HRSA-UIC Perinatal Project: Primary Care Tool for Assessment of Depression during Pregnancy and Postpartum

Note to health care provider: This tool is a guide to assessing pregnant and postpartum patients for major depression. It can be used for patients who score 10 or above on the Edinburgh Postnatal Depression Screening (EPDS) and/or for patients in whom you suspect major depression on clinical grounds. This is not a self-assessment tool, but a guide to interviewing patients. Questions in bold are suggestions for what to ask patients; for convenience, you can record answers directly below questions.

Your answers on our questionnaire showed that you might be having some symptoms common in pregnant/postpartum women. I'm going to ask you some questions to get a better idea of what you're experiencing.

First I'm going to ask you some questions about your mood.

Note: patients with major depressive episodes have at least one of two mood states – <u>depressed mood</u> and/or <u>anhedonia</u> - nearly every day for at least 2 weeks.

<u>Depressed mood</u>:

1. Lately, have you felt sad or down most of the day nearly every day?

Yes No

1a. (If yes): How long has that lasted?

Less than 2 weeks At least 2 weeks

<u>Anhedonia</u>:

2. Have you been a lot less interested in most things, or unable to enjoy the things you used to enjoy?

Yes No

2a. (If yes): Has that been nearly every day? How long has that lasted?

Less than 2 weeks At least 2 weeks

If "no" to the above two questions, 

. Patient does not meet criteria for Major Depressive Disorder. Consider having a case manager or related personnel administer the Stressors Assessment.

*If patient answers "yes" to either or both questions above, continue with the following questions. Patients with major depressive episodes have at least **four** additional symptoms from the ones below, nearly every day for at least 2 weeks:*

- *problems with appetite or weight*
- *problems with sleep*
- *psychomotor agitation or retardation*
- *fatigue or loss of energy*
- *feelings of worthlessness and/or excessive or inappropriate guilt*
- *diminished ability to think or concentrate, or indecisiveness*
- *recurrent thoughts of death, suicidal thoughts, and/or a suicide attempt*

Patients with fewer than four symptoms may still have clinically significant subsyndromal depression, if their symptoms impair their social and/or occupational functioning.

Problems with appetite or weight:

PREGNANCY

(If after the first trimester):
1. Have you had difficulty gaining the weight expected for pregnancy? Yes No
1a. Have you had to force yourself to eat even when you have not felt nauseous? Yes No

POSTPARTUM

1. Have you had to force yourself to eat? Yes No
1a. Have you been eating when you're not hungry, in order to comfort yourself or calm yourself? Yes No

Problems with sleep:

PREGNANCY

2. Have you had any sleep problems that don't seem related to being pregnant? Yes No
2a. (If yes) Describe them:

POSTPARTUM

2. Have you had difficulty sleeping even when you are tired and the baby is asleep? Yes No

Note to provider: The most common sleep disturbances associated with major depression are difficulty falling asleep, early morning awakening (not just because of physical discomfort or needing to urinate), not wanting to get out of bed in the morning, and not experiencing sleep as restful even after a full night's sleep.

Psychomotor agitation or retardation:

 ***PREGNANCY***

 ***POSTPARTUM***

3. Have you been so fidgety or restless that it's been difficult for you to sit still, not just because of feeling physically uncomfortable from being pregnant? Yes No	**3. Have you been so fidgety or restless that it's been difficult for you to sit still, even when you don't have to care for the baby?** Yes No
3a. Have you been talking or thinking more slowly than is normal for you? Yes No	**3a. Have you been talking or thinking more slowly than is normal for you?** Yes No

Fatigue or loss of energy:

 ***PREGNANCY***

 ***POSTPARTUM***

4. How has your energy level been, compared to what you would expect for being pregnant? Diminished Not diminished	**4. How has your energy level been, compared to what you would expect for having a baby?** Diminished Not diminished

Feelings of worthlessness and/or excessive or inappropriate guilt:

5. How have you felt about yourself?

Worthless/guilty Positive

Note to provider: If patient's answer suggests a negative self-image but is not specific, you can use these follow-up questions:

5a. Have you had thoughts that you are worthless?

Yes No

5b.. Have you felt guilty about things, even when others might not think it makes sense for you to feel guilty about them?

Yes No

5c. (*Postpartum*) Do you worry that you are not a good enough mother, even when others think you are doing a good job with the baby?

Yes No

Diminished ability to think or concentrate, or indecisiveness:

6. Are you having trouble thinking or concentrating?

Yes No

6a. Is it hard for you to make decisions about everyday things?

Yes No

6b. What are some examples of your difficulty with everyday decisions?

Note to provider: Use examples to confirm that patient feels overwhelmed by relatively minor decisions, such as what to wear or which dish to use.

Recurrent thoughts of death, suicidal thoughts, and/or a suicide attempt:

7. Has it ever gotten to the point where you started wishing you were dead?

Yes No

7a. Have you had thoughts about hurting yourself or killing yourself?

Yes No

If NO to both 7 and 7a  **UNLESS** *patient has endorsed item #10 on the EPDS.*

Note: if the patient says yes to questions about thoughts of death or suicide (and/or if the patient endorses Item #10 on the EPDS), conduct an Evaluation of suicide risk. If NOT, continue with Bipolar Disorder Assessment. Asking direct questions about suicide does NOT put the thought of suicide into a patient's mind if it wasn't already there. Rather, direct discussion of suicidal thoughts substantially decreases the risk of suicide attempts.

Key elements to assess include:

- *the patient's **intent** (i.e. patient not only has the thought, but wants to carry it out)*
- *her **plan** to attempt suicide (i.e. patient has a specific method or methods in mind)*
- *her **access** to means (e.g. patient has a gun in her home, has stockpiled medications, etc.)*

– *her **safety measures** (e.g. when she has suicidal thoughts, does she tell someone? Does she arrange to be around supportive people?)*

Evaluation of suicide risk

1. Have you done anything to hurt yourself, or to try to kill yourself?

Yes No

2. Do you want to be dead now?

Yes No

3. Do you feel like killing yourself now?

Yes No

4. If you killed yourself, how would you go about it?

Specific plan No specific plan

Note: If the patient mentions a specific plan, ask this follow-up question to make sure you have asked about all plans that have crossed her mind.

5. What other means of killing yourself have crossed your mind while you've been feeling this way?

6. Do you have access to a gun?

Yes No

7. Do you have any extra medication around your home that is not currently being prescribed?

Yes No

8. Have you ever saved up medication in case you would need to use it to overdose?

Yes No

9. What do you do when the thought of killing yourself crosses your mind?

Has a safety plan Has no safety plan

If your assessment suggests that the patient is at risk of suicide, an evaluation by a mental health crisis team or emergency room psychiatrist is indicated.

If your assessment suggests that the patient has a major depressive episode but is not at risk of suicide, first rule out medical causes (e.g. substance use, thyroid disease, calcium imbalance, HIV infection) based on your overall medical assessment.

Ruling out Bipolar Disorder

People assessed for depression should be checked for mania/hypomania. If someone has a history of bipolar disorder, antidepressant medication could trigger a manic episode.

Euphoria:

1. Have you ever felt so good or hyper that others thought you weren't your normal self or so hyper you got into trouble?

Yes No

Note to provider: If patient is unclear about questions ask…

1a. Was this more than just feeling good (did you feel like you were high on drugs, but without having actually use drugs or alcohol)?

Yes No

Irritability:

2. Have you felt so irritable that you would yell at people or start fights/arguments?

Yes No

2a. Have you been so irritable that you or others felt that you were not like your usual self?

Yes No

2b. How long did it last?

Less than four days At least four days

note to provider: If at least 4 days this might be a hypomanic or manic episode.

IF NO TO ALL (1 TO 2a) THEN 

(*It is unlikely that she has Bipolar Disorder).*

IF YES TO 1 OR 2 OR BOTH CONSIDER REFERRAL TO A MENTAL HEALTH CARE PROVIDER.

For guidance in treating patients with depression during pregnancy, and/or in preventing postpartum depression in women at high risk, you are welcome to call the HRSA/UIC Perinatal Consultation Service at **(800)573-6121**.