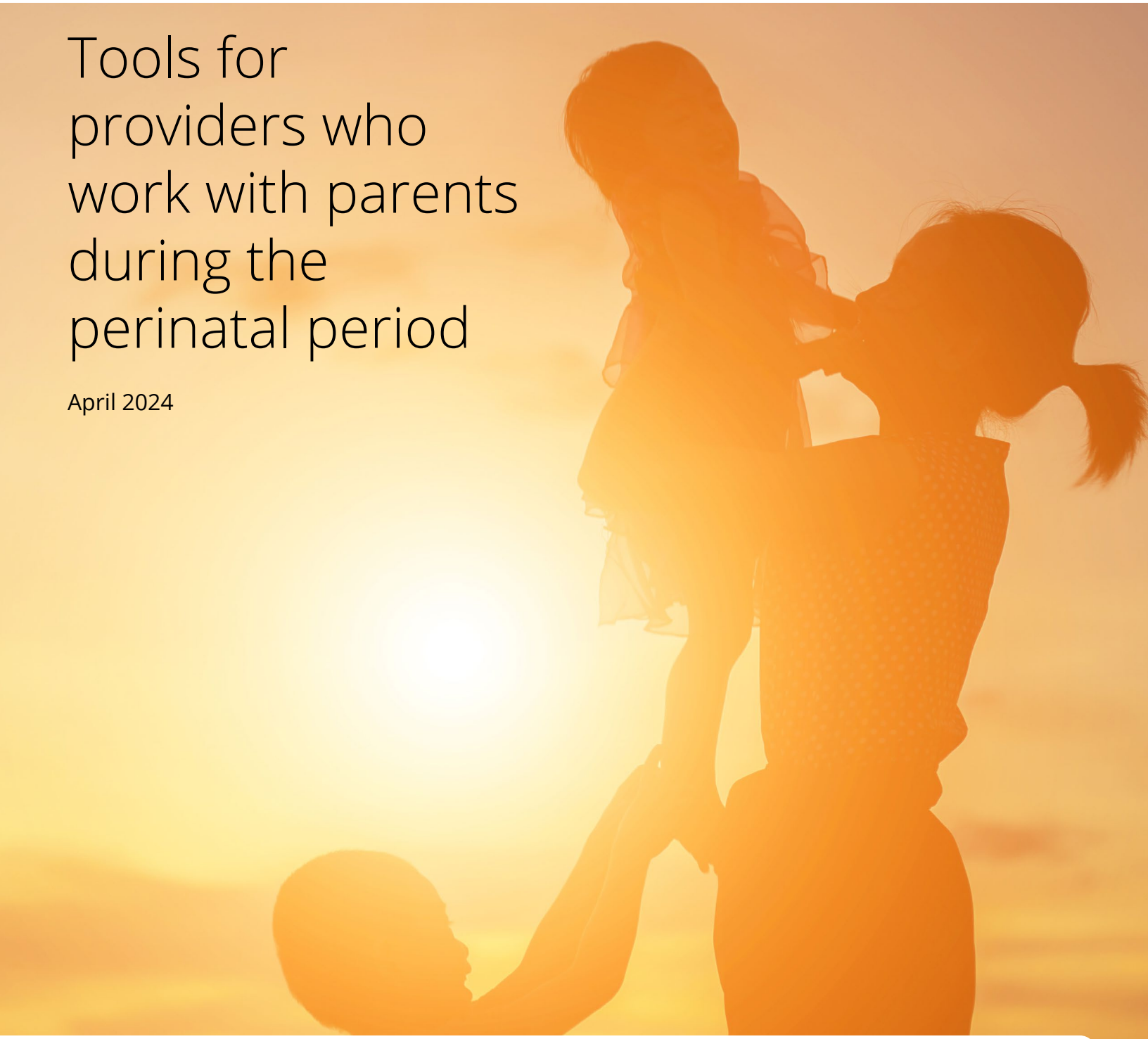
Utah maternal mental health toolkit

Tools for providers who work with parents during the perinatal period

April 2024



Created by the Utah Women and Newborns Quality Collaborative (UWNQC) Maternal Mental Health Subcommittee

Utah Department of Health & Human Services

Dear provider,

On behalf of the Utah Department of Health and Human Services and the Maternal Mental Health Subcommittee of the Utah Women and Newborns Quality Collaborative (UWNQC), we are pleased to provide you with the Utah Maternal Mental Health Toolkit: tools for anyone working with perinatal parents and their children. The toolkit provides information on how to identify and treat perinatal mood and anxiety disorders. As a healthcare provider, you are in a unique position to help women and their families face these challenges.

In Utah, at least 44.8% of new mothers will experience symptoms of depression or anxiety in the 3 months before birth, during pregnancy, or postpartum (Pregnancy Risk Assessment Monitoring System Perspectives 2018-2020). The rates of these conditions increase to 30-60% in highest risk populations such as women younger than age 24, those who are under- or uninsured, and people who have unintended pregnancies. Anxiety is even more prevalent than depression in pregnant women in Utah.

The impact of untreated perinatal depression and anxiety cannot be overstated. Left untreated, depression in mothers and other caregivers can put a strain on relationships at home, in addition to negatively impacting all aspects of the young child's development.

If you have any questions regarding this toolkit or the UWNQC Maternal Mental Health initiative, contact the Utah Department of Health and Human Services Maternal and Infant Health Program at rhpweb@utah.gov.

Sincerely,

The UWNQC Maternal Mental Health Subcommittee

The Utah Women and Newborns Quality Collaborative Maternal Mental Health Toolkit would not have been made possible without the tireless work from dedicated volunteers. A special thank you to the following people:

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Position statement

Position statement: screening for perinatal depression & anxiety

This Utah Women and Newborns Quality Collaborative (UWNQC) position statement explores the rationale and recommended plan for routine screening of pregnant and postpartum women for perinatal mood disorders including depression and anxiety.

Perinatal mood and anxiety disorders include major depression, generalized anxiety disorder, panic disorder, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), bipolar I and II, and psychosis. Although these conditions are not uncommon in the general population, they may go undetected or improperly treated due to their unique presentation in the perinatal period. For example, perinatal depression often includes an agitated or anxious component, intrusive thoughts that may not meet the criteria for OCD, as well as anger and rage. Women may think that excessive worry is "normal." Their symptoms may be dismissed merely as normal new parent worries or even the "baby blues" (which occurs in about 80% of women, and only lasts for 2 weeks or less after delivery or postpartum).

Mental health conditions, including depression and anxiety, are the leading complication of childbirth (Gavin et al., 2005; Wisner et al., 2006). When left untreated, they can have a significant negative impact on pregnancy and birth outcomes, maternal mortality and morbidity, infant and child development, and overall family life.

Unfortunately, perinatal mood and anxiety disorders are often missed or improperly diagnosed and subsequently, left untreated. Screening for these conditions is recommended by all major health authorities including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, United States Preventative Services Task Force, and Centers for Disease Control and Prevention. Screening and proper treatment improves health outcomes for moms and babies.

In Utah, pregnancy and the birth of a child are of special importance as Utah has the highest childbirth rate in the nation per capita (U.S. Census Bureau)— at around 50,000 births each year in Utah.

Providers have a responsibility to:

1. **Educate families on mental and emotional health—and that perinatal mood disorders are common and treatable.**
2. **Help women identify if and when they are not feeling like themselves.**
3. **Seek appropriate, timely help to minimize the duration and impact of maternal mental health conditions on their patients.**

Providing education and open, judgment-free conversations with patients and their families can help us collectively address the stigma around perinatal mental health. We can systematically begin to help families prevent and self-identify maternal mental health issues as well as create safe environments for them to openly ask for help.

Misconceptions about perinatal mood disorders by both providers and families may delay or interfere with adequate treatment. Additionally, stigma around mental and emotional health; lack of access to care with long wait times and lack of specialists; dismissive messages from community members, peers, and family; and the fear that a child could be removed from the mother or family are additional barriers to help-seeking.

The Pregnancy Risk Assessment and Monitoring System (PRAMS) surveys women who have recently given birth in Utah.

One respondent to the Pregnancy Risk Assessment and Monitoring System (PRAMS) Survey said,

"I would like to have [my] Dr. more open about being depressed or anxiety issues. It's hard as a woman/person to break down & admit they are having these feelings or issues. I felt dumb and that my feelings and thoughts would get better by the way I was brushed off...I think more women suffer with this and are afraid to say something & when you build up the nerve to finally say something and not feel heard, it was hard."

Diagnostic limitations abound, as current coding systems allow for only the first 6 weeks postpartum to meet criteria for "with postpartum onset." Despite this, perinatal experts agree that the postpartum period extends to at least 1 year after delivery and through weaning if the person is breastfeeding due to the potential hormonal implications of lactation. A recent study[1] showed that maternal depression persisted up to 3 years postpartum in one-fourth of the moms who participated in the study. A report from the Utah Perinatal Mortality Review Committee shows the majority of maternal deaths occurred between 43 and 365 days postpartum, and unsurprisingly, a history of mental illness was present in 75% of deaths during that time period.[2] For this reason, primary care and public health settings must be equipped to identify, screen, and treat these common illnesses. These conditions are treatable and patients respond well to appropriate treatment.

This toolkit includes Utah-specific materials as well as nationally recognized tools and recommendations, borrowed with permission by other experts. It also provides clinical information and considerations as well as links to resources for creating a workflow that is manageable in a variety of settings.

Facts to keep in mind as you develop a screening system in your office:

- Depression is the #1 complication of childbirth, affecting 1 in 7 women nationally with around 40% beginning during pregnancy.[3, 4]
- Accidental drug overdose and suicide are the top leading causes of death for Utah women during the perinatal period.[2]
- Only about half of Utah women who have perinatal anxiety will receive the help they need (PRAMS).
- The impact of untreated depression or anxiety during pregnancy includes higher rates of premature labor, cesarean sections, preeclampsia, and lower Apgar scores.[4, 5, 6]
- Perinatal mental illness negatively impacts infant, child, and adolescent development as well as mental health in adulthood.[7]
- Of depressed perinatal women, up to one in five may have thoughts of harming themselves.[3]
- In the largest study thus conducted with a clinical assessment of perinatal women, 20. percent of the group studied was diagnosed with bipolar disorder.[3]
- Untreated maternal depression can be long lasting and may not resolve on its own.
- Half of the Utah women diagnosed with perinatal depression have never experienced mental illness before in their life (PRAMS).
- More women will suffer from postpartum anxiety and depression in a year than the combined number of new cases for men and women of Tuberculosis, Leukemia, Multiple Sclerosis, Parkinson's Disease, Alzheimer's Disease, Lupus, and Epilepsy (The Bloom Foundation).

Other clinical considerations:

We cannot tell the mental health status of a woman by looking at someone; screening is necessary.

Disturbing or intrusive thoughts about the baby being harmed are common, and are most often not psychosis or a child endangerment issue. In fact, some studies suggest intrusive thoughts occur to as many as 90% of moms, but psychosis only occurs to one in every 1,000 women who will have a baby. Staff education is crucial to avoid traumatization through unnecessary child welfare involvement.

Inappropriate treatment of bipolar illness with a selective serotonin reuptake inhibitor (SSRIs) (SSRI) may trigger a manic episode, which is correlated with postpartum psychosis.[5]

Culturally relative treatment is essential. Studies suggest complaints about physical symptoms like pain or feeling tired may be more common than complaints about emotional symptoms among Latina or African American women due to stigma.[6]

Crisis response planning is an effective approach for lowering suicide risk when anything other than 0 is scored for item 10 on the Edinburgh Postnatal Depression Scale.

Perinatal mental illness can affect anyone including LGBTQIA+ individuals and couples, fathers, adoptive parents, those suffering from infertility issues, people who have experienced a pregnancy termination, those who have experienced infant loss and miscarriage, and grandparents. All caretakers should be screened and referred to help.

Disclaimer: The Utah Women's Newborn Quality Collaborative (UWNQC) understands and recognizes that not all people who have been pregnant or given birth identify as being a "woman." This toolkit uses the term "women" instead of "people" or "persons" as an intentional device to highlight the vulnerability of people who society typically identifies as being female. The use of "women" is not intended to exclude or silence those who do not identify as female, but to draw attention to the ways pregnant or postpartum people may be discriminated against because of their female gender assignment at birth. We acknowledge all pregnant people experience mental health complications during the perinatal period, and include all parent populations when we talk about moms.

Patient screening and referral resources

Implementing perinatal mental health screening in Utah

1. Who should be screened for perinatal mental health conditions?

All parents (mothers, fathers, people bearing children, and their partners) should be screened for mental health conditions.

Dads are twice as likely to suffer from perinatal mood and anxiety disorders when their partners are experiencing these disorders which can mean, often, children are being raised by two parents struggling with depression. (11)

2. When should patients be screened for perinatal mental health conditions?

The American College of Obstetricians and Gynecologists Committee Opinions #757 "Screening for Perinatal Depression"[7] recommends screening patients at least once during the perinatal period for depression and anxiety, and, if screening in pregnancy, it should be done again postpartum. Opinion #736 "Optimizing Postpartum Care"[8] recommends a full assessment of physical, social, and psychological well-being within a comprehensive postpartum visit that occurs no later than 12 weeks after birth The American Academy of Pediatrics recommends screening for postpartum depression and anxiety at the 1, 2, 4, and '6 month well-child visits.[9]

Nearly 26% of women with a history of anxiety or depression before or during pregnancy went on to experience symptoms of postpartum depression, compared to 8.3% of women without a history of mental health conditions (Utah Pregnancy Risk Assessment Monitoring System (PRAMS)). Pre-pregnacy depression and anxiety, and depression and anxiety during pregnancy are the biggest predictors of postpartum mental illness. Research[3] suggests that among women who screen positive for depression in the postpartum period, the onset of depression occurred before delivery for the majority of women.

Screening should occur at the following times (when applicable):

- First prenatal visit or the first visit to establish care during pregnancy
- One time during each trimester of pregnancy
- 1 or 2days after giving birth (postpartum)
- 2 week postpartum

- 6 week postpartum
- During all well-child checks for up to 6 months postpartum

3. What mental health conditions should a patient be screened for?

Depression and anxiety disorders are the most common mental health complications during the perinatal period. The Edinburgh Postnatal Depression Scale or EPDS is most sensitive for these 2 disorders. There are other screening tools that can be used to identify other perinatal mood and anxiety disorders.

4. What screening tools should be used?

Although there are many validated screening tools available, we recommend the Edinburgh Postnatal Depression Scale (EPDS). This screener is validated for perinatal depression, and has an anxiety subscale. The EPDS has been validated in more than 60 languages. It also comes up on Google when you search for “postpartum depression.”

We understand that all offices and clinic workflows are different, and some may have already established screening with other tools. The PHQ-9 is also validated for depression during the perinatal period; however, it will not be highlighted in this toolkit. For anxiety, the GAD-7 is recommended. Additional screening instruments are included at the end of this toolkit.

Information on each screening instrument

We recommend using the Edinburgh Postnatal Depression Scale (EPDS) to screen women for depression and anxiety. This screening tool only has 10 questions and the scoring is out of 30 points. Any score of 10 or greater means the person could be experiencing depression or anxiety. Any answer other than “never” on question 10 indicates the person is at risk for suicide or self-harm and immediate help is needed . The anxiety subscale is also highlighted on the triaging algorithm.

Two or more significant life events, such as moving to a new address or having a family member become ill, have been shown to put a person at greater risk for perinatal mood and anxiety disorders. A patient may score moderately on the EPDS, but high on the risk factors and previous history of mental illness, meaning they checked 2 or more items on either of these. These patients should also be monitored closely and referred to additional mental health support and resources.We have provided a checklist immediately following this FAQ section to help screen your patients for significant life events and previous history that may indicate risk for perinatal mood and anxiety disorders.

Patients may have other mental illnesses that the EPDS doesn’t adequately screen for. Other screening tools that may be helpful include:

- PC-PTSD: screens for post-traumatic stress disorder (PTSD) using 4 questions

- Mood Disorder Questionnaire (MDQ): screens for bipolar disorder using 14 questions. The MDQ needs to only be done one time in the perinatal period because it asks about a patient's lifetime experiences as compared to the other screening tools which only ask how a person has felt in the last 7 days. We recommend screening all women for bipolar disorder. This should be done before prescribing an antidepressant because selective serotonin reuptake inhibitors (SSRIs), common medications used to treat depression, may trigger a manic episode.

5. Who hands out, scores, and responds to the screening tools?

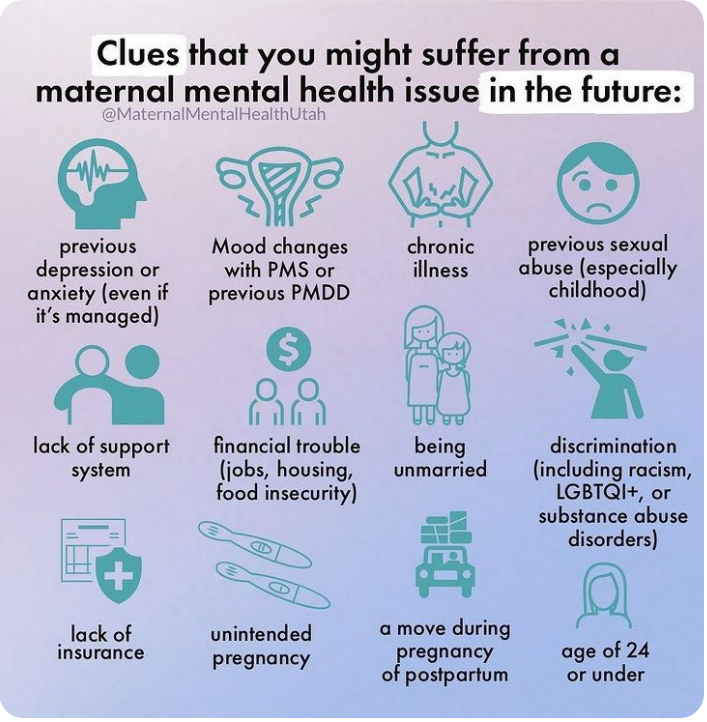
Every office is different. The workflow for addressing perinatal mood and anxiety disorders needs to be tailored to each clinic or practice. Clinical support staff can provide the screening tools to families electronically before an appointment, at the time of check-in or appointment registration, in the waiting room, or while waiting for the provider in the exam room. Many electronic health records can be customized with templates for these screening tools.

Patients should be given enough time to complete the screening tool without feeling rushedAfter a parent completes the screening tool, it should be scored by clinic staff and entered into the patient's chart and electronic medical record. The provider should be made aware of the patient's score before seeing the patient if they didn't administer the screening themself. Scoring is straightforward and can be done by any level of caregiver. It is imperative the screening tool is scored before the patient leaves their appointment so any concerns indicated by the tool can be addressed. The United States Preventative Services Task Force recommends that therapy and support groups can help prevent and address perinatal mood and anxiety disorders (12).

Information about how to respond to a positive screen on the EPDS can found in the Triage Algorithm on page.

Healthcare professionals who are appropriate for administering a screening include, but are not limited to are: Maternal child health workers, nurses, medical assistants, doctors, family practice doctors, pediatricians, nurse practitioners, OBs/GYNs, midwives, clinic staff, lactation consultants, perinatal care managers, doulas, community or public health workers, social workers, home visiting staff, WIC staff, employee assistance providers, occupational therapists, pharmacists, or employee health resource workers.

6. What are common risk factors for maternal mental health disorders?



Mental illness during pregnancy and postpartum is not limited to a particular culture, race, age, income or education level. No single cause has been identified for depression or anxiety during pregnancy or postpartum; however, there are several factors linked to the development of these conditions. Risk factors are important to recognize because someone may not score high enough on the EPDS to be considered at risk for a mental illness but they have factors in their life which put them at risk.

Risk factors for maternal mental health disorders include:

- Personal history of depression, anxiety, or other mental health concerns
- Personal history of substance abuse
- Difficult pregnancy or delivery (especially NICU parents, or emergency c-sections)
- Being younger than 24 years of age
- Experiencing the death of close family members or friends
- Having a close family member or friend with a significant illness or disability
- Being isolated from family or friends
- Less than 5 hours of sleep
- Not having people in your life who can help you during difficult times (support system)
- Being a single parent
- Marital problems
- Lack of health insurance
- Family history of mental illness
- Significant life stressors in the last 12 months (such as losing or changing jobs, moving, change in marital status, etc.))

- History of trauma or abuse (emotional, sexual, or physical)
- Having a chronic illness, or onset of illness during pregnancy and postpartum
- Unmet expectations in pregnancy, labor and delivery, or postpartum (not following a birth plan, inability to breastfeed, etc.)
- Having multiples versus a singleton pregnancy
- Experiencing discrimination based on race, sexual preference and gender identity, or substance use disorder
- Financial stresses or having a household income that is below the federal poverty level
- Negative maternal feelings towards the pregnancy or baby
- Having an unintended pregnancy

If a person experiences 2 or more of these risk factors, there is a higher chance they will develop mental illness during pregnancy and the postpartum period. These patients should be closely monitored and referred to mental health treatment, resources, and services. A risk factor screener is included on page.

7. What type of support can our office or clinic receive if we participate in screening?

UWNQC Maternal Mental Health Committee is ready to help you successfully implement perinatal screening, referral, and treatment protocols.

A gap analysis tool that outlines each step we recommend you do to implement an effective screening in your clinic or practice (which tools to use, how often to screen patients, how to administer the screening tools, and building a referral system including educational materials). The gap analysis tool will help evaluate your current clinic protocols and what things might be feasible to implement in the future.

Training for staff on PMADs both in-person, and via training videos.

Printed copies of this toolkit, SUNSHINE handout, or other instruments and resources in this toolkit.

8. How do you talk about mental health conditions in a strengths-based way?

Patients may be reluctant to discuss mental or emotional health challenges with family, friends, and providers for many reasons. As clinical support staff are often the first to interact with women regarding screening for mental health, it is important it is done with a strength-based approach that emphasizes:

- Mental and emotional health complications during pregnancy and postpartum are common.
- They are medical conditions, just like diabetes.
- They are treatable, and with appropriate help, patients will feel well again.
- Because mental health challenges are common, every pregnant and postpartum patient who is seen in the clinic is screened for these conditions – they are not being targeted.
- The practice cares for the whole woman.

When discussing treatment options, provide a balanced perspective of treated versus untreated illness and associated risks and benefits. Untreated illness has significant risk. Let parents know that a healthy parent is critical to the health of the baby and it is important to prioritize a parent's health, including mental health. Because of this, you will be checking in with them and their mental health regularly throughout their obstetric care, or care for their child.

9. Where can I find educational materials for patients and families?

Perinatal patients and their families, or other members of their support system, should be proactively provided with education so that they are aware of signs and symptoms of perinatal mood and anxiety disorders. Having these conversations early in the pregnancy and again in the early postpartum period, can decrease stigma, normalize screening and detection, and encourage women to discuss any mental health concerns. An environment with ample displays of, and access to, mental health-related information can help to reduce this stigma, and empower women and their families to seek help, while letting women know that they are not alone.

Recommendations for education:

- Provide educational materials to all new prenatal patients and again to patients at their postpartum visit.
- Place posters, pamphlets, and other materials throughout your offices.

Educational materials include but are not limited to the mental health worksheet, SUNSHINE or BAILANDO, and the half sheet of additional resources, all included in this Toolkit and downloadable online.

10. Where can I get additional training in Perinatal Mood and Anxiety Disorders?

A consultation line is available for medical providers who may have additional questions about the overall screening process, or who feel they may benefit from the guidance of fellow medical professionals on the treatment of patients on a case-by-case basis. The Perinatal Psychiatric Consult Line is staffed by reproductive psychiatrists who are members of PSI and specialize in the treatment of perinatal mental health disorders. The service is free, available by appointment and can be accessed at: https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line.

Additionally, Postpartum Support International holds regular two-day Components of Care trainings, along with additional two-hour specialized trainings for Psychopharmacology and Psychotherapy. These trainings can be found at: www.postpartum.net.

Local maternal mental health specialists can be requested for trainings by contacting the Maternal and Infant Health Program at the Utah Department of Health. These trainings would include local data, information on signs and symptoms, risk factors for Utah parents, and resources. Requests can be made by emailing: rhpweb@utah.gov.

FAQ adapted, with permission, for use by the Utah Women and Newborns Quality Collaborative.
Original source is Lifeline4Moms: https://www.umassmed.edu/lifeline4moms/

Edinburgh Postnatal Depression Scale (EPDS)

Date: _____ Clinic Name/Number: _____

Your Age: _____ Weeks of Pregnancy/Age of Baby: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time ___✔ (1)
No, not very often ____ (2)
No, not at all ____ (3)

This would mean: "I have felt happy most of the time" in 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:
   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)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (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 often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

TOTAL YOUR SCORE HERE ▶ ____

*** If you scored a 1, 2 or 3 on question 10, PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) OR GO TO THE EMERGENCY ROOM NOW** to ensure your own safety and that of your baby.

If your total score is 11 or more, you could be experiencing postpartum depression (PPD) or anxiety. **PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) now** to keep you and your baby safe.

If your total score is 9-10, we suggest you **repeat this test in one week or call your health care provider** (OB/Gyn, family doctor or nurse-midwife).

If your total score is 1-8, new mothers often have mood swings that make them cry or get angry easily. Your feelings may be normal. However, if they worsen or continue for more than a week or two, call your health care provider (OB/Gyn, family doctor or nurse-midwife). Being a mother can be a new and stressful experience. Take care of yourself by:

- ▶ Getting sleep—nap when the baby naps.
- ▶ Asking friends and family for help.
- ▶ Drinking plenty of fluids.
- ▶ Eating a good diet.
- ▶ Getting exercise, even if it's just walking outside.

Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.

Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

See more information on reverse. ▶

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

EPDS Screening and Interpretation Instructions

The EPDS was developed for screening postpartum women in outpatient, home visiting settings, or at the 6–8 week postpartum examination. It has been utilized among numerous populations including U.S. women and Spanish speaking women in other countries. The EPDS consists of 10 questions. The test can usually be completed in less than 5 minutes. Responses are scored 0, 1, 2, or 3 according to increased severity of the symptom. Items marked with an asterisk (*) the anxiety subscale. The total score is determined by adding together the scores for each of the 10 items, making the highest possible score 30.

Validation studies have utilized various threshold scores in determining which women were positive and in need of referral. Cut-off scores ranged from 9 to 13 points. Therefore, to err on safety's side, a woman scoring 10 or more points or indicating any suicidal ideation – that is she scores 1 or higher on question #10 – should be referred immediately for follow-up. Even if a woman scores less than 10, if the clinician feels the client is suffering from depression, an appropriate referral should be made. The EPDS is only a screening tool. It does not diagnose depression – that is done by appropriately licensed health care personnel.

Users may reproduce the scale without permission providing the copyright is respected by quoting

the names of the authors, title and the source of the paper in all reproduced copies.

The EPDS can be found in other languages here:

https://www.dchealthcheck.net/documents/10-2015-EPDS-Translations.pdf

Instructions for Users

1. The mother is asked to underline 1 of 4 possible responses that comes the closest to how she has been feeling the previous 7 days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Risk Factor Screener

Significant Life Events Checklist

During the past 12 months (check all that apply):

- ❑ I lost my job even though I wanted to go on working
- ❑ My husband or partner lost his job
- ❑ I had a lot of bills I couldn't pay
- ❑ I moved to a new address
- ❑ My husband or partner said he didn't want me to be pregnant
- ❑ I argued with my husband or partner more than usual
- ❑ I got separated or divorced from my husband or partner
- ❑ I have been physically or sexually abused in the past

Past Experience of Depression & Anxiety

At any time in the past, including during or after a previous pregnancy (check all that apply):

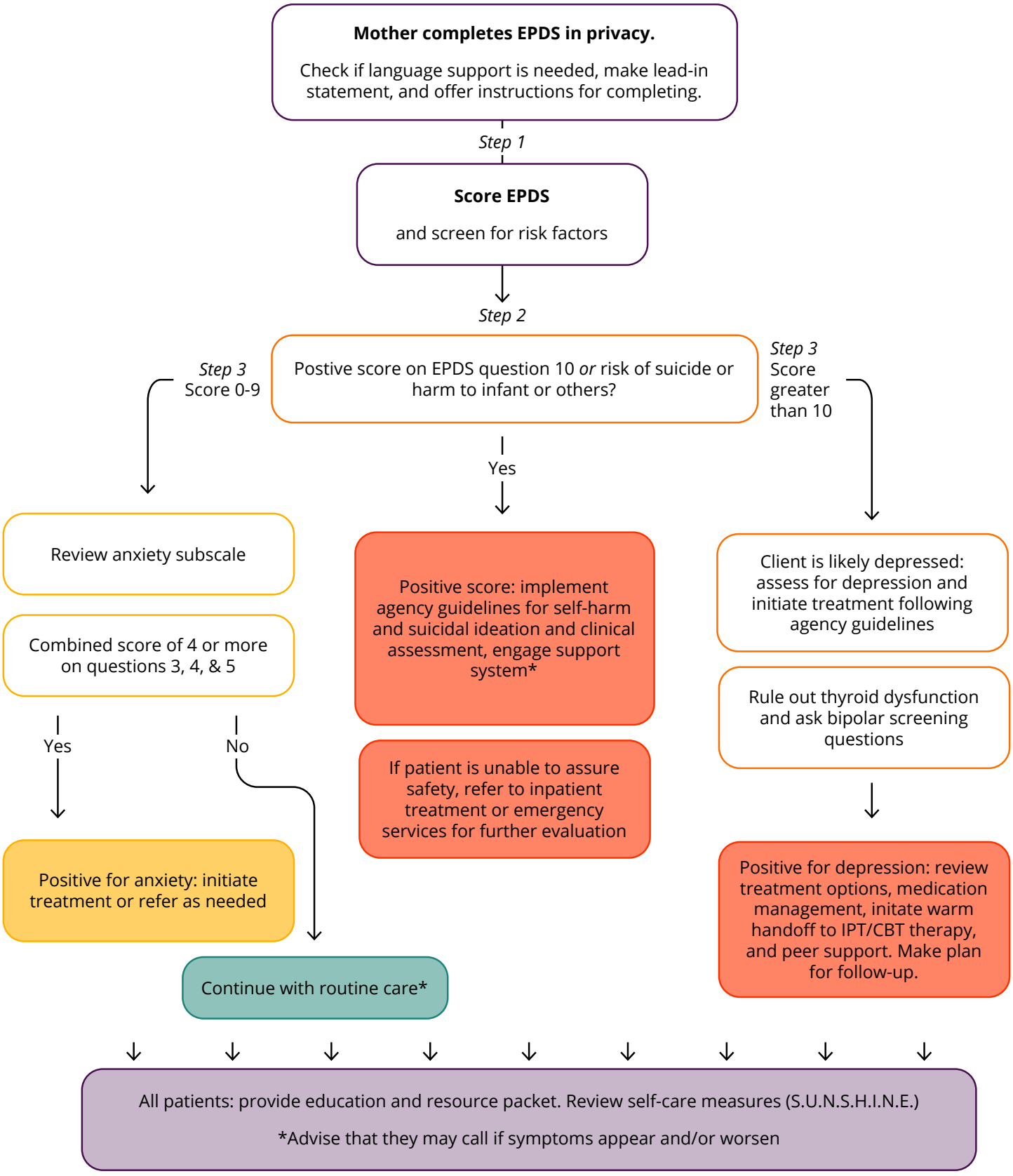
- ❑ A doctor, midwife, nurse, or counselor told me I had depression
- ❑ A doctor, midwife, nurse, or counselor told me I had anxiety
- ❑ I sought help for depression or anxiety from a doctor, midwife, nurse or counselor
- ❑ I had symptoms of depression or anxiety that lasted more than 2 weeks
- ❑ I have taken medications for depression or anxiety

Also Include:

Marital Status (single, married, living with partner, divorced, widowed) and Age

Scoring: if any patient selects two or more of the above, they are at risk for developing a Perinatal Mood and Anxiety Disorder, even if their EPDS score is low.

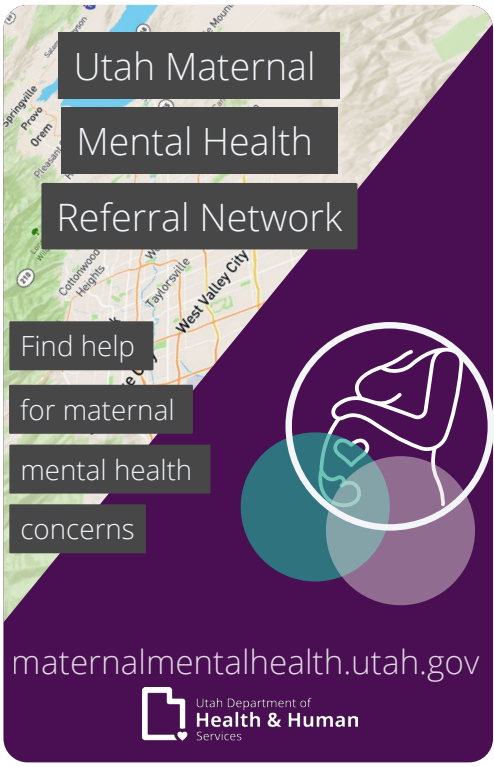
Utah response and triage algorithm



Patient referral quick reference

Maternal Mental Health Referral Network:

MaternalMentalHealth.utah.gov



The Maternal Mental Health Referral Network is a consolidated directory for all providers who have been trained in Maternal Mental Health here in Utah. The database is searchable by: provider type, location, insurance (including no insurance), and specialty type. We recommend providers who have undergone training be listed. Providers who will not be prescribing or providing psychotherapy are only required to attend six hours of maternal mental health training from a variety of training bodies. Providers who will prescribe or provide psychotherapy are required to attend 12 hours of training.

Help Me Grow Utah (Spanish and English)
English and Spanish: 801-691-5322

Help Me Grow Utah not only provides the Edinburgh Post Natal Depression Scale (EPDS) both online and over the phone, but they also provide services in both English and Spanish. Help Me Grow has access to the entire directory of maternal mental health providers, and will follow up with clients for free to ensure they are seeking appropriate help in a timely manner. Help Me Grow Utah will also make outbound calls if a practice or provider chooses to use them as a resource and referral service. Contact Help Me Grow for their referral form. All services are free of cost to Utah residents and providers.

Mother to Baby Utah: 801-328-2229

Mother to Baby Utah is a free, private, and easy-to-use service that answers questions about medications, drugs, chemicals and other environmental exposures that can potentially harm an embryo, fetus or infant. Providers can use Mother to Baby to consult regarding medication during pregnancy and postpartum.

Patient-focused handouts

Mental health tools during pregnancy and after birth

Utah Department of Health & Human Services

S **Sleep:** Aim for four to six hours of sleep in a row, at least three nights a week. Ask a family member or friend to give the first feeding of the night so you can get enough rest.

U **Understand:** Counseling with a trained maternal mental health professional prevents and treats mental health issues. Learn more by calling *Help Me Grow* at 801-691-5322, or by visiting *MaternalMentalHealth.utah.gov* to find help.

N **Nutrition:** Take a prenatal vitamin through one year postpartum. Avoid caffeine and sugar when possible. Include protein and unsaturated fats at every snack and meal. Drink two large pitchers of water daily.

S **Support:** Share your feelings with a trusted friend or family member, or find a support group online or in-person. Search for local support groups on *MaternalMentalHealth.utah.gov*. Ask for help with baby care – getting an hour each day to yourself is essential.

H **Humor:** Make time for silliness and joy each day. A funny movie, time with friends, or tickling your children can all improve your mood. If laughing seems impossible, it is time to seek more support.

I **Information:** Take the Edinburgh Postnatal Depression Scale monthly for a year postpartum to track your mental health. Call your provider if your score is 10 or above, or if you marked anything other than "never" on question 10 about self-harm.

N **Nurture:** Care for yourself through: nature, spiritual practices, music and art, meditation, dates with friends, etc. Schedule weekly time in your calendar to do things you enjoy outside of motherhood.

E **Exercise:** Walking 10-20 minutes a day can help your body, mind, and spirit heal and stay emotionally healthy. You can also try yoga or stretching if your provider gives you the go-ahead.

Created in partnership with the Utah Department of Health and Human Services and Postpartum Support International Utah

To find Utah-based support groups, a counselor/therapist, or any other maternal mental health professional, visit: *MaternalMentalHealth.utah.gov*

Herramientas para la salud mental durante el embarazo y después del parto

Departamento de Salud y Servicios Humanos de Utah

B **Bromear:** Dedique tiempo especial cada día para reír- vea una película, juegue con sus hijos, pase tiempo con amigos. Si no puede conectarse con la alegría y la risa, es hora de hablar con su doctor para obtener más ayuda.

A **Apoyo:** Comparta sus sentimientos con una amiga o familiar de confianza o encuentre un grupo de apoyo. Pida ayuda con el cuidado de sus bebés para que pueda tener una hora para si misma.

I **Información:** Lea sobre el bienestar emocional en www.postpartum.net y tome la pantalla de depresión postnatal de Edimburgo. Llame a su doctòr si su puntaje es 10 o más alto o marcó cualquier otra cosa que no sea “nunca” en la pregunta 10 sobre autolesiones.

L **Levántese:** Caminar por 10-20 minutos al día puede ayudar con su cuerpo, mente y espíritu. También puede tratar de bailar, hacer yoga, zumba, o alguna otra manera de hacer ejercicio si está bien con su doctòr.

A **Alimentar:** Beba al menos de 2 litros de agua al día. Tome multivitaminas prenatales hasta un año después del parto. Evite cafeína y azúcar cuando sea posible, e incluya proteínas y grasas no saturadas en cada comida.

N **Naturaleza:** Haga tiempo semanalmente para hacer cosas que disfruta afuera de la maternidad, como pasatiempos creativos, tiempo en la naturaleza, yoga, citas con amigos y con su pareja, etc.

D **Dormir:** Trate de dormir por lo menos 4-6 horas seguidas cada noche por lo menos 3 días a la semana. Cuando sea posible, pida a un familiar que dé la primera alimentación de la noche al bebé mientras duerme.

O **Observación:** El consultar con un profesional de salud mental materna previene y trata las problemas de salud mental. Aprenda más al llamar a Help Me Grow al número 801-691-5322 o por visitar postpartum.net.

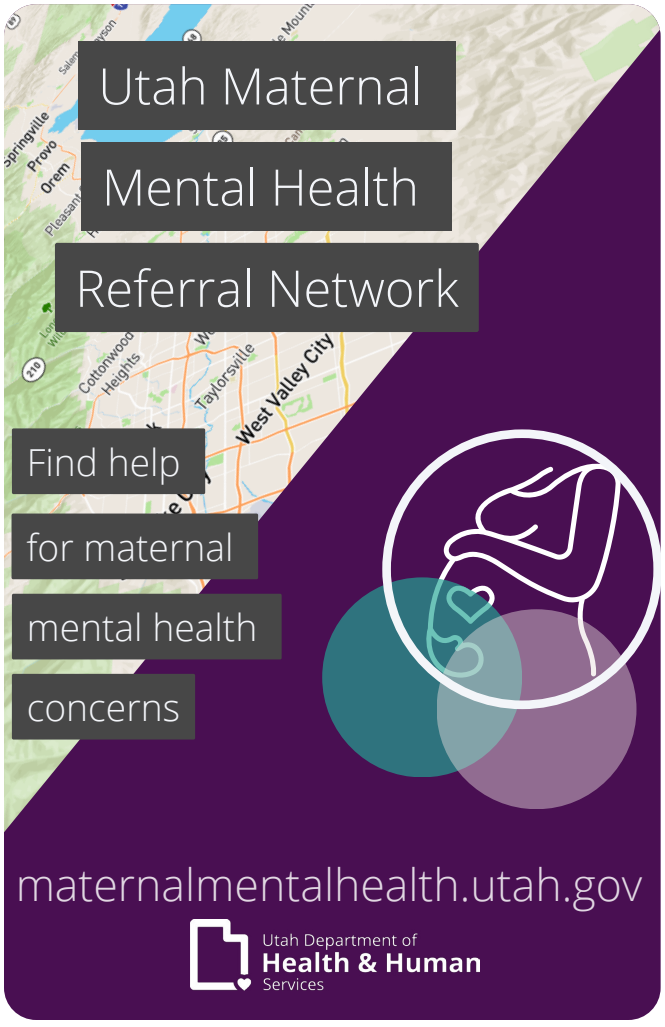
Creado en asociación con el Departamento de Salud y Servicios Humanos de Utah y la Universidad de Utah

Para encontrar grupos de apoyo en Utah, un consejero/terapeuta o cualquier otro centro de salud mental materna profesional, visite: *MaternalMentalHealth.utah.gov*

Resources and information available to parents

Where I can find help:

- To find someone trained in mental health during pregnancy and postpartum, including miscarriage, stillbirth, infant loss, and adoptive parents and partners, go to: MaternalMentalHealth.utah.gov. You can search by provider type, insurance type, and if they do virtual visits.
- To find support groups, go to MaternalMentalHealth.utah.gov and type “Support Groups” for provider type.
- To talk to someone who has gone through something similar, you can call a national HelpLine through Postpartum Support International: 1-800-944-4773 || #1 En Español or #2 English
- Or Text “Help” to 800-944-4773 (EN) || Text en Español: 971-203-7773
- Follow us on social media for daily positive messages, relatable memes, and information: @ MaternalMentalHealthUtah on Instagram and Facebook



My Mental Health Plan

Because Perinatal Mood and Anxiety Disorders (PMADs) are common - and treatable - **I am making a plan for my mental health and wellbeing.**

If I'm struggling, **there are things I can do to feel better**.
And **I can ask for help**.

My Basic Needs

If I'm going to take care of my baby and family, **I need to take care of myself.**

Rest

I can create a relaxing space.
I will sleep when I can.
If I can't sleep, I will rest.
If I can't rest, I will ask for help.

Nourishment

I will do my best to give my body what it needs to be healthy.
I know that I am still healing so I will feed and nurture my body.

Connection

We all need to love and be loved.
Bonding with my baby is important.
But it is also important that I stay connected to the people I care about - and who care about me.

Joy

My happiness matters. I will take time to do things that bring me joy.
Something I love to do is...

_____

_____

My Support Network

I am not alone. Here are some of the people who can help.

I can ask for help from:

- Family
- Friends
- My Partner
- Providers

My Mental Health Plan

Perinatal Mood and Anxiety Disorders (PMADs) are common.
1 in 7 of us will develop one. For many people, it will be the first time they seek mental health support. Fortunately, there are providers and therapies that can help.

People I Can Talk to If I Need Help

Trusted Provider

Trusted Provider

Trusted Family Member

Trusted Friend

Trusted Community Member

What I Can Say

On a good day I feel...

On a bad day I feel...

I'm looking forward to...

I'm worried about...

I need help with...

My Mental Health Plan

My mental health is important. It's normal to need help. Support is available. I know that many people need extra support during their pregnancies and postpartum. So **I am making a plan for what to do if I need help**.

If...

Then...

If...

Then...

If...

Then...

Examples: If I'm having trouble sleeping at night... Then I will ask my friend to come stay with me while I nap. If I am feeling like no one cares and I'm all alone... Then I will remind myself that PMADs are common and treatable.

What helps:

What doesn't help:

If I'm feeling like harming myself or someone else I will...

Get help. Call the Suicide Prevention Hotline. Dial **988**

Utah Maternal Mental Health Referral Network

Find help for maternal mental health concerns

maternalmentalhealth.utah.gov

Utah Department of **Health & Human** Services

Not Feeling Like Yourself?

Let's Talk About It.

National Maternal Mental Health Hotline

HRSA
Health Resources & Services Administration

Always Free — 24/7

Support & Resources

Confidential Call & Text

60+ Languages

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Don't wait. Reach out today.

1-833-TLC-MAMA (1-833-852-6262)

¿No te sientes como tú misma?

Vamos a platicar al respecto.

Línea Nacional de Asistencia a la Salud Mental Materna

HRSA
Health Resources & Services Administration

Siempre gratis — 24/7

Apoyo y recursos

Llamadas y mensajes confidenciales

Más de 60 idiomas

No esperes. Conéctate hoy mismo.
1-833-TLC-MAMA (1-833-852-6262)

NMMHH-004

CALL OR TEXT 'HELP' - 800.944.4773

Leave a confidential message any time, and a trained and caring volunteer will return your call or text. Our volunteers will listen, answer questions, offer encouragement, and connect you with local resources as needed.

Postpartum Support International | www.postpartum.net

LLAMAR: 800.944.4773, #1
O TEXTO: 971.203.7773

Deje un mensaje confidencial en cualquier momento y un voluntario capacitado y atento le devolverá la llamada o el mensaje de texto. Nuestros voluntarios escucharán, responderán preguntas, ofrecerán apoyo y lo conectarán con recursos locales según sea necesario.

Postpartum Support International | www.postpartum.net

CALL OR TEXT 'HELP' - 800.944.4773

Leave a confidential message any time, and a trained and caring volunteer will return your call or text. Our volunteers will listen, answer questions, offer encouragement, and connect you with local resources as needed.

Postpartum Support International | www.postpartum.net

1 DE CADA 10 PADRES

Sí, los papás también pueden estar deprimidos y ansiosos después del nacimiento de un bebé.

No estas solo.
Estamos aquí para ayudar.

LLAMAR: 800.944.4773, #1
O TEXTO: 971.203.7773

Deje un mensaje confidencial en cualquier momento y un voluntario capacitado y atento le devolverá la llamada o el mensaje de texto. Nuestros voluntarios escucharán, responderán preguntas, ofrecerán apoyo y lo conectarán con recursos locales según sea necesario.

Postpartum Support International | www.postpartum.net

SUPPORTING FATHERS' MENTAL HEALTH

Did you know?

- **One in 10** fathers get Paternal Postpartum Depression (PPPD);
- Up to **16 percent** of fathers suffer from an anxiety disorder during the perinatal period.

Helping dads be at their best—physically and mentally—during early childhood has a big impact on children's health.

Studies show that FATHER INVOLMENT LEADS TO CHILDREN WHO:

are more **ready for school**

have a **better vocabulary**

have **better social skills**

are better able to **regulate their emotions**

FATHER INVOLVEMENT HELPS MOMS TOO

- It increases both parents' confidence
- It helps both parents be more responsive to their baby
- It decreases mothers and fathers' potential for mental health issues

How Can Health Professionals Help Fathers?

1. Screen for paternal depression during well-child visits
2. Connect dads with resources and interventions

Provider resources for implementation

PSI Psychiatric Consult Line: 1-800-944-4773 Ext 4

Perinatal Psychiatric Consult Service

Medical prescribers can call our free consultation line. Within 24 hours of calling you will be connected with an expert perinatal psychiatrist who can provide advice on diagnosis, treatment and medication management for preconception, pregnant and postpartum women.

Postpartum Support International
Visit us at Postpartum.net

Massachusetts Child Psychiatry Access Project
MCPAP For Moms

Summary of Emotional Complications During Pregnancy and the Postpartum Period

	Baby Blues	Perinatal Depression	Perinatal Anxiety	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder	Postpartum Psychosis
What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.	Depressive episode that occurs during pregnancy or within a year of giving birth.	A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.	Distressing anxiety symptoms experienced after traumatic events(s).	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. May include rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.	Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.
When does it start?	First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.	Most often occurs in the first 3 months postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes.	Immediately after delivery to 6 weeks postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes.	May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.	1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.	Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.
Risk factors	Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeing, sleep problems.	Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss. Dysregulated baby – crying, feeding, sleep problems. .
How long does it last?	A few hours to a few weeks.	2 weeks to a year or longer. Symptom onset may be gradual.	From weeks to months to longer.	From 1 month to longer.	From weeks to months to longer.	Until treated.
How often does it occur?	Occurs in up to 85% of women.	Occurs in up to 19% of women.	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.	Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.	May occur in up to 4% of women.	Occurs in 1-2 or 3 in 1,000 births.
What happens?	Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of baby blues, but baby blues is a risk factor for postpartum depression.	Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotics symptoms.	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.	Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women).	Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g,. tactile and olfactory) hallucinations. May have moments of lucidity. **May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.**
Resources and treatment	May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.	For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings. Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications. Additional complementary and alternative therapies options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate.				**Requires immediate psychiatric help. Hospitalization usually necessary.** Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g., consistent sleep/wake times, help with feedings at night).

[1] Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996)

[2] **O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002. [Epub ahead of print]**

Funding provided by the Massachusetts Department of Mental Health

Recommendations for scripting and language

Training may be helpful for all of the staff involved in administering the postpartum depression screen and needed follow up. Here are scripts that could be used. These are scripts to be used as a guide by staff and providers to discuss perinatal mental health.

Please review and adapt to the needs of the families in the clinic population.

How to talk about perinatal depression and anxiety with moms*:

- How are you feeling about being pregnant/a mother?
- What things are you most happy about?
- What things are you most concerned about?
- Do you have anyone you can talk to that you trust?
- How is your partner doing?
- Are you able to enjoy your baby?

Ask open-ended questions

- "How are you managing to free yourself up to attend therapy appointments?"
- "I'm curious, what seems to be getting in the way of [xyz]?"

Use reflective listening

- "You're really not sure if your new therapist can be helpful."

Reinforce action, changes, and strengths

"With all the obstacles that you've described, it's impressive that you've been able to make your therapy appointments. This really speaks to your commitment to yourself and to being the best mom you can."

"It was difficult, and you still were able to make it to your visit today. That didn't just magically happen, you had to take specific, concrete action to get to where you are right now."

Normalize concerns

"It is common to feel concerned about how getting help for depression will affect your life."

"Based on everything you're going through, it would be odd for you not to feel overwhelmed."

Summarize the conversation

"So, based on what you've described, it sounds like you're concerned about your depression because it affects your relationship with your baby and your partner. You also said that you have to put in a lot of effort to attend therapy appointments and it costs money to get there, which makes you doubt the process. Do I have that right?"

Ask permission before providing advice/feedback and follow-up

- "Would it be ok if we talk about your depression?"
- "I have some thoughts about strategies to address this, would you be interested in hearing them?"
- "What's it like for you hearing this feedback?"
- "What questions do you have for me?"

Avoid saying "I understand"

Say instead, "I can't imagine what you're going through" or "that must be very difficult." Sometimes patients are looking for simple validation, rather than a solution.

Avoid using the word "but" because it negates what came before it

Avoid saying something like, "You're working really hard, but you still feel overwhelmed." Instead, use the word "and" to acknowledge both truths: "You're working really hard, and it's important to keep focusing on your mental health and self-care. You've already made progress by being here."

Avoid talking about yourself and your personal challenges or situations

No matter how well-intentioned or seemingly appropriate, patients often perceive this as you not hearing them.

Responding to different scores:

Response to a positive screen:

"Based on what you've told me and your score, I am concerned that you may be having a difficult time or be depressed. It can be hard to feel this way when you have a baby/young child. There are things you can do to feel better. Let's talk about some ideas that might work for you."

PROVIDER: This is a screen for depression. I'm concerned because you have a high score. Have you been feeling down, depressed, or anxious lately?

PROVIDER: Would you be willing to see someone for help?

PROVIDER: Do you have someone you feel comfortable talking with, such as your clinician, doctor, midwife, or a therapist you already see?

Yes: PROVIDER: Can we help you make an appointment?

No: PROVIDER: Let's talk about who you would like to talk with. Can we help you identify a provider or connect you to a therapist?

Follow up plan:

If the screen was high:

- A follow up phone call within hours or days after the initial screen was high
- Clinic should decide who will be the staff member who makes this call consistently use this staff member.
- A follow up appointment with the parent's provider or therapist should take place within a week.

Follow-up call:

PROVIDER: I wanted to follow up with you about the discussion we had when you were in last week. Have you been able to connect with your provider or therapist?

Yes: PROVIDER: How did everything go?

Things went well: PROVIDER: I am glad to hear that, please let us know if you need any additional information or referrals.

Things did not go well: PROVIDER: Can I help connect you to a different provider?

No: PROVIDER: What has prevented you from connecting with the referral?

Try to problem solve with the parent—if wait time is long provide second referral, if require childcare/ transportation provide additional information.

Response to a high positive screen (20 or more):

"Based on what you've told me and your score, I am concerned that you may be depressed. What you are feeling is real and it is not your fault. It can be very hard to feel this way when you have a baby/ young child. Getting help is the best thing you can do for you and your baby. Many effective support and treatment options are available. Let's talk about some ideas that might work for you.

Response to an extremely high positive screen, or anything other than "never" to question 10:

PROVIDER: This is a screen for depression. Based upon your response(s) and/or our discussion, I'm worried about your wellbeing. I believe you need to see someone today. I can help you set something up right now.

PROVIDER: Let's talk about how this process will go.

Discuss how clinic handles crisis- walk parent through the process, and physically have a staff member get them to emergency room, OR bring in behavioral health OR find transportation for them to emergency room.

It's very important that the clinic has a plan for the child while the parent receives care.

If the place where parent is being transferred does not have child care: ask parent if they have someone they can call to come and be with them, who can also watch child (mother, sister, partner). Help parent manage any additional responsibilities (Childcare, eldercare etc.)

If the parent says they do not want to see someone today:

PROVIDER: Is there a reason why you are hesitating?

Listen to parent, try to help parent deal with issues around why they don't want to see someone. Try NOT to be confrontational, rather gently work with parent to help them feel safe visiting additional resources.

PROVIDER: Can I call someone to be with you? (Such as your mom, partner, sister, friend etc.)

If a parent absolutely refuses to seek further care today, work as hard as you can to have someone come meet them.

Follow up for High Positive Screen:

Make a follow up call to high positive screens within days or hours. It would be best to have mother make an appointment for herself within 1 week. If a patient refused further care, call them within 24 hours and continue trying to follow up call until reached.

PROVIDER: I wanted to follow up with you about the referral you received when you were in last week. Have you been able to connect with the referral?

Yes: Did everything go alright?

Yes: I am glad to hear that, please let us know if you need any additional information or referrals

No: Would you like a referral to a different provider?

No: What has prevented you from connecting with the referral?

Scripting adapted for the Utah Women and Newborns Quality Collaborative. Original credit to: The Periscope Project, Lifeline4Moms, and The Kansas Chapter of American Academy of Pediatrics

Try to problem solve with the parent—if wait time is long provide second referral, if require childcare/ transportation provide additional information.

Every clinic should have a Crisis Response Plan prepared. If clinic has no Crisis Resource in place at time of emergency call 911.

ACOG
The American College of Obstetricians and Gynecologists

Coding for perinatal depression

Screening for depression

If a physician is providing the global obstetrical service (and reporting a global code), the payer may consider screening for depression as part of the global service and not reimburse additionally for the service. This is particularly true if the physician screens every patient for depression as routine. However, some payers may reimburse for this service. Physicians should check with their specific payers.

Treatment for patients with signs and symptoms

If the patient has signs of symptoms of depression (reported with an appropriate diagnosis code), then those services are reported separately from the global service and may potentially be reimbursed.

Diagnosis coding

Mental, behavioral, and neurodevelopmental disorder codes are found in chapter 5, *Mental, Behavioral, and Neurodevelopmental Disorders*, code block (F01-F99), of ICD-10-CM. Note that many payers will only reimburse a psychiatrist or psychologist for services linked to a diagnosis in the mental disorders chapter.

The possible ICD-10-CM diagnosis codes are as follows:

- F05 Delirium due to known physiological condition
- F30 Manic episode
- F34.1 Dysthymic disorder
- F32.9 Major depressive disorder, single episode, unspecified

Other diagnoses that may be reported may be found in the signs and symptoms and nervous system chapters. Symptoms, Signs and Abnormal Clinical Laboratory Findings, Not Elsewhere Classified, code block (R00-R99), are found in chapter 18 of ICD-10-CM. Sleep disorders are found in chapter 6, *Diseases of the Nervous System*, code block (G00-G99), sub code section G40-47: *Episodic and paroxysmal disorders.*

Additional Possible ICD-10-CM codes are as follows:

- G47.9 Sleep disorder, unspecified
- R53.81 Other malaise
- R53.83 Other fatigue
- R45 Symptoms and signs involving emotional state

Procedure Coding

The correct evaluation and management code will depend on whether the encounter was for screening or treatment of depression.

If the encounter was for screening for a patient without symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Whether or not these codes will be reimbursed by the payer will vary. Possible procedure codes are:

- 99401-99404 Preventive medicine, individual counseling
- 99411-99412 Preventive medicine, group counseling

If the encounter was for treatment for a patient with a diagnosis of depression or documented symptoms of depression, report an office or other outpatient evaluation and management code. These codes list a typical time in the code descriptions. Time spent face to face counseling the patient must be documented in the medical record. The record must document that either all of the encounter or more than 50% of the total time was spent counseling the patient. Possible procedure codes are:

- 99201-99205 New patient, office or other outpatient visit
- 99211-99215 Established patient, office or other outpatient visit

American college of Obstetricians and Gynecologists
409 12th Street SW, Washington, DC 20024-2188

Crisis-based resources

Lifeline4Moms

Assessing Risk of Suicide

Reports thoughts of self-harm and/or +self-harm question on the EPDS/PHQ-9 (any response other than "never")

Ask about thoughts of self-harm or wanting to die

Thoughts of death or of self-harm are common among women with perinatal mental health conditions. The following wording can help to get information about these thoughts.

Introduce assessment to patient

"Many people have intrusive or scary thoughts. When people are sad or down they often have thoughts about death or wanting to die. These thoughts can feel awful. They can sometimes feel reassuring or like an escape from a hard life or something else that feels too hard to bear. We are here to help you. We ask about these thoughts because they are so common."

To build up to assessing suicide risk, ask:

1. *"Have you been feeling sad or down in the dumps?"*
2. *"Is it difficult to shake those sad feelings?"*
3. *"Do you sometimes wish you weren't here, didn't exist?"*
4. *"Have you thought about ways to make that happen?"*

To assess risk of suicide, ask:

1. *"In the past two weeks, how often have you thought of death or wanting to die?"*
2. *"Have you thought about ways in which you could harm yourself or attempt suicide?*
3. *"Have you ever attempted to hurt yourself or attempted suicide in the past?"*
4. *"What prevents you from acting on thoughts of death or wanting to die?"*

Assess Risk

Assessment

LOW RISK	MODERATE RISK	HIGH RISK
Fleeting thoughts of death or wanting to die	Regular thoughts of death or wanting to die	Persistent thoughts of death/that life is not worth living
No current intent*	Has thoughts of possible plans yet plans are not well-formulated or persistent	Current intent*
No current plan**	History of suicide attempt	Current well-formulated plan**
No history of suicide attempt	Persistent sadness and tension, loss of interest, persistent guilt, difficulty concentrating, no appetite, decreased sleep	Hx of multiple suicide attempts, high lethality of prior attempt(s)
Future-oriented (discusses plans for the future)	Sometimes feels hopeless/helpless	Hx of multiple or recent psychiatric hospitalizations
Protective factors (e.g., social support, religious prohibition, other children, stable housing)	Somewhat future oriented	Continuous sadness, unrelenting dread, guilt, or remorse; not eating, < 2-3 hours of sleep/night, unable to do anything, unable to feel pleasure or other feelings`
No substance use	Limited protective factors (e.g., social support, religious prohibition, other children)	Hopeless/helpless all or most of the time
Few risk factors (e.g., mental health or medical illness, access to lethal means, trauma hx, stressful event)	+/-Substance use	Not future oriented (no plans for/cannot see future)
	Anxiety/agitation/impulsivity	No protective factors (e.g., social supports, religious prohibition, other children, stable housing)
	Poor self-care	Substance use
	Some risk factors	Not receiving mental health treatment
		Anxiety/agitation
		Many risk factors

Tell the patient that: *"I hear that you feel distressed and overwhelmed. So much so that you're having thoughts of death and dying."* (use patient's language to describe)
"When people are overwhelmed they often feel this way. It is common."
"I'm so glad you told me. I'm here to help. There are many things we can do to help you."

Intervene and Document Plan

Treatment

LOW RISK	MODERATE RISK	HIGH RISK
Treat underlying illness	Treat underlying illness	Do not alarm patient (reinforce her honesty). Do not leave mother and baby alone or let them leave until assessment is complete. Call another staff member
Maximize medication treatment and therapy	Maximize medication treatment and therapy	If assessed to be at imminent risk of harm to self or others, refer to emergency services (custom link)
Monitor closely	Discuss warning signs with patient and family	Treat underlying illness
Thoughts of suicide are common. Not all women need to be evaluated urgently or sent to emergency services, especially if risk factors are minimal and there is no plan or intent for suicide.	Discuss when and how to reach out for help should she feel unsafe	Maximize medication treatment and therapy
	Establish family, friends, and professional(s) she can contact during a crisis	Discuss warning signs with patient and family
	Establish and carry out a plan for close monitoring and follow-up (within 2 weeks)	Discuss when and how to reach out for help should she feel unsafe
		Contact family, friends, and professional(s) and establish how you and patient can contact them during a crisis
		Establish a plan for close monitoring and follow-up

Ideation: Inquire about frequency, intensity, duration—in last 48 hours, past month, and worst ever
***Intent:** Inquire about the 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.
****Plan**: Inquire about timing, location, lethality, access to lethal means (e.g., gun), making preparations (e.g., hoarding medications, preparing a will, writing suicide note).
Behaviors: Inquire about past attempts, aborted attempts, rehearsals (e.g., tying noose, loading gun) vs. non-suicidal self-injurious actions.

Lifeline4Moms

Assessing Risk of Harm to Baby

Ask about unwanted or intrusive thoughts

Unwanted or intrusive thoughts, including those of harming the baby, are common (up to 70%) among postpartum women. Most women will not act on these thoughts because they are usually due to anxiety, depression, and obsessive/compulsive disorder, which is very different than thoughts of harming the baby that are due to psychosis/delusions. The following wording can be used to get information about whether these thoughts are present and how current and concerning they are.

"People often have intrusive thoughts or thoughts that seem to pop in from nowhere. Women often have thoughts about something bad happening to their baby. These thoughts can feel awful and sometimes feel as if they could be an escape from something too hard to bear. We are here to help you. We ask about these thoughts because they are so common."

- *Have you had any unwanted thoughts?*
- *Have you had any thoughts of harming your infant, either as an accident or on purpose?*
- If the patient answers yes to the above question, follow up with:
  - *How often do you have them?*
  - *How recently have you had them?*
  - *How much do they scare you?*
  - *How much do they worry you?"*

Assess Risk

Assessment

LOW RISK *(symptoms more consistent with depression, anxiety, and/or OCD)*	MODERATE RISK	HIGH RISK *(symptoms more consistent with psychosis)*
Thoughts of harming baby are scary	Thoughts of harming baby are somewhat scary	Thoughts of harming the baby are comforting (ego syntonic)
Thoughts of harming baby cause anxiety or are upsetting (ego dystonic)	Thoughts of harming baby cause less anxiety	Feels as if acting on thoughts will help infant or society (e.g., thinks baby is evil and world is better off without baby)
Mother does not want to harm her baby and feels it would be a bad thing to do	Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do	Lack of insight (inability to determine whether thoughts are based on reality)
Mother very clear she would not harm her baby	Mother is less clear she would not harm her baby	Auditory and/or visual hallucinations are present
		Bizarre beliefs that are not reality based
		Perception that untrue thoughts or feelings are real

Consider Best Treatment

Treatment

LOW RISK	MODERATE RISK	HIGH RISK
Provide reassurance and education	Treat underlying illness	A true emergency, refer to emergency services (custom link), as needed
Treat underlying illness	Discuss warning signs with patient and family	Do not alarm patient (reinforce honesty) and do not leave mother and baby alone while help is being sought
Discuss warning signs with patient and family	Discuss when and how to reach out for help should she feel unsafe	Treat underlying illness
Discuss when and how to reach out for help should she feel unsafe	Establish family, friends, and professionals she can contact during a crisis	Discuss warning signs with patient and family
	Establish and carry out a plan for close monitoring and follow-up	Discuss when and how to reach out for help should she feel unsafe
		Establish family, friends, and professionals she can contact during a crisis
		Establish and carry out a plan for close monitoring and follow-up

Columbia Suicide Severity Rating Scale

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any 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?***		

	YES	NO
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 three months?***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Supplemental screening instruments

POSTPARTUM SUPPORT INTERNATIONAL

Perinatal Mental Health Discussion Tool

As many as 1 in 7 moms (1 in 10 dads) experience symptoms of depression and anxiety during the postpartum period. People of every age, income level, race and culture can develop Perinatal Mood Disorders (PMDs) during pregnancy and within the first year after delivery. This tool can help track your symptoms and discuss them with your medical provider. Being your own advocate is okay and you deserve to be well.

I have been experiencing the following symptoms: (please mark all that apply)

- ○ Feeling depressed or void of feeling
- ○ Feelings of hopelessness
- ○ Lack of interest in the baby
- ○ Trouble concentrating
- ○ Brain feels foggy
- ○ Feeling anxious or panicky
- ○ Feeling angry or irritable
- ○ Dizziness or heart palpitations
- ○ Not able to sleep when baby sleeps
- ○ Extreme worries or fears (including the health and safety of the baby)
- ○ Flashbacks regarding the pregnancy or delivery
- ○ Avoiding things related to the delivery
- ○ Scary and unwanted thoughts
- ○ Feeling an urge to repeat certain behaviors to reduce anxiety
- ○ Needing very little sleep while still functioning
- ○ Feeling more energetic than usual
- ○ Seeing images or hearing sounds that others cannot see/hear
- ○ Thoughts of harming yourself or the baby

Risk Factors

Below are several proven risk factors associated with postpartum depression (PPD) and postpartum anxiety (PPA). Knowing these risk factors ahead of time can help you communicate more effectively with your family and medical provider and put a strong self-care plan in place.

Please mark all risk factors that apply:

- ○ History of depression or anxiety
- ○ History of bipolar disorder
- ○ History of psychosis
- ○ History of diabetes or thyroid issues
- ○ History of PMS
- ○ History of sexual trauma or abuse
- ○ Family history of mental illness
- ○ Traumatic pregnancy or delivery
- ○ Pregnancy or infant loss
- ○ Birth of Multiples
- ○ Baby in the NICU
- ○ Relationship issues
- ○ Financial struggles
- ○ Single mother
- ○ Teen mother
- ○ No or little social support
- ○ Away from home country
- ○ Challenges with breastfeeding

RESOURCES

www.postpartum.net

- **PSI Helpline:** For local resources please call or text "HELP" 800.944.4773. We can provide information, encouragement, and names of resources near you.
- **FREE Online Weekly Support Groups:** Led by a trained facilitator. For days and times please visit: http://www.postpartum.net/get-help/psi-online-support-meetings/
- **FREE Psychiatric Consult Line:** Your medical provider can call 877.499.4773 and speak with a reproductive psychiatrist to learn about medications commonly used in the perinatal time period. For more detailed information please visit: http://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

** This is not a diagnostic tool and should not take the place of an actual diagnosis by a licensed professional. **

POSTPARTUM SUPPORT INTERNATIONAL

Guía de diálogo de la salud mental perinatal

Hasta 1 de cada 7 madres (1 de cada 10 padres) experimenta síntomas de depresión y ansiedad durante el período posparto. Las personas de todas las edades, niveles de ingresos, raza y cultura pueden desarrollar Trastornos del Estado de Ánimo Perinatal (PMD) durante el embarazo y dentro del primer año después del parto. Esta herramienta puede ayudar a rastrear tus síntomas y platicarlos con tu proveedor médico. Ser defensora de ti misma está bien y te mereces todo lo mejor.

He estado experimentando los siguientes síntomas: (marque todo lo que corresponda)

- ○ Sentimientos de desesperanza
- ○ Falta de interés en el bebé
- ○ Problemas para concentrarse
- ○ Tu mente se siente muy confundida
- ○ Sentirse ansioso o asustado
- ○ Sentirse enojado o irritable
- ○ Mareos o palpitaciones cardíacas
- ○ No poder dormir cuando el bebé duerme
- ○ Preocupaciones o temores extremos (incluyendo la salud y seguridad del bebé)
- ○ Recuerdos con respecto al embarazo o al parto
- ○ Evitar cosas relacionadas con el parto
- ○ Pensamientos aterradores y no deseados
- ○ Sentir la necesidad de repetir ciertos comportamientos para reducir la ansiedad
- ○ Durmiendo muy poco sueño para seguir funcionando
- ○ Sentirse más enérgico de lo habitual
- ○ Ver imágenes o escuchar sonidos que otros no puede ver/oír
- ○ Pensamientos de hacerse daño a ti mismo o al bebé

Factores de riesgo

A continuación, se presentan varios factores de riesgo comprobados que están asociados con la depresión posparto (PPD) y la ansiedad posparto (PPA). Aprender sobre estos factores de riesgo con anticipación puede ayudarte a comunicar eficazmente con tu familia y con tu proveedor médico tus síntomas y así crear un plan de bienestar emocional.

Marca todos los factores de riesgo que se apliquen:

- ○ Antecedentes de depresión o ansiedad
- ○ Antecedentes de trastorno bipolar
- ○ Antecedentes de psicosis
- ○ Antecedentes de diabetes o problemas de tiroides
- ○ Antecedentes de problemas premenstruales
- ○ Antecedentes de abuso o trauma sexual
- ○ Antecedentes familiares de enfermedades de salud mental
- ○ Embarazo o parto traumático
- ○ Pérdida durante el embarazo o del bebé
- ○ Nacimiento de bebés múltiples
- ○ Bebé en la incubadora (NICU)
- ○ Problemas en tus relaciones
- ○ Problemas financieros
- ○ Madre soltera
- ○ Madre adolescente
- ○ Nada o muy poco apoyo social
- ○ Lejos de tu país natal
- ○ Desafíos con la lactancia materna

RECURSOS

www.postpartum.net

- **Línea de ayuda de PSI:** Para conocer los recursos locales, llama al 800.944.4773 o envíenos un mensaje de texto al 971.203.7773. Podemos proporcionar información, acompañarte y tratar de conectarte con recursos cercanos a ti.
- **GRATIS:** Grupo de apoyo perinatal semanal por Zoom. Guiados por una facilitadora capacitada. Para más información y registración, por favor visita: https://bit.ly/3iJgqMZ
- **GRATIS:** Línea de consulta psiquiátrica Tu proveedor médico puede llamar al 800.944.4773 x 4 y hablar con un psiquiatra para consultar y aprender sobre los medicamentos que son seguros para tomar durante el embarazo y la lactancia. www.postpartum.net/professionals/perinatal-psychiatric-consult-line

**** Esta no es una herramienta de diagnóstico y no debe tomar el lugar de un diagnóstico real por un profesional con licencia. *[1]**

Edinburgh Postnatal Depression Scale (EPDS)

Date:_____ Clinic Name/Number:_____

Your Age:_____ Weeks of Pregnancy/Age of Baby:_____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time _✔_ (1)
No, not very often ____ (2)
No, not at all ____ (3)

This would mean: "I have felt happy most of the time" in 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:
   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)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (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 often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

TOTAL YOUR SCORE HERE ▶ ____

*** If you scored a 1, 2 or 3 on question 10, PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) OR GO TO THE EMERGENCY ROOM NOW** to ensure your own safety and that of your baby.

If your total score is 11 or more, you could be experiencing postpartum depression (PPD) or anxiety. **PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) now** to keep you and your baby safe.

If your total score is 9-10, we suggest you **repeat this test in one week or call your health care provider** (OB/Gyn, family doctor or nurse-midwife).

If your total score is 1-8, new mothers often have mood swings that make them cry or get angry easily. Your feelings may be normal. However, if they worsen or continue for more than a week or two, call your health care provider (OB/Gyn, family doctor or nurse-midwife). Being a mother can be a new and stressful experience. Take care of yourself by:

- ▶ Getting sleep—nap when the baby naps.
- ▶ Asking friends and family for help.
- ▶ Drinking plenty of fluids.
- ▶ Eating a good diet.
- ▶ Getting exercise, even if it's just walking outside.

Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.

Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

See more information on reverse. ▶

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Studies show that postpartum depression (PPD) affects at least 10 percent of women and that many depressed mothers do not get proper treatment. These mothers might 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 Edinburgh Postnatal Depression Scale (EPDS) was developed to assist health professionals in detecting mothers suffering from PPD; a distressing disorder more prolonged than the "blues" (which can occur in the first week after delivery).

The scale consists of 10 short statements. A mother checks off one of four possible answers that is closest to how she has felt during the past week. Most mothers easily complete the scale in less than five minutes.

Responses are scored 0, 1, 2 and 3 based on the seriousness of the symptom. Items 3, 5 to 10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is found by adding together the scores for each of the 10 items.

Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan. The scale indicates how the mother felt during the previous week, and it may be useful to repeat the scale after two weeks.

INSTRUCTIONS FOR USERS

1. The mother checks off the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or reading difficulties.
5. The scale can be used at six to eight weeks after birth or during pregnancy.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

Escala Edinburgh para la Depresión Postnatal (Spanish Version)

Nombre de participante: _____ Número de identificación de participante: _____

Fecha: _____

Como usted está embarazada o hace poco que tuvo un bebé, nos gustaría saber como se siente actualmente. Por favor MARQUE (√) la respuesta que más se acerca a como se ha sentido durante LOS ÚLTIMOS 7 DÍAS y no sólo como se ha sentido hoy.

A continuación se muestra un ejemplo completado:

Me he sentido feliz:

Sí, todo el tiempo	____ 0
Sí, la mayor parte del tiempo	✔ 1
No, no muy a menudo	____ 2
No, en absoluto	____ 3

Esto significa: "Me he sentido feliz la mayor parte del tiempo" durante la última semana. Por favor complete las otras preguntas de la misma manera.

1. He podido reír y ver el lado bueno de las cosas:

Tanto como siempre he podido hacerlo	____ 0
No tanto ahora	____ 1
Sin duda, mucho menos ahora	____ 2
No, en absoluto	____ 3

2. He mirado al futuro con placer para hacer cosas:

Tanto como siempre	____ 0
Algo menos de lo que solía hacerlo	____ 1
Definitivamente menos de lo que solía hacerlo	____ 2
Prácticamente nunca	____ 3

3. Me he culpado sin necesidad cuando las cosas marchaban mal:

Sí, casi siempre	____ 3
Sí, algunas veces	____ 2
No muy a menudo	____ 1
No, nunca	____ 0

4. He estado ansiosa y preocupada sin motivo alguno:

No, en absoluto	____ 0
Casi nada	____ 1
Sí, a veces	____ 2
Sí, muy a menudo	____ 3

5. He sentido miedo o pánico sin motivo alguno:

Sí, bastante	____ 3
Sí, a veces	____ 2
No, no mucho	____ 1
No, en absoluto	____ 0

6. Las cosas me oprimen o agobian:

Sí, la mayor parte del tiempo no he podido sobrellevarlas	____ 3
Sí, a veces no he podido sobrellevarlas de la manera	____ 2
No, la mayoría de las veces he podido sobrellevarlas bastante bien	____ 1
No, he podido sobrellevarlas tan bien como lo hecho siempre	____ 0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:

Sí, casi siempre	____ 3
Sí, a veces	____ 2
No muy a menudo	____ 1
No, en absoluto	____ 0

8. Me he sentido triste y desgraciada:

Sí, casi siempre	____ 3
Sí, bastante a menudo	____ 2
No muy a menudo	____ 1
No, en absoluto	____ 0

9. Me he sentido tan infeliz que he estado llorando:

Sí, casi siempre	____ 3
Sí, bastante a menudo	____ 2
Ocasionalmente	____ 1
No, nunca	____ 0

10. He pensado en hacerme daño:

Sí, bastante a menudo	____ 3
A veces	____ 2
Casi nunca	____ 1
No, nunca	____ 0

Edinburgh Postnatal Depression Scale (EPDS). Texto adaptado del *British Journal of Psychiatry,* Junio, 1987, vol. 150 por J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom. Items 3, 5-10 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. Users may reproduce the scale without further permission providing they respect copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist primary care health professionals in detecting mothers suffering from postpartum depression (PPD); a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery), but less severe than puerperal psychosis.

Previous studies have shown that PPD affects at least 10 percent 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 EPDS was developed at health centers in Livingston and Edinburgh. It consists of 10 short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than five minutes.

The validation study showed that mothers who scored above a threshold 12/13 were likely to be suffering from a depressive illness of varying severity. Nevertheless, the EPDS score should not override clinical judgement. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother felt during the previous week, and in doubtful cases it may be usefully repeated after two weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

INSTRUCTIONS FOR USERS

1. The mother is asked to underline the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at six to eight weeks to screen postnatal women or during pregnancy. The child health clinic, postpartum check-up or a home visit may provide suitable opportunities for its completion.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

Perinatal Anxiety Screening Scale (PASS)

☐ **ANTENATAL** ☐ **POSTNATAL** **DATE:** _____

Weeks pregnant ( ) Baby's age ( )

OVER THE PAST MONTH, *How often* have you experienced the following? Please tick the response that most closely describes your experience for *every* question.

	Not at all	Some times	Often	Almost Always
1. Worry about the baby/pregnancy	0 ○	1 ○	2 ○	3 ○
2. Fear that harm will come to the baby	0 ○	1 ○	2 ○	3 ○
3. A sense of dread that something bad is going to happen	0 ○	1 ○	2 ○	3 ○
4. Worry about many things	0 ○	1 ○	2 ○	3 ○
5. Worry about the future	0 ○	1 ○	2 ○	3 ○
6. Feeling overwhelmed	0 ○	1 ○	2 ○	3 ○
7. Really strong fears about things, eg needles, blood, birth, pain, etc	0 ○	1 ○	2 ○	3 ○
8. Sudden rushes of extreme fear or discomfort	0 ○	1 ○	2 ○	3 ○
9. Repetitive thoughts that are difficult to stop or control	0 ○	1 ○	2 ○	3 ○
10. Difficulty sleeping even when I have the chance to sleep	0 ○	1 ○	2 ○	3 ○
11. Having to do things in a certain way or order	0 ○	1 ○	2 ○	3 ○
12. Wanting things to be perfect	0 ○	1 ○	2 ○	3 ○
12. Needing to be in control of things	0 ○	1 ○	2 ○	3 ○
14. Difficulty stopping checking or doing things over and over	0 ○	1 ○	2 ○	3 ○
15. Feeling jumpy or easily startled	0 ○	1 ○	2 ○	3 ○
16. Concerns about repeated thoughts	0 ○	1 ○	2 ○	3 ○
17. Being 'on guard' or needing to watch out for things	0 ○	1 ○	2 ○	3 ○
18. Upset about repeated memories, dreams or nightmares	0 ○	1 ○	2 ○	3 ○
	Not at all	Some times	Often	Almost Always

Continued on Back

19. Worry that I will embarrass myself in front of others	0 ○	1 ○	2 ○	3 ○	
20. Fear that others will judge me negatively	0 ○	1 ○	2 ○	3 ○	
21. Feeling really uneasy in crowds	0 ○	1 ○	2 ○	3 ○	
22. Avoiding social activities because I might be nervous	0 ○	1 ○	2 ○	3 ○	
23. Avoiding things which concern me	0 ○	1 ○	2 ○	3 ○	
24. Feeling detached like you're watching yourself in a movie	0 ○	1 ○	2 ○	3 ○	
25. Losing track of time and can't remember what happened	0 ○	1 ○	2 ○	3 ○	
26. Difficulty adjusting to recent changes	0 ○	1 ○	2 ○	3 ○	
27. Anxiety getting in the way of being able to do things	0 ○	1 ○	2 ○	3 ○	
28. Racing thoughts making it hard to concentrate	0 ○	1 ○	2 ○	3 ○	
29. Fear of losing control	0 ○	1 ○	2 ○	3 ○	
30. Feeling panicky	0 ○	1 ○	2 ○	3 ○	
31. Feeling agitated	0 ○	1 ○	2 ○	3 ○	
	Not at all	Some times	Often	Almost Always	
Global Score					

Reference:

Somerville, S., Dedman, K., Hagan, R., Oxnam, E., Wettinger, M., Byrne, S., Coo, S., Doherty, D., Page, A.C. (2014).

The Perinatal Anxiety Screening Scale: development and preliminary validation. ***Archives of Women's Mental Health,*** **DOI: 10.1007/s00737-014-0425-8**

The Perinatal Anxiety Screening Scale (PASS):

Administration, Scoring and Interpretation Guidelines

Somerville, S., Dedman, K., Hagan, R., Oxnam, E., Wettinger, M., Byrne, S., Coo, S., Doherty, D., Page, A.C. (2014). The Perinatal Anxiety Screening Scale: development and preliminary validation. *Archives of Women's Mental Health,* DOI: 10.1007/s00737-014-0425-8

Description of the Scale

The PASS is a valid and reliable 31-item self-report instrument designed to screen for problematic anxiety in antenatal and postpartum women. It differentiates between high and low risk for presenting with an anxiety disorder by measuring four domains that address specific symptoms of anxiety as they present in perinatal women. These domains form subscales which include: 1) Excessive Worry and Specific Fears, 2) Perfectionism, Control and Trauma, 3) Social Anxiety, and 4) Acute Anxiety and Adjustment. The PASS was validated for perinatal (i.e., pregnant or less than 1 year postpartum) women who are English-speaking, literate, and aged 18 years and older. The average time taken for respondents to complete the PASS is 6 minutes.

Administration and Scoring

The PASS is suitable for use by researchers and clinicians in a variety of settings to screen for problematic perinatal anxiety. Respondents self rate each of the four clusters of anxiety symptoms, indicating the frequency of the symptoms over the previous month. The items are on a scale ranging from 0 ("not at all") to 3 "("almost always"). Example scoring:

	Not at all	Some times	Often	Almost Always
1. Worry about the baby/pregnancy	0	1	2	3

Total Score

A total PASS score is obtained by adding all of the items on the PASS. A **cut-off score of 26** is recommended to differentiate between high and low risk for presenting with an anxiety disorder.

Recommended severity ranges:

Anxiety Severity	Range of scores
Asymptomatic	0 - 20
Mild-moderate symptoms	21 – 41
Severe symptoms	42 – 93

Subscales

Subscale items describe clusters of symptoms which are characteristic of various anxiety disorders. Raised item scores indicate risk of types of anxiety disorder presentations as indicated in the table below.

The PASS is **not** a diagnostic scale. However for clinical purposes it can be useful to have some indication of the nature of the anxiety symptoms being experienced.
In addition, the answers to **item 7** should be considered individually, as this item is a **clinical indicator of phobia**.

Mood Disorder Questionnaire (MDQ for BiPolar)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

How to Use

The questionnaire takes less than 5 minutes to complete. Patients simply check the yes or no boxes in response to the questions. The last question pertains to the patient's level of functional impairment. The physician, nurse, or medical staff assistant then scores the completed questionnaire.

How to Score

Further medical assessment for bipolar disorder is clearly warranted if patient:

- Answers *Yes* to 7 or more of the events in question #1

AND

- Answers *Yes* to question #2

AND

- Answers *Moderate problem* or *Serious problem* to question #3

Primary Care PTSD Screen (PC-PTSD)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1.	Have had nightmares about it or thought about it when you did not want to?	Yes	No
2.	Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	Yes	No
3.	Were constantly on guard, watchful, or easily startled?	Yes	No
4.	Felt numb or detached from others, activities, or your surroundings	Yes	No

Primary Care PTSD Screen (PC-PTSD)

Scoring and Interpretation:
Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

References:

- Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F.D., Sheikh, J. I. (2003). (PDF) The primary care PTSD screen (PC-PTSD): development and operating characteristics. Primary Care Psychiatry, 9, 9-14
- Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F.D., Sheikh, J. I. (2004). The primary care PTSD screen (PC-PTSD): Corrigendum. Primary Care Psychiatry, 9, 151
- United States Department of Veterans Affairs National Center for PTSD. Available at: http://www.ptsd.va.gov Accessed March 15, 2012.

PTSD Checklist (Longer Version, PCL-C)

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, pick the answer that indicates how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD-Behavioral Science Div.

How is the PCL Scored?
1) Add up all items from each of the 17 items for a total severity score (range = 17-85)
17-29 This cut off shows little to no severity.

28-29 Some PTSD symptoms - If you are seeing or will be seeing a therapist, print the results of this Quiz and take to your therapist for further evaluation.

30–44 Moderate to Moderately High severity of PTSD symptoms - If you are seeing or will be seeing a therapist, print the results of this Quiz and take to your therapist for further evaluation.

45-85 High Severity of PTSD symptoms - If you are seeing or will be seeing a therapist, print the results of this Quiz and take to your therapist for further evaluation.

Substance use screening and resources

Pregnancy is an opportune time to screen and connect women to resources because of an increased motivation to change habits for the future well-being of their child. Estimates of perinatal psychiatric and substance use comorbidity range from 57 to 91%, with the most common diagnoses being depression, anxiety, and post-traumatic stress disorder (15, 16). For this reason it is crucial to screen, at minimum, those with positive perinatal mood and anxiety disorder scores for substance use risk. Referral and follow up are warranted for any positive scores on any of the screens below (the NAStoolkit or the NIDA).

It is important to encourage a woman who may be reluctant to admit to substance use or to accept help. Reassure her that by enrolling in supportive services earlier, she increases the likelihood of delivering a healthy baby that can remain safely in the home.

For more resources on substance and opiate use, visit NAStoolkit.org for the Mother & Baby Substance Exposure Toolkit.

To find help with substance use and recovery in Utah during pregnancy and postpartum visit https://mihp.utah.gov/opioids or, contact the Substance Use in Pregnancy Recovery Addiction Dependence Clinic (SUPeRAD): 801-581-8425

On the following page, if the patient says “Yes” for use of illegal or prescription drugs for nonmedical reasons proceed to the NIDA-Modified ASSIST found here: https://nida.nih.gov/sites/default/files/pdf/nmassist.pdf

NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

[1] *This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at http://archinte.ama-assn.org/cgi/reprint/170/13/1155) and the National Institute on Alcohol Abuse and Alcoholism's screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/ activities/assist_v3_english.pdf).*

Medication therapy and lactation

Many mothers are inappropriately advised not to breastfeed or to avoid taking essential medications due to fears of adverse effects on their infants. This advice is often not evidence-based and unnecessary in many cases (AAP, 2013).

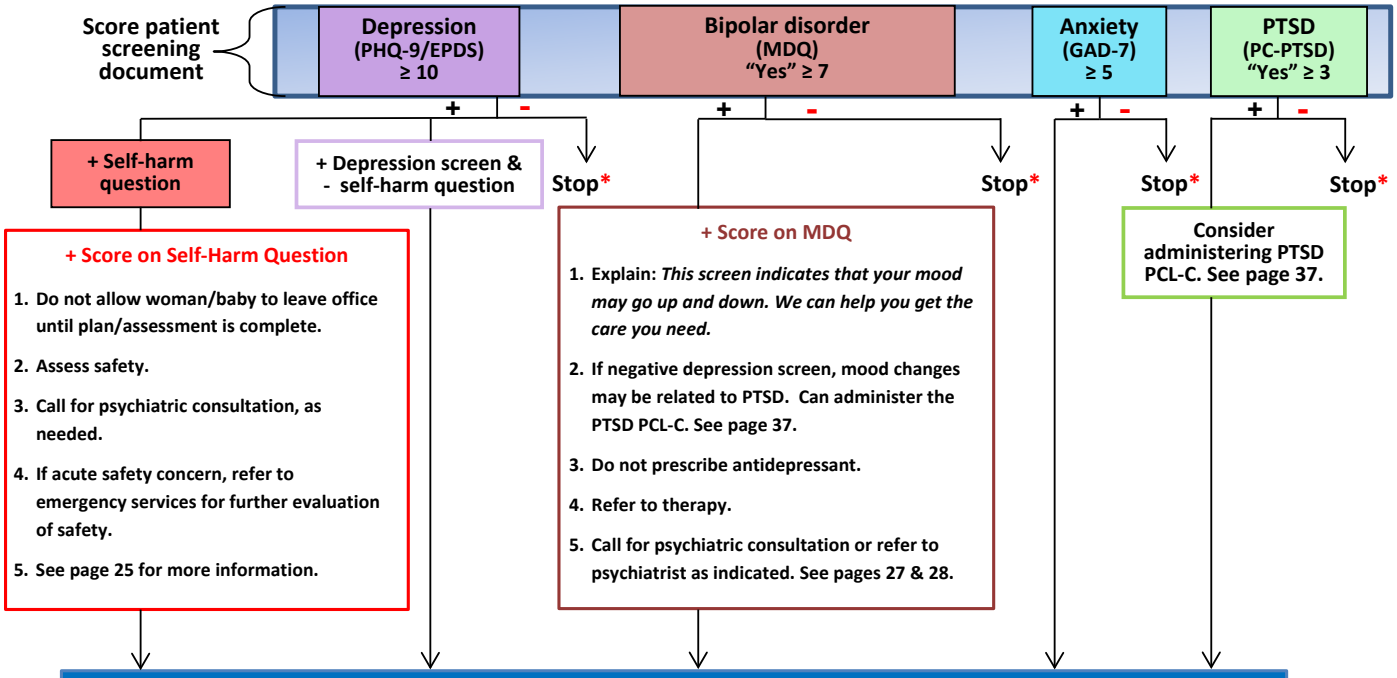
Considerations:

- The AAP recommends exclusive breastfeeding for the first 6 months of life.
    - » Benefits: Improved immunity, promotion of maternal-child bonding, and improved neurodevelopmental outcomes.
    - » The benefits of breastfeeding outweigh the risk of exposure to most therapeutic agents via human milk.
- Anti-depressants are found in very low amounts in breastmilk.
    - » Benefit of treatment often outweighs the small risk of transmission in the breastmilk.
- In general, most anti-depressants are considered safe due to low or undetectable levels in infants' serum.
- What is the mother's breastfeeding goal? Are her symptoms interfering with achieving that goal?
    - » Women who have PPD and anxiety are more likely to stop breastfeeding because of their symptoms.
- The goal is to find a solution that benefits the mother-baby dyad while posing the least amount of risk to each.
- If on an effective antidepressant during pregnancy, she should continue using the same agent during the postpartum period and while breastfeeding unless contraindicated.
- All risk and benefits of continuing or initiating medication therapy should be discussed with the mother, including the risk of withholding treatment.
- Use appropriate references for information on medication compatibility with pregnancy and lactation.

Call Mother to Baby Utah at (801) 328-2229 if you have questions about medication safety during pregnancy and lactation. MotherToBaby Utah provides free, confidential, and accurate information for anyone who is pregnant, breastfeeding, or thinking about getting pregnant or having a baby and their healthcare providers. You can also call the Postpartum Support International Psychiatric Consult Line at (877) 499-4773.

Adapted for Utah's Women and Newborns Quality Collaborative. Source: Nebraska Perinatal Quality Improvement Collaborative www.npqic.org

Assessing Perinatal Mental Health



To assess for presence and severity of perinatal mental illness, ask about:

- Recent stressors
- Symptom frequency
- Symptom duration
- How symptoms impact daily functioning
- Current treatment (meds/therapy)
- Feelings of hopelessness, helplessness
- Current suicidal ideation, plan, intent
- Family history
- Prior symptoms
- Previous suicide attempt(s)
- Past psychiatric treatment (meds/therapy)
- Previous psychiatric hospitalization(s)
- See pages 33-35 for more on perinatal mental health conditions

Determine Illness Severity

MILD

- Depression screener score 10-14
- GAD-7 score 5-9
- PC-PTSD answered "Yes" < 3 times
- No suicidal ideation
- Not feeling hopeless, helpless, worthless
- No previous psychiatric hospitalization
- No or minimal difficulty caring for self or baby

MODERATE

- Depression screener score 15-19
- GAD-7 score 10-14
- PC-PTSD answered "Yes" ≥ 3 times
- Suicidal ideation present
- Sometimes feels hopeless, helpless, worthless
- Previous psychiatric hospitalization
- Some difficulty caring for self or baby

SEVERE

- Depression screener score >19
- GAD-7 score ≥15
- PC-PTSD answered "Yes" ≥ 3 times
- Suicidal ideation, intent and/or plan
- Previous suicide attempt(s)
- Often feels hopeless, helpless, worthless
- History of multiple psychiatric hospitalization(s)
- Often feels unable to care for self or baby
- May experience hallucinations, delusions or other psychotic symptoms (e.g., major depression with psychotic features or bipolar disorder with psychotic features)
- History of multiple medication trials

For mild, moderate, and severe illness:

- Start treatment, see page 22.
- Check for underlying medical condition - order TSH, B12, folate, Hgb, Hct
- Assess for substance use or medications which can cause or worsen mood/anxiety disorders

*If all screens are negative, tell her they were negative and say, *"if something changes, please let us know. We are here."*

Continue to other side →

EPDS – Edinburgh Postnatal Depression Scale; GAD – Generalized Anxiety Disorder; MDQ – Mood Disorder Questionnaire; PHQ – Patient Health Questionnaire; PTSD – Posttraumatic Stress Disorder; PC-PTSD – Primary Care Post Traumatic Stress Disorder; PCL-C – PTSD CheckList-Civilian

Starting Treatment for Perinatal Mental Health Conditions

Consider treatment options based on highest level of illness severity

If severity of symptoms overlap, clinical decisions should be based on the assessment, with strong consideration of higher level treatment options.

MILD

Therapy referral

Consider medication treatment

MODERATE

Therapy referral

Strongly consider medication treatment

If depression onset occurs in late pregnancy or 1-3 months postpartum, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See page 23.

SEVERE

Therapy referral

Medication treatment

If depression onset occurs in late pregnancy or 1-3 months postpartum, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See page 23.

Call for psychiatric consultation/referral

- Use internal resource list to refer patient to therapy
- Call Postpartum Support International (PSI) at 1-800-944-4773 ext. 4 for psychiatric consultation
- Call a Perinatal Psychiatry Access Program, if one is available in your state
- If symptoms are mild and patient is able to follow through, direct patients to call their health insurance company or Postpartum Support International (PSI) at 1-800-944-4773 for resources, or direct patients to search online at https://directorypsichapters.com

Therapy and support options

- All women who screen positive, regardless of illness severity, should be referred to therapy or be advised to continue therapy
- Always discuss and encourage prevention and support options (e.g., peer and social supports and groups, sleep hygiene, self-care, and exercise). See page 30.

How to educate patients about treatment with antidepressants

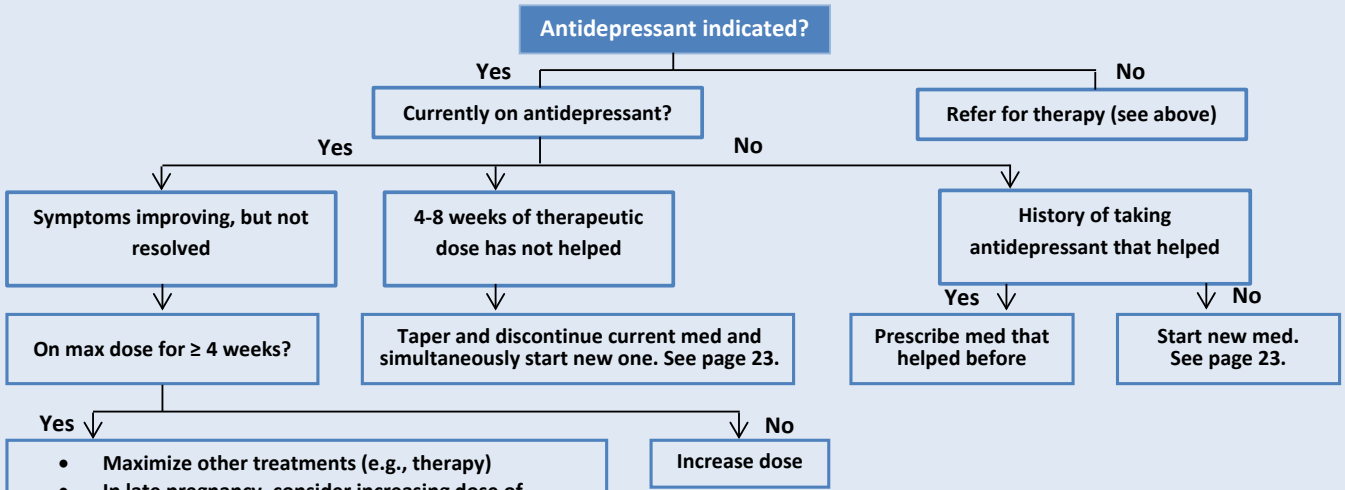
Antidepressant use during pregnancy:

- Does not appear to be linked with birth complications
- Has been linked with small but inconsistent risk of birth defects when taken in the first trimester, particularly paroxetine
- Has been linked with transient (days to weeks) neonatal symptoms (tachypnea, irritability, insomnia)
- Has inconsistent, overall reassuring, evidence regarding long-term (months to years) neurobehavioral effects on children

Under-treatment or no treatment of perinatal mental health conditions:

- Has been linked with birth complications
- Can increase the risk or severity of postpartum depression
- Can make it harder for moms to take care of themselves and their babies
- Can make it harder for moms to bond with their babies
- Can increase risk of mental illness among offspring
- Has been linked with possible long-term neurobehavioral effects on children

Medication treatment (when indicated)



Continue to page 23 →

Pharmacological Treatment Options for Depression, Anxiety, and PTSD

- Choose antidepressant that has worked before. If antidepressant naïve, choose antidepressant based on table below with patient preference in consideration. Antidepressants are similar in efficacy and side effect profile.
- In late pregnancy, you may need to increase the dose above usual therapeutic range (e.g., sertraline [Zoloft] 250mg rather than 50-200mg).
- If a patient presents with pre-existing mood and/or anxiety disorder and is doing well on an antidepressant, do not switch it during pregnancy or lactation. If patient not doing well, see page 24.
- Evidence does not support tapering antidepressants in the third trimester.
- Minimize exposure to both illness and medication.
  - Untreated/inadequately treated illness is an exposure
  - Use lowest effective doses
  - Minimize switching of medications
  - Monotherapy preferred, when possible

See page 22 for how to educate patients about treatment with antidepressants

First-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety, and PTSD

Medication	sertraline* (Zoloft)	fluoxetine (Prozac)	citalopram** (Celexa)	escitalopram** (Lexapro)
Starting dose	25 mg	10 mg	10 mg	5 mg
How to ↑	↑ to 50 mg after 4 days, ↑ to 100 mg after 7 days, then reassess monthly and ↑ by 50 mg until symptoms remit	↑ to 20 mg after 4 days, then reassess monthly and ↑ by 10 mg until symptoms remit	↑ to 20 mg after 4 days, then reassess monthly and ↑ by 10 mg until symptoms remit	↑ to 10 mg after 4 days, then reassess monthly and↑ by 10 mg up to 20 mg until symptoms remit
Therapeutic range***	50-200 mg	20-60 mg	20-40 mg	10-20 mg

*Lowest degree of passage into breast milk compared to other first-line antidepressants
**Side effects include QTC prolongation (see below)
***May need higher dose in 3rd trimester

In general, if an antidepressant has helped during pregnancy it is best to continue it during lactation.
Prescribe a maximum of two (2) antidepressants at the same time.

Medication	duloxetine (Cymbalta)	venlafaxine (Effexor XR)	fluvoxamine (Luvox)	paroxetine (Paxil)	mirtazapine (Remeron)	buproprion HCL (Wellbutrin XL)
Starting dose	20 mg	37.5 mg	25 mg	10 mg	7.5 mg	75 mg
How to ↑	↑ to 30 mg after 4 days, then reassess monthly and ↑ by 30 mg until symptoms remit	↑ to 75 mg after 4 days, then reassess monthly and ↑ by 75 mg until symptoms remit	↑ to 50 mg after 4 days, then ↑ to 100 mg after 7 days, then reassess monthly and ↑ by 50 mg until symptoms remit	↑ to 20 mg after 4 days, then reassess monthly and↑ by 10 mg until symptoms remit	↑ to 15 mg after 4 days, then reassess monthly and↑ by 15 mg until symptoms remit	↑ to 150 mg after 4 days, then reassess monthly and↑ by 75 mg until symptoms remit
Therapeutic range ***	30-120 mg	75-300 mg	50-200 mg	20-60 mg	15-45 mg	300-450 mg

General side effects oral antidepressants	Temporary (days to weeks)	Long-term (weeks to months)
	Nausea (most common)	Increased appetite/weight gain
	Constipation/diarrhea	Sexual side effects
	Lightheadedness	Vivid dreams/insomnia
	Headaches	**QTC prolongation (citalopram & escitalopram)

- Tell women to take medication with food and only increase dose if tolerating; otherwise wait until side effects dissipate before increasing.
- Start medication in morning; if patient finds it sedating recommend that she takes it at bedtime

Treatment for Moderate/Severe Depression with Onset in Late Pregnancy or Within 3 Months Postpartum – brexanolone (Zulresso)

- IV allopregnanolone infusion over 60 hours
- Needs to take place in an in-patient setting
- Can call PSI 1-800-944-4773 ext. 4 or direct patients to call PSI 1-800-944-4773 for more information

More information can be found at Reprotox and LactMed on all pharmacological treatments

Follow-Up Treatment of Perinatal Mental Health Conditions

Once patient is determined to have a mental health condition, repeat screen in 4 weeks and re-evaluate treatment plan via clinical assessment

If no/minimal clinical improvement after 4 weeks

- If patient has no or minimal side effects, increase antidepressant medication dose until full symptom remission (e.g., EPDS/PHQ-9 < 10, GAD-7 <5, PC-PTSD <3)
- If patient has intolerable or serious side effects, taper medication to discontinue, and simultaneously start new antidepressant
- Maximize other treatments (e.g., therapy, lifestyle changes, support groups)
- If late in pregnancy, given physiological changes in pregnancy, may need to increase the dose of antidepressant above usual therapeutic range (e.g., sertraline [Zoloft] 250 mg per day rather than 50-200 mg)
- Consider adding additional medication. See page 23.
- Repeat screens every 4 weeks and re-evaluate treatment via clinical assessment until remission, or, if you are not continuing to manage the patient, provide a hand-off to the primary care physician

If clinical improvement and no/minimal side effects

If clinical improvement and no/minimal side effects

- Re-evaluate every month in pregnancy and postpartum and adjust med accordingly. See page 23
- Encourage patient to stay on medication and continue therapy
- If you are not continuing to manage the patient, provide a hand-off to primary care physician

If you are not continuing to manage the patient postpartum:

- Contact PCP and provide handoff
- Ask patient to make appointment with PCP
- Send summary to PCP
- See patient again to make sure she is in treatment with PCP

Once patient experiences remission of symptoms (e.g., 2 sequential EPDS/PHQ-9 scores <10, GAD-7 <5, PC-PTSD <3)

Can consider tapering antidepressant when patient has been in remission for ≥ 6 months for depression and ≥ 12 months for anxiety

Taper medication slowly to minimize risk of relapse and discontinuation syndrome

- Shorter acting medications (e.g., paroxetine [Paxil], venlafaxine [Effexor]) have higher chance of discontinuation syndrome and thus need to be tapered slowly
- Establish postpartum birth control plan to help women make informed decision regarding family planning

Adjunctive Support Options

Talk to your patient about adjunctive support options such as:

- Self-care
- Sleep hygiene
- Mindfulness
- Exercise
- Books and workbooks (e.g., *The Pregnancy and Postpartum Anxiety Workbook* by Pamela S. Wiegartz and Kevin Gyoerkoe)
- See Self-Care Plan (page 30)

Social and Structural Determinants of Health

Ask about/consider social and structural factors that can be a barrier to engagement in care:

- Access to stable housing
- Access to food/safe drinking water
- Utility needs
- Safety in home and community
- Immigration status
- Employment conditions
- Transportation
- Childcare

Refer to social services as indicated

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HURT, INSULT, THREATEN, and SCREAM (HITS) Tool for Intimate Partner Violence Screening

How often does your partner?	NEVER	RARELY	SOMETIMES	FAIRLY OFTEN	FREQUENTLY
	(1)	(2)	(3)	(4)	(5)
1. Physically hurt you?					
2. Insult or talk down to you?					
3. Threaten you with harm?					
4. Scream or curse at you?					
5. (+) Force you to do sexual acts that you are not comfortable with?					
TOTAL SCORE:					

- (+) Added question to capture sexual violence

Each item is scored from 1-5. Score can range between 5-25. A score greater than 10 signify that you are at risk of domestic violence abuse, and should seek counseling or help from a domestic violence resource center such as the following:

Utah Domestic Violence Coalition: 1-800-897-LINK (5465)

YWCA 24 hour crisis line: 801-537-8600 or Toll-Free 855-992-2752

Background:

HITS was developed by Kevin Sherin, James Sinacore, Xiao-Quiang Li, Robert Zitter, and Amer Shakil in 1998. It was first tested in a female population at Christ Hospital in Chicago and involved family physicians and family practice offices. Since, the screening tool has been evaluated in diverse outpatient settings and internal reliability and concurrent validity have been tested and found to be acceptable.

The 2012 Annals of Internal Medicine's "Systematic Review of Evidence to Update the 2004 U.S. Preventative Services Task Force Recommendations," reviewed 36 studies about IPV screening in health care settings and determined that there are effective screening tools, that screening tools do not cause significant harm, and that some interventions, primarily for pregnant or post-partum women, have had positive results. The review examined 15 studies that evaluated 13 existing screening instruments. HITS was among the six instruments found to be highly accurate and recommended for use by the U.S. Preventative Service Task Force (USPSTF).

The USPSTF recommends that women of childbearing age be screened for intimate partner violence and women who screen positive be provided or referred for intervention services. This recommendation applies to women who do not have signs or symptoms of abuse. HITS was evaluated by the USPSTF and found to be among the top 6 tools that showed the most sensitivity and specificity. The HITS screen is simpler and faster than other IPV measure, which makes it more practical to use in a busy clinical setting. It is also unique in that it assesses both psychological IPV and physical aggression.

US Department of Health and Human Services, ASPE Policy Brief, August 2013
National Institute of Health, Intimate Partner Violence Screening Tools, May 2009
Clinical Research and Methods, Validation of the HITS Domestic Violence Screening Tool with Men, March 3005
U.S. Department of Veterans Affairs, Veteran Health Administration, December 2013

Additional links and resources

Perinatal Mental Health Toolkit for Pediatric Primary Care: Overview and Primer

https://www.dchealthcheck.net/documents/PMH%20Toolkit%20Spring%202020.pdf

Lifeline for Moms Perinatal Mental Health Toolkit:

https://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1140&context=pib

Safe Environment for Every Kid (SEEK):

https://seekwellbeing.org/evaluating-seek/

Standardized Screening for Health-Related Social Needs in Clinical Settings:

https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf

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