Area: Pregnant Women

Subject: PW07 – Perinatal/Postpartum Depression Screening

Reference: 1304.40 (c)(3)(iii)

Policy: Early Head Start grantee and delegate agencies will assist pregnant women to access comprehensive mental health interventions and follow-up as part of their prenatal and postpartum care, through referrals immediately after enrollment in and throughout their participation in the program.

Procedure:

1. The Patient Health Questionnaire: Depression Scale (PHQ-9) will be completed as follows:

    a. Within 30 days of enrollment, the pregnant women and their Child Care Specialist (CCS)/Home Based Educator (HBE) will complete the Patient Health Questionnaire: Depression Scale (PHQ-9) together.

    b. Within 6 weeks of giving birth, the postpartum women and their CCS/HBE will complete the Patient Health Questionnaire: Depression Scale (PHQ-9) together.

    c. Enter PHQ-9 into COPA.

2. CCS/HBE will utilize the Mental Health First Aid Action Plan when discussing mental health topics/concerns with pregnant/postpartum women.

Mental Health First Aid Action Plan	
Action A	Assess for risk of suicide or harm
Action L	Listen nonjudgmentally
Action G	Give reassurance and information
Action E	Encourage appropriate professional help
Action E	Encourage self-help and other support strategies

3. The CCS/HBE will review the completed Patient Health Questionnaire: Depression Scale (PHQ-9) screening results with the pregnant women to foster discussion that could lead to one or more of the following strategies: family partnership goal, Social Services Referral, and/or additional educational resources provided to the pregnant/postpartum woman by CCS/HBE.

4. All pregnant/postpartum women completing the Patient Health Questionnaire: Depression Scale (PHQ-9) will be provided a list of community resources for support.

5. Patient Health Questionnaire: Depression Scale (PHQ-9) screening results will be reviewed at monthly case conferencing with Head Start Nurse.

    A. When a PHQ-9 scores in referral range, notify the nurse through COPA

Referral or SCOE email

6. CCS/HBE will notify Head Start Nurse of the pregnant woman's PHQ-9 screening results to assist the pregnant/postpartum women with any needed medical follow-up.

7. CCS/HBE will enter completion dates into COPA to document mental health intervention and follow-up.

8. The following steps will be taken based on the screening score:

   A. If the pregnant/postpartum woman answers "Yes" on question #9 of the PHQ-9 go to Step E.

   B. Screening score of 4 or less
      i. Screening decision: No apparent Perinatal/Postpartum Depression
      ii. Next steps: CCS/HBE will rescreen pregnant woman after birth (see 1b), or if concerns arise.

   C. Screening score of 5 to 9
      i. Screening decision: Increased risk for Perinatal/Postpartum Depression
      ii. Next steps: CCS/HBE will provide pregnant woman education on Perinatal/Postpartum Depression (PPD), engage the family as a support for the pregnant/postpartum woman, offer a referral to a local mental health agency, and advise the pregnant/postpartum woman to contact their primary care physician for guidance.

   D. Screening score of 10 or more
      i. Screening decision: Perinatal/ Postpartum Depression Likely
      ii. Next steps: CCS/HBE will conduct a Risk Assessment to determine if the pregnant/postpartum woman is in immediate danger to harm self/others.

   E. Pregnant woman answers "Yes" on question #9 of the PHQ-9
      i. Screening decision: Pregnant/postpartum woman is "at risk" of harm to self/others
      ii. Next steps: CCS/HBE will conduct a Risk Assessment to determine if the pregnant/postpartum woman is in immediate danger to harm self/others

   F. Risk Assessment will include:
      i. Evaluation of (PHQ-9) screening score and response to question #9 and overall pregnant/postpartum woman's responses to screening questions.
      ii. Determination of whether the pregnant/postpartum woman is showing signs of a person who may be suicidal.

Signs a Person May Be Suicidal
Threatening to hurt or kill themselves
Looking for ways to kill themselves: seeking access to pills, weapons, or other means
Talking or writing about death, dying, or suicide
Hopelessness
Rage, anger, seeking revenge
Acting recklessly or engaging in risky activities, seemingly without thinking
Feeling trapped, like there's no way out
Increasing alcohol or drug use
Withdrawing from friends, family, or society
Anxiety, agitation, unable to sleep or sleeping all the time
Dramatic changes in mood
No reason for living, no sense of purpose in life

9. Results of the Risk Assessment:

    a. Pregnant/postpartum woman is determined to be <u>in immediate danger to self/others</u>. <u>Next steps:</u> CCS/HBE will **immediately** contact their supervisor to discuss the situation. If the danger to self/others is imminent CCS/HBE will call 911.

    b. Pregnant/postpartum woman <u>does not</u> appear to pose an immediate danger to self/others. <u>Next Steps:</u> CCS/HBE will offer a Social Services Referral to a local mental health agency, engage the family, and advise the pregnant/postpartum woman to contact their primary care physician.

Supervised by: Home Based Supervisor

Performed by: Child Care Specialist, Home Based Educator, Head Start Nurse

Forms needed: Patient Health Questionnaire: Depression Scale (PHQ-9), Pregnant Women Case Conference Tracking Sheet, Early Head Start Perinatal Health History, Social Services Referral Form

COPA Procedure: P03- Pregnant Women Prenatal Services

COPA Report: PIR Report

Frequency: Within 30 days of enrollment & 6 weeks after giving birth
Frequency of follow-up screening will be based on individual pregnant woman's need.