

# The Colorado Pediatric Postpartum Depression Screening and Referral Toolkit

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\*Some materials adapted with permission from the  
Dartmouth Parent Well-being Project and the UIC Perinatal Mental Health Project

## 1. Overview of Postpartum Depression and Mood Disorders & Rationale for Screening in Pediatric Practice

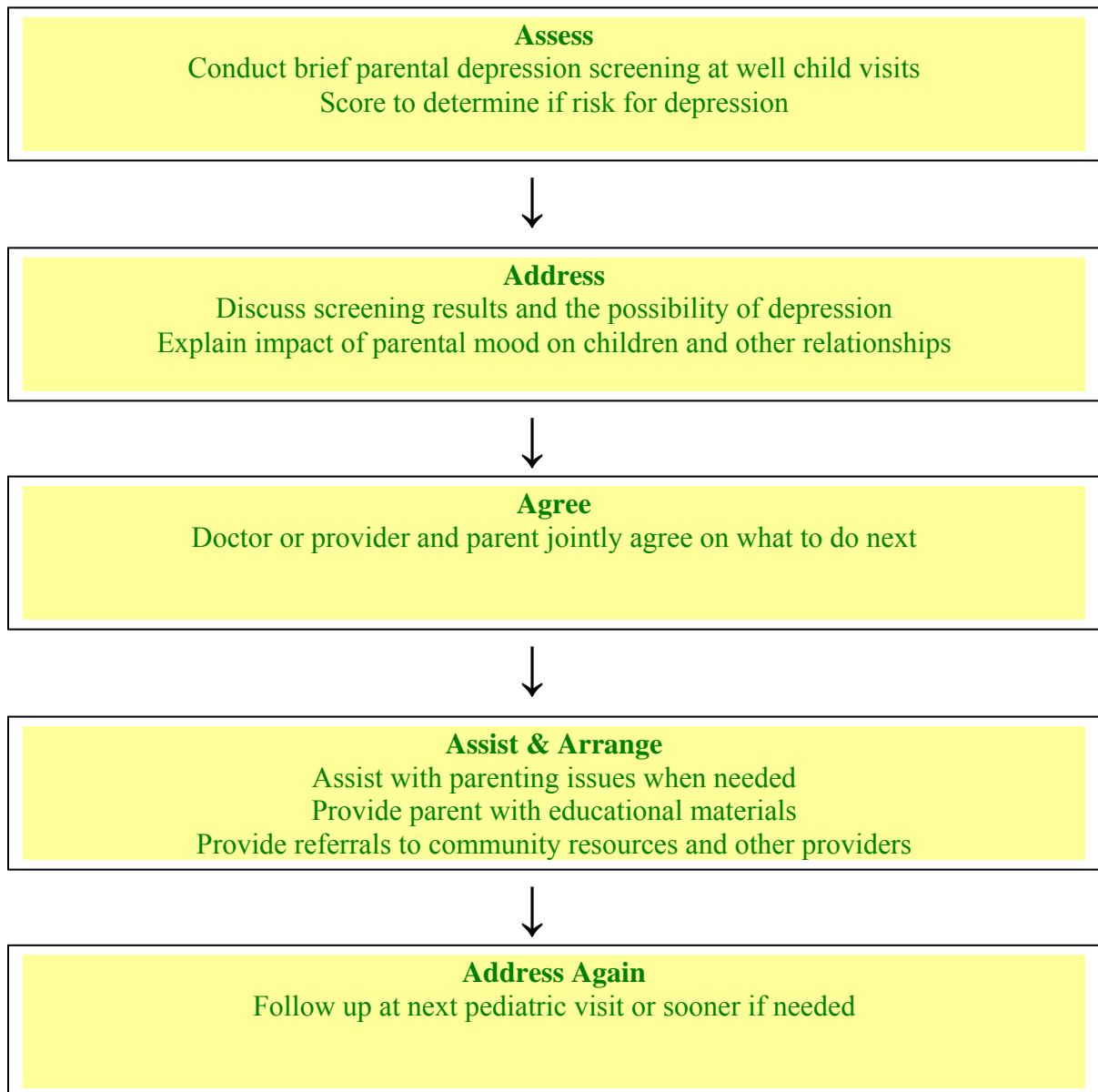
- ▶ Postpartum depression is a serious medical and psychiatric illness and a significant health concern.
- ▶ Approximately 12% of all new mothers develop symptoms consistent with a major depression in the post-partum period.
- ▶ If left untreated, half of these mothers, about half will continue to have symptoms that last greater than 1 year.
- ▶ These symptoms include sadness, lack of energy and pleasure, irritability, guilt, anxiety, as well as thoughts of wanting to harm the infant.
- ▶ Several lines of research have shown that post-partum depression has significant risk for the child's cognitive, social, and emotional development and may impact school readiness.
- ▶ In addition, the depressive symptoms lead to difficulties in the mother-infant and parental relationship.
- ▶ The depressive symptoms are also associated with excessive urgent care and emergency room visits as well as missed scheduled routine pediatric visits.
- ▶ Providing pediatric anticipatory guidance to a depressed caregiver does not change any parental behaviors in regard to safety, sleep, nutrition, reading, and interaction.
- ▶ Pediatric care providers of infants are in a strategic position to screen and refer depressed mothers for behavioral health evaluation and support.
- ▶ Pediatric provider inquiries about maternal health have been viewed as appropriate by mothers.
- ▶ Pediatricians, historically, like other primary care providers, have low rates of detecting maternal depression and few pediatricians have a systematic approach to screening for maternal depression.

**For these reasons, pediatricians have been encouraged by the American Academy of Pediatrics and The Bright Futures Task Force to incorporate detection of parental depression into routine care of the infant.**

## 2. ROLE OF PEDIATRIC PROVIDER IN THE SCREENING PROCESS

There are five required steps for a clinician to screen parents of their pediatric patients for depressive symptoms and assist these parents (Figure 1). Parental perinatal depression screening with the Edinburgh Postnatal Depression Screen identifies mothers and/or fathers with depressive symptoms who are at increased risk for major depression. It does not provide a diagnosis of depression. The EPDS tool can also be used to monitor severity of symptoms and improvement in treatment.

**Figure 1.**  
**Pediatric Clinician's Guide to Parental Depression Screening**



### **ASSESS:**

We recommend using the EPDS to systematically screen parents at suitable infant well visits. The ten questions are scored by simply adding up the numbers to the side of the endorsed symptoms.

- ▶ A parent who scores 10 or higher is considered at high risk for a depressive disorder.
- ▶ A parent who scores 12 or higher likely has a depressive disorder.

### **ADDRESS:**

The pediatric provider reviews the results and discusses positive scores (10 or greater) with the parent. If the parent has a low level of symptoms (< 10 score), the provider should only explore these issues further if a parent desires. If a parent with a low score is still concerned he or she may be depressed or has a borderline score, providers should discuss the possibility of depression, because lower levels of symptoms in parents can significantly affect parenting. This discussion may also provide an opportunity for parents to share social stressors in the family, current depression treatment, and other issues that may affect their parenting.

If the parent acknowledges he or she might be depressed or has a high level of depressive symptoms, the provider should offer information about how the parent's mood or mental health might impact the health and well-being of the child. The pediatric provider plays a key role in motivating parents to address depression. Many parents will get help if they understand it will help their child and other relationships as well.

### **AGREE:**

If the parent acknowledges depressive symptoms or that depression is a concern, then the provider should discuss options for further assessment and/or treatment. Coming to a joint decision that depression might be an issue is a good starting point for getting parents to take appropriate action.

### **ASSIST and AGREE:**

The pediatric provider can refer the parent to his or her primary care provider, a mental health clinician, or other community resources for further evaluation and assistance. Providers can offer parents educational materials about the impact of parental depression on children's health. Information about handling stress is particularly helpful because one-third of parents who screen positive say they have problems with stress.

The provider should also explore whether the parent has any concerns about how their child is doing. The provider can offer assistance with the child's developmental, behavioral, or emotional problems. The provider can also provide information about parenting approaches that will help children thrive even if the parent is having difficulties.

### **3. Implementation Guide for Screening**

#### **Instructions for Using the Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)**

The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for perinatal depression.

- ▶ It is a proven screening tool.
- ▶ It is easy to administer.
- ▶ It can be completed at home and brought to a physician's office (OB, Pediatric, Family Practice) or in the office of a mental health practitioner.
- ▶ It can also be completed in the medical setting.

The scale indicates how the woman has felt *during the previous week*.

If the screen is completed prior to 3 weeks postpartum, the woman may be suffering from postpartum blues and the algorithm for specialty screening should be consulted.

It may be useful to repeat the screen in 2 weeks in questionable cases.

**The EPDS score should inform but not override clinical judgment as a complete and thoughtful clinical assessment should be carried out to confirm the diagnosis.**

#### **Instructions for using the Edinburgh Postnatal Depression Scale:**

- Step 1. Ask the woman to check the response that comes closest to how she has been feeling in the previous 7 days.
- Step 2. All items must be completed.
- Step 3. The mother should complete the scale herself, unless she has limited English or has difficulty with reading. She should not discuss her answers with others.

#### **SCORING**

- ▶ A score of greater than 12 as a threshold value is: 100% sensitive, 95.5% specific for PPD
- ▶ Possible Depression: 10 or greater
- ▶ Always look at item #10 for suicidal thoughts.

Good clinical care also involves asking if the mother has fears about hurting the baby or fears of the baby coming to harm.

*Users may reproduce the scale for clinical use without further permission, providing they respect copyright by quoting the names of the authors, title, and source of the paper in all reproduced copies.*

<sup>1</sup>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.

<sup>2</sup>Boyce, P., Stubbs, J., and Todd, A. 1987. The EPDS: validation for an Australian sample. *Aust N Z J Psychiatry* 27:472-6.

#### **4. Jump Start Your Practice**

► **If you want to jump in and start screening today and referring to The Children’s Hospital Perinatal Mental Health Program or other Community Mental Health Program, do the following:**

- 1. Print out the next 2 pages of the toolkit as a 2-sided document. The (Edinburgh Postnatal Depression Scale) EPDS serves as the appropriate screening tool and the other side, Frequently Asked Questions by Women and Families, serves as the educational and counseling form and provides the woman the appropriate contact number to ask for help.**
- 2. If the patient scores higher than 12, go through the educational material on the back side and encourage her to call the referral number.**
- 3. Hand her the screener and referral form and document the screen and referral in the medical record.**

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For further technical assistance in implementing this toolkit in your practice, call 303-864-5252 and request an office presentation from Dr. Stafford or email him at [Stafford.brian@tchden.org](mailto:Stafford.brian@tchden.org).

## 5. Edinburgh Postnatal Depression Scale

Print the Edinburgh Postnatal Depression Scale (screening test) and answer the questions. Add the numbers to the left of the boxes. If you score greater than 10 on the EPDS, seek help from a healthcare professional. Take the completed scale with you to show the doctor or nurse in your primary care office, urgent care facility, or emergency room.

### Edinburgh Postnatal Depression Scale<sup>1</sup> (EPDS)

Name: \_\_\_\_\_ Baby's Name \_\_\_\_\_  
Your Date of Birth: \_\_\_\_\_ Address: \_\_\_\_\_  
Baby's Date of Birth: \_\_\_\_\_ Phone #s: \_\_\_\_\_

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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:

- (0)  Yes, all the time      This would mean: "I have felt happy most of the time" during the past week.  
(1)  Yes, most of the time      Please complete the other questions in the same way.  
(2)  No, not very often  
(3)  No, not at all

**In the past 7 days:**

- |   |   |
|---|---|
| 1. I have been able to laugh and see the funny side of things<br>(0) <input type="checkbox"/> As much as I always could<br>(1) <input type="checkbox"/> Not quite so much now<br>(2) <input type="checkbox"/> Definitely not so much now<br>(3) <input type="checkbox"/> Not at all | 6. Things have been getting on top of me<br>(3) <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all<br>(2) <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual<br>(1) <input type="checkbox"/> No, most of the time I have coped quite well<br>(0) <input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things<br>(0) <input type="checkbox"/> As much as I ever did<br>(1) <input type="checkbox"/> Rather less than I used to<br>(2) <input type="checkbox"/> Definitely less than I used to<br>(3) <input type="checkbox"/> Hardly at all     | 7. I have been so unhappy that I have had difficulty sleeping<br>(3) <input type="checkbox"/> Yes, most of the time<br>(2) <input type="checkbox"/> Yes, sometimes<br>(1) <input type="checkbox"/> Not very often<br>(0) <input type="checkbox"/> No, not at all  |
| 3. I have blamed myself unnecessarily when things went wrong<br>(3) <input type="checkbox"/> Yes, most of the time<br>(2) <input type="checkbox"/> Yes, some of the time<br>(1) <input type="checkbox"/> Not very often<br>(0) <input type="checkbox"/> No, never                   | 8. I have felt sad or miserable<br>(3) <input type="checkbox"/> Yes, most of the time<br>(2) <input type="checkbox"/> Yes, quite often<br>(1) <input type="checkbox"/> Not very often<br>(0) <input type="checkbox"/> No, not at all  |
| 4. I have been anxious or worried for no good reason<br>(0) <input type="checkbox"/> No, not at all<br>(1) <input type="checkbox"/> Hardly ever<br>(2) <input type="checkbox"/> Yes, sometimes<br>(3) <input type="checkbox"/> Yes, very often                                      | 9. I have been so unhappy that I have been crying<br>(3) <input type="checkbox"/> Yes, most of the time<br>(2) <input type="checkbox"/> Yes, quite often<br>(1) <input type="checkbox"/> Only occasionally<br>(0) <input type="checkbox"/> No, never  |
| 5. I have felt scared or panicky for no very good reason<br>(3) <input type="checkbox"/> Yes, quite a lot<br>(2) <input type="checkbox"/> Yes, sometimes<br>(1) <input type="checkbox"/> No, not much<br>(0) <input type="checkbox"/> No, not at all                                | 10. The thought of harming myself has occurred to me<br>(3) <input type="checkbox"/> Yes, quite often<br>(2) <input type="checkbox"/> Sometimes<br>(1) <input type="checkbox"/> Hardly ever<br>(0) <input type="checkbox"/> Never   |

Total Score (Add scores) \_\_\_\_\_ Date \_\_\_\_\_  
Administered/Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>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.

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## 6. Patient Education Materials and Referral Numbers

### Frequently Asked Questions by Women and Families

#### What Postpartum Depression Means for You and Your Family

**What is postpartum depression?**

**Postpartum depression affects 1 of 8 mothers.** Nearly all mothers experience the “baby blues,” a **two-week period** of mood instability, exhaustion, sleep problems, and crying. When the “baby blues” don’t go away, it may likely be due to postpartum depression.

**What are the symptoms of postpartum depression?**

Symptoms of postpartum depression include frequent crying spells, fatigue, difficulty concentrating, persistent sadness, sleep and appetite disturbance, and irritable mood. Some mothers are very anxious and overly concerned about their baby while others lack interest in their baby or other family members.

If the baby blues worsen or last longer than 2 weeks after delivery, you are likely suffering from postpartum depression.

**Should I get help?**

Yes, you should seek help. Treatment of depression is very successful. Without treatment, however, the depression is not likely to lift soon.

**What if I don’t get help?**

Half of all mothers who develop postpartum depression continue to have significant symptoms when their baby turns 1 year old unless they get treatment. Depression can affect all aspects of your life including your relationships.

Untreated Postpartum Depression can also lead to delays in your infant’s emotional, cognitive, and speech.

**Where can I get help?** There are many people who can help you. Your doctors or nurses or social worker can help.

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Help is available at  
The Children’s Hospital Perinatal Mental Health Program  
We have many experts in treating postpartum depression  
and other perinatal mood disorders.

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**What will my doctor do today?**

Your doctor will ask you questions about your mood and may request some blood tests to rule out medical conditions. S/he will discuss treating your depression through supportive talk therapy, medication, or a combination of both.

**What should I do next?**

**Call 303-864-5252 and schedule an appointment to see Dr Stafford at  
The Children’s Hospital Perinatal Mental Health Program**

## 7. Guidelines for Pediatricians:

### Detailed Tips for Addressing & Agreeing on Next Steps

#### When to screen:

- ▶ **2 month or 4 month visit**
  - The EPDS is a valid screen for depression any time after 3 weeks postpartum. It is a valid screening tool as well as a tracking tool for depressive symptoms
  
- ▶ **2- or 4-month Visit** Screen for depressive symptoms (EPDS).
  - A score greater than 12 at the 2 or 4 month visit is likely postpartum depression ---> provide education and refer for evaluation and treatment
  
  - A score between 10-12 is at high risk for postpartum depression. ---- > provide education and consider referral for evaluation and treatment
  
- ▶ **Step 1:** Screen for depressive symptoms (EPDS).
  - **A score greater than 10 is highly indicative of PP Depression**
    - For scores of **5-9**, encourage more family support, mild exercise, and other wellness behaviors
    - For score **>10** inquire further:
      - a) Ask about thoughts or behaviors of wanting to harm self or baby.
      - b) Ask about feelings of feeling so good, high, excited, or hyper that other people thought that you were not your normal self or you got into trouble.
      - c) Ask about feeling so irritable that you found yourself shouting at people or starting fights or arguments.
      - d) Ask about Family History of Bipolar Mood Disorder
      - e) Inquire about disorganized thought patterns, auditory or visual hallucinations.
  
- ▶ **Step 2:** If a, b, c, and d are negative, encourage more family support, mild exercise, and continue to monitor weekly. Repeat this screen weekly if the EPDS continues to stay above 10, or at the 2-month and 4-month checkups.
  
- ▶ **Step 3:** If 'a' is positive, assess severity of thoughts, plans, intent, and safety of situation, and consider referral to Mental Health.
  
- ▶ **Step 3:** If a, b, c, or d is positive, refer for psychiatric evaluation as these symptoms are consistent with postpartum mania.
  
- ▶ **Step 4:** If e is positive, refer for emergent psychiatric evaluation to rule out postpartum psychosis.

### **When to screen:**

- ▶ **2 week visit**
  - Screening at the 2 week visit is an excellent time to develop the relationship with the parent
  - The EPDS is not a valid screen for depression at the 2 week visit, but it is useful for identifying high risk as well as providing an educational opportunity and to discuss accessing instrumental and social supports.

### **Guidelines for Pediatric Visits**

- ▶ **2 week visit**
- ▶ **Step 1:** Screen for depressive symptoms (EPDS).
  - **A score greater than 10 is indicative of PP Blues**
    - For scores of **5-9**, encourage more family support, mild exercise, and continue to monitor closely.
    - Provide anticipatory guidance about the difference between the baby blues and postpartum depression : “If these symptoms and feeling persist for another week or two, seek care for postpartum depression and contact a Behavioral Health Provider or your Obstetric Care provider.
    - For score **>10** inquire further:
      - a) Ask about thoughts or behaviors of wanting to harm self or baby.
      - b) Ask about feelings of feeling so good, high, excited, or hyper that other people thought that you were not your normal self or you got into trouble.
      - c) Ask about feeling so irritable that you found yourself shouting at people or starting fights or arguments.
      - d) Ask about Family History of Bipolar Mood Disorder
      - e) Inquire about disorganized thought patterns, auditory or visual hallucinations.
- ▶ **Step 2:** If a, b, c, and d are negative, encourage more family support, mild exercise, and continue to monitor weekly. Repeat this screen weekly if the EPDS continues to stay above 10, or at the 2-month and 4-month checkups.
- ▶ **Step 3:** If ‘a’ is positive, assess severity of thoughts, plans, intent, and safety of situation, and consider referral to Mental Health.
- ▶ **Step 3:** If a, b, c, or d is positive, refer for psychiatric evaluation as these symptoms are consistent with postpartum mania.
- ▶ **Step 4:** If e is positive, refer for emergent psychiatric evaluation to rule out postpartum psychosis.

## **8. Guide for Psycho-tropics and Breast Feeding**

### **FAQ: by Pediatric Providers Regarding Psychotropic Medications Postpartum Mood and Anxiety Disorders**

Both medication and psychotherapy show benefit for postpartum depression and anxiety.

#### **Use in the Postpartum Period**

The American Academy of Pediatrics has concerns about infants being exposed to SSRIs during the postpartum period

- ▶ All medications enter into the mother's breast milk.
- ▶ In spite of these concerns, toxicologists and other researchers can rarely detect these medications in the infant's plasma.
- ▶ The exception to this finding is that Prozac (fluoxetine) has a very long half-life and has been detected in the infant's blood and can be associated with poor sleep, jitteriness, and colicky- like behavior in the infant.
- ▶ There are case reports of Adverse Drug side effects in infants whose mothers are taking the following medications: Prozac, Celexa, and Wellbutrin (seizure in the infant)
- ▶ Although concern for infant safety remains, these medications are rarely detectable in the infant and very rarely associated with immediate side effects.
- ▶ As with SSRI exposure in utero, researchers have not found any sequelae to exposure to SSRIs in breast feeding women. Rather, as before, the consequences of untreated postpartum and other maternal depressions appear to be toxic to infant development.
- ▶ Benzodiazepines are also rarely detected in the infants of breast feeding women
- ▶ The expert consensus is that medications are helpful in treating postpartum depression and show little risk to the infant.

**Specifically, prozac is recommended for non-breast feeding mothers and Zoloft is recommended for breast feeding mothers.**

**Most SSRIs and other atypical antidepressants are probably safe.**

- ▶ Antidepressants are not likely indicated for women who have a family history of Bipolar Disorder unless in conjunction with a psychiatric evaluation.

**Information for Physicians on Prescription Products to Treat Postpartum, Depression** – September, 2009  
Treatment decisions should be based on patient characteristics and clinical judgment.

<b>Anti -depressants</b>	<b>Recommended Dose* (mg/day)</b>	<b>Percent of Dose to Breastfeeding Baby**</b>	<b>Reported Side Effects to Breastfeeding Infants</b>	<b>Detectable Level in Infants?</b>	<b>Half-Life of Metabolites</b>	<b>FDA Class</b>
<b>Sertraline</b> (Zoloft)	• 50 – 200 mg (25,50, 100, 200)	• 0.4% - 1.7%	• None	Not detectable	26 hours	C
<b>Fluoxetine</b> (Prozac)	•20 – 60 mg (10, 20, 40)	• 1.2% - 12.0%	• Vomiting, watery stools, excessive crying, difficulty sleeping, tremor, somnolence, hypotonia, decreased weight gain	Serum levels evident given long half-life of fluoxetine and metabolite	9 days	C
<b>Paroxetine</b> (Paxil)	• 20 – 60 mg (10, 20, 30, 40)	• 0.1% - 4.3%	• None	Not detectable	21 hours	D
<b>Escitalopram</b> (Lexapro)	• 10 mg (5, 10, 20)	• Not known	• Not known	Rare report of detectable level	30 hours	C
<b>Citalopram</b> (Celexa)	• 20 – 40 mg (10, 20, 40)	• 0.7% - 9.0%	• Uneasy sleep	Rare report of detectable level	30 hours	C
<b>Bupropion</b> (Wellbutrin; Zyban)	• 200 – 300 mg (150XL, 300XL, 100SR, 150 SR, 200SR)	• Not known	Seizures (Case report)	Rarely detectable	21 hours	C
<b>Venlafaxine</b> (Effexor)	• 75 – 225 mg (37.5XR, 75XR, 150XR)	• 5.2% - 8.1% Higher for desvenlafaxine metabolite	• None	Metabolite present in breast milk, rare in infant serum	11 hours	C
<b>Mirtazapine</b> (Remeron)	•15 – 45 mg (15, 30, 45)	• Not known	Not known	• Unknown	30 hours	C
<b>Luvox</b> (Fluvoxamine)	• 50-200mg 20, 50, 100	•1.3%	None	None	25 hours	C
<b>Desvenlafaxine</b> (Pristiq)	• 50 50, 100mg ER	Higher for desvenlafaxine metabolite < 10%	None	None	40 hours	C
<b>Cymbalta</b> (Duloxetine)	• 20-120 20, 30, 60		None	None	17 hours	C
<b>Desipramine</b> (Norpramin)	•100 – 200 mg (10, 25, 50, 75, 100)	1.0%	None	Not detectable	17 hours	C
<b>Noryptiline</b> (Pamelor)	•50 – 150 mg (10, 25, 50, 75)	Not known	None	At limit of detectability	14 hours	C

Expert Consensus Favors Zoloft for Breast-feeding and Prozac for Non Breast-Feeding mothers.

All other SSRIs, SNRIs, and atypicals are likely safe

## 9. Other Educational Materials for Families and Providers

### **Information for family and other individuals concerned about a depressed mother**

- ▶ Postpartum depression (PPD) is a significant health concern. Approximately 10-15% of all new mothers develop symptoms consistent with a major depression in the post-partum period.
- ▶ Of these mothers, about half will continue to have symptoms that last greater than 1 year unless they seek treatment.
- ▶ These symptoms include irritability, guilt, anxiety, as well as thoughts of wanting to harm the infant.
- ▶ Mothers who have PPD do not like feeling this way nor can they “snap out of it.” It is not something within their control. PPD is a condition that is thought to be related to hormonal changes after the delivery of the child.
- ▶ The “baby blues” is a two-week period where new mothers are prone to mood instability, exhaustion, sleep problems, and crying. When the “baby blues” don’t go away, it may likely be due to postpartum depression.
- ▶ Symptoms of postpartum depression include frequent crying spells, fatigue, difficulty concentrating, persistent sadness, sleep and appetite disturbance, and irritable or unstable mood. In addition, some mothers are very anxious and overly concerned about their baby while others lack interest in their baby or other family members.
- ▶ Help is available for mothers with PPD. If you have a close relationship with the mother, gently share your concern and ask or insist that you attend the baby’s pediatric visit or the mother’s follow-up visit with her obstetrician.
- ▶ Share your concerns with the doctor. The physician will likely ask the mother to answer some questions to help him/her decide if there is a possibility that mother may be experiencing postpartum depression. The doctor may prescribe medication for her, refer her to a psychiatrist for an evaluation, and/or refer her for individual or group therapy. Several effective anti-depressant medications do not enter the mother’s breast milk and thus, are safe for the baby.

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**If you would like to have someone you care about seek treatment for  
postpartum depression at The Children’s Hospital  
Perinatal Mental Health Program, call 303-864-5252 today.**

## 10. Websites of interest

- [www.kempe.org/ppd](http://www.kempe.org/ppd): The Children's Hospital Perinatal Mental Health Program
- [www.mededppd.org](http://www.mededppd.org): Provider education website
- [www.pdin.org](http://www.pdin.org) : State System of Perinatal Mental Health Care Toolkit
- [www.health.harvard.edu/women](http://www.health.harvard.edu/women) Harvard Women's Health
- [www.postpartum.net](http://www.postpartum.net) Postpartum Support International Website

## **11. Practice Implementation Tips**

### **IMPLEMENTATION GUIDE FOR DEPRESSION SCREENING AT THE PRACTICE LEVEL**

Brief parental screening for depressive symptoms is designed to be incorporated into the routine well care of pediatric patients. As with any substantial change in a practice, it is easier to implement if the entire practice is involved. It is important to define the tasks involved in the screening and assign responsibilities to various staff members. The following steps are designed to assist the lead clinician and other staff in setting up a screening program in their practice.

A senior pediatric provider who wishes to add perinatal depression screening to their practice must champion the program with their colleagues and staff. We recommend forming a small group of about three people (one clinician and one to two staff) to lead the practice through the process of designing and implementing the new screening procedures. Every person in the practice plays a critical role in implementing the screening program, so representatives from all aspects of the operation should be included in the small leadership group.

Figure 2 is a worksheet that summarizes the steps needed to prepare to implement depression screening for parents. These steps are described in more detail below.

#### **PART 1: PREPARE YOUR PRACTICE**

##### **ENGAGE YOUR PRACTICE:**

Practice staff or other clinicians may have concerns about adding depression screening to routine well care. The first step is to meet with everyone in your practice and engage them in a discussion about the reasons for screening parents for depression and how it will improve patient care. Every person in the practice contributes to patient care, so it is important for every person to understand their role in the process.

The clinician champion can present the benefits of screening based on materials in this manual.

Staff or clinician burden is a primary consideration in deciding when to implement a change in a practice. Issues such as staff or clinician turnover or being in the middle of a change to an electronic medical record system can affect a practice's ability to initiate and maintain change. Practices should start perinatal depression screening when other aspects, such as clinical volume, staffing, and medical records systems, are relatively stable.

## **DEVELOP YOUR PRACTICE APPROACH:**

### *1. When and Who to Screen*

Effective screening requires a systematic method of identifying parents to screen and conducting the screening. Who will be screened? We recommend routinely screening parents who present with their children for well visits at the 2 week, 2month, and 4 month visit. Since depression and depressive symptoms can occur at any time and their severity may fluctuate, screening should be ongoing. If this is impractical, we recommend screening at the 2month visit.

Although the screening questionnaire is very brief, discussion with parents who are symptomatic or have concerns may require additional time that is best incorporated into well visits. The well-child visit is also the setting where parents expect to discuss parenting, their child's behavior, and development. All of these areas may be adversely affected by parental depression. In addition, since continuity may foster trust, parents may be more comfortable discussing these issues with their child's regular provider rather than the clinician seeing their child when he/she is sick.

### *2. Choose a Screening Tool*

We recommend a ten-question paper survey, the Edinburgh Postnatal Depression Scale (EPDS) with a written introduction. These questions have been widely tested and shown to accurately identify parents at high risk for a depressive disorder. A copy of the EPDS is available in the packet. Most practices like to put the Patient Education Materials and Referral Numbers Frequently Asked Questions by Women and Families page on the back side of the EPDS. This serves as an immediate educational tool and provides the referral number.

The EPDS is a screening tool and does not diagnose depression. Parents who report symptoms or score at risk need to complete a more comprehensive assessment or be referred for assessment and treatment with another clinician.

### *3. Explore Available Resources and Establish Triage / Referral Mechanism*

The Children's Hospital's Perinatal Mental Health Program can treat women with Denver Medicaid and all Private Insurances. We have also trained the local mental health centers how to provide suitable perinatal mental health care as well. **See attached referral list.**

## **DEVELOP AN OFFICE SYSTEM**

After developing a protocol for who to screen, when to screen, what screening questionnaire to use, and how to support parents who screen positive, the next step is to define a systematic office-wide approach or “office system.” This process consists of defining each step or task, the roles of clinicians and staff, and “tools” (EPDS, educational fliers, poster, etc) and considering how to integrate these new tasks into existing patient care.

The role of the pediatric provider in parental depression screening has been described earlier. However, many of these tasks can be delegated to staff. This process is outlined on the worksheet "Part 2: The Visit and Beyond" and described in more detail in the following section of the manual.

### *1. Train Staff*

Introduction of the screening is important to your patients’ acceptance of this process. Below is a sample script that has been used to inform parents about depression screening during their child’s visit. If the screen is asked on a separate paper survey, an introduction can be included on the survey.

“Since you were last here, we have implemented a new program that includes a depression screening tool. We know that a parent’s mood and emotional health significantly affect children, so we are interested in identifying and referring parents who might be depressed. I will leave this short questionnaire with you and I would like you to discuss it with Dr. Jones when s/he comes in to see Johnny. There are also some educational brochures on the table for you to read. Please feel free to take any that interest you.”

“As part of our routine care of your child, we are asking all parents who come in with their children to complete a depression screening form. We know that depression affects both parents and their children, so we are asking for this information as a part of your child’s routine care. After you complete the form, Dr. Jones will discuss the results with you and offer some resources that can be helpful if you are interested.”

It is important that practice staff who distribute or collect the survey information are comfortable dealing with common patient questions. A list of frequently asked questions and possible responses is included in the appendices. If your practice decides to offer parents further assessment or referral assistance, appropriate staff will need to receive training on the EPDS and referrals procedures.

### *2. Develop System to Distribute Screener and Record Results*

Once your practice decides which parents will be screened, it is necessary to develop a system to identify those parents when they present at the practice. Your practice probably has a system for identifying types of visits and paperwork for each type of visit. Your decision about when you will screen the parent and which tools you will use may be determined, in part, by your current processes, such as

using a paper health history or an electronic medical record (EMR). As with other assessments, the results need to be documented in a consistent manner. If a paper screener is used this may be charted or results of the screener may be noted in a problem list, visit notes, or other location based on other documentation of the events of a visit.

### *3. Change Office Environment and Select Monitor*

In addition to discussing parental perinatal depression during visits, a practice can heighten parental awareness and education about depression by placing posters and brochures in waiting rooms, hallways near scales, bathrooms, and exam rooms. Posters and other educational materials are provided in the appendices. As with all patient education materials, a staff member needs to monitor their availability and keep adequate supplies in designated areas.

## **PART 2: THE VISIT AND BEYOND**

It is important to involve the entire office in developing the office systems. A simple method for determining how to incorporate parental depression screening into your practice is a “walk through.” Pretend that you are a parent coming to a well visit and examine the activities that occur at each encounter during the visit. Ask yourself the following: Who does the parent speak with first? What is the parent asked during this first encounter? Do you want to add a screening task to this encounter? How would you do that? Repeat this process for each person the parent encounters: the individual who prepares the child for the visit, the clinician, the check-out person, etc.

The steps described in "Part 2, The Visit and Beyond" are based on our experiences in primary care practices that implemented parental screening. A copy of this worksheet is included in the appendices. The worksheet is color-coded to suggest which person in the practice might complete each task. One way to ensure consistent screening is to incorporate screening tasks into a job description, just as measuring height, weight, and blood pressure are incorporated into the job of a roomer, who prepares the child for the visit.

This manual includes a set of tools to help your practice carry out the tasks required to screen for parental depression. All staff involved in the planned approach should be trained in the use of the tools and the approach. Most practices will be able to integrate the defined tasks into existing procedures rather than developing new steps or tools. For example, the EPDS can be added to a paper health history, the results noted in the problem list, etc. If an EMR is used the system can be set up to prompt discussion of the EPDS, recording the results in the problem list, or tracking referrals.

Practices found that some of the posters that were strategically placed in the rooms, lobby, or by the baby scales prepared families for the screening and discussion. Access in the rooms to educational materials and Web resources made the clinician’s discussion of both parental depression and parenting issues more efficient.

**Implementation Guide for Depression Screening  
Part 1 "Prepare Your Practice"**

\*Before you begin screening, you need to prepare your practice. Consider the following list of tasks.

WHAT	WHO (In the space provided, write the person who will be responsible for performing the task)	HOW
<b>Engage Your Practice</b>		
1. Identify Champions	Who: _____ —	1. Identify a provider and a member of the practice staff who together will champion the screening program. Who are the practice champion(s)? _____
2. Motivate Staff	Who: _____	2. Get your staff involved by setting the expectation that helping depressed parents is important part of routine care, and seek their ideas about helping families understand and cope.
3. Educate Staff	Who: _____	3. Educate your staff about parental depression and its impact on children. Determine attitudes or misconceptions that may influence screening.
<b>Develop Practice Approach</b>		
1. When and Who to Screen	Who: <u>2wk (+/-) , 2month (Yes)</u>	1. Decide if screening is at all well child visits or limited by age or parent gender.
2. Choose Screening Tool	Who: <u>EPDS</u>	2. Select screening tool.
3. Explore Available Resources	Who: <u>Completed</u>	3. Develop a list of mental health referral options, community agencies, parental support groups, support lines, and Web sites.
4. Network with Colleagues	Who: <u>Completed</u>	4. Contact area providers and mental health agencies to inform them your practice will be screening for parental depression. Ask them if they are willing to accept referrals and provide clinical support.
5. Establish Triage/Referral Mechanism	Who: <u>Completed</u>	5. Determine practice role in linking parent to resources A. Options for practice 1) Individualized referral to outside resources 2) Partner with outside agencies who will perform these services 3) Utilize behavioral health clinician within practice setting for these services
<b>Develop Office System</b>		
1. Train Staff	Who: _____	1. Train staff to introduce screening tool and respond to parents' questions.
2. Develop System to Distribute and Record Screener	Who: _____	2a. Develop a system to have screening tool available at the beginning of the visit. 2b. Choose a method to indicate screening occurred and how to document results.
3. Select Monitor	Who: _____	3. Select a person to check and order materials for screening, and to stock exam rooms with brochures.
4. Change Office Environment	Who: _____	4. Place posters in waiting areas, exam rooms, by scales, etc.

Key: Provider = Blue Clinical Staff = Green Office Staff = Orange



Figure 3. Part 2: The Visit and Beyond

**Implementation Guide for Depression Screening  
Part 2 “The Visit and Beyond”**

<b>WHAT</b>	<b>WHEN</b>	<b>WHO</b>	<b>HOW</b>
<b>Assess</b>			
1. Introduction	In exam room, distribute screener to the parent before s/he sees the provider	Nurse or MA performs this role	1a. Explain the purpose of the screener to the parent 1b. Make sure parent has a pen, and a place to write 1c. Clip screener to chart or develop a method that ensures the health provider sees the completed screener
2. Review	Before going into the exam room or during the visit.	Physician, NP, or other provider performs this role	2. Review and score the screener
<b>Address &amp; Agree</b>			
1. Discuss Results	During the Visit	Physician, NP, or other provider performs these roles	1. Advise parent of negative or discuss positive screening results
2. Educate			2. Discuss with parent the significance of a positive result and the impact of parental moods on his or her child
3. Discuss Current Situation			3a. Talk with parent about stresses and issues that may influence his/her mood and also affect the child 3b. Explore how the child is coping if parent has symptoms
4. Agree on a Plan of Action			4. Jointly agree on what to do next (parent may not wish to take action)
<b>Assist, Arrange &amp; Address Again</b>			
1. Discuss Referral Options	During the visit	Physician, NP, or other provider performs these roles	1. If parent thinks s/he might be depressed, discuss options for treatment/assistance 2. Provide referrals as indicated
2. Provide Referral			3. Provide the parent with educational materials
3. Provide Information			4. Record screening results and actions taken
4. Record	At the end of the visit		
5. Arrange Referral	At the end of the visit	Designated staff member to perform this role	5. If necessary, arrange referral or contact referral provider
6. Follow-up visit	At next visit		6. Arrange to follow up with the parent during a specified time period, or at next visit inquire about how s/he is getting along and about the child’s well-being

Key: Provider = Blue Clinical Staff = Green Office Staff = Orange

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## Numbers for Referral for Perinatal Mental Health Issues

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### The Children's Hospital Perinatal Mental Health Program (Formerly at The Kempe Center)

*Accepts all Private Insurance except Kaiser*

**303-864-5252**

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*Kaiser HMO Insurance:*

Denver Highline Center	<b>303-367-2900</b>
Westminster Hidden Lake	<b>303-650-3900</b>
Wheat Ridge Executive Center	<b>303-467-5800</b>

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*Medicaid/Public/No Insurance:*

**Denver County**

Denver Health:	<b>A Mother's Circle</b>	<b>303-436-6393</b>
	<b>Circulo de Mujeres</b>	<b>303-602-9327</b>

Mental Health Corporation of Denver:	<b>303-504-1250</b>
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Colorado Access:	<b>720-744-5100</b>
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<b>*Boulder/Broomfield County:</b>	<b>Community Infant Program</b>	<b>720-562-0560.</b>
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**\*Jefferson County:**

Jefferson Center for Mental Health:	<b>Mom-Baby Group</b>	<b>303-425-0300</b>
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**\*Aurora**

Aurora Mental Health Center:	<b>Early Childhood and Family Program:</b>	<b>303-617-2465</b>
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**\*Arapahoe and Douglas Counties**

Arapahoe/Douglas Mental Health Center	<b>Mother-Infant Services</b>	<b>303-730-8858</b>
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**Free/Low COST Spanish Speaking Services**

Clinica Tepeyac:	<b>303-458-5302</b>
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<b>University of Colorado Depression Center</b>	<b>303-724-3300</b>
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Fee for Service. Does not accept any insurance.

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\* Trained or endorsed by The Children's Hospital Perinatal Mental Health Program