Massachusetts Child Psychiatry Access Project
MCPAP For Moms

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This is the MCPAP for Moms toolkit, created to assist front-line perinatal care providers in the prevention, identification and treatment of depression and other mental health concerns in pregnant and postpartum women. This toolkit contains the following:

Assessment Tools

- **Assessment of Depression Severity and Treatment Options**
  Highlights the signs and symptoms of depression and options for treatment as they relate to clinical assessment and/or EPDS score.
- **Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women**
  Highlights key information/concepts to consider when assessing the mental health of pregnant and postpartum women.
- **Summary of Emotional Complications During Pregnancy and the Postpartum Period**
  An overview of the range of emotional complications that can occur pregnancy and postpartum including Baby Blues, Perinatal Depression, Perinatal Anxiety, Posttraumatic Disorder (PTSD), Obsessive-Compulsive Disorder (OCD), and Postpartum Psychosis.

Screening Tools & Treatment Algorithms

- **Edinburgh Postnatal Depression Scale (EPDS)**
  The EPDS is a widely-used and validated 10-item questionnaire to identify women experiencing depression during pregnancy and the postpartum period.
- **Depression Screening Algorithm for Obstetric Providers (2-sided)**
  Provides guidance on administering the EPDS and next steps depending on EPDS score. Side one is a simplified version of the algorithm – side two provides more detailed information including talking points and suggested language re: how to discuss the EPDS and resultant scores with patients.

When Treatment with Antidepressants is indicated

- **Bipolar Disorder Screen**
  A brief screen derived from the Composite International Diagnostic Interview-Based Bipolar Disorder Screening Scale to be used prior to starting treatment with an antidepressant.
- **Recommended Steps before Beginning Antidepressant Medication Algorithm**
  Talking points re: antidepressant use, and the risks of antidepressant use vs. risks of under or no treatment of depression during pregnancy and the postpartum period.
- **Antidepressant Treatment Algorithm**
  Provides a step-by-step guide to prescribing antidepressants, with specific first and second line treatment recommendations and guidelines for ongoing assessment and treatment.

Informational Material

- **MCPAP for Moms Overview**
  A brief, one-page summary of the MCPAP for Moms program, including contact information for the Medical Director (Nancy Byatt, D.O.) and Program Director (Kathleen Biebel, Ph.D.).
- **How to Find a Primary Care Practitioner**
- **How to Talk to Your Health Care Provider**

Funding provided by the Massachusetts Department of Mental Health

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Assessment of Depression Severity and Treatment Options[1]

EPDS SCORE or clinical assessment	EPDS 0-8	EPDS 9-13	EPDS 14-18	EPDS≥19
SIGNS AND SYMPTOMS OF DEPRESSION **Signs and symptoms in each column may overlap*	**LIMITED TO NO SYMPTOMS**	**MILD SYMPTOMS**	**MODERATE SYMPTOMS**	**SEVERE SYMPTOMS**
	• Reports occasional sadness	• Mild apparent sadness but brightens up easily	• Reports pervasive feelings of sadness or gloominess	• Reports continuous sadness and misery
	• Placid - only reflecting inner tension	• Occasional feelings of edginess and inner tension	• Continuous feelings of inner tension/ intermittent panic	• Unrelenting dread or anguish, overwhelming panic
	• Sleeps as usual	• Slight difficulty dropping off to sleep	• Sleep reduced or broken by at least two hours	• Less than two or three hours sleep
	• Normal or increased appetite	• Slightly reduced appetite	• No appetite - food is tasteless	• Needs persuasion to eat
	• No difficulties in concentrating	• Occasional difficulty in concentrating	• Difficulty concentrating and sustaining thoughts	• Unable to read or converse without great initiative
	• No difficulty starting everyday activities	• Mild difficulties starting everyday activities	• Difficulty starting simple, everyday activities	• Unable to do anything without help
	• Normal interest in surroundings & friends	• Reduced interest in surroundings & friends	• Loss of interest in surroundings and friends	• Emotionally paralyzed, inability to feel anger, grief or pleasure
	• No thoughts of self-reproach, inferiority	• Mild thoughts of self-reproach, inferiority	• Persistent self-accusations, self-reproach	• Delusions of ruin, remorse or unredeemable sin
	• No suicidal ideation	• Fleeting suicidal thoughts	• Suicidal thoughts are common	• History of severe depression and/ or active preparations for suicide
TREATMENT OPTIONS **Treatment options in each column may overlap*	**LIMITED TO NO SYMPTOMS**	**MILD SYMPTOMS**	**MODERATE SYMPTOMS**	**SEVERE SYMPTOMS**
			• Consider inpatient hospitalization when safety or ability to care for self is a concern	• Consider inpatient hospitalization when safety or ability to care for self is a concern
		• Consider medication	• Strongly consider medication	• Strongly consider medication
	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby
	• Community/social support (including support groups)	• Community/social support (including support groups)	• Community/social support (including support groups)	• Community/social support (including support groups)
	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies(bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)
	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	Support with dysregulated baby; crying, sleep, feeding problems • Physical activity
	• Self-care (sleep, hygiene, healthy diet)	• Self-care (sleep, hygiene, healthy diet)	• Self-care (sleep, hygiene, healthy diet	• Self-care (sleep, hygiene, healthy diet)

[1]Information adapted from: Montgomery SA, Asberg M: A new depression scale designed to be sensitive to change. *British Journal of Psychiatry* 134:382-389, 1979

Limited or no symptoms of depression ***Severe symptoms of depression***

Funding provided by the Massachusetts Department of Mental Health

Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women

Assessing Thoughts of Harming Baby	
Thoughts of Harming Baby that Occur Secondary to Obsessions/Anxiety	**Thoughts of Harming Baby that Occur Secondary to Postpartum Psychosis /Suspected Postpartum Psychosis**
• Good insight • Thoughts are intrusive and scary • No psychotic symptoms • Thoughts cause anxiety ↓ **Suggests not at risk of harming baby**	• Poor insight • Psychotic symptoms • Delusional beliefs with distortion of reality present ↓ **Suggests at risk of harming baby**

Suggests Medication May Not be Indicated	Suggests Medication Treatment Should be Considered
• Mild depression based on clinical assessment • No suicidal ideation • Engaged in psycho-therapy or other non-medication treatment • Depression has improved with psychotherapy in the past • Able to care for self/baby • Strong preference and access to psychotherapy	• Moderate/severe depression based on clinical assessment • Suicidal ideation • Difficulty functioning caring for self/baby • Psychotic symptoms present (call MCPAP for Moms) • History of severe depression and/or suicide ideation/attempts • Comorbid anxiety dx/sxs

Risk Factors for Postpartum Depression[1]	
• Personal history of major or postpartum depression • Family history of PPD • Gestational diabetes • Difficulty breastfeeding • Fetal/Newborn loss • Lack of personal or community resources • Financial challenges	• Complications of pregnancy, labor/delivery, or infant's health • Teen pregnancy • Unplanned pregnancy • Major life stressors • Violent or abusive relationship • Isolation from family or friends • Substance use/addiction

Other Considerations During Clinical Assessment	
• Past history of psychiatric diagnosis • Previous counseling or psychotherapy • Previous psychiatric medication • History of other psychiatric treatments such as support groups	• History of substance use or substance use treatment • Anxiety and worry • Trauma history • Domestic violence

How to Talk about Perinatal Depression with Moms[1]
• *How are you feeling about being pregnant/a mother?* • *What things are you most happy about?* • *What things are you most concerned about?* • *Do you have anyone you can talk to that you trust?* • *How is your partner doing?* • *Are you able to enjoy your baby?*

[1]This guideline has been adapted from materials made available by HealthTeamWorks and the Colorado Department of Public Health and Environment (CDPHE) http://www.healthteamworks.org/guidelines/depression.html.

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Summary of Emotional Complications During Pregnancy and the Postpartum Period

	Baby Blues	Perinatal Depression	Perinatal Anxiety	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder	Postpartum Psychosis
What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.	Depressive episode that occurs during pregnancy or within a year of giving birth.	A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.	Distressing anxiety symptoms experienced after traumatic events(s).	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.	Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.
When does it start?	First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.	Most often occurs in the first 3 months postpartum. May begin after weaning baby or when menstrual cycle resumes.	Immediately after delivery to 6 weeks postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes.	May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.	1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.	Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.
Risk factors	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.
How long does it last?	A few hours to a few weeks.	2 weeks to a year or longer. Symptom onset may be gradual.	From weeks to months to longer.	From 1 month to longer.	From weeks to months to longer.	Until treated.
How often does it occur?	Occurs in up to 85% of women.	Occurs in up to 19% of women.	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.	Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.	May occur in up to 4% of women.	Occurs in 1-2 or 3 in 1,000 births.
What happens?	Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of blues, but blues is a risk factor for postpartum depression.	Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotics symptoms.	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.	Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women).	Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g. tactile and olfactory) hallucinations. May have moments of lucidity. **May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.**
Resources and treatment	May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.	For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications. Additional complementary and alternative therapies options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate.				**Requires immediate psychiatric help. Hospitalization usually necessary.** Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g. consistent sleep/wake times, help with feedings at night).

[1] Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996)

[2] **O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002. [Epub ahead of print]**

Funding provided by the Massachusetts Department of Mental Health

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

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

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.

[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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Depression Screening Algorithm for Obstetric Providers

The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following Glucola test
- *If high-risk patient,** 2 weeks postpartum
- 6 weeks postpartum visit

If first EPDS screen

Clinical support staff explains EPDS

If subsequent EPDS screen

Give EPDS to woman to complete

Woman completes the EPDS. Staff tallies score and enters into medical record. Staff informs OB provider of score prior to patient appointment.

EPDS Score

Provider steps are in this purple box

Score <10

Does not suggest depression

Clinical support staff educates woman about the importance of emotional wellness

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org), and we encourage women to engage in social supports. If woman is already in treatment, ensure follow up appointment is scheduled.

Score ≥ 10

Suggests patient is depressed

1. Assess to determine most appropriate treatment (refer to **Assessment of Depression Severity and Treatment Options** and **Key Clinical Considerations** documents)

Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).

If antidepressant medication is indicated

1. Screen for bipolar disorder **(**refer to **Bipolar Depression Screen)**
2. Refer to **Recommended Steps before Beginning Antidepressant Medication Algorithm** and **Antidepressant Treatment Algorithm**
3. Offer psychotherapy

Positive score on question 10

Suggests patient may be at risk of self-harm or suicide

Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.
Immediately assess further:

1. *In the past two weeks, how often have you thought of hurting yourself?*
2. *Have you ever attempted to hurt yourself in the past?*
3. *Have you thought about how you could harm yourself?*

Document assessment and plan in medical record.

If there is a clinical question, call MCPAP for Moms ***855-Mom-MCPAP (855-666-6272)*** or refer to emergency services.

ALWAYS DISCUSS ALL SUPPORT/TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS

** High-risk = women with a history of Depression or a positive EPDS Score, or those taking or who have taken psychiatric medications.*

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Massachusetts Child Psychiatry Access Project
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Depression Screening Algorithm for Obstetric Providers

(with suggested talking points)

The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following Glucola test
- *If high-risk patient,** 2 weeks postpartum
- 6 weeks postpartum visit

The clinical support staff/ provider *speak the italicized text*

If first EPDS screen

If subsequent EPDS screen

Clinical support staff explains EPDS

Emotional complications are very common during pregnancy and/or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact you and your baby's health. We will be seeing you a lot over the next months and want to support you.

Give EPDS to woman to complete

Woman completes the EPDS. Staff tallies score and enters into medical record. Staff informs OB provider of score prior to patient appointment.

EPDS Score

Provider steps are in this purple box

Score <10

Does not suggest depression

Clinical support staff educates woman about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every woman deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org).

My office staff and I are available to help you and provide ongoing support.

If woman is already in treatment, ensure follow up appointment is scheduled.

Score ≥ 10

Suggests patient is depressed

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

Assess to determine most appropriate treatment (refer to **Assessment of Depression Severity and Treatment Options** and **Key Clinical Considerations** documents)

Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).

If antidepressant medication is indicated

1. Screen for bipolar disorder **(**refer to **Bipolar Depression Screen)**
2. Refer to **Recommended Steps before Beginning Antidepressant Medication Algorithm** and **Antidepressant Treatment Algorithm**
3. Offer psychotherapy

Positive score on question 10

Suggests patient may be at risk of self-harm or suicide

It sounds like you are having a lot of strong feelings. It is really common for women to experience these kinds of feelings. Many effective support options are available. I would like to talk to you more about how you have been feeling recently.

Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.

Immediately assess further:

1. *In the past two weeks, how often have you thought of hurting yourself?*
2. *Have you ever attempted to hurt yourself in the past?*
3. *Have you thought about how you could harm yourself?*

If concerned about the safety of woman/baby: *You and you baby deserve for you to feel well. Let's talk about ways we can support you.*

Document assessment and plan in medical record. If there is a clinical question, call MCPAP for Moms ***855-Mom-MCPAP (855-666-6272)*** or refer to emergency services.

ALWAYS DISCUSS ALL SUPPORT/TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS

** High-risk = women with a history of Depression, a positive EPDS Score, or those taking or who have taken psychiatric medications.*

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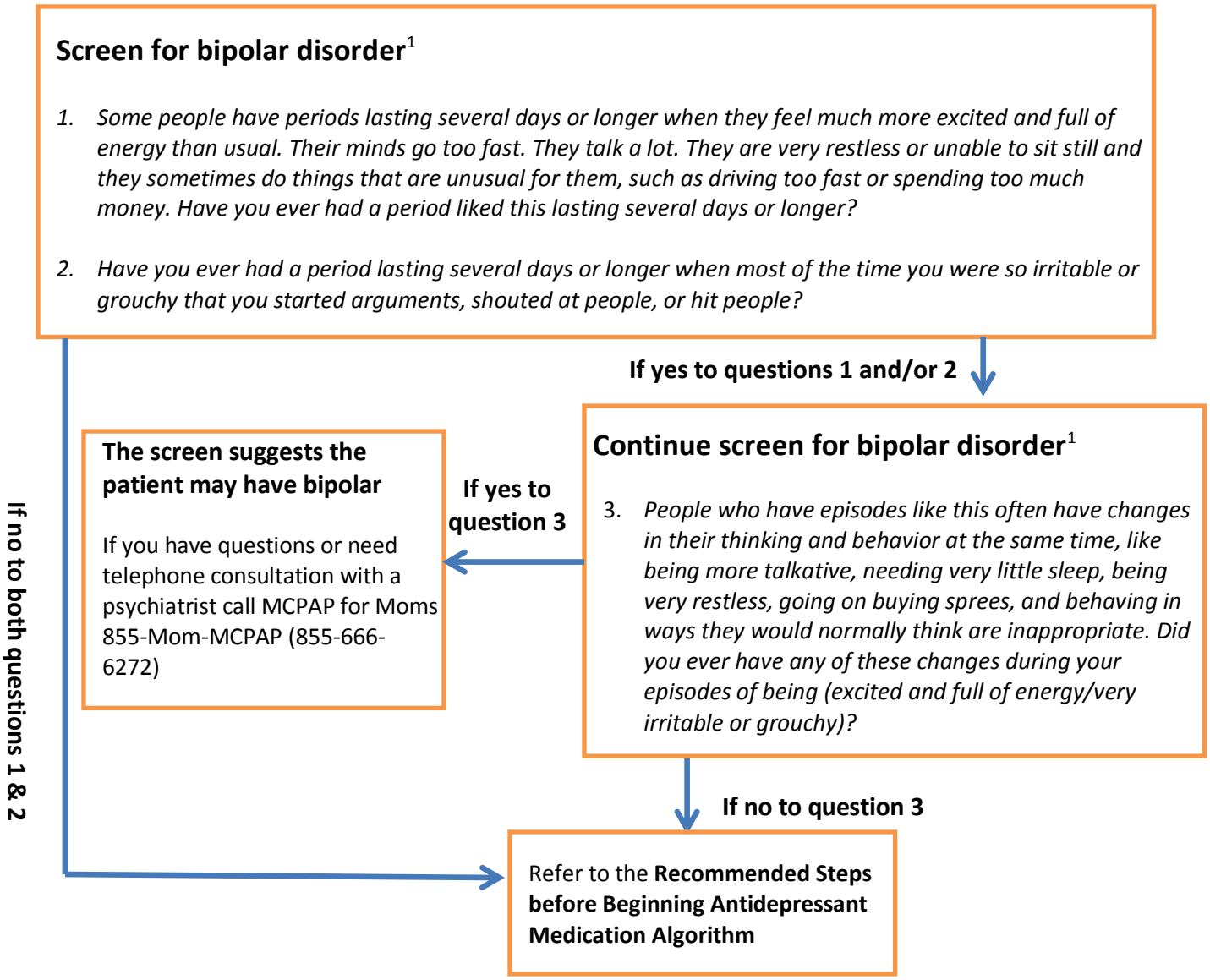
Bipolar Disorder Screen

This algorithm can be used when treatment with antidepressants is indicated, in conjunction with the **Depression Screening Algorithm for Obstetric Providers**.

In this algorithm, the provider *speaks the italicized text* and summarizes other text.



CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

[1]Taken from the Composite International Diagnostic Interview-Based Bipolar Disorder Screening Scale (Kessler, Akiskal, Angst et al., 2006)

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Recommended Steps before Beginning Antidepressant Medication Algorithm

(Discussion should include yet not be limited to the below)

Counsel patient about antidepressant use:

- No decision regarding whether to use antidepressants during pregnancy is perfect or risk free
- SSRIs are among the best studied class of medications during pregnancy
- Both medication and non-medication options should be considered
- Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment or as an alternative when clinically appropriate

Risks of antidepressant use during pregnancy	**Risks of under treatment or no treatment of depression during pregnancy**
➢ Small, but inconsistent increased risk of birth defects when taken in first trimester, particularly with paroxetine ➢ The preponderance of evidence does not suggest birth complications ➢ Studies do not suggest long-term neurobehavioral effects on children ➢ Possible transient neonatal symptoms	➢ Increases the risk of postpartum depression ➢ Birth complications ➢ Can make it harder for moms to take care of themselves and their babies ➢ Can make it harder for moms to bond with their babies

- *If pregnant: In your situation, the benefits of taking an antidepressant outweigh the chance of the things we just discussed.*
- *If lactating: SSRIs and some other antidepressants are considered a reasonable treatment option during breastfeeding. The benefits of breastfeeding while taking antidepressants generally outweigh the risks.*

SEE ANTIDEPRESSANT TREATMENT ALGORITHM ON BACK FOR GUIDELINES RE: PRESCRIBING MEDICATIONS

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

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Antidepressant Treatment Algorithm

(use in conjunction with **Depression Screening Algorithm for Obstetric Providers**)

Is patient currently taking an antidepressant?

Yes

If medication has helped and patient is on a low dose: increase dose of current medication (see table below)

If patient is on therapeutic dose for 4-8 weeks that has not helped: consider changing medication. If questions contact MCPAP for Moms for consultation

No

Does patient have a history of taking an antidepressant that has helped?

Yes

Prescribe antidepressant that helped patient in the past (see table below)

No

Use sertraline, fluoxetine or citalopram (see table below)

To minimize side effects, half the recommended dose is used initially for 2 days, then increase in small increments as tolerated.

First line treatment (SSRIs)

***sertraline (Zoloft) 50-200 mg** *Increase in 50 mg increments*	**fluoxetine (Prozac) 20-60 mg** *Increase in 10 mg increments*	**citalopram (Celexa) 20-40 mg** *Increase in 10 mg increments*	**escitalopram (Lexapro) 10-20mg** *Increase in 10 mg increments*

Second line treatment

SSRIs	**SNRIs**	**Other**	**If a first or second line medicine is currently helping, continue it** **Strongly consider using first or second line medicine that has worked in past**
*paroxetine (Paxil) 20-60mg *Increase in 10 mg increments*	venlafaxine (Effexor) 75-300mg *Increase in 75 mg increments*	bupropion (Wellbutrin) 300-450mg *Increase in 75 mg increments*	
*fluvoxamine (Luvox) 50-200mg *Increase in 50 mg increments*	duloxetine (Cymbalta) 30-60mg *Increase in 20 mg increments*	mirtazapine (Remeron) 15-45mg *Increase in 15 mg increments*	

*Considered a safer alternative in lactation because they have the lowest degree of translactal passage and fewest reported adverse effects compared to other antidepressants. **In general, if an antidepressant has helped it is best to continue it during lactation.**

Reevaluate depression treatment in 2-4 weeks via EPDS & clinical assessment

If no/minimal clinical improvements after 4-8 weeks

1. If patient has no or minimal side effects, increase dose.
2. If patient has side effects, switch to a different med.

If you have any questions or need consultation, contact MCPAP for Moms at 855-Mom-MCPAP (855-666-6272)

If clinical improvement and no/minimal side effects

Reevaluate every month and at postpartum visit. Refer back to patient's provider and/or clinical support staff for psychiatric care once OB care is complete. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

MCPAP for Moms: Promoting maternal mental health during and after pregnancy
Revision 07.24.14
www.mcpapformoms.org
Tel: 855-Mom-MCPAP (855-666-6272)

Funding provided by the Massachusetts Department of Mental Health

Massachusetts Child Psychiatry Access Project

MCPAP For Moms

MCPAP for Moms: Promoting Maternal Mental Health During and After Pregnancy

One out of every eight women experience depression during pregnancy or in the postpartum period. Many health care providers are on the front line serving these women and their families, often with limited access to the mental health resources and supports needed to address depression.

MCPAP for Moms is an exciting new statewide program designed to bridge this gap. It is an expansion of the successful Massachusetts Child Psychiatry Access Project (MCPAP), which has improved child mental health care in Massachusetts by offering pediatric primary care providers rapid access to child psychiatry consultation, education, and care coordination. MCPAP for Moms aims to promote maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage depression. Providers working with fathers and other caregivers experiencing postpartum depression can also access MCPAP for Moms.

MCPAP for Moms will have three core components:

- **Trainings and toolkits** for providers and their staff on evidence-based guidelines for: depression screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options.
- **Real-time psychiatric consultation and care coordination** for providers serving pregnant and postpartum women and their babies including obstetricians, pediatricians, adult primary care physicians, and psychiatrists.
- **Linkages with community-based resources** including mental health care, support groups and other resources to support the wellness and mental health of pregnant and postpartum women. MCPAP for Moms is partnering with MotherWoman and MSPP Interface Referral Service to develop community resources and link women with depression to these supports across the state.

The MCPAP for Moms phone line - 855-Mom-MCPAP (855-666-6272) - will open July 1, 2014.

Improving access to and engagement of pregnant and post-partum women in depression treatment leads to improved outcomes for mothers, which leads to better outcomes for babies, children, and families.

For more information about MCPAP for Moms and/or to schedule a training or informational session at your practice, please contact:

MCPAP for Moms Medical Director Nancy Byatt, DO, MBA, FAPM
Nancy.Byatt@umassmemorial.org

MCPAP for Moms Program Director Kathleen Biebel, PhD
Kathleen.Biebel@umassmed.edu

Or visit our website at: **www.mcpapformoms.org**

MCPAP is funded by the Massachusetts Department of Mental Health

MSPP INTERFACE Referral Service at the Massachusetts School of Professional Psychology

Massachusetts Child Psychiatry Access Project MCPAP For Moms

How to Find a Primary Care Practitioner

A primary care practitioner (PCP) is typically your first resource when you have a medical concern, including mental health concerns. For the purpose of most health insurance plans, this is also the person to coordinate your care. Your PCP's role is to provide preventive care to you, such as conducting a physical exam. They can also identify and treat common medical concerns, like a cold. It is important that you build a relationship with a PCP. This happens by seeing them over an extended period of time, so they become familiar with your medical history and can help identify specialists that can treat any specific needs that come up. Your PCP can also help optimize your mental health by providing direct treatment and/or ensuring that you receive the mental health care you need and deserve.

How do I start my search for a Primary Care Practitioner?

- Contact your insurance company, either by phone or online, to obtain a list of available practitioners that qualify as PCPs in your area. PCP's can be internal medicine doctors, family practitioners, nurse practitioners or physician assistants. In some cases, a doctor who is an obstetrician/ gynecologist can also be a PCP.
- A personal referral is another good way to identify a PCP. You may want to ask for suggestions from friends or family members that you trust. You can also ask your child's pediatrician or your OB/midwife that helped you during your pregnancy whom they would recommend. When asking for suggestions, consider your own temperament and qualities of the individuals that you have found comforting. A family member or friend who likes someone who is more strict and to the point might not be a good fit for you if you are looking for someone that values spending time with their patients and is more available for questions or concerns.
- State level medical associations, nursing associations or physician assistant associations also maintain lists of who is practicing in your area and can make referrals to providers who are members of the association.

How do I choose a Primary Care Practitioner?

- Making the final decision is up to you. Below are some questions you may want to consider:
  - Do you prefer working with a male or female PCP?
  - Is the age of the PCP or the years of experience important to you?
  - If a PCP is recommended by someone, do you know why they would recommend them?
  - Does this practice or PCP accept your insurance?
  - Is the PCP's office staff or location important?
  - Do you need a PCP who is available to you online so you can access them when you have time rather than during the typical work day?
  - Do you want a PCP who has certain training or experience?
  - What are your current health needs? Are you generally in good health and do not anticipate needing to see your PCP often, or do you have an ongoing medical issue where you may need ongoing support and consultation?
  - Does the PCP offer urgent appointments and who covers when your PCP is away?

What should I do if I don't have health insurance?

- All Massachusetts residents are required to have health insurance. If you are concerned you cannot afford health insurance, you can apply for MassHealth coverage. To apply for MassHealth, call the MassHealth Enrollment Center at 888-665-9993 or go online to download an application at: http://www.mass.gov/eohhs/consumer/insurance/apply-for-masshealth.html
- If you qualify for insurance through your work but have not enrolled because you are concerned about the costs, you may qualify for help for paying your premiums. To learn more about this option visit the Massachusetts Health Connector at: https://www.mahealthconnector.org/
- Having a baby is considered a "qualifying event," which means you can revisit your benefits if you need to change your plan to ensure your baby is covered. If you had insurance available to you through your work but didn't take it for yourself, you can now choose to enroll to cover yourself and your baby.
- You can also talk with the hospital at the time of delivery to ensure that your child has MassHealth if you do not have other insurance. At the time of delivery, you can also enroll in MassHealth as well.
- If you are just not sure where to turn or you need help in applying, contact Health Care for All, which has a free helpline available Monday through Friday from 9am to 5pm at 1-800-272-4232 or contact them at their website: https://www.hcfama.org/

Funding provided by the Massachusetts Department of Mental Health

MSPP INTERFACE Referral Service at the Massachusetts School of Professional Psychology

Massachusetts Child Psychiatry Access Project MCPAP For Moms

Pregnant or just had a baby? Are you worrying about your mental health?
How to talk to your health care provider

Emotional complications are very common during pregnancy and/or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. Depression often happens for the first time during pregnancy or after birth. It can impact you and your baby's health. Getting help is the best thing you can do for you and your baby. You may not be able to change your situation right now; however, you can change how you cope with it. Many effective support options are available. Women see health care providers a lot during pregnancy and after giving birth and it is important to let your health care provider know how you are feeling.

How do I know if I should talk to a health care provider about my mental health?

- Your mental health is an important aspect of your overall health during and after pregnancy. Just as you would talk with your health care provider about any other health related experience, you should let your provider know about any mental health experiences you've had.
- If you are planning on becoming pregnant, are currently pregnant or just had a baby and you have a history of depression, anxiety or other mental health concerns.
- If you have experienced any of the following for 2 weeks or more: feeling restless or moody, feeling sad, overwhelmed, or hopeless, having no energy or motivation, crying a lot, not eating enough or too much, feeling that you are sleeping too little or too much, not feeling like you can care for your baby, having no interest in your baby or are worrying about your baby so much that it is interfering with caring for yourself and/or baby.
- If you have experienced strong feelings that could include thoughts about hurting yourself or your baby, seeing or hearing things that aren't there or worrying that people may be out to get you or want to hurt you. If you are experiencing these kinds of feelings, it is important that you call your health care provider right away or go to the emergency room to seek help.

How do I prepare to talk with my health care provider?

- Start a list of specific things that are concerning you and how they affect your life. Include any questions and details about any previous mental health concerns. This will help ensure that you do not forget anything and that your questions are answered.
- Consider asking someone to attend your appointment with you like a family member or friend. You may hear a lot of new information and it can help to have someone with you so you do not miss anything.
- If you feel at any point that your provider is not hearing your concerns, let them know that you feel as if they are not hearing you. You also can also ask to speak with a different health care provider.

What will happen when I talk to my health care provider?

- They may talk with you to better understand the experiences you are having. This will allow him/her to offer you the most appropriate resources or treatment for your situation.
- They may suggest that you meet with a therapist to support you and help you learn how to cope with the intense emotional experiences that you may be experiencing.
- They may refer you to a support group to help you connect with other new mothers having similar experiences.
- They may discuss medication as a treatment option. If you took medication prior to becoming pregnant, talk with your provider about whether they would recommend that you stay on the medication during pregnancy.

Having a baby is always challenging and every woman deserves support.

 Authors: Byrns H., Hannah M., Byatt N., Biebel K., & Debordes-Jackson, G.
Funding provided by the Massachusetts Department of Mental Health