Navigating the Perinatal Journey: Mental Wellness Tools for Every Step

Washington State Health Care Authority

HCA 82-0660 (09/25)

Contents

Introduction

We adopted this toolkit to assist all front-line providers who support pregnant and postpartum individuals in the prevention, identification, and treatment of perinatal behavioral health concerns. This toolkit contains screening tools, processes, and clinical guidance which can be tailored to the specific practice environment.

About perinatal behavioral health disorders

Perinatal behavioral health is an umbrella term for both mental health and substance use of birth people during pregnancy and the first year after birth. Perinatal behavioral health disorders such as depression, anxiety, and substance use are among the most common, yet underdiagnosed and untreated, health issues of pregnancy and childbirth, affecting **around 20% of new and expectant parents**.

Poor maternal mental health is associated with numerous adverse outcomes for the patient and infant including labor and delivery, infant health status, and long-term health complications; difficulties in bonding with and nurturing a newborn; and is a risk factor for future mental health problems in children. Postpartum depression has also been deemed the greatest risk factor for maternal suicide which is a major contributor to maternal mortality. Moreover, untreated perinatal mood and anxiety disorders were estimated to cost the US $14.2 billion in 2017.

Front-line providers have long recognized the need for tools and better systems to help pregnant and postpartum individuals with these concerns. **Mandatory depression screening of pregnant and postpartum women throughout the perinatal period is now recommended by a number of professional organizations** including the American College of Obstetrics and Gynecology (ACOG, 2015), the American Academy of Pediatrics (2010), and the American Medical Association (AMA, 2017).

The good news is that perinatal behavioral health conditions can be addressed with support and appropriate care. We know perinatal behavioral health approaches that work across the continuum from promoting well-being through specialized behavioral health services. We hope this toolkit increases awareness and access to support when needed for new and expectant parents.

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- Department of Children, Youth, and Families
- Department of Health
- Health Care Authority
- University of Washington's Perinatal Mental Health and Substance Used Education, Research & Clinical Consultation (PERC) Center
- Washington State Perinatal Collaborative (WSPC)

The content of this toolkit was adapted from materials provided by NC Mental Health Matters at the University of North Carolina – Chapel Hill.

Perinatal anxiety toolkit

Perinatal anxiety impacts 1 in 5 pregnant and postpartum people.[1]

Risk factors[2,3,4]

- History of anxiety or depression
- Unplanned pregnancy
- Exposure to childhood abuse, domestic violence, or sexual assault
- History of pregnancy complications or loss
- Low socioeconomic status
- Lack of social support

Health disparities[5,6,7,8]

- Exposure to racism and inequities in social determinants of health likely contributes to increased stress and anxiety levels among minoritized women
- Hispanic and non-Hispanic black women report higher levels of stress and anxiety during pregnancy than non-Hispanic white women
- Indigenous women have higher odds of experiencing perinatal anxiety that non-Indigenous women
- Women of color are less likely to be diagnosed with and receive treatment for a perinatal anxiety disorder than white women

Potential consequences of untreated perinatal anxiety

Obstetric[9,10]

- Hypertensive disorders of pregnancy
- Preterm birth
- Low birth weight

Postpartum[11,12]

- Poor infant bonding
- Lower likelihood of breastfeeding
- Postpartum depression

Childhood[13]

- Negative early temperament
- Behavioral problems
- ADHD, anxiety, and depressive symptoms

Clinical presentation[14,15]

Psychological symptoms

- Excessive worry
- Feeling on edge
- Difficult to reassure
- Intrusive thoughts
- Sense of dread
- Insomnia

Common worry themes

- Fetal well-being
- Infant health and safety
- Parenting abilities

Physical symptoms

- Fatigue
- Muscle tension
- Nausea or abdominal discomfort
- Palpitations, chest tightness, or shortness of breath
- Dizziness

Identifying perinatal anxiety

Pregnancy and postpartum worries are common and can be normal.

How does perinatal anxiety differ from "normal" worry?

In perinatal anxiety:

- Anxiety is persistent
- Worries are excessive, intense, or irrational
- Symptoms cause significant distress
- Symptoms interfere with day-to-day activities (might include difficulty caring for self and/or infant)

To make a diagnosis:

Acronym guide
CBC = Complete Blood Count
CMP = Comprehensive Metabolic Panel
TSH = Thyroid-Stimulating Hormone
EKG = Electrocardiogram

- Use a validated screening tool (see page 3)
- Rule out medical etiologies (consider CBC, CMP, TSH, EKG), including complications of pregnancy (e.g., preeclampsia, gestational hypertension, gestational diabetes, anemia, and hyperthyroidism, among others)
- Consider co-occurring or alternative psychiatric diagnosis:
  - Depression
  - OCD
  - PTSD
  - ADHD
  - Bipolar disorder
  - Postpartum psychosis
- Ask about substance use (alcohol, illicit substances, controlled medications)

Screening

Screening pregnant and postpartum patients for mood and anxiety disorders is recommended by the American College of Obstetricians and Gynecologist (ACOG)[16], American Academy of Pediatrics (AAP)[17] and US Preventative Services Task Force (USPSTF)[18].

The American College of Obstetricians and Gynecologists (ACOG) recommends screening for perinatal anxiety at a minimum of 3 time points across pregnancy and postpartum. Consider screening at the first prenatal visit, once later in pregnancy during the 2nd and/or 3rd trimester, and once after delivery at postpartum visits.

1st trimester
- ✓ At initial prenatal visit

2nd trimester
- ✓ Once during 2nd trimester

3rd trimester
- ✓ Once during 3rd trimester

Postpartum
- ✓ 2 weeks postpartum
- ✓ 6 weeks postpartum
- ✓ 6 months postpartum
- ✓ 1 year postpartum

What do I say?

"We screen all of our patients for anxiety because mental health changes and concerns are so common during pregnancy. These forms do not diagnose you with a mental health condition. They help us to talk with you about the best way to support you during your pregnancy, if you would like support. There are educational materials and resources available, too. Feel free to ask about them anytime, whether or not you choose to share your feeling or any symptoms you are experiencing."

Note: This script is just a suggestion and can be adapted as appropriate.

Screening tools

Perinatal Anxiety Screening Scall (PASS)[19]

- 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-7 (GAD-7)[20,21]

- 7 items
- Not 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

Edinburgh Postnatal Depression Scale-3A (EPDS-3A)[22]

- 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/

Treating perinatal anxiety

Treatment for perinatal anxiety often involves a combination of approaches tailored to the individual's symptoms, preferences, and clinical needs. Both non-pharmacologic and pharmacologic options are available, and collaborative care is essential to ensure the well-being of the birthing person and their baby.

Pharmacologic treatment

Providers are encouraged to review PERC's Perinatal Anxiety Medications to support safe, informed, and compassionate care.

Guiding principles for prescribing:

- Use what has previously worked
- Monotherapy is preferable
- Be aware of need to increase dose due to physiological changes of pregnancy

Important points to discuss with patients:

- No medication is FDA-approved in pregnancy or lactation
- All psychiatric medications do cross the placenta and into breastmilk to some extent
- The risks of exposing the fetus/infant to medication
- Infants should be monitored for side effects of medications, especially sedation

Examples of alternative treatments

Psychotherapy[23,24,25]

- First line for mild to moderate perinatal anxiety
- Recommended in combination with medication for moderate to severe perinatal anxitey
- Types of therapy for perinatal anxiety:
  - Cognative-behavioral therapy
  - Interpersonal psychotherapy
  - Behavioral activation
  - Acceptance and commitment therapy

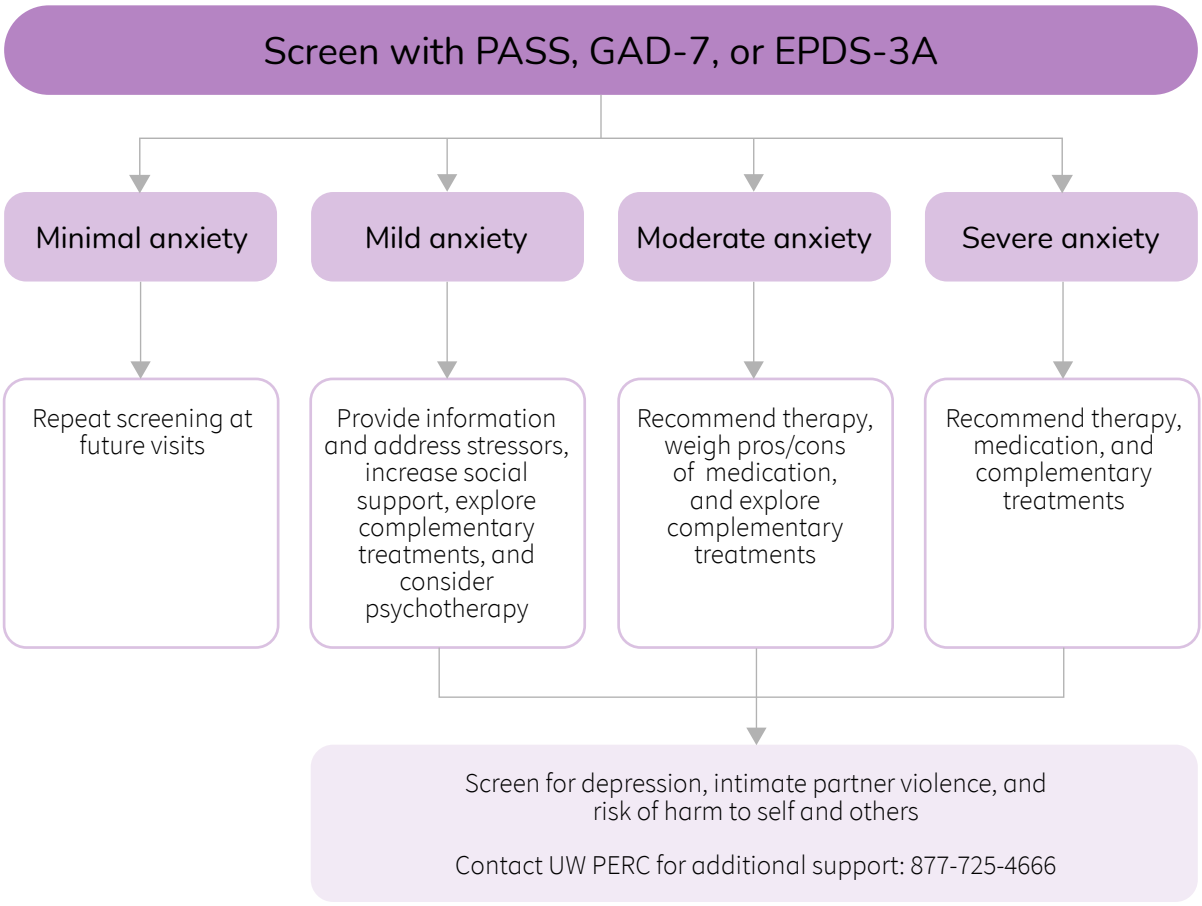
Complementary treatments[26,27,28,29,30]

- May be used as add-on to medication and/or psychotherapy
- Not stand-alone treatments for perinatal anxiety
- Examples:
  - Sleep protection
  - Physical activity
  - Yoga
  - Massage
  - Relaxation exercises

Treatment algorithm

PASS: Perinatal Anxiety Screening Scale, **GAD-7:** Generalized Anxiety Disorder-7, **EPDS-3A:** Edinburgh Postnatal Depression Scale-3A

For more detailed guidance, refer to the Perinatal Mental Health Care Guide developed by the Perinatal Mental Health & Substance Use Education, Research & Clinical Consultation (PERC) Center: **perc.psychiatry.uw.edu/perinatal-mental-health-care-guide-6/**



Resources

For patients

Perinatal Support Washington
Compassionate support for people in the emotional transition to parenthood, including new and expecting parents; pregnancy, postpartum, loss, infertility, anxiety, depression, and more. Services provided:

- Warm Line provides peer emotional support, information, and referrals to professionals and community resources.
- Mental health therapy
- Culturally-matched peer support available
- Training, consultation, education, and advocacy for health care providers
- All services can be accessed by calling the Warm Line. Call or text: 1-888-404-7763 (se habla español), interpreters provided
- Website: **perinatalsupport.org**

Help Me Grow Washington
A Washington statewide system connecting families with young children to health development, and basic needs resources.

- Call: 800-322-2588
- Website: **helpmegrowwa.org**

Postpartum Support International
A confidential helpline that provides basic information, support, and resources for pregnant and postpartum individuals.

- Call or text 24/7: 1-800-944-4773
- Text em español: 971-203-7773
- Website: **postpartum.net**

Mother to Baby
Information about medication and other exposures during pregnancy and breastfeeding.

- Get easy-to-read information on the safety or risk of medications, drugs, or other exposures from experts
- Call: 866-626-6847
- Text: 855-999-3525
- Website: **mothertobaby.org**

MGH Center for Women's Mental Health blog
Blog posts focused on topics related to reproductive and maternal well-being

- Website: **womensmentalhealth.org/blog/recent-posts**

For clinicians

Perinatal Psychiatry Consultation Line for Providers (Perinatal PCL) (Washington)
Perinatal PCL is a free, state-funded program providing perinatal mental health consultation, recommendations and referrals for Washington state providers caring for pregnant or postpartum patients.

- Consultations available on demand during business hours (9 am- 5 pm, Monday- Friday, closed for UW holidays), or schedule a consultation at: **perinatalpcl.as.me/schedule.php**.
- Call: 877-725-4666
- Email: **ppcl@uw.edu**
- Website: **perc.psychiatry.uw.edu/perinatal-pcl/**

Mother to Baby
English and Spanish language fact sheets summarizing information about common exposures during pregnancy and breast/chest-feeding.

- Chat with an exposure expert, enroll your patient in observational studies, or schedule a patient consult.
- Website: **mothertobaby.org**

Lactmed
Database which provides evidence-based information on drugs and other chemicals to which a breast/chest-feeding partent may be exposed.

- Website: **ncbi.nlm.nih.gov/books/NBK501922/**

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ADHD in women: Implications for treatment in the perinatal period

Key facts

- ADHD is one of the most common neurodevelopmental disorders, and symptoms typically extend across the lifespan.[1]
- Untreated or unmanaged ADHD symptoms are associated with a range of impairments in adulthood and during the perinatal period, including higher rates of unplanned pregnancies[2], poorer prenatal health,[3] and increased birth complications[4].
- As more adult women are receiving ADHD diagnoses, many are seeking support for managing their symptoms during preconception and the perinatal period (i.e., pregnancy and postpartum).

Note: In this document, the term "woman" is intended to include all people who identify as female or were assigned female at birth.

Background

What is ADHD?[5]

- A brain-based disorder that is characterized by levels of inattention and/or hyperactivity/impulsivity that are greater than what would be expected for a person's age or developmental level.
- For individuals aged 17 years and older to meet criteria for ADHD, a person must exhibit at least 5 symptoms of inattention or hyperactivity/impulsivity.
- Several symptoms must have been present in childhood (i.e., younger than age 12).
- Symptoms must be persistent for at least 6 months and occur across multiple settings.
- Symptoms cannot be better explained by other factors, such as another mental health condition (e.g., depression, anxiety, psychosis, etc.).
- To meet criteria for an ADHD diagnosis, symptoms must be associated with functional impairment. ADHD can contribute to a range of significant challenges including social and emotional difficulties, academic underachievement, financial hardships[6], employment challenges[7], and premature death[8].

See next page for list of symptoms.

ADHD symptoms

Inattention

- Trouble paying attention to details/makes careless mistakes
- Trouble sustaining attention
- Seems to not be listening
- Trouble following instructions/finishing tasks
- Difficulty organizing
- Avoiding tasks that require concentration
- Losing materials
- Easily distracted
- Forgetful

Hyperactivity and impulsivity

- Fidgeting
- Trouble staying seated when expected
- Often feeling or seeming restless
- Trouble engaging in tasks quietly
- "On the go" or "driven by a motor"
- Talking excessively
- Blurts out answers to questions before they are completed
- Trouble waiting turn
- Interrupting/intruding on others

What does ADHD look like in women?

ADHD criteria and considerations for women

Atypical levels of inattention, hyperactivity, and/or impulsivity that have been present for at least 6 months

- Women are more likely to present with symptoms of inattention rather than hyperactive and impulsive behaviors.[9]
- Women may show more hyperverbal behavior than hyperactive behavior.[10]
- There is some emerging evidence that hormones may impact symptom expression; for example, in response to fluctuating steroids across the menstrual cycle.[11]

Several symptoms of ADHD present in childhood (i.e., younger than age 12)

- Symptoms might not become apparent in women until around puberty.[12]

Symptoms present in at least two settings

- Women often "mask" or hide their ADHD symptoms from others.[13]
- Women frequently develop extensive coping strategies to cover up symptoms around others.[14]

Symptoms significantly impact functioning. Compared to women without ADHD:

- Women with ADHD are more likely to experience pregnancy as teenagers and have significantly greater rates of unplanned pregnancies.[15]
- Women with ADHD are 5 times more likely to experience intimate partner victimization.[16]
- Women with a childhood history of ADHD are twice as likely to have engaged in self-harm and are at significantly higher risk for attempting suicide.[17]

Symptoms are not better explained by another condition

- Women with ADHD are more likely to experience mood and anxiety concerns[18], which can make it especially hard to parse the potential contribution of ADHD from these symptoms.
- At least some difficulty with attention or behavior should have been present prior to a significant life change, such as pregnancy.

ADHD in the perinatal period

What do ADHD symptoms look like for perinatal patients?

- Hormonal, physical, and emotional changes during the perinatal period may impact the presentation of ADHD symptoms. ADHD symptoms can be hard to distinguish from other mental health or neurodevelopmental conditions that often co-occur with ADHD, or from life experiences such as pregnancy. Additionally, female ADHD patients may be more likely to experience premenstrual dysphoric disorder (PMDD) and postpartum depression after first childbirth.[19]
- Perinatal patients may also describe symptoms that sound like ADHD but are better attributed to other disorders. Having the symptoms and experiences associated with ADHD does not necessarily mean someone meets criteria but may indicate that further evaluation is warranted.

Symptom comparison

Note: The descriptions provided in the table below are general and may not apply to a person's individual experience or the presentation of the condition at all times. The table does not include all conditions and experiences that might overlap with ADHD.

Symptoms/experiences	ADHD[20]	Autism Spectrum Disorder[21]	Depression[22]	Anxiety[23]	Bipolar Disorder[24]	"Normal" psychological changes in peripartum[25]
Difficulty completing daily tasks	Often	Sometimes	Often	Sometimes	Sometimes	Sometimes
Trouble concentrating during different activities	Often	Sometimes	Often	Often	Often	Sometimes
Easily distracted and trouble getting back on track	Often	Sometimes	Sometimes	Sometimes	Sometimes	Sometimes
Frequently fidgeting or moving their body	Often	Sometimes	Sometimes	Sometimes	Sometimes	Rarely
Often forgetting steps in daily routines or information that they have been told	Often	Rarely	Sometimes	Rarely	Sometimes	Sometimes
Often engaging in risk-taking behavior	Often	Rarely	Sometimes	Rarely	Very often	Rarely
Often irritable or easily frustrated	Sometimes	Sometimes	Often	Often	Often	Sometimes
Changes in appetite or weight	Sometimes	Rarely	Very often	Sometimes	Very often	Very often
Frequently feeling guilty, worthless, or helpless	Sometimes	Rarely	Very often	Sometimes	Very often	Rarely
Thinking a lot about death or dying	Rarely	Rarely	Often	Sometimes	Often	Rarely
Experiencing worry about upcoming events	Rarely	Rarely	Rarely	Very often	Rarey	Often
Feeling prolonged periods of sadness, emptiness, or hopeless	Rarely	Rarely	Very often	Sometimes	Often	Rarely
Significant change in energy from person's typical level	Rarely	Rarely	Very often	Rarely	Very often	Very often
Changes in sleep quality, patterns, or habits	Rarely	Rarely	Very often	Often	Very often	Very often

How can I determine whether further evaluation for ADHD is warranted?

- Disparities in the diagnosis and treatment of people with ADHD have been well-documented, attributed in part to teacher and clinician biases, racism, social determinants of health and equitable access to resources, and stigma.[26]
- Providers can help address this by talking with their patients about their attention and/or behavioral concerns and may consider using some of the questions below to better understand the timeline and frequency of symptoms, particularly in the context of the perinatal period.
- The screening tools and questions listed below can help guide conversations and gather additional information. You may determine that further assessment for ADHD is needed.

Tools for screening

Self-report screening of ADHD symptoms during adulthood: Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

add.org/wp-content/uploads/2015/03/adhd-questionnaire-ASRS111.pdf

Screening of ADHD symptoms observed by someone who knows the patient well (e.g., partner, family member, friend, colleague, etc.): Adult Observer ADHD Questionnaire

mindoasis.com.au/wp-content/uploads/2021/01/Adult-ADHD-Questionnaire-For-observer.pdf

Self-report measure of childhood ADHD symptoms: Wender Utah Rating Scale for the Attention Deficit Hyperactivity Disorder

mcstap.com/docs/wender.pdf

Measure of childhood ADHD symptoms by someone who knew the patient well at that time: Wender Utah Rating Scale—Observer Rating

mindoasis.com.au/wp-content/uploads/2021/01/Adult-ADHD-Questionnaire-For-observer.pdf

Rating scale of how ADHD symptoms may impact aspects of life: Weiss Functional Impairment Rating Scale

caddra.ca/wp-content/uploads/WFIRS-S.pdf

Who can conduct an ADHD evalution?

- If you or your patient is wondering whether you might have ADHD as an adult, the evaluation process often starts with your primary care provider (PCP). PCPs can begin an initial assessment and refer to a mental health professional such as a psychologist or psychiatrist for a more comprehensive evaluation, which is often needed for a first-time diagnosis in adulthood.
- To better understand the types of professionals who can diagnose and treat ADHD, the **Duke Center for Girls & Women with ADHD** offers a helpful **guide**. Visit the Center website at **adhdgirlsandwomen.org**, and read the the guide at **adhdgirlsandwomen.org/wp-content/uploads/2024/02/Infographic_WhosWhoFINAL.pdf**
- For help finding local professionals, the **Children and Adults with ADHD (CHADD) resource directory** is a great resource: **chadd.org/professional-directory/?letter_sort=j&current_page=1**. You can also look for local professionals through the CHADD provider directory.
- If you're pregnant or recently postpartum and exploring an ADHD diagnosis, additional guidance is available through the University of Washington's Perinatal Psychiatry Center at **perc.psychiatry.uw.edu/wp-content/uploads/2024/06/Perinatal-ADHD-Care-Guide.pdf**. Providers can also consult the Perinatal Psychiatry Consultation Line (PPCL) for support: **perc.psychiatry.uw.edu/perinatal-pcl**.

Treating ADHD in perinatal patients

Can ADHD medication be initiated or continued during pregnancy and lactation?

- There is little evidence that the use of ADHD medications as prescribed increases risk to a fetus in a clinically meaningful way.[27] That said, all psychotropic medications will cross the placenta, be present in amniotic fluid, and enter breast milk.[28]
- Choosing to initiate, discontinue, or forgo medication should result from shared decision-making with the patient, who is informed of the risks of both treating and choosing not to treat their symptoms. Our priority is to help our patients maintain mental health stability and functioning.[29]
- Preliminary research suggests that discontinuing psychostimulants during pregnancy increases risk for depressive symptoms and impaired family functioning.[30] Discontinuing a medication that is beneficial prior to or early in their pregnancy may put the person, their family unit, and pregnancy at greater risk for a negative outcome than continuing to treat the person for their ADHD symptoms.
- The lowest, most effective dose should always be used.[31]

Need support with medications for your pregnant or postpartum patients?

Contact the **Perinatal Psychiatry Consultation Line (Perinatal PCL)** — a free, state-funded resource for Washington providers.

Get expert mental health consultation, medication recommendations, and referrals for perinatal patients.

Call: 877-725-4666 (Available Mon–Fri, 9 AM–5 PM, closed UW holidays)

Schedule a consult: **perinatalpcl.as.me/schedule.php**

Email: ppcl@uw.edu

Learn more: **perc.psychiatry.uw.edu/perinatal-pcl**

Alternative treatments (non-pharmacological)

Psychotherapy

- **Cognitive Behavioral Therapy (CBT) for Adults with ADHD**: an evidence-based therapy[32] that helps people change unhelpful ways of thinking that might be affecting their thoughts, actions, or overall wellbeing. It also teaches skills that help manage some of the problems that can come with ADHD, like trouble with time management, staying organized, and planning ahead.
- **Mindfulness for Adults with ADHD**: a method that does not have as much research behind it as CBT, but has been shown to help manage ADHD symptoms, stress, depression, and anxiety by helping people develop skills to help their mind stay focused on the present.[33]

Support groups

- **Postpartum Support International (PSI)** offers a virtual support group for pregnant and postpartum moms and birthing people with a diagnosis of ADHD. Learn more: **postpartum.net/get-help/psi-online-support-meetings**
- **Attention Deficit Disorder Association (ADDA)** offers virtual peer support groups and work groups. Learn more: **add.org/adda-virtual-programs**
- **Children and Adults with ADHD (CHADD)** has local support groups for individuals with ADHD. Learn more: **chadd.net**

Organizational support

- **ADHD coaching**: these professionals offer practical advice and help people with ADHD learn skills to stay organized, manage their time, and set goals.
- **Professional organizer/house manager**: these professionals can help with getting your home tidy/organized, creating easy-to-follow routines, and helping you to remember important tasks.
- **"Body-doubling"/accountability buddy**: having another person around while you work can make it easier to stay focused and get things done.

Digital interventions

- **ADHD apps**: there are several mobile apps available that can help with time management, reducing distractions, improving sleep, and organizing information. Find a comprehensive list at **additudemag.com**.

Self-care

- Engaging in self-care and doing things to reduce stress can help with ADHD symptoms and make it easier to get things done. You might try exercising, healthy eating, connecting with friends, spending time outside, getting good sleep, and resting.

Research and additional guidance

- **"ADHD, Pregnancy, and Motherhood: A Practical Guide for Hopeful Parents"** ADDitude webinar from 5/11/2023. Watch webinar: **additudemag.com/webinar/adhd-pregnancy-transition-to-motherhood/**
- **Duke Center for Girls & Women with ADHD**: a specialized center within the Duke ADHD Program dedicated to advancing knowledge about Attention-Deficit/ Hyperactivity Disorder (ADHD) in girls and women. Learn more: **adhdgirlsandwomen.org**
- **Massachusetts General Hospital (MGH) Center for Women's Mental Health**: evidence-based resources to help patients and their providers learn about new research in women's mental health so they can make good decisions together about care. Learn more: **womensmentalhealth.org**

Additional provider resources

Free provider consultations

Perinatal Psychiatry Consultation Line for Providers (Perinatal PCL) (Washington)

Perinatal PCL is a free, state-funded program providing perinatal mental health consultation, recommendations and referrals for Washington state providers caring for pregnant or postpartum patients.

Consultations available on demand during business hours (9 am- 5 pm, Monday-Friday, closed for UW holidays), or schedule a consultation at: perinatalpcl.as.me/schedule.php.

Call: 877-725-4666

Email: ppcl@uw.edu

Website: **perc.psychiatry.uw.edu/perinatal-pcl/**

Information on medication use during pregnancy and infant feeding

Mother to Baby

- Fact sheets on perinatal exposures to share with patients
- Chat with an exposure expert, enroll your patient in observational studies, or schedule a patient consult
- Website: **mothertobaby.org**

Infant Risk Center at Texas Tech University Health Sciences

- InfantRisk App where healthcare providers can access information on medication safety during pregnancy and breastfeeding
- Free call center for patients to discuss their questions with experienced nurses
- Website: **infantrisk.com**

Lactmed

- Database on exposure of drug and chemicals to which a breast/chest-feeding parent may be exposed
- Website: **ncbi.nlm.nih.gov/books/NBK501922**

Massachusetts General Hospital (MGH) Center for Women's Mental Health

- Weekly blog summarizing recent publications in women's mental health
- Free virtual grand rounds and live online courses for providers
- Website: **womensmentalhealth.org**

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Maternal suicide and risk assessment toolkit

Key facts

- Suicide and overdose combined are the leading cause of maternal death in the first year following childbirth.[1]
- Suicide accounts for up to 20% of maternal deaths that occur during the postpartum period.[2] Peak incidence is in the late postpartum period (9–12 months).[3]

Mental health conditions are the most common complications of pregnancy and childbirth[4] and 85% of cases go without treatment.[5]

A study in Massachusetts[6] found that 50% of new mothers who completed suicide had a documented mental health diagnosis.

Women of color have higher rates of perinatal depression and are less likely to receive treatment.[7]

Risk factors[8,9]

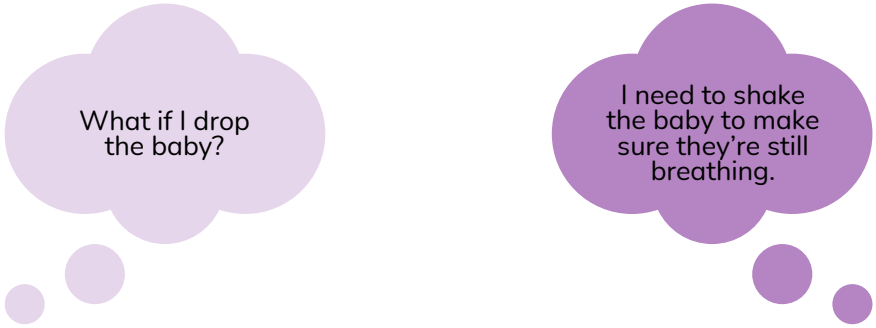
- Previous suicide attempt
- History of abuse
- Unplanned pregnancy
- Substance use disorder
- Personal or family history of mental health disorders

Perinatal Mood and Anxiety Disorders (PMADS)

- Depression
- Anxiety
- Panic Disorder
- Bipolar Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Postpartum Psychosis

Understanding intrusive thoughts

Intrusive thoughts are a common symptom of perinatal anxiety. Sometimes suicidal ideation is an intrusive thought for perinatal patients and does not represent intent. Intrusive thoughts can be difficult to assess and distinguish from higher-risk symptoms of psychosis.



Understanding suicidal ideation

Suicidal Ideation is used to describe a range of contemplations, wishes, and preoccupations with death and suicide.[10] It varies in duration, intensity, and character.

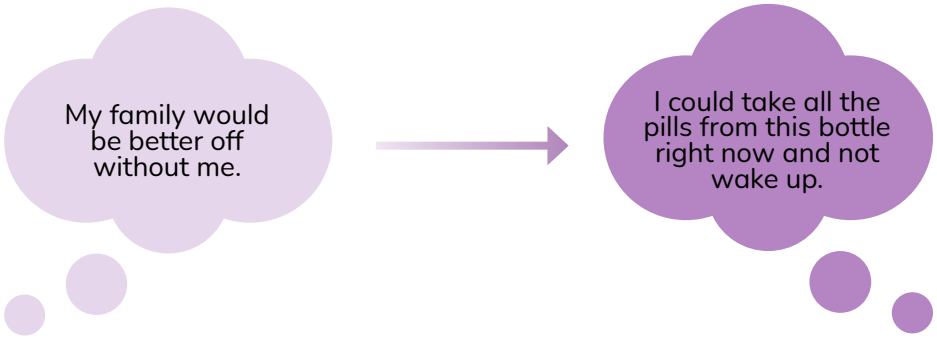
⚠ The fluctuating nature of suicidal ideation means that healthcare professionals should assess their patients routinely.

Passive suicidal ideation

Thoughts that life is not worth living or a desire for death, but without a plan to take one's own life.[11]

Active suicidal ideation

Thoughts of suicide with a plan and/or intent to harm oneself.



Questions to consider

To help **distinguish the two**, consider the following questions:

Q: Is the patient distressed by these thoughts?
A: Distress suggests intrusive thoughts rather than psychotic delusions.

Q: Does the patient recognize the thoughts as her/ their own (is insight preserved)?
A: Insight is usually preserved with intrusive thoughts, but may be lacking in psychosis.

Q: Are there other signs of psychosis such as hallucinations or delusional thinking?
A: Presence of these symptoms suggests a higher level of concern.

Screening for suicide risk

Consider incorporating one of these screening tools into your visits with perinatal patients if you are not already using one. Whatever screening tool is used, it should be given to all patients.

Keep in mind that patients don't always feel comfortable telling their providers about their suicidal thoughts, particularly during pregnancy and postpartum due to fears of being perceived as a bad parent or of being separated from their children.

What is most important is that you **foster an environment where patients feel safe** to disclose their thoughts and feelings about suicide to you, even when those thoughts may feel very scary to them.

What do I say?

"It is common for new parents to have intrusive or scary thoughts. When people are suffering, they often have thoughts about death or wanting to die. These thoughts can feel awful, and we don't want you to feel alone. We ask all patients if they are having thoughts of hurting themselves or their baby so that we can identify the best way to help."

Depression screening tools with suicide question included

Patient Health Questionnaire
apa.org/depression-guideline/patient-health-questionnaire.pdf

Edinburg Postnatal Depression Scale
med.stanford.edu/content/dam/sm/neonatology/documents/edinburghscale.pdf

Suicide specific questionnaires

Columbia Suicide Severity Rating Scale
suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf

National Institute of Mental Health Ask Suicide Screening Questions
www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit.pdf

Assessing risk

Assessment	Low risk	Moderate risk	High risk
Suicidal ideation	▶ No history of suicide attempt ▶ No current intent ▶ No current plan ▶ Protective factors present (i.e. social support, religious prohibition, other children) ▶ No substance use ▶ Hopeful about improvement	▶ Persistent sadness and tension, loss of interest, persistent guilt, difficulty concentrating, no appetite, decreased sleep ▶ History of suicide attempt ▶ Current intent ▶ Current plan (not well formulated) ▶ Limited protective factors ▶ Substance use ▶ Hopelessness	▶ Continual sadness, unrelenting dread or guilt, < 2-3 hours of sleep per night, unable to feel pleasure ▶ History of multiple suicide attempts ▶ High lethality of prior attempt(s) ▶ Current intent ▶ Current plan ▶ Limited protective factors ▶ Substance use ▶ Not receiving psychotherapy ▶ Hopelessness
Thoughts of harming baby	▶ Symptoms indicative of depression, OCD, and/or anxiety ▶ Thoughts of harming baby are scary, cause anxiety, or are upsetting ▶ Mother does not want to harm her baby and feels it would be a bad thing to do ▶ Mother very clear she would not harm her baby	▶ Thoughts of harming baby are somewhat scary ▶ Thoughts of harming baby cause less anxiety ▶ Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do ▶ Mother less clear she would not harm her baby	▶ Symptoms indicative of psychosis ▶ Thoughts of harming baby are comforting ▶ Feels as if acting on thoughts will help infant or society ▶ Lack of insight (inability to determine whether thoughts are based on reality) ▶ Having auditory and/or visual hallucinations ▶ Bizarre or fixed untrue beliefs that are not reality

What do I say?

- Normalize how stressful parenthood is and validate any feelings of anxiety and depression.[12]
- Don't be afraid to ask specific and direct questions, such as:

  - How are you feeling about being pregnant/a parent?
  - What things are you most worried about?
  - Is there anyone you feel comfortable with talking about your anxieties?
  - Are you having thoughts of killing yourself right now?
  - Who do you have for support?
  - What are your hopes for the future?

How do I help patients to stay safe?

A **safety guide** is a prioritized written list of coping strategies and sources of support. Here are some resources you can use when you want to contract with your patient for safety.

- **Safety Planning Quick Guide for Clinicians: health.maryland.gov/bha/suicideprevention/Documents/Suicide prevention tool kit/Risk management and reduction/safety planning/SafetyPlanningGuide Quick Guide for Clinicians.pdf**
- **Suicide Safe by SAMHSA (Substance Abuse and Mental Health Services Administration): store.samhsa.gov/product/suicide-safe**
- **Patient Safety Plan template: mysafetyplan.org**
- **Stanley-Brown Safety Plan: suicidesafetyplan.com**

What else can I do to support patient safety?

- **Learn your local resources**, including your local mobile crisis unit, to aid with referrals for patients with mental health or substance use disorders.
- **Ensure scheduling of postpartum follow-up appointments** for individuals with history of mood disorders or substance use disorders.
- **Find out if your patient has started or stopped taking any medications during pregnancy or lactation.** Some medications have been found to be associated with an increased risk of suicidality. Stopping medications abruptly can increase the risk of mood symptoms and therefore increase the risk of suicide.

Additional resources

Perinatal Psychiatry Consultation Line for Providers (Perinatal PCL) (Washington)
Perinatal PCL is a free, state-funded program providing perinatal mental health consultation, recommendations and referrals for Washington state providers caring for pregnant or postpartum patients.

This service is operated through Partnership Access Line for Moms – WA (PAL for Moms WA), a program of the University of Washington Psychiatry and Behavioral Sciences Department and funded by Washington State Health Care Authority.

To **contact a perinatal psychiatrist or mental health professional** for support, please call: 877-725-4666 (PAL4MOM). Available weekdays from 9 a.m. to 5 p.m. (Pacific Time).

If your **patient is actively suicidal**, call the **Crisis Connections 24-Hour Crisis Line:** 866-427-4747

Supply these **national hotline numbers** to your patient:

- **National Maternal Mental Health Hotline:** 1-833-TLC-MAMA (1-833-852-6262)
- **National Suicide Prevention Lifeline:** 988
- **National Domestic Violence Hotline:** 800-787-3224

Resources

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Maternal sleep toolkit

Key facts[1]

- Physiologic changes of pregnancy can make sleep more difficult. Sleep disturbances affect 75% of pregnant people, peaking in the third trimester.
- Insomnia (38%), restless leg syndrome (20%), and sleep apnea (15%) are the most common sleep disturbances affecting pregnant people.
- Insomnia and sleep disturbances during pregnancy are associated with gestational diabetes, hypertension, preterm birth, cesarean delivery, and preeclampsia/ gestational hypertension.

Course of action

1. Identify causes
   - Use the Global Sleep Questionnaire in this toolkit to identify possible causes
   - Incorporate health disparity and pregnancy-specific considerations from this toolkit
2. Implement treatment based on etiology
3. Provide resources and monitor outcomes

Common etiologies for poor sleep during pregnancy[2,3]

	Medical			Psychiatric
Common risk factors and comorbidities	• Thyroid Disorder • Diabetes • Renal Disease • Anemia • Fibromyalgia • GERD	• Migraines • Epilepsy • Bruxism • Obstructive Sleep Apnea • Asthma	• Restless Leg Syndrome • Chronic Pain	• Depression • Anxiety • PTSD • OCD • Bipolar
Review med list for culprits*	• Central nervous system stimulants • Central nervous system depressant • Bronchodilators • Antidepressants			• Beta antagonist • Diuretics • Glucocorticoids
Orders and referrals to consider (for diagnostic clarity)	• Thyroid function test (TFT) • Blood sugar & HbA1c • BUN & creatinine • Iron studies • Sleep consult or polysomnogram (PSG)			• History taking • Screeners • Perinatal PCL consult for diagnostic clarity

*Meds that might cause or exacerbate sleep disturbances

Screening for sleep disturbances

What do I say?

"Many pregnant people have problems with sleep during pregnancy and in the postpartum period. People don't sleep well for a lot of different reasons. The good news is that there are many things that we can try to help you get some more sleep. Let's talk a little more to figure out what might be keeping you from sleeping well."

To assess outcomes and guide treatment, consider the following screeners and diary

Insomnia Severity Index[4]
A five question scale assessing insomnia.
healthquality.va.gov/HEALTHQUALITY/guidelines/CD/insomnia/CST-03-Insomnia-Disorder-Screening-Guide-Final-508.pdf

Epworth Sleepiness Scale[5]
An eight question scale assessing sleepiness.
cdc.gov/niosh/work-hour-training-for-nurses/02/epworth.pdf

Consensus Sleep Diary[6]
A weekly sleep diary, available to print or download the app.
Print: cbtiweb.org/ResourceFiles/Consensus%20Sleep%20Diary%20(CSD)%20(1).pdf
Download app: consensussleepdiary.com

Global Sleep Assessment Questionnaire And Treatment Considerations[7,8]

The Global Sleep Assessment Questionnaire is a comprehensive screening tool for use in primary care. Consider the following diagnoses and interventions based on questionnaire responses.

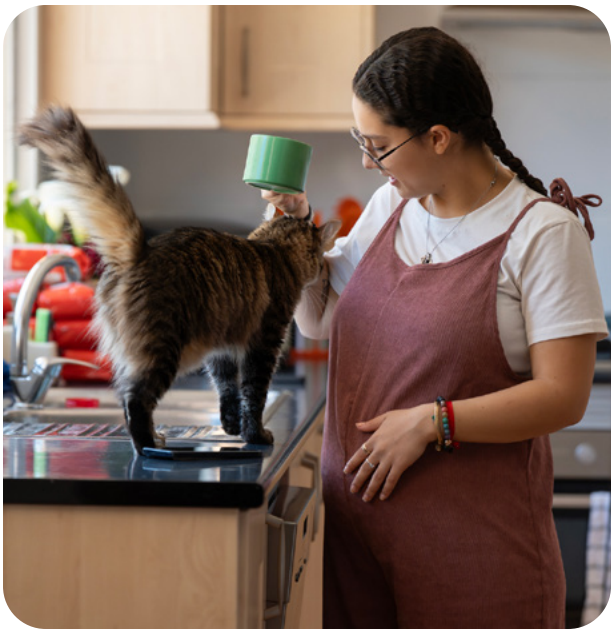
Global Sleep Assessment Questionnaire resource: **sleep.pitt.edu/sites/default/files/assets/Instrument%20Materials/GSAQ.pdf**

Questions	Consider diagnosis of...	Medical treatment		Psychiatric treatment		Sleep hygiene and education
		Treatment based on diagnosis	Sleep consult	Treatment based on diagnosis	CBT-I	
Do you have difficulty falling asleep, or feeling poorly rested in the morning?	Insomnia; Obstructive sleep apnea; Psychiatric	✓	✓	✓	✓	✓
Do you fall asleep unintentionally or have to fight to stay awake during the day?	Insomnia; Obstructive sleep apnea		✓		✓	✓
Do sleep difficulties or daytime sleepiness interfere with your daily activities?	Life activities; Insomnia; Psychiatric; Medical; Obstructive sleep apnea	✓	✓	✓	✓	✓
Do work or other activities prevent you from getting enough sleep?	Life activities					✓
Do you snore loudly?	Obstructive sleep apnea		✓			
Did you hold your breath, have breathing pauses, or stop breathing in your sleep?	Obstructive sleep apnea		✓			
Did you have restless or "crawling" feelings in your legs at night that went away if you moved your legs?	Restless leg syndrome	✓				✓
Did you have repeated leg jerks or leg twitches In your sleep?	Periodic limb disorder	✓	✓			
Do you have nightmares, or did you scream, walk, punch, or kick in your sleep?	Parasomnia; Psychiatric		✓	✓		
Did the following things disturb your sleep? Pain, other physical problems, worries, medications, other?	Life activities; Medical; Psychiatric	✓		✓		✓
Did you feel sad or anxious?	Psychiatric			✓	✓	✓

Note: Information in the header of the Global Sleep Assessment Questionnaire may facilitate detection of sleep disturbances (i.e. work shift data may aid in detection of circadian rhythm disorders). Also of note, this questionnaire does not screen for narcolepsy. Additional research on the validity of this screener is needed.

Screeners in this toolkit are available online and may require permission for reuse.

Pregnancy-specific considerations[9,10,11]



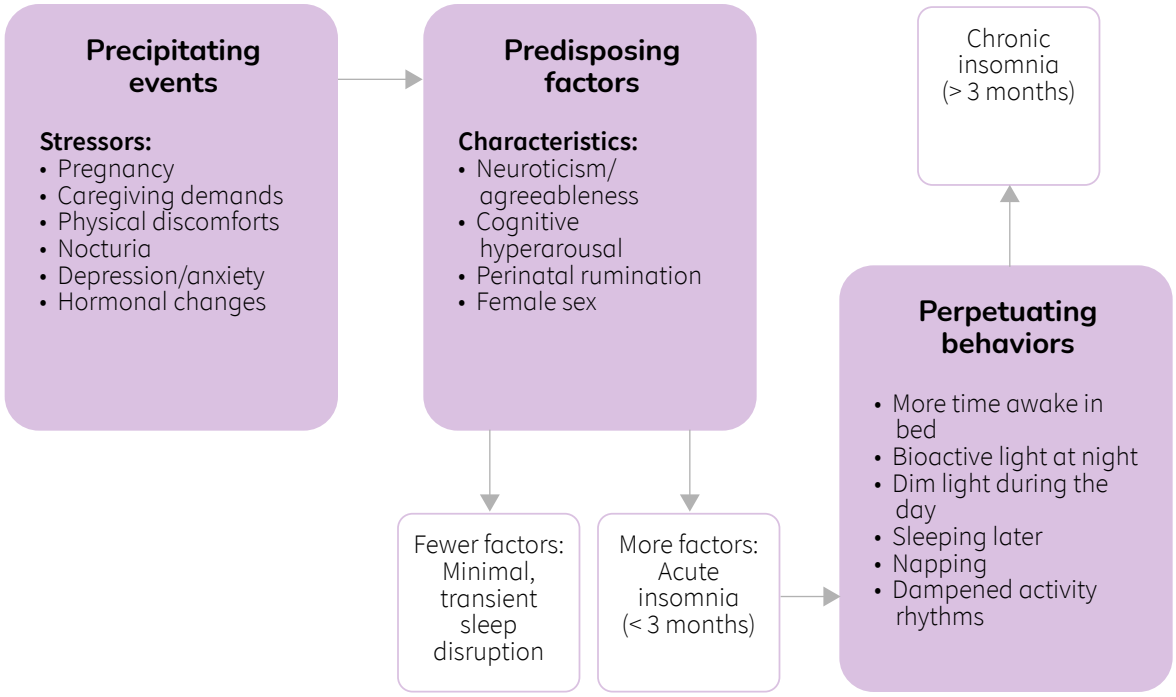
- Mental burden of adjusting to pregnancy
- Lifestyle, financial, and relationship changes
- Pressure on lungs affecting breath
- Pressure on bladder affecting urination
- Hormonal changes (e.g. estrogen and progesterone)

Common diagnoses: Insomnia, sleep apnea, restless leg syndrome

Insomnia[12]

Insomnia is classified into three categories: early (difficulty falling asleep); middle (difficulty staying asleep); and late (waking up too early). The disruption is distressing and results in daytime functional impairments.

3 P Model of Insomnia (as applied to the perinatal period)[13,14]



Sleep apnea[15,16]

- Sleep-disordered breathing is associated with obesity, hypertension disorders of pregnancy, gestational diabetes, and cardiomyopathy.
- Obstructive sleep apnea is associated with increased maternal morbidity and mortality, and increased risk for anesthesia complications.
- Frequent snoring is the most common symptom. Refer for a sleep consult for severe daytime drowsiness, debilitating fatigue, and other significant symptoms.
- Cpap settings may need to be adjusted in pregnancy for pre-existing sleep apnea.

Restless leg syndrome[17,18]

- Criteria used to confirm diagnosis:
  - Urge to move legs with unpleasant sensations,
  - Symptoms worsen with rest or inactivity,
  - Symptoms relieved with movement,
  - Symptoms worsen in the evening
- Can be a primary or secondary diagnosis; consider medications that may exacerbate (e.G. Some neuroleptics, antiemetics, antihistamines), end-stage renal disease, iron or folate deficiency (consider supplementation if indicated), and others.
- Benefits of non-pharmacologic measures are not well- studied, exercise in the first part of the day may be beneficial.

How do I help my patients?

Key: Pharmacological Non-pharmacological

Less severe

Severity of symptoms

More severe

Sleep hygiene

Provides basic support. Ineffective as standalone treatments for chronic insomnia.

Sleep hygiene basics:

- Avoid napping
- Limit caffeine
- Avoid nicotine and alcohol
- Exercise
- Quiet & dark sleep environment
- Use a clock (no electronic devices)
- Avoid large meals in the evening

Sleep education[19,20]

Provides basic support. Ineffective as standalone treatments for chronic insomnia.

Check out **babysleep.com** for expert tips on infant sleep.

Raise awareness and educate about:

- Perinatal-specific anatomical and physiological changes
- Beneficial lifestyle adjustments for stressors
- Detrimental practices based on misinformation

Additional considerations when addressing sleep concerns with your patient

Realistic expectations:

- Have household tasks been simplified?
- Have work adjustments been considered? (e.g. travel, FMLA usage, etc)
- Have you offered education on typical newborn sleep?

Social support:

- Are there concerns about interpersonal violence?
- How is the family adjusting to the pregnancy and/or new baby?
- Has sleep been prioritized over other activities?
- Would a sleep "prescription" be helpful?

Infant feeding:

- Has infant feeding been optimized? (Breastfeeding generally does not shorten nighttime sleep.)
- Have you evaluated for breastfeeding problems (e.g. mastitis, sore nipples, etc.)?

Infant sleep:

- Have you discussed a safe sleep environment for both parents and baby?
- Have you offered behavioral interventions for sleep?

Cognitive Behavioral Therapy-Insomnia (CBT-i)[21,22,23]

- First line treatment for chronic insomnia
- 6-8 sessions of therapy, focused on 3 aspects of sleep disturbance
- Treatment during pregnancy can prevent postpartum depression

Find a provider:

- CBTI directory: **cbti.directory** Some therapists may be able to provide telehealth sessions.
- Insomnia Coach: **mobile.va.gov/app/insomnia-coach** A free app from the VA.

CBT-i for pregnancy[24]

- Addresses pregnancy, newborn, and family dynamics
- Sleep restriction gudiance is modified to increase flexibility in bed/wake times

Components and purpose of CBT-i

- **Sleep education:** Improve understanding of normal sleep and behaviors that affect sleep
- **Cognitive therapy:** Change dysfunctional beliefs about sleep to reduce fear, anxiety, and effort around sleep
- **Behavioral**
  - **Sleep restriction:** Improve sleep efficiency by reducing time awake in bed and set stable schedule
  - **Stimulus control:** Reduce stimuli that increases wakefulness before and during sleep time
  - **Relaxation:** Reduce mental activity and physical tension before bed

Medications

Consider with these factors: Non-pharmacological treatment is ineffective, insomnia is severe, and/or benefits outweigh the risks.

For considerations for medication use for sleep management during pregnancy and lactation, visit the **PERC care guide** at **perc.psychiatry.uw.edu/wp-content/uploads/2024/02/Perinatal-Sleep-Care-Guide.pdf**

Resources for patients

Help with sleep management during pregnancy and lactation

Remember, we can't force ourselves to sleep...Just like our kids need a bedtime routine, adults also need signals that tell our bodies that it's time to sleep.

Sleep safety
safesleepnc.org

Sleep advice
babysleep.com

CBT-i App (free)
mobile.va.gov/app/cbt-i-coach

Medication safety
mothertobaby.org

Ask your provider for a "prescription" for sleep or extra help to share with loved ones using the form below.

Prescription for sleep

Dear _____ friends and family,
Patient name

_____ has recently given birth to _____.
Patient name *Baby name*

I would like to request your support for adequate rest and sleep for them.

Please consider helping them in the following ways so they can nap/rest:

- ☐ Make the beds
- ☐ Hold the baby
- ☐ Make a meal
- ☐ Prepare snacks (like chop fruits and veggies)
- ☐ Wash/load/unload the dishes
- ☐ Load/fold laundry
- ☐ Water the plants
- ☐ Walk the dog/empty the kitty litter
- ☐ Vacuum/dust
- ☐ Clean: _____
- ☐ Play with other kids
- ☐ Take the kids outside to play or for a walk
- ☐ Help the kids with homework/bedtime or nap routine/bathing/meal or snack
- ☐ Take/pick-up kids to/from school or activities
- ☐ Drive _____ to work
- ☐ Other: _____

Thank you for your support!

_____
Provider signature

My pregnancy bedtime checklist

Having a routine can help signal to our bodies that it's time to sleep.

My bedtime is: _____ am / pm

- ☐ Use this tool to calculate your bedtime: **sleepeducation.org/healthy-sleep/bedtime-calculator**
- ☐ Get up at the same time every day, even on weekends or during vacations

Every day:

- ☐ Get some exercise (the recommendation is generally 150 minutes per week)
- ☐ Eat healthy foods

10 hours before bed: _____ am / pm

- ☐ Stop drinking caffeine (limit total daily caffeine to <200 mg)
- ☐ Use this calculator to calculate your caffeine intake: **tommys.org/pregnancy-information/calculators-tools- resources/check-your-caffeine-intake-pregnancy**

60 minutes before bed: _____ am / pm

- ☐ Adjust temperature to make house cooler
- ☐ Lower the lights
- ☐ Consider a healthy snack (do not eat a meal before bed)
- ☐ Stop drinking fluids
- ☐ Elevate feet if they are swollen
- ☐ Consider making a 'to-do' list to help your mind unwind
- ☐ Try journaling if you mind is busy

30 minutes before bed: _____ am / pm

- ☐ Turn off electronic devices
- ☐ Do something relaxing to help your body unwind

These activities help me relax (check all that apply):

- ☐ Warm shower or bath
- ☐ Reading
- ☐ Music
- ☐ Deep breathing, body scan or other mindfulness activity
- ☐ Other: _____

Not asleep after 20 minutes?

- ☐ Get out of bed
- ☐ Go do a quiet activity without a lot of light exposure (read or audio content that is not too stimulating)
- ☐ Do not use electronics

Note: This is not intended to be medical advice—talk to your provider about what's right for you.
This checklist was developed by Karen Saxer based on and as a complement to the 4th Trimester Project Materials. 4th Trimester Project materials are available at **newmomhealth.com/toolkit/postpartum-plan-for-new-parents**

Additional resources for providers

Perinatal Psychiatry Consultation Line for Providers (Perinatal PCL) (Washington)

Perinatal PCL is a free, state-funded program providing perinatal mental health consultation, recommendations and referrals for Washington state providers caring for pregnant or postpartum patients.

Schedule a consultation: **perinatalpcl.as.me/schedule.php**.

Call: 877-725-4666 (Available Mon–Fri, 9 AM–5 PM, closed UW holidays)

Email: ppcl@uw.edu

Website: **perc.psychiatry.uw.edu/perinatal-pcl**

Information on medication use during pregnancy and infant feeding

Mother to Baby

- Fact sheets on perinatal exposures to share with patients
- Chat with an exposure expert, enroll your patient in observational studies, or schedule a patient consult
- Website: **mothertobaby.org**

Lactmed

- Database on exposure of drug and chemicals to which a breast/chest-feeding parent may be exposed
- Website: **ncbi.nlm.nih.gov/books/NBK501922**

Sleep safety in babies and young children

Safe to Sleep

- Sharable patient resources
- SIDS science and research updates
- Website: **safesleepnc.org**

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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/**.

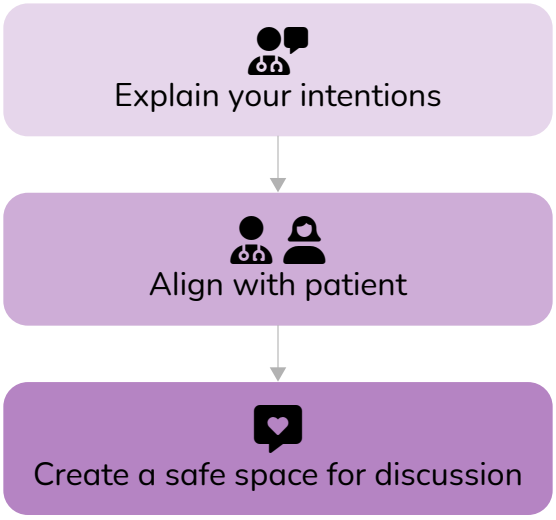
HCA 82-0660 (09/25)

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

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