the refugee population and to see the frequency of depression screener usage. The second survey explored whether culture, language, or education stood as a barrier in administering the EPDS questionnaire to non-English speaking refugees. A patient follow-up report was generated of patients scoring 10 or better on the EPDS to assess its ability to screen refugee patients.

Results: Of the health care workers, ten were surveyed; five had previous experience administering the EPDS to patients. Moreover, four of the five had experience with the EPDS. Fifteen Interpreters were surveyed, ten identified education to be the largest barrier and question six was the most problematic. The patient analysis revealed that there was no difference in patient follow-up outcomes in regards to the EPDS screening ability in comparing non-English speaking refugees with non-refugees.

Discussion: It is recommended that Health Care Workers utilize depression screening tools. Results showed evidence of provider concerns with interpreting the screener. Most of the interpreters' replies suggest that lack of patient education is the biggest barrier in interpreting the screener. Although it was thought that the EPDS was not effective in screening in refugee patients, the follow-up results suggest that it was able to screen refugee patients just as effectively as the non-refugee patients.

Key Words: Edinburgh Postpartum Depression Screener, Refugees and mental health, depression screening tools

Introduction

Refugees come to the US from traumatic situations of all forms. They are resilient people who have fled their homes and countries seeking refuge, escaping government persecution, wars, and or country instability. In the interim, they have endured violent acts, whether from personal experience or witnessed firsthand. According to the Universal Declaration of Human Rights, the definition of a refugee is "a person or persons that are owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside of the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country (1951 Cenvention Relating to the Status of Refugees, 2010)." Moreover, refugees epitomize survival; not only because of their traumatic pasts, but also for their strength and courage to embrace an entire new culture, language, and way of living; all in hopes of a better life and future for themselves and their family.

Mental Health and Refugees

The United Nations has declared refugees to be a global burden; therefore, 90% of the refugees resettle in the United States, Canada, and Australia (Frequently Asked Questions about Resettlement, 2012). Funding for the resettlement process for refugees is funded by the Department of State's Bureau of Population, Refugees, and Migration. Individuals who work with the refugee population make it a priority for refugees to adjust and become acquainted with the American culture, a process also known as acculturation. The course of acculturation produces a change in roles and priorities. Like with any culture, change produces stress; however, the reaction to stressors is what potentially leads to the adaptation. Contrarily, this process could be difficult and potentiate mental illnesses such as anxiety and or depression in a vulnerable population; depression can have an adverse reaction and lead to self-isolation and moreover hindrance of adaptation.

In a primary care setting, 13% to 22% of patients are diagnosed with a depressive disorder; unfortunately, only 50% of the cases are diagnosed (Simon, 1995). Because of this, screening for depression and posttraumatic stress disorder is important with the general population; and moreover, depression screening is imperative within the refugee population because of their history. According to the Canadian Collaboration for Immigrant and Refugee Health, screening for depression is difficult with the refugee population. It is complicated because most have comorbidities of depression and post-traumatic stress disorder (PTSD); furthermore, the website states that more than half of the refugees have PTSD (Evidence-Base Preventative Care Checklist for New Immigrants and Refugees, 2013). Depression prevalence statistics of the refugee population may be higher than reported due to the lack of access to

care and or failure to report their symptoms to their health care providers. Refugees may, (knowingly or unknowingly), suffer from depression, distress, PTSD, and or anxiety. The United States Preventative Services Task Force recommends the utilization of screeners for accurate identification of patients suffering from depression (Bienenfeld, 2014). They provide a quick means to screen for symptoms of depression and are normally a self-administered through a questionnaire in addition to a follow-up clinical interview is required for an official diagnosis. These are Common tools used for screening depression as well as the Patient Health Questionnaire-9 (PHQ-9) and the Refugee Health Screener-15 (RHS-15).

Background

The Edinburgh Postpartum Depression Scale (EPDS) is a self-administered examination that is used to screen pregnant women during pregnancy and is used post-pregnancy to detect signs and symptoms of depression. Due to possible existing socio-cultural differences within the Refugee population, the efficacy of the EPDS with refugee women is questionable. Discrepancies arise in the translation of the screener. Studies have identified barriers that reveal difficulties in translating the EPDS due to linguistics, lack of cultural competencies, and or educational background of the patient. It is not clear whether one distinct barrier, or a combination of all three barriers, hinder a successfully administered EPDS (Stapleton, 2013). Linguistically, when the screener is administered, the questions that are translated may lose their meaning. Cultural stigmas could pose as a barrier due to possible stigmas associated with mental illness that may exist within refugee communities, resulting in answers that reflect the patients' true feelings. Patient education also poses a barrier in that the patient may not understand the concepts covered in the screener.

At the Clinton Family Medical Clinic's Women's Center in Rochester, New York, the clinicians, social workers, and case workers use the EPDS with their prenatal, perinatal and postnatal patients. Whereby, much concern is expressed with the results of the screener specifically in relation to their refugee patients. The interpreters experience linguistic and educational barriers when verbally translating the screener, in addition to a concern that patients are not fully answering questions due to lack cultural competency of the EPDS. The intention of this project is to investigate the EPDS screener from the prospective of the health care workers and the interpreters from the clinics. Additionally, the study will follow-up with patients' data who were screened to see their mental health outcomes and treatment, an analysis that will assess if the EPDS successfully screened for depression with the refugee patients at Clinton Family Clinic's Women's Center.

Materials and Methods

Research Setting

This study was carried out in multiple settings. Some of the surveys were given at Penn Fair Primary Care, the Clinton Family Medical Clinic's Women's Center, and the Refugee Clinic at Rochester General Hospital. The remainder were given via telephone or email. The patient follow-up analysis was drawn from refugee patients seen and given an EPDS at Clinton Family Medical Clinic's Women's Center within the past 2 years. Also, medical information of non-refugee patients was retrieved as well for a potential comparison of the different cohorts. All of the women, however, scored a ten or higher on the EPDS. The minimal score of ten was used based on the protocol at Clinton Family Clinic's minimal score for mental health referral.

Research Study Design and Participants

In effort to gain perspective of the EPDS, this project was administered in three tiers: two surveys and a patient follow-up analysis. The surveys targeted healthcare professionals/social workers/case workers and medical interpreters to gain their perspective on the EPDS (See Appendix, Figure 1: Edinburgh Postpartum Depression Scale). For the sake of the study, this cohort of individuals surveyed will be referred to as 'health care workers'. The idea was to gauge potential barriers within the EPDS that could result in it being less effective with the refugee population. In addition, the study minimally investigates the prognosis of patients who were given the EPDS to assess its efficacy in screening for depression or anxiety within the refugee population.

Survey 1: The Healthcare Worker focused survey was given at random to healthcare professionals, social workers, and case workers (See Appendix, Figure 2: Health Care Worker Survey). This population was selected because the EPDS is mostly utilized in a clinical setting. First, the questions of the survey were constructed to measure how often the EPDS is used by healthcare professionals. If they have never administered the EPDS, then it further measured other depression screeners they may have had experience in using. Additionally, the survey was used to see if they have ever used the EPDS for refugee patients. Second, the survey used to measure the healthcare workers' confidence in the EPDS ability to screen for depression in English speaking patients and in Refugee patients. This survey overall assessed the prevalence that which the EPDS is utilized within departments of Rochester General Hospital network.

Survey 2: The Interpreter focused survey was given to the interpreters mostly used within the Rochester General Hospital system, including the clinical sites (See Appendix, Figure 3: The Interpreter Survey). In aim to measure barriers within the translating realm of the screener, interpreters were asked about their familiarity with the EPDS; moreover, their opinions were measured based on which questions of the screener is are not culturally sensitive and if it encompasses areas difficult to translate due to linguistic barriers. The survey was used to inquire about areas of the EPDS that may be difficult to translate because of lack of education of the patient. Furthermore, the survey measured their opinions of the largest barrier in translating the EPDS: culture, language, or lack of patient education. Lastly, the survey assessed whether difficulty in translating questions or translating the answer choices was hardest. It was not a criteria that the interpreters have experience with the EPDS; a copy of an EPDS was given to those who lack experience with it. Overall, this survey was given in hopes that the interpreters prospective would provide evidence of linguistic, cultural, and or educational barriers within the EPDS.

Patient follow-up analysis: The idea of the follow-up analysis is to gauge the efficacy of the EPDS with the refugee patient population. The analysis investigates refugee patients that speak either Nepali, Karen, Spanish, or Burmese and aims to compare them to English speaking patients. All of the patients in this study were seen at the Clinton Family Medical Clinic's Women's Health Center. The patients were randomly selected from a refugee cohort that scored a 10 or higher on the EPDS. This tier of the project studies the actions taken post-EPDS, observes if a mental health diagnosis of depression or anxiety and patient utilization of mental health services.

Data Analysis

The data was analyzed using Microsoft Excel. Percentages and graphs were generated using the program in efforts to see any trends and or differences with the survey responses and with the patient data.

Results

Data was obtained via surveys and electronic medical record (EMR) systems. The surveys are based on the EPDS, which can be found in the Appendix (See Figure 1). The surveys constructed to measure and gain feedback based on the EPDS can also be found in the Appendix (See Figures 2 & 3).

Health Care Worker Survey

The Health Care Worker survey was given to ten employees of the Rochester General Hospital. Their exact locations of employment varied; they were randomly selected from the Clinton Family Clinic's Women Center, the Refugee Clinic, and Penn Fair Primary Care. Experience with the EPDS was

not a requirement for this survey. Occupations of the health care workers varied; the survey was given to one physician, four physician assistants, three nurse practitioners, one social worker, and one health educator/case manager (See Figure 4 below).
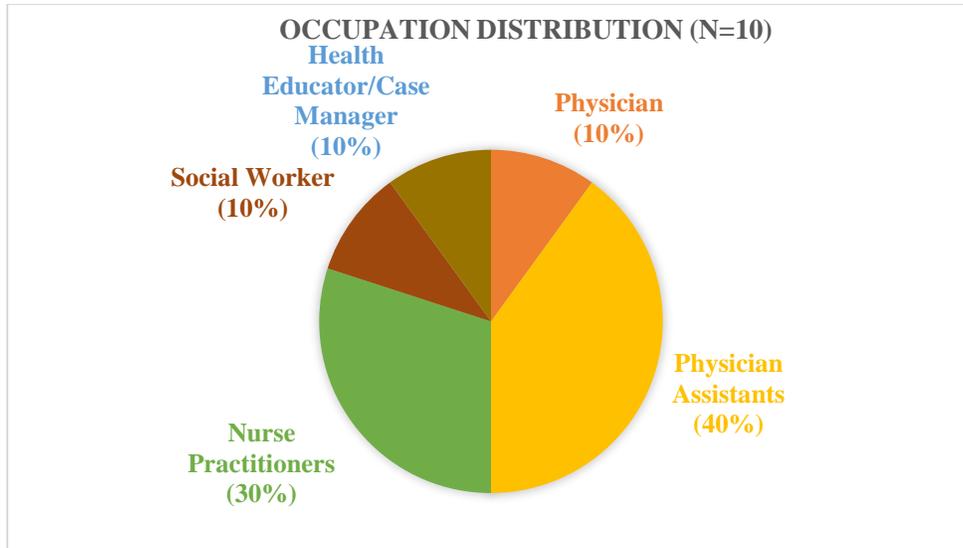

Figure 4 illustrates the distribution of the different occupations of the people that were surveyed. A total of ten people were surveyed.

The first couple questions address if the Health Care Workers have ever used the EPDS screener. Five of the ten people surveyed had used the EPDS in the past. Interestingly, one person who has never used the EPDS, had experience with the Patient Health Questionnaire-2 (PHQ-2) and another, used the RHS-15. The next question aimed to get an assessment of Health Care workers who have used the EPDS with a non-English speaking patient and required an interpreter; out of the five people that used the EPDS at least once in the past, four have used it with an interpreter (see Table 1 below for a complete summary).

Survey Questions	Yes		No	
Have you ever administered an EPDS? (n=10)	50%	5	50%	5
Have you ever required an interpreter's assistance in administering an EPDS? (n=10)	40%	4	60%	6

Table 1. Summary of results from the first part of the Health Care Worker survey (n=10). This particular part assess the Health Care Workers utilization of the EPDS screener.

The next set of questions were geared towards the assessment of confidence that the Health Care Workers had in the EPDS ability to screen for depression or anxiety. Looking solely at the Health Care workers' that have administered the EPDS, responses showed that 40% replied that the Edinburgh was "somewhat" reliable and 60% that it was "mostly" reliable, when give to English speaking patients.

Moreover, when given to refugee patients that did not speak, read or write English, 50% of the health care workers replied that it was "somewhat" reliable, 25% replied it was "mostly" reliable, and 50% replied that it was never reliable (see table 2 below for summary).

Survey Questions	Never	Somewhat	Mostly	Always
The EPDS is reliable when administering it to my English speaking Patients? (n= 5)	0	2	3	0
The EPDS is reliable when administering it to my refugee, non-English speaking Patients? (n=4)	1	2	1	0

Table 2. Summary of results from the second part of the Health Care Worker survey. These questions assess the opinions of those Health Care workers that utilize the screener. Note: the first question, five Health Care Workers actually used the EPDS; the second question, only four Health Care Workers have used the EPDS with at least one refugee patient.

Interpreter Survey

The Interpreter survey was used to gauge barriers that rise when interpreting the EPDS. Fifteen interpreters were surveyed, each interpreting for either Somali, Spanish, Burmese, Nepali, or Karen (see figure 5 below). The number of years of interpreting experience ranged from 0.75 years to 25 years; cumulatively, the average number of years interpreting is 5.7. Out of the fifteen interpreters, seven had previously interpreted the EPDS.

WHICH LANGUAGE(S) DO YOU INTERPRET?
(N=15)

Somali (1) 7%
Karen (2) 13%
Spanish (4) 27%
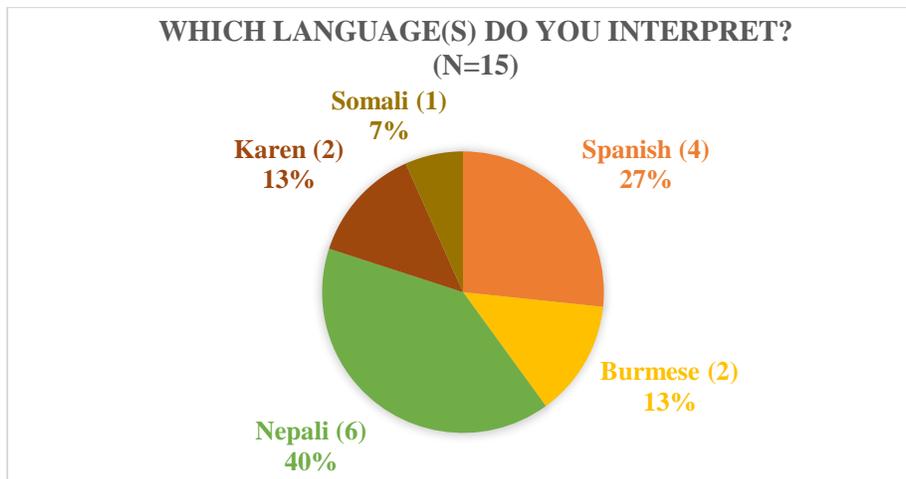Burmese (2) 13%
Nepali (6) 40%

Figure 5 illustrates an overview of the languages the interpreters medically interpret in a health care setting. Of the interpreters, four were Spanish speaking, two were Burmese speaking, six were Nepali speaking, two were Karen speaking and one was Somali speaking. (n=15)

The next part of the survey was structured to identify potential barriers that may hinder successfully interpreting the EPDS. When surveying the potential cultural barriers, thirteen of the interpreters felt the EPDS was culturally sensitive. When measuring whether or not the interpreters felt patient education posed as a barrier to interpret the EPDS successfully, there was a difference in opinion. Of the fifteen, seven felt that either question one, two, three, four, or six were or would be difficult to translate if the patient was not educated. Subsequently, the survey aimed to gauge if language posed as a barrier in interpreting. Ten of the fifteen interpreters said no, there was not a question that posed a language barrier. Contrarily, five of the fifteen felt that questions one, three, four or six do not directly translate and therefore translating the questions would lead to losing the initial meaning of the question (see table below for summary).

Survey Questions:	Yes		No		If yes, which questions
Have you ever interpreted the EPDS?	47%	7	53%	8	
Do you feel the EPDS is not culturally sensitive?	13%	2	87%	13	3 & 6
Is the EPDS difficult to translate due to lack of patient Education?	47%	7	53%	8	1, 2, 3, 4 & 6 *Note: 6 was a response 3 times
Do you feel the EPDS is difficult to translate because of Language barriers?	33%	5	67%	10	1, 3, 4, & 6 *Note: 6 was a response 2 times

Table 3 is a summary of the responses from the Interpreter survey. Fifteen interpreters were surveyed in the study.

When assessing the overall opinions of the EPDS, four of the fifteen said that language is the biggest barrier; ten stated that education was the biggest barrier, and one felt there was a cultural barrier that made it difficult to translate.

WHAT IS THE BIGGEST BARRIER IN TRANSLATING:
LANGUAGE, CULTURAL, OR EDUCATION

Language
(4)
27%

Cultural (1)
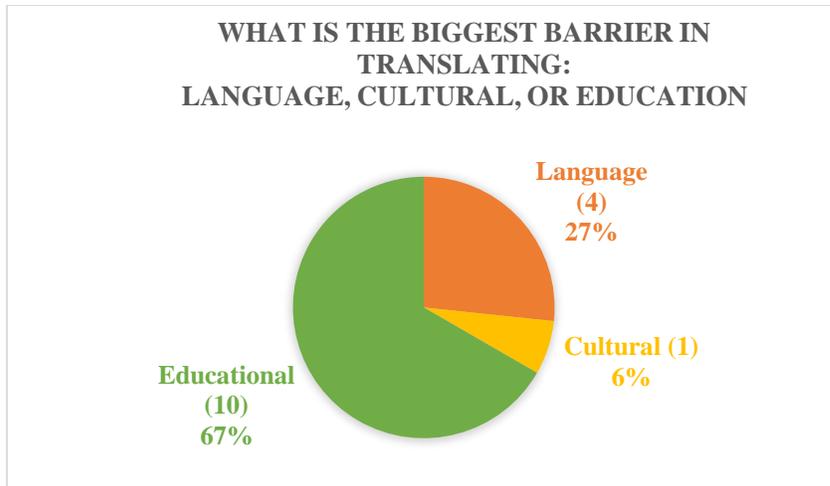6%

Educational
(10)
67%

Figure 6 illustrates the overall opinion of the interpreters based on the potential barriers that would make translating the EPDS difficult. Four interpreters replied that language posed as a barrier, one interpreter replied that there are cultural barriers, and ten replied that education posed as the biggest barrier.

Lastly, the survey measured if the questions or the answer choices were more difficult to interpret. Four of the interpreters stated the questions were more difficult to translate, six stated that the answer choices are more difficult to interpret, and five stated that neither the questions nor the answers would be difficult to interpret.

DO YOU FEEL THE QUESTIONS OR THE ANSWERS
ARE THE BIGGEST BARRIER IN TRANSLATING?

Neither (4)
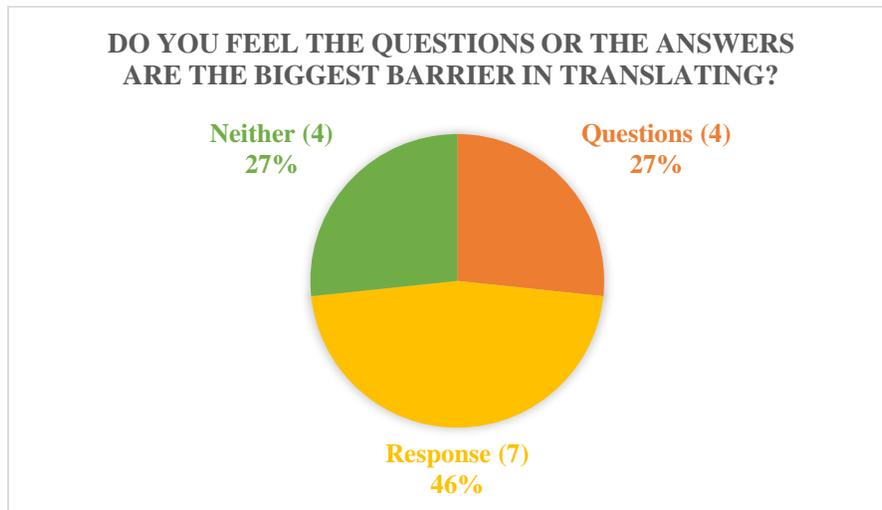27%

Questions (4)
27%

Response (7)
46%

Figure 7 illustrates the interpreters' responses in regards to what posed as the biggest barrier in translating the EPDS.

Patient Data Analysis

For the patient analysis portion of the project, fourteen prenatal, perinatal, and postnatal patients that were seen at the Clinton Family Clinic Woman's Center were chosen. Selection criteria included

patients that were given the EPDS and scored 10 or higher were selected; eight patients from the refugee patient population and seven from the English or Spanish patient population. Of the fourteen women, one spoke Burmese, five spoke Nepali, two spoke Karen, one spoke English and five spoke Spanish. The women that spoke Burmese, Nepali, and Karen were refugees and spoke very minimal English. Four patients spoke primarily Spanish but also spoke English, and one patient spoke only English (see figure 8 below).

NATIVE LANGUAGE

English (1) 7% **Burmese (1)** 7%

Spanish (5) 36%

Nepali (5) 36%

Karen (2) 14%
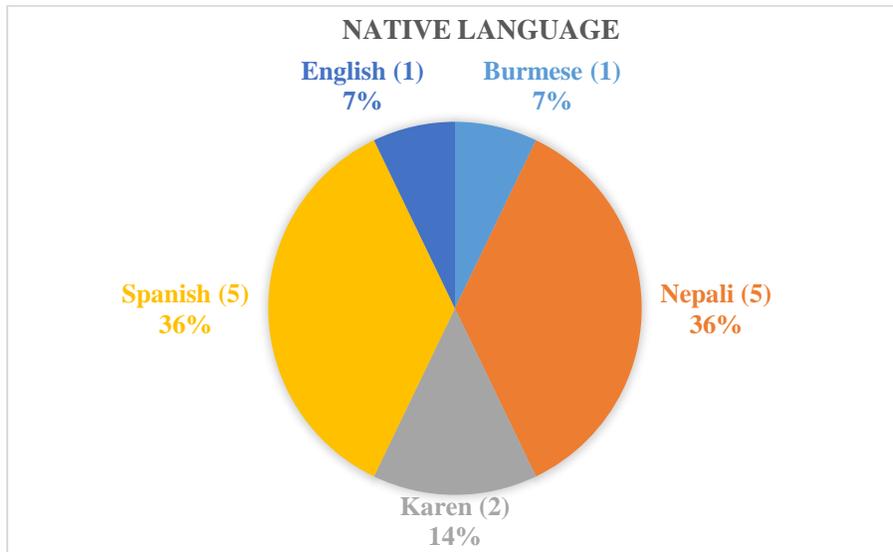
Figure 8 shows the distribution of the primary language that the women in study spoke. (n=14)

As for demographics of the patients analyzed, the average age of the patients analyzed was 29.4 years of age. The age range was 23-38 years. The refugee women were slightly older than the non-Refugee cohort. The average age of the refugees was 32.8 compared to the non-refugee group having an average age of 25. The EPDS range of the entire group was 10 to 24; the average score of all the women selected was 16.4. The refugee average score was 13.9; whereas the non-refugee average EPDS score was 19.8. Action taken post EPDS, were eleven referrals to mental health, two declined wanting to go to mental health, and one contemplated going to mental health (see Table 4 and Figure 9 for an overview of this data.)

Row Labels	Average of Age	Average of Edinburgh Score
Non-Refugee	**25**	**19.8**
Referral	25	19.8
Refugee	**32.8**	**13.9**
Contemplating	26	12
Declined	36	17
Referral	32.8	13
Contemplating Count	1	1
Declined Count	2	2
Referral Count	11	11
Grand Total	**29.4**	**16.4**

Table 4 shows comparisons of the Refugee versus the non-Refugee patients. It give a breakdown of statistical analysis based on age, EDPS score, and clinical action taken with the patients.

	Referral	Contemplating	Declined	Referral
	Non-Refugee		Refugee	
Average of Age	25	26	36	32.8
Average of Edinburgh Score	19.83333333	12	17	13
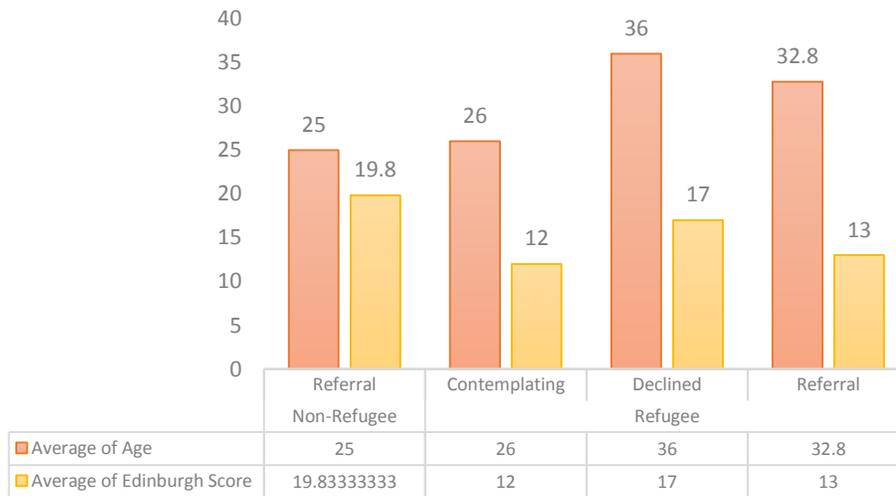
Figure 9 further breaks down the data in that it illustrates average age and EPDS score per action taken post EPDS scoring. Overall, these items are compared based on Refugee versus non-Refugee patients. Note that the number above each column is indicative of the average for that category.

Of the fourteen patients, ten were diagnosed with some form of depression and or anxiety, two were not diagnosed with a mental illness, one had not been diagnosed yet, and one diagnosis was unknown. Of the patients, six were prescribed an anti-psychotic medication because of their diagnosis, seven were not prescribed an anti-psychotic medication, and one was unknown. Although all of the non-

Refugee group that was diagnosed with depression and or anxiety, two patients that were not diagnosed utilize mental health services; whereas the two that take psychotic medications do not use mental health services. Overall, ten of the fourteen patients utilized mental health services, three did not, and with one patient it is not known whether or not she sees a mental health care provider.

| | Diagnosis Given | | |
	Yes	No	Unknown
Non-Refugee	**6**	**0**	**0**
Depression	5	0	0
Depression/Anxiety	1	0	0
Refugee	**4**	**3**	**1**
Anxiety	1	0	0
Depression	1	0	0
Depression/Anxiety	2	0	0
None	0	3	0
Unknown	0	0	1
Grand Total	**10**	**3**	**1**

Table 6

	Psych Meds	Utilize Mental Health Services
Non-Refugee	6	6
Refugee	4	4
Grand Total	**10**	**10**

Table 7

Figure 10

Table 6 breaks down the number of Refugees versus non-Refugees that were given a diagnosis of depression and or anxiety.

Table 7 shows the number of patients that were on psychotic medications and that utilize mental health services.

Figure 10 illustrates a count of number of patients diagnosed with depression and or anxiety of the two groups, refugee versus non-refugee.
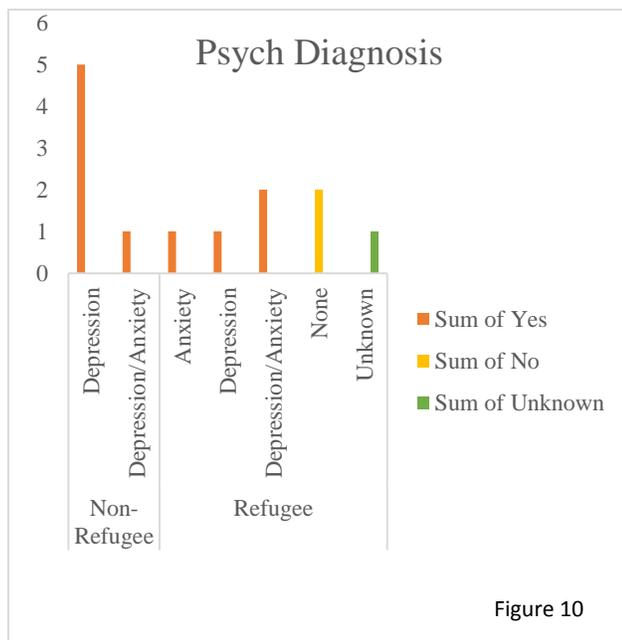
Lastly, when looking at history of physical and drug abuse, the refugee women did not admit to either types of abuse. On the other hand, the non-refugee cohort had two girls who openly admitted to being physically and or sexually abused; one of which also admitted to cigarette and marijuana use during pregnancy.

Discussion

Depression is a serious condition that effects individuals worldwide. Many people suffer from depression and either do not realize that they are depressed and or they are in denial about their condition. If not treated, it can result in suffering that could potentiate an individual harming themselves and or others around them. If treated, depression potentially has a promising prognosis. The challenge is catching these individuals when they present in clinics or doctor's appointments. Because these cases are not always obvious, it is important and highly recommended that clinicians to utilize depression screeners to improve the detection of depression.

In this study, it was evident that half the health care workers surveyed did not use a depression screening tool. It is understandable that some providers are very intuitive when it comes to their patients and therefore do not need to use a screener. However, for those that are not as intuitive, screeners can be very helpful identifying emotions and feelings that suggest depression. Additionally, they can serve as a tool to measure progress. Moreover, the screeners provide a platform of discussion for the patents' post-screener follow-up with their health care provider, which leads to the necessary supplemental treatment plan.

It is important that depression screeners are able to screen in patients of all cultural backgrounds. This will elicit clinical confidence in the screening tool and lead to widespread utilization at clinical practices. At the Clinton Family Clinic Women's Center in Rochester, New York, they use the Edinburgh Postpartum Depression Scale with their pregnant patients. The health care workers at the clinic showed much concern of the screener with their refugee patients. Consequently, this led to them not having much confidence in the reliability of the screener for the refugee population subset.

Many factors come into play when administering depression screeners to non-English speaking refugee patients that lead to questionable EPDS results. Providers surveyed in this study expressed concerns such as: timing of the administered EPDS, lack of patient education, cultural insensitivity of the screener, and difficulties in interpreting concepts within the screener. Timing in this case is in reference to the patient having a bad day and or week that could misconstrue results, leading to a false positive screen. Also, the EPDS is intended to be a self-administered screener. When the screener is administered to a non-English speaking refugee patient, the requirement of an interpreter introduces other factors that may

produce a false positive or false negative EPDS. For instance, the Rochester refugee community is such a small community in that the likelihood of the patient knowing the interpreter outside of work is somewhat likely, which could cause the patients to hesitate in expressing true feelings because of their acquaintances. This idea was not explored within this study. In fact, for future studies it would be interesting to get feedback from the patients in regards to this process. Overall, the health care workers, in these scenarios, have much trust in and rely heavily on the interpreter ability to understand the screener enough to interpret the questions and the patients' responses. Health Care workers in this study also fear that the patients are completing the screener questionnaire without completely understanding the questions or answer choices being presented to them.

The Health Care workers had much concern about the screener being culturally sensitive, and exploring if there are cultural stigmas associated with depression and or anxiety. Additionally, they were interested in discovering potential barriers that bring about difficulties for the interpreters. These concerns led to attaining prospective from the interpreters. Although majority of the interpreter expressed that the screener was culturally sensitive, language and patient education gained the much feedback. Most of the interpreters made it clear that lack of patient education made interpreting the EPDS most difficult and time consuming due to having to explain concepts in detail. The linguistics of the screener, however, the interpreters commented that question six (see Appendix, Figure 1) lost its meaning when translating "things have been getting on top of me". One of the interpreters stated that the concept, "good reason", (that is used in questions 3 and 4) is hard for the patient to decipher; providing examples would assist the interpreter in clarifying for the patient. It seems that interpreting the answer choices was a challenge as well. Another interpreters responded that "[the answer choices] have some quantitative expectation about the question that may not be obviously clear to the [Nepali] patients." Moreover, another interpreter replied that "the first and last answer choices clear and easy to interpret. However, it is helping the patient understand the difference between the middle two answer choices that is challenging and or problematic."

Although there was much concern of the validity of the EPDS in regards to the refugee patients, in comparison to non-refugee patients, their follow-up prognosis were very similar. This suggests that the screener was valid in detecting depression and or anxiety amongst the refugee cohort. Moreover, results showed that the patients are receiving treatment and are, for the most part, utilizing mental health services.

A history of trauma can potentiate depression. Knowing that refugees may come from traumatic backgrounds, the study explored the history of physical abuse and or substance abuse experienced by the patients. Interestingly, none of the refugees reported either type of abuse. Moreover, abuse was identified in the non-refugee patient subset.

Future Recommendations

The Clinton Family Clinic Women's Center is located in an underserved area. Socio-economic standards are most likely similar for the patients seen at this particular clinic. It would be interesting to repeat this study in different sites. This would identify whether the results are distinctive or unique to this Rochester community or if they are more widespread. Repeating the study would eliminate confounding variables to help validated the ideas that the study's results presented.

This study solely explored those patients that scored ten or above on the EPDS. Moving forward, it would be very interesting to see if there are any refugee and non-refugee patients that suffer from depression, but contrarily scored below a ten on the EPDS. This would examine if the EPDS is failing to screen depression cases.

Conclusion

This project explored many factors that may hinder accuracy of the EPDS. These factors show varying effects patient to patient. Keeping in mind that no screener is perfect, results from this study show that it is somewhat effective. However, discretion should be used when working non-English speaking patients, like the refugee populations. Clinicians should keep in mind the concepts explored in this investigation. Although EPDS results are questionable to some providers, it is a useful screening tool. To determine the best fit depression screener for refugees, more research should be carried out.

References

1951 Cenvention Relating to the Status of Refugees. (2010). Retrieved from UNHCR: www.unhcr.org/3b66c2aa10.html

Bienenfeld, D. a. (2014). *Screening Tests for Depression*. Retrieved July 2014, from Medscape: http://emedicine.medscape.com/article/1859039-overview

Evidence-Base Preventative Care Checklist for New Immigrants and Refugees. (2013). Retrieved from CCIRH Migreant Health Knowledge Exchange Network: http://www.ccirhken.ca/ccirh/checklist_website/en/recommendations/depression.html

Frequently Asked Questions about Resettlement. (2012). Retrieved from UNHCR: www.unhcr.org/4ac0873d6.html

Simon, G. a. (1995). Recognition and Management of Depression in Primary Care. *Arch Family Medicine, 4*, 99-105.

Stapleton, H. M. (2013). Lost in Translation: Staff and Interpreters' Experiences of the Edinburgh Postnatal Depression Scale with Women from Refugee Backgrounds. *Issues in Meantal Health Nursing, 34*, 648-657.

Appendix

Figure 1

Edinburgh Postnatal Depression Scale₁ (EPDS)

Name: _____   Address: _____
Your Date of Birth: _____   _____
Baby's Date of Birth: _____   Phone: _____

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
- [x] Yes, most of the time   This would mean: "I have felt happy most of the time" during the past week.
- [ ] No, not very often   Please complete the other question in the same way.
- [ ] No, not at all

In the past 7 days:

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
   - [ ] Rather less than I used to
   - [ ] Definitely less than I used to
   - [ ] Hardly at all

*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

*6. Things have been getting on top of me
   - [ ] Yes, most of the time I haven't been able to cope at all
   - [ ] Sometimes I haven't been coping as well as usual
   - [ ] No, most of the time I have copied 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

Administered/Reviewed by _____   Date: _____

Score: _____   Action Taken: _____

1Source: 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.

2Source: K.L. Wisner, B.L. Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Figure 2

I am conducting this survey as a part of my Independent Learning Service project for the Primary Care Leadership (PCLP) commitment. The aim of this survey is to assess Health Care Provider's attitude towards the Edinburgh Postpartum Depression Scale when administering to English speaking patients, and if applicable to Refugee Nepali speaking patients.

Health Care Provider Survey

Title: _____

Have you ever administered an Edinburgh Postpartum Depression screener?   Y   N

    If no, list the depression screeners that you use or have used in the past:

_____

Have you ever administered an Edinburgh Postpartum Depression screener that
required an interpreters assistance?   Y   N

When I administer the Edinburgh to my English speaking patients, I feel it is... (Circle one)

    a. Never Reliable   b. Somewhat Reliable   c. Mostly Reliable   d. Always Reliable

    e. Not Applicable, I've never administered an Edinburgh screener

When I administer the Edinburgh to my Refugee, non-English speaking patients,
I feel it is

    a. Never Reliable   b. Somewhat Reliable   c. Mostly Reliable   d. Always Reliable

    e. Not Applicable, I've never administered an Edinburgh screener

Additional Comments:

_____

_____

Thank you for participating in this survey. If you are interested in the results of this study, then I will happily send them to you. (Please check below)

___ Yes, I am interested in the outcome of the survey. My email is: _____
___ No, I am not interested

Figure 3

I am conducting this survey as a part of my Independent Learning Service project for the Primary Care Leadership (PCLP) commitment. The aim of this survey is to assess certain barriers that interpreters may encounter when administering the Edinburgh Postpartum Depression Scale.

Interpreter Survey

How many years of experience do you have interpreting? _____

What language(s) do you to interpret?

_____

Have you interpreted the Edinburgh for a patient?   Y   N

Is there a question on the Edinburgh that you feel is not culturally sensitive?   Y   N
(For example, you feel the patient will be offended when you translate the question.)
    If yes, which question number?   _____

Is there a question on the Edinburgh that you feel is difficult to translate due
to lack of patient education/understanding?   Y   N
(For example, the patient will not understand the question.)
    If yes, which question number?   _____

Is there a question on the Edinburgh that you feel could be difficult to translate
because there is not a direct translation?   Y   N
(For example, translating the question directly will result in it having a different meaning.)
    If yes, which question number?   _____

Which is the biggest barrier when translating for patients? (Circle one)

    a. Language   b. Cultural   c. Educational

Which is harder to translate? (Circle one)

    a. The Edinburgh questions are more difficult to translate
    b. The patients' response is more difficult to translate
    c. Not applicable

Additional Comments:

_____

_____

Thank you for participating in this survey. If you are interested in the results of this study, then I will happily send them to you. (Please Check below)

___ Yes, I am interested in the outcome of the survey. My email is: _____
___ No, I am not interested