# Quick Reference Guide to Maternal Mental Health in the Hospital Setting

*This guide is designed to accompany the online training Maternal Mental Health in the Hospital Setting: What to Know & How to Screen. Always follow your hospital's protocols and procedures.*

## I. Perinatal Mental Health Disorders (PMH)

- Perinatal Mental Health Disorders affect 1:7 mothers.
- Perinatal Mental Health Disorders can occur from conception through one year after birth. If left untreated, women can experience symptoms of depression and anxiety through two years after birth and beyond.
- Baby Blues is not a disorder and resolves on its own by two weeks postpartum.

| Condition | Characteristics |
|---|---|
| Depression | Helplessness, hopelessness, anger, feelings of inadequacy |
| Anxiety | Racing thoughts, inability to settle |
| Bipolar | Episodes of mania paired with periods of depression and low mood |
| OCD | Compulsions and intrusive thoughts – efforts to avoid harm to infant |
| Psychosis | Delusions and hallucinations – require immediate psychiatric attention. High risk with history of bipolar disorder. |
| PTSD | Often related to birth trauma |

## II. Screening

- It's a mother's right to be screened or not screened. It's important to provide the opportunity for informed consent.
- It is best practice for screening to be conducted verbally. However, if your hospital administers the screen by paper, you can introduce it the same way.
- Maintain confidentiality to the best of your ability. Ideally, the screen takes place privately without family members in the room.
- Remain non-judgmental and neutral while completing screening tool.
- Provide psychoeducation to reduce stigma.
- Screening tool results are NOT a diagnosis.

- Screening can and should be done at each contact with the mother from pre-conception through 1-2 years postpartum.
- Universal screening practices normalize conversations about emotional wellness.
- Screening tools are not a replacement for clinical judgment.
- If you have questions or concerns, always seek clinical supervision.

**ACOG recommends** mental health screening take place in the hospital post-delivery before discharge home, in addition to the following: the first prenatal visit, at least once in the second trimester, once in the third trimester, at the six-week postpartum visit and annually at well women exams. It is also recommended that screening take place in the pediatrician's office at the baby's 3, 6 and 12 month well child visits and in the primary care office.

**To facilitate screening**, hospitals need to create welcoming and non-stigmatizing environments that display information about perinatal mental health, thus educating and creating awareness about this important issue for every patient and their support person(s). It is important that screening is done with an inclusive, strength-based approach that emphasizes:

- Perinatal mental health conditions are common.
- They are medical conditions, like diabetes, that need to be treated.
- They are treatable.
- That the hospital screens every woman after childbirth and before discharge.
- The hospital cares for the whole woman.

When administering the screening tool, provide the patient with educational materials that outline relevant symptoms and resources.

## On first contact with patient after delivery ...

*"Hi Anna, I'm glad to see you here today. How are you feeling? I want to ask you a few questions to check-in on how you have been doing to gather as much information as possible in order to best treat you. These questions are standard practice that are asked of every patient, but some of them can be a bit uncomfortable to answer.*

*It is not uncommon for women to have difficult emotions during pregnancy or after childbirth, and if you find that any of these questions resonate with you just know that you are not alone. Having a new baby is a big adjustment for anyone.*

*Okay, let's begin. Over the past 2 weeks have you felt ..."*

## EPDS — Edinburgh Postnatal Depression Screen

| EDPS Score | Interpretation | Action |
|---|---|---|
| Less than 8 | Depression not likely | Continue support and education |
| 9 – 11 | Depression possible | Support, re-screen in 2–4 weeks. Consider referral to Primary Care Provider (PCP). |
| 12 – 13 | Fairly high possibility of depression | Monitor, support and offer education. Refer to PCP. |
| 14 and higher (positive screen) | Probable depression | Diagnostic assessment and treatment by PCP and/or specialist. |
| Positive score (1, 2 or 3) on Question 10 (risk of suicidality) | | Immediate discussion required. Refer to PCP ± mental health specialist or emergency resource for further assessment and intervention as appropriate. Urgency of referral will depend on several factors including: whether the suicidal ideation is accompanied by a plan, whether there has been a history of suicide attempts, whether symptoms of a psychotic disorder are present and/or there is concern about harm to the baby. |

*Source: BC Reproductive Mental Health Program and Perinatal Services BC. (2014), Best Practice Guidelines for Mental Health Disorders in the Perinatal Period.*

## PHQ-9 Patient Health Questionnaire

| PHQ-9 Score | Interpretation | Action |
|---|---|---|
| 0 – 4 | Minimal risk of depression | Continue support and education |
| 5 – 9 | Mild risk of depression | Continue support, education, and monitor. Re-screen often. Provide resources. |
| 10 – 14 | Moderate risk of depression | Refer to PCP ± mental health services for follow-up. Re-screen often. |
| 15 – 19 | Moderately severe risk of depression | Refer to PCP ± mental health services for follow-up. Re-screen often and monitor closely. Treatment plan that includes psychotherapy and possibly medications. |

| PHQ-9 Score | Interpretation | Action |
|---|---|---|
| 20 – 27 | Severe risk of depression | Initiate immediate referral to psychiatric collaborative care, psychiatric evaluations and/or therapy with close monitoring. |
| Positive score (1, 2 or 3) on Question 9 (risk of suicidality) | | Immediate action and referral to mental health care. Refer to PCP ± mental health specialist or emergency resource for further assessment and intervention as appropriate. Urgency of referral will depend on several factors including: whether the suicidal ideation is accompanied by a plan, whether there has been a history of suicide attempts, whether symptoms of a psychotic disorder are present and/or there is concern about harm to the baby. |

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

## GAD-7 — Generalized Anxiety Disorder Screen

| GAD-7 Score | Interpretation | Action |
|---|---|---|
| 0 – 4 | Minimal risk of anxiety | Continue support and education |
| 5 – 9 | Mild risk of anxiety | Continue support, education, and monitor. Re-screen often. Provide resources. |
| 10 – 14 | Moderate risk of anxiety | Refer to PCP ± mental health services for follow-up. Re-screen often. Assess for SI/HI and intrusive thoughts. |
| 15+ | Severe risk of anxiety | Refer to PCP ± mental health services for follow-up. Re-screen often and monitor closely. Treatment plan that includes psychotherapy and possibly medications. Assess for SI/HI and intrusive thoughts. |
| Notes on intrusive thoughts | | May <u>not</u> indicate immediate action and referral to mental health care. Refer to PCP ± mental health specialist or emergency resource for further assessment and intervention as appropriate. Urgency of referral will depend on several factors including: whether the intrusive thoughts that are homicidal in nature are accompanied by a plan or intentions, whether symptoms of a psychotic disorder are present and/or there is concern about harm to the baby. |

*Source: Adapted from First 5 LA High Risk Protocol*

**Validation and presence are important:**

"You are not alone."
"You are not to blame. "
"With the right help, you'll feel better."

*Source: Postpartum Support International*

### Basic tips for response following screening:

- Answer any questions they may have
- Explain what the score suggests
- Make recommendations and provide referrals with a warm hand-off
- Follow the suggestions in the high risk guidelines section for risk situations
- Use your clinical judgment!

## III. Scripts

Mother is presenting with anxious symptoms, is scared to be discharged home with her baby and has not allowed anyone else to touch or care for the baby since childbirth. Patient scored a 14 on the GAD-7 screen.

*"Thank you for completing this screening tool. It looks like you have endorsed some feelings of anxiety, would you say that this is accurate for you? I would like to ask you some more questions if that is okay, just to get a better sense of how you have been adjusting and how we can help you to feel better. My goal is to make sure that you feel as supported as possible, and that you and your baby are safe."*

*"When did you notice these symptoms began? And how have you been managing them?"*

*"Are you having any scary or unusual thoughts? If so, how do you feel about them?"*

*"What is your support system like? Is there anyone that you trust who we can involve in your care plan?"*

*"Would you be willing to receive a referral to talk to someone about how you've been feeling and get some additional help? Based on your screening and our discussion, I strongly recommend that we set something up before you go home."*

*"Can we help you to make an appointment?"*

Mother with depressive symptoms, does not seem to be bonding with her baby and has not been seen providing much infant care since birth. Patient scored a 14 on the EPDS.

*"Thank you for completing this screening tool. It looks like you have endorsed some feelings of depression, would you say that this is accurate for you? I would like to ask you some more questions if that is okay, just to get a better sense of how you have been adjusting and how we can help you to feel better. My goal is to make sure that you feel as supported as possible, and that you and your baby are safe."*

*"When did you notice these symptoms began? And how have you been managing them?"*

*"Are you having any scary or unusual thoughts? If so, how do you feel about them?"*

*"What is your support system like? Is there anyone that you trust who we can involve in your care plan?"*

*"Would you be willing to receive a referral to talk to someone about how you've been feeling and get some additional help? Based on your screening and our discussion, I strongly recommend that we set something up before you go home."*

*"Can we help you to make an appointment?"*

Mother with no apparent mental health concerns, but interested in what to monitor for in the postpartum period due to her history with depression and anxiety personally and in her family. Patient scored an 8 on the PHQ-9.

*"Thank you for completing this screening tool. It looks like you have endorsed some feelings of depression, would you say that this is accurate for you? I would like to ask you some more questions if that is okay, just to get a better sense of how you have been adjusting. My goal is to make sure that you feel as supported as possible, and that you and your baby are safe."*

*"How have you been feeling during this transition since having your baby?"*

*"Are you having any scary or unusual thoughts? If so, how do you feel about them?"*

*"What is your support system like?"*

*"It is not uncommon to feel some waves of emotion, crying, and difficulty sleeping in these first couple of weeks since having your baby. However, if these symptoms persist, worsen, or you feel something is generally off, it might be time to reach out for some additional assessment and support. Perinatal mental illness can occur anytime in the perinatal period, from pregnancy through the first two years after having your baby. Here are some resources that you can utilize in case you feel you need some support in the future."*

# IV. Referral Resources

It is best practice to research resources in your area to identify some of the following options and compile a resource list prepared to hand out when needed.

- Brochures
  - Perinatal Mental Health Learning Community
- 24/7 Hotlines
  - Postpartum Support International Warmline
  - Suicide Prevention Hotline
- Online Resources
  - Online support groups
  - Los Angeles County Maternal Mental Health Resource Directory
- Mental Health Clinics
  - Urgent Cares
  - Outpatient therapy
- Local Therapists
  - Psychology Today

- Psychiatric units with experience treating perinatal patients
    - Intensive Perinatal Psych Treatment
    - County Departments of Mental or Behavioral Health
    - CommonSpirit Health Perinatal Psychiatric Consultation Line — CommonSpirit Health is offering a provider-to-provider psychiatric telephone consultation service to all community providers in California (regardless of affiliation with CommonSpirit Health or Dignity Health), enabling providers to speak in real-time with perinatal psychiatrists for coaching on diagnosis, management, and pharmacology. This service is funded by the Dignity Health Maternal Mental Health Project, ***at no cost*** to providers, medical groups, patients or payers. Please watch this short video (tap here) for more information. Service Hours: Call toll free (833) 205-7141, Monday - Friday, 1 p.m. - 5 p.m. to speak with a consultant immediately or to receive call back within 30 minutes.
    - PSI Provider Psychiatric Consultation Line

# V. HIGH RISK GUIDELINES

## Child Abuse and Neglect

- Minors under age 18
- Includes: physical abuse, sexual abuse or exploitation, neglect, willful harm, injury or endangerment, unlawful corporal punishment, abuse or neglect in or out of the home

**Reporting:**

1) Call Child Protection Hotline to file verbal report (immediately)

Tap here to find the hotline number in your county

*This option is always available just for consultation with a Children's Social Worker if you are unsure. Intrusive thoughts alone do not always warrant a child abuse report, get more information about the nature of the thoughts and how mother feels about these thoughts before initiating a child abuse report. SEEK SUPERVISION!*

2) Online Mandated Report (file within 36 hours – must have referral number from verbal report)

Fax this form to the CPS office in your county

*Note: Mandated reporting of a minors sexual activity varies with age and circumstance, please look up these separately here: When Mandated Reporters in California Must Report Consensual Disparate Age Sexual Intercourse to Child Abuse Authorities*

## Suicide/Risk Assessment

> "Suicide is the number one cause of death in new mothers, over gestational diabetes, pregnancy induced hypertension ..."
>
> — Emily Dossett, MD, Director of Women's Health & Reproductive Psychiatry, Los Angeles County Department of Mental Health

1) Do you have thoughts of harming both yourself and the baby?

2) This past week, have you had any thoughts of hurting or killing yourself?

3) If yes, have you thought about how?

**Danger To Self (DTS) / Danger To Others (DTO)**

Utilize Columbia Suicide Severity Rating Scale (C-SSRS) to evaluate:

- Ideation
- Plan
- Means
- History

**Suicide Risk**

| | | |
|---|---|---|
| Low | Passive S.I., no plan, no means, no intentions | Safety planning, protective factors, education, referral. *Do not assume low risk = no risk* |
| Intermediate | S.I., possible plan but no intentions and able to discuss reasons to stay alive. | Psych referral, PCP contact, further assessment, everything from low risk. |
| High | S.I. with plan, means, intentions | Immediate psychiatric care + Low/Intermediate interventions. |

A patient who describes suicidal ideation, but indicates no clear plan, no clear wish to be dead, no history of self-injury, and fair social and family support may be appropriate to manage without immediate hospitalization.

Do not assume low risk = no risk.

***Asking about suicidality does not encourage suicidality.***

## Further assessment guidelines

- MSE
- Safety planning
- Support system
- History of substance abuse (personal/family)
- History of suicide attempts (personal/family)
- Coping/reasons to live
- Protocol – reduce risk
    - referral to social worker for follow-up
    - Psychiatric referral if needed – PMRT/PET or in house psychiatrist/LPS designated staff
    - Assist in calling counselor to set an appointment if able
    - Warm referral – refrain from providing a list of numbers with no follow through. Ask if they already have established MH care.
- Provide crisis contacts including suicide hotline:
    - **National Suicide Prevention Lifeline:** 800-273-8255 **or** 800-273-TALK
- Use your clinical judgment!! If something doesn't feel right, don't let it go.
- Seek clinical supervision for all suicidal cases.

## Document:

- Enter the results of the C-SSRS or other form of risk screening
- Document pt.'s MSE and AAO
- Document any collaboration with behavioral health and PCP, safety planning, consultation, and/or referrals provided
- Document crisis contact information was provided to the patient as well as referrals
- Document follow-up plan
- Document patient's level of participation

## Psychosis or Mania

Signs to be aware of:

- Bizarre thoughts
- Paranoia (often focus on baby)
- Delusions (may be religious in content)
- Hallucinations (visual or auditory)

- History of bipolar disorder
- May accompany fluctuating moods
- Symptoms may wax and wane
- Rapid speech, flight of ideas
- Decreased need for sleep or eating
- Agitation and restlessness

**POSTPARTUM PSYCHOSIS is considered a medical emergency.**

**If you believe someone is in a psychotic state:**

- **DO NOT LEAVE HER ALONE WITH THE BABY**
- **ORDER A PSYCH CONSULT OR ACCOMPANY HER TO THE ER**
- **SEEK CLINICAL SUPERVISION**

## Substance Use

Substance use during pregnancy exacerbates signs and symptoms of depression and anxiety.

If you have questions, concerns about substance use, here is a free, confidential guidance for providers regarding substance abuse and your patient: California Substance Use Line

## Cultural Humility and Considerations

Implicit bias

- Unconscious stereotypes projected toward certain groups that influence human interactions
- All humans have implicit bias and preferences toward or against certain social groups
- Biases affect the treatment of women of color resulting in a 4X higher rate of mortality among black infants and mothers specifically

Cultural influences impact the ways patients interact, interpret, and perceive the medical and childbirth experience

- Country of origin
- Legal status
- Language
- Cultural background/belief system
- Comfort with physical contact, eye contact and physical proximity
- Religion/spirituality

Keep in mind the following:

- Meet resistance with curiosity, rather than retreat.
- Ask questions to increase understanding about what is important to them, avoid assumptions.
- Manage and examine your own cultural influences regularly.
- Show sensitivity to various postpartum rituals and traditions. For example, many Asian cultures prefer warm beverages and room temperatures in the postpartum period. Other cultures observe a 30-40 day period of confinement which might impact their ability to visit NICU baby.
- Help patients recognize what strengths and supports they have and build from there.
- Always utilize interpreters over peer translation when able.

# VI. Additional Resources

California Assembly Bill 3032 | Maternal Mental Health Conditions Education, Early Diagnosis and Treatment Act

California Assembly Bill 2193 | Maternal Mental Health Screening

LifeLine4Moms Toolkit | Assessing Perinatal Mental Health