Title: Perinatal Depression and PHQ-9 Screening

OBJECTIVES:

Participants will be able to:

1. Describe the main aspects of screening for maternal depression.
2. Describe how the PHQ-9 can be used to screen for and track maternal depression.
3. Demonstrate how to administer and score the PHQ-9, utilizing appropriate language for effective screening.
4. Demonstrate the ability to link screening results to referrals/resources for perinatal depression in Los Angeles County.

AGENDA:

<table>
<thead>
<tr>
<th>TIME</th>
<th>PRESENTATION</th>
<th>FACILITATORS/ SPEAKERS</th>
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</thead>
<tbody>
<tr>
<td>8:00-8:30 am</td>
<td>BREAKFAST AND REGISTRATION</td>
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<tr>
<td>8:30-9:00 am</td>
<td>Welcome and Introductions</td>
<td>Terrie Anciano, BS</td>
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<td></td>
<td>Icebreaker</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC</td>
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<td></td>
<td>Overview of Training Objectives</td>
<td>Lili McGuinness, LCSW</td>
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<td>Pre Evaluation</td>
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<tr>
<td>9:00-10:45 am</td>
<td>Perinatal Mental Health-Overview</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC</td>
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<td>Lili McGuinness, LCSW</td>
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<tr>
<td>10:45-11:00 am</td>
<td>BREAK</td>
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<tr>
<td>11:00 -12:00 pm</td>
<td>What does Perinatal Depression Look Like?</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC</td>
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<td>Lili McGuinness, LCSW</td>
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<td>12:00-12:45 pm</td>
<td>LUNCH/VIDEO</td>
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<tr>
<td>12:45-1:45 pm</td>
<td>Screening for Maternal Depression</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC</td>
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<td>· Review WB Depression Protocol</td>
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<tr>
<td>1:45-2:15 pm</td>
<td>Review WB Risk for Suicide Protocol</td>
<td>Lili McGuinness, LCSW</td>
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</tbody>
</table>
| 2:15-2:30 pm | BREAK                                                             | Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC  
|           |                                                                  | Lili McGuinness, LCSW               |
| 2:30-3:30 pm | Putting It All Together: Applying Your Knowledge and Experience | Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC  
|           |                                                                  | Lili McGuinness, LCSW               |
| 3:30-4:00 pm | Key Learnings on Perinatal Depression and Self Care Post Evaluation | Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC  
|           |                                                                  | Lili McGuinness, LCSW               |
| 4:00-4:15 pm | WRAP UP AND EVALUATION                                           | Terrie Anciano, BS                  |
Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC is a dance/movement therapist and licensed professional clinical counselor with over 20 years’ experience in the helping profession. Currently, she is Director of Training and Technical Assistance for the Los Angeles County Perinatal Mental Health Task Force. Prior to this, she served as director of the New Moms Connect Program of Jewish Family Service of Los Angeles providing services to new parents, particularly those suffering from symptoms of postpartum depression. Ms. Kaufman has worked extensively with new families and aided in providing solutions to many parenting concerns. She has run several programs for high-risk children and teens, taught classes to parents of newborns and toddlers, and runs support groups for single parents and women with postpartum depression. Ms. Kaufman has spoken widely, published articles on parenting, and served as editor for Bringing Light To Motherhood. She serves as Los Angeles coordinator for Postpartum Support International also has a private practice in Los Angeles providing services in both English and Spanish languages.

Lili McGuinness, LCSW, CLE is a psychotherapist, trainer and manager, who has been working with low-income and high-risk families for over 15 years. Lili is a licensed clinical social worker who earned her Masters of Social Work from The University of Southern California and a Certificate of Lactation Education from The University of California, Los Angeles. Lili specializes in maternal and infant mental health, particularly in the area of home visitation. Lili is the Director of the Welcome Baby Program at Maternal and Child Health Access. As one of the leaders of the Welcome Baby Pilot, she helped establish the framework and structure of the program. Lili and her daughter, Emma Sophia are highlighted in This Emotional Life, Early Moments Matter video that is focused on healthy secure attachment. Lili is a member of the Los Angeles County Perinatal Mental Health Task Force, Los Angeles County Perinatal Mental Health Task Force Training Committee and the Maternal Mental Health Improvement Project at USC-Eisner. Lili is trained as an integrated body psychotherapist and provides psychodynamic therapy and life coaching to individuals, couples and families in her private practice.
Depression Protocol

**Purpose**
The depression protocol is intended to provide clear and consistent guidelines that allow Welcome Baby staff to effectively support clients who are experiencing depression.

I. In accordance with the Welcome Baby strength-based and relationship-based philosophies, depression and mental health issues will be addressed with empathy and in a nonjudgmental manner.

II. At each point of engagement, the Parent Coach (PC) or Registered Nurse (RN) will ask the following questions as part of the PHQ-2 depression screening. (The questions will be asked in a casual and conversational way without using a formal questionnaire.)
   a. Over the last two weeks have you felt down, depressed, or hopeless? ¿En las últimas dos semanas, se ha sentido decaída, deprimida, o sin esperanza?
   b. Over the last two weeks have you felt little interest or pleasure in doing things? ¿En las últimas dos semanas, ha sentido poco interés o placer en hacer las cosas?

III. If the client responds “yes” to at least one question from the PHQ-2, the PC or RN will complete the PHQ-9 depression screening.

IV. The steps below will be followed for clients exhibiting any symptoms of depression:
   a. Provide empathetic support and feedback.
   b. Normalize and validate client’s feelings and experience.
   c. Provide information about maternal depression.
   d. Explore support system with client and family.
   e. Explore ways to cope, manage, or overcome depression with client and possibly her family.
   f. Document key points, referrals and follow up in progress notes.
   g. Put original copy of PHQ-9 in client file.

V. The additional steps below will be followed based on the client’s PHQ-9 score:

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Additional Procedures to Support Client</th>
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</table>
| 5-9         | Minimal symptoms      | 1. Utilize tools such as a goal sheet and educational materials to explore ways she can take care of herself such as:  
|             |                       | a. Exercise                           |
|             |                       | b. Sleep                               |
|             |                       | c. Nutrition                           |
|             |                       | d. Talking to someone that she trusts  |
|             |                       | e. Spending time with friends and family|
|             |                       | 2. Offer referrals for home visiting programs, support groups, and/or mental health hotline, if the client is interested. |
**PHQ-9 Score** | **Provisional Diagnosis** | **Additional Procedures to Support Client**
--- | --- | ---
10-14 | Minor depression, Major depression, mild*  
*Note: If symptoms are present for ≥ two years, then it is a probable chronic depression which warrants antidepressant or psychotherapy (ask “In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?”). | 1. If appropriate (client has minor depression), utilize tools such as a goal sheet and educational materials to explore ways to support mom’s mental health such as:  
   a. Exercise  
   b. Sleep  
   c. Nutrition  
   d. Talking to someone that she trusts  
   e. Spending time with friends and family  
2. Provide referrals for mental health counseling, home visiting programs, support groups, and/or mental health hotline.  
3. Check in with direct Supervisor about client’s mental health status.  
4. Follow up with client to ensure that she is receiving the needed support and services.  
5. Continue to conduct PHQ-9 at every home visit thereafter.

15-19 | Major depression, moderately severe | 1. Connect mom with mental health services and support services immediately. Call during home visit to schedule appointment. Ensure that client has a way to get to the appointment (bus tokens/taxi voucher, if needed).  
2. Explore with client and family the need for a support system to help take care of mom and baby.  
3. Check in with direct Supervisor regarding client’s mental health status.  
4. Follow up with client and referral source to ensure that client has been served.  
5. Continue to conduct PHQ-9 at every home visit thereafter.

≥20 | Major depression, severe | Same as above

*Note: If client is a danger to self or others, please take immediate action and refer to the Suicide Risk Protocol.*
Risk for Suicide/Homicide Protocol

Purpose
The Risk for Suicide Protocol provides guidelines for Family Strengthening staff members (“Staff”) to follow to ensure the safety of clients, the community, and themselves.

I. In accordance with the Family Strengthening Network’s strength-based and client-centered philosophy, potential risk of suicide will be addressed with empathy in the context of the relationship between parent/caregiver and Staff, and also between parent/caregiver and child.

II. During the initial engagement point, Staff will provide detailed information regarding the program’s confidentiality policies, which states that if a client is identified to be “at risk” to harm self or others, Staff must break confidentiality to ensure the safety of the client, family, community members, and Staff.

III. It should never be taken lightly when a client tells you she wants to kill herself. Upon the first contact with the client, Staff will make every effort to determine the urgency of intervention based upon client’s:
   a. Signs and symptoms
      • Hopelessness/withdrawal/isolation
      • Increased rage/anger
      • Increased use of alcohol/drugs
      • History of suicide attempt or harm to others
      • Stated thoughts or ideation about suicide, death/dying, or harming another person
      • Has the client had a recent loss (job, relationship, ability) or death?
      • Has the client begun or abruptly stopped taking a psychotropic medication?
   b. Danger to self and others
      • What is the client’s intention to harm self or others?
      • Does the client have a plan or details of how they might complete suicide/homicide? For homicidal ideation, is there an identified victim?
      • Does the client have means to complete suicide or homicide?
        • For example- The client reports she wants to take lots of pills and not wake up anymore. Does the client have access to medication? If so, what medication does she have readily available?
      • What is the client’s intention to harm self or others?
   c. Make Observations on: (A mental health professional would give a Mental status exam (MSE))
      • Appearance (gait, posture, clothes, grooming)
      • Attitude (cooperative, hostile, open, secretive, defensive)
      • Observed behavior (mannerisms, gestures, expression, eye contact, compulsions)
IV. If Staff has identified that a client is having suicidal or homicidal thoughts, it is important to act immediately:
   a. Take steps to attend to the immediate safety of Staff, client, and others.
   b. Assess client’s motivation for seeking help. Is she willing to voluntarily seek out emergency treatment or triage?
   c. Do not leave client alone.
      - If appropriate, Staff can refer client and family support to walk in to emergency room/local hospital for support and SI/SA screening and/or intervention.
      - Always consult supervisor/manager prior to taking next step.
   d. Arrange appropriate psychological, medical, psychiatric, and/or social care, and community response. This might include:
      • Local police
      • Client’s doctor, therapist and psychiatrist
      • 911 Psychiatric Evaluation Team (PET) - client might be taken into 5150 or 55585.55 custody, if they are assessed to be harmful to self and/or others. For the DMH ACCESS Center 24/7 Helpline, call 1-800-854-7771.
      • Mental health services (counseling)
      • Suicide hotline: 1-800-273-8255
      • DMH ACCESS/HOTLINE: 1-800-854-7771
         • ACCESS operates 24 hours/day, 7 days/week as the entry point for mental health services in Los Angeles County. Services include deployment of crisis evaluation teams, information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services and patient transport.
      • DCFS, if a child is at risk for abuse or neglect
e. Contact appropriate direct Supervisor for consultation and direction as per agency protocol.
   f. Direct supervisor will contact Clinical Supervisor.
   g. Clinical Supervisor will contact Program Director.
h. Document details of incident in progress notes within 24 hours of incident. Clinical supervisor should review these notes.
i. Document all follow up and consultation in progress notes and have a supervisor review them.
j. Send message to Clinical Supervisor within the Stronger Families Database to effectively track high-risk cases.
k. Work with client or client’s family to provide additional referrals and support.
l. Complete all police forms and necessary legal documents if applicable.
m. Alert Staff of the suicide/homicide incident, and take extra safety precautions in the office, as necessary.
V. If Staff has good reason to believe that the client does not have a plan to hurt herself or others and does not seem to be in immediate risk, Staff will follow the next steps:
   a. Create a safety plan with client. A safety plan, created in collaboration with the client, provides steps the client can take to stay safe.
      • Keep blank safety plan templates in your visit materials.
      • Write up the “Safety Plan” on the spot and empower client to be a part of the process using her own words.
      • Have the client sign the Safety Plan and give her the original.
      • Take a copy for the client file and upload the document within Stronger Families Database.
   b. Make an immediate appointment with the client’s doctor and psychiatrist, if she has one. If she does not, support client in identifying and connecting a clinician.
   c. Make an immediate appointment for counseling with mental health professional with client in the home.
   d. Sign Release of Information authorizing Welcome Baby or Home Visiting program to contact the mental health providers that client was connected to in the visit. Keep one copy on file, and leave one with the client.
   e. Encourage client to call suicide hotline as soon as possible.
   f. Explore ways for client to get additional support.
   g. Encourage client to reach out and ask for help from friends and family (if appropriate).
   h. Identify person in client’s support system that can be with her or be on call.
   i. Strongly recommend to client and client’s family to remove lethal weapons or means from the home such as guns, knives, medications etc.
   j. Encourage client to reach out to Staff if she needs additional support but emphasize that Family Strengthening Network programs are not 24-hour crisis response teams. Instead direct client to the appropriate mental health resources (e.g., suicide hotline, PET, therapist/psychiatrist).
   k. Immediately follow up with direct Supervisor regarding incident and next steps.
   l. Direct Supervisor will immediately follow up with Clinical Supervisor for next steps.
   m. Send message to Clinical Supervisor within Stronger Families Database to effectively track high risk cases.
   n. Follow up with client within 24 hours to determine if she needs additional services.
   o. Follow up with mental health referrals to ensure that client is getting the needed services.
      - A follow-up could constitute a phone call and/or additional visit with client.
      - Document if client is not following through with services, and let supervisor know about this immediately.
   p. Document incident, all follow-up and consultations in progress notes.
What am I feeling right now? (Anxious, nervous, depressed?)

______________________________________________________________________

When I feel suicidal or hopeless, I will reach out to people who make me feel safe:

Name        Phone
__________________________________ __________________________________
Name        Phone
__________________________________ __________________________________
Name        Phone
__________________________________ __________________________________

If I feel like I want to kill myself, I will call:
1. 9-1-1
2. Suicide Prevention Lifeline: 800-273-8255 (available 24/7)
3. Psychiatric Mobile Response Team: 800-854-7771 (available 24/7)

Additional Contacts

Therapist:  
Name __________________________________ Phone ________________________

Psychiatrist:  
Name __________________________________ Phone ________________________

Medical Doctor:  
Name __________________________________ Phone ________________________

Home Visitor / Parent Coach:  
Name __________________________________ Phone ________________________

Home Visiting RN (if any):  
Name __________________________________ Phone ________________________

Nearest Emergency Room:  _____________________________________________

Authorization to Release - Exchange of Information has been signed.

Client Signature: __________________________________ Date: ________________

Staff Signature: __________________________________ Date: ________________
# Suicide Prevention and Risk Assessment: Quick Reference Tool

## 1. Identify Risk Factors
Note which ones can be modified to reduce risk.

- **Stressors**: events leading to shame or despair, loss of relationship, recent death, social isolation, illness
- **Suicidal behavior**: history of suicide attempts, aborted suicide attempts, self-injurious behavior
- **Observe**: current emotional distress, mood, affect. Current use of medication, alcohol, self-medicating
- **Psychiatric disorder (current, past, or undiagnosed)**: depression, anxiety, alcohol/substance use, trauma, previous PPD

## 2. Identify Protective Factors
Note which ones can be enhanced.

- **Internal**: ability to cope with stress, religious beliefs, frustration tolerance, outlook on parenting children
- **External**: responsibility to children or pets, positive therapeutic relationships, family/friends, stability, restricted access to lethal means (e.g., guns, pills, knives, razors), medical provider, social service programs, church, support group

## 3. Conduct Suicide Inquiry
Ask questions about suicidal thoughts, plans, behaviors, and intent.

- **Ideation**: frequency, intensity, duration (in last 48 hours, past month, worst ever)
- **Plans**: timing, location, lethality, availability, preparatory acts
- **Behaviors**: past attempts, rehearsals (loading gun, tying noose, etc.) vs. non-suicidal self-injurious acts
- **Intent**: client expects to carry out plan, believes the plan to be lethal, explores reasons to die vs. live

## 4. Determine Risk Level, Intervention
Determine risk and choose appropriate intervention. If unsure, consult.

- **Assessment of risk**: based on parent coach assessment and supervisory staff assessment
- **Reassessment**: if client situation/affect or environment changes
- **Connect to resources**: voluntary or involuntary psychiatric triage and hospitalization, contacting client’s therapist, psychiatrist or medical doctor, resource coordinator for mental health resources, emergency response

## 5. Consult
Check with your direct supervisor regarding plan of action. If supervisor is not available, follow chain of command.

- Check in with direct supervisor during or immediately after visit
- If direct supervisor is not available, contact clinical supervisor or program director
- Contact LA Best Babies Network or MCH Access, if necessary, to find resources for client
- Consult with client’s primary medical doctor or clinic, if appropriate

## 6. Document
Record assessment of risk, intervention, and follow-up.

- Complete all documentation within 24 hours
- Message clinical supervisor within the database to track high-risk cases
- Document all follow-up contacts/consultations in a timely manner (e.g., per WB Fidelity Framework)
Suicidal Ideation

- Have you been thinking about suicide or wanting to die?
- What was going on at the time you had these thoughts?
- Have you been eating and sleeping regularly? Tell me what that looks like.
- What sort of thoughts have you been having? Can you describe them?
- How often are you thinking about suicide? (Daily, weekly, monthly?) How long do those thoughts last?
- Are there any other things that you have noticed that trigger thoughts of suicide?

Method

- Do you have a plan?
- Have you thought about how you could end your life?
- What specifically are some of the ideas you’ve had?

Degree of Planning

- Have you worked out where you would do it and what you would use?
- Do you have what you need to carry out your plan?
- Do you have access to a gun, knives/ blades, pills?
- Have you done anything to prepare for or act out your plan?

Previous attempts

- Have you ever tried to kill yourself or die by suicide in the past?
- Can you tell me what happened and how long ago this was?
- Did you need to go to the hospital or get any other help? If hospitalized, for how long?
- Were you prescribed any medications? Are you taking any medications?

*When in doubt, CONSULT with a supervisor.*

*Developed for the Family Strengthening Network by Maternal and Child Health Access*
Maternal Depression Screening & Follow-up with the Patient Health Questionnaire-9
Los Angeles County Perinatal Mental Health Task Force & MCHA Welcome Baby

Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC
Lili McGuinness, LCSW, CLE

Objectives of Training

- Understanding the range of perinatal mental health disorders, prevalence, risk factors
- Describe main aspects of screening for maternal depression
- Describe how the PHQ-9 can be used to screen for, and track, maternal depression
- Learn to administer and score the PHQ-9, utilizing appropriate language for effective screening
- Demonstrate ability to link screening results to referrals/resources for perinatal depression in Los Angeles County
- Understand Welcome Baby approach & protocols pertaining to maternal mental health
Myths of Motherhood

STIGMA

• Good mothers don’t get depressed
• “How can you be depressed if you’re having a baby?” “How can you be depressed when you have such a beautiful baby?”

• Fear of judgment / “crazy”
• Fear of DCFS / children being taken away
• Fear of deportation

What Are Perinatal Mood and Anxiety Disorders?

• Perinatal- anytime from conception through one year after delivery, inter-conception period
• Depression or other mood disorder during the perinatal period
• Anxiety, with or without depression, during the perinatal period
Maternal Depression: A Major Public Health Issue

Every year, 800,000-1 million American women are affected by PMADs

- 10-15% during pregnancy and the postpartum year
- Cut across income, race, ethnicity, gender, age & sexual orientation
- Low income women, disproportionately impacted
- Per LAMB study, low-income or ethnic minority women in Los Angeles had rates of depressive symptoms closer to 30-40%

Perinatal Depression Crosses All Lines

- Perinatal depression can affect any woman
- Crosses cultural, racial, economic lines
- Culture may determine whether it is socially acceptable to acknowledge or discuss PMADs
- Culture may affect how symptoms are expressed
- Culture may influence if treatment is acceptable or not

Pregnancy & Social Concerns

Every year in the United States:

- 468,988 babies are born to teenage mothers
- 820,000 women smoke cigarettes while pregnant
- 221,000 women use illicit drugs during pregnancy
- 757,000 women drink alcohol while pregnant
Pregnancy & Domestic Violence

- 240,000 pregnant women are subject to domestic violence
- 40% of assaults begin during the first pregnancy
- Pregnant women are at twice the risk of battery

Risk Factors

Biological Risk Factors for Perinatal Depression

- "History repeats itself"—personal history of depression
- Family history of mood disorders
- Physically difficult pregnancy or postpartum
- Unplanned pregnancy
- Infertility history
- Birth trauma/difficult birth
- Ill or special needs baby
- PMDD (Premenstrual Mood Dysphoric Disorder)
- Postpartum Thyroiditis
Psychosocial Risk Factors for Perinatal Depression

- Financial hardship
- Emotional stress (intimate partner violence)
- Loss of own mother
- History of trauma or loss
- High expectations and disappointment
- Lack of active help-seeking
- Limited social support & resources

Vulnerable Populations at Significantly Greater Risk

- Teens
- Single moms
- Military women
- Recent immigrants
- NICU moms
- Low income families

Untreated Depression in Pregnancy Increases Risk of Postpartum Depression by 50-80%
What Causes Perinatal Mood Disorders?

- Mechanisms not entirely known
- Multiple/cumulative stressors -- lack of social support, poverty and all of its concomitant stressors
- Hormonal processes
- Inflammatory processes
- Psychological/trauma/loss

Depression/Anxiety During Pregnancy

- 10% during pregnancy
- 50%-75% relapse after med discontinuation
- Low birth weight
- Prematurity/preterm labor
- Constriction in placenta blood supply
- Heightened startle response
- Later behavioral problems
- Increased cortisol levels
- Organ malformation

The Face & Voice Postpartum Depression & Anxiety

“I want to cry all the time.”
“I feel like I’m on an emotional roller coaster.”
“I will never feel like myself again.”
“I don’t think my baby likes me.”
“Everything feels like an effort.”
“I think I made a big mistake. I’m not a good mom.”
“I hate the way I look now, it’s all the baby’s fault”
Difference Between Major Depression & “The Baby Blues”

- 50-80% of postpartum women
- Onset usually between day 3 and day 14 postpartum
- Tearfulness, sadness, anxiety, irritability, mood swings, feeling overwhelmed, feeling very emotional
- Symptoms persist no more than 14 days
- Symptoms usually diminish without intervention
- If it lasts more than 14 days it’s more than the blues

Perinatal Mood and Anxiety Disorders: The Most Common

- Depression
- Anxiety
- Obsessive Compulsive Disorder
- Bipolar I & II Disorders
- Post-traumatic Stress Disorder

Medical and Psychosocial Contributors to Perinatal Mood and Anxiety Disorders

- Stressors and genetic susceptibility
- Hormonal flux
- Sleep & circadian changes
- Neurotransmitter alterations
- Pain
- Inflammatory response
- Social role transitions
- Social rhythm changes
- Physical activity changes
What is Postpartum Depression?

How is it different from “the blues?”

- PPD can be triggered by the dramatic changes in hormonal levels during pregnancy and after delivery
- 13% of women
- Can occur anytime within the first year
- Early assessment & treatment critical
- Can become chronic
- 50% - 75% recurrence rate in subsequent births

Symptoms of Postpartum Depression

- Disruptions in sleep and appetite
- Feels in a fog – disoriented, confused
- Emotionally detached, going through motions
- Feeling inadequate, unable to cope
- Extreme anxiety
- Fear of caring for baby alone
- Hopelessness, guilt, shame
- Irritability
- Someone else would be better mother

Postpartum Depression with Anxiety

- Insomnia
- Weight loss
- Inability to cope
- Hopelessness
- Confusion and disorientation
- Difficulty concentrating
- Feeling detached from infant
- “going through the motions”
- Overwhelming anxiety-fear of being left alone
Postpartum Depression
With Panic
- Shortness of breath
- Chest pain
- Dizziness
- Trembling
- Numbness
- Restlessness
- Agitation
- Feels like a heart attack

Postpartum Obsessive-Compulsive Disorder
- Occurs in 5% of postpartum women
- Intrusive/repetitive thoughts/images
- Presents as thoughts of harming child, often accompanied by anxiety-reducing behaviors
- Very upsetting to mother; she recognizes these thoughts as "foreign"

BOTTOM LINE:
If ANY thoughts of harming baby, call a psychiatric consultation

Postpartum Bipolar Disorder
- Risk factors include family or personal history of BPD or "Manic Depression"
- There are 2 types BPD I & BPD II which can present as:
  - Periods of severely depressed mood and irritability (BPD- I&II)
  - Mood much better than normal (BPD- I&II)
  - Rapid speech (BPD- I&II)
  - Little need for sleep (BPD- I&II)
  - Racing thoughts, trouble concentrating (BPD- I&II)
  - Continuous high energy (BPD- I&II)
  - Overconfidence (BPD- I&II)
  - Delusions (often grandiose, but including paranoid) (BPD-I)
  - Impulsiveness, poor judgment, distractibility (BPD-I)
  - Grandiose thoughts, inflated sense of self-importance (BPD-I)
- In the most severe cases, delusions and hallucinations (BPD-I)

BOTTOM LINE:
If ANY thoughts of harming baby, call a psychiatric consultation
Postpartum Post Traumatic Stress Disorder

- Reliving of past traumatic events
- Flashbacks, nightmares, images
- Sense of doom
- Hyper vigilance/watchfulness
- Increased arousal
- Can be caused by birth trauma (subjective)
- History of trauma

Extreme Cases

Postpartum Psychosis: A True Emergency

- Occurs in 1/1000 births
- Thoughts of harming baby that are NOT recognized as “foreign”
- Hearing voices or seeing visions
- Acting paranoid or notably frightened
- Profound agitation and lack of sleep

A true emergency: protocol necessary
- Infanticide rates up to 4%
Pregnancy Denial

- Affective denial
- Pervasive denial
- Psychotic denial

Pregnancy Denial & Neonaticide

- Physical symptoms of pregnancy absent or denied
- Depersonalization and dissociation
- Labor pains misinterpreted/unassisted deliveries
- Brief psychosis
- Intermittent amnesia
- Childhood trauma (substance abuse, sexual/physical/emotional abuse)
- Poor insight/low intellectual functioning especially abstract thinking
- Dysfunctional family dynamics characterized by chaos, isolation, or rigidity and emotional neglect
- Hostile/estranged parental relationships (frequent threats of abandonment)

Paternal Perinatal Depression

Symptoms can include:
- Lowered stress threshold
- Increased aggression, anger
- Feeling burnt out & empty
- Restlessness, withdrawal
- Denial of problems
- Over working, increased drinking or substance use
- Refusal to get help
Implications of Maternal Depression and Anxiety

Why Do We Care So Much About Maternal Depression?

- Effects on Mother
- Effects on Fetus
- Effects on Infant and Child
- Effects on Attachment
- Effects on Family and Society at large
- If left untreated can become chronic depression; impact on woman, child, family then much greater
- Can have multigenerational impact

Attachment
Effects on Attachment

Depression can put attachment relationship at risk!
- A secure attachment provides a baby with:
  - An optimal foundation for life
  - Eagerness to learn
  - Healthy self-awareness
  - Trust and consideration for others

An insecure attachment relationship (one that fails to meet an infant’s need for safety and understanding) may lead to:
- Future vulnerability to mood disorders
- Confusion about oneself
- Difficulties in learning and in relating to others

Treatment
Interventions –What Works

• Basic self care (nutrition, exercise, social support, sleep)
• Support Groups (therapist or peer led)
• Psychotherapy - Cognitive Behavioral Therapy (CBT), psychodynamic psychotherapy, Interpersonal Behavioral Therapy (IPT), Dialectic Behavioral Therapy (IPT)
• Stress reduction / relaxation techniques
• Psychiatric Intervention – Medication (as needed)
• Mentors
• Psycho-education

Welcome Baby Interventions

• Client centered approach
  – Normalizing but emphasizing need for help
• Strengths based interventions
• Relationship based – dyadic interventions
• Cultural competency
• Reflective practice

Client Centered Approach

• Meeting client where she is
• Not trying to fix
• Motivational interviewing
• Assessment for client’s own
  – Values
  – Strengths
  – Cultures
  – Needs/goals
Strength-based Interventions

- Explore clients’ strengths, including compensatory strengths of the entire family
- Enhancing mother/baby dyad
- Capitalize on strengths
- Build resilience
- Social Support Groups: learn ways to overcome barriers-general support group

Relationship Based

- Modeling empathy and attunement
  - Parallel process
    - Developing rapport and trust
- Mother / infant dyad
  - Infant massage
  - Breastfeeding
  - Skin to skin
  - Tummy time – floor activities

Breastfeeding

- Can help mother and baby bond
- Many benefits to infant and mother. Can help some women with PMADs
- Breastfeeding releases oxytocin, the “feel good” hormone, which may combat depression.
- Breastfeeding is also an anti-inflammatory and depression link to inflammation.
- For some, struggles around breastfeeding may compound guilt and shame-respect each woman
- Depressed women may need extra support to be able to breast-feed
- Be aware of your own biases
Social Support

- Help parents build constructive friendships and other positive connections to reduce their isolation, and likelihood of depression, child abuse, neglect.
- Explore client’s support system -- never make assumptions about the client’s support system.
- Identify resources and people—which of the resources are actually available.
- Ask client who she can really talk to.
- Ask client who she can call in an emergency.

Cultural Competence

- Make her your teacher – never assume.
- Awareness of your biases.
- Listen with all your senses.
  - Body language
  - Environment
  - Tone of speech.
- Meet her where she is – be patient!
- Not only race or religion but family and parenting culture.

Reflective Practice

- Reflective listening.
  - Parallel process (supervisor with staff).
- Empathy and attunement.
- Coherent narrative.
  - Aiding client make sense of how past experiences impact:
    - current life functioning
    - decision making process
    - parenting.
Depression Self-Care

- Help each woman identify problems / stresses / symptoms
- Assess her understanding of depression and its effects on baby and child
- Address stigma / misinformation
- Help her create her own solutions
- Document care plan
- Welcome baby book

Medications & Perinatal Depression

- “Exposure Always Occurs”
  - Exposure to untreated illness
  - Exposure to medications (pregnancy and breastfeeding)
  - Difficult risk / benefit decision
- Refer to physician trained in perinatal depression
- Thomas Hale, MD

Barriers to Treatment
Barriers

- Feelings of guilt or shame, concerns about being seen as “crazy”
- Immigration Status
- Fear of baby being taken away by DCFS
- Language barrier
- Marital discord
- Family discord
- Exclusive reliance upon religion
- Apprehension about medical field and medication
- Lack of bicultural/bilingual services
- Insurance, Emergency Medical, low fee or free services.

How to Address Barriers

- Reframe depression: “mother and child wellness”
- Understand what motherhood means to each woman
- Build relationships of TRUST
- Portray open, non-judgmental attitude
- Build collaboration with all aspects of community, including faith communities
- Stay in connection-mom may not be ready
- Universal message
  - You are not alone
  - You are not to blame
  - With help, you will get better

Screening

Who to screen?
- No one is immune from depression
- Special attention to high risk groups

When to screen?
- Initial prenatal intake
- 1x in second and third trimester
- Postpartum period 2 weeks, 6-8 weeks, 6 months

How to screen?
- Normalizing, reducing stigma, providing education, reminding “THIS IS TREATABLE”
- PHQ2, PHQ9
- Using brochure and poster to introduce topic
Welcome Baby Depression Protocol

The depression protocol is intended to provide clear and consistent guidelines that allow Welcome Baby staff to effectively support clients who are experiencing depression.

I. In accordance with the Welcome Baby strength-based and relationship-based philosophies, depression and mental health issues will be addressed with empathy and in a nonjudgmental manner.

II. At each point of engagement, the Parent Coach (PC) or Registered Nurse (RN) will ask the following questions as part of the PHQ-2 depression screening. (The questions will be asked in a casual and conversational way without using a formal questionnaire.)

   a. Over the last two weeks have you felt down, depressed, or hopeless? ¿En las últimas dos semanas, se ha sentido decaído, deprimido, o sin esperanza?

   b. Over the last two weeks have you felt little interest or pleasure in doing things? ¿En las últimas dos semanas, ha sentido poco interés o placer en hacer las cosas?

How to Give PHQ-9

- As a verbal test:
  - Ask the questions in a user-friendly, accurate way
  - Clearly explain the answer choices

- As paper-and-pencil test:
  - Let the woman know the test’s purpose
  - Allow privacy
  - Explain confidentiality

Introduction to PHQ-9

- Based on DSM Criteria
- Derived from Primary Care Evaluation of Mental Disorders (PRIME-MD) validated in 1990s
- Used to screen for anxiety, depression, alcohol, eating disorders and somatoform
- 27 item scale, took 11-12 minutes if there was dx.
- Time a barrier in clinic
- Resulted in a self administered version
- PRIME-MD now rarely used
Sensitivity in Screening

- Fear of judgment – listen to her
- Doesn’t understand reasons for screening - explain
- Stigma - Normalize
- Issues around privacy – explain limits to privacy
- Organizational mistrust – consistency

Patient Health Questionnaire-9

PHQ-9 Question #9
- Always look at response to #9
- Any answer other than ‘Not at all’ means some risk and worth a follow up clinical screen
- Two types of suicide risk:
  - Passive….”I’d be better off if I died”
  - Active…..”I’m going to swallow a whole bottle of pills when I leave”
Evaluating Suicide Risk Further

- Never assume 'she'll be okay'
- Ask if she has a current plan
- What is the plan
  - FYI - Asking about suicide does not encourage suicide!
- Must ask about prior history of suicide
- Prior attempts means future risk of attempts
- Family history of suicide
- Ask about patient’s access to means and lethality
  - Do you own a gun? Does anyone in your house?

Welcome Baby Suicide Protocol

- Take steps to attend to the immediate safety of WB staff, client and others.
- Arrange appropriate psychological, medical, psychiatric and/or social care, and community response. This might include:
  - Local police
  - Client’s doctor and psychiatrist
  - M.D. Psychiatric Evaluation Team (PET) – client might be taken into S150 or S185.55 custody if they are assessed to be harmful to self and others
  - Mental health services (counseling)
  - Suicide hotline
  - DCS, if a child is at risk for abuse or neglect
- Contact direct supervisor and clinical supervisor for consultation and direction.
- Document details of incident in progress notes within 24 hours of incident.
- Document all follow-up and consultation in progress notes.
- Follow-up with client or client’s family to provide additional referrals and support
- Complete all police forms and necessary legal documents.
- Alert management staff of the suicide/homicide incident, to take extra safety precautions in the office.

Welcome Baby Protocol Breakdown

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tr>
<td>1. Identify Risk Factors</td>
<td>Evaluate high suicide risk factor, prior suicide and death, feelings, etc.</td>
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<td>2. Evaluate Indicators</td>
<td>Evaluate high suicide risk factor, prior suicide and death, feelings, etc., *suicide, *homicide</td>
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Quick Question Prompts

Questions to Ask - Suicidal Risk

- Have your feelings led you to think that you might be better off dead?
- In the past week, have you thought that life is not worth living or that you might be better off dead?
- Have you thought of ways to hurt or even kill yourself? Have you acted on them?

*Asking is NOT suggesting!!*

What to do with a positive screen?

- Empathic listening
- Determine safety
- Involve others
- Strength based supports
- Warm referrals
- Seek supervision
- If emergency – follow 211 protocols
What to do with a positive screen?

- Empathic listening
- Determine safety
- Involve others
- Strength based supports
- Warm referrals
- Seek supervision
- If emergency – follow Welcome Baby protocols

False Positives

Client may not understand the question
- Subtleties in language
- Secondary gain
- Actual symptoms may not match up with DSM Criteria
- Interviewer asking leading questions prior to screen
- Basing assessment on one or two symptoms (not range)
- Questions may not be culturally sensitive

Barriers to Screening

- Fear of judgment
- Stigma
- Issues around privacy
- Organizational mistrust
Environmental Influences

Where screening occurs:
- Nature of environment
- Quality of environment
  - Is it supportive?
- Hospital
- Home
- Clinic
- Warmth versus sterile

Case Vignettes

Referral: What to Do?

Warm Referral

- Know your resources-make personal connections
- Consult with peers
- LA County Perinatal Mental Health Task Force
  www.maternalmentalhealthla.org
- PSI Warmline -800-944-4773 www.postpartum.net
- Call 2-1-1 LA County-Updated Perinatal Mental Health Resource Guide
- National Suicide Prevention Lifeline – 800-273-8255
Brochures and Posters

- PMHTF brochures are available in 9 most common languages spoken in Los Angeles
- Posters “Speak Up When You’re Down” to reduce stigma

Self Care and Providers

Why is this important?
- Modeling for mothers / families
- Stay vibrant and resilient ourselves
- Better able to provide the necessary supports for clients
- Prevent burn-out

What have we learned?

- What is the PHQ-9?
- When and how do I use it?
- What are the things I should look out for when using it?
- What can I do if I detect that a mother is suffering from perinatal mental health symptoms?
- What can I do for my health?
Thank You!
PATIENT HEALTH QUESTIONNAIRE PHQ-9 FOR DEPRESSION

USING PHQ-9 DIAGNOSIS AND SCORE FOR INITIAL TREATMENT SELECTION

A depression diagnosis that warrants treatment or treatment change, needs at least one of the first two questions endorsed as positive (little pleasure, feeling depressed) indicating the symptom has been present more than half the time in the past two weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least “somewhat difficult.”

When a depression diagnosis has been made, patient preferences should be considered, especially when choosing between treatment recommendations of antidepressant treatment and psychotherapy.

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<td>Minimal symptoms*</td>
<td>Support, educate to call if worse; return in 1 month.</td>
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<td></td>
<td>Dysthymia*</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Major depression, mild</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>≥ 20</td>
<td>Major depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressant or psychotherapy (ask, “In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?”).

† † If symptoms present ≥ one month or severe functional impairment, consider active treatment.
USING THE PHQ-9 TO ASSESS PATIENT RESPONSE TO TREATMENT

- The goal of acute phase treatment is remission of symptoms as indicated by a PHQ-9 Score of < 5 points.
- Patients who achieve this goal enter into the continuation phase of treatment.
- Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, augmentation, combination treatment).
- Patients who do not achieve remission after two adequate trials of antidepressant and/or psychological counseling or by 20 to 30 weeks would benefit from a formal or informal psychiatric consultation for diagnostic and management suggestions.

### Initial Response after Four - Six weeks of an Adequate Dose of an Antidepressant

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of ≥ 5 points from baseline</td>
<td>Adequate</td>
<td>No treatment change needed. Follow-up in four weeks.</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Probably Inadequate</td>
<td>Often warrants an increase in antidepressant dose</td>
</tr>
<tr>
<td>Drop of 1-point or no change or increase.</td>
<td>Inadequate</td>
<td>Increase dose; Augmentation; Switch; Informal or formal psychiatric consultation; Add psychological counseling</td>
</tr>
</tbody>
</table>

### Initial Response to Psychological Counseling after Three Sessions over Four - Six weeks

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Treatment Response</th>
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</tr>
</thead>
<tbody>
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<td>Adequate</td>
<td>No treatment change needed. Follow-up in four weeks.</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline</td>
<td>Probably Inadequate</td>
<td>Possibly no treatment change needed. Share PHQ-9 with psychological counselor.</td>
</tr>
<tr>
<td>Drop of 1-point or no change or increase.</td>
<td>Inadequate</td>
<td>If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant For patients dissatisfied in other psychological counseling, review treatment options and preferences</td>
</tr>
</tbody>
</table>

* CBT – Cognitive-Behavioral Therapy; PST – Problem Solving Treatment; IPT – Interpersonal Therapy
**Use of the PHQ-9 to Make a Tentative Depression Diagnosis**
*(Symptomatology & Functional Impairment)*

**PATIENT HEALTH QUESTIONNAIRE (PHQ-9)**

**STEP 1:**
Need one or both questions endorsed as "2" or "3" ("More than half the days" or "Nearly every day")

Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></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</td>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**STEP 2:**
Need a total of five or more boxes endorsed within the shaded areas of the form to arrive at the total SYMPTOM COUNT.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
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</thead>
<tbody>
<tr>
<td>3</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>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>
</tr>
<tr>
<td>5</td>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>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>
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</tbody>
</table>

**STEP 3:**
FUNCTIONAL IMPAIRMENT is endorsed as "somewhat difficult" or greater.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Thoughts hurting you</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**TOTAL SYMPTOMS endorsed more than half the days**
(except question 9 - any positive endorsement)

<table>
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<tr>
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<th>Somewhat difficult</th>
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<tbody>
<tr>
<td>10</td>
<td>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?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Use of the PHQ-9 for Treatment Selection & Monitoring

*(Determining a Severity Score)*

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

<table>
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<tr>
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<td>3</td>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**STEP 1:**
Count each item in the column labeled "Several Days" and multiply by one. Enter that number below that column.

**STEP 2:**
Count each item in the column labeled "More than half the days" and multiply by two. Enter that number below that column.

**STEP 3:**
Count each item in the column labeled "Nearly every day" and multiply by three. Enter that number below that column.

**STEP 4:**
Add the totals for each of the three columns together. This is the SEVERITY SCORE.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
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<tbody>
<tr>
<td>8</td>
<td>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>
</tr>
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<td>9</td>
<td>Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
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</table>

**STEP 4:**
Add the totals for each of the three columns together. Enter the TOTAL. This is the SEVERITY SCORE.

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
## 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)*

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**add columns:** + + + +

**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**

---

**PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at [http://www.pfizer.com](http://www.pfizer.com). Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.**
PATIENT HEALTH QUESTIONNAIRE PHQ-9 FOR DEPRESSION

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</tr>
<tr>
<td>15-19</td>
<td>Major depression, *moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>≥ 20</td>
<td>Major depression, *severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressant or psychotherapy (ask, “In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?”).

†† If symptoms present ≥ one month or severe functional impairment, consider active treatment.
The goal of acute phase treatment is remission of symptoms as indicated by a PHQ-9 Score of < 5 points.
Patients who achieve this goal enter into the continuation phase of treatment.
Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, augmentation, combination treatment).
Patients who do not achieve remission after two adequate trials of antidepressant and/or psychological counseling or by 20 to 30 weeks would benefit from a formal or informal psychiatric consultation for diagnostic and management suggestions.

### Initial Response after Four - Six weeks of an Adequate Dose of an Antidepressant

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of ≥ 5 points from baseline</td>
<td>Adequate</td>
<td>No treatment change needed. Follow-up in four weeks.</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline.</td>
<td>Probably Inadequate</td>
<td>Often warrants an increase in antidepressant dose</td>
</tr>
<tr>
<td>Drop of 1-point or no change or increase.</td>
<td>Inadequate</td>
<td>Increase dose; Augmentation; Switch; informal or formal psychiatric consultation; Add psychological counseling</td>
</tr>
</tbody>
</table>

### Initial Response to Psychological Counseling after Three Sessions over Four - Six weeks

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Treatment Response</th>
<th>Treatment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop of ≥ 5 points from baseline</td>
<td>Adequate</td>
<td>No treatment change needed. Follow-up in four weeks.</td>
</tr>
<tr>
<td>Drop of 2-4 points from baseline.</td>
<td>Probably Inadequate</td>
<td>Possibly no treatment change needed. Share PHQ-9 with psychological counselor.</td>
</tr>
<tr>
<td>Drop of 1-point or no change or increase.</td>
<td>Inadequate</td>
<td>If depression-specific psychological counseling (CBT, PST, IPT*) discuss with therapist, consider adding antidepressant. For patients satisfied in other type of psychological counseling, consider starting antidepressant For patients dissatisfied in other psychological counseling, review treatment options and preferences</td>
</tr>
</tbody>
</table>

* CBT – Cognitive-Behavioral Therapy; PST – Problem Solving Treatment; IPT – Interpersonal Therapy
### Use of the PHQ-9 to Make a Tentative Depression Diagnosis
**(Symptomatology & Functional Impairment)**

#### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**STEP 1:**
Need one or both questions endorsed as "2" or "3" ("More than half the days" or "Nearly every day")

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></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</td>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**STEP 2:**
Need a total of five or more boxes endorsed **within the shaded areas** of the form to arrive at the total SYMPTOM COUNT.

<table>
<thead>
<tr>
<th></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</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>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>
</tr>
<tr>
<td>3</td>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>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>
</tr>
<tr>
<td>9</td>
<td>Thoughts hurting you</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**STEP 3:**
**FUNCTIONAL IMPAIRMENT** is endorsed as "somewhat difficult" or greater.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>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?</td>
<td>Not difficult at all</td>
<td>Somewhat difficult</td>
<td>Very difficult</td>
</tr>
</tbody>
</table>

---

**TOTAL SYMPTOMS endorsed more than half the days (except question 9 - any positive endorsement)**
### Use of the PHQ-9 for Treatment Selection & Monitoring

*(Determining a Severity Score)*

#### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></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</td>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**STEP 1:**
Count each item in the column labeled "Several Days" and multiply by one. Enter that number below that column.

**STEP 2:**
Count each item in the column labeled "More than half the days" and multiply by two. Enter that number below that column.

**STEP 3:**
Count each item in the column labeled "Nearly every day" and multiply by three. Enter that number below that column.

**STEP 4:**
Add the totals for each of the three columns together. This is the **SEVERITY SCORE**.

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 | 0 | 1 | 2 | 3 |

9 | Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**STEP 4:**
Add the totals for each of the three columns together. Enter the **TOTAL**. This is the **SEVERITY SCORE**.

---

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

---

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### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NOMBRE:** ___________________________ **FECHA:** ___________________________

**Durante las últimas 2 semanas, ¿cuán qué frecuencia le han molestado los siguientes problemas?**

<table>
<thead>
<tr>
<th></th>
<th>Nunca</th>
<th>Varios días</th>
<th>Más de la mitad de los días</th>
<th>Casi todos los días</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Tener poco interés o placer en hacer las cosas</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Sentirse desanimado/a, deprimido/a, o sin esperanza</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Con problemas en dormirse o en mantenerse dormido/a, o en dormir demasiado</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Sentirse cansado/a o tener poca energía</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Tener poco apetito o comer en exceso</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Sentir falta de amor propio – o que sea un fracaso o que decepcionara a sí mismo/a su familia</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Tener dificultad para concentrarse en cosas tales como leer el periódico o mirar la televisión</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Se mueve o habla tan lentamente que otra gente se podría dar cuenta – o de lo contrario, esta tan agitado/a o inquieto/a que se mueve mucho más de lo acostumbrado</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Se le han ocurrido pensamientos de que sería mejor estar muerto/a o de que haría daño de alguna manera</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**add columns:** ___________  ___________

**TOTAL:** ___________

---

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Si usted se identificó con cualquier problema en este cuestionario, ¿cuán difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?</td>
</tr>
<tr>
<td></td>
<td>Nada en absoluto</td>
</tr>
<tr>
<td></td>
<td>Algo difícil</td>
</tr>
<tr>
<td></td>
<td>Muy difícil</td>
</tr>
<tr>
<td></td>
<td>Extremadamente difícil</td>
</tr>
</tbody>
</table>

---

PHQ-9 is adapted from PRIMEMDTODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls6@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.
Maternal Mental Health - Clinical Vignettes

1. MB is 23 years old and African-American. MB is the mother of a 5 year old little girl and new parent of full term baby boy. Father of the baby is incarcerated. MB was in and out of foster care and has a history of trauma. MB reports feeling depressed and “hearing voices” during pregnancy. MB is receiving medication from psychiatrist at Kedren mental health services but is not receiving therapy. MB lives with her mother, who is now sober and works nights. MB is visited by an African American Public Health RN in home and the following information is disclosed: Mom is exclusively breastfeeding and shows signs of healthy secure attachment. MB gives eye contact to baby, caressing baby and smiling at baby. She is nursing and holding baby during entire visit. MB's affect is flat and low energy. She scores a 19 on the PHQ-9. MB expresses feeling hopeless and alone. MB says she is afraid the voices will come back and tell her to hurt herself. When RN asks if mom has a plan or a means to hurt herself, mom discloses that she does not want to hurt herself now but one night a few weeks ago she thought about taking all her medication to” shut out the world.” MB also discloses that she has been inconsistent in taking her medication and her medication is almost gone. RN checked in with grandmother and MB about the importance of taking her medication and the need to lock up medication and have grandmother administer medication if possible.

- What risk factors exist?
- How is her social support network?
- What strengths exist?
- What can we learn from her PHQ9 score?
- What symptoms are present?
- How would you address these issues?
- What referrals might be helpful?
- What are the next steps?
Maternal Mental Health - Clinical Vignettes

2. CA is a 30 year old mother of 4 children; a 10 year old boy, a 4 year old girl, a 2 year old girl and a newborn. CA was born in Mexico and moved to Los Angeles 5 years ago. All of her family still lives in Mexico. CA only speaks Spanish. CA is with the father of the baby. He is the father of the 2 year old and the newborn. CA lives in a small one bedroom apartment in an old apartment building in South Los Angeles. When the Parent Coach arrives for the 2-4 week visit, the house is dark, stuffy and messy. There is a smell of soiled diapers and last night’s dinner. CA is breastfeeding and formula feeding because she is afraid the baby is not getting enough milk. CA’s affect is flat and she avoids eye contact with parent coach. The newborn is asleep in the car seat because mom does not have a co-sleeper or crib. CA says he is “good baby” and sleeps most of the time. The 2 year old is trying to crawl into the CA’s lap and the 4 year old is trying to crawl onto the Parent Coaches’ lap and color on her paperwork. CA does not give the 2 year old eye contact but lets her sit on her lap. CA scores 16 on the PHQ-9. CA bursts into tears and says she has a hard time sleeping, is always tired and feels hopeless. The father of the baby is getting ready to go to work. He is a dishwasher at restaurant in Beverly Hills. CA says that she is always alone and has no one to help her. Father of the baby comes into the room and explains that he wants to help but he has to work. He says, “She would feel much better if she just got up and got out of the house.”

- What risk factors exist?
- How is her social support network?
- What strengths exist?
- What can we learn from her PHQ9 score?
- What symptoms are present?
- How would you address these issues?
- What referrals might be helpful?
- What are the next steps?
Maternal Mental Health - Clinical Vignettes

3. GS is a 35 year old first time mother. GS is Latina and prefers to speak English. GS is a preschool teacher and book keeper for a small business. GS wanted to have a natural childbirth but started having contractions when she was 32 weeks pregnant. GS had an emergency c-section and baby is currently in the NICU. RS is not with the father of the baby but is receiving support from her sister and mother. When the RN arrives at the GS’s home, she is welcoming and offers the RN cold water. The small house is very clean and tidy. GS is very talkative and friendly. As the RN begins to ask about the baby and her birth experience, GS begins to weep. She is worried and anxious about her baby and feels that it is her fault that the baby was born so early because she was always on her feet. She has hard time sitting down. GS scores 15 on her PHQ-9. She talks about her disappointment in not being able to have a natural birth, her strong desire to breastfeed and feeling ashamed that she is not married to the father of her baby. She is also struggling with feeling like her heart is constantly pounding and worries that she may not be able to care for her baby. She believes that she is a great disappointment to her family.

- What risk factors exist?
- How is her social support network?
- What strengths exist?
- What can we learn from her PHQ9 score?
- What symptoms are present?
- How would you address these issues?
- What referrals might be helpful?
- What are the next steps?
Post-training Evaluation, Los Angeles County Perinatal Mental Health Task Force

Please take your time to read and respond to each question. We value your time and your feedback—thank you!

1. Where do you currently work (or with what organization are you affiliated)?

2. Which of the following best describes your profession?

- Social work
- Therapy
- Nursing
- Physician's Assistant
- Physician
- Nutrition
- Agency / Program Administrator
- Advocate
- K-12 Education
- Infant - Preschool Education / Child Care
- Home visitation
- Community outreach
- Research
- Other (please specify)

3. How would you rate the following aspects of today's training?

- Trainers / Presenters
- Audio/visual (e.g., slides, movies, handouts)
- Amount of information
- Completeness of information
- Environment (e.g., comfort, set up of room)

4. How could this training be improved?

5. How would you rate your level of interest in future trainings on the following topics? Please check the answer that best fits your interest:

- Medication safety
- Addressing problems with infant attachment
- Accessing community mental health services
- PMADs and teens
- PMADs and men
- PMADs and special needs children
- PMADs and substance abuse
- Screening tools

6. Are there any additional topics of interest for future trainings?
7. Please read each statement in the center section below. On the left, check the box that best describes your knowledge **BEFORE** taking today’s training. In the section on the right, check the box that describes your knowledge / practices / comfort level **NOW, AFTER** attending today’s training. If a statement does not apply to you, please write “N/A” in any of the boxes.

<table>
<thead>
<tr>
<th>BEFORE today’s training</th>
<th>Now, AFTER today’s training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
</tr>
<tr>
<td>I know the prevalence of postpartum depression</td>
<td></td>
</tr>
<tr>
<td>I can describe the potential problems with infant and child development that may result from perinatal mood and anxiety disorders?</td>
<td></td>
</tr>
<tr>
<td>I can name 3 differential diagnoses of perinatal mental health</td>
<td></td>
</tr>
<tr>
<td>I can identify 5 risk factors related to perinatal mental health mood and anxiety disorders</td>
<td></td>
</tr>
<tr>
<td>I can name one evidence-based screening tools for use with women in the perinatal period.</td>
<td></td>
</tr>
<tr>
<td>I can identify 3 times during the pregnancy and postpartum period where screening for perinatal mood and anxiety disorders is recommended.</td>
<td></td>
</tr>
<tr>
<td>I feel comfortable talking with women/clients about perinatal mood and anxiety disorders.</td>
<td></td>
</tr>
<tr>
<td>I feel comfortable handing out the brochure about depression and mood disorders to my clients.</td>
<td></td>
</tr>
<tr>
<td>I feel prepared to talk with women/clients about symptoms they are experiencing.</td>
<td></td>
</tr>
<tr>
<td>I am prepared to offer support and make referrals to my clients with symptoms of PMADs?</td>
<td></td>
</tr>
</tbody>
</table>

8. Do you have any additional comments? (Please feel free to use the reverse side.) THANK YOU!
Suicide Prevention and Risk Assessment: Question Prompts

Suicidal Ideation

- Have you been thinking about suicide or wanting to die?
- What was going on at the time you had these thoughts?
- Have you been eating and sleeping regularly? Tell me what that looks like.
- What sort of thoughts have you been having? Can you describe them?
- How often are you thinking about suicide? (Daily, weekly, monthly?) How long do those thoughts last?
- Are there any other things that you have noticed that trigger thoughts of suicide?

Method

- Do you have a plan?
- Have you thought about how you could end your life?
- What specifically are some of the ideas you've had?

Degree of Planning

- Have you worked out where you would do it and what you would use?
- Do you have what you need to carry out your plan?
- Do you have access to a gun, knives/blades, pills?
- Have you done anything to prepare for or act out your plan?

Previous attempts

- Have you ever tried to kill yourself or die by suicide in the past?
- Can you tell me what happened and how long ago this was?
- Did you need to go to the hospital or get any other help? If hospitalized, for how long?
- Were you prescribed any medications? Are you taking any medications?

When in doubt, CONSULT with a supervisor.

Developed for the Family Strengthening Network by Maternal and Child Health Access
## Suicide Prevention and Risk Assessment: Quick Reference Tool

<table>
<thead>
<tr>
<th><strong>1. Identify Risk Factors</strong></th>
<th>Note which ones can be modified to reduce risk.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Stressors: events leading to shame or despair, loss of relationship, recent death, social isolation, illness</td>
</tr>
<tr>
<td></td>
<td>• Suicidal behavior: history of suicide attempts, aborted suicide attempts, self-injurious behavior</td>
</tr>
<tr>
<td></td>
<td>• Observe: current emotional distress, mood, affect. Current use of medication, alcohol, self-medication</td>
</tr>
<tr>
<td></td>
<td>• Psychiatric disorder (current, past, or undiagnosed): depression, anxiety, alcohol/substance use, trauma, previous PPD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2. Identify Protective Factors</strong></th>
<th>Note which ones can be enhanced.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Internal: ability to cope with stress, religious beliefs, frustration tolerance, outlook on parenting children</td>
</tr>
<tr>
<td></td>
<td>• External: responsibility to children or pets, positive therapeutic relationships, family/friends, stability, restricted access to lethal means (e.g., guns, pills, knives, razors), medical provider, social service programs, church, support group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3. Conduct Suicide Inquiry</strong></th>
<th>Ask questions about suicidal thoughts, plans, behaviors, and intent.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ideation: frequency, intensity, duration (in last 48 hours, past month, worst ever)</td>
</tr>
<tr>
<td></td>
<td>• Plans: timing, location, lethality, availability, preparatory acts</td>
</tr>
<tr>
<td></td>
<td>• Behaviors: past attempts, rehearsals (loading gun, tying noose, etc.) vs. non-suicidal self-injurious acts</td>
</tr>
<tr>
<td></td>
<td>• Intent: client expects to carry out plan, believes the plan to be lethal, explores reasons to die vs. live</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>4. Determine Risk Level, Intervention</strong></th>
<th>Determine risk and choose appropriate intervention. If unsure, consult.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Assessment of risk: based on parent coach assessment and supervisory staff assessment</td>
</tr>
<tr>
<td></td>
<td>• Reassessment: if client situation/affect or environment changes</td>
</tr>
<tr>
<td></td>
<td>• Connect to resources: voluntary or involuntary psychiatric triage and hospitalization, contacting client's therapist, psychiatrist or medical doctor, resource coordinator for mental health resources, emergency response</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>5. Consult</strong></th>
<th>Check with your direct supervisor regarding plan of action. If supervisor is not available, follow chain of command.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Check in with direct supervisor during or immediately after visit</td>
</tr>
<tr>
<td></td>
<td>• If direct supervisor is not available, contact clinical supervisor or program director</td>
</tr>
<tr>
<td></td>
<td>• Contact LA Best Babies Network or MCH Access, if necessary, to find resources for client</td>
</tr>
<tr>
<td></td>
<td>• Consult with client's primary medical doctor or clinic, if appropriate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Complete all documentation within 24 hours</td>
</tr>
<tr>
<td></td>
<td>• Message clinical supervisor within the database to track high-risk cases</td>
</tr>
<tr>
<td></td>
<td>• Document all follow-up contacts/consultations in a timely manner (e.g., per WB Fidelity Framework)</td>
</tr>
</tbody>
</table>

*Developed for the Family Strengthening Network by Maternal and Child Health Access*