

# SCREENING PROTOCOL FOR PERINATAL MOOD AND ANXIETY DISORDERS FOR PRIMARY CARE PROVIDERS



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# CONTENTS

<b>Introduction.....</b>	<b>2</b>
<b>Making the Choice to Screen.....</b>	<b>2</b>
Choosing a Screening Tool.....	3
Electronic Medical Records.....	3
<b>Administering Screening Tools.....</b>	<b>4</b>
Establishing the Screening Workflow.....	4
Who Gets Screened?.....	4
<b>Addressing Screening Tools with Clients.....</b>	<b>5</b>
<b>Responding to a Positive Screen.....</b>	<b>6</b>
Addressing Concerns of Suicidality.....	6
Open-Ended Probing Questions.....	7
Screening Schedule.....	8
<b>Recommended Additional Screening Tools.....</b>	<b>9</b>
<b>Resource and Referrals.....</b>	<b>10</b>
<b>Special Considerations.....</b>	<b>11</b>
High Risk Groups.....	11
Protective Factors.....	11
Risk Assessment.....	12
Screening Partners.....	12
<b>Using the Algorithm.....</b>	<b>12</b>
Algorithm.....	13
Algorithm Narrative.....	14
<b>References.....</b>	<b>15</b>



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# Introduction

In 2018, Healthy Mothers, Healthy Babies (HMHB) facilitated a yearlong research and vetting process in order to create a Montana-made screening protocol for Perinatal Mood and Anxiety Disorders (PMADs). Contributors included:

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## Making the Choice to Screen

Making the choice to implement a new screening tool in your practice can be difficult logistically, but the desire to meet client needs often outweighs these hurdles. Screening for perinatal mood and anxiety disorders (PMADs) is part of complete perinatal care as depression is the most common complication of pregnancy. Approximately 20% of women experience depression during the perinatal period, with rates tripling for higher risk groups such as teens and women with low-income (Lancaster, 2010; Robertson, 2004).

We hope that this protocol will help to ease some of the logistical hurdles, inform your screening choices, and make improving the quality of care in your office easier for your whole team. This guide will touch on choosing a screening tool, provide recommendations and resources on how to administer the tools, recommend additional screening tools, present an algorithm and response protocol, and briefly touch on establishing outside resources and referrals. We acknowledge there are many other excellent resources available to deepen your screening practice and knowledge of perinatal mental health and wellness. We hope this protocol will be a great starting point for your practice.

It is vital when making the choice to screen for perinatal mental health, to also provide your staff with education on perinatal mood and anxiety disorders. Providing foundational knowledge on the various types of experiences women may have when affected by a PMAD, ensures that your organization can provide the most sensitive, informed care, ensuring safety. This resource document provides some training options for your staff. Contact Healthy Mothers, Healthy Babies for further training opportunities and information ([hmhb@hmhb-mt.org](mailto:hmhb@hmhb-mt.org)).



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## Choosing a Screening Tool

After a review of many depression screening tools, our group recommends the use of either the Patient Health Questionnaire (PHQ-9) (Appendix A) or the Edinburgh Postpartum Depression Scale (EPDS) (Appendix B). Both of these screening tools are free, widely used, and validated for use in the perinatal period, which we define as pregnancy through the first year of a child's life. We have highlighted some pros and cons of each tool to help you choose what will work best in your practice.

### Patient Health Questionnaire (PHQ-9)

- 9 items; takes less than 5 minutes; Sensitivity 75%, Specificity 90%
- Greater familiarity within the medical community given its wide use in settings outside of perinatal care
- Asks about previous two weeks
- When used prior to perinatal period can offer baseline
- Does not detect anxiety symptoms, which are more common in depression in the perinatal period than in other stages of life (Kabir, Sheder & Kelly, 2008)
- We suggest supplementing the use of the PHQ-9 with the EPDS-3 (Appendix C) to help screen for anxiety if that is a concern

### Edinburgh Postpartum Depression Scale (EPDS)

- 10 items; takes less than 5 minutes; Sensitivity 59 - 100%, Specificity 49 - 100%
- Valid for use in both the pre and post-natal periods
- Asks about past 7 days
- Asks about anxiety, a common element of depression in the perinatal period
- Excludes constitutional symptoms such as sleep pattern changes, which are common in the perinatal period

Please note that no screening tool will detect all possible PMADs. While the EPDS and PHQ-9 are clinically validated for detecting possible depression and anxiety, they are not validated to detect other less common types of PMADs, such as Obsessive Compulsive Disorder (OCD) or Bipolar Disorder (BD). While less common, these PMADs can have devastating impacts and are not addressed in depth in this protocol. While we have included many additional screening suggestions, expertise in administering and responding to these screens is not covered in this document. One key additional screen is the Mood Disorder Questionnaire (MDQ). **Please see page 8 for an important note on Bipolar Disorder and the Mood Disorder Questionnaire as well as the recommend additional screening tools.**

### Electronic Medical Records

If your electronic medical system already has the PHQ-9 or the EPDS embedded, this may affect which screening tool you use. If your EMR can store screening results, it may be easier to assess client scores across time, and providers may be more likely to access scores if easily available electronically.



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# Administering Screening Tools

## Establishing the Screening Workflow

Each practice is distinct, and unfortunately there is no universal screening workflow we can recommend. Instead, we are offering a list of considerations for administering the screening tools. We hope these questions can help you more quickly and thoroughly evaluate screening from the patient perspective and develop a workflow that is tailored for your practice.

### WHO

- Gives it out? front desk, nurse, doctor, etc
  - Ensure that whoever presents the screen can provide information to every client that:
    - All clients are screened
    - That a positive screen is NOT a diagnosis

*See Administering the Screening section for helpful language*

- Scores it? front desk, nurse, doctor, etc.
- Communicates the results of the screen back to the provider? i.e. flagged in electronic record or scored tool placed on top of client file retrieved by provider upon entering the room
- Enters the screen back into the EMR? (if applicable)

### WHERE

- Given out at front desk to be done in lobby? Given in room? Done while waiting for doctor?

### HOW

- Does the client complete the screen? Both screening tools are recommended to be filled out on paper by the client alone, but in cases where language, literacy, sight or other barriers may prevent this, verbal screening can be done.

Note: If the EMR contains the screen, the client should still get a paper copy to fill out in private, and then results should be translated back into the EMR

### STORAGE

- Where does the paper copy go? How is it electronically recorded/stored if it is?

### BILLING

- Can providers bill for the screening? Billing codes?

## Who Gets Screened?

We strongly recommend universal screening for all clients. Universal screening reduces stigma and normalizes the inclusion of mental healthcare in routine medical care. It also decreases the influence of provider bias and increases the likelihood that those who are experiencing a perinatal mood and anxiety disorder will receive the services they need sooner.



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## Addressing Screening Tools With Clients

Equally as important to the workflow is the way a screening tool is presented, evaluated, and addressed with the patient. Training on PMADs will help ensure your staff has confidence in this subject matter. This can decrease staff anxiety about asking questions about mental health and lead to an increase in empathy and rapport. The use of soft skills, such as active and reflective listening, build rapport with patients and are essential to creating a space where people feel safe to disclose and discuss their lives.

- **Always address the screening tools a client has filled out regardless of the outcome.** Screening tools are just the start of the conversation about mental wellness, and no one is without risk of experiencing a PMAD. Addressing the screening results is part of the psychoeducation of all patients.
- Ensure that whoever hands the client the screening tool (reception staff, rooming nurse, etc.) can address why the screening tool is important to their care. This can be a daunting task, so we recommend having an answer ready to use. One script we would recommend is from People Centered Screening and Assessment: Module 4 - EPDS:

*“Having a new baby is an important and sometimes difficult change in any family. Sometimes it’s hard to know if our feelings are normal or a possible problem. This screen will provide you with valuable information. You will know whether or not it might be helpful to talk with your provider about how you are feeling since giving birth. It will also help me (us) understand if there are any additional resources I (we) should help you connect to.”* (Lilly Irwin Viteta, MCRP President, Common Worth, LLC)

- The Milwaukee Child Welfare Partnership offers a free online training in video format. The 48-minute video focuses on administering the EPDS and covers the logistics of screening and also addresses the interpersonal skills that can make screening and follow-up conversations more meaningful for patient and provider. This video is available at: <https://uwm.edu/mcwp/peoplecenteredassessment/>
- The AIMS Center at The University of Washington has published a very helpful guide for answering questions about presenting the PHQ-9 to a patient entitled, Using the PHQ-9: A Guide for Medical Assistants, Front and Back Office Staff (Appendix D). While this guide speaks directly to the PHQ-9, the information for speaking to patients about screening for depression can be extrapolated to EPDS and other screening tools.

**It is important to recall as a provider that the results of a screening tool are not a replacement for clinical judgment. If you feel as though a person is struggling during the perinatal period, you may still refer them to providers you feel are necessary. Remember that screening tools are simply conversation starters in the important discussion of mental health.**



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## Responding to a Positive Screen

***“You are not alone, you are not to blame, and with the right help you’ll get better.”***

First and foremost, when a person screens high for possible depression or anxiety, it is imperative to provide warm, strengths-based support in a non-judgmental manner. Follow this with education and referral to appropriate treatment if necessary.

- Emphasize that screening tools only measure risk and are not a diagnosis.
- Let them know that many people experience a PMAD.
- A PMAD is not their fault and does not reflect on their ability to parent.
- PMADs are highly treatable, and they will get better with appropriate treatment.
- Emphasize that caring for themselves is caring for the baby.

## Addressing Concerns of Suicidality

Montana’s suicide rate remains among the highest in the nation, and suicide is a leading cause of death for women during the perinatal period. We strongly recommend your office have a protocol in place to address suicidality that includes evaluation of the patient’s plan, intent and access to suicidal means, and safety planning. Further, this protocol should trigger providers to seek consultation with their peers and with resources outside of their office, including psychiatric care and when necessary, emergency department care. Here are some resources to help you and your practice build and strengthen these necessary emergency responses.

**National Suicide Prevention Lifeline** provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals. They also provide several different ways to contact a crisis counselor:

Suicide Prevention Lifeline 1-800-273-TALK (8255)  
En Español 1-888-628-9454  
Deaf & Hard of Hearing 1-800-799-4889  
Online Chat: <https://suicidepreventionlifeline.org/>

**Zero Suicide** is an organization with the foundational belief that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care. This resource can provide toolkits to help your practice develop a strong response plan. <https://zerosuicide.sprc.org/>



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## Open-Ended Probing Questions

A screening tool is not the end of a discussion, but instead, the beginning of one. While someone may screen as having a low risk of depression or anxiety, they may still be experiencing symptoms that you are detecting. Conversely, you may encounter folks who screen as high-risk, but seem to be managing well. Professional judgment is important in these situations, and we encourage all providers to use their practice wisdom along with evidence-based tools. In our research we have identified several open-ended questions that may help you to continue the discussion started with a screening tool.

**It is not uncommon for new mothers to experience intrusive, unwanted thoughts that they might harm their baby. Have any such thoughts occurred to you?**

**What are some of the triggers that make you feel this way?**

**If you had eight free hours and a clean, quiet place to sleep, could you?**

**It seems you are scoring high on this screening tool. How do you think you are feeling?**

**If you did not have an infant and you were feeling sad or anxious, what would you do to help those feelings?**

**In those times, what do you think would make you feel better?**

**Use the phrase, "Tell me more about..." in reference to any of the questions on a screening tool.**

Screening for mental health by a trained member of your office staff is a critical component of client care and education. When a provider presents the questions to the client in an open and safe environment, it allows for a conversation about potential symptoms or experiences common in the perinatal period. Universal screening reduces stigma and normalizes conversation about how the client is feeling about their pregnancy or motherhood. Phrases such as, "You are not alone, you are not to blame, and you can get help," empower the client to provide honest responses to the screening questions. Remember that screening is just the first step in this conversation, and it often takes many conversations before a client is ready to fully explore their mental health status.



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## Screening Schedule

After a thorough review of screening schedule recommendations including those from The American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American Congress of Obstetricians and Gynecologists (ACOG), US Preventative Services Task Force (USPSTF), Centers for Medicaid and Medicare Services (CMS), and Postpartum Support International (PSI), we recommend screening frequently. See chart below for recommended screening frequency.

### RECOMMENDED SCREENING INTERVALS

PRENATAL	POSTPARTUM	PEDIATRIC
Intake, 2nd and 3rd trimester	2 week pp checkup 6 week pp checkup	(Well child checks) 2 - 4 week visit 2, 4, 6, 9, & 12 month visits

Some Montana health insurance payors may cover your screening costs. Check with your contracted payors for benefits and reimbursement related to these services.

### RECOMMENDED SCREENING TOOLS

**Patient Health Questionnaire (PHQ-9)** (Appendix A)  
or the  
**Edinburgh Postpartum Depression Scale (EPDS)** (Appendix B)

## Postpartum Bipolar Disorder and the Mood Disorder Questionnaire

Recent research has shown that the postpartum period carries the highest lifetime risk for bipolar disorder (BD). Rates of BD in postpartum women with positive EPDS scores may be more than 20%. It is vital to rule out BD prior to prescribing any antidepressants as these may increase the risk of mania or psychosis, and thus hospitalization. As per the recent recommendations of the American College of Obstetricians and Gynecologists (ACOG), **we recommend using the Mood Disorder Questionnaire (MDQ)** (Appendix Q) in tandem with either screening tool to identify possible Bipolar Disorder.



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## Recommended Additional Screening Tools

While this protocol is specific to perinatal depression, we recognize that there are a host of other issues that may arise in the perinatal period. As a care provider, you will need more tools to adequately meet these client needs. Below you will find a list of evidence-based tools validated for use in the perinatal period. See Appendices for copies of these tools.

- **ANXIETY:**
  - Appendix E - Generalized Anxiety Disorder 7 (GAD-7)
  - Appendix F - Perinatal Anxiety Screening Scale (PASS)
- **INTIMATE PARTNER VIOLENCE:**
  - Appendix G - Hurt, Insult, Threaten, and Scream (HITS)
  - Appendix H - Abuse Assessment Scale (AAS)
- **SUBSTANCE ABUSE:**
  - Appendix I - CAGE-AID
  - Appendix J - T-ACE
  - Appendix K - The 4P's
  - Appendix L - TWEAK
  - Appendix M - AUDIT-C
  - Appendix N - AUDIT-C 2
- **OCD:**
  - Yale Brown Obsessive Compulsive Scale
- **SUICIDALITY:**
  - Appendix O - C-SSRS - Suicide Severity
- **TRAUMA:**
  - Appendix P - Impact of Events Scale Revised (IES-R)
- **BI-POLAR DISORDER:**
  - Appendix Q - Mood Disorder Questionnaire

In addition to screening tools that focus on illness, we also recommend using tools such as the Maternal Well-being Plan (Appendix R) or The Perinatal Wellness Worksheet from Perinatal Support Washington (Appendix S) to ensure that health promotion and wellness are parts of all conversations about mental health. Empowering a mother to focus on her strengths through a lens of wellness and education can lead to feelings of competency and enable moms to detect and communicate possible issues sooner.



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## Resources and Referrals

No single office will be able to meet all of the needs of every client, so it is important that your practice has a list of trusted and reputable resources that exist outside of your office. This requires finding what resources exist in your community and establishing a relationship with those providers whenever possible.

- Often, a good place to start is your local health department, especially if they have a Women Infant and Children (WIC) Program.
- More personal, or “warm handoffs” referrals, increase the likelihood that a person will take advantage of the resource. If possible, help your client make the appointment in the office that day. A referral from you, their trusted provider, is a transfer of trust from you to another provider.
- The best practice approach is to “close the loop” on any referrals with the other providers, ensuring that the client was able to access that care, and in cases when care is not accessed, contact the patient to offer assistance.
- The US Prevention Services Task Force recommends talk therapy as a first line approach to preventing and healing from a PMAD.
- In addition, home-based supports such as peer-to-peer mom groups, home visiting services, or postpartum doulas can provide social support that is critical to mental health stability.

Below is a list of nationally available and reliable resources that both providers and clients may find useful. These resources can be sources of immediate help, such as medication interactions or self-screening tools, but can also be sources of education and training that is necessary to effectively identify and treat PMADs.

**Postpartum Support International (PSI)** has been in existence for 30 years and is the leading organization devoted to increasing awareness about the prevalence and devastation of perinatal depression and anxiety. PSI also has Montana-based, regional coordinators that can help anyone find providers for perinatal mental health, including but not limited to, private counselors trained in perinatal mental health. In addition to a client warmline for folks who need immediate help, PSI also offers providers access to a reproductive psychiatric consultation.

<https://www.postpartum.net/locations/montana/>

**PSI Helpline:** 1-800-944-4773

**For patients:** #1 En Espanol or #2 English OR  
Text: 503-894-9453

**For providers:** #4 Perinatal Psychiatry  
Consultation Service

**The Seleni Institute** has been a resource for professional training and education specializing in maternal mental health. They have regularly updated online resources and offer trainings:  
<https://www.seleni.org/>

**2020Mom**, founded in 2011 as the California Maternal Mental Health Collaborative, has evolved as a national organization with a mission: Closing gaps in maternal mental health care through education, advocacy, and collaboration.  
<https://www.2020mom.org/>

**The Postpartum Stress Center** provides support and treatment for the pregnant or postpartum woman and her family as well as guidance for her treating physician or therapist. They are committed to providing excellent clinical care and education to both our clients and professionals who seek our expertise.  
<https://postpartumstress.com/>

**LactMed** is a drug and lactation database that is available both online and in an app format.  
<https://www.toxnet.nlm.nih.gov/cgi-bin/sis/search2/f?./temp/~2nER5K:1>

# Special Considerations

## High Risk Groups

Please note that there are certain clients in the perinatal period who are at higher risk of experiencing a PMAD due to social, economic, and health concerns. It is important to keep these groups in mind as you provide care. While this list is expansive, and we recommend universal screening, it may help you to better target education of clients and inform your clinical judgments.

- Adoption
- Breastfeeding difficulties
- Certain personality traits, including perfectionist tendencies or difficulty handling transitions
- Changes in thyroid function
- Complications of pregnancy, labor, or infant's health
- Endocrine-related dysfunction such as Polycystic Ovarian Syndrome (PCOS)
- Family history of PMAD
- High risk pregnancies
- History of a mental health diagnosis
- History of current or past substance use
- History of severe PMS
- Intimate partner / Domestic violence
- Low income
- Pregnancy loss/ Infertility
- Sleep disturbances
- Social isolation
- Teen mothers
- Trauma (IPV, childhood abuse and neglect, PTSD, death in family)
- Unwanted / Unplanned pregnancy
- Veteran / Service member in family

## Protective Factors

Equally as helpful as focusing on risk, is promoting protective factors. Protective factors can lessen the impact, or even prevent a PMAD. Further, while many of the risk factors listed above are based on client history, many protective factors are actionable. For example, while we cannot change past history of trauma, we can help to increase social and breastfeeding supports and build parenting skills and confidence.

- Balanced nutrition, physical activity or healthy sleep
- Family Planning for an intended pregnancy
- Perceived & intact social and maternal support
- Parenting confidence
- Recognition of traditional postpartum cultural practices
- Positive parenting role models
- Support of breastfeeding decision
- Healthy co-parent involvement



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## Risk Assessment

Some providers are beginning to include risk assessments as part of their standard of care. The Postpartum Stress Center's PPD Risk Assessment During Pregnancy Screening (Appendix T) is an example of reaching beyond the screening tools to ask about possible risk of a PMAD. This can be an integral part of psychoeducation between the provider and client, and can empower clients and their support networks to understand their risk level and navigate preventative measures, including how to increase protective factors.

## Screening Partners

The perinatal period is a time of great change for all involved. Perinatal mood and anxiety disorders impact the entire family unit, and about 10% of new dads experience a PMAD when the mother of their baby has a PMAD. Notably, this may also occur in the absence of a maternal PMAD. Screening partners is an essential part of understanding how the entire family unit is coping with this time of change. The use of the three-question abbreviated Edinburgh, the EPDS-3, is appropriate for this purpose, but also note that the full EPDS is validated for use in partners. The PHQ-9 would also be appropriate in this setting.

## Using the Algorithm

The following pages are an algorithm for perinatal mood and anxiety disorders and a companion narrative. We envision the algorithm as an at-a-glance resource for use in daily practice. The narrative provides a more detailed description of the algorithm and presents the same information and processes in an alternate format that may be more useful to others. We recommend you place this algorithm in exam rooms, at nurses stations, or where ever rooming, nursing or provider staff can have easy access for reference when needed.



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# Pregnancy Related Depression Screening

For those providing care from pregnancy through 1 year postpartum

## RECOMMENDED SCREENING INTERVALS

### PRENATAL

Intake, 2nd and 3rd trimester

### POSTPARTUM

2 week pp checkup  
6 week pp checkup

### PEDIATRIC

(Well child checks)  
2 - 4 week visit  
2, 4, 6, 9, & 12 month visits

**SCORE IS 9 OR LESS & RED FLAGS ARE NEGATIVE**

**EPDS OR PHQ-9 SCORE & CHECK RED FLAGS**

**SCORE IS 10 OR GREATER**

## LOW RISK

*"AT RISK FOR PMAD"*

- RESCREEN AT NEXT RECOMMENDED INTERVAL
- PROVIDE EDUCATION ABOUT PMADS & WELLNESS PLANNING

### PROVIDE VERBAL EDUCATION INCLUDING:

- SIGNS AND SYMPTOMS OF PMADS
- TREATMENT OPTIONS

**GIVE THEM A BLANK SCREENING TOOL WITH SCORING**

## RED FLAG Q'S

EPDS #10 >2 & PHQ-9 #9 >1

*"INDICATES RISK OF SELF HARM"*

- DO NOT LEAVE CLIENT/BABY ALONE
- REFER TO YOUR OFFICE SUICIDE RISK RESPONSE PROTOCOL
- COLLABORATE WITH CLIENT TO FIND SUPPORTIVE ADULT TO JOIN THEM AND SECURE CHILDCARE
- CONTACT PRIMARY CARE PROVIDER
- CREATE SAFETY PLAN
- IF NO CRISIS SERVICES AVAILABLE, COORDINATE WITH EMERGENCY DEPARTMENT CALL 911
- CONTACT CPS IF NECESSARY
- MAKE CRISIS MENTAL HEALTH APPOINTMENT
- DOCUMENT

## HIGH RISK

*"LIKELY EXPERIENCING A PMAD"*

- ADMINISTER MDQ TO SCREEN FOR BIPOLAR
- MAKE REFERRAL/ARRANGE APPOINTMENT FOR MENTAL HEALTH EVALUATION WITH PRIMARY CARE/OB PROVIDER ASAP
- REFER TO MENTAL HEALTH SERVICES

### PROVIDE VERBAL EDUCATION INCLUDING:

- SIGNS AND SYMPTOMS OF PMADS
- DISCUSS TREATMENT OPTIONS
- COVER POINTS OF EDUCATION & ENCOURAGE COMPLETION OF WELLNESS GUIDE

**GIVE THEM A BLANK SCREENING TOOL WITH SCORING**

## FOLLOW UP

- ENSURE CLIENT RECEIVED CARE WITHIN 3 DAYS
- HELP COORDINATE ONGOING SUPPORT NEEDS
- REFER TO FAMILY SUPPORT SERVICES, SUCH AS HOME VISITING SERVICES IF AVAILABLE
- DOCUMENT

## Algorithm Narrative

This section of the document is a screen algorithm that presents a process and response protocol for administering screening tools.

### STEP 1: ADMINISTER

Administer the EPDS or PHQ-9 at recommended screening intervals

### STEP 2: SCORE

Score the screening tool

### STEP 3: RESPOND

Talk to the client about their screening results. Use the following guidelines to tailor response to the patient's needs

**LOW RISK RESPONSE:** Response to Negative Screen (Score less than 10 and Red Flags are negative)

- Rescreen at next recommended interval
- Provide education about perinatal mood, anxiety disorders and wellness plan
- Wellness Plan

**HIGH RISK RESPONSE:** Response to a Positive Screen (Score 10 or greater)

- Likely experiencing a PMAD
- Administer MDQ to screen for Bipolar
- Make referral for mental health evaluation with primary care provider/OB within 2 weeks
- Provide verbal education including:
  - Signs and symptoms of PMADS
  - Discuss treatment options
  - Cover points of education and encourage completion of wellness guide
  - Give them a blank screening tool with scoring

### RED FLAG RESPONSE:

Red Flag Question responses (EPDS Q#10  $\geq$  2 and PHQ-9 Q#9  $\geq$  1)

- Both of the screening tools have a question that specifically addresses suicidality and self-harm
- On the EPDS is question #10, positive response = 2 or greater
- On the PHQ-9 is question #9, positive response = 1 or greater
  - Indicates a risk of self-harm
  - Do not leave client/baby alone
  - Make crisis mental health appointment
  - Collaborate with client to find supportive adult to join them and secure childcare
  - Contact primary care provider or OB
  - Decide on safety and treatment plans
  - If no crisis supports or services available, coordinate with Emergency Dept, call 911 and/or contact CPS if necessary
- Document

### STEP 4: FOLLOW UP

- A positive response to either of these questions triggers an emergency response to ensure safety of mom and baby
- This is where an established protocol is most helpful
- Asking questions about suicidality and self-harm is uncomfortable for some providers, but try to recall how uncomfortable it may be for your client to share this information
- This discomfort, in addition to the urgency of the situation, are reasons why a clear self-harm risk protocol is essential
- Document



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# Appendices

## DEPRESSION:

Appendix A - Patient Health Questionnaire (PHQ-9).....Page 18  
Appendix B - Edinburgh Postpartum Depression Scale (EPDS).....Page 20  
Appendix C - Edinburgh Postpartum Depression Scale-3 (EPDS-3).....Page 22

Appendix D - Using the PHQ-9: A Guide for Medical Asst, Front and Back Office Staff.....Page 23

## ANXIETY:

Appendix E - Generalized Anxiety Disorder 7 (GAD-7).....Page 25  
Appendix F - Perinatal Anxiety Screening Scale (PASS) .....Page 26

## INTIMATE PARTNER VIOLENCE:

Appendix G - Hurt, Insult, Threaten, and Scream (HITS) .....Page 27  
Appendix H - Abuse Assessment Scale (AAS).....Page 28

## SUBSTANCE ABUSE:

Appendix I - CAGE-AID.....Page 30  
Appendix J - T-ACE.....Page 31  
Appendix K - The 4P's.....Page 32  
Appendix L - TWEAK Tes.....Page 33  
Appendix M - Alcohol Use Disorders Identification Test (AUDIT).....Page 34  
Appendix N - Alcohol Use Disorders Identification Test (AUDIT-C).....Page 35

## SUICIDALITY:

Appendix O - Columbia-Suicide Severity Rating Scale (C-SSRS).....Page 37

## TRAUMA:

Appendix P - Impact of Events Scale Revised (IES-R).....Page 39

## BI-POLAR DISORDER:

Appendix Q - Mood Disorder Questionnaire (MDQ).....Page 40

## WELLNESS

Appendix R- My Maternal Wellbeing Plan, Minnesota Department of Health.....Page 41  
Appendix S - Creating a Wellness Plan, Perinatal Support Washington.....Page 43  
Appendix T - PPD Risk Assessment During Pregnancy, The Postpartum Stress Ctr.....Page 45



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## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns  +  +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

<b>10.</b> If you checked off <i>any</i> problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

# PHQ-9 Patient Depression Questionnaire

## For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

### *Consider Major Depressive Disorder*

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

### *Consider Other Depressive Disorder*

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

## To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

## Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;  
More than half the days = 2; Nearly every day = 3

## Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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A2662B 10-04-2005

## 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) <input checked="" type="checkbox"/>
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.

*Please note:* Users may reproduce this scale without further permission providing they respect the copyright (which remains with the *British Journal of Psychiatry*), quote the names of the authors and include the title and the source of the paper in all reproduced copies. Cox, J.L., Holden, J.M. and Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

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.

# Edinburgh Postpartum Depression Screening Tool

The Edinburgh Postnatal Depression Scale (EPDS) is the screening instrument most commonly used to identify women with postpartum mood disorders.

This is a 10-item questionnaire which has been validated in many different populations and is available in almost every language.

On this scale, a score of 10 or greater or an affirmative answer on question 10 (presence of suicidal thoughts) is suggestive of postpartum depression.

*(Setting the cut-off score of 12 improves the specificity of the EPDS for identifying major depression; however, the sensitivity falls off significantly, making it less useful for screening.)*

Most importantly it should be emphasized that an elevated score on the EPDS does not necessarily confirm the diagnosis of postpartum depression; this requires a more thorough diagnostic evaluation.

## EPDS–3

A recent study indicated that the EPDS may be further abbreviated to a three question version which can be used to screen for postpartum depression.

Given the prevalence of anxiety symptoms among women with postpartum depression, the authors chose a screening tool using the 3 items which comprise the anxiety subscale of the EPDS:

- I have blamed myself unnecessarily when things went wrong
- I have been anxious or worried for no good reason
- I have felt scared or panicky for no very good reason

---

The Edinburgh Postpartum Depression Scale-3 exhibited the best screening performance characteristics, with sensitivity at 95% and negative predictive value at 98%. It identified 16% more mothers as depressed than the Edinburgh Postpartum Depression Scale did. “Identifying Postpartum Depression: Are 3 Questions as Good as 10?” Karolyn Kabir, Jeanelle Sheeder, Lisa S. Kelly

## Using the PHQ-9: A Guide for Medical Assistants, Front and Back Office Staff

### ***What is the Patient Health Questionnaire (PHQ-9)?***

The PHQ-9 is a simple, nine question form used to screen depression and monitor changes in signs/symptoms of depression. The patient's PHQ-9 score should be recorded at the beginning of a visit, like blood pressure or other vitals.

Depression screening workflows often include front office staff, medical assistants, and other care team members who might not be used to tracking depression in the same way as other vitals. It is important that the patient sees that all staff feel just as comfortable administering the PHQ-9 as any other vital sign, creating a welcoming environment.

### ***Screening with the PHQ-9***

The PHQ-9 can be filled out two ways; directly handing a copy to the patient to complete on their own or being administered verbally by staff as part of the rooming process. Studies have shown that patients can successfully fill out this form by themselves and do not always require assistance. If the PHQ-9 is being administered verbally, it is crucial that the administrator asks the question to the patient exactly as it is written on the form to ensure accurate data.

Once a patient fills out the PHQ-9, the person administering the scale should immediately enter the numbers into EHR and/or registry. **Do NOT enter "0" on the PHQ-9 if the patient did not complete the form.** Instead, a note should be made in the EHR and/or registry outlining why PHQ-9 scores are not available. Entering a score of "0" falsely shows improvement in the patient's symptoms.

### ***Common Questions When Presenting PHQ-9 to Patients***

The following Q&A is intended to help staff feel more comfortable answering the questions they may be asked by patients about the PHQ-9.



## Example Questions from Patients Regarding the PHQ-9

<b>Patient Question:</b>	<b>Why do I need to fill this out?</b>
<b>Answer</b>	<p><b>SCREENING</b> Much like taking your blood pressure or temperature, we're also focused on your overall health and well-being over the past 2 weeks.</p> <p><b>FOLLOW-UP</b> (<i>already in treatment</i>) Your provider wants to know more about your overall health so that we can properly gauge if the treatment is working the way it should.</p>
<b>Patient Question:</b>	<b>If I don't feel like I have these problems, should I still fill this out?</b>
<b>Answer</b>	<p>Absolutely, it's just as vital as tracking your blood pressure or temperature to properly assess your overall health and well-being. Like other factors, this metric is particularly useful when tracked over time.</p> <p>[Ask the patient if they have concerns. If they do then say I'll tell your provider you would like to talk about it.]</p>
<b>Patient Question:</b>	<b>Do I have to fill this out even if I'm not comfortable answering these questions?</b>
<b>Answer</b>	You never have to fill out a form or answer questions that you're not comfortable with, but we strongly recommend you do to help us provide better care.
<b>Patient Question:</b>	<b>I would rather just talk to my provider about these questions instead of filling this out. Is that OK?</b>
<b>Answer</b>	Yes, of course.
<b>Patient Question:</b>	<b>I don't understand some of these questions. Can you help me?</b>
<b>Answer</b>	If you have questions about the specific items on the form and how they apply to you, it would be best to talk about that with your provider.



## Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score ( <i>add your column scores</i> ) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_

Somewhat difficult \_\_\_\_\_

Very difficult \_\_\_\_\_

Extremely difficult \_\_\_\_\_

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### PERINATAL ANXIETY SCREENING SCALE (PASS)

ANTENATAL  
Weeks pregnant (      )

POSTNATAL  
Baby's age (      )

DATE: \_\_\_\_\_

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

Continued on Back

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

Clear fields

Print / Save PDF

**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

Department of Health, State of Western Australia (2013).  
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## Hurt, Insulted, Threatened with Harm and Screamed (HITS) Domestic Violence Screening Tool

*Please read each of the following activities and place a check mark in the box that best indicates the frequency with which your partner acts in the way depicted.*

Date: \_\_\_\_\_

Age: \_\_\_\_\_

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Ethnicity: Caucasian \_\_\_\_\_ Hispanic \_\_\_\_\_ African American \_\_\_\_\_ Asian \_\_\_\_\_ Indian \_\_\_\_\_

How often does your partner?	Never	Rarely	Sometimes	Fairly Often	Frequently
1. Physically hurt you					
2. Insult or talk down to you					
3. Threaten you with harm					
4. Scream or curse at you					
	1	2	3	4	5
Total Score:					

Each item is scored from 1-5. Range between 4-20. 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:

**The Family Place Hotline**– 214.941.1991

**Genesis Women’s Shelter**– 214.389.7700; Genesis Hotline– 214.946.HELP (4357)

**Texas Council on Family Violence**– 800.525.1978

**National Domestic Violence Hotline**– 1.800.799.SAFE (7233)

For more information, call **1.800.4BAYLOR** or visit us online at **BaylorHealth.com/DallasTrauma**.

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# Abuse Assessment Screen

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*This tool may be used to quickly screen for domestic violence. Prior to use the agency should have record-keeping and confidentiality standards that ensure against disclosure of participant information and maximize participant safety.*

**Instructions: Circle Yes or No for each question.**

1. Have you ever been emotionally or physically abused by your partner or someone important to you? YES NO

2. Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? YES NO

If YES, by whom? (Circle all that apply)

Husband Ex-Husband Boyfriend Stranger Other Multiple

Total no. of times \_\_\_\_\_

3. (If applicable): Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? YES NO

If YES, by whom? (Circle all that apply)

Husband Ex-Husband Boyfriend Stranger Other Multiple

Total no. of times \_\_\_\_\_

4. Within the last year, has anyone forced you to have sexual activities?

If YES, by whom? (Circle all that apply)

Husband Ex-Husband Boyfriend Stranger Other Multiple

Total no. of times \_\_\_\_\_

5. Are you afraid of your partner or anyone you listed above?

YES NO Multiple (please list)

**Developer:** Judith McFarlane, Barbara Parker, Karen Soeken, and Linda Bulloc  
Copyright (c) 1992, American Medical Association. All rights reserved. Journal of the American Medical Association, 1992, 267, 3176-78.

**Administration method:** Provide a private and confidential setting. Inform each woman that all women attending this service are being assessed for abuse. Read the Abuse Assessment Screen (AAS) questions to the woman.

**Scoring procedures:** If any questions on the screen are answered affirmatively, the AAS is considered positive for abuse (Weiss, Ernst, Cham, & Nick, 2003).

**Follow-up procedures:** At a minimum, all agencies should offer women with positive screens referral sources and legal options (Soeken et al. 1998).

## CAGE-AID Questionnaire

Patient Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

<b>Questions:</b>	<b>YES</b>	<b>NO</b>
1. Have you ever felt that you ought to cut down on your drinking or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning <b>to steady your nerves or to get rid of a hangover?</b>	<input type="checkbox"/>	<input type="checkbox"/>

### Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

### Psychometric Properties

The CAGE-AID exhibited:	<b>Sensitivity</b>	<b>Specificity</b>
One or more <b>Yes</b> responses	0.79	0.77
Two or more <b>Yes</b> responses	0.70	0.85

(Brown 1995)

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## SCREENING TESTS

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Several hundred screening instruments are available today to aid clinicians and others in identifying patients with alcohol problems. Many of these tools are presented in the guide, *Assessing Alcohol Problems: A Guide for Clinicians and Researchers*,<sup>1</sup> available from the National Institute on Alcohol Abuse and Alcoholism.

This issue of *Alcohol Research & Health* highlights some of the most popular screening tools for identifying hazardous or risky drinking. Two instruments in particular, the AUDIT and the CAGE, are cited throughout this issue—primarily because of their usefulness in a variety

of settings and with a range of target populations. In contrast, the T-ACE is a test developed to ascertain drinking in a very specific population—pregnant women.

The AUDIT, CAGE, and T-ACE are presented here in their entirety. See the *Assessing Alcohol Problems* guide for a full description of these and other instruments, including their target audiences, reliability, clinical utility, research applications, and source references, as well as administrative issues such as scoring, time requirements, training required to deliver the screening tests, their costs, and copyright issues.

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<sup>1</sup> National Institute on Alcohol Abuse and Alcoholism. *Assessing Alcohol Problems: A Guide for Clinicians and Researchers*, 2d ed. NIH Pub. No. 03–3745. Washington, DC: U.S. Dept. of Health and Human Services, Public Health Service. Revised 2003, may be accessed online at [www.niaaa.nih.gov/publications/protraining.htm](http://www.niaaa.nih.gov/publications/protraining.htm).

### *CAGE*

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- C** Have you ever felt you should **cut down** on your drinking?
- A** Have people **annoyed** you by criticizing your drinking?
- G** Have you ever felt bad or **guilty** about your drinking?
- E** **Eye opener:** Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

The CAGE can identify alcohol problems over the lifetime. Two positive responses are considered a positive test and indicate further assessment is warranted.

### *T-ACE*

---

- T** **Tolerance:** How many drinks does it take to make you feel high?
- A** Have people **annoyed** you by criticizing your drinking?
- C** Have you ever felt you ought to **cut down** on your drinking?
- E** **Eye-opener:** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

The T-ACE, which is based on the CAGE, is valuable for identifying a range of use, including lifetime use and prenatal use, based on the DSM–III–R criteria. A score of 2 or more is considered positive. Affirmative answers to questions A, C, or E = 1 point each. Reporting tolerance to more than two drinks (the T question) = 2 points.

The 4Ps Plus has a cost associated with its use. This image is from a scholarly article providing evidence for its use of screening for substance use in the perinatal period.

**Figure 1**

- Parents** Did either of your parents ever have a problem with alcohol or drugs?
- Partner** Does your partner have a problem with alcohol or drugs?
- Past** Have you ever drunk beer, wine, or liquor?
- Pregnancy**
  - In the month before you knew you were pregnant, how many *cigarettes* did you smoke?
  - In the month before you knew you were pregnant, *how many beers/how much wine/how much liquor* did you drink?

The 4P's Plus<sup>®</sup>. Published with permission, NTI Publishing<sup>27</sup>.

[Full size image >>](#)

Chasnoff, IJ, McGourty, RF, Bailey, GW. (2005). The 4P's Plus screen for substance use in pregnancy: clinical application and outcomes. *Journal of Perinatology*. 25(6), 368–374. Retrieved from: <https://www.nature.com/articles/7211266#ref27>

UW ADAI Sound Data Source

TWEAK Test

Protocol Number: XXXXXXXX-XXXX

Participant #: _____ <sup>a</sup>	Name Code: _____ <sup>b</sup>	Visit #: _____ <sup>c</sup>
Form Completion Status: _____ <sup>d</sup>	Visit Date: _____ <sup>f</sup> / _____ <sup>g</sup> / _____ <sup>h</sup> m m d d y y y y	
1=CRF administered 2=Participant refused 3=Staff member did not administer 4=Not enough time to administer 5=No participant contact 6=Other (specify: _____) <sup>e</sup>		
Node #: _____ <sup>i</sup>	Site #: _____ <sup>j</sup>	

Do you drink alcoholic beverages? If you do, please take our "TWEAK" test.

T. Tolerance: How many drinks can you "hold"? \_\_\_\_\_<sup>1</sup>  
Record number of drinks on line at right.

W. Have close friends or relatives Worried or Complained about your drinking in the past year? Yes  1<sup>2</sup>  
No  0

E. Eye-Opener: Do you sometimes take a drink in the morning when you first get up? Yes  1<sup>3</sup>  
No  0

A. Amnesia (Blackouts): Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? Yes  1<sup>4</sup>  
No  0

K(C). Do you sometimes feel the need to Cut Down on your drinking? Yes  1<sup>5</sup>  
No  0

Scoring:

To score the test, a seven-point scale is used. The tolerance question scores two points if a woman reports she can "hold" more than five drinks without passing out, and a positive response to the worry question scores two points. Each of the last three questions scores one point for positive responses. A total score of three or more points indicates the woman is likely to be a heavy/problem drinker.

Completed by (Staff #): _____	6
Reviewed by (Staff #): _____	7
Entered by (Staff #): _____	8

*Alcohol Use Disorders Identification Test (AUDIT)*

Please circle the answer that is correct for you.

1. How often do you have a drink containing alcohol?  

Never	Monthly or Less	Two to four times a month	Two to three times per week	Four or more times a week
-------	-----------------	---------------------------	-----------------------------	---------------------------
2. How many drinks containing alcohol do you have on a typical day when you are drinking?  

1 or 2	3 or 4	5 or 6	7 to 9	10 or more
--------	--------	--------	--------	------------
3. How often do you have six or more drinks on one occasion?  

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week
-------	-------------------	---------	-----------------------------	---------------------------
4. How often during the last year have you found that you were not able to stop drinking once you had started?  

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week
-------	-------------------	---------	-----------------------------	---------------------------
5. How often during the last year have you failed to do what was normally expected from you because of drinking?  

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week
-------	-------------------	---------	-----------------------------	---------------------------
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?  

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week
-------	-------------------	---------	-----------------------------	---------------------------
7. How often during the last year have you had a feeling of guilt or remorse after drinking?  

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week
-------	-------------------	---------	-----------------------------	---------------------------
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?  

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week
-------	-------------------	---------	-----------------------------	---------------------------
9. Have you or someone else been injured as a result of your drinking?  

No	Yes, but not in the last year	Yes, during the last year
----	-------------------------------	---------------------------
10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?  

No	Yes, but not in the last year	Yes, during the last year
----	-------------------------------	---------------------------

The Alcohol Use Disorders Identification Test (AUDIT) can detect alcohol problems experienced in the last year. A score of 8+ on the AUDIT generally

indicates harmful or hazardous drinking. Questions 1–8 = 0, 1, 2, 3, or 4 points. Questions 9 and 10 are scored 0, 2, or 4 only.

## AUDIT-C

*Please circle the answer that is correct for you.*

<b>1. How often do you have a drink containing alcohol?</b>					<b>SCORE</b>
Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	_____
<b>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</b>					
1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)	_____
<b>3. How often do you have six or more drinks on one occasion?</b>					
Never (0)	Less than Monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	_____
<b>TOTAL SCORE</b>					
Add the number for each question to get your total score.					_____

Maximum score is 12. A score of  $\geq 4$  identifies 86% of men who report drinking above recommended levels or meets criteria for alcohol use disorders. A score of  $> 2$  identifies 84% of women who report hazardous drinking or alcohol use disorders.

**Table 1.1 Interpreting AUDIT-C Plus 2 Screening Results**

Screening Measure	Screening Results	Interpretation	Clinical Guidance
AUDIT-C (0-12 points)	Women: < 3 points Men: < 4 points	<b>Negative Screen</b> – lowest risk (if no contraindications for drinking or cannabis use)	<ul style="list-style-type: none"> <li>Consider offering positive feedback and educating patients who drink and use cannabis about:                             <ul style="list-style-type: none"> <li>Recommended drinking limits<sup>27</sup></li> <li>Low-risk cannabis use.<sup>28</sup></li> <li>Health risks of alcohol (e.g. cancers, driving after drinking, pregnancy or planning)<sup>29</sup> and cannabis use (e.g. impaired driving, use disorder).<sup>28</sup></li> </ul> </li> </ul>
Cannabis question (0-4 points)	0-1 points (0 or < monthly)		
Other drugs question (0-4 points)	0 points (no use)		
AUDIT-C (0-12 points)	Women: 3-6 points Men: 4-6 points	<b>Positive Screen</b> – drinks or uses cannabis regularly, at levels that can impact health	<ul style="list-style-type: none"> <li>Brief counseling per <a href="#">Key Elements</a> in a patient-centered manner consistent with motivational interviewing:                             <ul style="list-style-type: none"> <li>Begin conversation, build rapport</li> <li>Provide feedback on screening</li> <li>Provide advice or recommendation</li> <li>Support patient in setting a goal and/or making a plan</li> </ul> </li> </ul>
Cannabis question (0-4 points)	2-3 points (monthly or weekly)		
AUDIT-C (0-12 points)	≥ 7 points <sup>30, 31</sup>	<b>High Positive Screen</b> – drinks, uses cannabis and/or other drugs at a level that is more likely to impact health and therefore needs further assessment	<ul style="list-style-type: none"> <li>Elicit symptoms (<a href="#">Change #2</a>)</li> <li>Ongoing brief counseling (<a href="#">Change #3</a>)</li> <li>Manage alcohol and/or other drug use disorders (<a href="#">Change #4</a>)</li> <li>Follow-up monitoring of use and symptoms and progress towards goal (<a href="#">Change #5</a>)</li> </ul>
Cannabis question (0-4 points)	4 points (daily or almost)		
Other drugs question (0-4 points)	1-4 points (any use)		

## COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen Version*

<b>SUICIDE IDEATION DEFINITIONS AND PROMPTS</b>	<b>Past month</b>	
<b>Ask questions that are bolded and <u>underlined</u>.</b>	<b>YES</b>	<b>NO</b>
<b>Ask Questions 1 and 2</b>		
<b>1) Wish to be Dead:</b> Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.  <b><u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></b>		
<b>2) Suicidal Thoughts:</b> General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan.  <b><u>Have you actually had any thoughts of killing yourself?</u></b>		
<b>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</b>		
<b>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act):</b> Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "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."  <b><u>Have you been thinking about how you might kill yourself?</u></b>		
<b>4) Suicidal Intent (without Specific Plan):</b> Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them."  <b><u>Have you had these thoughts and had some intention of acting on them?</u></b>		
<b>5) Suicide Intent with Specific Plan:</b> Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out.  <b><u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></b>		
<b>6) Suicide Behavior Question:</b>  <b><u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u></b>  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.  <b>If YES, ask: <u>How long ago did you do any of these?</u></b> • Over a year ago?    • Between three months and a year ago?    • Within the last three months?		

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## IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to \_\_\_\_\_

\_\_\_\_\_ (event) that occurred on \_\_\_\_\_ (date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score: \_\_\_\_\_

INT: 1, 2, 3, 6, 9, 14, 16, 20  
 AVD: 5, 7, 8, 11, 12, 13, 17, 22  
 HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD: a practitioner's handbook* (2<sup>nd</sup> ed., pp. 168-189). New York: Guilford Press.

AETR2N

22

1/13/2012

## Revised Impact of Event Scale (22 questions):

The revised version of the Impact of Event Scale (IES-r) has seven additional questions and a scoring range of 0 to 88.

On this test, scores that exceed 24 can be quite meaningful. High scores have the following associations.

### Score (IES-r)    Consequence

24 or more	PTSD is a clinical concern. <sup>6</sup> Those with scores this high who do not have full PTSD will have partial PTSD or at least some of the symptoms.
33 and above	This represents the best cutoff for a probable diagnosis of PTSD. <sup>7</sup>
37 or more	<b>This is high enough to suppress your immune system's functioning</b> (even 10 years after an impact event). <sup>8</sup>

The IES-R is very helpful in measuring the affect of routine life stress, everyday traumas and acute stress

### References:

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# Mood Disorder Questionnaire (MDQ)

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

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.

## My Maternal Wellbeing Plan

### SLEEP

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It is often very hard to get rest or sleep when you have a new baby, as a young baby is not meant to sleep through the night. It is normal for them to sleep in 2-3 hour stretches. This will change as baby grows. Sleep is important for your health. Your sleep will probably change after the baby comes, but you can try these things to help yourself get needed rest.

- You may need to sleep in 2-3 hour blocks at a time, strung together to get you the 7-9 hours you need.
- During that time, don't do anything except try to sleep. If you need to get up for feeding, do it, change his diaper, but don't play with him, and then go right back to bed. Keep lights off, low, or use a red bulb. Don't start watching TV, turn music on, or check your phone or other electronics.
- Create a healthy sleep environment—dark, quiet, comfortable, with not a lot of distractions.
- In addition to the main sleep time, rest or nap when the baby is sleeping. Don't use that time for house chores or any work.
- You and your baby need time together. Take advantage of offers for help by asking others to do household tasks.
- If you are feeling depressed or anxious, you may need to find a way to get 5-6 hours of continuous sleep—research shows this may make your depression or anxiety better. Have someone else feed and care for the baby during that time.



### EAT WELL

- Always have on hand: protein, veggies, fruit, whole grains.
- Prepack single-serve portions in baggies for easy eating.
- Keep healthy snacks where you sit to feed the baby.
- Drink water as you need it, have it easily available.

### MOVE & Get Outside

- Aim for 30 minutes a day of movement. Start easy! Walk, light housework or gardening, quick trip to the store or errands or library.
- Try to get outside every day, even if just for a slow walk.

### CONNECT

- Stay connected to supportive family and friends by phone, email and text.
- Encourage short visits, and be very clear about “visiting hours”.
- Accept offers of help. Ask for it if you need it!

### Resources

Getting Good Sleep:

[www.sleep.org](http://www.sleep.org)

Baby Development:

[www.helpmegrowmn.org](http://www.helpmegrowmn.org)

Nutrition for New Moms:

<http://www.health.state.mn.us/wic/nutrition/morenutinfo.html>

Places to find other parents/  
new moms:

- Early Childhood Family Education
- Family Home Visiting
- Community Parks or Libraries



MATERNAL AND CHILD HEALTH SECTION

PO Box 64882, St. Paul, MN 55164-0882 651-201-3625

English July 19, 2016

## My Maternal Wellbeing Plan

### PLAN AHEAD

My best place for relaxing in my home is: \_\_\_\_\_

Healthy, easy foods I like to eat are: \_\_\_\_\_

People I can ask for help when I need it:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Ways I like to exercise and connect with other people, which I could do with a small baby:

1. \_\_\_\_\_ 2. \_\_\_\_\_

### JUST IN CASE

Having a new baby is a big change.

There are resources to help people figure out how to adjust. You can find help to keep you and your baby healthy, mentally and physically. If it's not going well, it's good to recognize that and get help.

My early signs that I am feeling bad, depressed, or too anxious:

- \_\_\_\_\_
- \_\_\_\_\_

It can be difficult to talk about not doing well. If you feel like this, who are 3 people you would talk with?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What will you say?

\_\_\_\_\_

### GET HELP

If it is not an emergency, but I need advice:

- Provider's office daytime:  
\_\_\_\_\_
- Provider/clinic after hours:  
\_\_\_\_\_
- Pregnancy and Postpartum Support warm help line: call or text:  
612-787-7776
- Mother Baby Program: (warm line, will call you back):  
612-873-HOPE (4673)

If it is an emergency and I am scared I will hurt myself or my baby:

\* 911

\* Crisis hot line: 866-379-6363

Please visit our webpage for more information or printouts of this plan:

<http://www.health.state.mn.us/divs/cfh/to pic/pmad/>



# Creating a Wellness Plan

Need help completing this plan or finding referrals?  
Call Perinatal Support Washington's Warm Line to complete a wellness plan: 1-888-404-7763.

**Therapy:** *Therapy with a professional experienced in PMADs is crucial to getting better. Detail names, phone numbers, addresses, and next appointments.*

**Medical Management/Medications:**  
*Medication might be the right decision for you. Detail names of health care providers; appointment details, medication names and dosages.*

**Nutrition Plan:**  
*Emphasize protein to improve mood. Detail shopping, meal prep, and food ideas.*

**Support Group:**  
*Social support is critical to reducing stress and to feel valued and cared for. Detail names, locations and meeting info for local groups.*

**Me Time/Couple Time:**  
*What things rejuvenate you? Detail when you will have time by yourself and time with your just your partner.*

**Sleep Plan:**  
*Aim for chunks of 3-5 hours of uninterrupted sleep. Detail how to schedule sleep.*

**Other Support Team Members:**  
*Grandparents, sisters, friends, church members, postpartum doula....*

**Household Help:**  
*What can you delegate? What can you give up for now? List ideas and who will do what.*

## *Common Questions About Creating a Wellness Plan:*

### **Do I need therapy? How could a therapist or counselor help?**

This might be exactly the question that a therapist could answer with you. There are so many things happening to you right now--talking through them would be helpful. A therapist can also offer perspective on whether what you are experiencing is postpartum depression/anxiety/traumatic response, etc. For parents experiencing these issues, a specialist with training and experience is important. Find a therapist near you on our providers list: [www.perinatalsupport.org/providers](http://www.perinatalsupport.org/providers).

### **What about medications? I've never used them before. Will I have to be on them forever? What if I am breastfeeding?**

First off, needing/wanting medication is not a weakness and it may not be the right choice for everyone. Medication is a tool that can be helpful for some and may be needed for others. We highly encourage you to meet with a well-trained provider on this issue, and to use the following sites to learn more: [infantrisk.com](http://infantrisk.com) or [womensmentalhealth.org](http://womensmentalhealth.org). You can find more resources for medication management on our website, [perinatalsupport.org](http://perinatalsupport.org).

### **I obviously want more sleep, but how? Can sleep deprivation really cause the feelings I am having?**

Sleep dramatically impacts our mood, and can be the biggest risk factor for mental health symptoms. Often the very first treatment intervention for depression or anxiety symptoms will be sleep--that's how important it is. A sleep plan is way more than "sleep when the baby sleeps." It entails scheduling shifts and asking for help to ensure that you are getting a minimum of 4-5 hours of sleep plus shorter stretches throughout the night and day.

### **A support group--really?**

Support groups get a bad rap--maybe we should call them something else. The bottom line is that you will likely be surprised by our groups. They are down-to-earth, refreshingly honest, and often bring some humor to an otherwise difficult time. Also, they are a great way to meet other parents, and they are a great baby/parent-friendly place to go in the first weeks when you just want to get out of the house but haven't mastered breastfeeding in public, are not sure what to bring, etc. We have groups all around the state with times throughout the day and week. Social support is crucial to reducing stress; meeting other parents going through the same life struggles can be the best medicine.

### **How am I supposed to eat healthy when I can't even find time to eat, let alone cook?**

Have you found yourself stuck holding a sleeping baby, without food or water for hours on end? Stash water bottles and healthy snacks on the coffee table. Prepare hardboiled eggs, 12 at a time. Focus on eating high-protein and highly nutrient-rich foods often. These will help balance your blood sugar. Have foods available that you can eat one-handed, such as yogurt, meat, cheese, pre-cut veggies and fruit, or pre-made smoothies from the store. Aim for no cooking, no plates, no utensils (well sometimes)--just open the fridge, grab, and put in your mouth. This phase won't last forever and usually when you're not taking good care of yourself, you feel worse and vice versa. It seems small, but eating well matters.

### **How can I possibly fit in me time? I'm feeding or attending to my baby all the time.**

Taking care of yourself in the first weeks and months can seem like an impossible task, and taking care of your relationship might seem even harder. We strongly encourage you (and your partner) to take time every few days to yourself. This will look very different for each of us. And for many of us, the things we used to do to take care of ourselves are not possible. It's important to think small and schedule time regularly. What brought you joy pre-baby? Here are some ideas: hot shower by yourself, phone a friend, play music that makes you feel good, journal/jot down your thoughts and feelings (sticky notes ok!), or listen to a mindfulness meditation or a podcast.

### **I'm overwhelmed by the state of my home, and it's stressing me out. How can I get on top of things?**

For household help, think of what you can delegate and what you can give up for now. Enlist everyone to do everything you don't want to do. Your job is to rest, heal, and take care of the baby. We mean it! If you don't have someone to ask, let things stay undone. You will get to it--at some point you will need clean dishes and you will do them.

### **What do you mean by a support team?**

Is there someone in your life that you feel comfortable telling it like it is? A friend, a sibling, a parent, a partner? It's important to share how you are really feeling and process this intense experience you have been through. These are the people who you can ask for help, you can ask to just sit with you, or you can trust to take care of your baby.

People often want to help but are not sure how to navigate those first days and weeks of new parenting. If you don't want people over, definitely say no. But if you'd like help or company, please ask them to come over and bring a meal on their way in and bring the garbage out when they leave! You can also find more information about support groups and our warm line on our website, [perinatalsupport.org](http://perinatalsupport.org).

Perinatal Support Washington  
[perinatalsupport.org](http://perinatalsupport.org)  
Warm Line 1.888.404.7763



# THE POSTPARTUM STRESS CENTER

The Postpartum Stress Center, LLC • 610.525.7527 • [www.postpartumstress.com](http://www.postpartumstress.com)

## PPD Risk Assessment During Pregnancy

### *Important Note:*

This assessment is not diagnostic. Risk factors do not cause postpartum depression. Our intention is to help you become aware of the factors that can potentially make you vulnerable to depression, so you can mobilize your support network and make use of the resources available to you. The list below are factors that can increase your susceptibility to depression. Check all that apply and discuss the results with your doctor. In fact, we would encourage you to print it out and take the list so your treating physician can see it and keep it in your patient file.

- I was not happy to learn I was pregnant.
- My partner was not happy to learn I was pregnant.
- I have had a previous episode of postpartum depression and/or anxiety that was successfully treated with therapy and/or medication.
- I might have experienced symptoms of postpartum depression following previous births, but I never sought professional help.
- I have had one or more pregnancy losses.
- I have a history of depression/anxiety that was not related to childbirth.
- I have lost a child.
- I have been a victim of the following:
  - Childhood sexual abuse
  - Childhood physical abuse
  - Physical assault by someone you know
  - Physical assault by stranger
  - Physical assault during this pregnancy
  - Sexual assault by someone you know
  - Sexual assault by stranger
- There is a family history of depression/anxiety, treated or untreated.
- I have a history of severe PMS.
- I have experienced suicidal thoughts or have considered doing something to hurt myself in my past.
- I do not have a strong support system to help me if I need it.
- I have a history of drug or alcohol abuse.
- People have told me I'm a perfectionist.
- During this pregnancy, I have experienced some emotions about which I am very concerned.
- I feel sad.
- My relationship with my partner is not as strong as I'd like it to be.
- My partner and I have been thinking about separating or divorcing.
- I am not likely to admit it when I need help.



# THE POSTPARTUM STRESS CENTER

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- During the past year, I have experienced an unusual amount of stress (ex: Move, job loss, divorce, loss of loved one)
- I have little interest in things that I used to find pleasurable.
- I am having anxiety attacks.
- Sometimes I worry about things so much that I can't get the thoughts out of my head.
- I am bothered and frightened by thoughts that I can't get out of my mind, especially about my baby's well-being.
- I have thoughts of hurting myself.
- I have thoughts of hurting my baby.
- I am more irritable and/or angry than usual.
- I just don't feel like myself.
- Sometimes, I feel like I can't shake off these bad feelings no matter what I do.
- I'm afraid if I tell someone how I really feel, they will not understand or they will think something is really wrong with me.