# Clinical Guidelines for Implementing Universal Perinatal Depression Screening

Nebraska Perinatal Quality Improvement Collaborative
www.npqic.org
5/2023

# Clinical Guidelines for Implementing Universal Perinatal Depression Screening

## Table of Contents




The Nebraska Perinatal Quality Improvement Collaborative created this document as part of a Perinatal Depression Screening Grant from First Five Nebraska and the Pritzker Children's Initiative. Special thanks to the Kansas Department of Health and Environment, Minnesota Department of Health, DC Collaborative for Mental Health in Pediatric Primary Care, and the Massachusetts Child Psychiatry Access Program for Moms for allowing us to use and modify their work.

## Overview

Perinatal depression, or depression occurring during pregnancy or the postpartum period, is one of the most common obstetric complications in the United States. It is estimated that 1 in 7 women and 1 in 10 men experience symptoms of postpartum depression and anxiety. Rates are nearly double for African American women and those living in poverty. Perinatal depression is a tragic and preventable cause of maternal and infant morbidity and mortality.

## Why screen for perinatal depression?

Perinatal depression affects the entire family, and if untreated, can have serious adverse effects, including:

- Poor adherence to medical care and increased health care costs
- Inadequate prenatal care, higher rates of preterm birth, low birth weight, pre-eclampsia, and spontaneous abortion
- Smoking and substance use
- Loss of financial resources
- Family dysfunction and increased risk of abuse and neglect
- Impaired parent-child interaction- bonding and attachment issues
- Discontinuation of breastfeeding
- Failure to thrive and colic
- Infantile sleep disorders
- Delays in motor, cognitive, and language development
- Emotional and behavioral disorders that persist into adolescence

Effective, free, and validated screening tools exist to identify mothers and fathers at risk for perinatal depression. Treatment is available and can have a significant impact on outcomes.

For a review of perinatal mood and anxiety disorders (PMAD's) see Appendix A and the following resources:

Van Niel, M. S., & Payne, J. L. (2020). Perinatal depression: A review. *Cleveland Clinic Journal of Medicine*, *87*(5), 273–277. https://doi.org/10.3949/ccjm.87a.19054
Available here: https://www.ccjm.org/content/ccjom/87/5/273.full.pdf

Videos:

KidsCare Canada "Postpartum Depression – Not the Baby Blues"
Available here: http://postpartum.org/videos/video/postpartum-depression-baby-blues/

National Institute of Mental Health (NIMH) "Baby Blues—or Postpartum Depression"
Available here: https://www.youtube.com/watch?v=6kaCdrvNGZw

## Who and When to Screen?

Pregnant women and new parents have frequent contact with the health care system. These encounters offer providers multiple opportunities to conduct depression screening, make referrals, and provide follow-up care for new parents at prenatal, perinatal, and well-child checkups.

The American College of Obstetricians and Gynecologists (ACOG), American College of Nurse-Midwives (ACNM), and the U.S. Preventative Services Task Force (USPSTF) recommend universal screening of pregnant and postpartum women for depression as a component of quality obstetric care.

Screening for postpartum depression in both mothers and fathers is recommended by Bright Futures and the American Academy of Pediatrics and is a best practice in caring for infants and their families (AAP, 2020).

**Screening is recommended with timing as follows:**

**MOTHERS**

- At least once in prenatal period
- Comprehensive postpartum visit
- By 1 month, and then 2, 4, 6-month well-child visits

**FATHERS**

- At least once in the first 6 months after birth of baby

** Screening mothers during the birth hospitalization and NICU parents is highly encouraged.

For screening recommendations:
USPSTF Screening for Depression in Adults (January, 2016- update in progress)
ACOG Committee Opinion 757 Opinion 757 (October, 2018)
AAP Policy Statement (January, 2019)
AAP Call to Action: Screening Fathers (January, 2020)
AAP Integrating Postpartum Depression Screening in Your Practice in Four Easy Steps (July, 2022)
National Clinical Recommendations for Maternal Depression Screening Table (2020mom.org)
The Maternal Mental Health Continuum of Care: From Identification Through Treatment (2020mom.org)

## Which screening tool to use?

Edinburgh Postnatal Depression Scale (EPDS) (Appendix B)

- 10-question self-administered scale
    - Includes the EPDS-3A anxiety subscale
    - Excludes constitutional symptoms
- Takes less than 5 minutes to complete
- Designed and validated with postpartum women
- Has since been validated for new fathers
- Available in the electronic medical record (EMR) and multiple languages
- Tool with scoring instructions
    - EPDS in English
    - EPDS in Spanish
    - EPDS in Other Languages

Edinburgh Postnatal Depression Anxiety Subscale (EPDS-3A)

- Used to calculate a specific anxiety score
    - Items 3, 4, and 5 of the EPDS are totaled
    - Cut off of ≥ 6 warrants further evaluation for anxiety

Patient Health Questionnaire 9 (PHQ-9) (Appendix C)

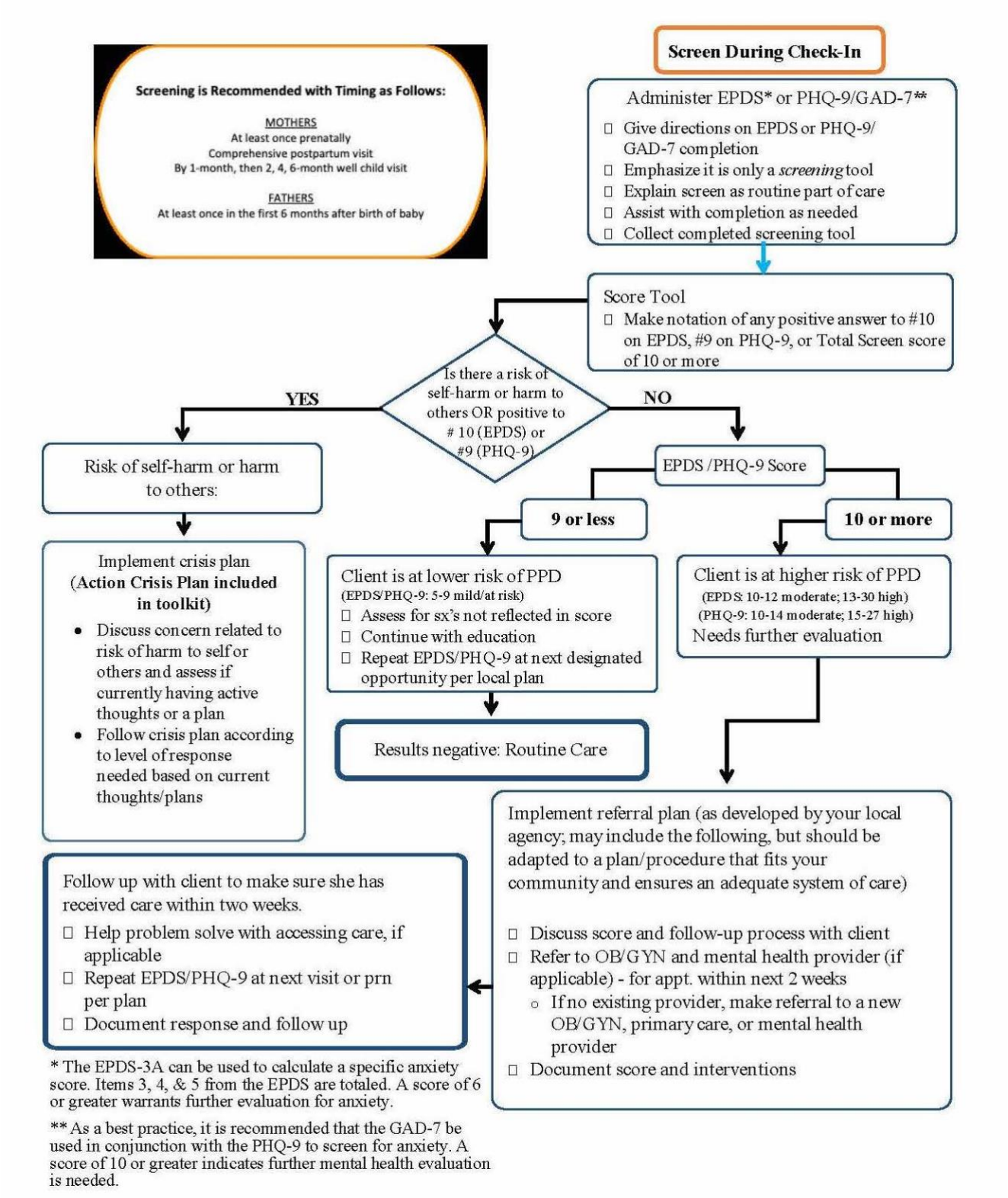
- 9-question self-administered scale
    - Does not screen for anxiety
- Takes less than 5 minutes to complete
- Used in screening for adult depression
    - Not specific to pregnancy or postpartum
- Available in EMR and multiple languages
- Tool with scoring instructions
    - PHQ-9 in English
    - PHQ-9 in Spanish
    - PHQ-9 in Other Languages

Generalized Anxiety Disorder Screener (GAD-7) (Appendix D)

- Should be utilized with the PHQ-9 to screen for possible anxiety
- 7-question self-administered scale
- Takes 3 minutes or less to complete
- Used in screening for adult anxiety
    - Not specific to pregnancy or postpartum
- Available in multiple languages
- Tool with scoring instructions
    - GAD-7 in English
    - GAD-7 in Spanish
    - GAD-7 in Other Languages

See Appendix E for Sample Scripts for Screening and Referral

# Sample Screening Algorithm for EPDS and PHQ-9/GAD-7




Adapted for use by the Nebraska Perinatal Quality Improvement Collaborative. Credit is given to the Kansas Maternal and Child Health Programs and the Minnesota Department of Health for their work to create perinatal mental health screening algorithms.
https://www.kdhe.ks.gov/DocumentCenter/View/2897/Screening-for-Perinatal-Mood-and-Anxiety-Disorders-PDFMood-and-Anxiety-Disorders-PDF

Sample Action Crisis Plan

# Action Crisis Plan

If patient answered “YES” to #10 on EPDS, "YES" to #9 on PHQ-9 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

## 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: Used with permission from DC Collaborative for Mental Health in Pediatric Primary Care
Children's National Health System: Overview and Primer Spring 2020. 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: Used with permission from DC Collaborative for Mental Health in Pediatric Primary Care
Children's National Health System. *Overview and Primer Spring 2020*. Originally 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 Resources

Providers and clinics are encouraged to develop a referral plan that fits their community. The following resources provide a starting point for locating local services for treating mothers and fathers who may be experiencing perinatal depression. See Appendix E for local resource template from NEP-MAP Screening and Referral Guide.

Emergency Services

- Call 9-1-1, or escort parent to Emergency Room
- 988 Suicide and Crisis Lifeline: Call, text, or chat 9-8-8 to be connected to the National Suicide Prevention Hotline. The Lifeline provides ,24/7, confidential crisis counseling and mental health referrals. https://988lifeline.org/
    - The previous number 800-273-TALK (8255) continues to function.
    - Available in Spanish: 888-628-9454. https://988lifeline.org/help-yourself/en-espanol/
- National Crisis Text Line: Text HOME to 741741 from anywhere in the USA, anytime, about any type of crisis.

Nebraska Network of Care

- Interactive website for finding licensed mental health providers in the six behavioral health regions of Nebraska (See Appendix F). https://portal.networkofcare.org/NebraskaBehavioralHealth

Blue Valley Behavioral Health

- Private non-profit organization, provides professional outpatient behavioral and mental health services. https://bvbh.net/
- Twelve offices that serve 16 rural counties in Southeast Nebraska.
- After Hours Crisis Line: 833-662-4951

Nebraska Partnership for Mental Healthcare Access in Pediatrics (NEP-MAP)

- Screening and Referral Guide

Google Search

- Search for Licensed Mental Health Provider and geographic location

Local Health Department

- May be able to provide assistance locating licensed mental health providers in your area

Postpartum Support International (PSI) Perinatal Psychiatric Consult Line

- Call 877-499-4773 or request an appointment on line at https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/
- FREE service, available for medical professionals who have questions about mental health care related to pregnant, postpartum patients, and pre-conception planning.

Nebraska Family Helpline

- Telephone 888-866-8660, 24/7, http://dhhs.ne.gov/Pages/Nebraska-Family-Helpline.aspx

United Way 2-1-1, formerly Healthy Mothers Healthy Babies Hotline

- Call or text 2-1-1, available in multiple languages, http://www.ne211.org
- Comprehensive information and referral system for Nebraskans to DHHS, community, and government programs

The Nebraska Rural Response Hotline: Counseling, Outreach, and Mental Health Therapy Program (COMHT)

- 1-800-464-0258
- Provides vouchers for free, confidential mental health crisis counseling to farm, ranch, and rural families

## Medication Therapy and Lactation

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

Considerations:

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

## Lactation Resources

LactMed Database

- Maintained by the U.S. National Library of Medicine (NLM) at the National Institutes of Health (NIH)
- Provides a summary of drug-use during lactation, known drug levels, reports of adverse effects in breastfed infants, effects on lactation, drug alternatives to consider if indicated.
- https://www.ncbi.nlm.nih.gov/books/NBK501922/

MotherToBaby

- A service of the Organization of Teratology Information Specialists (OTIS)
- Provides evidence-based information on the safety of medications and other exposures during pregnancy and while breastfeeding.
    - Fact-sheets available to print and distribute.
- No-cost information service is available to mothers and health professionals via chat, test, phone and email.
    - Available Monday through Friday 8 am-5 pm.
    - Toll free: 866-626-6847
    - Text: 855-999-3525
    - Chat and Email link available on website.
- Web-site and materials available in English and Spanish.
- https://mothertobaby.org/

Infant Risk Center (Texas Tech University Health Sciences Center)

- General education about medications and lactation.
- Includes a forum to send questions to Dr. Thomas Hale, author of Medications and Mother's Milk.
- https://www.infantrisk.com/forum/

Medications and Mothers' Milk

- Hale, T. W. (2021). *Hale's medications & mothers' milk, 2021: a manual of lactational pharmacology* (19th ed.). Springer Publishing Company. ISBN 9780826189257.

Briggs Drugs in Pregnancy and Lactation

- Briggs, G. G., Freeman, R. K., Towers, C. V., & Forinash, A. B. (2021). *Briggs drugs in pregnancy and lactation: A reference guide to fetal and neonatal risk* (12th ed.). Lippincott Williams & Wilkins. ISBN 9781975162375.

## Resources for Families

Emergency Services

- Call 9-1-1, or go to Emergency Room
- 988 Suicide and Crisis Lifeline: Call, text, or chat 9-8-8 to be connected to the National Suicide Prevention Hotline. The Lifeline provides ,24/7, confidential crisis counseling and mental health referrals. https://988lifeline.org/
    - The previous number 800-273-TALK (8255) continues to function.
    - Available in Spanish: 888-628-9454. https://988lifeline.org/help-yourself/en-espanol/
- National Crisis Text Line: Text HOME to 741741 from anywhere in the USA, anytime, about any type of crisis.

Postpartum Support International (PSI) www.postpartum.net

- Provides support for mothers and fathers. Website available in Spanish and English.
- Telephone 800-944-4773
- Text option in English 800-944-4773, Spanish 971-420-0294
- Offers free weekly online support groups for all parents specific to race and background. Register on their website at https://www.postpartum.net/get-help/psi-online-support-meetings/

HRSA National Maternal Mental Health Hotline
https://mchb.hrsa.gov/national-maternal-mental-health-hotline

- Provides 24/7, free confidential support, resources, and referrals to professional counselors for any pregnant or postpartum mother facing mental health challenges.
- Counselors offer support in English and Spanish, with interpreter services available in 60 languages.
- Call or text 1-833-TLC-MAMA (833-852-6262)

Postpartum Progress www.postpartumprogress.com

Connected Forever https://connected4ever.org/

- Support for families of infants in the NICU

## Specific to Fathers

Postpartum Support International (PSI)-
https://www.postpartum.net/get-help/resources-for-fathers/

- Chats for Dads: First Monday of each Month
  (Chat with Daniel B. Singley, Ph.D., ABPP)
  Schedule of Call-In Times: First Monday of every month, 7 PM CST
  Call in number is 1-800-944-8766, code 73162#
- Dad Support Group: First Friday, 9 AM CST, Third Friday of every month, 7:30 PM CST
  Free online space for dads to connect with other dads
- Support Coordinators for Dads
  Available in all fifty states
  The PSI Nebraska Coordinators can help guide you through the process of finding resources near you. https://psichapters.com/ne/ - get-help

Postpartum Men

- Provides information for fathers and hosts an online forum
- https://postpartummen.com/

The Center for Men's Excellence
https://www.menexcel.com/advice-for-new-dads/

- A social network that offers advice and videos for fathers

Padre Cadre

- A "just for dads" social support network dedicated to connecting fathers with fathers and other resources to help make the most out of the fatherhood journey. https://www.padrecadre.com

## Patient Handouts and Education

Nebraska DHHS: Reach out and Discover a New Day. A Guide to Understanding Pregnancy-Related Depression

- English: https://dhhs.ne.gov/MCAH/MI-Re-MPPD-Eng.pdf
- Spanish: https://dhhs.ne.gov/MCAH/MI-Re-MPPD-Spa.pdf

American Academy of Pediatrics: Feeling Very Sad or Anxious? (Handout) (free)

- English: https://downloads.aap.org/
- Spanish: https://downloads.aap.org/Spanish

Mom's Mental Health Matters: Action Plan for Depression and Anxiety Around Pregnancy Tear Pad (50 sheets per pad) (free)

- English: https://www.nichd.nih.gov/publications/pages/pubs_details.aspx?pubs_id=5889
- Spanish: https://www.nichd.nih.gov/publications/pages/pubs_details.aspx?pubs_id=5893

Moms' Mental Health Matters: Talk About Depression and Anxiety Around Pregnancy (Postcard) (free)

- English: https://www.nichd.nih.gov/publications/pages/pubs_details.aspx?pubs_id=5890
- Spanish: https://www.nichd.nih.gov/publications/pages/pubs_details.aspx?pubs_id=5894

Mom's Mental Health Matters: Happiest Time (Poster) (free)

- English: https://www.nichd.nih.gov/publications/product/470?pubs_id=5888
- Spanish: https://www.nichd.nih.gov/publications/product/474?pubs_id=5892

Mom's Mental Health Matters: Prepared for Anything (Poster) (free)

- English: https://www.nichd.nih.gov/publications/product/469?pubs_id=5887
- Spanish: https://www.nichd.nih.gov/publications/product/473?pubs_id=5891

Postpartum Support International: Supporting Postpartum Families (brochure)

- English: http://www.postpartum.net/wp-content/uploads/2014/11/EnglishBrochure.pdf
- Spanish: http://www.postpartum.net/wp-content/uploads/2017/08/SpanishBrochure.pdf

Supporting Fathers' Mental Health Infographic – NICHQ (free)
https://www.nichq.org/FathersInfographic

Paternal Postpartum Depression (brochure)
https://www.kdhe.ks.gov/Paternal-Postpartum-Depression-Brochure-English
https://www.kdhe.ks.gov/Paternal-Postpartum-Depression-Brochure-Spanish

# References


ACOG Committee Opinion No. 757 Summary: Screening for Perinatal Depression. (2018). *Obstetrics & Gynecology*, *132*(5), e208–e212. https://doi.org/10.1097/aog.0000000000002928

DC Collaborative for Mental Health in Pediatric Primary Care Children's National Hospital. (2020). Perinatal Mental Health Toolkit for Pediatric Primary Care: Overview and Primer. https://www.dchealthcheck.net/resources/healthcheck/mental-health-tools.html

Earls, M. F., Yogman, M. W., Mattson, G., & Rafferty, J. (2019). Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. *Pediatrics*, *143*(1). https://doi.org/10.1542/peds.2018-3259

Kansas Department of Health and Environment. Kansas Department of Health and Environment: Maternal and Child Health (MCH) Block Grant - Mental Health Integration. https://www.kdhe.ks.gov/623/Kansas-Perinatal-Behavioral-Health

Kendig, S., Keats, J. P., Hoffman, M. C., Kay, L. B., Miller, E. S., Moore Simas, T. A., … Lemieux, L. A. (2017). Consensus Bundle on Maternal Mental Health. *Obstetrics & Gynecology*, *129*(3), 422–430. https://doi.org/10.1097/aog.0000000000001902

*MCPAP for Moms Obstetric Provider Toolkit*. MCPAP for Moms. (2019, December 9). https://www.mcpapformoms.org/Toolkits/Toolkit.aspx#Mood

*MCPAP for Moms Toolkit- Pediatric Provider*. MCPAP for Moms. (2018, March 14). https://www.mcpapformoms.org/Toolkits/PediatricProvider.aspx

*Minnesota Department of Health*. Prenatal or Postpartum Depression or Anxiety. https://www.health.state.mn.us/people/womeninfants/pmad/index.html.

Sachs, H. C. (2013). The transfer of drugs and therapeutics into human breast milk: An update on selected topics. Pediatrics, 132(3), e796–e809. https://doi.org/10.1542/peds.2013-1985

Siu, A. L., Bibbins-Domingo, K., Grossman, D. C., Baumann, L. C., Davidson, K. W., Ebell, M., … Pignone, M. P. (2016). Screening for Depression in Adults. *JAMA*, *315*(4), 380-387. https://doi.org/10.1001/jama.2015.18392

*System of Care Regions: BHECN: University of Nebraska Medical Center*. UNMC. https://www.unmc.edu/bhecn/education/nebraska-system-of-care/soc-map.html.

2020 Mom. https://www.2020mom.org/.

Van Niel, M. S., & Payne, J. L. (2020). Perinatal depression: A review. *Cleveland Clinic Journal of Medicine*, *87*(5), 273–277. https://doi.org/10.3949/ccjm.87a.19054

Walsh, T. B., Davis, R. N., & Garfield, C. (2020). A Call to Action: Screening Fathers for Perinatal Depression. *Pediatrics*, *145*(1). https://doi.org/10.1542/peds.2019-1193

Wisner, K. L., Sit, D. K., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., … Hanusa, B. H. (2013). Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women with Screen-Positive Depression Findings. *JAMA Psychiatry*, *70*(5), 490. https://doi.org/10.1001/jamapsychiatry.2013.87

Appendix A

# 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<br>• Personal history of depression or anxiety<br>• Family history of depression or anxiety<br>• Recent, big life changes (in addition to pregnancy/new baby)<br>• Lack of social support<br>• Poor marital/partner relationship<br>• Multiples<br>• Difficult pregnancy<br>• Difficult infant temperament (colic, fussy) or related problems (sleep, feeding)<br>• Special needs/NICU baby<br>• Prior pregnancy or infant loss<br>• Infertility treatments | | | Risk factors for Depression, Anxiety, and OCD, plus:<br>• Traumatic birth (as experienced by mother) and/or<br>• 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.<br>Low SES: 33-50% | Generalized anxiety: 6-8%<br>Panic disorder: 0.5-3%<br>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:<br>• Self-Care: Exercise, Sleep, Nutrition, Time off from childcare<br>• Peer Support Groups<br>• Psychotherapy (Individual, Dyadic [mother-baby], Couples, Family)<br>• Medication<br><br>Additional complementary and alternative therapy options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate. | | | | **Requires immediate psychiatric help.**<br>• Hospitalization and medication are usually indicated.<br>• If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies.<br>• Encourage sleep hygiene for prevention (e.g. consistent sleep/wake times, help with feedings at night). |

# Appendix B

## Edinburgh Postnatal Depression Scale[1] (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:

1. 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

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 _____

[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

# 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.

## 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

## Escala Edinburgh para la Depresión Postnatal (Spanish Version)

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

Fecha: _____

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

*A continuación se muestra un ejemplo completado:*

Me he sentido feliz:
Sí, todo el tiempo ___ 0
Sí, la mayor parte del tiempo ✔ 1
No, no muy a menudo ___ 2
No, en absoluto ___ 3

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

1. He podido reír y ver el lado bueno de las cosas:
   Tanto como siempre he podido hacerlo ___ 0
   No tanto ahora ___ 1
   Sin duda, mucho menos ahora ___ 2
   No, en absoluto ___ 3

2. He mirado al futuro con placer para hacer cosas:
   Tanto como siempre ___ 0
   Algo menos de lo que solía hacerlo ___ 1
   Definitivamente menos de lo que solía hacerlo ___ 2
   Prácticamente nunca ___ 3

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   Sí, casi siempre ___ 3
   Sí, algunas veces ___ 2
   No muy a menudo ___ 1
   No, nunca ___ 0

4. He estado ansiosa y preocupada sin motivo alguno:
   No, en absoluto ___ 0
   Casi nada ___ 1
   Sí, a veces ___ 2
   Sí, muy a menudo ___ 3

5. He sentido miedo o pánico sin motivo alguno:
   Sí, bastante ___ 3
   Sí, a veces ___ 2
   No, no mucho ___ 1
   No, en absoluto ___ 0

6. Las cosas me oprimen o agobian:
   Sí, la mayor parte del tiempo no he podido sobrellevarlas ___ 3
   Sí, a veces no he podido sobrellevarlas de la manera ___ 2
   No, la mayoría de las veces he podido sobrellevarlas bastante bien ___ 1
   No, he podido sobrellevarlas tan bien como lo hecho siempre ___ 0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   Sí, casi siempre ___ 3
   Sí, a veces ___ 2
   No muy a menudo ___ 1
   No, en absoluto ___ 0

8. Me he sentido triste y desgraciada:
   Sí, casi siempre ___ 3
   Sí, bastante a menudo ___ 2
   No muy a menudo ___ 1
   No, en absoluto ___ 0

9. Me he sentido tan infeliz que he estado llorando:
   Sí, casi siempre ___ 3
   Sí, bastante a menudo ___ 2
   Ocasionalmente ___ 1
   No, nunca ___ 0

10. He pensado en hacerme daño:
    Sí, bastante a menudo ___ 3
    A veces ___ 2
    Casi nunca ___ 1
    No, nunca ___ 0

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

# Appendix C

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**_____ **DATE:**_____

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

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

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



A26631B 10-04-2005

# PHQ-9 Patient Depression Questionnaire

**For initial diagnosis:**

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

***Consider Major Depressive Disorder***

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

***Consider Other Depressive Disorder***

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

**Note:** Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

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

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

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

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

**Interpretation of Total Score**

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



A2662B 10-04-2005

# CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

| **Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?** *(Marque con un "□" para indicar su respuesta)* | Ningún día | Varios días | Más de la mitad de los días | Casi todos los días |
|---|---|---|---|---|
| **1.** Poco interés o placer en hacer cosas | 0 | 1 | 2 | 3 |
| **2.** Se ha sentido decaído(a), deprimido(a) o sin esperanzas | 0 | 1 | 2 | 3 |
| **3.** Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado | 0 | 1 | 2 | 3 |
| **4.** Se ha sentido cansado(a) o con poca energía | 0 | 1 | 2 | 3 |
| **5.** Sin apetito o ha comido en exceso | 0 | 1 | 2 | 3 |
| **6.** Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia | 0 | 1 | 2 | 3 |
| **7.** Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión | 0 | 1 | 2 | 3 |
| **8.** ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal | 0 | 1 | 2 | 3 |
| **9.** Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera | 0 | 1 | 2 | 3 |

**FOR OFFICE CODING** 0 + _____ + _____ + _____

**=Total Score:** _____

**Si marcó <u>cualquiera</u> de los problemas, ¿qué tanta <u>dificultad</u> le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?**

| **No ha sido difícil** | **Un poco difícil** | **Muy difícil** | **Extremadamente difícil** |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

# Appendix D

## GAD-7

| Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| **2.** Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| **3.** Worrying too much about different things | 0 | 1 | 2 | 3 |
| **4.** Trouble relaxing | 0 | 1 | 2 | 3 |
| **5.** Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| **6.** Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| **7.** Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

***(For office coding: Total Score T____ = ____ + ____ + ____ )***

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

GAD-7 Anxiety Severity.
This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of —not at all,‖ —several days,‖ —more than half the days,‖ and —nearly every day,‖ respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cutpoints for mild, moderate, and severe anxiety, respectively. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for anxiety disorders, a recommended cutpoint for further evaluation is a score of 10 or greater.

# GAD-7

| **Durante las <u>últimas 2 semanas</u>, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?** *(Marque con un " " para indicar su respuesta)* | **Ningún día** | **Varios días** | **Más de la mitad de los días** | **Casi todos los días** |
|---|---|---|---|---|
| **1.** Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta | 0 | 1 | 2 | 3 |
| **2.** No ha sido capaz de parar o controlar su preocupación | 0 | 1 | 2 | 3 |
| **3.** Se ha preocupado demasiado por motivos diferentes | 0 | 1 | 2 | 3 |
| **4.** Ha tenido dificultad para relajarse | 0 | 1 | 2 | 3 |
| **5.** Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a) | 0 | 1 | 2 | 3 |
| **6.** Se ha molestado o irritado fácilmente | 0 | 1 | 2 | 3 |
| **7.** Ha tenido miedo de que algo terrible fuera a pasar | 0 | 1 | 2 | 3 |

**(*For office coding: Total Score T*____ = ____ + ____ + ____ )**

# Appendix E

## Sample Scripts for Screening and Referral

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

These scripts should NOT be given to patients. Segments of it could be adapted into written form if desired. The italics are recommended words to be used when speaking to the parent.

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

### Handing out the Screen

This block can be printed on the screen.

*Congratulations on your new baby! It's a big adjustment and we would like to know how you are feeling. Please check the answer that comes closest to how you have been feeling in the past 7 days, not just how you feel today.*

Front desk staff: (The person handing the parent the screening tool.)
*Having a baby is a big adjustment and your provider would like to check in with you and find out how you are feeling. Please fill this out, thinking about how you have been feeling over the past week. Your (nurse/MA) will collect it from you in the room.*

### Introducing the Screen to Patients:

Well-Child Visit:

- PROVIDER: *As your child's provider, I'm concerned about the wellbeing of your child and so I'm also concerned about the wellbeing of the people who take care of your child. I'd like to know how you are feeling and how you have been coping. Please take a few minutes to fill out this short survey.* (OR – *Thank you for filling this out.)*

Prenatally:

- PROVIDER: *I'd like to check in with you to understand how you are feeling since you've become pregnant. Please take a few minutes to fill out this short survey*.

Postpartum Visit:

- PROVIDER: *Now that you have had your baby I would like to know how you are feeling and how you have been coping lately. Please take a few minutes to fill out this short survey.*

Response to a positive PPD screen:

- PROVIDER: *This is a screen for depression and anxiety. I'm concerned because you have a high score. Have you been feeling down, depressed, or anxious lately?*
    - PROVIDER: *Would you be willing to see someone for help?*
        - PROVIDER: *Do you have someone you feel comfortable talking with, such as your clinician, doctor, midwife, or a therapist you already see?*
            - Yes: PROVIDER: *Can we help you make an appointment?*
            - No: PROVIDER: *Let's talk about who you would like to talk with.*
                O PROVIDER: *Can we help you identify a provider or connect you to a therapist?*

Follow Up Plan:

If the screen was high:

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

Follow-up Call:

- PROVIDER: *I wanted to follow up with you about the discussion we had when you were in last week. Have you been able to connect with your provider or therapist?*
    - Yes: PROVIDER: *How did everything go?*
        - Things went well: PROVIDER: *I am glad to hear that, please let us know if you need any additional information or referrals.*
        - Things did not go well: PROVIDER: *Can I help connect you to a different provider?*
    - No: PROVIDER: *What has prevented you from connecting with the referral?*
        - Try to problem solve with the parent—if wait time is long provide second referral, if require childcare/transportation provide additional information.

How to Respond to High Positive Screen:

- PROVIDER: *This is a screen for depression and anxiety. Based upon your response(s) and/or our discussion, I'm worried about your wellbeing. I believe you need to see someone today. I can help you set something up right now.*
    - PROVIDER: *Let's talk about how this process will go.*
        - Discuss how clinic handles crisis- walk parent through the process, and physically have a staff member get them to emergency room, OR bring in behavioral health OR find transportation for them to emergency room.

- It's very important that the clinic has a plan for the child while the parent receives care: Ask parent if they have someone they can call to come and be with them, who can also watch child (mother, sister, partner).

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

- PROVDIER: *Is there a reason why you are hesitating?*
  - Listen to parent, try to help parent deal with issues around why they don't want to see someone. Try NOT to be confrontational, rather gently work with parent to help them feel safe visiting additional resources.
  - PROVIDER: *Can I call someone to be with you? (Such as your mom, partner, sister, friend etc.)*
  - If a parent absolutely refuses to seek further care today, work as hard as you can to have someone come meet them.

Follow up for High Positive Screen:

Make a follow up call to high positive screens within days or hours. Child's clinic will make call to see if the mother has connected to care. It would be best to have mother make an appointment for herself within 1 week.

If a patient refused further care, call them within 24 hours and continue trying to follow up call until reached. If having trouble reaching them use emergency contact to try and reach them (without breaking HIPAA-just ask if the emergency contact can help you reach the parent for follow up)

- *I wanted to follow up with you about the referral you received when you were in last week. Have you been able to connect with the referral?*
  - Yes: *Did everything go alright?*
    - Yes: *I am glad to hear that, please let us know if you need any additional information or referrals*
    - No: *Would you like a referral to a different provider?*
  - No: *What has prevented you from connecting with the referral?*
    - Try to problem solve with the parent—if wait time is long provide second referral, if require childcare/transportation provide additional information.

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

Source: Adapted for use by the Nebraska Perinatal Quality Improvement Collaborative. This document was created by the Minnesota Department of Health as part of a larger Adult Medicaid Quality Grant from the Centers for Medicare and Medicaid Services (CMS), awarded to the Minnesota Department of Human Services.

# Appendix F

## LOCAL RESOURCES TEMPLATE: CREATE YOUR OWN DIRECTORY

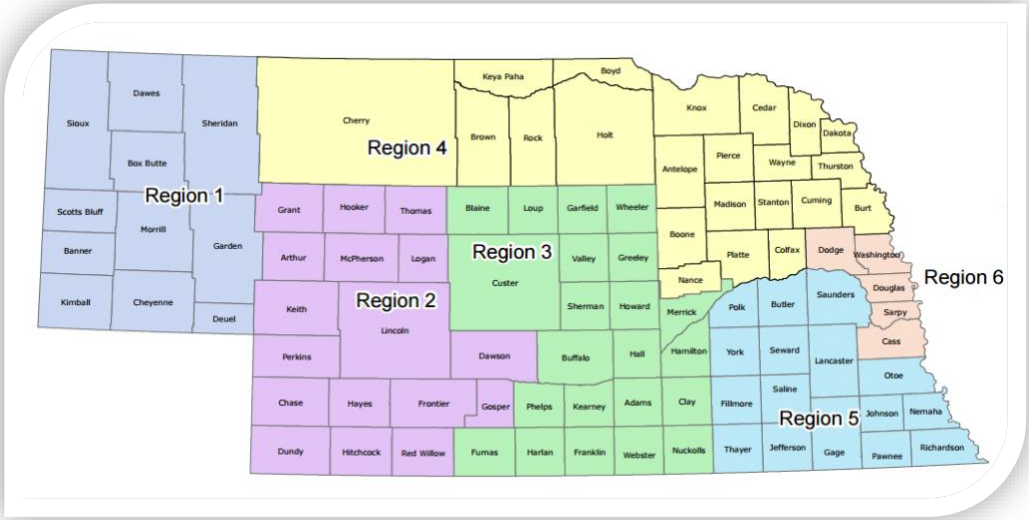
*Providers are encouraged to locate and build relationships with local community resources.*

| |
|---|
| **Organization Name:** |
| **Contact Information:** |
| **Website:** |
| **Services Offered:** |
| **Eligibility Restrictions:** |

Source: Nebraska Partnership for Mental Healthcare Access in Pediatrics, *Screening and Referral Guide* (2021). Available at https://dhhs.ne.gov/Pages/Nebraska-Pediatric-Mental-Healthcare-Access-Partnership.aspx

# Appendix G

Behavioral Health System of Care Regions
https://portal.networkofcare.org/NebraskaBehavioralHealth




**Region 1 Behavioral Health Authority:**
**(308) 635-3173 / https://region1bhs.net/**
**Panhandle Partnership: (308) 633-3818 / https://panhandlepartnership.com/**

**Region 2 Human Services: (308) 534-0440 / https://www.r2hs.com/**
**Families 1st Partnership: (308) 520-3743**
**Families CARE: (308) 237-1102 / https://familiescare.org/**

**Region 3 Behavioral Health Services: 1-800-321-4981 / http://www.region3.net/**
**Hall County Community Collaborative: (308) 385-5125 / http://www.h3cne.org/**
**Families CARE: (308) 237-1102 / https://familiescare.org/**

**Region 4 Behavioral Health System: (402) 370-3100 / https://www.region4bhs.org/**
**Dakota County Connections: (402) 494-3337 ext: 22 / http://dakotacountyconnections.com/**
**Zero 2 Eight Collaborative: (402) 562-5661**
**Norfolk Family Coalition: (402) 640-2409 / http://norfolkfamilycoalition.org/**
**Parent to Parent Network: 1-877-379-9926 / http://parent-parent.org/**

**Region 5 Systems: (402) 441-4343 / http://region5systems.net/**
**United Way of Lincoln and Lancaster County: (402) 441-7774 / http://www.unitedwaylincoln.org/**
**Families Inspiring Families: 1-888-441-4369 / http://familiesinspiringfamilies.org/**

**Region 6 Behavioral Healthcare: (402) 444-6573 / http://www.regionsix.com/**
**Fremont Family Coalition: (402) 402-721-4158 / http://www.fremontunitedway.org/fremont_family_coalition.html**
**Douglas County Collaborative:**
**Lift Up Sarpy: (402) 292-2961 / http://liftupsarpycounty.org/**
**Nebraska Family Support Network:**
**1-800-245-6081 / https://nefamilysupportnetwork.org/**

Behavioral Health Education Center of Nebraska, Systems of Care Regions. https://www.unmc.edu/bhecn/education/nebraska-system-of-care/soc-map.html. Retrieved December 29, 2020.