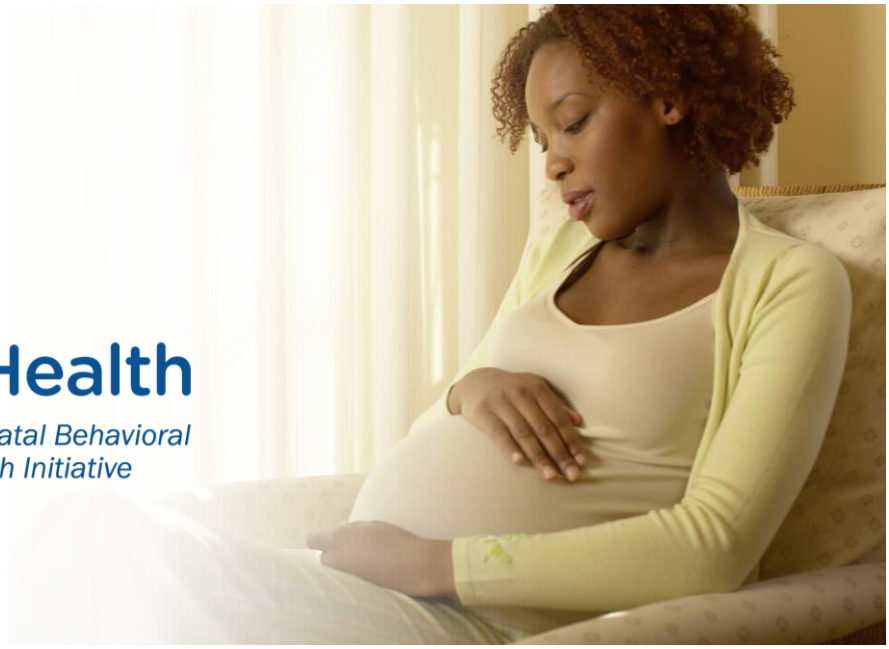

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Perinatal Behavioral Health Initiative

Perinatal Mood and Anxiety Screening Toolkit

Executive Summary

Creating a Universal Screening Protocol has been a central part of the Perinatal Behavioral Health Initiative's work to promote the health of mothers and babies in St. Louis. This toolkit was created to be a user-friendly method of accessing the recommendations and the screens that are considered best practice for addressing Perinatal Mood and Anxiety Disorders or PMAD. PMAD are a spectrum of disorders that may include-Depression, Anxiety, Panic Disorder, Bi-Polar, OCD, PTSD, and Psychosis; and can develop anytime during the perinatal period. The language for postpartum depression (PPD) has evolved to be more inclusive encompassing the experiences of women over the life course. PMAD can occur with no previous history of anxiety or depression and can happen to anyone in any walk of life whether they have risk factors or not. By using evidence-based screens rather than ones created by individual organizations, we can ensure that Black mothers are not "slipping through the cracks" and are receiving the care they deserve from their providers. This toolkit contains screening recommendations in the areas of Depression, Anxiety, Substance Use, and Intimate Partner Violence.

Furthermore, this toolkit provides guidance on how to integrate recommended screens into practice for providers as well as suggestions on how to respond when a woman screens for concern. By using these guidelines to screen perinatal women, we can all work together to support healthy families where children can grow and thrive.

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Screening Recommendations

Generate Health (Based on Professional Recommendations)	Pregnancy: • 1 screen/trimester. Post-partum: • Six-week postpartum obstetrical visit (or at first postpartum visit). • OB and primary care settings: Repeated screening every 6 and/or 12 months up to 3 years postpartum. • Pediatric settings: 3, 9, and 12 month well baby visit.

American College of Obstetricians and Gynecologists (ACOG)	• Screen for depression and anxiety symptoms at least once during perinatal period. • Complete a full assessment of mood and emotional well-being (including depression and anxiety) during the comprehensive postpartum visit. • If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum
American Academy of Pediatrics	Screen at 1, 2, 4, 6 month visit.
US Preventative Services Task Force (USPSTF)	"A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted."
Postpartum Support International (PSI)	• First prenatal visit. • At least once in second trimester. • At least once in third trimester. • Six-week postpartum obstetrical visit (or at first postpartum visit). • Repeated screening at 6 and/or 12 months in OB and primary care settings. • 3, 9, and 12 month pediatric visits.

Depression and Anxiety Screening Tools

EPDS and PHQ

Edinburgh Postnatal Depression Scale (EPDS)

Background

- The EPDS was developed in health centers in Edinburgh and Livingston Scotland in 1987 by researchers who determined there was a need for a valid test for postnatal women who may be experiencing a mood or anxiety disorder. It was originally only recommended for postnatal women but can now be used for all women in the perinatal phase (Cox, Holden, & Sagovsky, 1987).
- The original intention of the EPDS was to be used in the community by community health workers but it was recognized as useful by nurses and general physicians as well. The screening tool is used in all health settings today from in-home care to pediatric offices (Cox, Holden, & Sagovsky, 1987).
- The EPDS-3 was developed in the interest of time and workflow needs in practices. This scale has been found to have 95% sensitivity and is ideal when not wanting to asses severity of symptoms, but rather detecting if depression is present (Kabir, Sheeder, & Kelly, 2008).

How to Administer

The EPDS is meant to be self-administered and should take no longer than five minutes for a client to complete. However, assistance may be needed if the client is unable to read or write. The following are the instructions from the tool (Cox, Holden, & Sagovsky, 1987):

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous **7 days**.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

How to Score

How to Score

The scoring for the EPDS only requires some simple math. Take extra caution in the questions that are reverse scored:

Questions 1, 2, & 4

These are scored 0, 1, 2, or 3 with the top box assigned a value of 0 and the bottom box assigned a value of 3

Questions 3, 5-10 (Marked with an *)

These are reverse scored, meaning the top box is assigned a value of 3 and the bottom box assigned a value of 1

Maximum Score is 30:

Depression is indicated with a score greater than 10

Pay special attention to answer to question 10 as it indicates suicidal ideation.

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

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Escala Edinburgh para la Depresión Postnatal (EDPS)

Como usted está embarazada o hace poco tuvo un bebé, nos gustaría saber cómo se siente actualmente. Por favor dígame la respuesta que más represente cómo se ha sentido durante LOS ÚLTIMOS 7 DÍAS *y no sólo cómo se ha sentido hoy.*

A continuación se muestra un ejemplo completado:

Me he sentido feliz:

Sí, todo el tiempo ____0
Sí, la mayor parte del tiempo ✔ 1
No, no muy a menudo ____2
No, en absoluto ____3

Esto significa: "Me he sentido feliz la mayor parte del tiempo" durante la última semana. Por favor complete las otras preguntas de la misma manera.

1. Me he podido reír y ver el lado bueno de las cosas:
   Tanto como siempre ____0
   Algo menos que antes ____1
   Mucho menos que antes ____2
   No, en absoluto ____3

2. Me entusiasmo cuando pienso en mi futuro:
   Tanto como siempre ____0
   Algo menos de lo que antes ____1
   Mucho menos de lo que antes ____2
   Prácticamente nunca ____3

3. Me he culpado sin necesidad cuando las cosas marchan mal:
   Casi siempre ____3
   Algunas veces ____2
   No muy a menudo ____1
   Nunca ____0

4. He estado ansiosa y preocupada sin motivo alguno:
   No, en absoluto ____0
   Casi nada ____1
   Sí, a veces ____2
   Sí, muy a menudo ____3

5. He sentido miedo o pánico sin motivo alguno: Sí, bastante ____3
   Sí, a veces ____2
   No, no mucho ____1
   No, en absoluto ____0

6. Las cosas me oprimen o agobian:
   Sí, casi siempre ____3
   Sí, a veces ____2
   No muy a menudo ____1
   No, en absoluto ____0

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   Sí, casi siempre ____3
   Sí, a veces ____2
   No muy a menudo ____1
   No, en absoluto ____0

8. Me he sentido triste y desgraciada:
   Sí, casi siempre ____3
   Sí, bastante a menudo ____2
   No muy a menudo ____1
   No, en absoluto ____0

9. Me he sentido tan infeliz que he estado llorando:
   Sí, casi siempre ____3
   Sí, bastante a menudo ____2
   Ocasionalmente ____1
   No, nunca ____0

10. He pensado en hacerme daño:
   Sí, bastante a menudo ____3
   A veces ____2
   Casi nunca ____1
   No, nunca ____0

Escriba el puntaje aquí: _____

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Patient Health Questionnaire (PHQ)

Background

- The PHQ is based on the 9 criteria of the DSM-5 of depressive disorders: depressed mood, significant weight change or appetite disturbance, sleep disturbance, psychomotor agitation, fatigue, feelings of worthlessness, diminished ability to think or concentrate, suicidal ideation, and anhedonia (Kroenke, Spitzer, & Williams, 2001).
- The PHQ-2 can be used to detect a presence of depression or anxiety symptoms and if either question is positively identified should be followed up with further screening.

How to Administer

This screen is to be self-administered in conjunction with services from a clinician. Assistance may be needed if the client is unable to read or write:

1. The mother is asked to identify the symptoms she identifies with over the **past 2 weeks**.
2. All items must be completed
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

How to Score

The PHQ is used to both score the presence of depressive symptoms and the severity of the symptoms:
Consider each number on the screen to equate to the following:

Not at all = 0
Several Days = 1
More than Half the Days = 2
Nearly Every Day = 3

To score, add up the identified answers and consult the chart below for possible severity of symptoms. It should be noted that this result must be confirmed with the consultation of a certified clinician.

When scoring the PHQ-2, if either question is answered positively this is an indication further screening is needed. Proceed to using the PHQ-9 and following the recommended screening protocol.

Score	Possible Clinical Indication
5-9	Mild depression/anxiety
10-14	Moderate depression/anxiety
15-19	Moderately severe depression/anxiety
20-17	Severe depression/anxiety

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	**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 figety 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	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	_____
Somewhat difficult	_____
Very difficult	_____
Extremely difficult	_____

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A2663B 10-04-2005

Patient Health Questionnaire PHQ-9
Nine Symptom Checklist (Spanish)

Nombre_____ Médico_____Fecha De Hoy_____

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

	Nunca 0	Varios dias 1	Más de la mitad de los dias 2	Casi todos los dias 3
a. Tener poco interés o placer en hacer las cosas	☐	☐	☐	☐
b. Sentirse desanimado/a, deprimido/a, o sin esperanza	☐	☐	☐	☐
c. Con problemas en dormirse o en mantenerse dormido/a, o en dormir demasiado	☐	☐	☐	☐
d. Sentirse cansado/a o tener poca energía	☐	☐	☐	☐
e. Temer poco apetito o comer en exceso	☐	☐	☐	☐
f. Sentir falta de amor propio – o que sea un fracaso o que decepcionara a si mismo/a su familia	☐	☐	☐	☐
g. Tener dificultad para concentrarse en cosas tales como leer el periódico o mirar la televisión	☐	☐	☐	☐
h. Se mueve o habla tan lentamente que otra gente se podria dar cuenta – o de lo contrario, esta tan agitado/a o inquieto/a que se mueve mucho más de lo acostumbrado	☐	☐	☐	☐
i. Se le han ocurrido pensamientos de que sería mejor estar muerto/a o de que haría daño de alguna manera*	☐	☐	☐	☐

---

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

   ☐ Nada en absoluto ☐ Algo difícil ☐ Muy difícil ☐ Extremadamente difícil

3. Si estos problemas le han causado dificultad, ¿le han causado dificultad por dos años o más?

   ☐ Sí, he tenido dificultad con estos problemas por dos años o más.

   ☐ No, no he tenido dificultad con estos problemas por dos años o más.

**Si tiene pensamientos de que es major estar muerto/a o hacerse daño en alguna manera, favor de hablar con su médico, ir a una sala de emergencia o llamar al 911.*

Number of symptoms:_____ Total score:_____

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Patient Health Questionnaire-2 (PHQ-2)

Instructions:

Please respond to each question.

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

Give answers as 0 to 3, using this scale:

0=Not at all; 1=Several days; 2=More than half the days; 3=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

Instructions

Clinic personnel will follow standard scoring to calculate score based on responses.

Total score: _ _

Developed by Drs. R.L. Spitzer, J.B. Williams, K. Kroenke and colleagues with an educational grant from Pfizer, Inc. No permission required to reproduce, translate, display or distribute.

Cuestionario sobre la salud del paciente-2 (PHQ-2)

Durante las *últimas 2 semanas*, ¿qué tan seguido ha tenido molestias debido a los siguientes problemas?	**Ningún día**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3

For office coding: _____*0* _____+_____+_____+_____

= Total Score _____

Adapted from the patient health questionnaire (PHQ) screeners (www.phqscreeners.com). Accessed October 6, 2016. See website for additional information and translations.

Substance Use Screening Tools

CAGE-AID, CRAFFT, and NIDA-modified ASSIST

CAGE-AID

Background

- The CAGE was developed in 1968 at North Carolina Memorial Hospital to identify the presence of alcoholism in patients. The original questionnaire only uses language referencing alcohol in the questions (Ewing, 1984).
- The word CAGE serves as a mnemonic device that stands for the following themes within the questions: (Ewing, 1984)
    - Cut-down
    - Annoyed
    - Guilty
    - Eye-opener
- The CAGE-Aid uses expanded language from the original version to include alcohol and other drugs (Sullivan & Flemming, 2005).

How to Administer

This screening can either be self-administered or done by the clinician.

If self-administered, take into consideration that assistance may be needed if the client is unable to read or write

How to Score

The scoring for the CAGE-Aid is quite simple.

If the client responds “yes” to any of the questions, then it is considered to be a positive score and further action is needed.

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	**YES**	**NO**
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning **to steady your nerves or to get rid of a hangover?**	☐	☐

Scoring
Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	**Sensitivity**	**Specificity**
One or more **Yes** responses	0.79	0.77
Two or more **Yes** responses	0.70	0.85

(Brown 1995)

CRAFFT

Background

- The CRAFFT was developed in 1999 to be a specific tool that can assess alcohol and drug use in adolescents. It was derived by combining themes of questions from other screening tools to make the questions more age-appropriate and relatable to adolescent experiences (Knight & Lydia, 1999).
- The letters of CRAFFT are a mnemonic device for the emphasis of each question in the screening tool (Knight & Lydia, 1999):

  C - car
  R - relax
  A - alone
  F - forget
  F - friends
  T - trouble

How to Administer

The CRAFFT is meant to be administered verbally between a clinician and an adolescent client.

For Part A

Ask all three questions and indicate responses “yes” or “no”

For Part B

If client responded **“no”** to all questions only continue by asking the **CAR** question
If client responded **“yes”** to any of the first three continue by asking all CRAFFT questions

How to Score

The scoring for CRAFFT is very simple. Add up the number of questions the client answered “yes” to.

If they answered “yes” to two or more questions there is a clinical indication for further treatment.

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	No	Yes
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

Part B	No	Yes
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

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NIDA-modified ASSIST

Background

- Adapted from the World Health Organization's screening tool, Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (The NIDA Quick Screen, 2012).
- The screening tool begins with the NIDA Quick Screen that assesses drug use in the past year, followed by the NIDA-modified ASSIST that assesses the drug use in the past year (The NIDA Quick Screen, 2012).

How to Administer

The NIDA-modified ASSIST screen can be either self-administered by the client or done verbally by the clinician. The instructions throughout the screening tool could be confusing for some clients to follow, so a clinician should offer to administer the screen and be there to help (The NIDA Quick Screen, 2012).

The NIDA Quick Screen questions are to be completed first. If the client positively identifies they have used an illegal drug, then proceed with the remainder of the NIDA-modified ASSIST questions. If they identify positively to any of the other questions, proceed to use one of the other recommended screens in this toolkit (The NIDA Quick Screen, 2012).

Throughout the screening tool there are detailed instructions that will guide the clinician to what questions are most appropriate based upon the client's answers.

How to Score

Total the score for questions 2-7 for each identified drug (a-j) in the questions. The sum of these totals is their overall Substance Involvement (SI) score and indicates their level of risk for drug use.

Substance Involvement Score and Drug Use Risk	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

NIDA Quick Screen V1.0[1]

Name: ..... Sex ( ) F ( ) M Age.....

Interviewer..... Date ...../...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the "Monthly" column in the "illegal drug" row.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says **"NO"** for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says **"Yes"** to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website "How to Help Patients Who Drink Too Much: A Clinical Approach" http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says **"Yes"** to **use of tobacco**: *Any* current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see "Helping Smokers Quit: A Guide for Clinicians" http://www.ahrq.gov/clinic/tobacco/clinhlpsmksqt.htm
- If the patient says **"Yes"** to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

Intimate Partner Violence Screening Tool

AAS

Abuse Assessment Screen (AAS)

Background

PBHI contacted the creators of the Abuse Assessment Screen to determine if the screen would remain valid if the terms changed to be more inclusive of LBGTQIA relationships. It was determined this is the case, so the answers a client can select have changed from the original screen.

How to Administer

This screening tool is to be administered by a clinician verbally. It is imperative that this screen is done in a private environment, with the proper consent in place prior to administration, and that the client knows the subject matter is abuse prior to the screen.

How to Score

Any answer of “yes” on the screen should be considered a positive screen for abuse. If this is the case, immediately refer to the next steps for support for abuse.

Abuse Assessment Screen

This tool may be used to quickly screen for intimate partner violence. Prior to use the agency should have record-keeping and confidentiality standards that ensure against disclosure of participant information and maximize participant safety.

****

1. Have you ever been emotionally or physically abused by your partner or someone important to you? Yes____ No____

2. Within the last year, have you been hit, slapped, kicked, pushed, shoved or otherwise physically hurt by someone? Yes ____ No____
If Yes, by whom? (Circle all that apply)
Partner Ex-partner Stranger Other Multiple
Total no. of times _____

3. *(If applicable):* Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone? Yes ____ No____
If yes, by whom? (Circle all that apply)
Partner Ex-partner Stranger Other Multiple
Total no. of times _____

4. Within the last year, has anyone forced you to have sexual activities?
Yes ____ No____
If Yes, who? (Circle all that apply)
Partner Ex-partner Stranger Other Multiple
Total no. of times _____

5. Are you afraid of your partner or anyone you listed above?
Yes ____ No____ Multiple (please list) _____

Administration method: Provide a private and confidential setting. Inform each client that all clients attending this service are being assessed for abuse. Read the Abuse Assessment Screen (AAS) questions to the client.

Scoring procedures: If any questions on the screen are answered affirmatively, the AAS is considered positive for abuse (Weiss, Ernst, Cham, & Nick, 2003).

Follow-up procedures: At a minimum, all agencies should offer clients with positive screens referral sources and legal options (Soeken et al. 1998).

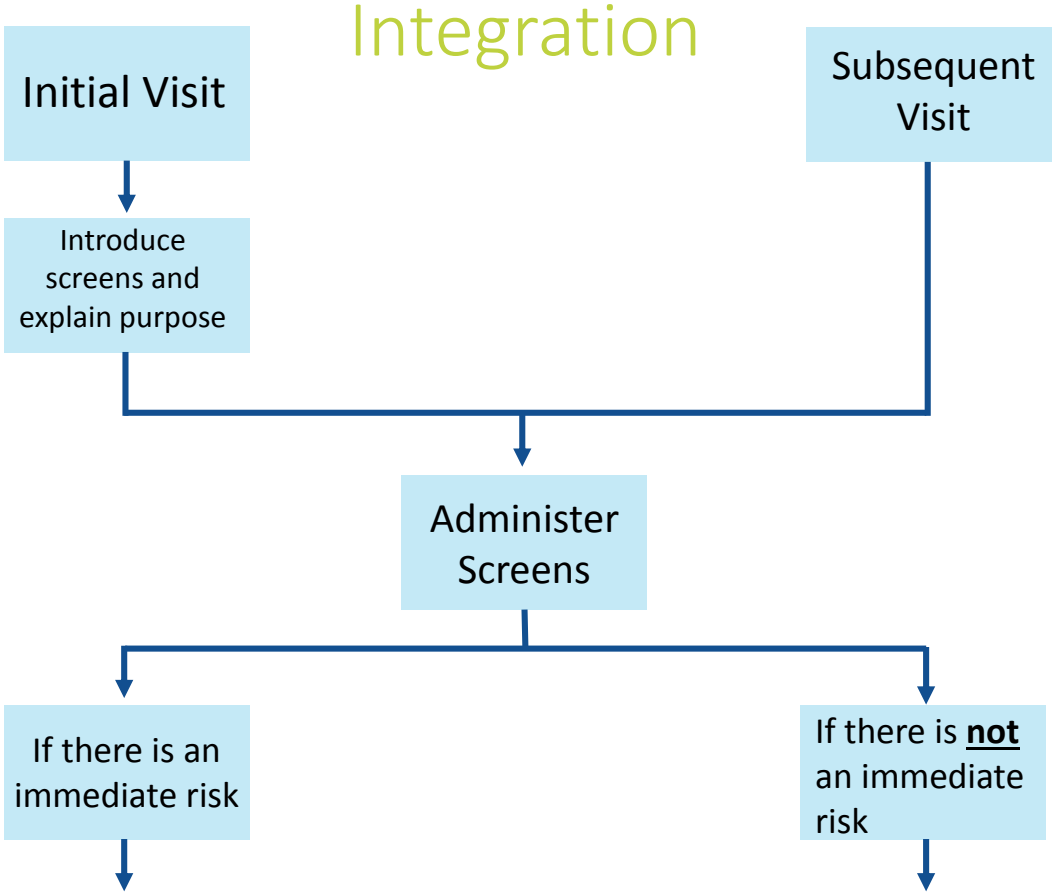
Adapted from Judith McFarlane, Barbara Parker, Karen Soeken, and Linda Bulloc
Copyright (c) 1992, American Medical Association. All rights reserved. Journal of the American Medical Association, 1992, 267, 3176-78.

Workflow Integration

Screening Integration, Counseling/Psychiatric Resources

GenerateHealth

Screening Integration



ASK:
"Have you had any thoughts of hurting yourself?"
"Have you had any thoughts of hurting the baby or anyone else?"

If **"YES"** to either question

- Call or visit to the primary/mental health provider
- Go to the nearest Emergency Department
- Call to 911 or
- Call Behavioral Health Response (BHR)

Crisis Intervention:
1-800-270-0041

Do not leave the caregiver and baby alone while establishing further treatment.

1. Document in chart/EMR
2. Provide support, PMAD Education and resources
3. Assess anxiety/depression symptoms
4. Arrange short term follow up visit
5. Discuss treatment options:
   - Self-care and practical support
   - Refer for counseling and/or **
   - Consider antidepressant therapy
6. Evaluate response to treatment after 4-6 weeks

****See Next Sheet for Counseling/Psychiatric Options**

GenerateHealth

Counseling/Psychiatric Resources

Counseling

Woman chooses **ADDITIONAL Services:**

- Refer woman to Perinatal Resource Network
- Offer list of mental health providers
- Discuss barriers to receiving help (child care/ transportation/co-pays)
- Follow up call in **3 DAYS to check status of MH appointment**

Mental Health Referral:

- Coordinate MH appointment
- Notify PCP/OB about referral plan via phone or EMR
- Discuss barriers to receiving help (child care/ transportation/co-pays)
- Document intervention
- **Follow up call in 1-2 weeks**

Woman **DECLINES** referral:

- Document refusal
- Follow up call/visit
- Notify PCP/OB

Psychiatry

When to Refer or Consult

- Any woman with active bipolar/psychotic disorder or symptoms
- Diagnosis is unclear
- Depression or anxiety that is not responding to antidepressant treatment
- YES for Harm to self/others
- Any other case that is clinically indicated

Washington University-Perinatal Behavioral Health Service (PBHS)

- Psychiatric care in the Perinatal Behavioral Health Clinic
- Psychotherapy onsite within the NICU, OB Clinic, 5300 and in BJH and 4444 Forest Park
- Psychiatric Clinics
- Mental Health Treatment

314-454-5052

Additional Supportive Services

- Screening of pregnant and postpartum women for perinatal depression
- Education on perinatal mood disorders, mindfulness, and emotional regulation, healthy emotional support, self-care, and infant development
- Coordinate referrals

What's Next

Referrals and Treatment Planning, Scoring Response, Receiving a Referral, and Emergency Response

GenerateHealth

Referrals and Treatment Plans

When a consumer is received by the organization who has not been screened or received care previously, the following actions should be taken.

1. Perform all screening with respective tools
2. Assessment with activity of daily living (i.e., DLA-20), develop treatment plan and outcomes and referrals

	Level 1: Low-Moderate Scoring	Level 2: Moderate-Severe Scores
EPDS	10-11: indicates likelihood of depression/anxiety symptoms	12+: Likely to be suffering from a depressive/anxiety condition
PHQ-9:	5-9: mild depression/anxiety 10-14: moderate depression/anxiety	15-19: moderately severe depression/anxiety 20-27: severe depression/anxiety
CRAFFT	"Yes" to 1 question: low concern	"Yes" to 2 or more questions: moderate-severe concern
CAGE-Aid		"Yes" to 1 Question: moderate-severe concern
NIDA-modified ASSIST	0-3: indicates low risk Drug/Alcohol	4-26: moderate risk Drug/Alcohol 27+: high risk Drug/Alcohol
Abuse Assessment		"Yes" to 1 question: indicates abuse

Level 3: Other Reason for Referral	Frequently it takes time to build a relationship with a new consumer/patient. If a new mom scores a 'zero' or if you have reason to be concerned it never hurts to screen a woman. Life changes happen from visit to visit

Scoring Response

Level 1 Response	Level 2 Response	Level 3 Response
Screening scores show possible need for support services and clinical treatment.	Screening scores show increased need for support services and clinical treatment.	Screening scores do not necessarily show need for concern. Alternative reason for referral given.
Provide individual with options, either for support services, clinical treatment, or further assessment.	Refer for psychological evaluation if necessary.	Based on perceived severity, provide options to individual.
Monitor and rescreen based on screening tool recommended intervals.	Provide individual with options for support services, clinical treatment, or further assessment.	If necessary, refer individual to support services and/or clinical treatment services.
	In partnership with individual, refer either internally or externally to organizations in the network for necessary support.	Follow-up with individual to encourage engagement with treatment.
	Follow-up with individual to encourage engagement with treatment.	Monitor and rescreen based on screening tool recommended intervals.
	Monitor and rescreen based on screening tool recommended intervals.	

Receiving a Referral

When a consumer has been screened for concern by another organization and the referral is received, the following actions should be taken.

- Connect with the consumer.
- Collect demographic, PRAMS, and DLA-20 (or other assessment form) information or other evidence based activity of daily living assessment.
- Provide immediate support options if necessary.

Step 1

- If applicable, perform any additional screenings as indicated by the original assessment.
- If the consumer answers **"YES" to Harm to self or others**, there is an automatic requirement to follow up, and an automatic referral to BHR or an equivalent crisis intervention response.

BHR Crisis Intervention:
1-800-270-0041

Step 2

- Confirm consumer diagnosis based on results from screening/assessment tools.
- Discuss diagnosis with consumer in length to ensure understanding.
- Provide options to consumer, including support services and/or clinical treatment services, if necessary.

Step 3

- If applicable, develop a treatment plan up to 3 months in length, including secondary outcomes, in conjunction with the consumer.
- Discuss the developed treatment plan with the consumer to encourage engagement with treatment.
- Follow-up with consumer to monitor compliance with treatment.

Emergency Response

Several of these screens could result in a need for an emergency response from the clinician. When this happens, it is imperative that the clinician responds appropriately to ensure the client and their baby are safe.

If the woman expresses, at any point, thoughts of harm to self or others there is an automatic requirement to immediately follow-up. This may include one or more of the following:

- Call or visit to the primary/mental health provider
- Go to the nearest Emergency Department
- Call to 911 or
- Call Behavioral Health Response (BHR) **Crisis Intervention: 1 – 800 – 270 - 0041**

Other Support Options

National Suicide Prevention Life Line (24 hours)
800-273-8255

SSM MOM's Line (Peer Support Line)
314-768-MOMS
(This is a peer support warm line and does not handle emergencies. Will return call within 24 hours)

Postpartum Support International
For postpartum mood and anxiety disorders
800-944-4PPD (4773)
www.postpartum.net
*PSI is not a crisis hotline and does not handle emergencies. People in crisis should call their physicians, the local emergency line (BHR above) or the National Suicide Prevention number above.

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