
Reproductive Mental Health Guideline 3

**IDENTIFICATION AND ASSESSMENT OF REPRODUCTIVE MENTAL ILLNESS
DURING THE PRECONCEPTION AND PERINATAL PERIODS**

SIGNIFICANCE

From the early newborn period, infants are very sensitive to the emotional states of their mothers and other caregiver.^{1,2} Maternal mental illness during and following pregnancy may have long lasting effects on the developing fetal brain which extend into childhood. At birth, the specific developmental pathway an infant takes is a function of the interaction of the infant's genetic potential and his or her biological characteristics with the family environment into which he or she is born. An infant whose mother becomes clinically depressed at the time of birth may have, at the outset, a more restricted range of developmental pathways available.² If the mother recovers from her depression and changes the way she treats the child, or if alternate caregivers are available, a negative pathway can slowly be corrected, and the child can ultimately develop along a more favourable trajectory. The number of potential pathways open to the child appears to become more limited with development, and changes become increasingly difficult after "sensitive" developmental periods have passed.² Early identification of mental illness is imperative to minimise the impact of maternal mental illness on the infant.

Research indicates depressed women have difficulty relating to their infants, develop more negative attitudes towards their children, and are less responsive to their social signals.³ Mother's experiencing mental illness in the postpartum period have been described as:

- attending more to her own problems, thus diminishing her sensitivity and responsiveness to the infant's needs²
- showing fewer contented facial expressions⁴
- having more negative face-to-face interactions with their infants in the first months of life than non-depressed mothers⁵
- having decreased eye gaze during feeding⁶
- partaking in less reciprocity and playfulness with their infants⁵
- seem angrier, and handle their infants roughly⁷
- mothers are withdrawn, they are disengaged from their infants, express flat affect⁷

Infants whose mothers are depressed in the perinatal period are described as:

- having more negative impressions of their mothers, being more temperamental and suffering more cognitive deficits than do children of non-depressed mothers⁴
- far more likely to show an insecure attachment pattern (either avoidance or ambivalent) to their mothers in the Strange Situation at age 18 months⁸
- exhibit an insecure-disorganized attachment pattern and to lack coherent strategies for obtaining contact with their caregivers⁹
- typically look away, protest more than infants of non-depressed mothers⁷
- less positive and more "flat" in affect as early as 3 months of age and more withdrawn¹⁰

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More recent research provides evidence that women who have been treated for depressive disorders, anxiety disorders and obsessive compulsive disorders have infants and children whom:

- look less at mother, engage less with objects, show less positive and more negative affect and have lower activity levels.
- have difficulty engaging in social and object interactions as early as 2 months of age⁵
- react with more anger, sadness, fussiness and crying⁶
- have poorer mental and motor development; more behaviour difficulties, more disturbances in the mother-infant interactions and more adverse child cognitive functioning⁷
- have more problematic childhood sleep behaviours^{8,9}

As children grow, the effects of maternal mental illness appear to extend beyond the newborn period and into childhood. At 1 year of age many infants of depressed mothers show poor performance on developmental tests e.g. Bayley Scale of Infant Development.^{10,11} These findings suggest that children of depressed mothers are at risk for cognitive compromise. There are also indications that insecure attachment to the mother also occurs.¹² Insecure attachment may be related to family psychopathology, and has been linked to a number of behavioural difficulties including conduct disorders during preschool and school periods.¹³⁻¹⁶ Increased rates of psychiatric difficulties have been reported in children of anxious mothers.¹⁷ A large number of studies dating back to the early part of the 1900's support the association between parental mental illness and psychiatric disorders in children,¹⁸ and show that children of mothers with panic disorders are at risk for developing anxiety disorders themselves.

Women with shorter depressive episodes that have been effectively treated show no signs of infant-mother interaction compromise, or any of the above emotional and cognitive sequels.⁷ Conversely, women with untreated mental illness during the pregnancy and postpartum period have children who demonstrate the most severe adverse effects in motor, emotional and cognitive development.^{4,19,20}

Although postpartum depression has been referred to for decades in the literature, early identification and prevention has only recently been addressed. Kleiman and Raskin²¹ discuss reducing the risk of recurrent postpartum depression in women. Placksin²² suggests that screening for risk of postpartum depression become a standard part of prenatal and postpartum health care, childbirth education classes, hospital discharge routines, and home-visiting service and paediatric practices. Locicero et al²³ recommends that Placksin's early identification strategies be part of their proposal for prevention of postpartum depression.

EARLY IDENTIFICATION GUIDE

The **Early Identification Guide** provides a summary of the educational, screening, and general assessment tools utilised in the Reproductive Mental Health Best Practices Guidelines, and the time periods when they should be used. A detailed explanation of the Early Identification Guide follows on page 3 and is adapted from the New York General Plan of Care Schedule for Postpartum Depression/Anxiety: Prevention, Diagnosis and Treatment: A Hospital Checklist.²⁴

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Table 1. Early Identification Guide.

Timing	Contact Person	Action
Preconception *Target <i>Initial Contact</i>	GP, OB/GYN Midwife Community Health Nurse Multicultural worker Mental Health worker- if appropriate	<ul style="list-style-type: none"> - Educate with the Perinatal Mental Health Fact Sheet (Appendix A) - Educate with the web site: www.bcrmh.com and www.postpartum.ca - Ask if the woman has a family and/or personal history of mental illness' e.g. depression anxiety, psychosis? - General Perinatal Mental Health Assessment Tool (Appendix D)
Prenatal *Target <i>Initial Contact</i> <i>Third Trimester</i> <i>Every Contact if Family/Personal History of Mental Illness</i>	GP, OB/GYN Midwife Community Health Nurse Childbirth Educator, Doula Pregnancy Outreach Program Nurses in Offices & Hospitals Social Workers Educators in Pregnant Teen Programs Mental Health worker- if appr Ministry of Child & Family Development- if appropriate	<ul style="list-style-type: none"> - Educate with the Perinatal Mental Health Fact Sheet (Appendix A) - Educate with the web site: www.bcrmh.com and www.postpartum.ca - Pacific Postpartum Support Society Pamphlet - Perinatal Mental Health Risk Assessment Questionnaire (Appendix C) - Postpartum Depression Predictors Inventory (PDPI) Revised, Beck, 2002 - Edinburgh Postnatal Depression Inventory (EPDS) - General Perinatal Mental Health Assessment Tool (Appendix D) - Antenatal Psychosocial Health Assessment (ALPHA)- to investigate: woman abuse, child abuse, depression, marital/couple dysfunction (Appendix B)
Labour & Delivery *Target <i>Initial Contact</i>	GP, OB/GYN Midwife Labour & Delivery Nurses Doula Social Workers Paediatrician Mental Health worker- if appr Ministry of Child & Family Development- if appropriate	<ul style="list-style-type: none"> - Educate with the Perinatal Mental Health Fact Sheet (Appendix A) - Educate with the web site: www.bcrmh.com and www.postpartum.ca - Pacific Postpartum Support Society Pamphlet (Appendix B) - Postpartum Depression Predictors Inventory (PDPI) Revised, Beck, 2002 - Edinburgh Postnatal Depression Inventory (EPDS) - Perinatal Mental Health Risk Assessment Questionnaire (Appendix C)
Postpartum *Target <i>1-2 days</i> <i>1-2 weeks</i> <i>6-8 weeks</i> <i>4 & 6 months</i> <i>Every contact if family/personal history of mental</i>	GP, OB/GYN Midwife Endocrinologist Paediatrician Community Health Nurse Hospital Nurses, S.W. Doula, Lactation Consultants Pregnancy Outreach Program Educators in Pregnant Teen Programs Support group leaders: new moms, etc. Mental Health worker- if appr Ministry of Child & Family Development- if appr.	<ul style="list-style-type: none"> - Educate with the Perinatal Mental Health Fact Sheet (Appendix A) - Educate with the web site: www.bcrmh.com and www.postpartum.ca - Pacific Postpartum Support Society Pamphlet; book 'Postpartum Depression & Anxiety: A Self-Help Guide for Mother' - Videos: Postpartum Emotions: The Blues & Beyond; Heartache and Hope - Perinatal Mental Health Risk Assessment Questionnaire (Appendix C) - Postpartum Depression Predictors Inventory (PDPI) Revised, every 2 months, Beck, 2002 - Edinburgh Postnatal Depression Inventory (EPDS) > 1 week - General Perinatal Mental Health Ass. Tool (App. D) - Postpartum Depression Screening Scale > 2 weeks

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I. TIMING

The Reproductive Mental Health guidelines focus on four different time frames which target awareness, education, and screening of women at risk for mental illness. These include the:

- preconception period
- prenatal period
- labour and delivery
- postpartum period

Service providers may perform the actions listed in the Early Identification Guide when counselling women during their “Initial Contact”, “Every Contact” or at “Targeted Times” during the perinatal period.

A. Initial Contact

Initial contact may occur during preconception, prenatal, labour and delivery or the postpartum periods. Action may occur by any of the service providers with whom the woman comes into contact.

B. Every Contact

Action and reassessment should occur at every contact for women with a family and/or personal history of mental illness. Women who have experienced a previous postpartum depression are at a 50 -62% increased risk of recurrent episodes with subsequent pregnancies.²⁵

C. Targeted Times

Women are at highest risk of experiencing a mental illness during:

- **Third trimester:** women are most vulnerable to mental illness during the third trimester²⁶
- **1-2 days Postpartum:** for early onset psychosis²⁷
- **1 Week Postpartum:** onset of psychosis²⁷ and early onset of postpartum depression
- **6-12 Weeks Postpartum:** later onset of psychosis²⁸⁻³²
- **4 and 6 Months Postpartum:** postpartum depression³³

II. ACTION – EDUCATIONAL, SCREENING AND GENERAL ASSESSMENT TOOLS

The educational, screening and general assessment tools utilised in the Reproductive Mental Health Best Practices Guidelines and listed in the “Action” component of the Early Identification Guide may be used on a single occasion or repetitively, depending on the individual needs of the woman. They are outlined as follows:

A. Education Tools

1. **Perinatal Mental Health Fact Sheet** - refer to Appendix A
2. **Pacific Post Partum Support Society Pamphlet** in English, Punjabi and Chinese. This is an excellent source of information that can be given to women and their partners during the perinatal period (refer to Appendix E Community Resources, Guideline 2).
3. **The British Columbia Reproductive Mental Health Program Web site:**
www.bcrmh.com
4. **Video: Heartache and Hope: Living through Postpartum Depression**
Women and their partners give a retrospective account of their experience of living through postpartum depression. (To order, contact the Parent Development Centre, 2749 Sinai Ave, South West, Calgary, Alberta, T3E 7A9)

B. Screening Tools

1. Family and/or Personal History of Mental Illness

During the initial contact with a woman, the service provider should ask her about her family and/or personal history of mental illness. A woman with a family history of depression or previous history of depression/or postpartum depression are at highest risk of developing mood disorders in the perinatal period (refer to guidelines 4, 5 and 6).

2. Postpartum Depression Predictors Inventory (PDPI)- Revised

In 1998 Beck developed the Postpartum Depression Predictors Inventory (PDPI)³⁴ from a quantitative review of the literature of antenatal predictors of postpartum depression, and assessment tools ie.

- Braverman & Roux's 19-item yes/no questionnaire³⁵
 - Petrick's 16 –item self-administered yes/no checklist, no published data on it's predictive value³⁶
- 3 scored self-administered questionnaires:
- **Antenatal Screening Questionnaire** is a 10–item on psychosocial risk factors (no interpretation of the scoring provided).³⁷ Not predictive of postpartum depression.
 - **Modified Antenatal Screening Questionnaire** is a 19- item questionnaire; each item scores 0-2; total score > or = to 2 predictive of minor depression.³⁸
 - **Antepartum Questionnaire** is a 22 item scale, each item scoring 0-6.³⁹ A total score > or = to 46 refer for psychiatric assessment.

Beck published the revised Postpartum Depression Predictors Inventory (PDPI- Revised) based on 13 risk factors: prenatal depression; child care stress; life stress; social support; prenatal anxiety; marital satisfaction; history of previous depression; infant temperament; maternity blues; self-esteem; socioeconomic status; marital status; and unwanted/unplanned pregnancy.^{40,41} Beck indicates the PDPI- revised be completed

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once each trimester and periodically for 12 months after delivery. Beck indicates that “women identified during pregnancy as being at risk for developing postpartum depression should be referred for follow-up after delivery” and “some women may need to be referred for psychiatric evaluation”.³⁹ If a woman has several risk factors she has an increased probability of developing a postpartum mood disorder, although it is not a guarantee. Beck plans to develop a self-administered version of the PDPI- revised.

3. Antenatal Psychosocial Health Assessment (ALPHA)

The ALPHA form was developed by obstetricians, family physicians, midwives, and antenatal clinic nurses in Ontario, Canada (Appendix B).^{42,43} In 1999 the 5 categories of the ALPHA form were added to the Ontario Antenatal Record. The 5 categories of the ALPHA form are:

- Family factors-social support, stressful life events, couple’s relationship
- Maternal factors-prenatal care & education, feelings towards pregnancy, relationship with parents, self-esteem, history of psychiatric problems, depression in pregnancy
- Substance abuse- alcohol/drug abuse
- Family Violence-experienced or witnessed abuse, current or past abuse, previous child abuse, child discipline.

The ALPHA form is designed to gather data associated with poor postpartum family outcomes of woman abuse, child abuse, postpartum depression, marital/couple dysfunction and increased physical illness.

4. Perinatal Mental Health Risk Assessment Questionnaire

The Perinatal Mental Health Risk Assessment Questionnaire was developed by the Best Practices working group as an alternative tool to engage women in a dialogue with their service provider regarding potential risk of mental illness in the perinatal period (refer to App. C). This questionnaire was critiqued by selected members of the Provincial Reproductive Mental Health Outreach Steering Committee, and leaders in the area of perinatal mental health for content validity. However, it has not been tested for reliability or construct validity. If a woman responds positively to the questionnaire, then conduct a more detailed assessment using the General Perinatal Mental Health Assessment Tool, Appendix D.

C. General Assessment Tools

1. General Perinatal Mental Health Assessment Tool refers to Appendix D.

This tool was developed in consultation with the Psychiatrists at the Reproductive Mental Health Program. The tool consists of a:

- **history:** personal, presenting illness, past psychiatric and family psychiatric history, medical review of body systems, obstetrical history, past medical, surgical history
- **psychiatric assessment:** appearance, motor, speech, affect, thought content & process, perception, insight

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- **psychosocial assessment:** relationship and supports, cultural/spiritual supports, mothering needs, housing, finances, transportation, and legal issues.

If further assessment is required in relation to depressive, anxious or psychotic symptoms refer to Guidelines 4, 5, and 6.

2. **Perinatal Suicide Assessment Questionnaire** (refer to Appendix E)
3. **Infanticide Ideation Assessment Questionnaire**, (refer to Appendix F)

Women experiencing severe depression or postpartum psychosis may contemplate self-harm or suicide and in very rare cases may harm their unborn child or infants. Infanticide has been reported to take place in 1-3 in 50,000 births.^{44,45} Among mothers who commit infanticide, 62% commit suicide.⁴⁶ If there is any concern about suicide or infanticide, the service provider should access both assessment questionnaires.

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APPENDIX A
PERINATAL MENTAL HEALTH FACT SHEET:
Women's Emotional Wellness during Pregnancy and in the Postpartum Period

Before Birth

During pregnancy a women's body, mind and spirit undergo monumental changes. Some pregnant women have difficulty coping with pregnancy and find support from friends, health nurses, neighborhood groups and family doctors. However, other women may encounter a range of mood disturbances, such as anxiety, depressive and obsessive/compulsive disorder.

10%- 16% of pregnant women experience depression.
2% to 4% of pregnant women experience anxiety or have a Panic Disorder

These mood and anxiety disturbances are more difficult to recognize in the first and third trimester of pregnancy because many of the symptoms are similar to those experienced by most women during pregnancy. In the second trimester they may be more easily noticed because most women enjoy this period as they start to feel the baby move. Women who are depressed for instance may experience pervasive sadness, a sense of hopelessness, crying spells, and in severe cases suicidal ideation. Women who have mood disturbances during the third trimester of their pregnancy are at high risk of having mood disorders during the postpartum period.

Approximately 30% of women with a history of depression prior to conceiving will develop postpartum depression.

Anxiety

The most frequently cited difficulties include:

- Nervousness, anxiety
- Sleep and appetite disturbances
- Over concern for the baby
- Poor concentration, confusion & memory loss
- Uncontrollable crying & irritability
- Panic attacks may also occur

Depression

These may include some of the symptoms listed with anxiety along with:

- Sluggishness, fatigue, exhaustion
- Sadness, hopelessness, and/or uncontrollable crying
- Over concern or lack of interest in the baby
- Sense of guilt, inadequacy, or worthlessness
- Lack of interest in sex

Obsessive/Compulsive Disorder

This occurs in approximately 2-3% of the new mothers and may include anxiety and depression reactions along with a deep fear of losing control and harming their babies. Women typically have intrusive thoughts about things which could hurt the baby. Studies indicate that as long as the woman is repulsed by the thought of harming her baby, she is extremely unlikely to act on her thoughts. Her fears may however limit her interactions with the baby and could cause problems with bonding.

After Birth

After birth, the mother often feels a combination of feelings. Joy and relief that the birth is over may be combined with uncertainty, frustration and anxiety. Her body's changes include hormonal fluctuations that are part of her emotional adjustment. Taking care of a new baby is hard work and mother sometimes experience "ups" and "downs" during the first year. Having the continued support of family members and friends is extremely helpful while the mother becomes accustomed to her new and very important role. New mothers especially need other mothers to help them to adjust to their new lives. Sometimes, however, the mother experiences bewildering emotions that can cause considerable concern. These feelings can be grouped into two main categories:

Baby Blues:

The "blues" occurs in approximately 70 to 80 percent of all mothers. It usually appears suddenly during the first few days after delivery and usually resolves itself within a week or two, it is generally not treated. Symptoms include: weepiness, irritability, restlessness and anxiety.

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Postpartum Mood Disturbances

The term “postpartum depression” has been used for many years to describe a variety of problems that are now referred to by several names, such as mood disturbances, adjustment problems, or specific reactions such as anxiety reactions, depressive reactions, obsessive/compulsive reactions or postpartum psychosis. Each woman’s symptoms are unique, she may also be experiencing a combination of reactions.

- 12-16% of women experience postpartum depression
- Up to 26% of adolescent mothers experience postpartum depression

Postpartum Psychosis

This is the least common and most severe postpartum disturbance. One in 1,000 women experience a postpartum psychosis usually within the first two weeks following the birth of their baby. Symptoms are severe and may include insomnia, agitation, hallucinations, bizarre perceptions and behaviour which indicate a disconnection with reality. Women experiencing these symptoms are at risk of harming themselves or their babies. This is a psychiatric emergency and the woman needs to be hospitalized immediately.

Women experiencing mood disturbances need to know that they are not alone

Reasons why women with Mood Disturbances should seek treatment in pregnancy or postpartum:

- A woman with untreated depression or anxiety in pregnancy is at a higher risk of developing post-partum depression.
- Treating women with mental illness in pregnancy increases their coping skills during pregnancy and in the post partum period.
- Untreated mood disturbances may affect the mother-child relationship and the woman’s ability to parent in the postpartum period.
- A woman with untreated mental illness in the post partum period may minimize her interactions with her baby for fears she may harm him/her. Treating the woman promptly may help her normalize her fears, increase her interactions with the child and therefore promote the bonding between mother and child.

Reaching Out

Sometimes it is difficult for women to ask for help because they fear being misunderstood. Often when they have tried to explain their feelings to others, the response is not appropriate or helpful. Most of the time, it is a lack of education and understanding about emotional distress during pregnancy and the postpartum period that causes misunderstandings.

But there are people who do know how to help. In recent years emotional problems during pregnancy and postpartum mood disorders have been studied in more depth. This fact sheet is part of a document informing physicians, nurses, midwives, social workers and mental health providers about: early identification, assessment, treatment options and follow-up of pregnant and postpartum women with mood disorders.

You can and should talk to your:

- Physician
- Community health nurse
- Mental health worker
- Midwife or doula
- Hospital nurse in labour & delivery
- Hospital social worker

You can also access more information from the:

Pacific Postpartum Support Society, Vancouver, BC Tel. (604) 255-7999 or www.postpartum.ca
They offer a telephone support helpline, volunteer telephone support, facilitator led support groups, partner’s information sessions, and literature. They also published a book entitled “Postpartum Depression and Anxiety: A Self-Help Guide for Mothers”.

Access the Reproductive Mental Health website for more information about mood disorder and treatment options such as light therapy, and the latest on medication use during pregnancy and while breastfeeding.
www.bcrmh.com

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APPENDIX B

ANTENATAL PSYCHOSOCIAL HEALTH ASSESSMENT (ALPHA)

Antenatal psychosocial problems may be associated with unfavorable postpartum outcomes. The questions on this form are suggested ways of inquiring about psychosocial health. Issues of high concern to the woman, her family or the caregiver usually indicate a need for additional supports or services. When issues of some concern are identified, follow-up and/or referral should be considered. Additional information can be obtained from the ALPHA Guide.*
 Please consider the sensitivity of this information before sharing it with other caregivers.

Addressograph

ANTENATAL FACTORS	COMMENTS/PLAN
FAMILY FACTORS	
Social support (CA, WA, PD) <ul style="list-style-type: none"> • How does your partner/family feel about your pregnancy? • Who will be helping you when you go home with your baby? 	
Recent stressful life events (CA, WA, PD, PI) <ul style="list-style-type: none"> • What life changes have you experienced this year? • What changes are you planning during this pregnancy? 	
Couple's relationship (CD, PD, WA, CA) <ul style="list-style-type: none"> • How would you describe your relationship with your partner? • What do you think your relationship will be like after the birth? 	
MATERNAL FACTORS	
Prenatal care (late onset) (WA) <ul style="list-style-type: none"> • First prenatal visit in third trimester? (check records) 	
Prenatal education (refusal or quit) (CA) <ul style="list-style-type: none"> • What are your plans for prenatal classes? 	
Feelings toward pregnancy after 20 weeks (CA, WA) <ul style="list-style-type: none"> • How did you feel when you just found out you were pregnant? • How do you feel about it now? 	
Relationship with parents in childhood (CA) <ul style="list-style-type: none"> • How did you get along with your parents? • Did you feel loved by your parents? 	
Self esteem (CA, WA) <ul style="list-style-type: none"> • What concerns do you have about becoming/being a mother? 	
History of psychiatric/emotional problems (CA, WA, PD) <ul style="list-style-type: none"> • Have you ever had emotional problems? • Have you ever seen a psychiatrist or therapist? 	
Depression in this pregnancy (PD) <ul style="list-style-type: none"> • How has your mood been during this pregnancy? 	

ASSOCIATED POSTPARTUM OUTCOMES

The antenatal factors in the left column have been shown to be associated with the postpartum outcomes listed below. **Bold, Italics** indicates **good** evidence of association. Regular text indicates fair evidence of association.

CA - Child Abuse CD - Couple Dysfunction PI- Physical Illness PD - Postpartum Depression WA - Woman Abuse

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ANTENATAL FACTORS	COMMENTS/PLAN
<p>SUBSTANCE USE</p> <p>Alcohol/drug abuse (WA, CA)</p> <ul style="list-style-type: none"> • How many drinks of alcohol do you have per week? • Are there times when you drink more than that? • Do you or your partner use recreational drugs? • Do you or your partner have a problem with alcohol or drugs? • Consider CAGE (Cut down, Annoyed, Guilty, Eye opener) 	
<p>FAMILY VIOLENCE</p> <p>Woman or partner experienced or witnessed abuse (physical, emotional, sexual) (CA, WA)</p> <ul style="list-style-type: none"> • What was your parents' relationship like? • Did your father ever scare or hurt your mother? • Did your parents ever scare or hurt you? • Were you ever sexually abused as a child? 	
<p>Current or past woman abuse (WA, CA, PD)</p> <ul style="list-style-type: none"> • How do you and your partner solve arguments? • Do you ever feel frightened by what your partner says or does? • Have you ever been hit/pushed/slapped by a partner? • Has your partner ever humiliated you or psychologically abused you in other ways? • Have you ever been forced to have sex against your will? 	
<p>Previous child abuse by woman or partner (CA)</p> <ul style="list-style-type: none"> • Do you/your partner have children not living with you? If so, why? • Have you ever had involvement with a child protection agency (ie Children's Aid Society)? 	
<p>Child discipline (CA)</p> <ul style="list-style-type: none"> • How were you disciplined as a child? • How do you think you will discipline your child? • How do you deal with your kids at home when they misbehave? 	

FOLLOW-UP PLAN:

<input type="checkbox"/> Supportive counselling by provider	<input type="checkbox"/> Homecare	<input type="checkbox"/> Assaulted women's helpline / shelter / counseling
<input type="checkbox"/> Additional prenatal appointments	<input type="checkbox"/> Parenting classes / parents' support group	<input type="checkbox"/> Legal advice
<input type="checkbox"/> Additional postpartum appointments	<input type="checkbox"/> Addiction treatment programs	<input type="checkbox"/> Children's Aid Society
<input type="checkbox"/> Additional well baby visits	<input type="checkbox"/> Smoking cessation resources	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Public Health referral	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Prenatal education services	<input type="checkbox"/> Psychologist / Psychiatrist	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Psychotherapist / marital / family therapist	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Community resources / mothers' group		

COMMENTS:

Date Completed

Signature

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*The ALPHA Guide is available through the Department of Family and Community Medicine, University of Toronto.

APPENDIX C

PERINATAL MENTAL HEALTH RISK ASSESSMENT QUESTIONNAIRE

This tool addresses major contributing risk factors for women developing a mental health illness during the perinatal period. The questions are meant to be a guide for service providers. If you have any concerns about the answers you receive proceed to the General Perinatal Mental Health Assessment Tool in Appendix C or the other tools mentioned in Guidelines 4, 5, and 6.

- 1) Is there a history of mental illness in your family (blood relative e.g. depression, anxiety or psychosis)? If yes, explain.
- 2) Have you ever suffered from depression, anxiety, or psychosis? If yes, when did it occur? What did you do about it?
- 3) Have you suffered from depression, anxiety, or psychosis during a pregnancy or postpartum period, (ask where appropriate)?
- 4) Have you experienced any mood changes that last more than 2 weeks which are:
 - related to your menstrual cycle, pregnancy or postpartum or
 - unrelated to these events?
- 5) Have you experienced any changes in your eating or sleeping habits in the last 2 weeks?
- 6) Does your relationship with your partner (if applicable) make you feel safe?
- 7) Are you satisfied with the support that you receive from your partner (if applicable)? Your family? Your friends?
- 8) Do you have other social supports in your life? Are you satisfied with these supports?
- 9) Have you experienced any major life events in the last year? Have you moved, changed jobs, separated from a partner or lost someone close to you?
- 10) Do you or your infant/child/children (if appropriate) have any acute or chronic health problems? If yes, do you have any difficulty coping with this health problem?
- 11) Do you find that your monthly income is sufficient to meet your monthly bills?
- 12) **If the woman is pregnant:** How do you feel about this pregnancy?
- 13) **If the woman has an infant or child:** Do you perceive your infant/child as having a difficult temperament?

Attention: This questionnaire is merely a tool to assist service providers in initial conversation with women. It has not been tested for its reliability or validity. If a woman responds positively to any of these questions further assessment can be done utilising the General Perinatal Mental Health Assessment Tool, Appendix D.

PERINATAL MENTAL HEALTH RISK ASSESSMENT QUESTIONNAIRE WITH REFERENCES

This tool addresses major contributing risk factors for women developing a mental health illness during the perinatal period. The questions are meant to be a guide for service providers. If you have any concerns about the answers you receive proceed to the General Perinatal Mental Health Assessment Tool in Appendix C or the other tools mentioned in Guidelines 4, 5, and 6.

- 1) Is there a history of mental illness in your family (blood relative e.g. depression, anxiety or psychosis)? If yes, explain.^{1,2,3}
- 2) Have you ever suffered from depression, anxiety, or psychosis? If yes, when did it occur? What did you do about it?^{3,4,5}
- 3) Have you suffered from depression, anxiety, or psychosis during a pregnancy or postpartum period, (ask where appropriate)?⁶
- 4) Have you experienced any mood changes that last more than 2 weeks which are:
 - related to your menstrual cycle, pregnancy or postpartum or
 - unrelated to these events? (refer to Signs & Symptoms Guideline 4, 5, 6)
- 5) Have you experienced any changes in your eating or sleeping habits in the last 2 weeks? (refer to Signs & Symptoms Guideline 4, 5, 6)
- 6) Does your relationship with your partner (if applicable) make you feel safe?^{7,8,9}
- 7) Are you satisfied with the support that you receive from your partner (if applicable)? Your family? Your friends?^{1,3,6,7}
- 8) Do you have other social supports in your life? Are you satisfied with these supports?^{1,3,7,8}
- 9) Have you experienced any major life events in the last year? Have you moved, changed jobs, separated from a partner or lost someone close to you?^{3,7,8}
- 10) Do you or your infant/child/children (if appropriate) have any acute or chronic health problems? If yes, do you have any difficulty coping with this health problem?^{4,5}
- 11) Do you find that your monthly income is sufficient to meet your monthly bills?^{4,5}
- 12) **If the woman is pregnant:** How do you feel about this pregnancy?^{1,5,6}
- 13) **If the woman has an infant or child:** Do you perceive your infant/child as having a difficult temperament?^{5,6}

Attention: This questionnaire is merely a tool to assist service providers in initial conversation with women. It has not been tested for its reliability or validity. If a woman responds positively to any of these questions further assessment can be done utilising the General Perinatal Mental Health Assessment Tool, Appendix D.

**REFERENCES FOR PERINATAL MENTAL HEALTH RISK ASSESSMENT
QUESTIONNAIRE**

1. Kumar, R., & Robson, M. K. (1984). A prospective study of emotional disorders in childbearing women. British Journal of Psychiatry (144), 35-47.
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9. Health Canada (1999). A handbook for Health and Social Service Professional Responding to Abuse during Pregnancy (available on website: www.healthcanada.ca)

APPENDIX D

GENERAL PERINATAL MENTAL HEALTH ASSESSMENT TOOL

This assessment represents a standard way of conducting an interview with a woman with mental illness during the perinatal period. This tool should not be used as a checklist of items to ask of the women and should not influence the flow of the psychiatric interview. Listen to the content of the woman's speech and:

- observe affect and motor behavior
- monitor the amount, flow and quality of speech and
- note whether the connections between words, phrases, and sentences deviate from normal goal directed speech.

I. HISTORY

A. Personal History

- Age, marital status, number of children, age of the children
- Presently working or plans to return to work
- Number of children in the family, relationship with siblings
- Relationship with parents, in-laws (if relevant)
- History of moves or memorable childhood experiences
- Education, area of work
- Present occupation, plans to work or return to work
- Relationship with partner
- Addictions history (see BCRCP Substance Use Guideline 3: General Clinical Management of Pregnant Substance Using Women)

B. Presenting illness to determine:

- 1) First onset of major depression, anxiety, or psychosis
 - 2) Exacerbation of dormant mental illness
 - 3) Chronic mental illness
- When did the symptoms first appear
 - What was done to manage these symptoms, what helped
 - What treatment was sought and from whom
 - What herbal remedies were tried, how effective were they, and what is their present use

C. Past Psychiatric History

- Is there any history of past psychiatric illness (other than the presenting illness)? If so, indicate the diagnosis, when it occurred, and the treatment.

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- Agitation (unable to sit still, wringing hands, rocking, picking at skin or clothing, pacing)
- Abnormal movements (tremor, lip smacking, tongue thrust, mannerisms, grimaces, tics)
- Gait (shuffling, broad based, limping, stumbling, festinating)

C. Speech

- Rate (slowed, long pauses before answering questions, hesitant, rapid, pressured)
- Rhythm (monotonous, stuttering)
- Volume (loud, soft, whispered)
- Amount (monosyllabic, hyperactive, mute)
- Articulation (clear, mumbled, slurred, dysarthric)
- Spontaneity

D. Affect

- Stability (stable, fixed, labile)
- Range (constricted, full)
- Appropriateness (content of speech and circumstances)
- Intensity (flat, blunted, exaggerated)
- Affect (depressed, sad, happy, euphoric, irritable, anxious, neutral, fearful, angry, apathetic, and pleasant)
- Mood (woman's report)

E. Thought Content

- Suicidal Ideation- Refer to Appendix D: Perinatal Suicide Assessment Questionnaire
- Infanticide ideation- Refer to Appendix E: Infanticide Ideation Assessment Questionnaire
- Depressive cognitions (guilt, worthless, hopeless)
- Obsessions
- Ruminations
- Phobias
- Paranoid ideation
- Magical ideation
- Delusions
- Overvalued ideas
- Other major themes discussed by patient

F. Thought Process

- Associations
- Coherent, incoherent
- Logical, illogical
- Stream (goal directed, circumstantial tangential, loose, flight of ideas, rambling,)
- Clang associations

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- Preseveration (continued repetition of meaningless words or phrases)
- Neologism
- Blocking
- Attention (distractibility, concentration)

G. Perception

- Hallucinations (auditory, visual, olfactory, gustatory, tactile)
- Illusions
- Depersonalization
- Derealization- Déjà vu, Jamais vu
- Insight- Awareness of illness

III. PSYCHOSOCIAL ASSESSMENT OF THE WOMAN

A. Relationships and Supports (for further discussion on supports refer to Guideline 6)

- Does the woman have a partner? What is her relationship with this partner? Does she feel supported within this relationship? Is marital counselling an option?
- Does the woman feel safe within this relationship?
NOTE: 21% of women in Canada who reported being abused by an intimate partner said they were abused during pregnancy (Statistics Canada, 1993).³ Pregnant women should be asked about abuse as early as possible in their pregnancy (Health Canada, 1999).⁴ Also refer to BCRCP Obstetrical Guideline 13: Intimate Partner Violence during the Perinatal Period, website: www.rcp.gov.bc.ca
- Does the woman perceive her family, extended family and in-laws as supportive? Specify, expand on frequency and quality of contact etc.
- Does the woman have any friends? Specify, work related, neighbourhood, church etc. Does the woman perceive any of these friends as supportive?
- Would the woman like to be linked with:
 - Community Health Nursing
 - Pregnancy Outreach Programs
 - Building Blocks Programs
 - Mental Health Worker
 - Ministry of Children and Families e.g. child protection or support services
 - Alcohol and drug treatment programs or services
 - Psychotherapy counselling
 - Marital counselling
 - Postpartum Support Agencies- Pacific Post Partum Support Services
 - Community agency within the woman's region (also refer to Guideline 2. Discharge Planning and Community Follow-up)

* A Handbook for Health and Social Service Professional Responding to Abuse during Pregnancy by Health recommends service providers: be supportive when abuse is disclosed, to

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focus on empowering women and to involve women in decisions affecting their health and safety.³

B. Cultural and/or Spiritual

- Does the woman have any beliefs or practices (e.g. cultural affiliations or spiritual beliefs) about mental illness, pregnancy or birth that she would like taken into account during her assessment and treatment for mental illness during pregnancy and/or the postpartum period? If so, what are they?
- How does she believe they will influence her pregnancy, delivery, hospital stay and care of the baby in the postpartum period?

C. Mothering Needs

- Does the woman have specific issues regarding mother/baby attachment?
- Has she had previous experiences with other pregnancies/children? If so, what are they?
- Has she experienced previous losses of children due to child protection issues, custody, or death? Does she have any residual fears from these losses?

D. Housing

- Is the woman satisfied with her housing arrangement?
- Is housing safe, affordable and adequate?
- Is temporary housing needed?

E. Finances

- Are the woman's finances adequate to meet her needs and the future needs of the child? E.g. Housing, clothing, food, crib and other necessities
- Does she qualify for Ministry support? Has she applied for social assistance?

F. Transportation

- Access to on-going transportation e.g. bus pass, access to a vehicle, etc.
- Transportation to psychiatric and medical appointments?

G. Legal Issues

- Does the woman have any legal concerns e.g. restraining orders, refugee issues, child protection issues, custody issues, immigration etc

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APPENDIX E

PERINATAL SUICIDE ASSESSMENT QUESTIONNAIRE

Begin the discussion with: “Often when women come to me and are depressed like you are they have experienced negative thoughts about harming themselves”. Then proceed to the following two questions.

1. Have you had any thoughts of harming yourself?

If Yes:

- Did you think of a way to do it?
- How close have you come to doing it?
- Can you give me more details?

If No:

- Do you wish you were dead?
- When you go to sleep, do you often wish you would not wake up?

2. Have you attempted to harm yourself in the past?

If Yes:

- Can you give me more details?

APPENDIX F

INFANTICIDE IDEATION ASSESSMENT QUESTIONNAIRE

Begin the discussion with: “Often when women come to me and are depressed like you are they have experienced negative thoughts about the baby”.

1. Have you had any negative thoughts about harming your baby?
2. If yes, have you made any plans to harm your baby or are they just ideas? Can you give me more details?
3. Have you attempted to harm your baby? If yes, when?
4. Do these thoughts disturb you?
5. Some women have thoughts or images about harming their baby when
 - they are holding a knife
 - giving the baby a bath

NOTE: Women who have guilt feelings about harming their infants may also have suicidal thoughts and be suffering from Major Depression (refer to Guideline 3). Women who have no guilt feelings related to the infanticide ideation and are being compelled to act on their thoughts may have a psychosis (refer to Guideline 5).