Project TEACH

FAMILIES THRIVE WITH GOOD MENTAL HEALTH

TOOLKIT

Perinatal Mental Health

This toolkit was developed by the Reproductive Mental Health Team at Project TEACH, a program funded by the New York State Office of Mental Health (OMH). Project TEACH supports perinatal and pediatric clinicians across New York State in delivering quality mental health care.

Designed as a practical clinical resource, this brief toolkit is an evidence-based instrument that can be used in perinatal mental health decision-making. To maximize its value, we encourage clinicians to use this toolkit alongside Project TEACH's full range of services, including our:

1. Consultation services where clinicians can ask general questions or discuss clinical cases in real time with perinatal psychiatrists and psychologists.
2. Perinatal mental health training programs that include professional credits and are offered at no-cost.
3. Referral assistance to identifying appropriate community mental health programs for those you serve.
4. Project TEACH services can be accessed by calling our warmline: 1-855-227-7272 (Monday–Friday, 9:00 a.m.–5:00 p.m., excluding federal holidays). You can also learn more about Project TEACH and find additional tools and resources on our website: www.ProjectTEACHny.org.

We hope you find this toolkit helpful and that you take advantage of all Project TEACH services. Together we can help meet the mental health care needs all perinatal individuals in New York State.

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Introduction

This toolkit was designed to support non-mental health clinicians to provide comprehensive support to their patients' mental health needs. Each of the five instruments contains hyperlinks to other instruments within the toolkit and other recommended resources.

INSTRUMENT 1: PERINATAL SCREENING FOR DEPRESSION & ANXIETY

Learn about the evaluation of perinatal depression and anxiety, including recommendations for next diagnostic and treatment steps.

INSTRUMENT 2: STEPS TOWARD DIAGNOSIS & TREATMENT PLANNING

Learn about screening for bipolar disorder and or co-occuring medical or psychiatric conditions, how to evaluate current/past psychiatric and psychological treatment use and how to assess depression severity.

INSTRUMENT 3: SUICIDE & HARM RISK ASSESSMENT

Learn about assessing suicide or harm risk, the severity of suicide or harm risk, and thoughts of harming the baby/child.

INSTRUMENT 4: PSYCHOTHERAPY

Learn about the role of psychotherapy in perinatal mental health conditions, how to discuss psychotherapy with patients, the goals of psychotherapy, how to support your patients' success in psychotherapy and how to use existing resources to support your patients.

INSTRUMENT 5: INITIATING ANTIDEPRESSANTS FOR PERINATAL DEPRESSION AND/OR ANXIETY

Learn how to optimize non-medication options and choose/start/titrate commonly used antidepressants.

The Project TEACH Perinatal Mental Health Toolkit is for educational purposes only and does not constitute medical advice. The toolkit is not a replacement for careful medical judgment by qualified medical personnel.

A PROJECT FUNDED BY NEW YORK STATE Office of Mental Health

Instrument 1: Perinatal Screening for Depression & Anxiety

WHO SHOULD BE SCREENING

Perinatal health clinician:
Physician, NP, PA, midwife, or other health care practitioner

Pediatric/infant health clinician:
Physician, NP, PA, or other health care practitioner

WHOM TO SCREEN AND HOW

- Every patient, using a standardized, validated tool such as EPDS, PHQ-9, and GAD-7
- For validated screening tools in additional languages, visit https://projectteachny.org/maternal-rating-scales/

WHEN TO SCREEN

Perinatal health clinician:
- Initial prenatal visit, later in pregnancy and at postpartum visits
- Screen for bipolar disorder before initiating pharmacotherapy for anxiety or depression
- Perinatal patients with a psychiatric disorder require close monitoring throughout the perinatal period

Pediatric/infant health clinician:
- At a prenatal visit with a pediatric clinician and at well-child visits up to 6 months postpartum

HOW TO INTEGRATE INTO CLINICAL PRACTICE

Clinician explains the screening tool and its purpose ▶ Patient responses are transferred to electronic medical record ▶ Clinician reviews and interprets the responses, conducts a clinical evaluation and initiates treatment and/or referral (see next page)

CONTINUED ▶

EPDS – Edinburgh Postnatal Depression Scale; PHQ-9-Patient Health Questionnaire-9; GAD-7 – General Anxiety Disorder-7

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Instrument 1: Perinatal Screening for Depression & Anxiety

HOW TO INTERPRET RESULTS

Not indicative of clinically significant depression or anxiety if:	Indicative of possible clinical depression or anxiety if:	Indicative of possible self-harm or at risk for suicide if:
EPDS ≤ 10 **PHQ9 ≤ 10** **GAD-7 < 5**	**EPDS or PHQ-9 ≥ 10 (mild: 10-14, moderate: 15-19, severe: > 19)** **GAD-7 ≥ 5 (mild: 5-9, moderate: 10-14, severe: ≥ 15)**	**EPDS: positive score on q. 10** **PHQ9: positive score on q. 9**

NEXT STEPS

• Provide patient education on perinatal depression and anxiety • Provide resources in the community if clinically indicated • Encourage to reach out with any concerns	• Provide patient education on perinatal depression and anxiety • Call Project TEACH 855-227-7272 to speak with a perinatal psychiatrist in real-time to assist with diagnosis, treatment planning and help with referrals. • Discuss treatment options including psychotherapy and/or an antidepressant • If an antidepressant is indicated, first screen for bipolar disorder using MDQ* • Provide resources in the community	• Assess suicide/self-harm risk with validated tool such as ASQ or CSSRS, see instrument 3 • Identify risk and protective factors • Create a safety plan • If patient is at acute risk for suicide, activate emergency services. • Call Project TEACH if you need assistance in assessing risk

CALL PROJECT TEACH FOR GUIDANCE AT 855-227-7272

EPDS – Edinburgh Postnatal Depression Scale; PHQ-9-Patient Health Questionnaire-9; GAD-7 – General Anxiety Disorder-7; MDQ – Mood Disorder Questionnaire; CSSRS – Columbia-Suicide Severity Rating Scale; ASQ - Ask Suicide-Screening Questions

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Instrument 2: Steps Towards Diagnosis & Treatment Planning

STEP 1: SCREENING FOR BIPOLAR DISORDER

Distinguishing unipolar depression from bipolar disorder is important in peripartum individuals as the treatment approaches differ. Bipolar disorder can sometimes present as a depressive episode in the peripartum period and the use of antidepressants in bipolar disorder can worsen their clinical outcome (e.g. increased cycling).

- **Bipolar I** disorder is defined by the presence of at least one manic or mixed episode in a lifetime. Symptoms of mania last at least 1 week and cause marked functional impairment.
- **Bipolar II** disorder requires at least one lifetime hypomanic episode AND at least one major depressive episode. Symptoms of hypomania are the similar to mania, but present for at least 4 days and WITHOUT marked impairment

Screen for Bipolar disorder using the MDQ if considering antidepressants for treatment

Mood Disorder Questionnaire: View »

How to Use:
Patients self-administer this questionnaire. The physician, nurse, or medical staff assistant then scores the completed questionnaire.

How to Score:
Positive screen:
- >7 symptoms from Q1
- *AND* YES to Q2
- *AND* moderate or serious problem to Q3.

Further medical assessment is needed for all positive screens before an antidepressant is started.

Call Project TEACH 855-227-7272
to speak with a perinatal psychiatrist in real-time to assist with diagnosis, treatment planning and help with referrals to psychiatry.

STEP 2: SCREEN FOR CO-OCCURRING MEDICAL OR SUBSTANCE USE DISORDERS

- Use validated rating scales to evaluate current substance use
  - Drug Abuse Screening Test (DAST-10)
  - Alcohol Use Disorders Identification Test (AUDIT)
  - Tolerance, Worried, Eye Opener, Amnesia, K-/cut Down (TWEAK) (use for pregnancy)
  - Tolerance, Annoyance, Cut Down, Eye-Opener (T-ACE) (for pregnancy)
- Consider: CBC with differential to assess for anemia, thyroid function tests to assess for thyroid dysfunction, and basic metabolic profile and hepatic function tests to assess for electrolyte or hepatic dysfunction.

STEP 3: EVALUATE CURRENT/PAST PSYCHIATRIC TREATMENT AND PSYCHOTHERAPY USE

Assess previous or current psychiatric/psychological treatment

- Current/past pharmacotherapy trials: What medications and doses? Did it help? Were there side effects? How long did the patient stay on it? Was it an adequate dose and duration to see an effect?
- Current/past psychotherapy trials: What type of therapy (i.e. Cognitive Behavioral Therapy, Dialectical Behavorial Therapy, supportive, if known)? Was it helpful? Do they have access to therapy now (resources, referrals, time)?

CONTINUED ▶

Instrument 2: Steps Towards Diagnosis & Treatment Planning (continued) –

PATIENTS WHO MANY BE A GOOD CANDIDATE FOR PSYCHOTHERAPY	PATIENTS WHO MAY BENEFIT FROM PSYCHOTHERAPY PLUS PHARMACOTHERAPY
MILD-MODERATE (PHQ-9/EPDS 10-14)	**MODERATE-SEVERE (PHQ-9/EPDS ≥15)**
• No suicidal ideation • Has ready access to psychotherapy • Prior good response to psychotherapy • Good social supports • Able to care for self/baby • Sleep disruption responsive to more support	• Suicidal ideation* • Obsessional thoughts about harm* • Psychotic symptoms* • Difficulty functioning caring for self/baby • History of severe depression and/or suicide attempts • Severe sleep disruption despite behavioral interventions and support • Comorbid anxiety disorder, panic attacks • Subjective distress, impact on family systems

*** Needs immediate assessment, call Project TEACH and/or consider activating emergency response.**

Some examples of how to discuss your treatment recommendations:

Based on your screening responses and what you have told me, I think you have clinical depression. In addition, you are experiencing a lot of anxiety. Your wellbeing is very important, not only for yourself, but for your pregnancy/baby. I would like to discuss how best to help you feel better.

For mild to moderate symptoms:
I think you may really benefit from some additional support, and I would like to give you some resources and help you find a support group and a therapist. For most people with the symptoms you are describing to me, studies show that a combination of psychotherapy, social support, exercise and nutrition can help you feel like yourself again. However, if you feel worse instead of better, or if it is not helping enough, please let me know right away and we can discuss other options.

For moderate to severe symptoms:
I am really concerned about your wellbeing. I would like to connect you with a therapist, which can be extremely helpful. In addition, I think we should consider (re)starting medications. Although many people are concerned about taking medications in pregnancy or breastfeeding, many medications can be safely used during this time. We can discuss the potential medication risks and also have to consider the risks for you, your baby and your family of not treating your depression and anxiety.

References:
Mesches GA, Wisner KL, Betcher HK. A common clinical conundrum: antidepressant treatment of depression in pregnant women. Seminars in Perinatology 2020; 44:151229
Chessick, C. A., & Dimidjian, S. (2010). Screening for bipolar disorder during pregnancy and the postpartum period. Archives of women's mental health, 13(3), 233-248
https://www.ahrq.gov/health-literacy/professional-training/shared-decision/workshop/mod1-guide.html.

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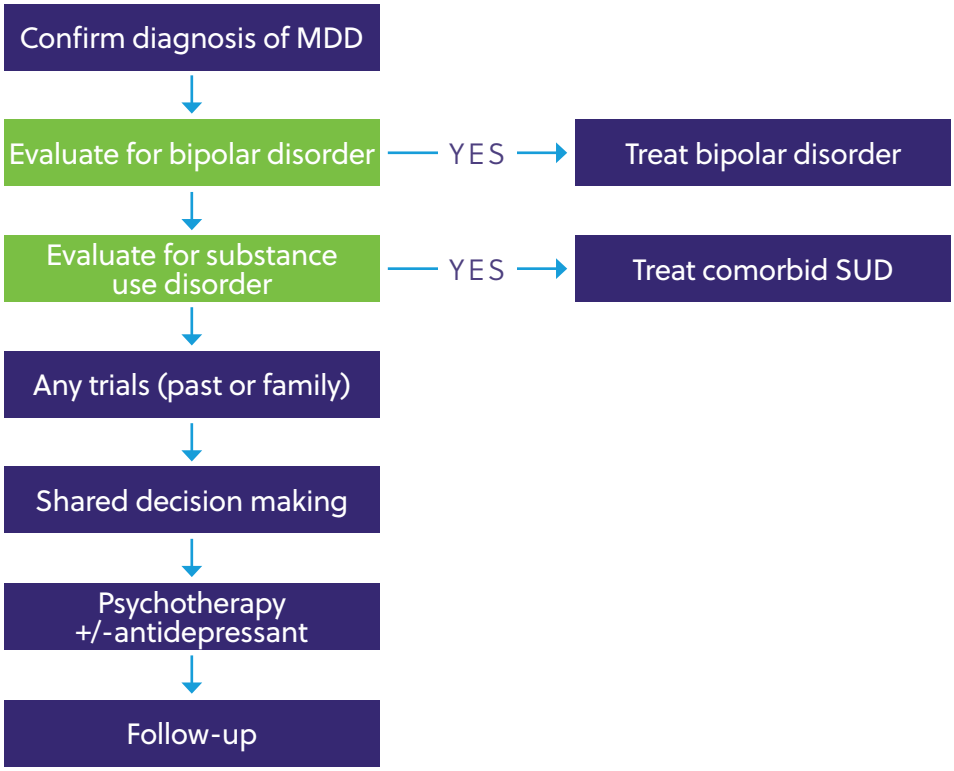
Instrument 2: Steps Towards Diagnosis & Treatment Planning (continued) –

FIG I: DECISION-MAKING ALGORITHM



CALL PROJECT TEACH FOR GUIDANCE AT 855-227-7272

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Instrument 3: Suicide and Harm Risk Assessment

The following tool has been adapted from the ASQ. We recommend the use of any validated screening tool, e.g. the ASQ or the C-SSRS. For validated screening tools in additional languages, click here.

If risk of suicide or self harm is present, ask these questions in a private place:

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past few weeks, have you had thoughts about killing yourself?
4. Have you ever tried to kill yourself? *Past suicidal behavioral is the strongest predictor for future attempts.*

YES
ON ANY QUESTION

NO
TO ALL QUESTIONS

Are you having thoughts about killing yourself right now?

YES

NO

YES ← 1. Do you have a plan to kill yourself? If yes, what is your plan?
2. If no plan, ask: If you were going to kill yourself, how would you do it?

If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail.

YES

NO

HIGH RISK /ACUTE POSITIVE SCREEN

Patient needs a STAT safety/ full mental health evaluation.

- Don't leave the patient alone until evaluated for safety. Keep patient in sight and remove all dangerous objects from room.
- Call 911 or escort to ED

Common Clinical Features:

- Continual sadness, unrelenting dread or guilt, <2-3 hours of sleep per night, unable to feel pleasure
- History of multiple suicide attempts
- High lethality of prior attempt(s)
- Current intent and/or current plan
- Limited protective factors
- Substance use
- Not in treatment
- Hopelessness

MODERATE RISK /NON-ACUTE POSITIVE SCREEN

- Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient refuses the assessment, this should be treated as "against medical advice."
- Call Project TEACH for clinical guidance and help with referrals at 855-227-7272
- Make a safety plan
- Schedule a psychiatric evaluation as soon as possible and continue to monitor safety until patient is evaluated by psychiatry.

Common Clinical Features:

- Persistent sadness & tension, loss of interest, persistent guilt, no appetite, difficulty concentrating, decreased sleep
- History of suicide attempt
- Limited protective factors
- Substance use
- Hopelessness

LOW RISK /NEGATIVE SCREEN

- May benefit from psychiatric treatment and/or referral
- Call Project TEACH at 855-227-7272

Common Clinical Features:

- No history of suicide attempt
- No current intent OR plan
- Protective factors present (i.e. social support, religious prohibition, other children)
- No substance use
- Hopeful

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Instrument 3: Suicide and Harm Risk Assessment

ASSESSING THOUGHTS OF HARMING BABY/CHILD

Ask these questions in a private place:

1. *Have you ever worried that your baby's life was in danger?*
2. *Have you ever wished your baby was dead?*
3. *Are worried that you might do something to harm your baby? Either on purpose or by accident?*

For each question, assess the frequency of the thoughts or worries and ask if they scare the patient or not.

CALL PROJECT TEACH FOR GUIDANCE AT 855-227-7272

SUGGESTS BABY IS *NOT* AT RISK FOR HARM

- Thoughts are intrusive/unwanted and frightening
- Thoughts lead to anxiety/worry
- Good insight
- NO psychotic symptoms

Set up a plan for close monitoring and follow-up

SUGGESTS BABY IS AT *RISK FOR HARM*

- Thoughts are comforting
- Symptoms of psychosis are present
- Poor insight

Activate your Crisis Protocol and call 911

CRISIS RESOURCES FOR YOUR PATIENTS

- 988 Suicide & Crisis Line: https://988lifeline.org/
- NYS Crisis Text Line Partnership. Text GOT5 to 741741 or Got5U to 741741 if you're a college student. https://www.crisistextline.org/partnerships/
- NYS Suicide Prevention Resources: https://omh.ny.gov/omhweb/suicide_prevention/
- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

References:

ASQ Suicide Risk Screening Toolkit. National Institute of Mental Health. Accessed 11/7/22. https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

The Columbia Protocol for Health and Other Community Settings. Accessed 10/14/22. https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.healthcare.english

Stanley-Brown Safety Planning Intervention. Accessed 5/2/24. https://suicidesafetyplan.com/wp-content/uploads/2024/12/Stanley-Brown-Safety-Plan-05-02-2024.pdf

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Instrument 4: Psychotherapy

All patients with mental health conditions should be offered psychotherapy as a treatment option. Given the demonstrated effectiveness of both psychotherapy and medication, patient preference is important in choosing between psychotherapy, medication, or combined approaches. Patients with significant life stressors, such as trauma, loss, illness, and interpersonal difficulties, are unlikely to respond to medication alone. Many pregnant patients and patients of color report preferring non-pharmacological interventions.

CALL PROJECT TEACH FOR GUIDANCE AT 855-227-7272

Sample script for introducing psychotherapy:

Psychotherapy involves discussion between a patient, couple, or family and their therapist to help with a variety of problems, including:

- Family issues, grief, trauma, or work/life dissatisfaction
- Emotional distress, such as depression, anxiety or fear
- Negative or destructive thoughts or actions

The goals of psychotherapy are to eliminate or manage the troubling symptoms people experience and to increase overall well-being. Typically, psychotherapy begins with an assessment, which focuses on the patient's background and what issues led them to seek help. Afterward, the therapist and patient will agree on a treatment strategy and session schedule. Everyone's needs vary and each treatment is tailored to the patient's concerns, personality, and life circumstances.

How to help your patient succeed in psychotherapy:

- Offer a warm hand-off to known psychotherapists whenever possible
- Normalize that fit between therapist and patient matters and encourage patients to consider their unique needs; this may be especially important for patients who have experienced previous bias or unhelpful psychotherapy
- Problem-solve potential barriers such as cost, transportation, and childcare
- Be available to the psychotherapist to share updates on patient's care and needs
- Follow-up with patient to monitor engagement and progress and modify plan if needed

Helping patients find a therapist can be challenging! Here are some recommendations to help:

- Build an active network of trusted therapists; this can include establishing relationships with local community mental health centers, training programs, and private practitioners
- Only seek out therapists licensed to practice in New York State
- Well-trained and licensed therapists may have different degrees and credentials, for example:
  - Clinical psychologists with PsyD or PhD
  - Social workers (LCSW)
  - Licensed mental health counselor (LMHC)
  - Licensed marriage and family therapist (LMFT)
- Use existing resources to help determine therapist availability, expertise, insurance coverage, telehealth vs in-person options, etc. Two examples are below.
  - Call Project TEACH at 1-855-227-7272 for assistance with perinatal mental health linkages and referrals (for providers)
  - Call Postpartum Resource Center of NY at 1-855-631-0001 for assistance with perinatal mental health linkages and referrals (for patients) and download their state-wide resource list. https://postpartumny.org/resourcedirectory/

Instrument 5: Initiating Antidepressants for Perinatal Depression and/or Anxiety

Once you have determined the patient would benefit from antidepressant treatment, engage with the patient to choose the right medication, take steps to maximize effects and minimize exposures, review risks of medications as well as illness, and monitor for effect and side effects.

OPTIMIZE NON-MEDICATION OPTIONS:

- Refer for psychotherapy (see our toolkit and/or call Project TEACH 1-855-227-7272 for assistance with linkages and referrals)
- Engage patient with group and peer support
- Consider bright light therapy for unipolar depression
- Engage family, friends or other supports if available to provide practical and emotional support
- Encourage self-care practices such as yoga, exercise, acupuncture if available.

EVALUATE SLEEP AND OPTIMIZE WITH BEHAVIORAL INTERVENTIONS:

- Consider this no-cost mobile app from the US Dept. of Veterans Affairs for veterans and all patients with insomnia.
  Learn More »

CHOOSING AN ANTIDEPRESSANT:

- If patient has a history of past successful trials or family history of effective antidepressant trials, begin with the antidepressant that was effective and tolerated
- There are no known differences in risks/benefits between most SSRIs (e.g. sertraline, fluoxetine, citalopram, escitalopram) when used in pregnancy. Sertraline if often used in patients who have not had prior antidepressant trials, but differences among SSRI/SNRI/NDRIs are small.
- If patient is taking an antidepressant which is effective, continue it or consider a dose increase if depressive symptoms are present but the dose has not been optimized
- If patient fails two adequate SSRI trials (i.e. taken at adequate dose over 4-6 weeks duration), try an antidepressant of a different class (e.g. serotonin-norepinephrine reuptate inhibitors (SNRI) or norepinephrine-dopamine reuptake inhibitors (NDRI))
- For moderate-severe postpartum depression, consider a 14-day course of the FDA-approved oral antidepressant zuranolone.
- Evaluate the risk for drug interactions with other concomitant medications
- Prescriber information on medications during lactation and breastfeeding are indexed on https://www.ncbi.nlm.nih.gov/books/NBK501922/

ENGAGE WITH PATIENT THROUGH SHARED DECISION-MAKING:

- Explore your patient's values, preferences and concerns about medications
- Discuss potential risks of antidepressant use in pregnancy or lactation and risks of untreated/undertreated underlying illness on patient and fetus/infant

RISKS OF UNDERTREATED PERINATAL DEPRESSION	RISKS OF SEROTONERGIC ANTIDEPRESSANT USE IN PREGNANCY OR LACTATION
• Low birth weight • Small for gestational age infant • Preterm birth • Stillbirth • Poor maternal quality of life • Lactation difficulties • Maternal suicidal ideation • Relationship difficulties • Altered infant neurodevelopment	• Postnatal adaptation syndrome • Persistent pulmonary hypertension of the newborn • Infant sedation, irritability, poor feeding, gastrointestinal upset (with lactation exposure)

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Instrument 5: Initiating Antidepressants for Perinatal Depression and/or Anxiety

- For the patient:
  - Project TEACH website (projectteachny.org)
  - Mother to Baby (mothertobaby.org)
  - Postpartum Support International (postpartum.net)

INITIATING SSRI/SNRI/NDRI TREATMENT: "START LOW, GO SLOW"

- Side effects usually start immediately, most common side effects of SSRIs (mild gastrointestinal upset, activation, headache, dry mouth) usually resolve within 1-2 weeks
- Patients with co-morbid anxiety are particularly sensitive to akathisia and activation when starting an SSRI/SNRI/NDRI antidepressant and may need low doses to start. Educate patient about this side effect as they may feel worse before feeling better. If activation worsens over time, consider possible hypomania, call Project TEACH

SSRI/SNRI/NDRI FOLLOW-UP

- SSRI/SNRI/NDRI antidepressants can take 2-4 weeks for initial benefit and up to 6 weeks for full effect of any dose change
- Use rating scales to measure antidepressant treatment effects and to guide need for dose increases (i.e. repeat PHQ-9, EPDS, GAD-7)
- For mild/moderate depression in a low-risk patient, follow-up in 2-4 weeks to assess for side effects and to adjust SSRI/SNRI/NDRI dose. For higher risk patients, or those with depression with comorbid psychiatric illnesses, more frequent check-ins are needed to assess risk, potential side effects and treatment effects
- Avoid polypharmacy when possible
- Continue to monitor the patient's treatment response until depressive symptoms have resolved completely or patient has transfered treatment to a mental health specialist.
- Avoid abrupt and quick changes in antidepressant dose
- A successful treatment course for SSRI/SNRI/NDRI for perinatal depression includes treatment until full remission and then maintenance. After a period of euthymia, the SSRI/SNRI/NDRI can be tapered slowly over several weeks

USE OF FDA-APPROVED ZURANOLONE FOR POSTPARTUM DEPRESSION

- Zuranolone is a single acute treatment course dosed at 50mg PO qpm for 14 days. Main side effects include somnolence, dizziness, sedation and headache. Dose may be reduced to 40mg PO qhs for the remainder of 14 day course if side effects are troublesome. There is a boxed warning for impaired ability to drive or engage in hazardous activities due to central nervous system depressant effects. Administer zuranolone with a fat-containing meal. Patients should avoid pregnancy while taking zuranolone. Because of the low amounts of zuranolone in breastmilk (similar to or lower than SSRI/SNRI/NDRIs), it would not be expected to cause any adverse effects in breastfed infants. If zuranolone is required by the mother, it is not a reason to discontinue breastfeeding.

CALL PROJECT TEACH FOR GUIDANCE AT 855-227-7272

CONTINUED ▶

Instrument 5: Initiating Antidepressants for Perinatal Depression and/or Anxiety

TABLE I: ANTIDEPRESSANT DOSING FOR PERINATAL DEPRESSION AND ANXIETY (IN ALPHABETICAL ORDER)

ANTIDEPRESSANT	BRAND NAME	TOTAL DAILY DOSE		
		INITIAL	FDA RANGE	MAX
Citalopram	Celexa	10mg	20-40mg	40mg
Escitalopram	Lexapro	5-10mg	10-20mg	20mg
Fluoxetine	Prozac	10mg	20-80mg	80mg
Sertraline	Zoloft	25mg	50-200mg	200mg
Venlafaxine XR	Effexor XR	37.5-75mg	75-225mg	225mg
Zuranolone	Zurzuvae	50mg	50mg use lower dosage if side effects or renal or hepatic impairment	50mg

CALL PROJECT TEACH FOR GUIDANCE AT 855-227-7272

Quick Links

The following tools are referenced throughout this toolkit:

Ask Suicide-Screening Questionnaire (ASQ) Brief Suicide Safety Assessment

Ask Suicide-Screening Questions (ASQ) Suicide Risk Screening Tool

Columbia Suicide Severity Rating Scale (C-SSRS)

Edinburgh Postnatal Depression Scale (EPDS)

Generalized Anxiety Disorder 7-item (GAD-7) Scale

Mood Disorder Questionnaire (MDQ)

Patient Health Questionnaire-9 (PHQ-9)

Safety Plan Template

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