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>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:30 am</td>
<td>BREAKFAST AND REGISTRATION</td>
<td></td>
</tr>
<tr>
<td>8:30-9:00 am</td>
<td>Welcome and Introductions</td>
<td>Terrie Anciano, BS</td>
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<tr>
<td></td>
<td>Icebreaker</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC</td>
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<tr>
<td></td>
<td>Overview of Training Objectives</td>
<td>Lili McGuinness, LCSW</td>
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<td></td>
<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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<tr>
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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>
</tr>
<tr>
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<td></td>
<td>Lili McGuinness, LCSW</td>
</tr>
<tr>
<td>12:00-12:45 pm</td>
<td>LUNCH/VIDEO</td>
<td></td>
</tr>
<tr>
<td>12:45-1:45 pm</td>
<td>Screening for Maternal Depression</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC</td>
</tr>
<tr>
<td></td>
<td>· Review WB Depression Protocol</td>
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<td>Time</td>
<td>Session Title</td>
<td>Presenter(s)</td>
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<tr>
<td>1:45-2:15 pm</td>
<td>Resources for Perinatal Depression in Los Angeles County</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC, Lili McGuinness, LCSW</td>
</tr>
<tr>
<td>2:15-2:30 pm</td>
<td><strong>BREAK</strong></td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC, Lili McGuinness, LCSW</td>
</tr>
<tr>
<td>2:30-3:30 pm</td>
<td>Putting It All Together: Applying Your Knowledge and Experience</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC, Lili McGuinness, LCSW</td>
</tr>
<tr>
<td>3:30-4:00 pm</td>
<td>Key Learnings on Perinatal Depression and Self Care Evaluation</td>
<td>Gabrielle Kaufman, MA, LPCC, BC-DMT, NCC, Lili McGuinness, LCSW</td>
</tr>
<tr>
<td>4:00-4:15 pm</td>
<td><strong>WRAP UP AND EVALUATION</strong></td>
<td>Terrie Anciano, BS</td>
</tr>
</tbody>
</table>
Perinatal Depression and PHQ-9 Scoring

SPEAKER BIO

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>
</tr>
</thead>
</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. |
### Depression Protocol

#### PHQ-9 Score | Provisional Diagnosis | Additional Procedures to Support Client
---|---|---
10-14 | Minor depression, Major depression, mild* | 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:
   - Exercise
   - Sleep
   - Nutrition
   - Talking to someone that she trusts
   - 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.

*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?”).

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)
• Speech (talkative, rate, volume, slurred, hesitant)
• Mood (inquired)
• Affect (blunted, flat, normal intensity, appropriate to situation)
• Bizarre behavior (doing things that don’t make sense, behavior that is throwing off family and friends)
• Thought processes (insight, judgments, delusions and or hallucinations – false beliefs or seeing things that are not really there)

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.
MY SAFETY PLAN

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)

*Developed for the Family Strengthening Network by Maternal and Child Health Access*
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
More than Just the Blues: Perinatal Mental Health

Lili McGuinness, LCSW, CLE
Faculty, Training
Marisela Rosales, LCSW, IFCHM
Faculty, Training
Angelica Gonzalez, MS, LMFT
Faculty, Training

MMH-NOW as an Agent of Change

- RAISE awareness and to improve prevention, recognition and treatment of Perinatal Mood and Anxiety Disorders
- HELP each woman experience a happy and healthy pregnancy and postpartum transition
- HELP each child bond with a loving, attentive mother
- HELP each family enjoy a smoother transition to parenthood
- BEGIN to align efforts to support a system of care

Why & How MMH-NOW Formed

- From Empanadas to Infinity & Beyond - A Recipe
- Our founder’s story: the need for informed services and access to care in own backyard
Mission & Vision: A Three-Legged Chair

#1: Public Awareness

#2: Training Institute

#3: Policy: Advocacy & Legislation

Myths, Expectations, and Stigma

Good Mothers ... Bad Mothers

Good mothers...

Bad mothers...
Significance of Perinatal Period

Vulnerability also can come with possibilities, openness and opportunities for growth transformation and healing.

“There's a crack in everything...that's where the light gets in” Leonard Cohen

What Are Perinatal Mood and Anxiety Disorders?

- “Perinatal”- anytime from conception through one year after delivery
- Inter-conception (before 1st pregnancy or between pregnancies)
- Depression or other mood disorder during the perinatal period
- Anxiety, with or without depression, during the perinatal period

Myths of Parenthood STIGMA

- Pregnancy & Parenting are easy, intuitive, instinctive
- Pregnant women “glow”
- Good mothers don’t get depressed
- “How can you be depressed if you’re having a baby?”
- “But you have such a beautiful baby?”
- If I tell you what I really feel... 
  - Fear of judgment / “crazy”
  - Fear of DCFS / children being taken away
  - Fear of deportation
Perinatal Depression Crosses All Lines

- Perinatal depression can affect any woman
- Crosses cultural, racial, economic lines
  - Some communities are more or less open to expressing mental health issues
- Culture can determine whether it is socially acceptable to acknowledge or discuss perinatal mood and anxiety disorders
- Culture may affect range of symptoms
- Culture may influence treatment
  - Is it acceptable?
  - Compliance
  - Treatment team
  - Types of treatment

Sources: Abbasi et al., 2014; Bina, R., 2008.

Prevalence of Maternal Mental Health Concerns & Risk Factors

ACES

10 Types of Trauma
- Physical abuse
- Sexual abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Mother treated violently
- Household substance abuse
- Household mental illness
- Parental separation or divorce
- Incarcerated household member

Higher score greater implications for physical and emotional illness (chronic disease) and risk for early death in adults.

Toxic stress changes brain architecture
Trauma and Brain Development

Misunderstood Symptoms of Trauma

‘Difficult clients’
“Non-compliant”
“Resistant parent”

Trauma Informed Care

Becoming “trauma-informed” means recognizing that people often have many different types of trauma in their lives. People who have been traumatized need support and understanding from those around them. Often, trauma survivors can be re-traumatized by well-meaning caregivers and community service providers.

Helping professionals are often attracted to the field because of their own trauma history.
Trauma Informed Care

- Building a coherent narrative of life story
- Trustworthiness and transparency
- Peer support
- Collaboration, mutuality and shared decision making
- Safety
- Acknowledging and understanding cultural, historical, and gender issues
- Get grounded—move out of “fight or flight” response
  - Breathing
  - Physical activity
  - Mindfulness
  - Self reflection/Self awareness
  - Strength-based work *Validation*Building confidence
  - Telling your story (coherent narrative)

Reflective Activity

We do our best work when we are in our higher brain.

- How do you know when you are in your lower brain or higher brain?
- Do you feel it in your body?
- What helps you move into your higher brain?

Maternal Depression: A Major Public Health Issue

- Every year, approximately 1 million American women self-report postpartum depression are affected by Perinatal Mood and Anxiety Disorders
- 10-15% experience a Perinatal Mood and Anxiety Disorders during pregnancy and the postpartum year
- Cuts across income, race, ethnicity, gender, age and sexual orientation/expression
- Per LAMB study, low-income or ethnic minority women in Los Angeles had rates of depressive symptoms closer to 30-40%

Maternal Depression: California Report

- Every year, half a million babies are born in California.
- Maternal Mental Health issues arise in up to 1 in 5 pregnancies
- In California, as many as 1 in 4 mothers have prenatal or postpartum depression
- Underserved populations, impacted by race, poverty and other social factors increase frequency and severity of MH conditions.
- Low income mothers are 1.4x more likely than wealthier moms to exhibit depressive symptoms before, during or after pregnancy.
- MIHA 2013 – Higher rates in mono-lingual Spanish speakers


Depressive Symptoms More Common with Women with Less Education (MIHA 2013 CDPH)

Low Income Women More likely to report Depressive Symptoms (MIHA 2013 CDPH)
MIHA Data on CHILDHOOD HARDSHIPS (2013)
All corresponded to higher rates of depressive symptoms
- Parent/guardian divorced or separated
- Problems paying rent/mortgage
- Went hungry
- Parent/guardian in jail or problems with law
- Parent/guardian using substances
- Spent time in Foster Care
- Exposed to violence
- Lack of social support

Maternal Depression: Untreated = $$$
- While highly treatable, few mothers are identified by screening or diagnosis and among those recognized, only 15% receive treatment
- COSTS? – including lost income/productivity and negative outcomes for children, untreated maternal depression costs (PDF) an estimated $22,500 per mother, which totals $2.5 billion yearly in California!

Depression in Pregnancy

Untreated Depression in Pregnancy Increases Risk of Postpartum Depression by 50-80%
Pregnancy and Intimate Partner 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

Pregnancy and 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

![Graph showing asked about depression/anxiety at medical visit in Los Angeles County, 2010-2014.](image)
Reported depression during pregnancy Did not report depression during pregnancy

Self-reported depression more than two years after giving birth

Perinatal Mood & Anxiety Disorders
Risk Factors and Prevention

Packing your bags

• What are the expectations of parenthood?
Perinatal Mental Health

- Psychological Risk Factors
  - Interpersonal Stress
  - Unsupportive spouse
  - Poor relationship with woman's own mother
  - Mixed feelings about motherhood
  - Past experience of trauma
    - Physical, emotional, sexual abuse
  - Drugs and alcohol in the family
  - Previous unresolved losses
    - Death, divorce, miscarriage, abortion, stillbirth

- Biological Risk Factors
  - Personal/family history of depression and/or anxiety disorder
  - Personal/family history of postpartum depression
  - Depression/anxiety during pregnancy
  - Difficulty with menstrual pain
  - Personal/family history of thyroid illness
  - Long/short intervals between pregnancies
  - Fertility treatment - unsuccessful IVF etc.

Sources: Payne et al., 2009; Peterson et al., 2013; Yim et al., 2015.
Psychosocial Stressors

- Complicated pregnancy and/or delivery
- Premature delivery
- Infertility issues
- Sick/colicky infant
- Stressful life events (moving, financial pressures)

Sources: Blom et al., 2010; Takeda et al., 2010; Yin et al., 2011.

More Vulnerable Populations at Significantly Greater Risk

- Teens
- Single moms
- Military women
- Low income women
- Socially isolated women
- Recent immigrants
- Women with high-risk pregnancies/infertility problems/history of miscarriage or stillborn baby
- NICU moms
- LGBTQI


Miscarriage, Stillbirth, Infertility

- Expectations and Loss
- Shame & Blame
- Medical environment vs. home environment
- Rituals for loss
- Rainbow babies (pregnancy after loss)
  - Struggle to form attachment
  - Struggle to believe baby will survive
  - Guilt over bonding with new baby
  - Complex Grief - triggers may be unexpected
I wish I had known...

“I thought having a new baby would make the sad feelings from my earlier miscarriage go away. I was wrong.”

-Mother of a “rainbow baby”

Perinatal Mood & Anxiety Disorders Diagnoses

Emotional Reactions Following Birth
What is to be expected?

Joy
- Fulfillment / being a family
- Protectiveness
- Instant love for baby

Positive Feelings

Not interested in baby

Exhaustion / Feeling Distant

Negative Feelings

Disappointment

Overwhelmed by sense of responsibility
Sometimes depression and anxiety can be confused with the changes in the body during pregnancy

- Limited energy
- Sleep struggles and exhaustion
- Digestive problems can be part of anxiety or pregnancy
- Difficulty breathing could be medical health or may be anxiety

It can be difficult to know if what she is going through is just normal pregnancy changes in the body or if she is struggling with depression and anxiety.

Sources: Manber et al., 2008; Sadikzay & Ross-Hamid, 2011; Nylen et al., 2013.

Baby Blues

- 50%-80% of postpartum women
- Different in different cultural communities
- Begins between day 3 and day 14 postpartum
- Feelings can last for a few days to a few weeks
- Usually go away on their own

**WHAT CAN YOU DO TO HELP HER?**

- Help mom get sleep and eat well
- Remind her to reach out if she needs help
- Tell her not to WAIT for things to get better

Sources: Halbreich & Farber, 2006; O'Hara & Wisner, 2014.

Symptoms of the Blues

*How are these different from postpartum depression?*

- Crying
- Anger
- Sadness
- Sleeplessness
- Anxiety
- Exhaustion

Source: O'Hara & Wisner, 2014.
The Language of Postpartum Depression

- No one has ever felt as bad as I do - helplessness
- I have made a terrible mistake - anxiety
- I am all alone and no one understands - isolation and withdrawal
- I am a failure as a mother, woman and wife - guilt, poor self-esteem
- I will never be myself again - hopelessness
- I’m losing it - despair
- I am on an emotional roller coaster - mood changes
- I want to cry all the time - tearfulness
- Everything is an effort - no energy
- I feel like I’m in a fog - disorientation, confusion
- Sometimes I think everyone would be better off without me - suicidal thinking

Postpartum Depression - Symptoms

- Unable to sleep
- Weight loss
- Difficulty coping
- Hopelessness
- Confusion
- Difficulty concentrating
- “Going through the motions”
- Sadness
- Feelings of failure
- Forgetfulness
- Fear of being left alone
- Overwhelming anxiety
- Hard to connect with baby
- Suicidal thoughts

Question to Ask New Mothers
to determine if she has trouble sleeping due to baby not sleeping or anxiety

“If you could have 8 hours to yourself, in a nice, quiet, clean bed, would you be able to sleep?”

If no, refer to a clinician for assessment
Postpartum Obsessive-Compulsive Disorder

- OCD may begin in the perinatal period. The severity of preexisting symptoms may change.
- General prevalence 2-3%. Prevalence for OCD during postpartum is still unclear, but evidence of higher risk than general prevalence.
- Compulsive/repetitive behaviors (cleaning, counting, checking).
- 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.

Sources: Miller et al., 2013; Russell et al., 2013; Uguz et al., 2007.

Postpartum Post Traumatic Stress Disorder

- Reliving of past traumatic events.
- Flashbacks, nightmares, images.
- Sense of doom.
- Hyper-vigilance.
- Increased arousal.
- Can be caused by birth trauma (subjective) – birth can also trigger early trauma.

1-3% develop PTSD as direct response to birth.


Postpartum Psychosis: A True Emergency

- VERY RARE - Occurs in 0.1-0.2% of births.
- Break from reality.
- Is she acting strangely?
- Is she talking about hurting herself or the baby?

- A true emergency – baby and mother at risk.
- CALL 911, Emergency Room.
- Don’t leave mother alone with baby.

Postpartum Psychosis SYMPTOMS

• Refusal to eat
• Inability to sleep
• Agitation
• Depressed or elevated mood (mania)
• Delusions
• Hallucinations
• Paranoia
• Psychotic features occur alone or in combination with rapidly fluctuating mood symptoms
• Often delusions and paranoia focus on baby
• Waxes and wanes – difficult to diagnose

Postpartum Bipolar Disorder

DSM 5 - IX
• Mood elevated or irritable (mania)
• Withdrawal or catatonia
• Agitation and restlessness (atypical depressive symptoms)
• Flight of ideas and pressured speech
• Increased energy and hyperactivity
• Decreased need for sleep
• In pregnancy, some women taken off mood stabilizer
• Women with history of Bipolar Disorder at high risk for relapse during postpartum period (studies suggest 1 in 3 relapse)
• In postpartum period, often first psychotic episode
• Sometimes triggered by SSRI for depressive symptoms
• Rapid onset, rapid decline

Paternal Perinatal Depression

• Loss of good sleep
• Depressed partner
• Has had his own depression
• Conflict in relationship
• Isolated
• Economic problems or limited resources
• Changes in family role and structure
• Difficulty connecting with the baby
Paternal Perinatal Depression – symptom differences

SYMTOMS MAY BE DIFFERENT THAN FOR MOM

- Gets angry easily
- Feeling burnt-out and empty
- Easily Frustrated
- Feels disconnected
- Alcohol or substance use
- Uses work to escape the home
  - (or drugs, or video games, or porn)
- Resistant to getting help
- Denial of problems
- Problems with self-control

Source: Kim & Swain, 2007; Philpott, 2008; Paulson & Bazemore, 2010.

LUNCH

Scope of Impact, Causes, Implications
Why Care So Much About Maternal Depression?

- If left untreated can become chronic depression; impact on woman, child, family then much greater
- Can have multigenerational impact

**Effects**

- Mother
- Fetus
- Society at Large
- Family
- Infant & Child

Source: Vliegen, et al., 2014.

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**Impact on Mother**

- May not go to prenatal care
- May not follow doctor’s orders
- May not eat well enough for fetus to grow
- Fatigue, sleep problems
- Increased risk of substance use
- Increased risk of smoking
- Suicidal thoughts
- If untreated can become chronic depression


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**Impact on Fetus**

- Risk of exposure to substance abuse, domestic violence, etc.
- Preterm delivery
- Risk of being small at birth

Sources: Burt & Stein, 2002; Davis et al., 2010; Zuckerman et al. 1989.
Impact on the Family

Postpartum depression can:
• Be a significant factor in marital problems and divorce
• Add to dad’s feelings of helplessness and depression
  24-50% of dads with partners who experience Postpartum Depression are depressed themselves
• Affect older children
• Affect father’s connection to baby
• Cause feelings of loss and grief in family – not what they expected
• Affect extended family


Impact on Parenting

• Less likely to follow the back-to-sleep guidelines for prevention of SIDS, use car seats or socket covers
• Less likely or reduced time breastfeeding than non-depressed mothers
• Less likely to follow preventive health advice, including managing chronic health conditions such as asthma or disabilities in their young children
• Less likely read to baby


Impact on Attachment

• Helps baby and caregiver communicate
• An emotional tie that exists throughout life
• A model for future relationships

What Can Get in the Way of the Attachment Relationship?

- Separations from the primary caregiver
- Death of the primary caregiver
- Mental illness of the primary caregiver

How does a baby respond when she isn’t being attuned to?

5 basic ways an infant may respond to overwhelming stress such as trauma or a very depressed or anxious primary caregiver:

- Cries a lot and cannot be soothed
- Always on alert – looks frightened
- “Glazed over” does not respond or interact
- Poor sleeping
- Poor eating

Source: Field & Tiffeny, 1995.

Edward Tronick Still Face Experiment

Video & Discussion
Screening Tools

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

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
False Positives/Negatives

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
- Fear of judgement or children being taken away
- Negative experience with systems
Suicide Assessment: What Are You Looking For?

Current thoughts
Current plan
History of suicide attempt

Suicide Screening Questions

• "Have these feelings / symptoms led you to think you might be better off dead?"
• "This past week, have you had any thoughts that life is not worth living or that you’d be better off dead?"
• "What about thoughts about hurting or killing yourself? If YES, what have you thought about? Have you acted on it?"


What To Do If You’re Worried about Suicidality

• Have clinic policy in place – knowing what to do makes screening easier
• Options:
  o Emergency Room
  o Calling 911
  o Psychiatric Emergency Teams
  o Mental Health Specialist on-site
What DO you say?

• This is not your fault
• There is support out there, I will help you get some
• The sooner you get help, the sooner you will feel better
• You are not alone, I'm here for you
• I know you are trying as hard as you can
• This must be very difficult for you
• Other people have gone through this and have gotten better with help
• You are a good mom, good moms can ask for help

Family Strengthening 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
  — 911 Psychiatric Evaluation Team (PET) – client might be taken into 5150 custody, if they are assessed to be harmful to self and others.
  — Mental health services (counseling)
  — Suicide hotline
  — DCFS, 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.

What can you say? What can you do?
Sometimes it’s hard to talk about difficult things

Why is it hard to ask?

- We don’t want to be intrusive
- We don’t want to make assumptions
- We don’t feel qualified to ask
- We feel uncomfortable with the feelings
- We are afraid to nag or repeat things

"I felt so much better when my friend asked me how I was feeling. People were asking only about the baby. I was having such a rough time and my friend made me feel loved. She got me the help I needed." — Mom with Postpartum Depression

But we can make a difference!

What NOT to say

- You’ll feel better soon, don’t worry
- Get a positive attitude, that will make it all better
- Think of all the things you have to be grateful for
- If you don’t stop crying you will damage your baby
- What you need is to stop worrying so much
- We never complained back in the day
- I never felt that way, I don’t understand why you do
- Motherhood is your job
- Please don’t complain, no one likes a complainer

The Universal Message

- You are not alone
- You are not to blame
- With the right help, you will get better
What empathy is NOT?

- Fixing it - What will help is...
- Giving advice - I think you should...
- Interrogating - How did it happen?
- Explaining - She said that only because...
- Educating - You can learn from this
- Shutting down - Don’t worry about it
- Consoling - It wasn’t your fault
- Correcting - That’s not how it was
- Commiserating - He did that to you? The jerk!
- One upping - You should hear what happened to...
- Evaluating - If you hadn’t been so rude
- Sympathizing - You poor thing!
- Taking blame - Sorry I should have

Source: Ruth Beaglehole and Echo Center for Parenting Education

Barriers to Care

- Access to resources
- Stigma & Judgment
- Fear of “failure” as mom
- Fear of their children being taken away
- Fear of deportation
- Lack of information
- Lack of understanding
- Lack of trust in system
- Bad experience in past
- Financial limitations
- Language
- Cultural belief system
- Insurance restrictions
- Transportation
- Childcare
- Lack of trust in others
- Isolation
- Anxiety & Depression

Source: Ruth Beaglehole and Echo Center for Parenting Education

How to Address Barriers to Treatment

- Reframe mental health, “mother and child wellness”
- Understand what motherhood means to each woman
- Build relationships of TRUST
- Be open and non-judgmental
- Help her make connections with all aspects of community, including faith communities
- Stay in connection even if she isn’t ready now, she may be later

Source: Ruth Beaglehole and Echo Center for Parenting Education
What Kinds of Interventions Work?

- Group therapy
- Couples therapy
- Individual therapy
  - Cognitive Behavioral
  - Interpersonal Psychotherapy
  - Psychodynamic
  - Exposure Therapy
- Dyadic & Parenting
  - Child Parent Psychotherapy
  - Positive Parenting (Triple P)
  - Reflective Parenting Program
  - PCIT
- Home Visitation
- Medication – ? exposures
- Healthy habits
- Nutrition
- Exercise
- Community Support
- Faith
- Schools
- Family
- Integrated care

Medications & Perinatal Mental Health

- “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

Community Resources
Community Resources
- Faith based – prayer groups, mom circles, mommy and me classes
- Family support – close and extended family
- School support – what resources are available at school?
  - Parenting education
- WIC – Breastfeeding Support groups
- Best Start Communities (First 5)
- Parks and Recreation
  - Mommy and Me
  - Playgroups
  - Parenting education classes and lectures

More Resources
- Infant Massage Classes
- Integrated care clinics – Medical home with Behavioral Health
- Hospital Prenatal classes
- Hospital breastfeeding groups
- Home visitation programs
- Regional Centers for Children with Special Needs
- School based healthcare
- Healthy Start
- Pediatrician office support – in office social worker/case manager
- NICU support groups

Cultural Considerations
- Immigration status and fears
- Language of origin
- Culture of origin
- Cultural expectations of pregnancy and parenthood
- Traditions of parenthood
Involving Family Members

- Education
- Transportation
- Childcare
- Expectations (lower)
- Encouragement
- Referrals
- Basic self-care
- Sleep care

Advice for Fathers and Partners

- Offer support and encouragement — your positive actions and words can reduce some of her suffering
- Encourage her to seek help — this is the quickest path to recovery (and to stay in treatment — all too often women quit too soon)
- Listen: Her feelings are real, so let her express them to you
- Allow her to focus on her own needs: Physical and social activities help women suffering from Perinatal Depression feel stronger, more relaxed, and better about themselves
- Take time for yourself. It is important for spouses and partners to continue with their work, hobbies, and outside relationships

Maternal Mental Health NOW Resource Directory

www.directory.maternalmentalhealthnow.org
How to Talk to Women about Mental Health Referrals

- Clarify for her the benefits of getting help
  - Provide specifics about what to expect
- Support her in setting up and getting to appointments
  - Address her concerns or fears
  - Who can help her with caring for the baby, getting help
- Remind her why she should get help
  - Let her know that getting help is not only for her, but is for her baby and her whole family
  - What are the cultural issues that are at play?
    - Help identify and support within her support system

Prevention

- Evidence for direct and indirect effect of screening
- Assess risk factors
- Prenatal care – making sure she goes to her appointments
- Forming attachment relation during pregnancy
- Inter-conception care
- Protective factors (Center for the Study of Social Policy)
- Resilience
- Building social supports
- Knowledge of parenting and child development
- Concrete support
- Communication skill

Source: O'Connor et al., 2016.
Intergenerational Transmission of Resilience

- Psycho-education (knowledge of depression)
- Social Support (family, friend, mentor, professional)
- Ability to tell your story, be self-reflective
- Capacity to ask for and receive help
- Community Support
  - Faith based
  - Community
  - Education
- Access to healthcare
- Forming Positive Attitudes
- Listening to feelings


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Case Studies
Form table groups: Review and Discuss

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Discussion about Case Studies

- What concerns do you have?
- How is her social support network?
- What strengths does she have?
- How would you talk to her?
- What referrals might be helpful?
- What are the next steps?
Brochures
Brochures are available in 7 most common languages in Los Angeles
Share brochure with everyone, use it as a talking tool

Other Resources
• www.Directory.MaternalMentalHealthNOW.org
• Stories online at www.maternalmentalhealthnow.org
• Postpartum Support International www.postpartum.net
• Interested in starting a peer support group? Contact us...
gabrielle@maternalmentalhealthnow.org

Questions?
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.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal symptoms*</td>
<td>Support, educate to call if worse; return in 1 month.</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ††</td>
<td>Support, watchful waiting</td>
</tr>
<tr>
<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.

<table>
<thead>
<tr>
<th>Initial Response after Four - Six weeks of an Adequate Dose of an Antidepressant</th>
<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>
<td></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>
<td></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>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initial Response to Psychological Counseling after Three Sessions over Four - Six weeks</th>
<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>
<td></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>
<td></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>
<td></td>
</tr>
</tbody>
</table>

* CBT – Cognitive-Behavioral Therapy; PST – Problem Solving Treatment; IPT – Interpersonal Therapy

Copyright © 3CM™ September 2009 – Obtained from www.depression-primarycare.org
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>
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<td>4</td>
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<tr>
<td>5</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</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>7</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>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>
<tr>
<td>9</td>
<td>Thoughts hurting you</td>
<td>1</td>
<td>2</td>
<td>3</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>
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<td>1</td>
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<tr>
<td>9</td>
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</tr>
</tbody>
</table>

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

**STEP 3:**

FUNCTIONAL IMPAIRMENT is endorsed as "somewhat difficult" or greater.

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></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
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### PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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<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.

<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>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>
<tr>
<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>
</tr>
</tbody>
</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)

<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. 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 in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**add columns:**  

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**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?**

<table>
<thead>
<tr>
<th></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

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

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.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal symptoms*</td>
<td>Support, educate to call if worse; return in 1 month.</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ††</td>
<td>Support, watchful waiting</td>
</tr>
<tr>
<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.

<p>| Initial Response after Four - Six weeks of an Adequate Dose of an Antidepressant |</p>
<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>

<p>| Initial Response to Psychological Counseling after Three Sessions over Four - Six weeks |</p>
<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
### 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>5</td>
<td>Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</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>7</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>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>
<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.

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

<table>
<thead>
<tr>
<th></th>
<th>Not difficult 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>

---

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# 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.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
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</thead>
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<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>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
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<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>
# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NOMBRE:** __________________________  **FECHA:** __________________________

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

<table>
<thead>
<tr>
<th>Número</th>
<th>Descripción</th>
<th>Nunca</th>
<th>Varios días</th>
<th>Más de la mitad de los días</th>
<th>Caso 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>
<td>3</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>
<td>3</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>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>Sentirse cansado/a o tener poca energía</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Tener poco apetito o comer en exceso</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</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>
<td>3</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>
<td>3</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>
<td>3</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>
<td>3</td>
</tr>
</tbody>
</table>

**add columns:** + + +

**TOTAL:**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

**Si usted se identificó con cualquier problema en este cuestionario, ¿cuan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?**

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>

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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?
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?

<table>
<thead>
<tr>
<th></th>
<th>excellent</th>
<th>good</th>
<th>fair</th>
<th>poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainers / Presenters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audio/visual (e.g., slides, movies, handouts)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amount of information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completeness of information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment (e.g., comfort, set up of room)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th></th>
<th>little or no interest</th>
<th>some interest</th>
<th>high interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication safety</td>
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<tr>
<td>Addressing problems with infant attachment</td>
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<tr>
<td>Accessing community mental health services</td>
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<tr>
<td>PMADs and teens</td>
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<td>PMADs and men</td>
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<tr>
<td>PMADs and special needs children</td>
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<td>PMADs and substance abuse</td>
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<tr>
<td>Screening tools</td>
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</tbody>
</table>

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>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>I know the prevalence of postpartum depression</td>
<td></td>
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<tr>
<td>I can describe the potential problems with infant and child development that may result from perinatal mood and anxiety disorders?</td>
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<tr>
<td>I can name 3 differential diagnoses of perinatal mental health</td>
<td></td>
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<tr>
<td>I can identify 5 risk factors related to perinatal mental health mood and anxiety disorders</td>
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<tr>
<td>I can name one evidence-based screening tools for use with women in the perinatal period.</td>
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<tr>
<td>I can identify 3 times during the pregnancy and postpartum period where screening for perinatal mood and anxiety disorders is recommended.</td>
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<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>
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<tr>
<td>I feel prepared to talk with women/clients about symptoms they are experiencing.</td>
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<tr>
<td>I am prepared to offer support and make referrals to my clients with symptoms of PMADs?</td>
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</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
<table>
<thead>
<tr>
<th>1. Identify Risk Factors</th>
<th>2. Identify Protective Factors</th>
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</thead>
<tbody>
<tr>
<td>Note which ones can be modified to reduce risk.</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>
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</tbody>
</table>

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<thead>
<tr>
<th>3. Conduct Suicide Inquiry</th>
<th>4. Determine Risk Level, Intervention</th>
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</thead>
<tbody>
<tr>
<td>Ask questions about suicidal thoughts, plans, behaviors, and intent.</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>

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<tbody>
<tr>
<td>Check with your direct supervisor regarding plan of action. If supervisor is not available, follow chain of command.</td>
<td>Complete all documentation within 24 hours</td>
</tr>
<tr>
<td>Check in with direct supervisor during or immediately after visit</td>
<td>Message clinical supervisor within the database to track high-risk cases</td>
</tr>
<tr>
<td>If direct supervisor is not available, contact clinical supervisor or program director</td>
<td>Document all follow-up contacts/consultations in a timely manner (e.g., per WB Fidelity Framework)</td>
</tr>
<tr>
<td>Contact LA Best Babies Network or MCH Access, if necessary, to find resources for client</td>
<td>Consult with client’s primary medical doctor or clinic, if appropriate</td>
</tr>
</tbody>
</table>

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Suicide Prevention and Risk Assessment: Quick Reference Tool

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