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FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Recognizing Risk: Practical Approaches to Screening and Safety in Perinatal Mental Health

NEW YORK STATE | Office of Mental Health

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Nicole Tchalim, MD

Assistant Professor of Psychiatry
Women's and Reproductive Mental Health Program
Columbia University Irving Medical Center
Reproductive Psychiatry Consultant, Project TEACH NY

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Disclosures

"Neither I nor my spouse has a relevant financial relationship with a commercial interest to disclose."

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Objectives:

- Review the epidemiology and risk factors associated with perinatal mental health conditions, substance use disorders, and intimate partner violence (IPV).
- Discuss recommended screening tools during the perinatal period
- Discuss epidemiology and risk factors related to perinatal suicide
- Learn how to use use structured tools to aid in risks assessment and suicide safety planning

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Defining PMADs

PMADs are a leading complication associated with childbirth

Perinatal — Present during conception to first year after giving birth

Mood — major depressive disorder, bipolar disorder, psychotic symptoms secondary to mood disorder, postpartum psychosis

Anxiety — generalized anxiety disorder (GAD), panic disorder, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD)

Disorders — impairment of daily functioning

Zivin, K et al, 2024

Limitations of the PMADs Framework

While use of the terminology PMADs has helped advance awareness of perinatal mental health, the term has notable limitations including limited recognition of substance use disorders and interpersonal/structural factors such as intimate partner violence.

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Learning & Understanding the Stats

- Estimated PMAD prevalence is about 20-25%
- Up to 23% of PMADs start during pregnancy
- PMADs are both underdiagnosed and undertreated
  - Up to 70% of birthing individuals with PMADs go undetected
  - Up to 85% of birthing individuals with PMADs go untreated

Vesga-lopez et al 2008; Vigeura et al 2011, Cox et al 2016

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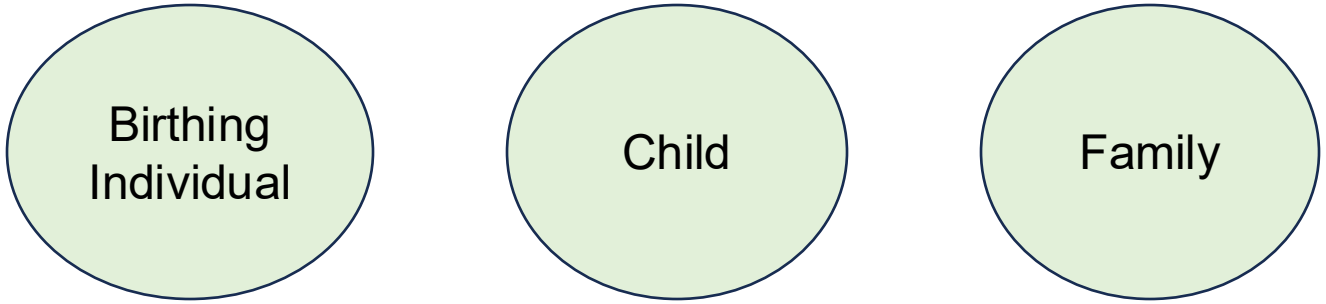
PMADs Associated with Adverse Health Behaviors & Outcomes for the Entire Family System



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Birthing Individual

Maternal/Birthing individual associated adverse health outcomes/behaviors with PMADs	
Psychosocial associations	• Suicide • Illness suffering • Decreased perinatal care • Impaired nutritional intake • Increase of substance use • Impaired work functioning • Impaired bonding with infant • Adverse effect on family dynamics including relationship with partner • Lactation failure or unplanned weaning
Obstetrical associations	• Miscarriage • Preeclampsia/Pregnancy Induced Hypertension • Preterm labor Increased # of surgical delivery interventions • Cesarean delivery • Maternal gestational weight retention • Increased # of hospital transfers

Mckee et al 2020; Bonari et al., 2004; Kimmel MC, et al, 2018; Bansil P et al 2010; Dennis CL et al 2009; Stuebe AM et al, 2014

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Child

Fetal/Child associated adverse health outcomes/behaviors with PMADs

- Intrauterine growth restriction
- Low birth weight
- Infanticide
- Decreased fetal reactivity
- Altered infant brain development
- Postpartum maternel-infant attachment difficulties
- Delays in non-verbal communication in 14-month-old infants
- Increased risk of hyperactivity and conduct disorder in children ages 6-16

Bonari et al., 2004; Kimmel MC, et al, 2018; Rifkin-Graboi A., 2013 & 2015 et al; Qiu A. et al, 2013; Scheinost et al, 2016; Perry DF et al, 2011; Kawai E et al, 2016; MacKinnon N et al, 2017; Murray L, et.al., 2011

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Perinatal Substance Use

- Co-occurrence of mental health conditions and substance use disorders is common in the perinatal period
- Approximately 5% of pregnant women use one or more addictive substances
- Untreated maternal SUDs are linked to high-risk pregnancies, poor infant health outcomes, and maternal mortality

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Perinatal IPV

- Approximately 5.4% of women in the US report IPV during pregnancy
- Perinatal IPV is associated with significant morbidity including pelvic fracture, placental abruption, fetal injury, low birth weight, preterm delivery, and stillbirth
- Approximately 40% of homicides of women pregnant or within a year of pregnancy are related to IPV
- Women are more likely to die from homicide than obstetrical complications during the perinatal period

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Screening in Peripartum:
How often do you and your practice conduct perinatal psychiatric screening?

- Never
- At the initial pregnancy or postpartum visits only
- Several times during the perinatal period
- At every visit.

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Screening: ACOG 2023 Updated Guidelines

ACOG JUNE 2023 Clinical Practice Guidelines:
Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum

- **Everyone** receiving pre-pregnancy, prenatal, and postpartum care should be screened for depression and anxiety using standardized instruments.
- Screening for perinatal depression and anxiety **should occur at the initial prenatal visit, later in pregnancy, and at the postpartum visits.**
- Mental health screening should be **implemented with systems in place** to ensure timely access to assessment and diagnosis, effective treatment, appropriate monitoring, and follow-up based on severity.
- Screening for bipolar disorder should be performed before initiating pharmacotherapy for anxiety or depression, if not previously done

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Screening

- APA recommends screening for depression with a validated screening tool twice during pregnancy, once in early pregnancy for pre-existing psychiatric disorders and once later in the pregnancy; it also recommends postpartum patients be screened for depression during pediatric visits **throughout the first 6 months postpartum**

- The AAFP and the USPSTF recommend screening for depression in the adult population, including pregnant and postpartum persons.

Ko JY et al, 2020

Common Screening Tools

Visit projectteachny.org/maternal-rating-scales for additional scales/screeners

Table 2. Commonly Used Perinatal Mental Health Validated Screening Instruments

PMH Condition	Screening Instrument	No. of Items/Self-Administered (Y/N)	Sensitivity and Specificity	Score for Positive Screen
Depression	EPDS	10/Y	Sensitivity: 55–98% Specificity: 68–97%	≥10
	PHQ-9	9/Y	Sensitivity: 53–77% Specificity: 85–94%	≥10
Anxiety	GAD-7	7/Y	Sensitivity: 73% Specificity: 67%	≥5
	EPDS—anxiety subscale (items 3, 4, 5)	3/Y	Not enough data to estimate; correlates with GAD-7	≥5
	STAI	20/Y	Sensitivity: 81% Specificity: 78%	≥40
Bipolar disorder	MDQ	3 (Q1 with 13 items)/Y	Sensitivity: 44–90% Specificity: 61–92%	≥7 of the 13 items in Q1
	CIDI	2–3 (branching logic)/N	Sensitivity: 69–100% Specificity: 98–99%	Yes to Q3 (Q3 is asked if Q1 or Q2 are affirmed)

Abbreviations: CIDI, Composite International Diagnostic Interview; EPDS, Edinburgh Postnatal Depression Scale; GAD-7, Generalized Anxiety Scale-7; MDQ, Mood Disorder Questionnaire; PMH, perinatal mental health; PHQ-9, Patient Health Questionnaire-9; Q, question; STAI, State-Trait Anxiety Inventory.

Data from Byatt N, Masters GA, Bergman AL, Moore Simas TA. Screening for mental health and substance use disorders in obstetric settings. Curr Psychiatry Rep 2020;22:62 *and* Byatt N, Mittal LP, Brenckle L, Logan DG, Masters GA, Bergman A, et al. Lifeline for moms perinatal mental health toolkit. University of Massachusetts Medical School; 2019. Accessed December 7, 2022. https://www.umassmed.edu/lifeline4moms/products-resources/toolkits-and-apps/2019/11/lifeline4moms-perinatal-mental-health-toolkit/

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Depression Screening Tools

PHQ-9 (Patient Health Questionnaire - 9)

- One of the most widely used depression screening tools
- It has been studied in peripartum populations and found to be valid, comparable to the EPDS (Wang et al, 2021)
- Translated into various languages
- Like the EPDS, the PHQ-9 is a self-report questionnaire (consisting of 9 questions)
- Similarly, a score of 10 is the most commonly used cutoff for a positive screen for depression
- Question 9 specifically addresses suicidal ideation

Edinburgh Postnatal Depression Scale (EPDS)

- First tool developed specifically to screen for depression in peripartum people
- Consists of a 10 item self-rated questionnaire
- A score of 10 is the most commonly used cutoff for possible depression; scores >13 are suggestive of moderate depression
- Question 10 addresses the presence/absence of suicidal ideation

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Anxiety Screening Tools

GAD (Generalized Anxiety Disorder) – 7

- Widely used across many settings to screen for GAD, and has some evidence for validity in pregnant populations
- Consists of a self-report questionnaire made up of 7 questions
- The typical cutoff score used is 10

EPDS

- contains 3 questions (Q3,4,5) which assess anxiety (EPDS 3A)
- A cutoff of 5 or more on this subscale yields a sensitivity of around 70%, specificity of around 92% (Smith-Nielson et al, 2021)

The three questions comprising this EPDS anxiety subscale are:

1. I have blamed myself unnecessarily when things went wrong
2. I have been anxious or worried for no good reason
3. I have felt scared or panicky for no very good reason

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Anxiety Screening Tools (Cont'd)

Perinatal Anxiety Screening Scale (PASS)

- 31 self report questionnaire
- Validated in pregnancy and postpartum
- Assesses four categories of anxiety
  1. Acute Anxiety and Adjustment
  2. General worry and specific fears
  3. Perfectionism, control, and trauma
  4. Social Anxiety

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Bipolar Screening

- Up to 20% of individuals that screen positive for depression in the perinatal period, may have bipolar disorder
- Recognition of bipolar disorder during the perinatal period is often challenging as the most commonly presenting episode is depression
- Using the bipolar screening tools like the MDQ alongside depression screening tools like PHQ-9 or EPDS can help in recognition

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Bipolar Screening Cont'd.

MDQ (Mood Disorders Questionnaire)

- Self-report questionnaire assessing 13 symptoms with yes/no questions, as well as a question assessing timing of symptoms, and a question assessing the degree of impairment caused by the symptoms
- A score of 7 or more is typically used as the cutoff for a positive screen
- Must answer positive to question 2 (assessing the presence of multiple symptoms simultaneously) as well as indicate moderate or serious severity in question 3 as well

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Screening in Peripartum:
How often do you and your practice conduct perinatal substance use or IPV screening?

- Never
- At the initial pregnancy or postpartum visits only
- Several times during the perinatal period
- At every visit.

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Substance Use Screener

Table 3. Screening and Assessment Tools

Tool	Substance Type		Patient Age		Administered by	
	Alcohol	Drugs	Adults	Adolescents	Patient	Clinician
Brief Screener for Alcohol, Tobacco, and Other Drugs (BSTAD)	X	X		X	X	X
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Car, Relax Alone, Forget, Friends, Trouble (CRAFFT)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication and other Substance use (TAPS)	X	X	X		X	X

Adapted from National Institute on Drug Abuse. Screening and assessment tools chart. Accessed April 15, 2024. https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools.

ACOG recommends universal screening for substance use during pregnancy

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Intimate Partner Violence Screening

- ACOG recommends that all pregnant/postpartum women be screened for IPV at periodic intervals during the perinatal period

Table 2: The Verbal HITS* Screening Questions

1. Does your partner physically hurt you?
2. Does he insult you or talk down to you fairly often?
3. Does he threaten you with harm?
4. Does he scream or curse at you fairly often?

* The patient answers "yes" or "no" to each question. A "yes" to one or more questions classifies the patient as a positive screen. Answering "no" to all of the items renders a negative screen. The items can be remembered by the acronym HITS.

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Intimate Partner Safety Planning

- National domestic violence hotline has an online screener that patient can go through includes items like:
  - Creating an emergency exit plan
  - Identifying emergency contacts
  - Legal and law enforcement protections
  - Safety for children, pets, and other dependents
  - Technology and digital safety
- Will provide an emailed copy to patient

NATIONAL DOMESTIC VIOLENCE HOTLINE

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Assessment

- Remember that a screening tool does not make a diagnosis – further assessment is warranted after any positive screen
- Areas for further assessment:
  - Reproductive history
  - Severity, chronicity and co-morbidity
  - **Safety risk**
  - Current stressors
  - Previous treatment experience
  - Treatment preferences
  - Strengths, social support and resources

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Suicide Assessment and Suicide Planning

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Suicide in the Perinatal Period

- Suicide is a leading cause of maternal death
- Mothers with perinatal depression have a 3x higher risk of suicidal behavior
- Methods are more lethal (hanging, jumping)
- Risk for suicide remain elevated throughout the entire postpartum period
  - In NYS (2018-2020), 72.2 percent of pregnancy related deaths attributed to mental health conditions occurred within 43-365 days post-delivery; 22.2% within first 42 days post delivery

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NYS Maternal Mortality Review 2018-2020

Table 6. Distribution of Manner of Death Among Pregnancy-Related Deaths, 2018-2020

Manner of Death	Count (%)
Natural	87 (71.9%)
Accident	19 (15.7%)
Suicide	11 (9.1%)
Homicide	2 (1.7%)
Undetermined	2 (1.7%)
Total	**121 (100%)**

Source: New York State Maternal Mortality Review

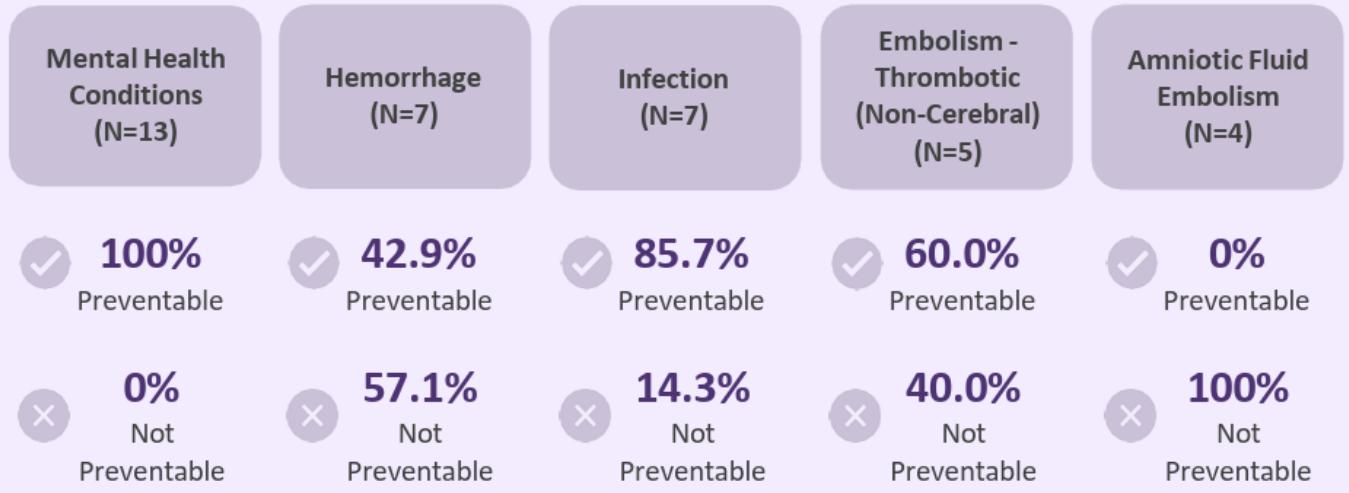
In 2021,100% of pregnancy related deaths due to mental health conditions were judged preventable in NYS

Substance use was found to be a major contributor to maternal mortality related to mental health

TABLE 5. PREVENTABILITY OF PREGNANCY-RELATED DEATHS AND CHANCE TO ALTER THE OUTCOME, 2021

Preventability	Good Chance	Some Chance	No Chance	Overall
Preventable	15 (46.9%)	17 (53.1%)	0	32 (65.3%)
Not Preventable	0	0	17 (100%)	17 (34.7%)

FIGURE 22. DISTRIBUTION OF PREVENTABILITY AMONG PREGNANCY-RELATED DEATHS BY LEADING CAUSES OF DEATH, 2021



In 2021, **100%** (N=**13**) of pregnancy-related deaths due to mental health conditions were deemed **preventable**. In contrast, **100%** (N=**4**) of pregnancy-related deaths due to amniotic fluid embolism were determined to be **not preventable**.

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Protective Factors

Social Support; Belongingness	Strong Therapeutic Relationship with a Trusted Provider
Life Satisfaction	Problem-Solving Skills, Cognitive Flexibility
Sense of responsibility to family	Reality Testing Ability
Coping Skills	Religious Faith

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Risk Factors

Individual	Pregnancy related	Socioeconomic
History of of self harm or prior suicide attempts	Obstetrical or neonatal complications	Younger age
Prior or current psychiatric illness/substance use	Unwanted unintended pregnancy	Intimate partner violence
History of of trauma	Avoidance of health services from fear of losing custody	Lack of social support
Family history of psychiatric illness, suicide ideations, suicide attempt		Social, racial gender discrimination, inequalities

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Suicide Risk Assessment

- Remember that asking about SI does not increase the risk of suicide attempts or “give people ideas”
- Normalize the process: the more uncomfortable you appear, the less forthcoming your patient is likely to be
- Don’t assume a negative response and don’t use vague language/euphemisms
- Follow up and be thorough – adequate risk assessment (and management) requires details
- SI can occur across many diagnosis including depression, postpartum psychosis, and OCD

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What We Would Like To Know

- Current suicidal thoughts (nature, timing, intent)
- Current suicidal plan (access to means, details, preparation)
- Current treatment (accessibility to treatment, current
- Previous attempt (timing, intent, method, consequences)
- Current substance abuse
- Current psychiatric diagnosis and severity of symptoms
- Current medications
- Ongoing substance use
- Current stressors and social supports
- Impulsivity
- Protective factors
- Collateral information

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Suicide Risk Assessment

- There are a lot of tools available to help guide the conversation
- Both the PHQ-9 and the EPDS include questions which can identify the presence of suicidal ideations, but need follow up
- Ask Suicide Screening Questions (ASQ)
- Columbia Suicide Severity Rating Scale (CSSRS)

ASQ Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741741

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Columbia Suicide Severity Rating Scale

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		**High Risk**

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Management

Imminent Risk: Seek a higher level of care

This is appropriate whenever a patent is felt to represent an imminent risk of harm, or is unable/unwilling to engage in safety planning

Mild to Moderate Risk

- Monitor and re-assess
- Safety Plan
- Treatment of underlying psychiatric illness
- Linkage to therapy
- Optimize social supports

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Safety Planning: Suicide Risk is Dynamic

- Steps to limit access to lethal means
- List of concrete warning signs of a developing crisis
- Available coping strategies the patient can utilize
- Social supports patient can reach out to
- Professional contact information's for use during crisis
- Always include planning for safety for any children
  - Ask: *What would be the impact on your child(ren)*

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

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Suicide Risk Resources

- 988 Suicide and Crisis Lifeline
- https://projectteachny.org/maternal-rating-scales/
- Home - Suicide Prévention Center NY (preventsuicideny.org)
- Alliance of Hope For Suicide Loss Survivors | Home

Project TEACH Website

- Resource for rating scales
- https://projectteachny.org/maternal-rating-scales/

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Thank You !