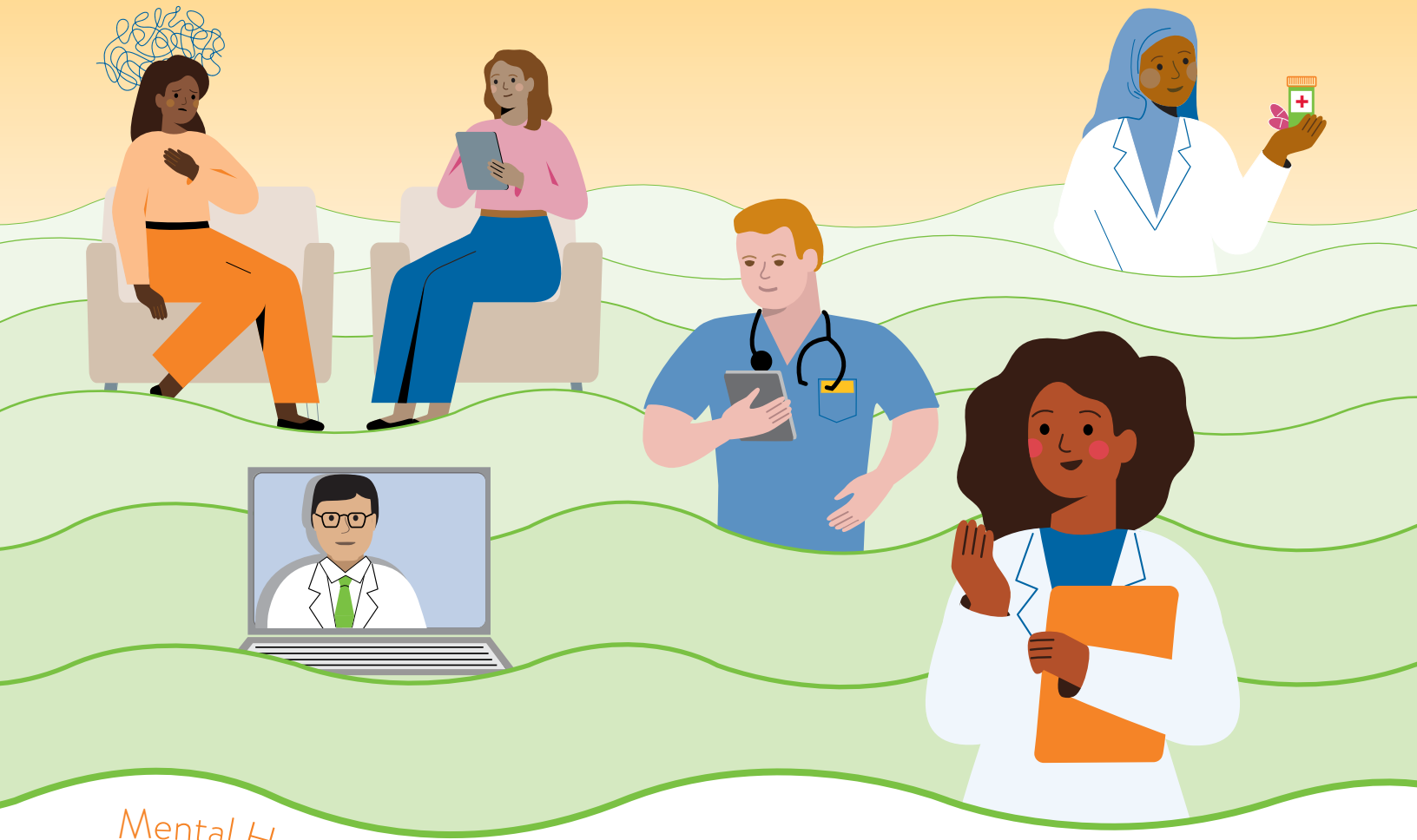
Focus on ME

Mental Health is Essential Health

Provider Change Package 2024



Mental Health is Essential Health

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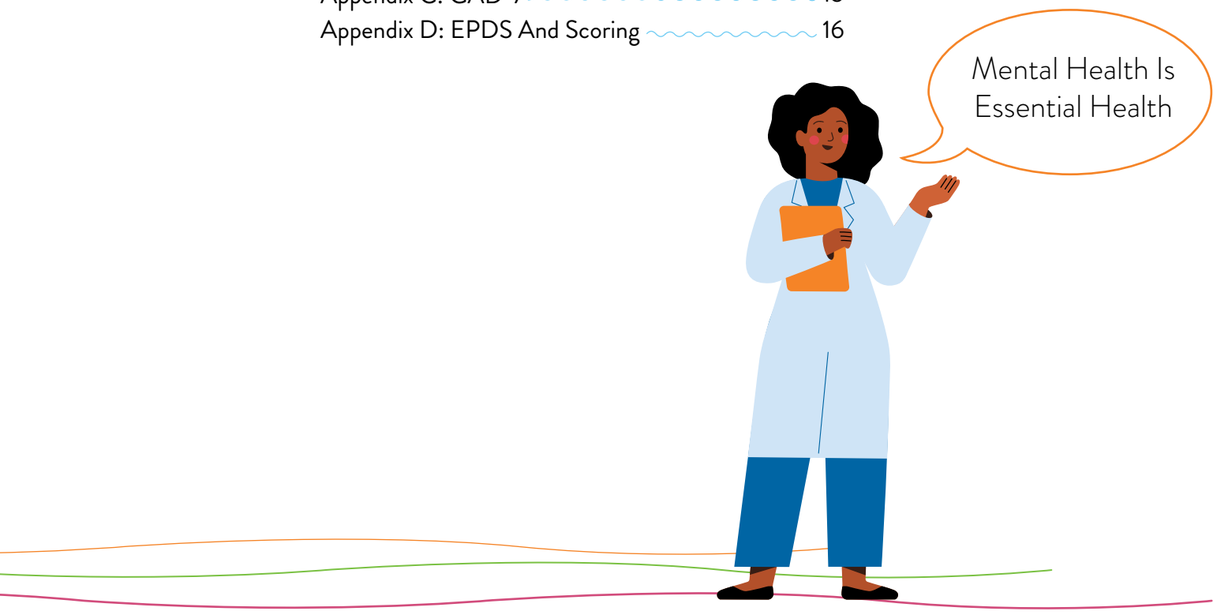

Focus on ME

Mental Health is Essential Health

Provider Change Package Quick Start Guide

Goal: To improve care related to anxiety and depression for women of reproductive age in Ohio seen at primary care practices.

Why?

- Primary care practices are ideal settings to identify and address mental health conditions among women of reproductive age.
- Women are twice as likely as men to experience anxiety or depression; this has been exacerbated by the COVID-19 pandemic.
- Stigma affects all women with mental health concerns and there are disparities in mental health screening and treatment.

Learning Objectives:

- Optimize current workflow to include screeners for anxiety and depression;
- Connect women to affordable/accessible behavioral health resources, including community based services;
- Establish a care plan and provide treatment to women with depression and/or anxiety; and
- Reduce the stigma around mental health issues.

Focus on ME is funded by the Ohio Department of Children and Youth, the Ohio Department of Health, and the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. This change package has been developed in conjunction with clinical experts (listed below) to provide tools to ensure providers have necessary resources to work towards the project's goals.:

- Dr. Seuli Bose-Brill, Chief; OSU Combined Internal Medicine/ Pediatrics Section; Director, OSU Maternal-Infant Dyad Practice; Director, OSU Center for Health Outcomes in Medicine Scholarship and Service; Director, OSU Pragmatic Clinical Trials Network; Associate Professor, Clinical, Department of Medicine, OSU College of Medicine
- Dr. Lisa M Christian, Clinical Health Psychologist, Department of Psychiatry and Behavioral Health, Institute for Behavioral Medicine Research OSU College of Medicine
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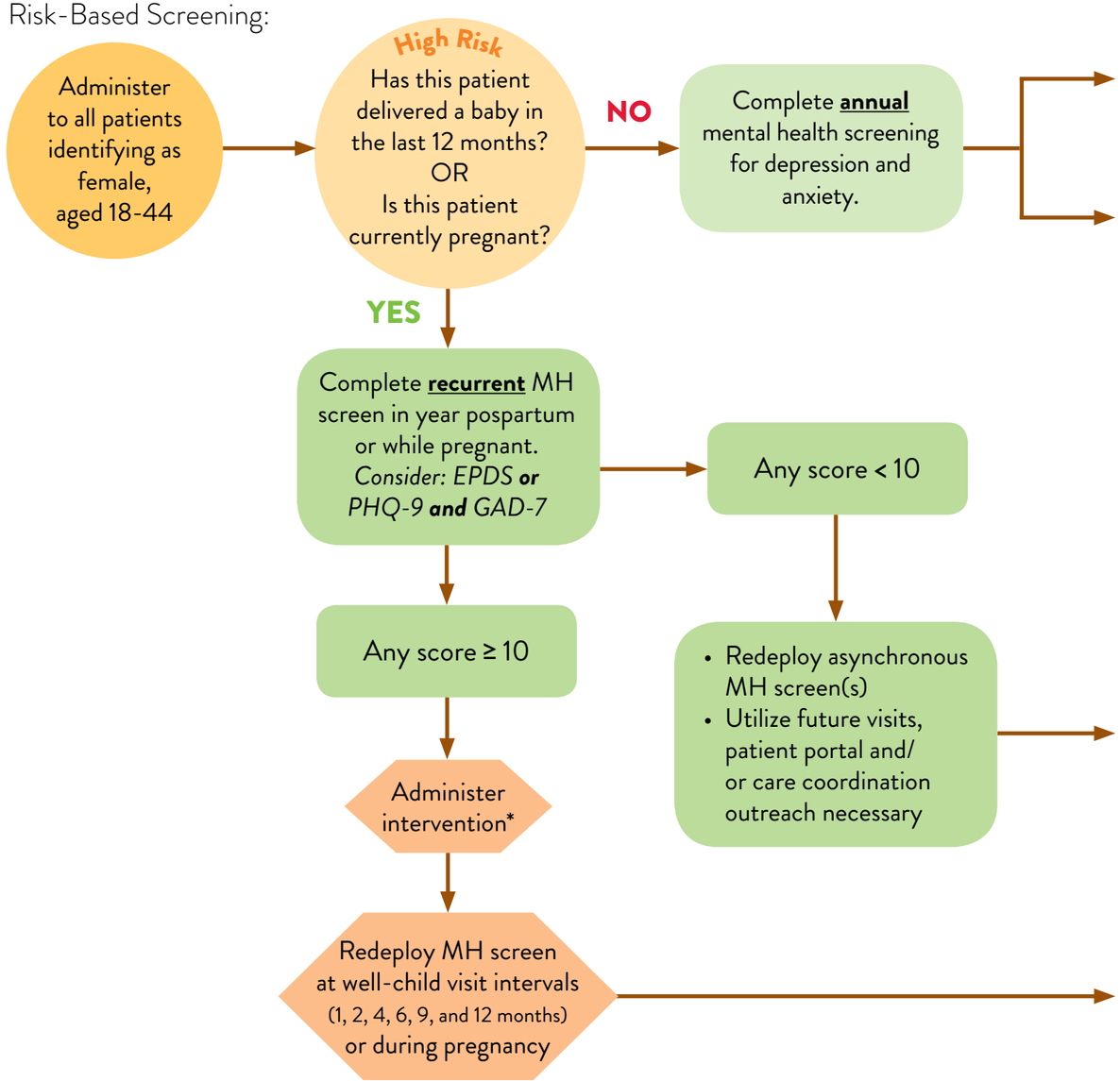
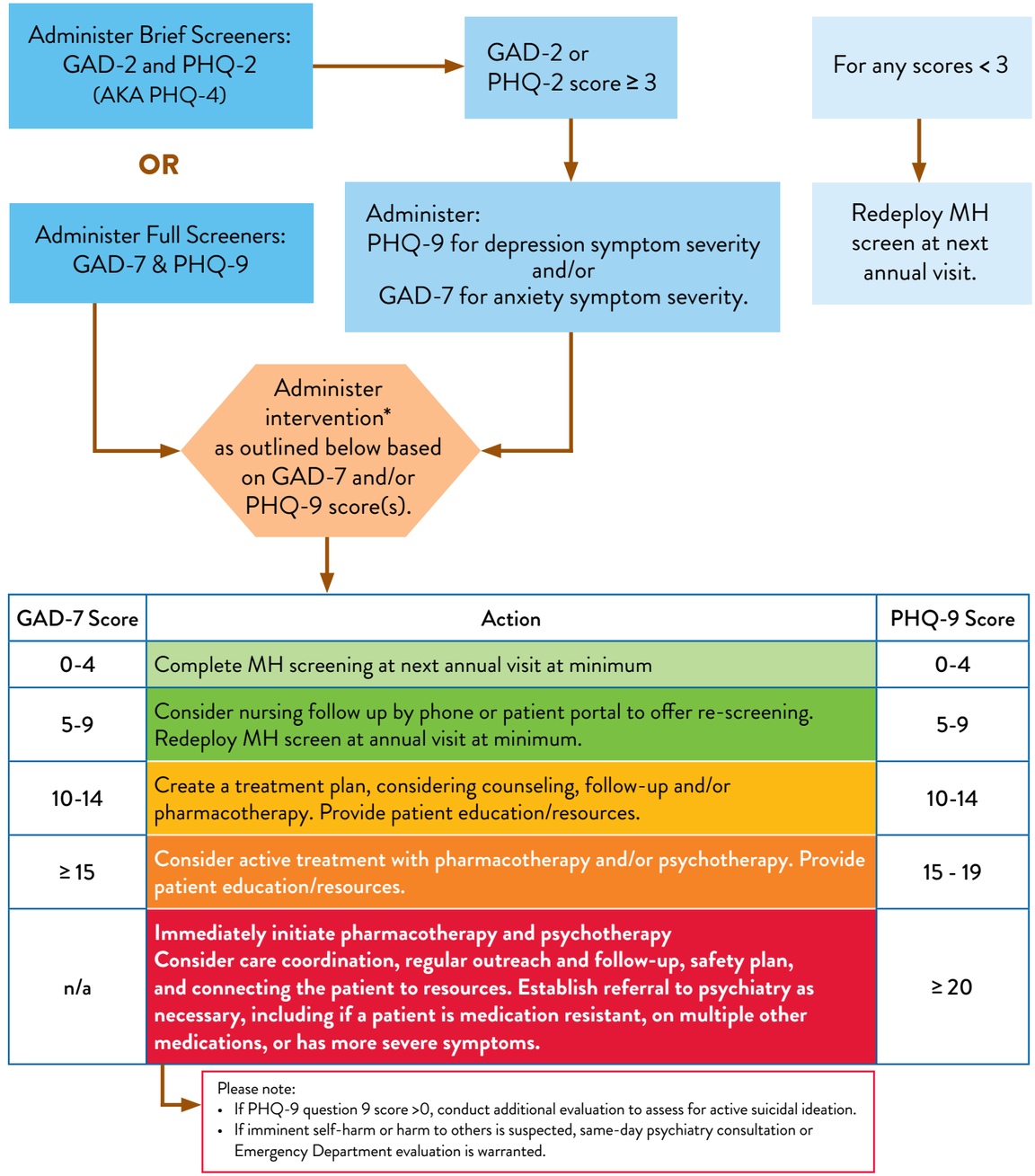
- Dr. Casia Horseman, Clinical Assistant Professor of Psychiatry and Behavioral Health, Division of General Psychiatry, OSU Department of Psychiatry and Behavioral Health, OSU College of Medicine
- Dr. Colleen Waickman, Child & Adolescent Psychiatry Fellow, OSU Department of Psychiatry and Behavioral Health, OSU College of Medicine
- The project team would like to recognize Dr. Jaina Amin for her contributions to these materials.

Workflow

The following workflow can be used to determine whom to screen, which screener to use, and how to determine the next actions based upon screener scores.

Risk-Based Screening:





GAD-7 Score	Action	PHQ-9 Score
0-4	Complete MH screening at next annual visit at minimum	0-4
5-9	Consider nursing follow up by phone or patient portal to offer re-screening. Redeploy MH screen at annual visit at minimum.	5-9
10-14	Create a treatment plan, considering counseling, follow-up and/or pharmacotherapy. Provide patient education/resources.	10-14
≥ 15	Consider active treatment with pharmacotherapy and/or psychotherapy. Provide patient education/resources.	15 - 19
n/a	**Immediately initiate pharmacotherapy and psychotherapy Consider care coordination, regular outreach and follow-up, safety plan, and connecting the patient to resources. Establish referral to psychiatry as necessary, including if a patient is medication resistant, on multiple other medications, or has more severe symptoms.**	≥ 20

Please note:
- If PHQ-9 question 9 score >0, conduct additional evaluation to assess for active suicidal ideation.
- If imminent self-harm or harm to others is suspected, same-day psychiatry consultation or Emergency Department evaluation is warranted.

Acronyms:
MH - Mental Health
EPDS - Edinburgh Postpartum Depression Screen
PHQ - Patient Health Questionnaire
GAD - Generalized Anxiety Disorder

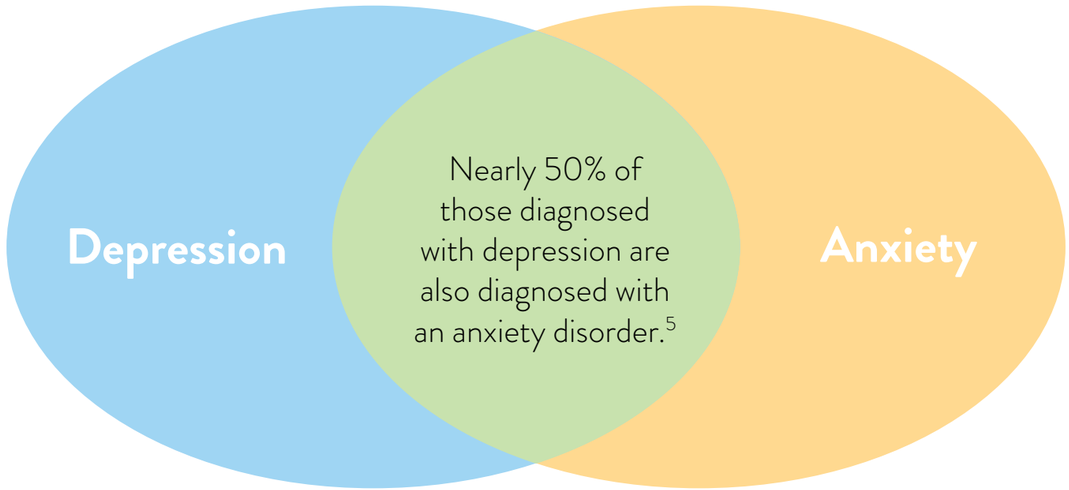
* Intervention to include referral, medication, follow-up and/or therapy. If currently pregnant, POEMS referral should be included.

- Barry, M. J., Nicholson, W. K., Silverstein, M., Coker, T. R., Davidson, K. W., Davis, E. M., U.S. Preventive Services Task Force. (2023). Anxiety in adults: Screening. U.S. Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/anxiety-adults-screening
- Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. Psychiatric Annals, 32(9), 509–515. https://doi.org/10.3928/0048-5713-20020901-06
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine, 166(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Initial Risk-Based Screening

Women are twice as likely as men to develop depression or anxiety throughout their lifetime.[1,2] Additionally, the COVID-19 pandemic has had a significant impact on mental health. The number of women who reported mental health impacts from COVID-19 was threefold that of men with more than a quarter of women reporting increased stress, anxiety, and other mental health struggles.[3] Depression in women is most common among the ages 25-44.[4]

Focus on ME is dedicated to improving health outcomes for women of childbearing age. Participating sites will implement best practice mental health interventions for screening, diagnosing, and treating women of reproductive age for depression and anxiety symptoms and disorders.



1 Farr, S. L., Bitsko, R. H., Hayes, D. K., & Dietz, P. M. (2010). Mental health and access to services among US women of reproductive age. American Journal of Obstetrics and Gynecology, 203(6). *https://pubmed.ncbi.nlm.nih.gov/20817143/.*

2 Remes, O., Brayne, C., van der Linde, R., & Lafortune, L. (2016). A systematic review of reviews on the prevalence of anxiety disorders in adult populations. Brain and Behavior, 6(7). *https://doi.org/10.1002/brb3.497*.

3 CARE Insights. In Practice Rapid Gender Analysis. Rapid gender analysis. *https://insights.careinternational.org.uk/in-practice/rapid-gender-analysis*.

4 Depression in women. Mental Health America. (2021). Retrieved from *https://www.mhanational.org/depression-women#3*.

5 "Facts & Statistics" Anxiety & Depression Association of America, *https://adaa.org/*

Population to Screen

All women between the ages of 18-44 should be screened for mental health symptoms. Screening for detection and treatment of mental health issues in primary care settings can improve quality of life, help contain health care costs, and reduce complications from co-occurring mental health and medical comorbidities.[6] Screeners, such as PHQ-2 or 9 and GAD-2 or 7, should be used at every annual visit to assess mental health repeatedly throughout a woman's life.

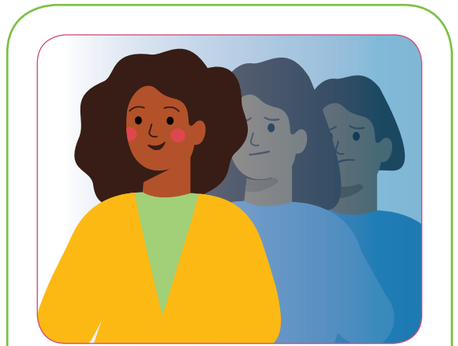
High Risk Groups

Pregnant/Postpartum Women:

- This time involves considerable life changes that can cause additional stress.
- Additional factors can elevate the risk of depression or anxiety including: experiencing infertility, a history of postpartum depression, experiencing environmental stressors during pregnancy and postpartum, or perinatal loss/ traumatic birth, among others.

Individuals with Current or History of Substance Use Disorder:

- Addiction and mental health concerns are co-occurring disorders for many individuals.[7]
- Be sure to get a social history and screen for substance use/abuse by asking your patient about alcohol consumption, opioid use, and using any other non-prescribed substances.



Fewer than half of women who experience clinically significant depression or anxiety receive care.[1]

6 Mulvaney-Day N, Marshall T, Downey Piscopo K, et al. Screening for Behavioral Health Conditions in Primary Care Settings: A Systematic Review of the Literature. J Gen Intern Med. 2018;33(3):335-346. doi:10.1007/s11606-017-4181-0.

7 Anxiety disorders and depression research & treatment. Anxiety and Depression Association of America, ADAA. (2021). Retrieved from https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression.

Addressing Health Equity

Providers should be aware of stigma surrounding mental health diagnosis and treatment among women of color and non-dominant cultural communities may be greater than among other women.[8] Screening tools may be less likely to detect depression/anxiety symptoms for certain groups, so consider physical symptoms and/or phrasing like "I don't feel like myself" to help make a determination of next steps. Since screener scoring might not identify a relevant issue; clinical judgment is always needed. Trust your training and instinct. If the score is 0, but patient is exhibiting signs/symptoms, consider that stigma and other cultural components may be impacting scores.

Source: Adapted from an infographic by the American Psychological Association (2015)

Stigma affects all women with mental health concerns, but it may be particularly acute in minority populations. Cultural differences may make it less likely for women in minority groups to seek treatment, including: distrust of health care providers, lack of connection to a provider, and concern for how they would be seen in their communities. Providers should be aware of cultural differences that may be barriers to receiving care.

8 Misra, S., Jackson, V. W., Chong, J., Choe, K., Tay, C., Wong, J., & Yang, L. H. (2021). Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States: Implications for interventions. American Journal of Community Psychology. *https://doi.org/10.1002/ajcp.12516*.

Steps Following Mental Health Screening

1) Initial Screen Option

While brief screeners exist for anxiety and depression (GAD-2, PHQ-2, PHQ-4), many clinics opt to streamline their workflow and complete the full PHQ-9 and GAD-7. Screeners are available in Appendices A-D.

- If initial brief screeners are used, be sure to complete the full screener (PHQ-9 or GAD-7) for individuals with scores ≥ 3.
- Starting with a full screener (PHQ-9, GAD-7, or Edinburgh Postnatal Depression Scale (EPDS)) is recommended for women that have history of a psychiatric condition; are pregnant; or within 12 months of delivery.
- Additionally, consider social determents of health screenings for this group as many risk factors go unrecognized and postpartum depression is driven by these risk factors (e.g. stress, financial difficulties, etc.).

2) Interpret Full Screener Score

Scores on the PHQ-9 and GAD-7 will determine next steps in treatment and referrals, based on score severity.

- PHQ-9 scores of 5, 10, 15, and 20 represent points for mild, moderate, moderately severe and severe depression, respectively.
- GAD-7 scores of 5, 10, and 15 represent points for mild, moderate, and severe anxiety, respectively.
- EPDS scores ≥ 10 require additional follow-up to determine an appropriate treatment and/or referral plan. EPDS has a high anxiety component and may underscore somatic depression.
  - » If using the EPDS, score information can be found here: *https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf*

3) Establish Care Plan

Establishing a care plan should include a monitoring schedule, follow-up treatment, and risk-based interval rescreening.

- If the PHQ-4 screener score indicates an issue, rescreen in 3 months and utilize nurse-based care coordination.
- Identify when in-person follow up is needed and connect the patient with resources.
- Pregnant or postpartum women can be connected to POEM – Perinatal Outreach & Encouragement for Moms.

When utilizing the PHQ-9 and GAD-7, refer to the table on page 3 to determine next steps based on score severity.

- Consider discussing therapeutic modalities with the patient including, lifestyle additions/changes, medications, primary care integrated behavioral health referral, a collaborative care program (PCP/Psychiatry), or full psychiatry referral.
- Engaging social workers may be appropriate for addressing social determinant of health needs.

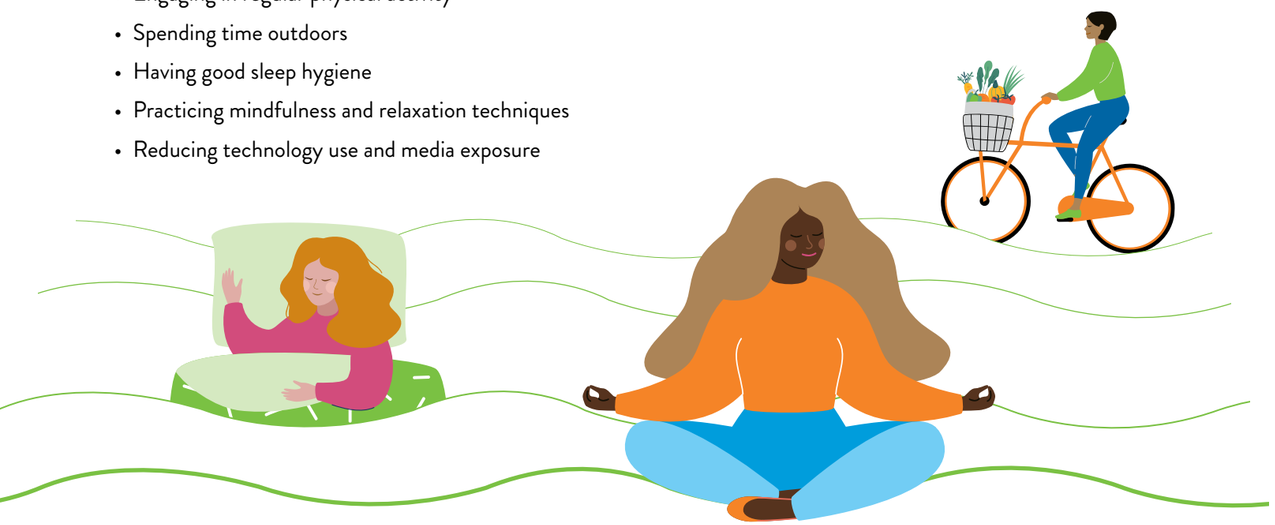
Treatment Options

Treatment options may include medication, therapy, or a combination of both. Consider the role of shared decision making, which has been proven to improve outcomes in routine mental health care.[9]

Wellness Activities

Encourage patients to engage in one or more wellness activities to help improve their mental health, including:

- Following a healthy eating plan
- Engaging in regular physical activity
- Spending time outdoors
- Having good sleep hygiene
- Practicing mindfulness and relaxation techniques
- Reducing technology use and media exposure



Therapy/Counseling

Counseling is appropriate any time a person is experiencing considerable life stress, anxiety, depressed mood, or other type of emotional challenges regardless of the severity of symptoms. Counseling can sometimes be helpful when people are feeling well, but concerned about an upcoming life event.

Consider counseling prior to medication if GAD-7 and/or PHQ-9 is less than 14 if the patient is receptive to this treatment approach.

Psychologytoday.com can be used to find therapists in your area and can filter for insurance and illness expertise.

9 Slade M. Implementing shared decision making in routine mental health care. World Psychiatry. 2017;16(2):146-153. *doi:10.1002/wps.20412*.

Medication

Start a conversation with your patient to see if they will benefit from medication. Before starting medication, complete a clinical interview to assess the severity of the symptoms and the negative impact on her day-to-day life. Symptoms interfering with functioning should be treated. Continue medications if there is a recent history of depression or moderate to severe anxiety, and the patient is stabilized on the medication. Patients requiring mood stabilizers, antipsychotics, and/or benzodiazepines should be under the care of a psychiatrist. The below table is intended to provide medications for consideration and high-level guidance but should not replace patient specific risk/benefit analysis. The decision to use medication should involve shared decision between the healthcare provider and the patient.

For more specific information related to medication use during pregnancy/postpartum, refer to *LactMed database*.
To see a list of medications covered by Medicaid, check the Ohio Department of Medicaid's *Ohio Unified Preferred Drug List*.

Medication Class	Name of Medication	Symptom Coverage	May Consider Use in Pregnancy	May Consider Use in Lactation	Reduce Risk in Lactation
SSRIs*					
	Zoloft, Lexapro Celexa Prozac Paxil**	Anxiety, Depression	Yes Yes Yes Yes	Yes Yes Yes Yes	Low cross over into breastmilk
	*Risk of adverse effects from illness in pregnancy include: Low Birth Weight; Preterm Labor; Miscarriage.[10]				
	**Paxil – 2006 study indicated cardiac malformations with Paxil use; Subsequent studies have not supported this data.[11,12]				
SNRIs					
	Effexor, Pristiq	Anxiety, Depression	Yes	Yes	Low cross over into breastmilk
	Cymbalta	Anxiety, Depression, Pain	Yes	Yes	Low cross over into breastmilk
Other Antidepressants					
	Wellbutrin	Depression, Smoking Cessation	Yes	Yes	Low cross over into breastmilk
	Remeron	Anxiety, Depression, Nausea, Sleep	Yes	Yes	Low cross over into breastmilk
	Trazodone	Anxiety, Depression, Sleep	Yes	Yes	Low cross over into breastmilk
FGA/SGA[13]					
	Haldol, Thorazine	Psychosis, Mood stabilization, Hyperemesis	Yes	Yes	Low cross over into breastmilk
	Seroquel, Zyprexa, Risperdal, Invega, Geodon	Psychosis, Mood stabilization	Yes	Yes	Low cross over into breastmilk
	Abilify†, Vraylar	Psychosis, Mood stabilization	Yes	Yes	Low cross over into breastmilk
	†Reduction in milk production has been reported.				
Mood Stabilizers[13]					
	Lithium°	Mood Stabilization	Yes, w/caution	Yes, w/caution	Low cross over into breastmilk
	°Lithium- Ebstein anomaly over estimated correlation; Have a prelevel prior to pregnancy when pt is stable, for comparison throughout pregnancy to adjust dosing. Risk of Ebstein anomaly if lithium given in first trimester; discuss risks versus benefits with patient.				
	Lamictal°°	Mood Stabilization	Yes	Yes	Low cross over into breastmilk
	°°Lamictal – Have a pre-level prior to pregnancy, for comparison throughout pregnancy to adjust dosing.				
	Depakote	Contraindicated In Pregnancy.	No	No	
Benzodiazepines◊					
	Xanax Ativan Klonopin		*Yes, with caution.	*Yes, with extreme caution.	High cross over into the breast milk
	◊Benzodiazepines – closer to delivery, shorter half-life medications preferred over longer half-lives; utilize lowest needed dose. Can cause maternal sedation.[10]				

10 Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 5. (2023). Obstetrics and gynecology, 141(6), 1262–1288. *https://doi.org/10.1097/AOG.0000000000000520*.

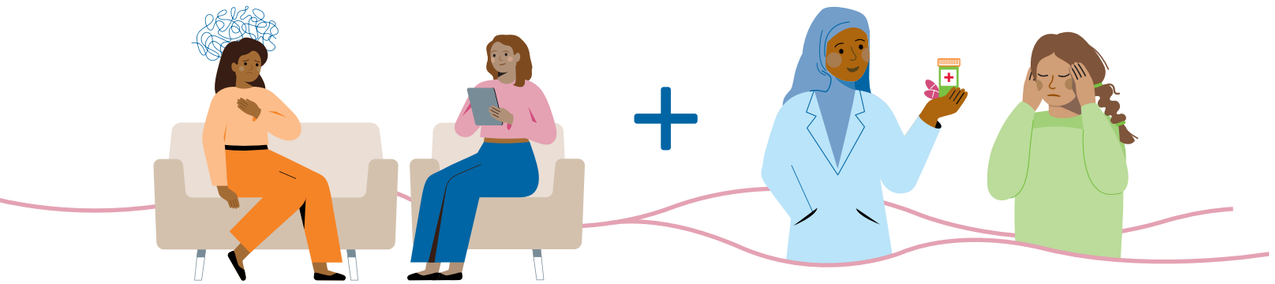
11 Huybrechts, K. F., Palmsten, K., Avorn, J., Cohen, L. S., Holmes, L. B., Franklin, J. M., Mogun, H., Levin, R., Kowal, M., Setoguchi, S., & Hernández-Díaz, S. (2014). Antidepressant use in pregnancy and the risk of cardiac defects. The New England journal of medicine, 370(25), 2397–2407. *https://doi.org/10.1056/NEJMoa1312828*.

12 Jimenez-Solem, E., Andersen, J. T., Petersen, M., Broedbaek, K., Jensen, J. K., Afzal, S., Gislason, G. H., Torp-Pedersen, C., & Poulsen, H. E. (2012). Exposure to selective serotonin reuptake inhibitors and the risk of congenital malformations: a nationwide cohort study. BMJ open, 2(3), e001148. *https://doi.org/10.1136/bmjopen-2012-001148*.

13 Clark, C. T., & Wisner, K. L. (2018). Treatment of Peripartum Bipolar Disorder. Obstetrics and gynecology clinics of North America, 45(3), 403–417. *https://doi.org/10.1016/j.ogc.2018.05.002*.

Medication + Counseling

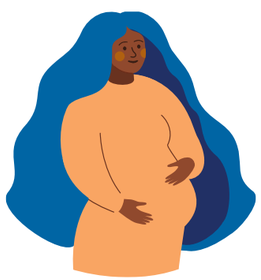
Evidence shows that counseling and medication together may be an effective method of treatment for depression and anxiety. Medication can often help ease symptoms of anxiety or depressed mood and help people better engage in therapy. This allows the opportunity to make long-term changes in their lifestyle and develop ways of coping to support their mental health. For those who benefit from medication, counseling can help prevent relapse or recurrence of symptoms if or when medication is discontinued.



The benefits of both counseling and medication in moderate to severe symptomology has been shown to be more effective than medication or counseling alone.[14] Counseling in cases of mild depression symptoms has been shown to have equivalent outcomes to medications.

Considerations for Pregnancy and Postpartum

Counseling for both depression and anxiety during pregnancy will provide patients with support and skills that can be utilized in the postpartum period. Support groups in pregnancy have been shown to help postpartum outcomes for prevention of postpartum depression and postpartum anxiety. During pregnancy women can be connected to centering programs and other support groups focused on preventing postpartum depression. During the postpartum period, Postpartum Support International (*https://www.postpartum.net/*) has non-clinical support groups for postpartum women.



Connect your patient with a POEM (Perinatal Outreach and Encouragement for Moms; (*https://mhaohio.org/get-help/maternal-mental-health/*) referral and/or social work engagement. POEM provides a variety of services for pregnant and postpartum women around Ohio, including: a mom-to-mom support line (614-315-8989), a peer mentoring program, support groups, and the Rise Program providing support for Black and African American women.

14 American Psychological Association. (2021). How do I choose between medication and therapy? American Psychological Association. Retrieved from *https://www.apa.org/ptsd-guideline/patients-and-families/medication-or-therapy*.

Barriers to Care

Fewer than half of women who experience clinically significant depression or anxiety receive care.[15] There are many barriers to care to consider when a patient needs treatment.

Cost of Care

The personal cost of receiving care can act as a barrier to treatment. It is important to know that there are state and federal laws to protect mental health treatment insurance coverage.

1. **State Law:** A state law was enacted in 2006 requiring coverage for the diagnosis and treatment of biologically based mental health issues.
2. **Federal Law:** The Mental Health Parity and Addiction Equity Act was enacted in 2008, and generally requires health plans to provide coverage for mental health and substance use disorder benefits in the same or similar manner as physical health benefits in the same plan.[16]
3. Pharmacy savings programs, such as Good RX, can also reduce the out-of-pocket medication cost.

Check the Ohio Department of Medicaid's Ohio Unified Preferred Drug List, to see a list of medications covered by Medicaid:
https://pharmacy.medicaid.ohio.gov/unified-pdl

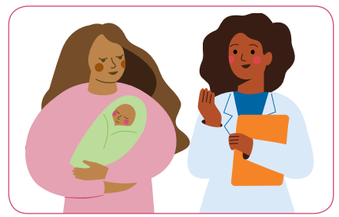
Lack of Available Care

Access to care is another barrier to mental health treatment. It can be difficult to get a timely appointment with a mental health professional. Your role in addressing depression and anxiety disorders in a primary care setting helps address the lack of available specialized care.

Using telehealth reduces burdens related to time and transportation.

Pregnancy/Postpartum

Stigma may also affect pregnant or postpartum women who have mental health concerns. Bringing up these concerns can allow the provider to address the reality of depression/anxiety in pregnancy and postpartum and that it affects 10-25% of mothers.[17]



Openly discuss concerns around:
- Child removal
- Family and societal judgments
- Not being a good mother because they are not happy with their pregnancy or newborn

15 Depression in women. Mental Health America. (2021). Retrieved from *https://www.mhanational.org/depression-women#13*.
16 Ohio Department of Insurance. (2024). Mental health and substance use disorder benefits: Understand your coverage. Retrieved from *https://insurance.ohio.gov/consumers/mental-health/resources/01-understanding-your-benefits*
17 Lebel, C., MacKinnon, A., Bagshawe, M., Tomfohr-Madsen, L., & Giesbrecht, G. (2020). Elevated depression and anxiety among pregnant individuals during the COVID-19 pandemic. *https://doi.org/10.31234/osf.io/gdhkt*.

Patients to Escalate:

Emergency Care and Psychiatry Supported Needs Criteria

If your patient meets any of the following criteria, an urgent referral to psychiatry for follow up within 24-48 hours is recommended, or immediate evaluation in the Emergency Department (ED) if imminent self-harm or harm to others is suspected.

- Immediate Evaluation in the ED

  Women that screen as dealing with some of the following:

  - » Postpartum psychosis,
  - » Suicidal thoughts,
  - » Exacerbation of schizophrenic symptoms, or
  - » Other mental health conditions requiring potential hospitalization

  Note: Postpartum obsessive compulsive disorder may be confused with postpartum psychosis

- Referral to psychiatry
  - » Complicated depression, not responding to the first line SSRI treatment at maximum dosing
  - » Bipolar, schizophrenia, or post traumatic stress disorder

Your nearest academic center may have a reproductive mental health service that can provide consultation or collaborate in your patient's care. See the resources section for information on local resources.

If your patient meets any of the criteria noted, an urgent referral to psychiatry for follow up within 24-48 hours is recommended, or immediate evaluation in the Emergency Department (ED) if imminent self-harm or harm to others is suspected.

Resources

For additional information on depression and anxiety in women and the Focus on Me project, visit: *https://grc.osu.edu/Projects/Focus-on-Me*

Emergency mental health assistance: *https://988lifeline.org/*

The following resources can be provided to pregnant or postpartum women:

www.Mothertobaby.org

https://womensmentalhealth.org/

https://www.cdc.gov/reproductivehealth/features/maternal-depression/index.html

https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/antidepressants/art-20046420

Information related to medication use during pregnancy/postpartum:

Reprotox app for phones, quick access

LactMed – Drugs and lactation database: LactMed is available online at *https://www.ncbi.nlm.nih.gov/books/NBK501922/*

Transportation and Other Assistance Resources

Individuals insured by Medicaid have access to a transportation assistance program through Paramount Advantage: *https://www.paramounthealthcare.com/medicaid/additional-services/transportation-assistance-program*.

For assistance with food, housing, employment, healthcare, counseling, and more: call 211 or visit *www.211.org*

For the screeners:

PHQ-4, PHQ-9 & GAD-7 Screeners: *https://www.phqscreeners.com/*

EPDS and Score Interpretation: *https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf*

For training opportunities on women's mental health, any provider is able to do a self-study to increase personal knowledge through the National Curriculum in Reproductive Psychiatry: *https://www.ncrptraining.org*

Ohio Resources for Depression and Anxiety

NAMI Ohio Helpline Resource Guide	Assists individuals seeking help for themselves or a loved one experiencing mental illness. *https://namiohio.org/wp-content/uploads/2021/01/Helpline-Manual-8.pdf*
OhioMHAS Ohio Department of Mental Health and Addiction Services	Coordinates a statewide system of mental health and addiction prevention, treatment and recovery services. *http://mha.ohio.gov/*
OSPF Ohio Suicide Prevention Foundation	Prevention, education and resource organization focused on promoting suicide prevention. *http://www.ohiospf.org/*
OACBHA Ohio Association of County Behavioral Health Authorities	Statewide organization that represents the interests of Ohio's county Alcohol, Drug Addiction, and Mental Health Boards. *https://www.oacbha.org/*
Ohio Council of Behavioral Health & Family Services Providers	Statewide trade and advocacy association that represents 150 private organizations that provide alcohol and other drug addiction, mental health, and family services. *http://www.theohiocouncil.org/*
Ohio Psychiatric Physicians Association	Dedicated to promoting the highest quality care for people with mental disorders and to serving the professional needs of Ohio's psychiatric physicians. *http://www.ohiopsychiatry.org/aws/OPPA/pt/sp/home_page*

Source: *https://namiohio.org/resources/*

Appendix A

PHQ-4

	Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
GAD-2	1. Feeling nervous, anxious or on edge	0	1	2	3
	2. Not being able to stop or control worrying	0	1	2	3
PHQ-2	3. Little interest or pleasure in doing things	0	1	2	3
	4. Feeling down, depressed, or hopeless	0	1	2	3

Scoring

PHQ-4 total score ranges from 0 to 12, with categories of psychological distress being:

None	0-2
Mild	3-5
Moderate	6-8
Severe	9-12

Anxiety subscale = sum of items 1 and 2 (score range, 0 to 6)

Depression subscale = sum of items 3 and 4 (score range, 0 to 6)

On each subscale, a score of 3 or greater is considered positive for screening purposes

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The PHQ scales were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, and Kurt Kroenke and colleagues. The PHQ scales are free to use. For research information, contact Dr. Kroenke at kkroenke@regenstrief.org

Kroenke K, Spitzer RL, Williams JBW, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics 2009;50:613-621.

Source: *https://www.oregonpainguidance.org/app/content/uploads/2016/05/PHQ-4.pdf*

Appendix B

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

Source: *https://www.phqscreeners.com/*

Appendix C

GAD-7

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

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

Source: *https://www.phqscreeners.com/*

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 — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

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 copied 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

Source: *https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf*

Appendix D

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

Source: *https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf*

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