Screening, assessment, and treatment of behavioral health conditions in primary care settings

Emotional health challenges are common during pregnancy and the postpartum period. While many parents experience short-term "baby blues," some face more serious conditions like perinatal depression, anxiety, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), or postpartum psychosis. Early recognition, compassionate conversations, and appropriate screening are essential to providing timely, effective care.

This toolkit offers practical guidance for care providers to screen, assess, and support patients experiencing perinatal behavioral health concerns. It includes information on how to start mental health conversations, create safe screening environments, and use validated tools like the EPDS, PHQ-9, and GAD-7. The goal is to support patient-centered, trauma-informed care that fosters trust and connection.

Your role in identifying and addressing behavioral health concerns can significantly improve health outcomes for both parents and their babies. This toolkit helps you begin that conversation with confidence and compassion.

Common perinatal emotional complications

Understanding the emotional challenges that can arise during pregnancy and the postpartum period is key to providing compassionate and effective care. While many new parents experience "the baby blues"—a short-term, common reaction to hormonal shifts and sleep disruption—some may face more serious perinatal mental health disorders. These include perinatal depression, anxiety, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and postpartum psychosis, each with distinct symptoms, risk factors, and treatment needs. Early recognition and support can make a significant difference in recovery and well-being.

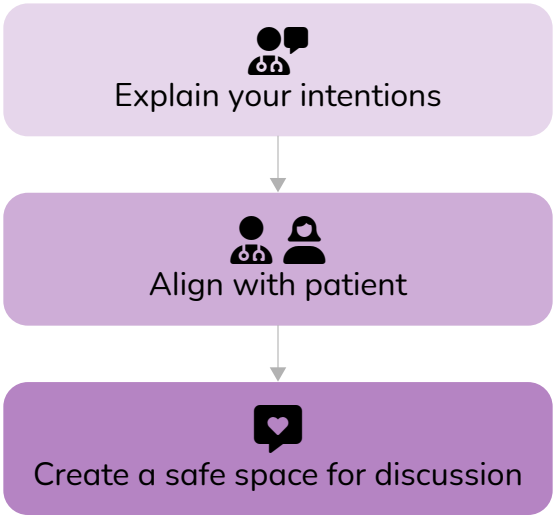
To learn more about these conditions please refer to the Perinatal Mental Health Care Guide at **perc.psychiatry.uw.edu/perinatal-mental-health-care-guide-6/**.

Core screening tools

Starting the conversation

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

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



Here are some example statements:

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

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

Citation

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

Creating safe and supportive screening environments for pregnant and post-partum patients

Always use your clinical judgment.

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

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

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

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

- All screeners except the PASS are validated for use in Spanish and English.
- Many patients feel uncomfortable disclosing that they cannot read the screeners. Use non-judgmental language to assess for patient's preferences:

> "Some patients prefer to complete these screeners on their own and some prefer to complete them with a medical professional, which option would you prefer"

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

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

Citation

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

Behavioral health screening

Why do we screen?

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

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

What do we do with your answers?

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

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

Screening for perinatal depression

Edinburgh Postnatal Depression Scale (EPDS)

Edinburgh Postnatal Depression Scale-3A (EPDS-3A) tool[1]

- 3 items
- Items #3, 4, 5 of full EPDS
- Does not quantify anxiety severity
- Scoring:
  - 0-4: negative screen for anxiety
  - 5-9: positive screen for anxiety

Learn more:
womensmentalhealth.org/posts/using-the-epds-to-screen-for-anxiety-disorders-conceptual-and-methodological-considerations/

About the EPDS

The EPDS was developed to assist primary care health professionals in detecting persons suffering from perinatal depression.

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

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

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

Continued on next page

Instructions for users

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

Scoring the EPDS

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

EPDS score of:

< 13: Depression likely not indicated
≥ 13: Positive screen for depression
Responds "yes" to Q10 (self harm): conduct further risk assessment

Citation

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 150, 782-786.

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

About the PHQ-2/PHQ-9

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

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

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

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

Instructions for users

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

Scoring the PHQ-2

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

Scoring the PHQ–9

Response categories are scored 0 – 3 according to increased severity of the symptom with a maximum score of 27. For more details on scoring and interpretation, see the PHQ-9 Quick Guide: **file.lacounty.gov/SDSInter/dmh/1133179_PHQ-9QuickGuide03312020.pdf**.

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

Citation

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

Screening for perinatal anxiety

Perinatal Anxiety Screening Scale

Perinatal Anxiety Screening Scale (PASS) tool[2]

- 31 items
- Most sensitive screening tool for perinatal population
- Quantifies anxiety severity
- Scoring:
  - 0-20: minimal anxiety
  - 21-41: mild-moderate anxiety
  - 42-93: severe anxiety

Learn more:
womensmentalhealth.org/posts/screening-for-perinatal-anxiety-using-pass-the-perinatal-anxiety-screening-scale

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

Generalized Anxiety Disorder-7 (GAD-7) tool[3,4]

- 7 items
- Specific to perinatal population
- Quantifies anxiety severity
- Scoring:
  - 0-4: minimal anxiety
  - 5-9: mild anxiety
  - 10-14: moderate anxiety
  - 15-21: severe anxiety

Learn more:
adaa.org/sites/default/files/GAD-7_Anxiety-updated_0.pdf

About the GAD-2/GAD-7

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

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

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

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

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

Instructions for users

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

Scoring the GAD-2

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

Scoring the GAD-7

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

Citation

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

Other screening tools

Interpersonal Violence – HARK

About the HARK

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

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

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

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

Instructions for users

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

Scoring the HARK

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

Citations

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

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

Substance Use – Modified 5Ps

About the Modified 5P's

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

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

Instructions for users

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

Scoring the modified 5Ps

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

Citation

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

Risk assessment

When supporting pregnant and postpartum individuals experiencing mental health or substance use concerns, it's important to assess for risk of suicide or self-harm as well as risk of harm to the baby. For more information on risk assessments and treatment resources, visit the **Maternal Suicide and Risk Assessment Toolkit**: **hca.wa.gov/assets/program/82-0660-perinatal-suicide-and-risk-assessment-toolkit.pdf**

References

1 Smith-Nielsen J, Egmose I, Wendelboe KI, Steinmejer P, Lange T, Vaever MS. Can the Edinburgh Postnatal Depression Scale-3A be used to screen for anxiety?. BMC Psychol. 2021;9(1):118. Published 2021 Aug 7. doi:10.1186/ s40359-021-00623-5

2 Somerville S, Dedman K, Hagan R, et al. The Perinatal Anxiety Screening Scale: development and preliminary validation. Arch Womens Ment Health. 2014;17(5):443-454. doi:10.1007/s00737-014-0425-8

3 Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166(10):1092- 1097. doi:10.1001/archinte.166.10.1092

4 Simpson W, Glazer M, Michalski N, Steiner M, Frey BN. Comparative efficacy of the generalized anxiety disorder 7-item scale and the Edinburgh Postnatal Depression Scale as screening tools for generalized anxiety disorder in pregnancy and the postpartum period. Can J Psychiatry. 2014;59(8):434-440. doi:10.1177/070674371405900806