MCPAP for Moms: A Primer for Pediatric Providers

MCPAP for Moms aims to improve outcomes for babies, children, and families by helping pregnant and postpartum women access and engage in depression treatment.

Pediatric providers in Massachusetts are well acquainted with the Massachusetts Child Psychiatry Access Project (MCPAP), created as a statewide response to the widespread lack of access to child psychiatry in 2004. MCPAP is broadly recognized as enhancing the capacity of pediatric primary care providers to treat children and adolescents with behavioral health issues.

In 2014, MCPAP launched a new program, MCPAP for Moms, to promote maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage depression. MCPAP for Moms aims to help pediatric providers screen mothers and fathers for postpartum depression within the context of well-child care.

MCPAP for Moms aims to:
- Implement universal screening for depression during pregnancy and postpartum for the approximately 72,000 women who deliver babies in Massachusetts each year;
- Increase access to mental health care among pregnant and postpartum women; and
- Improve mental health outcomes for mothers and fathers, and thereby improve outcomes for babies and families.

Why is postpartum depression important to pediatric providers?

Postpartum depression (PPD) is a widespread problem that can complicate birth, infant, and child outcomes.\(^3\)-\(^5\)

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

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

Most perinatal or obstetrical settings only see postpartum women and screen for PPD at the 4-6 week postpartum visit. Pediatric providers caring for children under the age of five may be the only medical provider many mothers see during the child’s first year of life. Since PPD can be identified in pediatric settings, training pediatric providers to detect and address PPD during the first postpartum year can enhance providers’ impact on maternal mental health, carrying the potential to have a trans-generational impact.

How does MCPAP for Moms help pediatric providers and practices?

MCPAP for Moms can help pediatric providers in two distinct ways. MCPAP for Moms provides real-time psychiatric consultation and care coordination for pediatric providers as they provide well-care to infants and their families and when they need support around perinatal mental health concerns as they care for pregnant and postpartum teenagers.

MCPAP for Moms encourages all pediatric providers to screen for postpartum depression in:
- mothers and fathers of infant patients during well-child visits; and
- pregnant or postpartum women receiving primary care from a pediatric provider.

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

The preferred screening instrument is the SWYC/MA (Survey of Wellbeing of Young Children for Massachusetts), available on the MCPAP website at www.mcpap.org (click on “Access Tool Here” under the SWYC logo). Massachusetts has created an augmented version of the SWYC screening tool because maternal mental health is critical to the development and well-being of infants and young children. Choose the 2-, 4-, or 6-month version depending on the age of the infant. Embedded in the SWYC/MA is the Edinburgh Postnatal Depression Scale (EPDS), a widely used and validated 10-item questionnaire to identify women experiencing depression during pregnancy and the postpartum period. The rest of the SWYC/MA at these three ages is identical to the generic SWYC. The SWYC is a comprehensive screening instrument used to assess children’s cognitive, language, motor, and social-emotional development as well as family risk factors (parental depression, conflict, or substance abuse, and hunger). It is short and easy to score. Instructions for scoring the SWYC/MA are also available on the MCPAP website.

Other instruments that can be used to screen for PPD include the Patient Health Questionnaire (PHQ-9. The PHQ-9 is a validated questionnaire to identify depression during pregnancy and the postpartum period. The EPDS can also be used as a standalone instrument. The generic SWYC tool includes the first two items of the PHQ-9, known as the PHQ-2. The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The purpose of the PHQ-2 is to screen for depression in a "first-step" approach to determine if further screening is necessary. Patients who screen positive on the PHQ-2 should then be evaluated with the PHQ-9 or the Edinburgh Postnatal Depression Scale to help determine whether they have symptoms suggestive of depression. The PHQ-9 and EPDS can be found in the Appendix or at www.mcpapformoms.org/Toolkits/PediatricProvider.aspx.
Can I bill for PPD screening?

If you use the SWYC that includes a PPD screen, you can bill for the developmental-behavioral screen for the child using the procedure code 96110. The SWYC/MA and the generic SWYC are approved by MassHealth for compliance with MassHealth’s behavioral health screening requirement under the Children’s Behavioral Health Initiative. For other screening tools at this time, please consult the infant’s insurer.

What about the Department of Public Health PPD screening reporting requirements?

Currently, providers (e.g., pediatricians, family medicine physicians, nurse practitioners, and physician assistants supervised by a physician) are not required to report PPD screening to the Department of Public Health when an infant is the patient. However, pediatric providers can voluntarily report PPD screening (such as the PHQ-9 or EPDS as part of the SWYC/MA or standalone) on the infant claim using the code S3005 with the modifier U3 for a positive screen and U4 for a negative screen. These codes will be used by MassHealth for reporting purposes only.

When an Infant is the Patient

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

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

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

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

For all parents with a positive screen, first determine risk: (Practices with a co-located behavioral health clinician may want to use their clinician for this task.)

1. If there is a crisis or safety concern or the parent gave a positive response on the EPDS or PHQ-9 suicide question, refer to the parent’s local emergency service. For MassHealth members, contact the local Emergency Services Program at 1-877-382-1609.
2. If the parent is already in mental health treatment or has access to a mental health provider (e.g., someone they have used in the past), refer to and with parent’s consent notify that mental health provider.

3. If the EPDS score <13 or if the parent appears to have good self-care and seems able to follow through with resources and referrals:
   - Give parent information about community resources such as support groups. Refer to MCPAP for Moms website (www.mcpapformoms.org) to find resources. You can order MCPAP for Moms resource cards from your local MCPAP hub.
   - You may call MCPAP for Moms (1-866-666-6272) to get the names of local community mental health providers who serve patients with PPD. When you call, we suggest that you have the parent’s insurance so that the MCPAP for Moms care coordinator can match resources to the appropriate insurance plan.
   - Refer and with consent notify parent’s PCP and/or OB/GYN for monitoring and follow-up. You may recommend that the PCP or OB/GYN call MCPAP for Moms if they have clinical questions.

4. If the parent does not meet any of the above criteria or if you are concerned about safety, call MCPAP for Moms (1-855-MOM-MCPAP/1-855-666-6272) for a consultation.

5. Engage natural supports and encourage parent to utilize them. Most likely you will have only one parent in the office when a PPD screen is positive. A depressed parent who is alone or feeling alone is at higher risk for suicide. It is important for someone else in the parent’s life to be aware of the presence of depression and be able to step in to help. With parent’s consent, notify natural support. This is an excellent time to screen for domestic violence to ensure that the natural support is appropriate.

Just as many pediatric providers have become comfortable with managing uncomplicated ADHD, depression, and anxiety, with the help of MCPAP for Moms, we hope that obstetric and adult PCP providers will become comfortable managing PPD. Therefore, we recommend that pediatric providers and their office staff refer parents to an adult provider such as their PCP or OB/GYN. If there are difficulties referring women to their PCP or OB/GYN, pediatric providers may call MCPAP for Moms for assistance in identifying mental health providers in the parent’s community.

MCPAP for Moms recommends that pediatric providers document the screening result and your planned action in the medical record as you would with other risk factors that may affect the infant’s health such as substance use disorders or domestic violence. MCPAP for Moms recommends that pediatric practices continue to use their current strategies for appropriately documenting potentially sensitive family information, especially when there are custody concerns.

**When a Pregnant/Postpartum Young Mother is the Patient**

MCPAP for Moms recommends that pediatric providers caring for pregnant teens or postpartum young mothers screen for depression during pregnancy and in the postpartum period. New mothers should also be screened for PPD during well-child visits. Questions that arise specific
to mental health concerns during screening and/or providing care for a pregnant teen or postpartum young mother should be directed as follows:

For **perinatal psychiatry** questions: Pediatric providers can call MCPAP for Moms (1-855-MOM-MCPAP/1-855-666-6272) to speak with a MCPAP for Moms perinatal psychiatrist for consultation regarding mental health care. If it is determined that the patient needs additional mental health services (e.g., a therapist, a support group), a MCPAP for Moms care coordinator can work to identify and/or schedule services. Additional information on PPD during pregnancy is available at [www.mcpapformoms.org](http://www.mcpapformoms.org).

For **general child psychiatry** questions: Pediatric providers can call their MCPAP regional hub to speak to a MCPAP child psychiatrist for a consultation and/or the MCPAP care coordinator to identify and/or schedule mental health services for the mom. MCPAP and MCPAP for Moms psychiatrists and care coordinators will work together to consult on cases and identify appropriate mental health resources.

**Antidepressant Medications and Lactation**

Considerations for lactating women:

- SSRIs (and some other antidepressants) are considered a reasonable treatment option during breastfeeding.
- When antidepressants are indicated, the benefits of breastfeeding while taking antidepressants generally outweigh the risks.
- Most psychiatric medications are passed into breast milk, though in very low amounts.
- The benefits of other psychiatric medications, including benzodiazepines, antiepileptics, stimulants, and antipsychotics, may outweigh the risks of the medication during breastfeeding.
- It is important to consider the risk of untreated illness to the mother-baby dyad, as well as the entire family, and balance this with the risk of medication use during breastfeeding.
- It is crucial that evaluation of the risks and benefits of medication use during breastfeeding is done on a patient-by-patient basis and considers the needs of the family.
- Recommendations are ideally made collaboratively with well-informed patients and family members.
- Monitor for medication side effects in nursing infants.

We also recommend the NIH website [LactMed](https://lactmed.nlm.nih.gov), that contains information on medications to which breastfeeding mothers may exposed. Providers can also download the [LactMed app for mobile devices](https://lactmed.nlm.nih.gov/). We encourage providers to call MCPAP for Moms for any questions regarding the use of antidepressants or other psychiatric medications during breastfeeding. Pediatric providers can also visit the [MCPAP for Moms](http://www.mcpapformoms.org) website for additional information and treatment algorithms.

**MCPAP for Moms Pediatric Toolkit**

The MCPAP for Moms Pediatric Toolkit provides information to support pediatric providers as they detect and screen for mental health concerns. We recommend pediatric providers review
The complete MCPAP for Moms Pediatric Toolkit can be found at www.mcpapformoms.org under “Provider Toolkit/MCPAP for Moms toolkit – Pediatric Provider.”

The MCPAP for Mom Toolkit includes:

1. **This primer**
2. **Assessment Tools**: Highlights the range of depression and mental health concerns that may occur postpartum, possible treatment options, and key issues to consider when assessing mental health status during the postpartum period
   - **Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women**: Provides key information/concepts to consider when assessing the mental health of pregnant and postpartum women
   - **Summary of Emotional Complications During Pregnancy and the Postpartum Period**: An overview of the range of emotional complications that can occur during pregnancy and postpartum including Baby Blues, Perinatal Depression, Perinatal Anxiety, Posttraumatic Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), and Postpartum Psychosis
3. **Screening Tools and Algorithms**: Includes depression screens and a depression screening algorithm designed for pediatric providers
   - **Edinburgh Postnatal Depression Scale (EPDS) as part of SWYC/MA or standalone**
   - **Patient Health Questionnaire – 9 (PHQ-9)**
   - **Postpartum Depression Screening Algorithm for Pediatric Providers during Well-Child Visits**: Provides guidance on administering the EPDS, or PHQ-9 and next steps depending on the score. Side one is a simplified version of the algorithm. Side two provides more detailed information including talking points and suggested language regarding how to discuss the screen and resultant scores with a parent.

**Community Resources - MCPAP for Moms Partners**

Key to the success of MCPAP for Moms are partnerships with two critical community-based organizations, to help facilitate linkages to resources including mental health care, support groups, and other activities to support the wellness and mental health of pregnant and postpartum women. MCPAP for Moms partners with MotherWoman and MSPP Interface Referral Service to identify community resources and link women with perinatal supports across the state.

MotherWoman partners with community providers across the Commonwealth to provide training and development around the Community-based Perinatal Support Model (CPSM), an intervention that addresses the challenge of ensuring that mothers experiencing perinatal depression receive the care and treatment they need. CPSM assists communities in their efforts to effectively prevent, identify, and treat mothers with perinatal depression both within agencies and organizations and across systems of care by addressing barriers at the maternal, provider, and system levels. MotherWoman has developed perinatal community coalitions and support groups for mothers with children under the age of one in six communities in Massachusetts (Springfield, Cape and the Islands, New Bedford, Lynn, Brockton, and Worcester). MotherWoman will continue to expand this model to additional communities.
The William James College Interface Referral Service works with MCPAP for Moms to collect and categorize resources specifically related to perinatal mental health and wellness. These resources are utilized and updated daily and accessed by the MCPAP for Moms care coordinators as they refer and coordinate mental health care for vulnerable parents. Support group resources can be found on the [MCPAP for Moms website](https://www.mcpapformoms.org) under the “For Mothers and Families” tab.

**Home Visiting Programs**

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

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

For home visiting resources please see the For Mothers and Families tab, Resources for Pregnant and Postpartum Women on the [MCPAP for Moms website](https://www.mcpapformoms.org).

**MCPAP for Moms Web-Based Resources for Pediatric Providers**

There are many web-based resources available to support pediatric providers and their patients and families. The MCPAP for Moms website provides detailed information about how MCPAP for Moms works, FAQs, and online resources to assist providers on various issues specific to PPD including evidence-based approaches and medication decision-making.

- MCPAP for Moms website – [www.mcpapformoms.org](http://www.mcpapformoms.org)
o **Provider Toolkit/MCPAP for Moms Toolkit – Pediatric Providers:** Provides all the assessment tools, screening tools, and algorithms that make up the Pediatric Provider Toolkit. All tools are available for download.

o **Provider Toolkit/MCPAP for Moms Toolkit – Adult Providers:** Provides additional information about the delivery of treatment, including information about medication and lactation, and services to parents experiencing PPD and other mental health concerns by adult primary care providers.

o **For Mothers and Families:** General information pertaining to PPD as well as in-person, online, and telephone support options for mothers and fathers
  - **Talking to Your Provider about Perinatal Mental Health Concerns:** Provides guidance for parents talking with providers about their mental health concerns.
  - **How to Find a PCP:** Provides step-by-step instructions to help parents find and choose a PCP.
References

Appendix

- Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women
- Summary of Emotional Complications During Pregnancy and the Postpartum Period
- Edinburgh Postnatal Depression Scale
- Patient Health Questionnaire – 9 (PHQ-9)
- Postpartum Depression Screening Algorithm for Pediatric Providers during Well-Child Visits
## Assessing Thoughts of Harming Baby

<table>
<thead>
<tr>
<th>Thoughts of Harming Baby that Occur Secondary to Obsessions/Anxiety</th>
<th>Thoughts of Harming Baby that Occur Secondary to Postpartum Psychosis/Suspected Postpartum Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Good insight</td>
<td>• Poor insight</td>
</tr>
<tr>
<td>• Thoughts are intrusive and scary</td>
<td>• Psychotic symptoms</td>
</tr>
<tr>
<td>• No psychotic symptoms</td>
<td>• Delusional beliefs with distortion of reality present</td>
</tr>
<tr>
<td>• Thoughts cause anxiety</td>
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</tbody>
</table>

Suggests not at risk of harming baby

Suggests at risk of harming baby

## Assessing Suicidal Ideation

<table>
<thead>
<tr>
<th>Lower Risk</th>
<th>Higher Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No prior attempts</td>
<td>• History of suicide attempt</td>
</tr>
<tr>
<td>• No plan</td>
<td>• High lethality of prior attempts</td>
</tr>
<tr>
<td>• No intent</td>
<td>• Current plan</td>
</tr>
<tr>
<td>• No substance use</td>
<td>• Current intent</td>
</tr>
<tr>
<td>• Protective factors (what prevents you from acting?)</td>
<td>• Substance use</td>
</tr>
<tr>
<td></td>
<td>• Lack of protective factors (including social support)</td>
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</table>

Suggests Medication May Not Be Indicated

Suggests Medication Treatment Should be Considered

<table>
<thead>
<tr>
<th>• Mild depression based on clinical assessment</th>
<th>• Moderate/severe depression based on clinical assessment</th>
</tr>
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<tbody>
<tr>
<td>• No suicidal ideation</td>
<td>• Suicidal ideation</td>
</tr>
<tr>
<td>• Engaged in psycho-therapy or other non-medication treatment</td>
<td>• Difficulty functioning caring for self/baby</td>
</tr>
<tr>
<td>• Depression has improved with psychotherapy in the past</td>
<td>• Psychotic symptoms present</td>
</tr>
<tr>
<td>• Able to care for self/baby</td>
<td>• History of severe depression and/or suicide ideation/attempts</td>
</tr>
<tr>
<td>• Strong preference and access to psychotherapy</td>
<td>• Comorbid anxiety dx/sxs</td>
</tr>
</tbody>
</table>

## Risk Factors for Postpartum Depression

- Personal history of major or postpartum depression
- Family history of postpartum depression
- Gestational diabetes
- Difficulty breastfeeding
- Fetal/newborn loss
- Lack of personal or community resources
- Financial challenges
- 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
- 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?

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This guideline has been adapted from materials made available by HealthTeamWorks and the Colorado Department of Public Health and Environment (CDPHE) [http://www.healthteamworks.org/guidelines/depression.html](http://www.healthteamworks.org/guidelines/depression.html).
## Summary of Emotional Complications During Pregnancy and the Postpartum Period

<table>
<thead>
<tr>
<th></th>
<th>Baby Blues</th>
<th>Perinatal Depression</th>
<th>Perinatal Anxiety</th>
<th>Posttraumatic Disorder (PTSD)</th>
<th>Obsessive-Compulsive Disorder</th>
<th>Postpartum Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.</td>
<td>Depressive episode that occurs during pregnancy or within a year of giving birth.</td>
<td>A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.</td>
<td>Distressing anxiety symptoms experienced after traumatic events(s).</td>
<td>Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. May include rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.</td>
<td>Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.</td>
</tr>
<tr>
<td><strong>When does it start?</strong></td>
<td>First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.</td>
<td>Most often occurs in the first 3 months postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes.</td>
<td>Immediately after delivery to 6 weeks postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes.</td>
<td>May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.</td>
<td>1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.</td>
<td>Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.</td>
</tr>
<tr>
<td><strong>Risk factors</strong></td>
<td>Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.</td>
<td>Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.</td>
<td>Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.</td>
<td>Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.</td>
<td>Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.</td>
<td>Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss. Dysregulated baby – crying, feeding, sleep problems.</td>
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<tr>
<td><strong>How long does it last?</strong></td>
<td>A few hours to a few weeks.</td>
<td>2 weeks to a year or longer. Symptom onset may be gradual.</td>
<td>From weeks to months to longer.</td>
<td>From 1 month to longer.</td>
<td>From weeks to months to longer.</td>
<td>Until treated.</td>
</tr>
<tr>
<td><strong>How often does it occur?</strong></td>
<td>Occurs in up to 85% of women.</td>
<td>Occurs in up to 19% of women.</td>
<td>Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in 5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.</td>
<td>Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.</td>
<td>May occur in up to 4% of women.</td>
<td>Occurs in 1-2 or 3 in 1,000 births.</td>
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<tr>
<td><strong>What happens?</strong></td>
<td>Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of baby blues, but baby blues is a risk factor for postpartum depression.</td>
<td>Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms.</td>
<td>Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts.</td>
<td>Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.</td>
<td>Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessive thoughts about harming baby that scare women).</td>
<td>Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g., tactile and olfactory) hallucinations. May have moments of lucidity. May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.</td>
</tr>
<tr>
<td><strong>Resources and treatment</strong></td>
<td>May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems - in context of perinatal emotional complications.</td>
<td>For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings. Address infant behavioral dysregulation -crying, sleep, feeding problems - in context of perinatal emotional complications.</td>
<td>Additional complementary and alternative therapy options for depression include bright light therapy, omega-3, fatty acids, acupuncture and folate.</td>
<td>Requires immediate psychiatric help. Hospitalization usually necessary. Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g., consistent sleep/wake times, help with feedings at night).</td>
<td></td>
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1. Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL (“Parents” September 1996)  

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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 \textit{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  ______________________________


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Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

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

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

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

**SCORING**

**QUESTIONS 1, 2, & 4 (without an *)**
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

**QUESTIONS 3, 5-10 (marked with an *)**
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

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

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**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.


# 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)*

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

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

TOTAL: [ ] [ ] [ ]

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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?  

<table>
<thead>
<tr>
<th>Difficulty Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not difficult at all</td>
</tr>
<tr>
<td>Somewhat difficult</td>
</tr>
<tr>
<td>Very difficult</td>
</tr>
<tr>
<td>Extremely difficult</td>
</tr>
</tbody>
</table>

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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**

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Depression Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>Minimal depression</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild depression</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate depression</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately severe depression</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe depression</td>
</tr>
</tbody>
</table>

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A2662B 10-04-2005
Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (with suggested talking points)

Parent completes the PHQ-2, PHQ-9 or EPDS screen during the following well child visits and during other visits as indicated:
- Within first month
- 2 month visit
- 4 month visit
- 6 month visit

If first screen for depression

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

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

Score does not suggest depression
Clinical support staff educates parent about the importance of emotional wellness:

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

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

Suggests parent may be at risk of self-harm or suicide
It sounds like you are having a lot of strong feelings. It is common for parents to experience these kinds of feelings. Many effective support options are available. I would like to talk to you about how you have been feeling recently.

Do NOT leave parent/baby in room alone until further assessment or treatment plan is established. Immediately assess further:
1. In the past two weeks, how often have you thought of hurting yourself?
2. Have you ever attempted to hurt yourself in the past?
3. Have you thought about how you could harm yourself?

If concerned about the safety of parent/baby: You and your baby deserve for you to feel well. Let’s talk about ways that we can support you. If there is a clinical question, call MCPAP regional hub. For safety concerns, refer to emergency services. Document in medical record.

If subsequent screen for depression

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

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

If positive score on self-harm question For all positive screens
1. If parent is already in mental health treatment or has previous provider, refer to/notify* parent’s provider.
2. If EPDS <13 or parent seems ok to follow through:
   - You may call MCPAP for Moms care coordinator for community resource (know mom’s insurance).
   - Give parent community resource information (e.g., MCPAP for Moms card, and website).
   - Refer to/notify* parent’s PCP and/or OB/GYN for monitoring and follow-up.
3. If the parent does not meet any of above criteria or if you are concerned about safety, call MCPAP for Moms for consultation.
4. Engage natural supports* and encourage parent to utilize them.

*Obtain parent’s consent

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.

If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.

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www.mcpapformoms.org
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In addition to billing 96110, we encourage all providers to use the S3005 billing code with modifier U3 for positive and U4 for negative screen that allows the Department of Public Health to track screening.
Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits

**If first screen for depression**

- Clinical support staff explains screen
  - Give SWYC/MA screen (includes EPDS) to parent to complete in the waiting room or in a private exam room.

**EPDS < 10**

- Score does not suggest depression
  - Clinical support staff educates parent about the importance of emotional wellness.
  - Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

**EPDS ≥ 10**

- If positive score on self-harm question
  - Score suggests depression
    - For all positive screens
      1. If parent is already in mental health treatment or has previous provider, refer to/notify parent’s provider.
      2. If EPDS < 13 or parent seems ok to follow through:
        - You may call MCPAP for Moms care coordinator for community resource (know mom’s insurance).
        - Give parent community resource information (e.g., MCPAP for Moms card, and website).
        - Refer to/notify parent’s PCP and/or OB/GYN for monitoring and follow-up.
      3. If the parent does not meet any of above criteria or if you are concerned about safety, call MCPAP for Moms for consultation.
      4. Engage natural supports* and encourage parent to utilize them.
        *Obtain parent’s consent

- Suggests parent may be at risk of self-harm or suicide
  - Do NOT leave parent/baby in room alone until further assessment or treatment plan has been established. **Immediately assess further.**
  - If there is a clinical question, provider calls MCPAP regional hub. For safety concerns, refer to emergency services. Document the assessment and plan in medical record.

**If subsequent screen for depression**

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

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.

**If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.**