

Maternal Depression Screening in Pediatric Settings

Toolkit and Guidelines

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Toolkit for Maternal Depression Screening in Pediatric Settings

This Toolkit provides information to support pediatric providers as they detect and screen for mental health concerns. MCPAP for Moms in Massachusetts has developed this toolkit to support the inclusion of the Edinburgh Postpartum Depression Scale (EPDS) in the SWYC screening tool. We recommend pediatric providers review the entire toolkit.

The Toolkit includes:

1. *Guidelines*
2. *Assessment Tools*: Highlights the range of depression and mental health concerns that may occur postpartum, possible treatment options, and key issues to consider when assessing mental health status during the postpartum period
 - **Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women**: Provides key information/concepts to consider when assessing the mental health of pregnant and postpartum women
 - **Summary of Emotional Complications During Pregnancy and the Postpartum Period**: An overview of the range of emotional complications that can occur during pregnancy and postpartum including Baby Blues, Perinatal Depression, Perinatal Anxiety, Posttraumatic Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), and Postpartum Psychosis.
3. *Screening Tools and Algorithms*: Includes depression screens and a depression screening algorithm designed for pediatric providers
 - **Edinburgh Postnatal Depression Scale (EPDS) as part of SWYC or standalone (with permission)**
 - **Postpartum Depression Screening Algorithm for Pediatric Providers during Well-Child Visits**: Provides guidance on administering the EPDS as part of the SWYC and next steps depending on the score. Side one is a simplified version of the algorithm. Side two provides more detailed information including talking points and suggested language regarding how to discuss the screen and resultant scores with a parent.

Why is postpartum depression important to pediatric providers?

Postpartum depression (PPD) is a widespread problem that can complicate birth,¹ infant,² and child outcomes.³⁻⁵

Prevalence and risk factors

Perinatal depression - depression before, during, and in the year following pregnancy - can have far-reaching, harmful effects for all family members. One in five women screen positive for depression during their first postpartum year.⁶ One in three fathers in families struggling with maternal depression experience PPD themselves.⁷ Depression in fathers may present differently than in mothers. Men with depression are more likely to report substance abuse and disturbances in work and social functioning.⁸ Adoptive parents have similar rates of depression as birth parents during the postpartum period.^{9,10} Individuals with a family history of depression, substance use, or a personal history of depression are at increased risk for perinatal depression.¹¹ Large health disparities in the U.S. place low-income and racial and ethnic minority families at increased risk for parental depression, stress, and poorer child outcomes compared to affluent families.¹²

Impact on birth outcomes

Birth outcomes can be adversely affected by depression in pregnancy,^{1,13-16} and PPD can have a long-term impact on child outcomes. PPD is associated with attachment insecurity,³ difficult infant/childhood temperament,^{3,17} developmental delay, and impaired language development.^{4,5} Treatment of maternal depression until remission is associated with decreased psychiatric symptoms and improved functioning outcomes among offspring.^{18,19} Despite the profound, negative effects on mother and child, some of which improve with depression treatment,^{18,19} the vast majority of women with PPD go untreated.²⁰⁻²³

What is known about PPD screening in pediatric settings?

Most perinatal or obstetrical settings only see postpartum women and screen for PPD at the 4-6 week postpartum visit.²⁴ Significant numbers of women do not keep their postpartum visits. Pediatric providers caring for children under the age of five may be the only medical provider many mothers see during the child's first year of life.^{25,26} Pediatric providers see mothers frequently and may get to know them better than their own obstetric or primary care provider PCPs. Since PPD can be identified in pediatric settings,²³ training pediatric providers to detect and address PPD during the first postpartum year can enhance providers' impact on maternal mental health,²⁷ carrying the potential to have a trans-generational impact.

What screening instrument should I use for PPD screening during the infant's well-visit?

The preferred screening instrument is the Survey of Wellbeing of Young Children (SWYC), available on the SWYC website at <https://www.TheSWYC.org>. The developers of the SWYC have created an augmented version of the SWYC screening tool because maternal mental health is critical to the development and well-being of infants and young children. You may choose the 2-, 4-, or 6-month version depending on the age of the infant. Embedded in the SWYC is the Edinburgh Postnatal Depression Scale (EPDS),²⁹ a widely used and validated 10-item questionnaire to identify women experiencing depression during pregnancy and the postpartum period. The rest of the SWYC at these three ages is identical to the generic SWYC. The SWYC is a comprehensive screening instrument used to assess children's cognitive, language, motor, and social-emotional development as well as family risk factors (parental depression, conflict, or substance abuse, and hunger). It is short and easy to score. Instructions for scoring the SWYC are also available on the SWYC website.

Other instruments that can be used to screen for PPD include the Patient Health Questionnaire (PHQ-9). The PHQ-9 (<http://www.phqscreener.com>) is a validated questionnaire to identify depression during pregnancy and the postpartum period.²⁸ The EPDS with permission can also be used as a standalone instrument with instructions in Appendix 3.²⁹

Can I bill for PPD screening?

If you use the SWYC that includes a PPD screen, in Massachusetts you can bill for the developmental-behavioral screen for the child using the procedure code 96110. In other states and for other tools, please consult the infant's insurer.

When an infant is the patient

Well-child visits provide an ideal opportunity to detect and address PPD. As pediatric providers are most often not providing primary care to mothers, their main role is one of screening and referral. PPD screening is recommended for mothers and fathers as part of well-child visits (and at other times if indicated) at the following ages:

- Within first month
- 2-month visit
- 4-month visit
- 6-month visit

This toolkit provides a [Depression Screening Algorithm for Pediatric Providers During Well-Child Visits](#) (see Appendix), which offers step-by-step guidelines for administering and responding to a PPD screen. While the majority of mothers and fathers will not screen positive for PPD, the postpartum period can be challenging, and depression and other mental health concerns can arise at any time.

The baby's behavior offers a window into the emotional state of the family. Problems of crying, sleep, and feeding are intimately intertwined with perinatal emotional complications, both as cause and result. Parents' mood affects the baby, and baby's mood affects the parent. Time spent in the primary care setting addressing these issues in the context of evaluating the parents' emotional wellbeing can be a first step in treatment.

For all parents with a positive screen, first determine risk:

(Practices with a co-located behavioral health clinician may want to use their clinician for this task.)

1. If there is a crisis or safety concern or the parent gave a positive response on the EPDS or PHQ-9 self-harm question, refer to the parent's local mental health emergency service or emergency room. Parent should not be left alone and someone should accompany parent to emergency services.
2. If the parent is not in need of emergency evaluation and is already in mental health treatment or has access to a mental health provider (e.g., someone they have used in the past), refer to and with parent's consent notify that mental health provider.
3. If the parent is not in need of emergency evaluation and if the parent does not already have a mental health provider:
 - Give parent information about community resources such as support groups.
 - Refer and with consent notify parent's PCP and/or OB/GYN for monitoring and follow-up.
4. If you are concerned about the parent keeping the referral, consider calling in a week to verify that the parent followed through. If your practice has a care coordinator, follow up should be a routine part of your practice work flow.
5. Engage natural supports and encourage parent to utilize them. Most likely you will have only one parent in the office when a PPD screen is positive. A depressed parent who is alone or feeling alone is at higher risk for suicide. It is important for someone else in the parent's life to be aware of the presence of depression and be able to step in to help. With parent's consent, notify natural supports. This is an excellent time to screen for domestic violence to ensure that the natural support is appropriate.

We recommend that pediatric providers document the screening result and your planned action in the medical record as you would with other risk factors that may affect the infant's health such as substance use disorders or domestic violence. Follow your organization's policy about screening tools as to whether or not to scan in the actual screening form. Pediatric practices should continue to use their current strategies for appropriately documenting potentially sensitive family information, especially when there are custody concerns.

When a pregnant/postpartum young mother is the patient

Pediatric providers caring for pregnant teens or postpartum young mothers should screen for depression during pregnancy and in the postpartum period. New mothers should also be screened for PPD during well-child visits. If you decide to treat a teen with depression during the perinatal period, you may find the adult MCPAP for Moms toolkit helpful at <https://www.mcpapformoms.org/Toolkits/Toolkit.aspx>.

Antidepressant medications and lactation

Considerations for lactating women:

- SSRIs (and some other antidepressants) are considered a reasonable treatment option during breastfeeding of healthy infants. In premature or ill infants, the safety is less clear.
- When antidepressants are indicated, the benefits of breastfeeding a healthy infant while taking antidepressants generally outweigh the risks.
- Most psychiatric medications are passed into breast milk, though in very low amounts.
- The benefits of other psychiatric medications, including benzodiazepines, anti-epileptics, stimulants, and antipsychotics, may outweigh the risks of the medication during breastfeeding. It is important to take into consideration the infant's health as a factor when weighing the risks and benefits of the medication to mother and infant. Each class of psychiatric medications carries a different risk and decisions should be made on a patient-by-patient basis and consider the needs of the family.
- It is important to consider the risk of untreated illness to the mother-baby dyad, as well as the entire family, and balance this with the risk of medication use during lactation.
- It is crucial that evaluation of the risks and benefits of medication use during breastfeeding is done on a patient-by-patient basis and considers the needs of the family.
- Recommendations are ideally made collaboratively with well-informed patients and family members.
- Monitor for medication side effects in nursing infants.

We also recommend the NIH website [LactMed](#), that contains information on medications to which breastfeeding mothers may be exposed. Providers can also download the [LactMed app for mobile devices](#). Pediatric providers can also visit the [MCPAP for Moms website](#) for additional information and treatment algorithms.

Home visiting programs

Many states and communities have home visiting programs. Home visiting programs offer voluntary, family-focused services to expecting or new families with infants and children. Services are predominately provided in a family's home. Many home-visiting programs offer group-based services as well. Home visits are provided in a routine and sustained manner, ranging from a weekly to a monthly basis. Typically, families are eligible to remain in home-visiting programs for three to five years, although this varies by individual program. Home-visiting services are delivered by trained home-visiting professionals or paraprofessionals, with the goal of addressing specific issues based upon the family's eligibility for the program. While each home visiting program has different eligibility criteria — and thus delivers different services to their participants— there are many elements that are consistent across programs. The common core elements of most home visiting programs include, but are not limited to: addressing mother and child health, safety, and mental health; positive parenting; child development and school readiness; and injury prevention including safe homes. These programs also introduce parents to education and employment opportunities.

The home visitor works collaboratively with the family to set family goals, provide screenings, assessments and parenting information, make referrals on behalf of families, and connect families to any other community-based resources as needed. The following are some of the outcomes that home visiting programs across the country have demonstrated:

- Increased rates of teen moms staying in school and graduating
- Increased access to primary care medical services for the child
- Increased child immunization rates
- Improved parent-child bonding
- Improved school readiness
- Decreased number of low-birth weight babies
- Decreased number of child abuse and neglect cases
- Decreased families' need for welfare, or TANF (Temporary Assistance to Needy Families) and other social services
- Non-organic failure to thrive

References

1. Grote NK, Bridge JA, Gavin AR, Melville JL, Iyengar S, Katon WJ. A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. *Arch Gen Psychiatry* 2010;67:1012-24.
2. Britton HL, Gronwaldt V, Britton JR. Maternal postpartum behaviors and mother-infant relationship during the first year of life. *J Pediatr* 2001;138:905-9.
3. Forman DR, O'Hara MW, Stuart S, Gorman LL, Larsen KE, Coy KC. Effective treatment for postpartum depression is not sufficient to improve the developing mother-child relationship. *Dev Psychopathol* 2007;19:585-602.
4. Deave T, Heron J, Evans J, Emond A. The impact of maternal depression in pregnancy on early child development. *BJOG* 2008;115:1043-51.
5. Paulson JF, Keefe HA, Leiferman JA. Early parental depression and child language development. *J Child Psychol Psychiatry* 2009;50:254-62.
6. Wisner KL, Sit, DY, McShea, M. Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry* 2013;70(5): 490-498. doi:10.1001/jamapsychiatry.2013.87.
7. Ramchandani P, Stein A, Evans J, & O'Connor TG. Paternal depression in the postnatal period and child development: A prospective population study. *The Lancet* 2005;365(9478):2201-2205.
8. Carter J, Joyce, P, Roger, M, Luty, S, McKenzie, J. Gender differences in the presentation of depressed outpatients: A comparison of descriptive variables. *Journal of Affective Disorders* 2000;61: 59-67.
9. Mott S, Schiller CE, Richards JG, O'Hara MW, Staurt S. Depression and anxiety among postpartum and adoptive mothers. *Arch Womens Ment Health* 2011;14:335-343.
10. Senecky Y, Agassi H, Inbar D, Horesh N, Diamond G, Bergman YS, Apter A. Post-adoption depression among adoptive mothers. *Journal of Affective Disorders* 2009;115:62-68.
11. Earls, M and the Committee on Psychosocial Aspects of Child and Family Health. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics* 2010;126:1032.
12. Stewart AL, Dean ML, Gregorich SE, Brawarsky P, Haas JS. Race/ethnicity, SES and the health of pregnant women. *Journal of Health Psychology* 2007;12(2):285–300. doi:10.1177/135910530707425.
13. Cripe SM, Frederick IO, Qiu C, Williams MA. Risk of preterm delivery and hypertensive disorders of pregnancy in relation to maternal co-morbid mood and migraine disorders during pregnancy. *Paediatr Perinat Epidemiol* 2011;25:116-23.
14. Suri R, Altshuler LA, Mintz J. Depression and the decision to abort. *AJ Psychiatry* 2004;161:1502.

15. Flynn HA, Chermack ST. Prenatal alcohol use: the role of lifetime problems with alcohol, drugs, depression, and violence. *J Stud Alcohol Drugs* 2008;69:500-9.
16. Gotlib IH, Whiffen VE, Wallace PM, Mount JH. Prospective investigation of postpartum depression: factors involved in onset and recovery. *J Abnorm Psychol* 1991;100:122-32.
17. Britton JR. Infant temperament and maternal anxiety and depressed mood in the early postpartum period. *Women Health* 2011;51:55-71.
18. Pilowsky DJ, Wickramaratne P, Talati A, et al. Children of depressed mothers 1 year after the initiation of maternal treatment: findings from the STAR*D-Child Study. *Am J Psychiatry* 2008; 165(9): 1136-1147.
19. Foster CE, Webster MC, Weissman MM. Remission of maternal depression: relations to family functioning and youth internalizing and externalizing symptoms. *J Clin Child Adolescent Psychology* 2008; 37(4): 714-724. Smith MV, Shao L, Howell H, Wang H, Poschman K, Yonkers KA. Success of mental health referral among pregnant and postpartum women with psychiatric distress. *Gen Hosp Psychiatry* 2009;31:155-62.
20. Carter FA, Carter JD, Luty SE, Wilson DA, Frampton CM, Joyce PR. Screening and treatment for depression during pregnancy: a cautionary note. *Aust N Z J Psychiatry* 2005;39:255-61.
21. Marcus SM, Flynn HA, Blow FC, Barry KL. Depressive symptoms among pregnant women screened in obstetrics settings. *J Womens Health (Larchmt)* 2003;12:373-80.
22. Rowan P, Greisinger A, Brehm B, Smith F, McReynolds E. Outcomes from implementing systematic antepartum depression screening in obstetrics. *Archives of Women's Mental Health* 2012;15:115-20.
23. Chaudron L, Klein M, Remington P, Palta M, Allen C, Essex M. Prodromes, predictors and incidence of postpartum depression. *J Psychosom Obstet Gynaecol* 2001;22:103-112.
24. Chaudron LH. Review of beyond the blues: A guide to understanding and treating prenatal and postpartum depression. *Birth: Issues in Perinatal Care* 2004;31(1):75.
25. National Ambulatory Medical Care Survey (NAMCS) and Periodic Survey #42. American Academy of Pediatrics News Research Update Column; October 2001.
26. Chaudron L, Szilagyi PG, Campbell AT, Mounts KO, McInerney KT. Legal and ethical considerations: Risks and benefits of postpartum depression screening at well-child visits. *Pediatrics* 2007;119:123-128.
27. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* 2001;16(9):606-613. doi:jgi01114[pii].
28. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 1987;150:782.
29. Sheldrick, RC, Perrin, EC. Surveillance of children's behavior and development: Practical solutions for primary care. *Journal of Developmental and Behavioral Pediatrics* 2009;30:151-3. PMID 19363367

Appendix

- [Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women](#)
- [Summary of Emotional Complications During Pregnancy and the Postpartum Period](#)
- [Edinburgh Postnatal Depression Scale and Scoring as part of the SWYC](#)
- [Postpartum Depression Screening Algorithms for Pediatric Providers during Well-Child Visits](#)

Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women

Assessing Thoughts of Harming Baby	
Thoughts of Harming Baby Secondary to Obsessions/Anxiety/Depression	Thoughts of Harming Baby Secondary to Postpartum Psychosis/Suspected Postpartum Psychosis
<ul style="list-style-type: none"> • Good insight • Thoughts are intrusive and scary • No psychotic symptoms • Thoughts cause anxiety ↓ <p>Suggests not at risk of harming baby</p>	<ul style="list-style-type: none"> • Poor insight • Psychotic symptoms • Delusional beliefs with distortion of reality present ↓ <p>Suggests at risk of harming baby</p>

Assessing Suicidal Ideation	
Suggests Lower Risk	Suggests Higher Risk
<ul style="list-style-type: none"> • No prior attempts • No plan • No intent • No substance use • Protective factors (can ask patient: <i>what prevents you from acting on suicidal thoughts?</i>) 	<ul style="list-style-type: none"> • History of suicide attempt • High lethality of prior attempts • Current plan • Current intent • Substance use • Lack of protective factors (including social support)

Considerations for Prescribing Medication	
Suggests Medication May Not be Indicated	Suggests Medication Treatment Should be Strongly Considered
<ul style="list-style-type: none"> • Mild depression based on clinical assessment • No suicidal ideation • Engaged in psychotherapy or other non-medication treatment • Depression has improved with psychotherapy in the past • Able to care for self/baby • Strong preference and access to psychotherapy 	<ul style="list-style-type: none"> • Moderate/severe depression based on clinical assessment • Suicidal ideation • Difficulty functioning caring for self/baby • Psychotic symptoms present • History of severe depression and/or suicide ideation/attempts • Comorbid anxiety diagnosis/symptoms

Risk Factors for Postpartum Depression ¹	
<ul style="list-style-type: none"> • Personal history of major or postpartum depression • Family history of postpartum depression • Gestational diabetes • Difficulty breastfeeding • Fetal/newborn loss • Lack of personal or community resources • Financial challenges • Substance use/addiction 	<ul style="list-style-type: none"> • Complications of pregnancy, labor/delivery, or infant's health • Teen pregnancy • Unplanned pregnancy • Major life stressors • Violent or abusive relationship • Isolation from family or friends

How to Talk about Perinatal Depression with Moms ¹
<ul style="list-style-type: none"> • <i>How are you feeling about being pregnant/a mother?</i> • <i>What things are you most happy about?</i> • <i>What things are you most concerned about?</i> • <i>Do you have anyone you can talk to that you trust?</i> • <i>How is your partner doing?</i> • <i>Are you able to enjoy your baby?</i>

¹These materials have been adapted from those made available by HealthTeamWorks and the Colorado Department of Public Health and Environment (CDPHE)
<http://www.healthteamworks.org/guidelines/depression.html>.

Summary of Emotional Complications During Pregnancy and the Postpartum Period

	Baby Blues	Perinatal Depression	Perinatal Anxiety
What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason	Depressive episode that occurs during pregnancy or within a year of giving birth	A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period
When does it start?	First week after delivery; Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum	Most often occurs in the first 3 months postpartum; May also begin during pregnancy, after weaning baby or when menstrual cycle resumes	Immediately after delivery to 6-weeks postpartum; May also begin during pregnancy, after weaning baby or when menstrual cycle resumes
Risk factors	N/A	Personal history of depression or postpartum depression; Family history of postpartum depression; Fetal/newborn loss; Lack of personal/community resources; Substance use/addiction; Complications of pregnancy, labor/delivery, or infant's health; Unplanned pregnancy; Domestic violence or abusive relationship	Personal history of anxiety; Family history of anxiety; Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby); Prior pregnancy loss
How long does it last?	A few hours to two weeks	2 weeks to a year or longer; Symptom onset may be gradual	From weeks to months to longer
How often does it occur?	Occurs in up to 85% of women.	One in seven women.	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in 0.5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.
What happens?	Dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability; Baby blues is a risk factor for postpartum depression	Change in appetite, sleep, energy, motivation, and concentration; May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness; May also experience suicidal thoughts and evolution of psychotic symptoms; Thoughts of harming baby	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying; May have intrusive thoughts; Fear of going out; Checking behaviors; Bodily tension; Sleep disturbance
Resources and treatment	Resolves on its own; Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings); Address infant behavioral dysregulation - crying, sleep, feeding problems - in context of perinatal emotional complications	For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication treatment. Encourage self-care and exercise and healthy diet. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings. Address infant behavioral dysregulation - crying, sleep, feeding problems - in context of perinatal emotional complications.	

Summary of Emotional Complications During Pregnancy and the Postpartum Period

	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder (OCD)	Postpartum Psychosis
What is it?	Distressing anxiety symptoms experienced after traumatic event(s)	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother; May include rituals (e.g., counting, cleaning, hand washing); May occur with or without depression	Very rare and serious; Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder); Usually involves poor insight about illness/symptoms, making it extremely dangerous; Psychotic symptoms include auditory hallucinations, delusions, paranoia, disorganization, and rarely visual hallucinations
When does it start?	May be related to trauma before birth or as a result of traumatic birth; Underlying PTSD can also be worsened by traumatic birth	1 week to 3 months postpartum; Occasionally begins after weaning baby or when menstrual cycle resumes; May also occur in pregnancy	Onset is usually between 24 hours to 3 weeks after delivery; Watch carefully if sleep deprived for ≥ 48 hours
Risk factors	Subjective distress during labor and birth; Obstetrical emergency and infant complication; Depression or trauma/stress during pregnancy; Prior trauma or sexual abuse; Lack of partner support; Fetal newborn loss	Personal history of OCD; Family history of OCD. Comorbid depression; Panic or generalized anxiety disorder; Premenstrual dysphoric disorder; Preterm delivery; C-Section delivery; Postpartum worsening; Prior pregnancy loss	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly); Prior pregnancy loss
How long does it last?	1 month or longer	From weeks to months to longer	Until treated
How often does it occur?	Occurs in 2-15% of women; Occurs after childbirth in 2-9% of women	Occurs in up to 4% of women	Occurs in 1-2 or 3 in 1,000 births
What happens?	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event	Disturbing repetitive and invasive thoughts (which may include harming baby), compulsive behavior (such as checking) in response to intrusive thoughts	Mood fluctuation, confusion, marked cognitive impairment; Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g., tactile and olfactory) hallucinations; May have moments of lucidity; May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately
Resources and treatment	For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication treatment. Encourage self-care and exercise and healthy diet. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings. Address infant behavioral dysregulation - crying, sleep, feeding problems - in context of perinatal emotional complications.		Requires immediate psychiatric help; Hospitalization usually necessary; Medication is usually indicated; If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies; Encourage sleep hygiene for prevention (e.g., consistent sleep/wake times, help with feedings at night)

Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996) and O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002.

Edinburgh Postnatal Depression Scale (EPDS)

Name: _____

Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

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

In the past 7 days:

- | | |
|--|---|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I always could<input type="checkbox"/> Not quite so much now<input type="checkbox"/> Definitely not so much now<input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"><input type="checkbox"/> As much as I ever did<input type="checkbox"/> Rather less than I used to<input type="checkbox"/> Definitely less than I used to<input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, some of the time<input type="checkbox"/> Not very often<input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> No, not at all<input type="checkbox"/> Hardly ever<input checked="" type="checkbox"/> Yes,<input type="checkbox"/> sometimes<input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite a lot<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> No, not much<input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<input type="checkbox"/> No, most of the time I have coped quite well<input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, sometimes<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input type="checkbox"/> Yes, quite often<input type="checkbox"/> Not very often<input type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, most of the time<input checked="" type="checkbox"/> Yes, quite often<input type="checkbox"/> Only occasionally<input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes, quite often<input type="checkbox"/> Sometimes<input type="checkbox"/> Hardly ever<input type="checkbox"/> Never |
|--|---|

Administered/Reviewed by _____ Date _____

Edinburgh Postnatal Depression Scale¹ (EPDS)

Postpartum depression is the most common complication of childbearing.² The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt **during the previous week**. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center <www.womenshealth.gov> and from groups such as Postpartum Support International <www.postpartum.net> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

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

³Source: Cox, J., Holden, J., Henshaw, C. (2014). *Perinatal Mental Health: the Edinburgh Postnatal Depression Scale (EPDS) Manual*. RCPsych Publications: London

Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (with suggested talking points)

Parent completes the SWYC with EPDS screen during the following well child visits and during other visits as indicated:

- Within first month
- 2 month visit
- 4 month visit
- 6 month visit

If first screen for depression

If subsequent screen for depression

Clinical support staff explains screen

Emotional complications are very common during pregnancy and or after birth. 1 in 7 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact you and your baby's health. Dads can also experience depression or anxiety before or after the baby is born. We will be seeing you and your baby a lot over the next few months/years and want to support you.

Give SWYC screen (includes EPDS) to parent to complete in the waiting room or in a private exam room.

Parent completes the SWYC (includes EPDS). See primer for other screening tools.

EPDS < 10

EPDS ≥ 10

Score does not suggest depression

Clinical support staff educates parent about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every parent deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups,) to support emotional wellness.

Score suggests depression

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

If positive score on self-harm question or if patient reports thoughts of harming baby

For all positive screens

Suggests parent may be at risk of self-harm or suicide or harm to baby

It sounds like you are having a lot of strong feelings. It is common for parents to experience these kinds of feelings. Many effective support options are available. I would like to talk to you about how you have been feeling recently.

Do not leave parent/baby in room alone until further assessment or treatment plan is established. **Immediately assess further:**

1. In the past two weeks, how often have you **thought** of hurting yourself?
2. Have you ever **attempted** to hurt yourself in the past?
3. Have you thought about how you could harm yourself? AND/OR (if thoughts of harming baby)
 1. Do the thoughts of harming the baby scare you or make you feel anxious?
 2. Have you felt tempted to hurt the baby?

If concerned about the safety of parent/baby:
You and your baby deserve for you to feel well. Let's talk about ways that we can support you.

For safety concerns, refer to emergency services. Document in medical record.

1. If parent is already in mental health treatment or has previous provider, refer to/notify* parent's provider.
2. Give parent community resource information
3. Refer to/notify* parent's PCP and/or OB/GYN for monitoring and follow-up.
4. Engage natural supports* and encourage parent to utilize them.

* Obtain parent's consent

Provider documents the screening result and your plan in the medical record.

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