Screening for Depression, Anxiety and Substance Use in the Perinatal Period

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RI MomsPRN
Maternal Psychiatry Resource Network

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Why do we care about Women's Mental Health?

- **"Depression is the leading cause of lost years of healthy life among women."**
- **Active maternal mental illness carries risks to the mother, fetus, and infant**

World Health Organization

Perinatal Depression and Anxiety

- **COMMON**
  - **Prevalence: 15% - 21% (all PMADs)**
  - **The *most common, unrecognized* complication of the perinatal period (compare to 2-5% gestational diabetes)**
- **MORBID**
  - **Devastating consequences for women, infants and families:**
    - **Poor maternal nutrition**
    - **Missed prenatal appointments**
    - **Low birth weight**
    - **Preterm birth**
    - **Small for gestational age**
- **TREATABLE**

Byrnes (2019) Arch Psych Nursing
Davalos et al (2012) Arch Women Ment Health 15:1-14
Gavin et al (2005) Obstetrics & Gynecology:
Gaynes et al (2005) AHRQ Systematic Review;
Grigoriadis S et al (2017)Canad Medic Assoc J 189(34)

Perinatal Substance Use

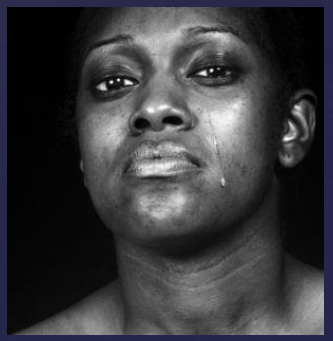
- **ON THE RISE**
  - **Prevalence: up to 10% consume alcohol and 3% binge drink during pregnancy**
  - **2% report illicit opioid use**
  - **# of women with OUD at labor and delivery quadrupled from 1999 to 2014**
- **MORBID**
  - **Impaired decision-making and parenting**
  - **Family more likely to become involved with legal and child welfare agencies**
  - **Risk of Neonatal Abstinence Syndrome (NAS)**
- **TREATABLE**

Ordean et al. (2017) Substance abuse: research and treatment
U.S. Center for Disease Control and Prevention (2018)

Risk Factors

Women with:

- Prior history of PPD or MDD
- Family History
- Depression during Pregnancy*
- Intimate Partner Violence
- Absence of support
- Primary relationship distress
- Single parenthood
- Current or historical stressful life events (poverty, trauma, death in family)



English et al (2018) Scientific Reports; Lancaster CA et al (2010) et al Am J Ob Gyn,; Koleva et al (2011) Arch Women's Ment Health; Gavin et al. (2005) Obst & Gyn; Gaynes et al. (2005) AHRQ Systematic Review

Screening: Gaining Traction

- Recording of Depression Dx increased 7-fold from 2000-2015 in 27 of 28 states analyzed in women admitted for delivery.

Haight SC et al (2019) Obstet Gynecol 13 (6): 1216-1223.

ACOG Committee Opinion November 2018

- Screen at least once during the perinatal period
- Full assessment of mood and emotional well-being during comprehensive postpartum visit
- Screen for depression and anxiety symptoms
- Use a standardized, validated tool (EPDS or PHQ-9)
- Closely monitor women with current symptoms, known histories or risk factors
- With positive screens, be prepared to initiate medication and/or refer to appropriate behavioral health specialists
- Systems should be in place to ensure follow-up for diagnosis and treatment

ACOG Committee Opinion N0. 757 (2018)

Tuesday October 29, 2019

Edinburgh Postnatal Depression Scale (EPDS)

- Most commonly used screen for PPD world-wide
- 10 items and available in 23 languages
- Easily administered and scored. Available on the Internet
- Validated for use with adolescents
- Validated for use with pregnant women
- High sensitivity 78%(identified correctly as depressed)
- High specificity 99% (identified correctly as non-depressed)
- Only stipulation is that Dr. Cox be cited as the author on copies administered

Moraes et al (2016) Trends Psychiatry Psychother
Longsdon MC et al (2009) Archives of Women's Ment Health 12: 433-40
Bergink V et al (2011) J Psychosom Res 70: 385-9

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Edinburgh Postnatal Depression Scale (EPDS)

- The mother is asked to check the response that comes closest to how she has been feeling ***in the previous 7 days.***
- All the items must be completed.
- The mother should complete the scale herself without discussing with others, unless she has difficulty with reading

Maximum score: 30
Possibly depressed: 13 or greater
Always look at item 10 *(thoughts of self-harm/suicide)*

Cox et al (1987). *British Journal of Psychiatry* 150:782-786

Patient Health Questionnaire-9 (PHQ-9)

- Free & available for download at https://www.phqscreeners.com/
- Available in 30+ languages
- Validated for use with pregnant women
- High sensitivity in pregnancy (85%)
- High specificity in pregnancy (84%)
- Validated for use with adolescents
- Easily administered and scored
- 9 items
- Commonly utilized worldwide

Kroenke K, Spitzer RL. Psychiatric Annals 2002;32:509-521.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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Patient Health Questionnaire-9 (PHQ-9)

- The patient is asked to respond to each of the 9 items based on how they've been feeling ***over the last 2 weeks.***
- The final question asks the patients to report – *"How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?"*
  - not used in calculating score but represents the patient's global impression of symptom-related impairment
  - may be useful in decisions regarding initiation of or adjustments to treatment

Maximum score: 27
Possibly depressed: 10 or greater
Always look at item 9 *(thoughts of self-harm/suicide)*

Kroenke K, Spitzer RL. Psychiatric Annals 2002;32:509-521.

Generalized Anxiety Disorder – 7 (GAD-7)

- Free & available for download at https://www.phqscreeners.com/
- Available in 30+ languages
- Validated for use with pregnant women
- Good sensitivity in pregnancy (73%)
- Good specificity in pregnancy (67%)
- Easily administered and scored
- 7 items

Spitzer et al (2006), *Arch Intern Med* 166:1082-1097
Sinesi et al (2019) *BJPsych Open* 5(1)

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Generalized Anxiety Disorder – 7 (GAD-7)

- The patient is asked to respond to each of the 9 items based on how they've been feeling ***over the last 2 weeks.***
- Designed primarily for Generalized Anxiety Disorder but has moderately good operating characteristics for Panic Disorder, Social Anxiety Disorder and Post-traumatic Stress Disorder

Maximum score: 21
Possible anxiety: 7 or greater

Kroenke K, Spitzer RL. Psychiatric Annals 2002;32:509-521.

Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

- Free & available online
- Available in English and Spanish
- Validated for use in pregnant women
- High sensitivity in pregnancy (94%)
- High specificity in pregnancy (84%)
- Easily administered and scored
- 3 items

Dawson et al (2005) *Alcoholism: Clinical and Experimental Research, 29*(5), 844–854.
Bush et al (1998) *Arch Internal Med 3: 1789-1795*

AUDIT-C Questionnaire (modified)

Name: _____ Date: _____

These questions refer to the last 12 months, *excluding the time during which you knew you were pregnant*.

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

Alcohol Use Disorders Identification Test-Concise (AUDIT-C)

- The patient is asked to answer the 3 questions about frequency of alcohol consumption, based on the last 12 months, ***excluding the time during which they knew they were pregnant.***
- **In perinatal women, a score of 3 or more is considered positive.** ***However, when the points are ALL from Q1 alone (Q2 and Q3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake in the last few months prior to pregnancy to confirm accuracy.***

Maximum score: 12
Possible alcohol misuse: 3 or greater

Kroenke K, Spitzer RL. Psychiatric Annals 2002;32:509-521.

Drug Abuse Screening Test-10 (DAST-10)

- Free & available online
- Available in English and Spanish
- Validated for use in pregnant women
- High sensitivity in pregnancy (80%)
- Good specificity in pregnancy (68%)
- Validated for use with adolescents
- Easily administered and scored
- 10 items, Yes/No

Lam et al (2019), *Scientific Reports*, 5
Yudko et al (2007) *Journal of Substance Abuse Treatment*. 32(2):189-198.

DAST-10 Questionnaire

These questions refer to the last 12 months, *excluding the time during which you knew you were pregnant.*	**No**	**Yes**
1. Have you ever used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you feel bad or guilty about your drug use? (If never use drugs, choose "No.")		
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.?)	0	1

Drug Abuse Screening Test-10 (DAST-10)

- The patient is asked to answer 10 YES/NO questions based on the past 12 months, ***excluding the time during which they knew they were pregnant***
- "Drug abuse" refers to the use of prescribed or over-the-counter medications/drugs in excess of the directions AND any non-medical use of drugs
- Questions ***do not include alcohol or tobacco***.

Maximum score: 10
Possibly substance misuse: 1 or greater

Screening: What to ask

- *How are YOU doing?*
- *Are you feeling moodier than normal?*
- *How is your sleep? Can you sleep when the baby sleeps?*
- *Even though everyone expects this to be a happy time, many women who have just had a baby feel sad, nervous, irritable or just "not themselves". Has this been your experience?*

Dawson et al (2005) *Alcoholism: Clinical and Experimental Research, 29*(5), 844–854.
Bush et al (1998) *Arch Internal Med 3: 1789-1795*

Screening: What to look for

- *Tearfulness*
- *Appearing unusually tired*
- *Disheveled, poor hygiene*
- *Poor eye contact*
- *Irritability*
- *Discomfort holding/handling the baby*
- *Significant weight loss*
- *Excessive concern about the baby despite reassurance*

Dawson et al (2005) *Alcoholism: Clinical and Experimental Research, 29*(5), 844–854.
Bush et al (1998) *Arch Internal Med 3: 1789-1795*

Screening: Assessing Risk of Harm

Suicidal Ideation	
HIGHER RISK	**LOWER RISK**
• Hx of Attempts • High lethality of past attempts • Hx of significant mental illness requiring admissions • Current plan/intent • Substance abuse • Unstable social situation • No protective factors	• No Hx of Attempts • No Hx of significant MH issues • No plan • No intent • No substance use • Protective factors (i.e. social connections, spiritual/religious beliefs, meaningful employment)

Thoughts of Harming Baby	
HIGHER RISK	**LOWER RISK**
• Poor insight • Psychotic symptoms • Delusional beliefs with distortion of reality	• Thoughts are intrusive and disturbing • No psychotic symptoms • Thoughts cause fear/anxiety • Good insight

Adapted from MCPAP for Moms (2017).
Morriss et al(2013). *BMJ: British Medical Journal, 347*(7928), 33-35.

Positive Screen

- Utilize established clinical protocols
- Call 401-430-2800 ***RI MomsPRN*** (located at Women's Behavioral Health - 2 Dudley)
- Initiate Treatment
- Refer

RI MomsPRN Services

Resource and Referral Specialist (Social Worker)	Clinical Consultation (Psychiatrist and Psychologist)	Continuing Education
• Call intake and triage • Make connections to treatment and support services • Schedule provider teleconsultation with perinatal behavioral health experts	• Same day provider-to-provider teleconsultation services • Diagnostic support • Treatment planning • Medication and dosage recommendations • Advisement about prescription concerns	• Deliver continuing medical education sessions on a variety of perinatal behavioral health topics • Provider "toolkit" including screening tool guidelines and tips for teleconsultation

RI MomsPRN
Maternal Psychiatry Resource Network

Calling RI MomsPRN

RI MomsPRN is a psychiatric telephone consultation and support service that can help healthcare providers with diagnosis, treatment planning, and medication management of pregnant and postpartum patients experiencing depression, anxiety, substance use disorder, or other mental health concerns.

Call 401-430-2800
Monday – Friday, 8 a.m. – 4 p.m.

RI MomsPRN Staff

- **Zobeida Diaz, MD**; Perinatal Psychiatrist
- **Margaret Howard, PhD**; Perinatal Psychologist
- **Eva Ray, LICSW**; Perinatal Resource and Referral Specialist

When calling RI MomsPRN, please be prepared to provide the following information to the Resource and Referral Specialist:

Provider Information

- ✓ Provider name
- ✓ Practice name
- ✓ Call-back phone number
- ✓ Best time(s) for a callback
- ✓ Did patient consent to provider contact with RI MomsPRN?
- ✓ Primary concern or question

Patient Information

- ✓ Patient name
- ✓ Patient insurance information and demographics (date of birth, race, ethnicity, address)
- ✓ Reproductive status
  - Number of weeks pregnant/postpartum
  - Pre-conception
  - Perinatal loss
- ✓ Lactation status
- ✓ Current and past psychiatric diagnoses and medication(s)
- ✓ Safety concerns
  - Current or past suicide ideation and/or attempt?
  - Risk to self or others?

Additional Information (if applicable/available)

- ✓ Screening tools administered and scores
  - EPDS
  - PHQ-9
- ✓ Pertinent psychosocial history
- ✓ Pertinent family psychiatric history

RI MomsPRN
Maternal Psychiatry Resource Network

Women & Infants

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Thank You and Questions

RI MomsPRN
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