NC Maternal Mental Health MATTERS

Screening, Assessment, and Treatment of Behavioral Health Conditions in Primary Care Settings

NC Maternal Mental Health MATTERS Toolkit:
Screening, Assessment, and Treatment of Behavioral Health Conditions in Primary Care Settings

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THIS TOOLKIT WAS CREATED BY THE NC MENTAL HEALTH MATTERS TEAM AT THE UNIVERSITY OF NORTH CAROLINA – CHAPEL HILL

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OVERVIEW

We created this toolkit to assist front-line obstetric and primary care providers in the prevention, identification, and treatment of perinatal behavioral health concerns in pregnant and postpartum patients. This toolkit contains screening tools, algorithms, and clinical guidance which can be tailored to the specific practice environment.

About Perinatal Behavioral Health Disorders

Perinatal behavioral health disorders such as depression, anxiety, and substance use are among the most common, yet underdiagnosed, complications of pregnancy and childbirth, affecting **1 in 7 women**.

Poor maternal mental health is associated with numerous adverse outcomes for the patient and infant including obstetric, neonatal, and long-term health complications; difficulties in bonding with and nurturing a newborn; and is a risk factor for future mental health problems in children. Postpartum depression has also been deemed the greatest risk factor for maternal suicide which is a major contributor to maternal mortality. Moreover, untreated perinatal mood and anxiety disorders were estimated to cost the US $14.2 billion in 2017.

Front-line clinicians have long recognized the need for tools and better systems to help women with these concerns. **Mandatory depression screening of pregnant and postpartum women is now recommended by a number of professional organizations** including the American College of Obstetrics and Gynecology (ACOG, 2015), the American Academy of Pediatrics (2010), and the American Medical Association (AMA, 2017).

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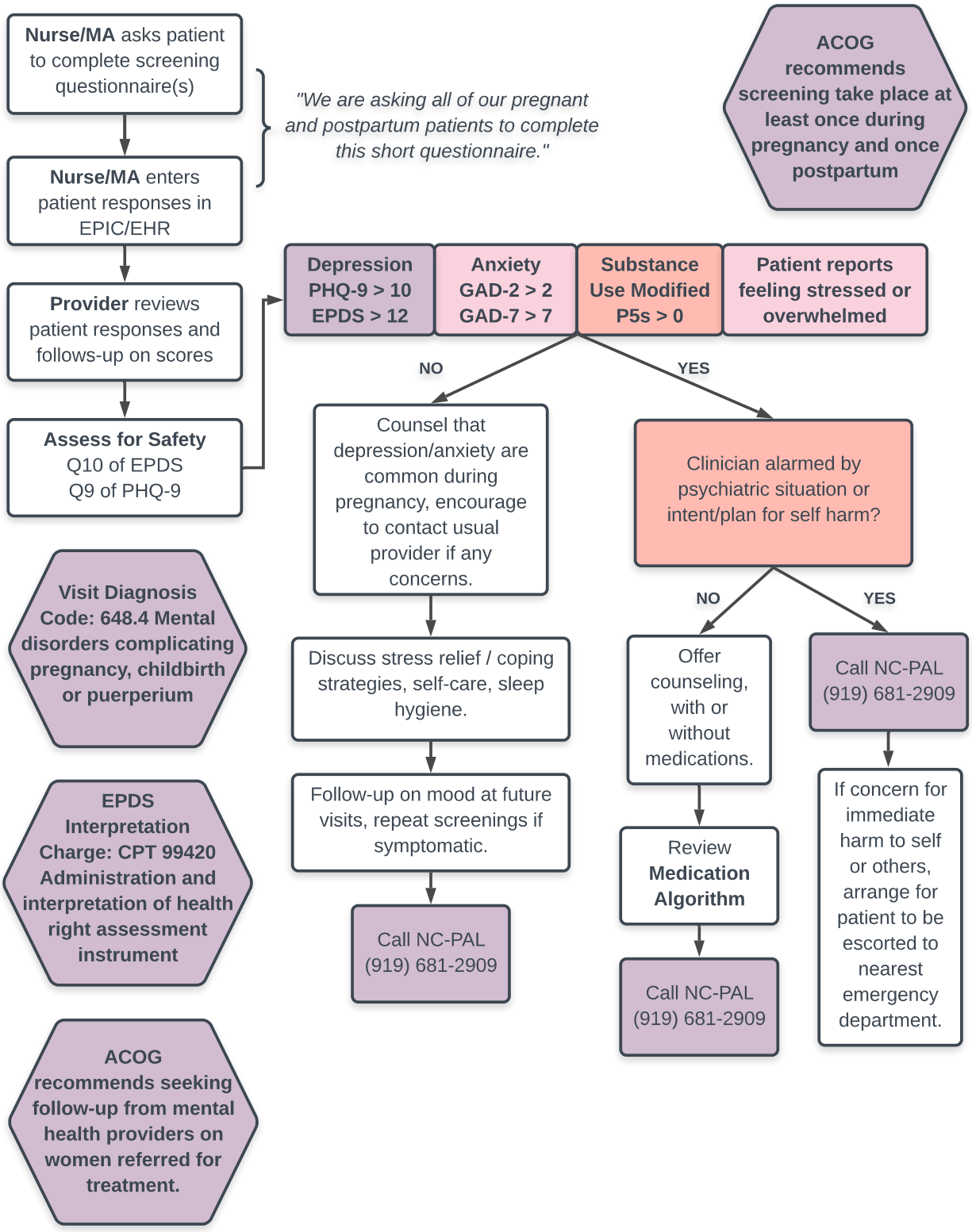
SUMMARY OF COMMON PERINATAL EMOTIONAL COMPLICATIONS

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.

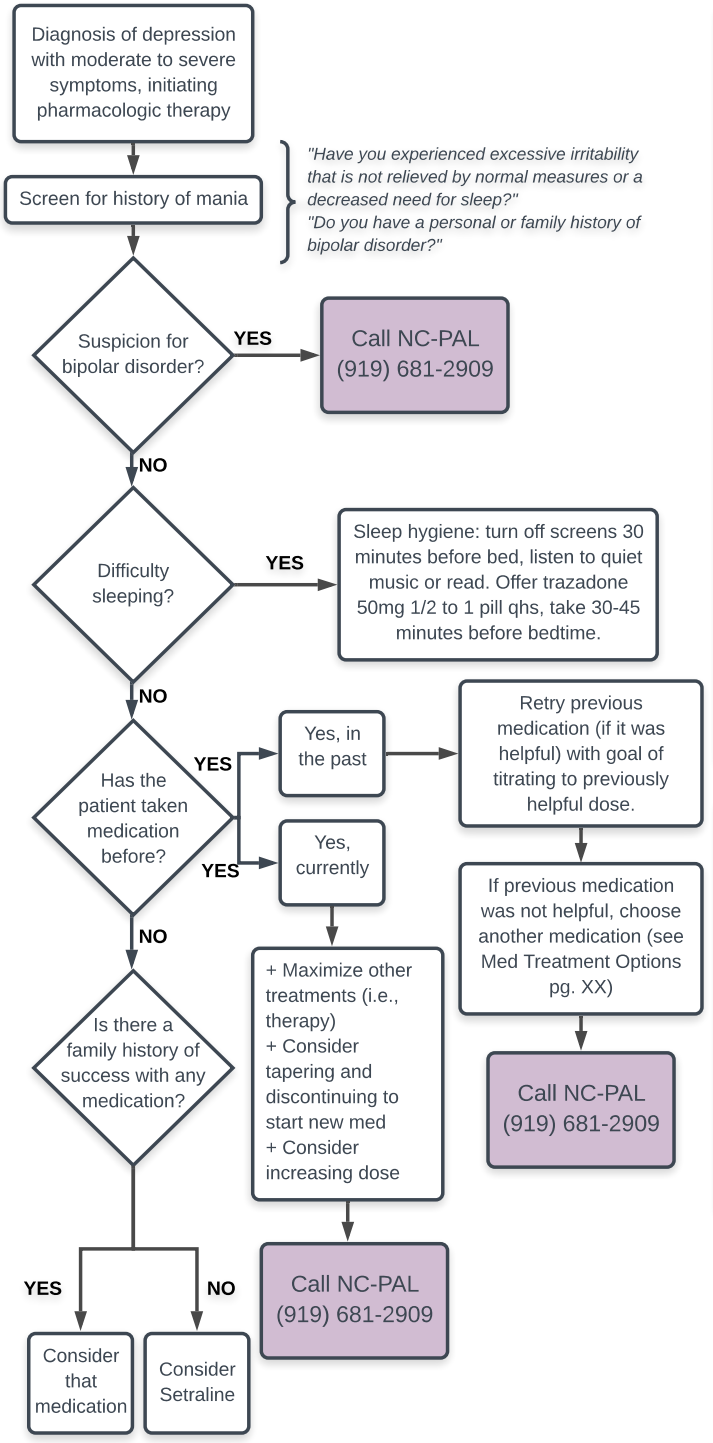
Disorder:	Perinatal Depression	Perinatal Anxiety	Obsessive Compulsive Disorder (OCD)	Post-Traumatic Stress Disorder (PTSD)	Postpartum Psychosis
What is it?	Depressive episode that occurs during pregnancy or within a year of giving birth	A range of anxiety disorders, including generalized anxiety, panic 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 (ex. counting, hand washing, re-checking) may or may not be present	Specific anxiety symptoms, including nightmares, flashbacks, and hyper-vigilance, experienced after traumatic events, including traumatic births.	Sudden onset of psychotic symptoms following childbirth, particularly 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 postpartum. Can also be triggered by weaning and/or when menstrual cycle resumes.				Onset between 2-12 weeks after delivery. Watch carefully sleep deprived for ≥48 hours
Risk factors:	• History of perinatal mood/anxiety disorder • Personal/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, disturbed 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

Disorder:	Perinatal Depression	Perinatal Anxiety	Obsessive Compulsive Disorder (OCD)	Post-Traumatic 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: • Peer Support Groups • Psychotherapy (Individual, Dyadic [mother-baby], Couples, Family) • Medication (see Common Medication Treatments pg. 39) • Self-Care: Exercise, Sleep, Nutrition, Time off from childcare *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 as a method of treatment (e.g. consistent sleep/wake times, help with feedings at night)

Perinatal Screening and Treatment



Initiating Medication for Perinatal Depression and Anxiety



Screening for Mania History
Because SSRI therapy can trigger mania or psychosis in women with bipolar disorder, screening for history of manic symptoms is recommended prior to initiating therapy.
-
Mania symptoms include:
+ Excessive irritability
+ Decreased need for sleep (e.g., feels rested after 3 hours of sleep).
+ More talkative than usual or pressure to keep talking.
+ Flight of ideas or subjective experience that thoughts are racing.
+ Distractibility, as reported or observed.
+ Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
+ Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
-
Additional resources for screening for bipolar are available at http://www.cqaimh.org/tool_bipolar.html

Additional Considerations
+ Schedule follow-up within two weeks of initiating new antidepressant.
+ Educate patients about reasonable timeline for improvements and side effects of medication. Closely monitor patients around week three due to increased risk of suicide from activating effects of antidepressant.
+ Counsel patient about antidepressant use in pregnancy. The benefits of taking antidepressants while pregnant or breastfeeding generally outweigh the risks.
+ Non-medication treatments (e.g., psychotherapy) should also be offered.

Common Medication Treatment Options

Generic Names	Trade Name	Dosage Range	Unique Considerations
SSRIs			
Setraline	Zoloft, Serafem	50-200 mg, increase by 25 mg or 50 mg for very anxious patients 12.5 mg	Due to half-life, small, even negligible amounts transmitted into breast milk
Fluxotine	Prozac	20-80 mg, increase by 10 mg or 20 mg	Longer half-life → withdrawal less likely if doses are missed, but also longer to get out of the system if there are adverse effects, likely greater amount in breast milk, thought to be more activating
Citalopram	Celexa	20-40 mg, increase by 10 mg or 20 mg	FDA Drug Safety Communication that > 40 mg could result in life-threatening heart arrhythmia.
Escitalopram	Lexapro	10-20 mg, increase by 5 mg or 10 mg	
Paroxetine	Paxil, Pexeva, Brisdelle	10-60 mg, increase by 10 mg or 20 mg, CR in 12.5 mg doses	Older data demonstrated potential for a 1.5 to 2.0 fold increase risk in cardiovascular malformations, leading to a 2005 warning. Recent data show no consistent information to support teratogenic risks
Fluvoxamine	Luvox, Faverin, Fevarin, Floxyfral, Dumrox	25-150 mg, increase by 25 mg	More often used for treatment of obsessive compulsive disorder
Other antidepressants			
Buproprion	Wellbutrin SR, Wellbutrin XL, Zyban, Aplenzin, Forfivo XL	150-450 mg, increase by 150 mg, SR BID dosing	Not to exceed 450 mg due to increased risk of seizure. Helpful in smoking cessation and even evidence for lowering prematurity risk for smokers. May help ADHD and other addictive disorders, such as overeating.
Mirtazepine	Remeron	15-45 mg, increase by 7.5 mg, 15 mg	Antiemetic effects in addition to antidepressant and anxiolytic effects, and helps with sleep and decreased appetite
Trazodone, nefazodone	Oleptro, Desyrel, Serzone	50-400 mg, ½ tablet (25 mg)-100 mg for sleep	Sleep aid at lower dosages, higher dosages more antidepressant affects. No differences in the rate of major malformations

Kimmel, M, Cox, E., Schiller, C., Gettes, E., & Meltzer-Brody, S. (2018.) Pharmacological treatment of perinatal depression. *Obstetrics and Gynecology Clinics of North America. (45)*3, 419-440.

CORE SCREENING TOOLS

- Starting the Conversation
- Creating a Safe & Supportive Screening Environment
- Behavioral Health Screening Surveys

STARTING THE CONVERSATION

Many clinicians are hesitant to start a conversation with their patients about their behavioral health needs. It can feel daunting to identify the appropriate questions to ask and how to respond, especially when appointments feel rushed. However, patients often look to their medical providers to begin conversations about behavioral health and are grateful for the honest communication.

Inquiring about patients' behavioral health needs at their *first* visit, helps to identify yourself as a resource for their current and future concerns. A good place to start the conversation is by conveying how common mental health concerns are prior to conception, throughout pregnancy, and during the postpartum period. Focus on using normalizing statements. This enables you to explain your intentions, align with your patient, and help to create a neutral, open space for safe discussion.

Here are some example statements:

"While I'm not expecting any particular issues with you or your pregnancy, I would just like to briefly discuss mental health. It is common for women to develop concerns or anxieties about what can be a difficult stage in their life: dealing with pregnancy, childbirth and coping with a newborn baby. It's important to understand these concerns are nothing to be ashamed of, and we can provide lots of help and support."

"Pregnancy, childbirth and looking after a newborn baby can be a difficult time in a woman's life. It is common for women to feel anxious or low in mood, and they may hide these feelings for fear of seeming like they cannot cope. We can discuss anything here, and I'd like to help wherever possible, so tell me, how have you been feeling recently?"

Bambridge, G. A., Shaw, E. J., Ishak, M., Clarke, S. D., & Baker, C. (2017). Perinatal mental health: How to ask and how to help. The Obstetrician & Gynaecologist, 19(2), 147–153. https://doi.org/10.1111/tog.123

Creating Safe and Supportive Screening Environments for Pregnant and Post-Partum Patients

Always use your clinical judgment.

- Research shows that many patients minimize their symptoms on screeners out of shame or fear of being perceived as unfit to parent. Just because a patient scores below the cut off on a screening tool DOES NOT mean that they are not struggling with their mental health.
- Pay special attention if patients complete most questions on a screener, but skip over more sensitive questions, like question 9 on the PHQ-9 or question 10 on the EDPS, which assess for self-harm. This could indicate that the patient is experiencing these symptoms but feels too fearful or embarrassed to answer honestly.

If possible, have the patient complete all screeners in private.

- Many patients will not answer honestly if they feel like someone (ie. their partner, child, family member, or another patient in the waiting room) is looking over their shoulder and judging their answers.
- This is especially important for the HARK, which assesses for IPV, the SDOH, which assesses for social determinants of health, and the Modified 5Ps, which assesses for substance use.

Ensure that all screeners are provided in the patient's *preferred* language.

- All screeners except the PASS are validated for use in Spanish and English.
- Many patients feel uncomfortable disclosing that they cannot read the screeners. Use non-judgmental language to assess for patient's preferences:
  "Some patients prefer to complete these screeners on their own and some prefer to complete them with a medical professional, which option would you prefer"

Always review patient privacy, medical disclosure, and limits of confidentiality BEFORE instructing the patient to complete any screeners.

- This promotes a culture of transparency and opens lines of communication if a patient does disclose that they are actively suicidal or homicidal and hospitalization is required.
- Clear information on privacy and disclosure also helps reassure patients with trauma histories or those who are experiencing IPV, that they are in control of their personal medical information.

Polmanteer, R. S. R., Keefe, R. H., & Brownstein-Evans, C. (2019). Trauma-informed care with women diagnosed with postpartum depression: A conceptual framework. Social Work in Health Care, 58(2), 220–235. https://doi.org/10.1080/00981389.2018.1535464.
Sperlich, M., Seng, J. S., Li, Y., Taylor, J., & Bradbury-Jones, C. (2017). Integrating Trauma-Informed Care Into Maternity Care Practice: Conceptual and Practical Issues. Journal of Midwifery & Women's Health, 62(6), 661–672. https://doi.org/10.1111/jmwh.12674.

CORE SCREENING TOOL (with PHQ-2/PHQ-9)

Behavioral Health Screening

Why do we screen?

Emotional complications are the most common complication during pregnancy and/or after birth. 1 in 5 women experience depression, anxiety or frightening thoughts during this time. Your behavioral health (such as feeling down, irritability, feeling anxious, overwhelmed or scared) can impact your health and your baby's health.

Some thoughts like this during pregnancy are normal, and even if the extent of these are not a clinical problem, you deserve support around this time of great transition.

What do we do with your answers?

Because emotional changes and substance use are so common, we use questionnaires to screen for them just like we screen for other health conditions like preeclampsia or diabetes. If you are having a hard time, getting help is the best thing you can do for you and your baby. You are not alone. We can help.

Your answers are confidential. Your provider will review your answers and provide education around options for help if needed. Many effective options are available. We can connect you with various support options like support groups and therapy. We will be seeing you a lot during your pregnancy and after giving birth. We are here to help you. It is important to let us know how you are feeling.

Please complete the following questionnaires.

The questionnaires will help us understand what type of support and resources you may need, and how we can make sure we you get everything you need to have a healthy pregnancy and postpartum period.

Because women's emotions change over the course of pregnancy and after having a baby, to make sure we're listening to your specific needs, we will ask you to complete these questionnaires several times during pregnancy and after delivery.

PHQ-2/PHQ-9				
Circle the number that indicates: Over the past **2 weeks**, how often have you been bothered by any of the following problems?				
	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Total = _____	**+_____**	**+_____**	**+_____**	**+_____**

TURN PAGE OVER TO FINISH →

GAD-2/GAD-7				
Circle the number that indicates: Over the past **2 weeks.** how often have you been bothered by any of the following problems?				
	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Feeling nervous, anxious or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3
Total = _____	**+_____**	**+_____**	**+_____**	**+_____**
If you checked any problems, how difficult have they 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

Modified 5 Ps				
			Yes	No
Did any of your parents have a problem with alcohol or other drug use?			0	1
Do any of your friends have a problem with alcohol or other drug use?			0	1
Does your partner have a problem with alcohol or other drug use?			0	1
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			0	1
	Not at all	Rarely	Sometimes	Frequently
Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?	0	1	2	3
In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?	0	1	2	3

HARK		
	No	Yes
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?	0	1
Within the last year, have you been afraid of your partner or ex-partner?	0	1
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	0	1
Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?	0	1

CORE SCREENING TOOL (with EPDS)

Behavioral Health Screening

Why do we screen?

Emotional complications are the most common complication during pregnancy and/or after birth. 1 in 5 women experience depression, anxiety or frightening thoughts during this time. Your behavioral health (such as feeling down, irritability, feeling anxious, overwhelmed or scared) can impact your health and your baby's health.

Some thoughts like this during pregnancy are normal, and even if the extent of these are not a clinical problem, you deserve support around this time of great transition.

What do we do with your answers?

Because emotional changes and substance use are so common, we use questionnaires to screen for them just like we screen for other health conditions like preeclampsia or diabetes. If you are having a hard time, getting help is the best thing you can do for you and your baby. You are not alone. We can help.

Your answers are confidential. Your provider will review your answers and provide education around options for help if needed. Many effective options are available. We can connect you with various support options like support groups and therapy. We will be seeing you a lot during your pregnancy and after giving birth. We are here to help you. It is important to let us know how you are feeling.

Please complete the following questionnaires.

The questionnaires will help us understand what type of support and resources you may need, and how we can make sure we you get everything you need to have a healthy pregnancy and postpartum period.

Because women's emotions change over the course of pregnancy and after having a baby, to make sure we're listening to your specific needs, we will ask you to complete these questionnaires several times during pregnancy and after delivery.

EPDS				
Please circle the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.				
	0	**1**	**2**	**3**
I have been able to laugh and see the funny side of things	As much as I always could	Not Quite so much now	Definitely not so much now	Not at all
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
I have blamed myself unnecessarily when things went wrong	No, never	Not very often	Yes, some of the time	Yes, most of the time
I have been anxious or worried for no good reason	No, not at all	Hardly ever	Yes, sometimes	Yes, very often
I have felt scared or panicky for no very good reason	No, not at all	No, not much	Yes, sometimes	Yes, quite a lot
Things have been getting on top of me	No, I have been coping as well as ever	No, most of the time I have coped quite well	Yes, sometimes I haven't been coping as well as usual	Yes, most of the time I haven't been able to cope at all
I have been so unhappy that I have had difficulty sleeping	No, not at all	Not very often	Yes, quite often	Yes, most of the time
I have felt sad or miserable	No, not at all	Not very often	Yes, quite often	Yes, most of the time
I have been so unhappy that I have been crying	No, never	Only occasionally	Yes, quite often	Yes, most of the time
The thought of harming myself has occurred to me	Never	Hardly ever	Sometimes	Yes, quite often
Total = _____	**+_____**	**+_____**	**+_____**	**+_____**

TURN PAGE OVER TO FINISH →

GAD-2/GAD-7				
Circle the number that indicates: Over the past **2 weeks**, how often have you been bothered by any of the following problems?				
	Not At All	Several Days	More Than Half The Days	Nearly Every Day
Feeling nervous, anxious or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid, as if something awful might happen	0	1	2	3
Total = _____	**+_____**	**+_____**	**+_____**	**+_____**
If you checked any problems, how difficult have they 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

Modified 5 Ps				
			No	Yes
Did any of your parents have a problem with alcohol or other drug use?			0	1
Do any of your friends have a problem with alcohol or other drug use?			0	1
Does your partner have a problem with alcohol or other drug use?			0	1
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?			0	1
	Not at all	Rarely	Sometimes	Frequently
Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?	0	1	2	3
In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?	0	1	2	3

HARK		
	No	Yes
Within the last year, have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?	0	1
Within the last year, have you been afraid of your partner or ex-partner?	0	1
Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?	0	1
Within the last year, have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?	0	1

Edinburgh Postnatal Depression Scale (EPDS)

About the EPDS

The EPDS was developed to assist primary care health professionals in detecting persons suffering from postpartum depression (PPD).

Previous studies have shown that PPD affects at least 10-20 percent of patients and that many persons remain untreated. Aside from individual impacts, PPD has the potential to pose long term effects on the family.

The EPDS is a self-report scale consisting of 10 short statements. The patient indicates which of the four responses is closest to how they have been feeling **during the past week**. The scale will not detect persons with anxiety neuroses, phobias or personality disorders. For this reason, it is recommended that the EPDS be used in conjunction with other screening tools.

Studies show that with a threshold score of 13 or higher, sensitivity and specificity of the EPDS for diagnosing major depression were 90% and 92.1% respectively. **Nevertheless, the EPDS score does not confirm the presence or absence of depression.** Careful clinical assessment should be carried out in conjunction with the screening tool to confirm whether or not depression is currently present.

Instructions for Users

1. The person completing the EPDS is asked to indicate the response that comes closest to how they have felt during the previous week.
2. All 10 items must be completed.
3. Review assessment responses with the patient, providing relevant education and resources.
4. Following a positive screen, the EPDS may be used at six to eight weeks to screen postnatal persons or during pregnancy.

Scoring the EPDS

Scores on the EPDS range from 0 – 30. Response categories are scored on a scale of 0-3 according to increased severity of the symptom Items 3 and 5-10 are reverse scored. The total score is calculated by adding together the individual scores for each of the ten items.

EPDS Score of

< 13 Depression likely not indicated
≥ 13 Positive screen for depression

Responds “yes” to Q10 (self harm): conduct further risk assessment

Citation

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.

Patient Health Questionnaire (PHQ-2/PHQ-9)

About the PHQ-2/PHQ-9

The PHQ-2/PHQ-9 were developed to assist primary care health professionals in detecting patients suffering from unipolar depression. Without systematic screening, family physicians miss as many as 50% of patients struggling with major depression.

The PHQ-2 is a validated 2-question screener that consists of the first 2 questions on the PHQ-9. The PHQ-2 is often used as a preliminary screening tool to indicate whether a patient should complete a full PHQ-9 for further assessment.

The PHQ - 9 is a validated 9-question screener that is often used as a stand alone or follow-up screener to a positive PHQ-2 screen.

Among family medicine patients, studies show that with a threshold score of 2 or higher, sensitivity and specificity of the PHQ - 2 for diagnosing major depression was 86% and 78% respectively. For the PHQ-9, a score of 10 or higher, had 74% sensitivity and 91% specificity.

Instructions for Users

1. The person completing the PHQ-2/PHQ-9 is asked to indicate the response that comes closest to how they have felt during the previous two weeks.
2. All 9 items must be completed for the PHQ-9. Both items must be completed for the PHQ-2.
3. Following a positive screen, the PHQ-9 should be retaken every four weeks to monitor symptom severity and assess treatment effectiveness.

Scoring the PHQ-2

Response categories are scored 0 – 3 according to increased severity of the symptom. A score of 2 or more indicates a possible positive screen for depression and suggests that patients should subsequently complete the PHQ- 9.

Scoring the PHQ-9

Response categories are scored 0 – 3 according to increased severity of the symptom with a maximum score of 27. A threshold score of 10 or higher is considered to indicate mild major depression, 15 or higher indicates moderate major depression, and 20 or higher severe major depression.

Conduct further risk assessment if the patient indicates risk for self-harm (Question 9).

Citation

Arroll, B.,Goodyear-Smith, F.,Crengle,S., Gunn,J., Kerse, N., Fishman, T., … Hatcher,S. (2010).Validation of PHQ-2 and PHQ-9 to screen for major depression in the primary care population. *Annals of family medicine*, *8*(4), 348- 353. doi:10.1370/afm

Generalized Anxiety Disorder (GAD-2/GAD-7)

About the GAD-2/GAD-7

The GAD-2 and GAD-7 were developed to assist primary core health professionals in screening for generalized anxiety disorder.

These tools are also fairly effective at detecting panic disorder, social anxiety, and post-traumatic stress disorder. Because anxiety disorders often share symptoms and co-morbidities, directing patients to complete the PC-PTSD, HARK, and Modified 5ps can also assist with differential diagnosis.

The GAD-2 is a validated 2-question screener that consists of the first 2 questions on the GAD-7. The GAD-2 is often used as a preliminary screening tool to indicate whether a patient should complete a full GAD-7 for further assessment.

The GAD-7 is a validated 7-question screener that is often used as a stand alone or follow-up screener to a positive GAD-2 screen.

Studies show that with a threshold score of 3 or higher, sensitivity and specificity of the GAD-2 for diagnosing generalized anxiety disorder were 76% and 81%, respectively. For the GAD-7, a score of 8 or higher, had 83% sensitivity and 84% specificity.

Instructions for Users

1. The person completing the GAD-2/GAD-7 is asked to indicate the response that comes closest to how they have felt during the previous two weeks.
2. All 7 items must be completed for the GAD-7. Both items must be completed for the GAD-2.

Scoring the GAD-2

Response categories are scored 0 – 3 according to increased severity of the symptom. A score of 3 or more indicates a possible positive screen for generalized anxiety disorder and suggests that patients should subsequently complete the GAD-7.

Scoring the GAD-7

Response categories are scored 0 – 3 according to increased severity of the symptom. A score of 8 indicates a possible positive screen for generalized anxiety disorder.

Citation

Plummer, F., Manea, L., Trepel, D., & McMillan, D. (2016). Screening for anxiety disorders with the GAD-7 and GAD-2: a systematic review and diagnostic metaanalysis. *General Hospital Psychiatry. 39,* (24-31).

Interpersonal Violence - HARK

About the HARK

The HARK (Humiliation, Afraid, Rape, and Kick) was developed to assist primary care health professionals in identifying persons experiencing interpersonal violence (IPV).

Previous studies have shown that IPV affects at least 3-9 percent of patients during pregnancy. Experiencing IPV during pregnancy is associated with other mental health conditions, i.e. depression, and poor neonatal outcomes (i.e. low birth weight and preterm birth).

The HARK is a self-report scale consisting of 4 short statements. The patient indicates whether or not they have experienced any of the attitudes or behaviors **during the past year**. The scale will not detect persons experiencing other mental health conditions like depression, anxiety, or post-traumatic stress disorder.

A validation study of the HARK showed that patients who answered "Yes" to any 1 of the 4 items are 81% likely to be affected by IPV. **Nevertheless, the HARK score does not confirm the presence or absence of IPV.** Careful clinical assessment should be carried out to confirm whether or not the patient is affected by IPV.

Instructions for Users

1. The person completing the HARK is asked to indicate whether or not they have experienced the attitudes and behaviors within the past year.
2. All 4 items must be completed for the HARK.
3. Following a positive screen, the HARK should be administered at each trimester.

Scoring the HARK

Scores on the HARK range from 0 – 4. Response categories are scored on a scale of 0 – 1. A score of 1 or more is indicative of a positive screen.

Citation

Alhusen, J. L., Ray, E., Sharps, P., & Bullock, L. (2015). Intimate partner violence during pregnancy: maternal and neonatal outcomes. *Journal of women's health (2002)*, *24*(1), 100–106. doi:10.1089/jwh.2014.4872

Sohal, H., Eldridge, S., & Feder, G. (2007). The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC family practice*, *8*, 49. doi:10.1186/1471-229-849

Substance Use – Modified 5Ps

About the Modified 5P's

The Modified 5P's was developed to assist primary care health professionals in identifying patients using substances. The Modified 5P's was adapted from the 4P's Plus©, which was originally developed and validated in 2001. The Modified 5P's assesses patient's use of alcohol or illicit drugs and risk of substance use based on parent, peer, partner, and past risk factors.

A history of parental substance use can increase a patient's risk of developing a substance use disorder but is not as strong a predictor of problematic substance use as questions 4-6. Similarly, peer and partner substance use are considered a secondary risk factor for substance abuse disorder. However, partner substance use is a stronger risk factor for predicting interpersonal violence than patient substance use.

Instructions for Users

1. Prior to handing the patient the Modified 5P's, be sure to clarify that tobacco use and vaping are included in drug use.
2. Ask the patient to complete all six questions on the Modified 5P's.
3. If the patient scores positively on question four, five, or six ask follow-up questions to assess which substances the patient has previously used or is currently using.

Scoring the Modified 5Ps

Response categories are stratified into low risk, average risk, and high risk. Low risk is classified as patients who have never used alcohol or other drugs. Average risk is classified as patients who report using drugs and/or alcohol in the past, but not since learning of their pregnancy. High risk is classified as patients who used alcohol or drugs in the past month.

Citation

Chasnoff, I. (2001). Screening for substance use in pregnancy: A practical approach for the primary care physician. American Journal of Obstetric Gynecology.*148*, 752-758

RISK ASSESSMENT

- Assessing Risk of Suicide or Self-Harm
- Assessing Risk of Harm to Baby
- Additional resources for crisis and substance use

Assessing Risk of Suicide or Self-Harm

If risk of suicide or self-harm is indicated…

- Inquire with patient about unwanted or intrusive thoughts
- Introduce assessment to patient using non-judgmental and normalizing language
  "*Many people have intrusive or scary thoughts. When people are suffering, they often have thoughts about death or wanting to die. These thoughts can feel awful. Because of this, we don't want you to feel alone and ask patients if they are experiencing them, so that we can identify the best way to support you.*"
- Further assess for risk of suicide or self-harm
  - **Ideation: Inquire about frequency, intensity, duration – in last 48 hours, past month, worst ever**
    - *"In the past week, how often have you thought about death, wanting die, or self-harm?"*
  - **Plan: Inquire about timing, location, lethality, availability, making preparations**
    - *"What ways have you thought you could harm yourself or attempt suicide?"*
  - **Behaviors: Inquire about past attempts, aborted attempts, rehearsals**
    - *"What ways have you ever attempted to hurt yourself or attempt suicide in the past?"*
  - **Intent: Inquire about extent to which patient 1) expects to carry out plan, 2) believes plan/act to be lethal/self-injurious. Explore ambivalence: reasons to die vs. reasons to live.**
    - *"On a scale of 1-10, what is the likelihood that you will carry out this plan?"*

Assess Risk

Low Risk

- No history of suicide attempt
- No current intent*
- No current plan*
- Protective factors present (i.e. social support, religious prohibition, other children)
- No substance use
- Hopeful about improvement

Moderate Risk

- Persistent sadness and tension, loss of interest, persistent guilt, difficulty concentrating, no appetite, decreased sleep
- History of suicide attempt
- Current intent*
- Current plan** (not well formulated)
- Limited protective factors
- Substance use
- Hopelessness

High Risk

- Continual sadness, unrelenting dread or guilt, <2-3 hours of sleep per night, unable to feel pleasure
- History of multiple suicide attempts
- High lethality of prior attempt(s)
- Current intent*
- Current Plan**
- Limited protective factors
- Substance use
- Not receiving psychotherapy
- Hopelessness

Treatment Options

Low Risk

- Treat underlying mental health condition
- Maximize medication treatment and therapeutic interventions
- Monitor closely

Moderate Risk

- Treat underlying mental health condition
- Maximize medication treatment & therapeutic interventions
- Discuss warning signs with patient & family
- Discuss when & how to reach out for help if patient feels unsafe
- Identify family, friends, & professional(s) that can be contacted during a crisis
- Ensure close follow-up & monitoring

High Risk

- Do <u>not</u> leave patient alone until assessment is complete
- *If assessed to be at imminent risk of harm to self or others,* ***call 911***
- If NOT assessed to be at imminent risk, follow all directions listed in moderate risk box

Adapted by the NC MATTERS team from Lifeline4Moms Assessing Risk of Suicide or Self Harm and Harm to Baby. Funding provided by CDC grant number U01DP006093. Original Authors: Byatt N., Mittal L., Brenckle, L., Logan D., & Moore Simas, T.

Assessing Risk of Harm to Baby

If risk of suicide or self-harm is indicated…

- Inquire with patient about unwanted or intrusive thoughts
- Introduce assessment to patient using non-judgmental and normalizing language
  "People often have intrusive thoughts. Sometimes these thoughts are about something bad happening to their baby. These thoughts can feel awful, uncontrollable, and sometimes too hard to bear. We are here to help you. We ask everyone about these thoughts because they are so common."
  ASK: *Have you had any unwanted thoughts?*
  ASK: *Have you had any thoughts of harming your infant, either as an accident or on purpose?*
  If the patient answers yes to the above question, follow-up with:
  1. *How often do you have these thoughts?*
  2. *How recently have you had these thoughts?*
  3. *How much do these thoughts scare you?*

Assess Risk

Low Risk

- Symptoms indicative of depression, OCD, and/or anxiety
- Thoughts of harming baby are scary, cause anxiety, or are upsetting
- Mother does not want to harm her baby and feels it would be a bad thing to do
- Mother very clear she would not harm her baby

Moderate Risk

- Thoughts of harming baby are somewhat scary
- Thoughts of harming baby cause less anxiety
- Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do
- Mother less clear she would not harm her baby

High Risk

- Symptoms indicative of psychosis
- Thoughts of harming baby are comforting
- Feels as if acting on thoughts will help infant or society
- Lack of insight (inability to determine whether thoughts are based on reality)
- Having auditory and/or visual hallucinations
- Bizarre or fixed untrue beliefs that are not reality

Treatment Options

Low Risk

- Provide reassurance and education
- Treat underlying illness
- Discuss warning signs patient and family can look for
- Discuss when and how to reach out for help if patient feels unsafe

Moderate Risk

- Treat underlying illness
- Discuss warning signs with patient & family
- Establish a collaborative safety plan: **who** patient can go to for help, **what** the patient can do if they feel unsafe, **where** patient can go if they feel unsafe, and **when** patient should ask for help
- Determine a plan for close monitoring and follow-up

High Risk

- **If psychosis is indicated refer to your clinic's crisis plan or call 911**
- **Do not leave patient and baby alone while help is being sought**
- If NOT assessed to be at imminent risk, follow all directions listed in moderate risk box

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Additional Crisis Resources

Program	Description	Number	Location
UNC Perinatal Psychiatry Inpatient Unit	5-bed inpatient unit at UNC-Chapel Hill Hospital for women with severe perinatal mood disorders. Intended to support stabilization and recovery. Family & baby can visit, but cannot stay with patient overnight.	To refer a patient from any county please call UNC Psychiatry Admissions at (984)-974-3834 THIS IS NOT FOR PATIENTS ACTIVELY IN CRISIS AS THERE MAY BE A WAIT TIME OR NO AVAILABLE BEDS	101 Manning Drive, Ground Floor, Neurosciences Hospital Chapel Hill, NC, 27599-7160
Mobile Crisis	Mobile Crisis Teams are available 24/7 in all NC counties. If a patient or loved one is in crisis, they can call their county's mobile crisis number and professional counselors will come to assist the person in crisis. Average response time is 2 hours.	Franklin, Granville, Halifax, Vance & Warren County: Daymark Recovery Services- (866)-275-9552 Person County: Freedom House Recovery Center – (919)-967-8844	Mobile crisis teams will come to the location of the person in crisis.
Crisis Center	Crisis centers are specialized clinics that patients and their loved ones can walk in for a crisis assessment and referral to additional resources. Appointments are not needed. Patients MUST be residents of the crisis center's designated county to receive services.	Person County: Freedom House Recovery Center – 336-599-8566 Monday-Friday- 8am-4pm Halifax County: RHA Behavioral Health Services – (252)-308-0294 Monday-Friday – 8am-5pm Vance County: Daymark Recovery Services- (252)-433-0061 Monday-Friday – 8am-5pm	Freedom House Recovery Center 335-C S Madison Blvd, Roxboro, NC 27573 RHA Behavioral Health Services 60 NC HWY 125 Roanoke Rapids, NC, 27870 Daymark Recovery Services 943 West Andrews Ave, Henderson, NC 27536
Suicide Prevention Lifeline	24/7 suicide hotline available for patients and their loved ones	1-800-273-8255	Telephone line only – National availability
Crisis Intervention Team (CIT) Officer	Many counties have at least one CIT officer who is trained in deescalating behavioral health crises.	If there is an eminent, life-threatening emergency that requires police, call **911** and ask for a CIT officer	Telephone line only – CITs are not available in all NC counties.

Additional Substance Use Resources

Program	Description	Number	Location
Perinatal Substance Use Project	Provides screening, information & referral (in-patient CASAWORKS & out-patient treatment) for pregnant and parenting women with dependent children. Also, provides consultation for medical providers.	Patients or providers can call to get information or seek services at: 1-800-688-4232 Monday-Friday – 8am-6pm	Perinatal Substance Use Project serves all counties in NC and is a division of the Alcohol/Drug Council of North Carolina.
CASAWORKS	CASAWORKS programs are residential SUD treatment centers aimed at supporting pregnant and parenting women with dependent child(ren) (under 12yrs old). There are 13 CASAWORKS programs across the state. CASAWORKS programs house patients with their children and provide intensive biopsychosocial intervention (MAT, therapy, medical care, job training, resources for children).	For more information on bed availability and qualifications call: 1-800-688-4232 Monday-Friday – 8am-6pm Professionals Only: Email Judith at jjones@alcoholdrughelp.org to be added to the weekly NC bed availability listserve for in-patient perinatal SUD treatment options	Patients can enroll in CASAWORKS program outside of their local county. CASAWORKS programs are located in: • Buncombe County • Durham County • Forsyth County • Mecklenburg County • Randolph County • Orange County • Wake Country
Horizons Program at UNC-Chapel Hill	Horizons is a CASAWORKS program located in Orange County	Interested patients can call 1-800-862-4050 for information To refer a patient call (919)-966-9803	UNC OB-GYN at Weaver Crossing on Weaver Dairy Rd in Chapel Hill
Cardinal Innovations Healthcare Solutions	Cardinal Innovations is the MCO for Franklin, Granville, Halifax, Person, Vance & Warren County. If a patient needs help finding in-patient or out-patient substance use or mental health resources, Cardinal customer service specialists can help locate resources.	Available 24/7 Call: 1-800-939-5911	Cardinal Innovations 201 Sage Rd #300, Chapel Hill, NC, 27514