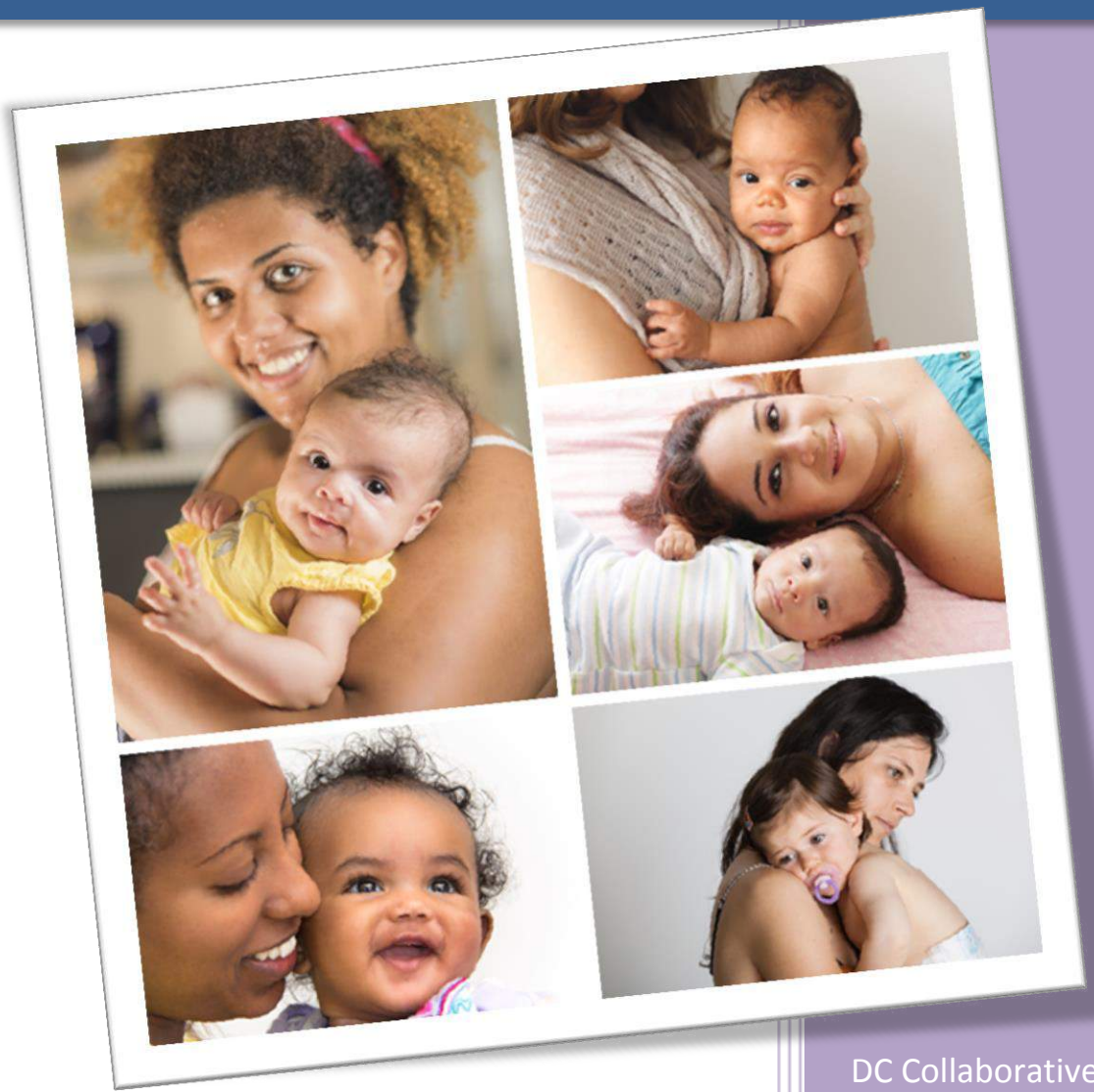
2017

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



DC Collaborative for Mental Health in Pediatric Primary Care

Children's National Health System

Spring 2017

Executive Summary

The DC Collaborative for Mental Health in Pediatric Primary Care (the Collaborative) is a local public-private partnership dedicated to improving the integration of mental health in pediatric primary care for children in the District of Columbia. The Collaborative is particularly focused on supporting pediatric primary care providers (PPCPs) in the promotion of mental health for their youngest patients and those patients' families, which includes perinatal mental health. The Collaborative supports Pediatric Primary Care Providers (PPCPs) in screening for perinatal mood and anxiety disorders, such as postpartum depression, during well-child visits in the first year postpartum, and has created a Perinatal Mental Health Toolkit to aid PPCPs in this important work. The toolkit includes:

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Overview

Why is postpartum depression important to pediatric providers?

10-20%

of women are affected by PMADs

Perinatal mood and anxiety disorders (PMADs) affect between 10 – 20% of women, with even higher rates for low-income women. PMADs are one of the most common, yet underdiagnosed, complications of pregnancy and childbirth in America. They lead to increased costs of medical care, inappropriate medical care, child abuse and neglect, discontinuation of breastfeeding, family dysfunction, and adverse effects on early brain development.[1] Birth outcomes can be negatively affected by PMADs in pregnancy,[2,6-9] and PMADs can have a long-term impact on child outcomes. PMADs are associated with attachment insecurity,[3] difficult infant/childhood temperament,[3,10] developmental delay, and impaired language development.[4,5] Treatment of maternal depression until remission is associated with decreased psychiatric symptoms for the mother and improved functional outcomes among offspring.[11,12] Despite the profound negative effects on mother and child, some of which improve with treatment,[11,12] the vast majority of women with PMADs go untreated.[13-16]

What is known about PMAD screening in pediatric settings?

Most perinatal care or obstetrical settings only see women at the 4-6 week postpartum visit, and only a minority screen for PMADs.[17] Pediatricians may be the only medical provider many mothers see during the child's first year of life.[18,19] PMADs can be identified in pediatric settings during the first postpartum year.[16] Training pediatric providers to detect and address PMADs can enhance pediatric providers' impact on maternal mental health,[20] carrying the potential to have a trans-generational impact.

Can I bill for screening?

YES!

Use code:
96127

If you are using the Edinburgh Postnatal Depression Scale and the child is insured through a DC Medicaid Managed Care Organization or DC Medicaid Fee-for-Service, you can bill using 96127 and receive reimbursement. For other screening tools and insurances, please consult the infant's insurer.

Screening when an infant is the patient

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

- **TWO** month visit
- **SIX** month visit
- **TWELVE** month visit

The Edinburgh Postnatal Depression Scale (EPDS) Pediatric Screening & Referral Algorithm included in this toolkit offers guidelines for administering and responding to a screen. Even for those not screening positive (score of 13 or above), education and potential referrals for support and/or treatment may be indicated.

For all mothers with a positive screen:

1. If the parent is already in mental health treatment, refer to/notify (with consent) parent's provider.
2. Give parent information and/or referral about community mental health resources.
3. Refer to/notify* (with consent) parent's PCP and/or OB/GYN for monitoring and follow-up. Consider scheduling brief follow-up visit for infant and parent in pediatric office.
4. Assess for natural supports and encourage parent to utilize them. 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.
5. If pediatric providers have clinical questions, they should call DC Mental Health Access in Pediatrics (DC MAP) at 1-844-30DCMAP. Information about DC MAP is available at www.dcmap.org.
6. Assess if there is an acute crisis or safety concern. If there is a crisis or safety concern, refer to Crisis Action Plan below, or parent's local Emergency Services.

Screening when a pregnant/postpartum young mother is also your patient

The Collaborative recommends that pediatric providers caring for pregnant teens or postpartum young mothers screen for perinatal mood and anxiety disorders during pregnancy and in the postpartum period. Questions that arise specific to mental health concerns during screening and/or providing care for a pregnant teen or postpartum young mother should be directed to DC MAP at 1-844-30DCMAP.

DC MAP
1-844-303-2627

Documenting Screening Results

The Collaborative recommends that pediatric providers document the screening result in the medical record as you would with other risk factors that may affect the child health such as substance use or domestic violence. The Collaborative also recommends that pediatric practices continue to use their current strategies for appropriately documenting potentially sensitive family information.

Antidepressant medications and lactation

Considerations for lactating women:

- SSRIs (and other antidepressants) are considered a reasonable treatment option during breastfeeding.
- Most psychiatric medications are passed into breast milk, though in very low amounts.
- When antidepressants are indicated, the benefits of breastfeeding while taking antidepressants generally outweigh the risks. The benefits of other psychiatric medications, including benzodiazepines, antiepileptics, stimulants, and antipsychotics, may outweigh the risks of the medication during breastfeeding. It is important to consider the risk of untreated illness to the mother-baby dyad, and balance this with the risk of medication use during breastfeeding.
- 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 side effects in nursing infants.

The Collaborative also recommend the NIH website **LactMed** which contains information on which medications breastfeeding mothers may be exposed:
http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

Community Resources

A variety of community resources exist, from support groups to psychiatric treatment for mothers suffering from a perinatal mood and anxiety disorder. Resources can be found in the following places:

- Perinatal Mental Health section of the Collaborative's Child and Adolescent Mental Health Resource Guide at http://dchealthcheck.net/resources/healthcheck/mental-health-guide.html
- The Perinatal Mental Health Community Resources section of this toolkit

Home Visiting Programs

Home visiting is an early childhood intervention that supports pregnant women and parents/caregivers in their role of raising children by bringing services to them in their natural setting: their home. This model provides visits for families on a weekly or monthly schedule. Home visitors utilize various screening tools to link families to needed community resources. Additionally, home visitors implement evidence-based programs that have been proven to help prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. The District of Columbia offers these voluntary, family-focused home visiting services to expecting or new families with infants and children, which are delivered by trained home visiting professionals or paraprofessionals.

For more information about home visiting services, please see the following:

- The Early Childhood section of the DC Collaborative Child and Adolescent Mental Health Resource Guide at http://dchealthcheck.net/resources/healthcheck/mental-health-guide.html
- The DC Home Visiting Council at http://www.dchomevisiting.org/about/

You may also contact the following for home visiting referrals:

Prenatal up to age 2 of the baby: Mary's Center, Healthy Families America
Fernanda Ruiz 202-420-7178 or Abayea Pelt 202-302-6669.

Ages 3-5: The Family Place, Home Instruction for Parents of Preschool Youngsters (HIPPY):
Katherine Rosas at 202-265-0149

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' *A Primer for Pediatric Providers*, available at www.mcpapformoms.org

Summary of Mood and Anxiety Disorders During Pregnancy and the Postpartum Period (PMADs)

Note about "The Baby Blues": A temporary and common experience after childbirth, with peak onset 3-5 days after delivery and a maximum duration of two weeks. Occurs in 80% of new mothers. Features symptoms such as mood swings and excessive worry which are also seen in many PMADs. Can be a risk factor but is not a determinant for a PMAD. Usually resolves naturally, though outside intervention such as a peer support group can be helpful.

Disorder:	Perinatal Depression	Perinatal Anxiety	Obsessive-Compulsive Disorder (OCD)	Posttraumatic Stress Disorder (PTSD)	Postpartum Psychosis
What is it?	Depressive episode that occurs during pregnancy or within a year of giving birth.	A range of anxiety disorders, including generalized anxiety, panic disorder and/or social anxiety, experienced during pregnancy or the postpartum period.	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Compulsions (e.g., counting, hand washing) may or may not be present.	Specific anxiety symptoms, including nightmares, flashbacks, and hyper-vigilance, experienced after traumatic events(s), including a traumatic birth.	Sudden onset of psychotic symptoms following childbirth, in particular delusions regarding self and/or child(ren). Increased risk with bipolar disorder.
When does it start?	Onset can be anytime during pregnancy or first year postpartum. Peaks at 3-4 months. Can also be triggered by weaning and/or when menstrual cycle resumes.				Onset between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.
Risk factors	• History of perinatal mood/anxiety disorder • Personal history of depression or anxiety • Family history of depression or anxiety • Recent, big life changes (in addition to pregnancy/new baby) • Lack of social support • Poor marital/partner relationship • Multiples • Difficult pregnancy • Difficult infant temperament (colic, fussy) or related problems (sleep, feeding) • Special needs/NICU baby • Prior pregnancy or infant loss • Infertility treatments			Risk factors for Depression, Anxiety, and OCD, plus: • Traumatic birth (as experienced by mother) and/or • Previous sexual trauma	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, severe sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly).

Disorder:	Perinatal Depression	Perinatal Anxiety	Obsessive-Compulsive Disorder (OCD)	Posttraumatic Stress Disorder (PTSD)	Postpartum Psychosis
What happens?	Change in appetite, sleep, energy, motivation, concentration. Negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms.	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment /doom, fear of going crazy or dying. Excessive sometimes debilitating worry. May have intrusive thoughts (see OCD).	Disturbing repetitive thoughts (which may include harming baby or fear of harm coming to baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women).	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.	Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations. May have moments of lucidity. May include altruistic delusions about infanticide and/or homicide and/or suicide.
How common is it?	Occurs in up to 20% of all new mothers. Low SES: 33-50%	Generalized anxiety: 6-8% Panic disorder: 0.5-3% Social anxiety: 0.2-7%	Reported in up to 4% of new mothers; likely higher due to fear of reporting.	Presents after childbirth in 2-9% of mothers.	Occurs in 1-2 in 1,000 births.
Resources and treatment	For depression, anxiety, PTSD and OCD: • Self-Care: Exercise, Sleep, Nutrition, Time off from childcare • Peer Support Groups • Psychotherapy (Individual, Dyadic [mother-baby], Couples, Family) • Medication Additional complementary and alternative therapy options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate.				**Requires immediate psychiatric help.** • Hospitalization and medication are 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).

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Response categories are scored 0, 1, 2 and 3 according to increased severity of the symptom. Items 3 and 5-10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items. Users may reproduce the scale without further permission providing they respect copyright (which remains with the *British Journal of Psychiatry*) quoting the names of the authors, the title and the source of the paper in all reproduced copies.

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

Previous studies have shown that PPD affects at least 10-20 percent of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long term effects on the family.

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

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

INSTRUCTIONS FOR USERS

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

SUGGESTED LANGUAGE

When introducing the EPDS, the Collaborative recommends using the following supportive language:

"Feeling depressed or anxious is 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 since it is twice as common as gestational diabetes. It can also impact you and your baby's health. We will be seeing you and your baby a lot over the next few months/years and want to support you."

CITATION

Modified from: 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 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
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the Past 7 Days:

1. I have been able to laugh and see the funny side of things as
   - ☐ I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5. I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8. I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9. I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10. The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

Source: 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 .

Escala Edinburgh para la Depresión Postnatal (EPDS)

Nombre:_____ Dirección: _____
Su fecha de Nacimiento_____ _____
Fecha de Nacimiento del Bebé:_____ Teléfono: _____

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

Me he sentido feliz:

- ☐ Me he sentido feliz:
- ✓ Sí, todo el tiempo
- ☐ No, no muy a menudo
- ☐ No, en absoluto

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

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas
   - ☐ Tanto como siempre he podido hacerlo
   - ☐ No tanto ahora
   - ☐ Sin duda, mucho menos ahora
   - ☐ No, en absolute

2. He mirado al futuro con placer para hacer cosas
   - ☐ Tanto como siempre
   - ☐ Algo menos de lo que solía hacerlo
   - ☐ Definitivamente menos de lo que solía hacerlo
   - ☐ Prácticamente nunca

*3. Me he culpado sin necesidad cuando las cosas marchaban mal
   - ☐ Sí, casi siempre
   - ☐ Sí algunas veces
   - ☐ No Definitivamente menos de lo que solía hacerlo
   - ☐ Prácticamente nunca

4. He estado ansiosa y preocupada sin motivo alguno
   - ☐ No, en absoluto
   - ☐ Casi nada
   - ☐ Sí, a veces
   - ☐ Sí, muy a menudo

*5. He sentido miedo o pánico sin motivo alguno
   - ☐ Sí, bastante
   - ☐ Sí, a veces
   - ☐ No, no mucho
   - ☐ No, en absolute

*6. Las cosas me oprimen o agobian
   - ☐ Sí, la mayor parte del tiempo no he podido sobrellevarlas
   - ☐ Sí, a veces no he podido sobrellevarlas de la manera
   - ☐ No, la mayoría de las veces he podido sobrellevarlas bastante bien
   - ☐ No, he podido sobrellevarlas tan bien como lo hecho siempre

*7. Me he sentido tan infeliz, que he tenido dificultad para dormir
   - ☐ Sí, casi siempre
   - ☐ Sí, a veces
   - ☐ No muy a menudo
   - ☐ No, en absolute

*8. Me he sentido triste y desgraciada
   - ☐ Sí, casi siempre
   - ☐ Sí, bastante a menudo
   - ☐ No muy a menudo
   - ☐ No, en absolute

*9. Me he sentido tan infeliz que he estado llorando
   - ☐ Sí, casi siempre
   - ☐ Sí, bastante a menudo
   - ☐ Ocasionalmente
   - ☐ No, nunca

*10. He pensado en hacerme daño
   - ☐ Sí, bastante a menudo
   - ☐ A veces
   - ☐ Casi nunca
   - ☐ No, nunca

Administrada/Revisada por: _____ Fecha: _____

Fuente: Cox, J.L., Holden, J.M. y Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. Revista Británica de Psiquiatría 150:782-786.

Edinburgh Postnatal Depression Scale[1] (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.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> 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.

[1]Source: 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.

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

Implementing the Edinburgh Postnatal Depression Scale

— Pediatric Primary Care Well-Child Visits —

1. **After the EPDS has been distributed, collected, and scored - explain the screener:**

   “ *Feeling depressed or anxious is 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. It can also impact the health of you and your baby. We will be seeing you and your baby a lot over the next few months to years and we want to support you.* ”

2. **Explain the results and provide education specific to the woman’s risk level** (see p*age 6)*.
   Below are recommendations and suggested language for discussing results in each range:

Score of 0-9: Normal/Negative Screen (likely not suffering at this time)

- Provide education about risks/incidence (see *Summary of PMADs* on Page 6).
- Use clinical judgment regardless of score.
- Provide Postpartum Support DC contact for support groups and other community resources: 202-643-7290.

  “ *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 you would like to talk to us about? In the future, should you start to have a difficult time or develop depression or anxiety, please follow-up with your doctor or talk to me about it at your child's next visit.* ”

Score of 10-12: At-Risk for Depression and/or Anxiety

- Discuss results and provide education (see *Summary of PMADs* on Page 6).
- Strongly consider making referral and/or providing Postpartum Support DC number: 202-643-7290.

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

Score of 13+: Positive Screen (likely suffering from depression and/or anxiety)

- Discuss results and provide education (see *Summary of PMADs* on Page 6).
- Make referral and/or give Postpartum Support DC number: 202-643-7290.

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

Question #10 (self-harm): If "Yes" to – hardly ever, sometimes, or quite often –
MOVE TO CRISIS ACTION PLAN

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms’ *Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits,* available at www.mcpapformoms.org

Action Crisis Plan

If patient answered "YES" to #10 on EPDS or patient reports thoughts of harm to self or others, follow these steps:

1. Ask further questions:

- **Intent**: "You have said that you think about killing or harming yourself. Have you made any plans?"
- **Means**: "Can you describe your plans? How have you thought about killing yourself (your infant)? Do you have access to [stated method]?"
- **Likelihood: "**Do you think you would actually harm or kill yourself or someone else?"
- **Protective Factor: "**What is keeping you from following through with your plan?"
- **Impulsivity: "**Have you tried to harm yourself or someone else in the past?"

2. If patient has a plan and provider or patient feels she cannot be safe, follow these steps:

1. Do not leave patient by herself or alone with baby
2. Contact and engage supportive person in their life (partner, relative, friend)
3. Make this person aware of current circumstance
4. Engage them to plan for: child care, transportation to emergency services, emotional support

3. Coordinate immediate psychiatric/crisis intervention or evaluation:

- Be familiar with Emergency Department policies and referral processes
- When no resources are available, call 911 (ask for Crisis Intervention Officer/Team if available)

4. If patient is not in the office and feels she cannot be safe or worries if she will be safe follow these steps:

1. Ask where she is and if she is alone
2. Assess degree of risk
3. Arrange for immediate psychiatric/crisis intervention or evaluation while patient remains on phone
4. Assess availability and proximity of resources and support

Source: Adapted from *Crisis Action Plan* discussed at "Transforming Science into Strategy: A Multidisciplinary Model for Perinatal Mood Disorder Screening" presentation by Alison Palmer at PSI Conference 2013

Key Clinical Considerations

When Assessing the Mental Health of Pregnant and Postpartum Women

Assessing Thoughts of Harming Baby

Thoughts of harming baby that occur secondary to obsessions/anxiety:

- Good insight
- No psychotic symptoms
- Thoughts are intrusive, scary, and cause mother anxiety
- Ego-dystonic

Suggests not at risk of harming baby

Thoughts of harming baby that occur secondary to postpartum psychosis:

- Poor insight
- Symptoms of psychosis (eg. auditory and/or visual hallucinations)
- Delusional beliefs with distortion of reality present
- Ego-syntonic

Suggests at risk of harming baby

Medication

Factors Indicating Medication May Not be Necessary:

- Mild depression based on clinical assessment
- No suicidal ideation
- Able to care for self/baby
- Engaged in psycho-therapy or other non-medication treatment
- Depression has improved with psychotherapy in the past
- Strong preference for and access to psychotherapy

Factors Indicating Medication Should Be Considered:

- Moderate or severe depression based on clinical assessment
- Suicidal ideation
- Difficulty functioning caring for self/baby
- Psychotic symptoms present
- History of severe depression and/or suicidal ideation and/or attempts
- Comorbid anxiety diagnosis or symptoms

Postpartum Depression

Risk Factors

- Personal history of anxiety disorder, major depression and/or postpartum depression
- Family history of mood or anxiety disorder
- Gestational diabetes
- Difficulty breastfeeding
- Fetal/Newborn loss
- Lack of personal or community resources
- Financial challenges
- 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; lack of social support
- Substance use/addiction

How to Talk about Perinatal Depression with Moms

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

Other Considerations During Clinical Assessment

- Past history of psychiatric diagnosis
- Previous counseling or psychotherapy
- Previous psychiatric medication
- History of other psychiatric treatments such as support groups
- History of substance use or substance use treatment
- Excessive anxiety and worry
- Trauma history
- Domestic Violence

Source: Adapted from Massachusetts Child Psychiatry Access Project for Moms' *Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women*, available at www.mcpapformoms.org

Perinatal Mental Health Community Resources

Resources for treating mothers who may be experiencing postpartum depression or anxiety, or be in need of support during pregnancy or the postpartum period.

Postpartum Support International (PSI) – Greater Washington, DC Area

PSI's coordinators are trained to provide supportive counseling and local resource and referral information to mothers, their families, and the providers who serve them. Providers are welcome to refer their patients to PSI coordinators directly, or to contact coordinators themselves to obtain information and referrals.

Washington DC	Maryland	Virginia
Postpartum Support DC 202-643-7290 info@postpartumdc.org Website: PSI: DC Support Groups DC Coordinator: Michelle High	**Postpartum Support Maryland** 240-432-4497 mdpostpartum@gmail.com Website: PSI: MD Support Groups MD Coordinator: Nadia Monroe	**Postpartum Support Virginia** 703-243-2904 info@postpartumva.org Website: PSI: VA Support Groups VA Coordinator: Adrienne Griffen
To contact coordinators in other states and countries, please visit: PSI: US Support Group & Area Coordinators		

Outpatient Treatment Programs *(e.g., assessment, therapy, medication management)*

Organization	Services Provided	Ages Served	Insurance, Referral, & Availability
George Washington University Medical Center, Department of Psychiatry & Behavioral Sciences - The Five Trimesters Clinic Medical Faculty Associates Building 2120 L Street NW 6th Floor WDC 20037 Foggy Bottom/GWU – Orange and Blue Bus: D1, D3, D5, D6, H1, L1, N3, 38B P: 202-741-2888 and specify that you want to be seen in the 5 Trimesters Clinic. http://www.gwdocs.com/psychiatry/women's-mental-health	• Help women assess need for treatment before, during or after pregnancy for mood or anxiety disorder. Each woman meets once or twice with a psychiatrist-in-training; partners may be included. Each case is reviewed by senior psychiatrists specializing in perinatal mental health. • Services include: outpatient evaluation and screening; short-term individual therapy and medication management; couples and family therapy; access to community resources. Languages: English	Child-bearing age women	**Insurance**: N/A. $60 for initial assessment; $25 for follow-up. If finance is an issue, call anyways. Women on Medicaid whose child is a Children's National Health System patient and/or delivered at George Washington get services for free. **Referral**: Asks that patient tells intake coordinator the referring physician to ensure appropriate referral. **Availability**: Generally 3-4 weeks

Mary's Center, Mental Health Department, Maternal Mental Health Program 2333 Ontario Road NW WDC 20010 Bus: 90, 93, 96, X3, S1, S2, S4, S9 3912 Georgia Avenue NW Washington, DC 20011 Georgia Ave/Petworth – Green/Yellow Bus: 60, 62, 63, 64, 70, 79, H8 P: 202-545-2061: Morgan Gross, Manager, Maternal Mental Health Program P: 202-420-7122: Cindy Flores/Jeanette Delgado, MH Program Assistant/front desk staff for scheduling http://www.maryscenter.org/course/behavioral-health-services	• Perinatal mental health therapist - Morgan Gross • Women's/ perinatal mental health psychiatrist - Dr. Nicole Perras (available Tuesdays at Georgia Ave site) • Support/education/therapy groups for pregnant and postpartum women. Languages: English/Spanish	Child-bearing age women	**Insurance overview**: DC & MD Medicaid's MCOs, uninsured DC residents, private insurances (if client or family member receives medical/dental services from Mary's Center). See list of insurances below: Aetna, AmeriHealth, Beacon (Behavioral Health), CareFirst, MD and DC Medicaid, HSCSN, Medstar, Trusted, Unison (Alliance, Medicaid), United Health Care (Optimum Choice and Mamsi). Uninsured DC residents. **Referral**: No referral necessary. **Availability**: Accepting patients.
SPRING Project Multiple locations in NW Washington, MD, & VA Metro and bus accessible: Red, Blue, Yellow lines P: 301-654-2322, Dr. Laura Hickock P: 703-356-4710, Elizabeth Fritsch www.springproject.org	• The SPRING Project offers affordable psychotherapy for expectant and postpartum mothers and their families experiencing perinatal mood problems. The Project has a network of experienced psychodynamic therapists trained in work with this population committed to working on a reduced fee basis with session fees set as low as $20/session for a period of up to one year. Languages: English	Child-bearing age women	**Insurance**: Fees are set based on need. Within network insurance availability is limited but all providers will work on a reduced fee basis so that insurance limitations are not a concern. **Referral**: Contact Dr. Laura Hickok, Laurahickok@verizon.net or Dr. Elizabeth Fritsch, DrElizabethFritsch@gmail.com and the patient will be connected to an available, conveniently located provider. **Availability**: Contact will be made within 48 hours and wait times are minimal.

Women's Mental Health Clinic, **MedStar Washington Hospital Center** 110 Irving St NW Room 5B25 Washington, DC 20010 Bus: 80, D8, H1, H2, H3, H4 Clinic hours are Mondays 8am-3:30pm. P: Health care providers- 292-877-6321 P: Patient- 202-877-6333	• Dr. Nicole Perras is a psychiatrist who specializes in maternal mental health. Clinic hours are Mondays 8am-3:30pm. • Services include psychiatric evaluations, medication management, consultations for psychiatric medications in pregnancy, short-term therapy, grief and loss counseling, and fertility support. Languages: English	Child-bearing age women	**Insurance:** DC Medicaid, most major insurance plans. **Referral:** Women must be receiving services at WHC and/or delivered at WHC to qualify for services. Providers should call Thalia Nash at 202-877-6321 to refer a patient, or have the patient call 202-877-6333 to make an appointment. **Availability:** Currently accepting new patients.
Women's Mental Health Program **Department of Psychiatry,** **MedStar Georgetown University Hospital** 2115 Wisconsin Avenue Suite 200 WDC 20007 Bus: 30N, 30S, 31, 33 P: 202-944-5400 for appointments Director: Aimee Danielson, PhD. Psychiatrist: Nicole Perras, MD Providers should call 202-944-5400 with questions. http://www.medstargeorgetown.org/our-services/psychiatry/treatments/womens-mental-health	• Offers outpatient evaluation and treatment of psychiatric disorders and adjustment problems experienced by women who are transitioning into motherhood. Provide diagnostic evaluations and multidisciplinary treatment for women experiencing mood and anxiety disorders during pregnancy and postpartum, infertility-related distress, pregnancy loss, and difficulty with the transition to motherhood. • In cases where psychiatric medication is necessary, psychiatrists with expertise in use of medication in pregnant and lactating women are available. • Reproductive psychiatrists on staff, as well as residents in training, and part-time therapists who specialize in perinatal mental health. • Services are generally time-limited for 1 year postpartum (may be longer dependent on when woman is diagnosed) Languages: English/Spanish	Child-bearing age women	**Insurance**: Most major private insurance and MedStar Family Choice (MCO). **Referral**: No referral necessary. **Availability**: Accepting new patients.

New Mother's Groups

Organization	Services Provided	Ages Served	Insurance, Referral, & Availability
Postpartum Support International Michelle High P: 202-643-7290 info@postpartumdc.org	• Telephone, email and in-person supportive counseling • Referrals for reproductive mental health specialists in DC • Twice-monthly peer support group in Tenleytown neighborhood of NW DC (English) Languages: English/Spanish/French	Child-bearing age women	No cost for group or other services. Email or telephone communication with PSI volunteer is necessary before attending first group.
PACE Marketing, hiring, donations contact Judy Itkin: pace.registrar@gmail.com General information & Public Relations contact Beth Morgenstern: beth624@gmail.com http://www.pacemoms.org/	• Provides educational and emotional support groups for new and second time around mothers in the DC area led by professional mental health educators. Languages: English	New and second time mothers	$175-$325 depending on chosen workshop
Other Support Groups for Expectant/New Moms (not clinically led/based)	• Mamistad: Groups in DC and NoVA http://www.meetup.com/Mamistad/ • Moms on the Hill (MOTH - A virtual and real-world community for parents living in Capitol Hill.) https://www.facebook.com/pages/Moms-on-The-Hill/83988628593 • Mothers of North Arlington, VA (MONA is a local social and support group for mothers) https://www.monamoms.org/	Child-bearing age women	Mamistad – one-time fee of $50 if placed in private group

Online Resources

Organization	Services Provided	Ages Served	Insurance, Referral, & Availability
DC-MD-VA Perinatal Mental Health Resource Guide Search or download guide at: http://www.dmvpmhresourceguide.com	• Comprehensive and current regional directory of specialized mental health providers, support groups, advocacy organizations, and other clinical resources pertaining to perinatal mental health. It can be helpful to cross reference the list of providers with a list of in-network providers given by your insurance.	Child-bearing age women	Free
LactMed – Drugs and Lactation Database http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm	• Contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. Includes information on the levels of such substances in breast milk and infant blood, and the possible adverse effects in the nursing infant. Suggested therapeutic alternatives to those drugs are provided, where appropriate. All data are derived from the scientific literature and fully referenced.	Child-bearing age women	Free
Motherisk P: Helpline for mothers and health care providers: 1-877-439-2744 www.motherisk.org	• Provides evidence-based information and guidance about the safety; or risk to the developing fetus/infant; of maternal exposure to drugs, chemicals, diseases, radiation and environmental agents.	Child-bearing age women	Free
MothertoBaby P: Helpline for mothers, health care professionals, and the general public: 1-866-626-6847 http://www.mothertobaby.org/	• Provides evidence-based information about medications and other exposures during pregnancy and while breastfeeding.	Child-bearing age women	Free

Research Studies

Organization	Services Provided	Ages Served	Insurance, Referral, & Availability
National Institute of Mental Health *Behavioral Endocrinology Branch* Annie Shellswick, LCSW-C P: 301-402-9207 annieshellswick@mail.nih.gov https://www.nimh.nih.gov/labs-at-nimh/join-a-study/adults/adults-postpartum-depression.shtml	• Series of outpatient studies to learn more about the cause of and effective treatments for PPD. Study participants are women with past PPD currently medication free, including birth control. Languages: English/Spanish	Contact NIMH for details	No charge; participants may be compensated.

Source: DC Collaborative for Mental Health in Pediatric Primary Care's Child & Adolescent Mental Health Resource Guide available at: http://dchealthcheck.net/resources/healthcheck/mental-health-guide.html

UPDATES, QUESTIONS OR COMMENTS

Contact Sarah Hoffman at sbhoffma@childrensnational.org or Morgan Kraybill Gross mgross@maryscenter.org

References and Acknowledgments

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