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All Project TEACH services are funded by

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Epidemiology, Screening, and Assessment of Perinatal Mental Health Disorders

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Disclosures

I have no a relevant financial relationship with a commercial interest to disclose.

Learning Objectives

- Recognize the prevenance and impact of perinatal mental health disorders
- Apply evidence-based screening protocols for perinatal mental health disorders using validated tools
- Utilize clinical assessment to differentiate between perinatal mental health disorders and recommend appropriate treatment options

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Poll 1:
How often do you and your practice conduct perinatal mental health screening?

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

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The Case for Perinatal Mental Health Screening

- Pregnant people report it is important for their prenatal care clinicians to understand their mental health needs. (Itani, 2025)
- Screening
  - Is cost effective (Waqas et al., 2022)
  - Increases treatment engagement (Waqas et al., 2022)
  - Is associated with improved maternal mental health and parenting (Reilly et al., 2020)
- Despite recommendations that perinatal individuals be screened multiple times during pregnancy, 1 in 5 individuals report not being asked at all (Bauman et al., 2020)

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Prevalence Perinatal Mental Health Disorders

- Depression 10-23% (Bauman et al. 2020)
- Any anxiety disorder 20%(Fawcet et al., 2019)
  - Generalized Anxiety 2.4% (Fawcet et al., 2019)
  - Obsessive Compulsive Disorder 2.2% (Fawcet et al., 2019)
- Posttraumatic Stress Disorder 3-6%
- Bipolar 2.6% (Masters et al., 2022)
- Psychosis 1-2 in every 1000 perinatal individuals (Sit et al., 2006)

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Risk Factors for Developing Mental Health Concerns

Biological	Psychological	Social
Obstetric complications	Family history of mental health condition	Social-role conflict
High-risk pregnancy	Personal history of mental health condition	Intimate partner violence, sexual abuse
Hormonal sensitivity	Substance use disorders	Lack of support
Discontinuation of psychiatric medications		Racism/discrimination
Perinatal loss		Birth trauma

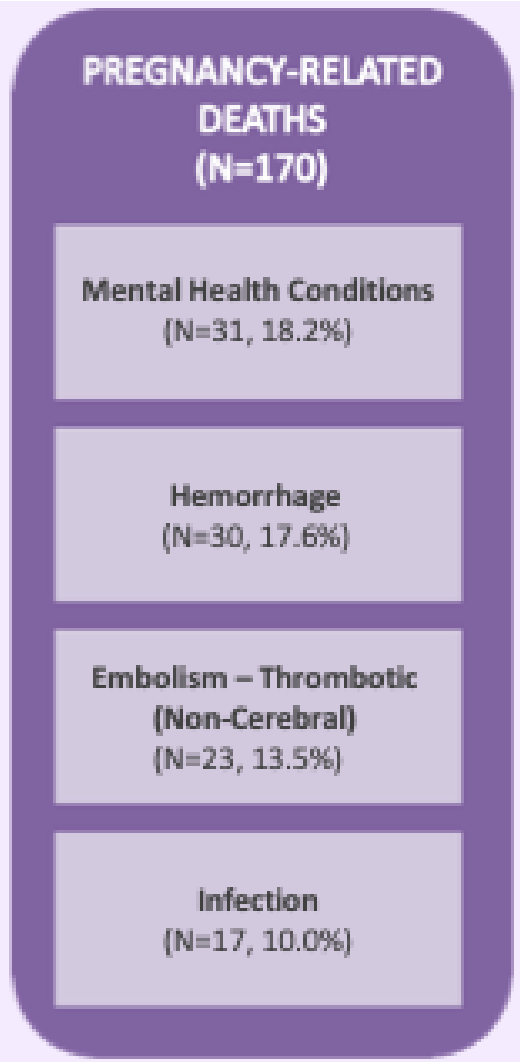
Furtado M et al 2018; Hutchens & Kearney 2020; Sommer et al., 2021; Yang et al., 2022; Yildiz et al., 2017

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Untreated Perinatal Mental Health Disorders are Associated with Adverse Maternal Outcomes

- Decreased maternal functioning (Field, T, 2010)
- Psychosis, suicidal ideation, homicidal ideation and suicide attempt are psychiatric emergencies that lead to psychiatric hospitalization, maternal death (Rodriguez-Cabezas et al, 2019)
- Bidirectional relationship between depression and gestational diabetes mellitus (Fischer et al, 2023)

Mental Health Conditions Are the Leading Cause of Death



Manner of Death	Mental Health (MH) Conditions as Cause of Death		
	MH Deaths Related to Substance Use Disorder	MH Deaths Other than Substance Use Disorder	Total
Suicide	2	11	13
Non-Suicide	16	2	18
Total	**18**	**13**	**31**

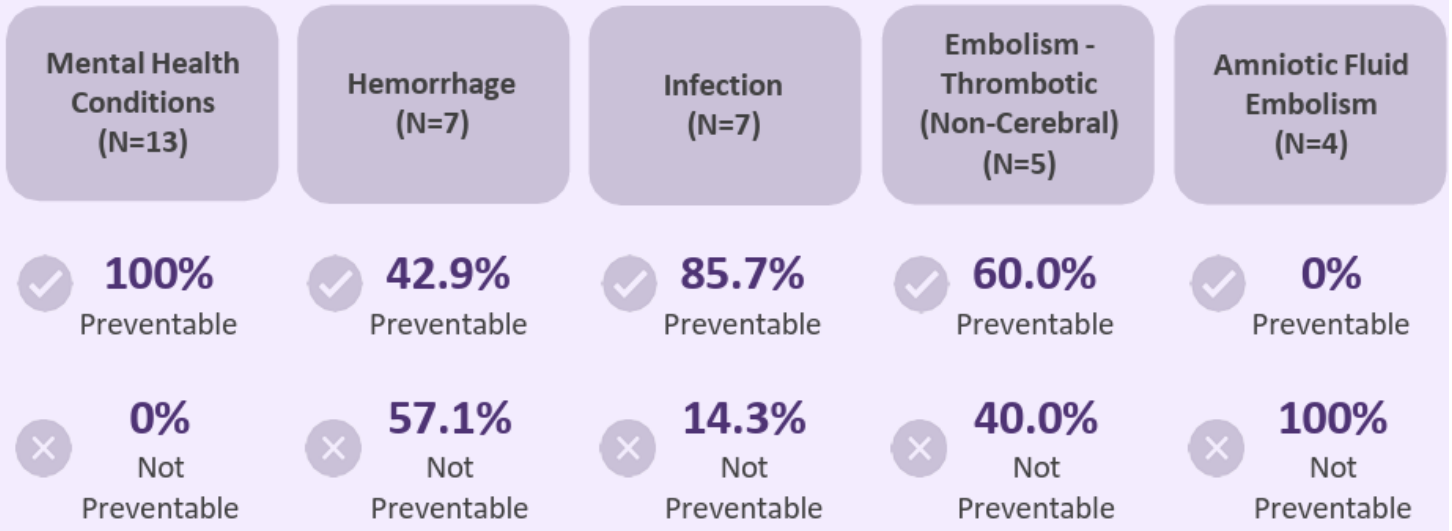
New York State Report on Pregnancy-Associated Deaths in 2021. Albany, NY: New York State Department of Health. 2025.

Mental Health-Related Deaths Are Preventable

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



New York State Report on Pregnancy-Associated Deaths in 2021. Albany, NY: New York State Department of Health. 2025.

Untreated Perinatal Mental Health Disorders are Associated with Adverse Obstetrical Outcomes

- Preterm labor (Bansil P et al, 2010)
- Preterm birth (Grigoriadis S et al, 2013),
- Stillbirth/neonatal death
- Hypertensive disorders of pregnancy (Staub et al, 2012, Thombre et al, 2015, Delanerolle et al, 2022)
- Increased requirement for surgical delivery interventions (Wang SY & Chen CH, 2010) and cesarean delivery (Bansil P et al, 2010)

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Untreated Perinatal Mental Health Disorders are Associated with Adverse Infant and Child Development

- Inadequate maternal-infant bonding prenatally and post-delivery (Rossen et al, 2016; Betcher et al, 2020, Dagher et al, 2021)
- Lactation failure or unplanned weaning (Dennis CL & McQueen K, 2009; Stuebe AM et al, 2014)
- Impaired child cognitive, (Tuovinen S et al, 2018), behavioral, and emotional development (Leis JA et al, 2014; Pearson RM et al, 2013)
- Impaired child brain development/antenatal stress from mental illness is associated with accelerated development of offspring neural networks via fetal (developmental) programming (Schinost D et al, 2016; Rotem-Kohavi, N et al, 2020)

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Unipolar Perinatal Depression

Major Depressive Disorder (MDD) with Peripartum Onset

includes 5 of the following symptoms, one of which must be either depressed mood or decreased interest or pleasure, beginning in pregnancy or within 4 weeks of delivery

- Depressed mood, often overshadowed by severe anxiety, crying episodes, feel trapped/overwhelmed
- Markedly diminished interest or pleasure in activities - lack of interest in baby/not feeling close to baby
- Appetite disturbance - food has no taste, forces self to eat, poor gestational weight
- Sleep disturbance - cannot fall or stay asleep - even when the baby is sleeping
- Physical agitation (on-edge) or feeling slowed down
- Fatigue or loss of energy, exhausted
- Feelings of worthlessness or excessive or inappropriate guilt – feeling like a bad mother
- Decreased concentration or ability to make decisions
- Recurrent thoughts of death or suicidal ideation – my family/baby would be better off without me
    - †Symptoms must be present most of the day nearly every day for two weeks.

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Distinguishing Baby Blues from PPD

	Baby Blues	Postpartum Depression
Prevalence	40-75% of mothers	14% of mothers
Onset	First few days after delivery, typically peaking on fourth or fifth day	Typically emerges in pregnancy and approx. 2 months postpartum
Duration	A few hours or a few days, remitting spontaneously within 2 weeks of delivery	Longer than 2 weeks; can last up to 3 years
Severity	Mild symptoms (mood lability, tearfulness, anxiety, irritability)	Clinical diagnosis of major depressive episode
Impaired functioning	No	Yes
Symptom resolution	**Resolves spontaneously**	Requires treatment
Association with psychopathology	Unrelated to psychiatric history and not predictive of future problems	More common in women with history of major depression and bipolar disorder and predictive of future depressive episodes

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Bipolar Disorder

- Bipolar 1 Disorder: characterized by at least one lifetime manic episode
- Bipolar 2 Disorder: characterized by at least one lifetime hypomanic episode **AND a** depressive episode

Manic episode (sx for 7 consecutive days) and Hypomanic episode (sx for 4 consecutive days) is characterized by abnormally and persistently elevated or irritable mood and increased activity/energy plus 3 or more if mood is elevated, 4 or more if irritable mood with a change in functioning

- inflated self-esteem, grandiosity
- decreased need for sleep (e.g. feels rested after only 3 hours)
- more talkative, pressure to keep talking
- flight of ideas, racing thoughts (but not anxious in nature)
- Distractibility
- increase in goal-directed activity or psychomotor agitation
- excessive involvement in activities with high potential for painful consequences

Clinical Pearls: Perinatal Bipolar Disorder

- 22.6% of individuals with postpartum EPDS ≥10 had bipolar disorder (Wisner KL et al 2013)
- 54% of individuals with a history of a mood disorder have recurrence in perinatal period (Masters et al., 2022)
- 20% of individuals with Bipolar I experience mania or psychotic depression in perinatal period (Floria et al., 2013)
- People who discontinue medication when they become pregnant are more likely to experience recurrences (85.5% vs. 37%) and spend more time ill (Viguera AC et al, 2007)
  - Abrupt discontinuation of medication is significant risk factor (Alcantarilla et al., 2023)
- Medication to treat Major Depressive Disorder often differs from medication to treat a depressive episode of Bipolar Disorder
- Most recurrences are depressive or mixed (74%) and 47% occurred in first trimester (Viguera AC et al, 2007)

Common Features of Bipolar Depression

These characteristics increase the likelihood that an individual has bipolar disorder even if they are presenting as depressed currently:

- Depression with mixed symptoms (distractibility, racing thoughts, irritation, and agitation) more common than pure hypomania/mania
- More frequent (>3) episodes of depression
- Non-response to 3 or more anti-depressants
- Younger age of first depressive episode
- Family history of bipolar disorder

Cuellar AK et al, 2005

Generalized Anxiety Disorder

- Excessive worry over many things, for at least 6 months – often focused on fears of fetal/child wellbeing, maternal wellness, partner illness, and parental mortality (Misri et a., 2015)
- Worry is difficult to control
- At least 3 of the following symptoms:
  - Restlessness
  - Fatigue
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep difficulties

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Post-Traumatic Stress

- PTSD Criteria (DSM-5)
  - Intrusion
    - Can occur in context of medical symptoms, exams, labor and delivery
  - Avoidance
    - Prenatal care
  - Negative Alterations to Cognition and Mood
    - Mistrust of medical professionals
  - Marked Arousal and Reactivity
    - Sleeplessness, vigilant to threats to fetus/baby
- Can occur with or without dissociation



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Obsessive Compulsive Disorder

- Obsessions - Recurrent and persistent thoughts, urges or images experienced as intrusive/unwanted, cause marked anxiety or distress; individual attempts to ignore or suppress with some thought or action
- Compulsions - Repetitive behaviors or mental acts performed in response to an obsession, or according to the rules that must be applied rigidly; these are aimed at preventing or reducing distress or preventing some dreaded event but are not connected in a realistic way or are clearly excessive.

Perinatal OCD Presentation

Obsessions/Intrusive Thoughts	Compulsions/Avoidance Behavior
“What if I accidentally cut my child with a knife?’	Throws out knives from the home/avoids cutting things
“What if I don’t see the car, and my baby and I get hit?”	Avoids going outside
“I keep getting images of me drowning my baby”	Avoids washing baby
“I keep imagining that I will touch my baby inappropriately”	Avoids spending time with baby; Avoids changing diaper
“What if I drop my baby?”	Avoids breastfeeding baby
What if my baby stops breathing suddenly?	Stays up at night, frequent checking of baby

Acting on harm thoughts is rare, however can see indirect harm through avoidance/compulsive behaviors

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Psychosis During the Perinatal Period

- Symptoms can include Must include delusions, hallucinations, or disorganized speech, grossly disorganized or catatonic behavior
- No specific diagnosis for perinatal psychosis according to DSM-5
  - Psychosis can be added as a specifier to a mood or depressive disorder along with *peripartum onset* specifier

Characteristics of Perinatal Psychosis

- Strongest risk factor for postpartum psychosis is a personal history of bipolar disorder
- Sudden onset within 2 weeks of delivery with >50% of onsets within 3 days of delivery
- Often initially presents as irritability, mood lability, anxiety and insomnia that progresses to mania, depression, mixed episode with delusions and rapid deterioration
  - Delusions can be pregnancy and child related – may include thoughts around harming self or the baby i.e “altruistic” delusions of harm
  - Delusions are ego syntonic and involve limited insight
- Psychiatric Emergency: Associated with increased risk of suicide and potential risk to infant
- large differential diagnosis and work-up required

Tinkleman et al., 2017

Differentiating OCD "Harm Thoughts" from Psychotic Intrusive "Harm Thoughts"

Postpartum OC intrusive thoughts	**Psychotic intrusive thoughts**
Thoughts are ego-dystonic (inconsistent with their behavior, personality)	Thoughts are ego-syntonic (consistent with confusion, mood lability, bizarre delusions or hallucinations) i.e *I must drown my baby to save them eternal damnation*
Thoughts associated with guilt, shame, anxiety	Thoughts may not be distressful
Engages in excessive avoidance and rituals in attempt to control thoughts to ensure they do not act on thoughts	Symptoms are not associated with fears or rituals; rather may see disorganized behavior
Very common, not a psychiatric emergency	Much less common, but is *psychiatric emergency*
Low risk of harm to infant	Patient at risk for unpredictable aggressive behavior



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Perinatal Screening

ACOG JUNE 2023 Guideline Summary Recommendations:
Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum

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

Postpartum Mental Health Screening

- ACOG (2018) recommends all perinatal individuals have contact with their obstetric care providers within the first 3 weeks postpartum. This initial assessment should be followed up with a comprehensive postpartum visit no later than 12 weeks after birth.
- 40% of individuals do not attend a postpartum appointment
- American Academy of Pediatrics (AAP) recommends that pediatricians screen mothers for postpartum depression at baby's 1, 2, 4, and 6 month visits (Earls 2019)

Standardized Mental Health Screening Tools

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/

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

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PTSD Screening

- 11% of perinatal people screened for PTSD and depression, had ONLY PTSD (Padin et al., 2022)
- Primary Care Screen for PTSD (PC-PTSD-5) (Prins et al., 2015)
  - 5-item screen
  - Total score 0-5
  - Free to download and use
  - Cut score greater than or equal to 1 (Lathan,et al., 2023)
- PCL-5 can be used as follow up to positive screens (ACOG; Blevins et al., 2015; Bovin et al., 2016)

In the past month, have you …

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?	YES	NO
2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	YES	NO
3. been constantly on guard, watchful, or easily startled?	YES	NO
4. felt numb or detached from people, activities, or your surroundings?	YES	NO
5. felt guilty or unable to stop blaming yourself of others for the event(s) or any problems the events may have caused?	YES	NO
Total score is sum of "YES" responses in items 1-5.	**TOTAL SCORE**	

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Psychosis Screening Questions

New parents often have thoughts about something bad happening to their baby. These thoughts can feel awful and sometimes feel as if they could be an escape. We are here to help you. We ask about these thoughts because they are so common."

- Have you had any thoughts of harming your infant, either as an accident or on purpose?
  - How often do you have them?
  - How recently have you had them?
  - How much do they scare you?
  - How much do they worry you?

Byatt et al., 2019

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Psychosis Assessment

- Is this the patient's first psychiatric presentation?
- If she has a psychiatric history, is it of depression, mania, or both?
- Is there any family history of bipolar disorder?
- Has the patient been using any substances?
- Can use Columbia to assess suicide risk.
- Assess mental status with Mini Mental State Exam (MMSE) or Montreal Cognitive Assessment (MoCA)

Osborne, 2018

Formal Assessment

- Positive screening results require further assessment
- Evaluation includes an interview of patient and consideration of differential diagnosis
  - Should include questions about the type, duration, and frequency of symptoms and how symptoms impact functioning
- Diagnosis and severity information gleaned through evaluation inform treatment/recommendations

Practice-Level Response

It is essential to develop a workflow prior to initiating screening

- Screening and not responding is worse than not screening
- It takes the team to respond to mental health needs

Building Screens into Practice Workflows

- How will screens be administered? (paper vs tablet)
- When will screens be administered? (e.g., at home; waiting room; exam room)
- Who will administer screens? (e.g., automated electronic administration, receptionist, tech, nurse)
- Who will review the screens and how do we make sure positive results aren't missed?
- What are the resources we can offer?
- What is the plan if suicidal ideation is endorsed?
- How to ensure appropriate f/up occurs

Tips for Screening Workflows

- Team-based approach: every discipline is included in the plan
- Communication is key
- Leverage electronic health record
  - Automated scoring, best practice alerts, etc.
- Develop current resource information with existing community mental health resources
- Establish partnerships with local mental health clinicians
- Readminister tools at future visits if positive
- Train entire practice and write up workflows (including billing for screens)

Address Risk in Workflows

- ACOG's (2025) recommendations for tailored Perinatal Care provide a model of how to address psycho-social risk factors implicated in maternal mental and physical health throughout the course of the perinatal period
- US Preventative Services Task (2019) force recommends clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.
  - Counseling interventions associated with 39% reduction in likelihood of perinatal depression (O'Connor et al., 2019)

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Case Example

Ramona is a 40-year-old, Indigenous American cis-gender woman, who is married but currently separated from her partner. She is currently 28 weeks into an unplanned pregnancy and has been diagnosed with gestational hypertension. She completed the EPDS at her first prenatal visit and received a total score of 4. She called the office repeatedly 3 times over the past week to discuss a single incident of light spotting. In addition to checking for blood when she uses the bathroom, she has been taking multiple breaks at work to check her underwear. She presents as tearful prior to the start of her nonstress test, stating, “I haven’t been able to sleep for the past 3 days because I just know something is terribly wrong.”

Case Example

- Ramona's completes an EPDS in the waiting room, receiving a total score of 22. Her score on the anxiety subscale is 8. The results of her nonstress test are normal. Her OB tells her, this is great news, now you don't have to worry!

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Provider Resources

- *Parental Depression Screening for Pediatric Clinicians Implementation Manual* Ardis Olsen, Commonwealth fund
- *Postpartum Psychosis Webinar* Massachusetts Child Psychiatry Access Program
- Alliance for Innovation on Maternal Health implementation resources