

Perinatal Depression Screening, Diagnosis, and Treatment Guideline

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Guidelines are systematically developed statements to assist patients and providers in choosing appropriate health care for specific clinical conditions. While guidelines are useful aids to assist providers in determining appropriate practices for many patients with specific clinical problems or prevention issues, guidelines are not meant to replace the clinical judgment of the individual provider or establish a standard of care. The recommendations contained in the guidelines may not be appropriate for use in all circumstances. The inclusion of a recommendation in a guideline does not imply coverage. A decision to adopt any particular recommendation must be made by the provider in light of the circumstances presented by the individual patient.

Changes as of May 2024

- The shared decision-making section on treating depression with SSRIs during pregnancy and breastfeeding was updated.

Target Population

The recommendations in this guideline apply to

- Pregnant women.
- Postpartum women from childbirth through the first year of the baby's life.
- Women who are already taking antidepressant medications and are considering becoming pregnant.

Role of Mental Health and Wellness

Maternal Mental Health (MMH) Screening is part of the initiative that focuses on pregnant and postpartum women through an infant's first year of life. Recent research demonstrates that pregnancy and the first year of the infant's life pose increased risks to the mother's mental health and well-being, including depression, anxiety, and domestic violence. MMH screening tools and processes are similar to those used in Integrated Mental Health, but they are tailored for maternal health and include questions about domestic violence.

The **Integrated Mental Health (IMH)** model has been incorporated in all KPWA clinics. Primary care social workers function as provider extenders to address patient needs without disrupting patient flow and team cycle time. Social workers offer consultation to providers, brief interventions, and short-term (4–6 visits) counseling for individuals with mild to moderate depression and alcohol or substance use disorders. The goal is to improve access, reliability, and quality of care for patients with mental health and substance use concerns by integrating mental health into primary care clinics.

The **Collaborative Care Model (CoCM)** is an emerging approach at KPWA that has been implemented in several clinics so far with plans to be rolled out to all KPWA clinics by 2026. CoCM expands our IMH model with additional Collaborative Care Clinicians (CCCs) who work with patients ages 13 and older with moderate to moderately severe depression and anxiety (IMH focuses on patients with mild to moderate symptoms). Collaborative Care Clinicians include social workers who provide therapeutic counseling and monitor patient progress, and RNs who provide medication management. Psychiatric consultants (MDs) work with the CCCs and PCPs to advise about treatment options and to discuss patients who might not be improving as expected. See the Collaborative Care Sharepoint site for more information about the program.

Screening and Diagnosis

Routine screening using the [Maternal Mental Health \(MMH\) Screening questionnaire](#) is recommended for all pregnant and postpartum women. MMH screening is optimally performed at four visits during the pregnancy and four times through the infant's first year, at the following routine visits:

Pregnancy care (In Women's Health or Family Practice)	Pediatric care (In Pediatrics or Family Practice)
<ul style="list-style-type: none">• First prenatal visit• 16-week visit• 32-week visit• Postpartum	<ul style="list-style-type: none">• 7–14-day well baby visit• 4-month well baby visit• 6-month well baby visit• 12-month well baby visit

MMH screening has been integrated into the OB and Well Child Visit SmartSets. The MMH incorporates the Patient Health Questionnaire (PHQ-9), the Generalized Anxiety Disorder (GAD-2) questionnaire, and questions about substance abuse and domestic violence.

Note: Pregnant and postpartum women who have a current diagnosis of depression—whether made prior to pregnancy or during the perinatal period—should be followed with the Maternal Mental Health Screening questionnaire at the same set of routine visits.

Severity assessment

The first nine questions on the MMH questionnaire comprise the PHQ-9. The PHQ-9 score is the sum of these responses.

Depression severity is correlated with PHQ-9 scores as follows:

- 20–27: Severe major depression
- 15–19: Moderately severe major depression
- 10–14: Moderate major depression
- 5–9: Indeterminate or mild depression. People with this score could have had major depression that is now improved, chronic mild depression (dysthymia), or transient mild depression. The PHQ-9 cannot distinguish among these. Use clinical judgment to determine appropriate next steps.

Screening for suicidal ideation

Suicidal ideation is assessed by question 9 on the PHQ-9.

Over the past 2 weeks, how often have you been bothered by any of the following problems: thoughts that you would be better off dead, or hurting yourself in some way?

If the patient scores 2 or 3 on this PHQ-9 question (or otherwise expresses suicidal thoughts, exhibits suicidal behaviors, or has suicide risk factors), administer the [Columbia Suicide Risk Assessment \(C-SRA\)](#). Also available as a KP HealthConnect Flowsheet.

The C-SRA is scored by adding the “yes” answers together.

- 6: Acute risk for suicide
- 3–5: Moderate risk
- 0–2: Low risk

C-SRA score of 3 or higher

Requires completion of a crisis response plan and lethal means removal. Use **.LOCK2LIVE** to direct patients to a web-based decision aid to help individuals at risk of suicide make decisions about lethal means safety, particularly firearms and prescription medications.

While the patient is still in the room, obtain immediate consultation with a mental health professional through:

- Warm patient hand-off to clinic social worker/integrated mental health specialist, or

- Mind Phone

C-SRA score of 0–2

Arrange a follow-up appointment with Mental Health through:

- Order Urgent referral to Mental Health, or
- Warm patient hand-off to integrated mental health specialist
- Consider a safety plan.

Psychiatric comorbidities and other life stressors

The remaining questions on the Maternal Mental Health Screen (questions 10–21) are designed to assess for other mental health conditions and life stressors. Consider consultation or referral to Mental Health for more definitive diagnosis and management if any of these factors are present.

Table 1. Mental health conditions or life stressors to consider in pregnant and postpartum women		
Mental health condition or life stressor	MMH screening question	Next steps
Anxiety disorders, including generalized anxiety disorder, obsessive-compulsive disorder, and panic disorder	<p>GAD-2</p> <p>Over the last 2 weeks, how often have you been bothered by the following problems?</p> <ul style="list-style-type: none"> • MMH #10: Feeling nervous, anxious, or on edge • MMH #11: Not being able to stop or control worrying 	If score of 3 or higher, follow with the GAD-7 (available in KP HealthConnect).
Alcohol misuse	<p>AUDIT-C</p> <ul style="list-style-type: none"> • MMH #13: How often did you have a drink containing alcohol in the last 3 months? • MBH #14: How many drinks containing alcohol did you have on a typical day when you were drinking in the last 3 months? • MMH #15: How often did you have 4 or more drinks on one occasion in the last 3 months? 	See the Adult Unhealthy Drinking Guideline.
Marijuana misuse	<ul style="list-style-type: none"> • MMH #16: In the last 3 months, have you used marijuana? 	If daily or almost daily, use the Substance Use Symptom Checklist in KP HealthConnect.
Drug misuse	<ul style="list-style-type: none"> • MMH #17: In the last 3 months, have you used an illegal drug or used a prescription medication for non-medical reasons? 	If yes, use the Substance Use Symptom Checklist in KP HealthConnect.
Abuse/violence	<ul style="list-style-type: none"> • MMH #19: Are you currently in a relationship where your partner hits, slaps, kicks, or hurts you? • MMH #20: Does your partner control where you go or make you feel afraid? • MMH #21: Have you had a partner who physically hurt or threatened you? 	If yes, follow up with open-ended, non-leading questions to encourage self-disclosure. Consider referral to Social Work.

Treatment: Overview of Options

Treatment recommendations are based on the patient's PHQ-9 score and may include psychotherapy, antidepressants, or both. On average, antidepressant medication and psychotherapy have similar effectiveness. Supportive care is recommended for *all* patients receiving care for depression.

The goals of treatment are to achieve complete remission and prevent relapse or recurrence of depression. Remission is defined as a PHQ-9 score of < 5.

20–27: Severe major depression

For patients with severe major depression, **combined antidepressant medication and psychotherapy** is the preferred treatment recommendation. Antidepressant medication alone is an alternative recommendation. Psychotherapy alone is *not* recommended for these patients.

Moderately severe (15–19) and moderate (10–14) major depression

For patients with moderately severe or moderate major depression, **shared decision-making** around treatment options—antidepressants, psychotherapy, and combination therapy—is recommended. For patients with moderately severe depression (PHQ-9 score of 15–19), combining psychotherapy and antidepressants may be more effective than using either treatment alone.

5–9: Indeterminate or mild depression

For patients with indeterminate or mild depression, treatment with antidepressants or psychotherapy is usually not recommended. Supportive care, including patient education and emotional support and guidance, is recommended.

Supportive care

Support and education in the primary care setting are critical and contribute to the likelihood of good follow-through on treatment. Supportive care is recommended for *all* patients receiving care for depression.

Patient education should include:

- The cause, symptoms and natural history of major depression
- Shared decision-making about treatment options
- Information on what to expect during treatment
- Follow-up (office visits, e-mail, and/or telephone)

In addition to patient education, supportive care includes emotional support and guidance. Providers can engage in behavioral activation by encouraging patients to consider and adopt some self-management responsibilities, such as writing in a journal or reading self-help books, scheduling pleasant activities, spending time with people who support them, and engaging in physical activity. Patients who are receiving supportive care but are not prescribed medications should be encouraged to follow up with a member of their clinical team within 2–4 weeks of diagnosis, as early behavioral activation may improve patients' self-efficacy and continued investment in treatment (Cuijpers 2014). If possible, schedule follow-up at the time of diagnosis.

Psychotherapy

Psychotherapy often involves a series of structured sessions in which a provider helps the patient identify and change behaviors (isolation, inactivity, avoidance of problem-solving) and cognitions (negative rumination, magnification of bad news, minimization of good news). Individual therapy can be accessed internally via REF MENTAL HEALTH and IMH social workers, and through external partners. Both in-person and virtual care options are available. Online cognitive behavioral therapy (CBT) may be an attractive option as access to

psychotherapy may be a significant barrier to care. We continue to recommend use of apps and telehealth services as adjunct or first-line treatment, based on patient preference.

Combination therapy

For some patients, particularly those with severe depression (PHQ-9 score of 15 or higher), combining psychotherapy and antidepressants may be more effective than using either treatment alone.

Antidepressants

Pregnant and postpartum women considering antidepressants need to be informed of the risks and benefits of pharmacologic treatment through a shared decision-making process.

Shared Decision-Making: Treating Depression with SSRIs in PREGNANT and BREASTFEEDING Women

Assessing the benefits and risks of taking an antidepressant during pregnancy and lactation is challenging because the evidence is limited to observational studies that are subject to confounding and bias. SSRIs have the most data for use during pregnancy and lactation. The potential risks of medication exposure must be balanced with the potential harms of untreated maternal depression. The benefits of breastfeeding seem to outweigh the potential side effects of SSRIs.

For pregnant women, the risks of untreated depression include poor prenatal care, increased risk of cigarette, alcohol, and other substance misuse, and decreased social support. Untreated maternal depression is also associated with low birth weight and preterm birth. In the postpartum period there is a greater risk of disturbance in the development of the maternal-infant bond in severely depressed mothers; in addition, postpartum depression has been associated with lower IQ, slower language development, increased risk of ADHD and an increased risk of psychiatric illness in the child later in life.

Table 2. Shared decision-making: Treating depression with SSRIs during PREGNANCY and BREASTFEEDING

SSRIs during PREGNANCY	
<p>Advantages/Benefits</p> <p>There are few good studies about the long-term effects of SSRI exposure in pregnancy. Only small, less rigorous studies are available and seem to indicate no effect on the child's behavioral, language or IQ development.</p> <p>During pregnancy, women with depression have a higher risk of relapse off medications. Relapse occurs in approximately 68% of those who go off medication compared with 26% of those who continue antidepressants.</p> <p>Similar risk of birth defects as for women who don't take SSRIs during pregnancy (about 3–5%)</p>	<p>Disadvantages/Risks</p> <p>For common antidepressants (escitalopram, sertraline, fluoxetine), there is no clear evidence of increased risk of malformations, but we do not have enough evidence to be sure there is no risk.</p> <p>SSRI use during pregnancy is associated with the following possible risks: gestational age decreased by an average of 1 week, and increased risk of persistent pulmonary hypertension in the newborn with exposure after 20 weeks gestation.</p> <p>Babies born to mothers taking SSRIs may have a withdrawal syndrome characterized by poor feeding, abnormal sleeping patterns, changes in muscle tone, and difficulty being consoled. These symptoms tend to be mild and are usually treated conservatively with monitoring of the baby, symptomatic support, increased skin-to-skin contact, and swaddling.</p>
SSRIs during BREASTFEEDING	
<p>Advantages/Benefits</p> <p>The benefits of breastfeeding generally seem to outweigh the potential side effects of SSRIs.</p> <p>Infant drug exposure is generally higher through placental passage than through breast milk. Thus, if a woman has taken an antidepressant during pregnancy, it generally makes sense to continue with the same antidepressant during breastfeeding to minimize the number of medications the infant is exposed to.</p> <p>In severely depressed postpartum women, the risk of SSRIs is generally considered less than the risk of disturbing the development of the maternal-infant bond.</p>	<p>Disadvantages/Risks</p> <p>There is weak evidence (e.g., from case studies) linking antidepressant use in breastfeeding mothers with mild adverse events in infants, but because the reported adverse effects were non-specific (e.g., irritability, sedation, and "colic"), it is unclear whether they were directly related to the medication exposure.</p> <p>The risk of drug accumulation and associated toxicity may be higher in premature infants or in infants with signs of compromised hepatic metabolism.</p> <p>To minimize the risk to the baby, use the minimum medication dose that provides adequate control of the mother's symptoms. There does not appear to be any benefit to altering the timing of nursing or selectively discarding portions of the breast milk to minimize drug exposure to the baby.</p>

Pharmacologic Options for Pregnant and Breastfeeding Women

In a patient who is not currently receiving drug therapy, sertraline is the drug of first choice because literature supports its use during preconception, throughout pregnancy, and during breastfeeding. However, if the patient previously failed an adequate dose and duration or experienced intolerable side effects on the first-line option, then escitalopram is a reasonable alternative.

For patient-specific consultations, refer to Mental Health or OB/GYN, or call the Mind Phone.

Sertraline is a preferred SSRI during pregnancy and lactation because of its short half-life and the relatively low drug levels found in cord blood and breast milk. For women stable on fluoxetine or citalopram during pregnancy, the possible benefits of switching to sertraline for breastfeeding must be balanced against the possible disruption of switching medication.

Escitalopram: Based on limited data, escitalopram appears to be preferable to citalopram during pregnancy and breastfeeding and is considered second-line. Escitalopram shows lower drug levels in breast milk and a general lack of adverse reactions in breastfed infants.

Citalopram: Compared with other SSRI antidepressants, the relative dose to the infant from citalopram is comparable to fluoxetine but higher than that for sertraline and paroxetine. If citalopram is required by the mother, it is not a reason to discontinue breastfeeding.

Fluoxetine: While recent data shows a statistically significant increased *relative* risk of major birth defects when fluoxetine is taken in early pregnancy, the *absolute* risks are small. However, it is still reasonable to switch from fluoxetine if the patient would like to minimize the risks. Adverse effects such as colic, fussiness, and drowsiness have been reported in some breastfed infants. Notably, some KP regions do recommend fluoxetine as a reasonable option during pregnancy and breastfeeding.

Venlafaxine and bupropion: While data is limited and evidence for use of these medications during pregnancy and breastfeeding is less clear than for other antidepressants, it is reasonable to consider **continuing** their use in women who are responding to them. The American Academy of Pediatrics classifies bupropion and venlafaxine as drugs whose effect on the nursing infant is unknown but may be of concern.

Paroxetine is associated with cardiovascular teratogenicity when taken in the first trimester of pregnancy; avoid new starts and consult with Mental Health when needed.

Table 3. Recommended antidepressant dosing for PREGNANT OR BREASTFEEDING WOMEN

For women starting or continuing antidepressants during or after pregnancy, use SmartPhrases
 .AVSPREGDEPRESSIONMEDSTART, .AVSPREGDEPRESSIONMEDCONT
 .AVSDEPRESSIONBREASTFEEDING, .AVSPREGDEPRESSIONPOSTPARTUM
 .AVSDEPMATERNALCAREPLAN

Line	Medication	Initial dose	Titration schedule If unsatisfactory clinical response after 2–4 weeks, then:	Usual therapeutic dose range
1st	Sertraline	50 mg daily x 7 days, then increase to 100 mg daily.	Increase by 50 mg increments at 4-week intervals.	50–200 mg
2 nd	Escitalopram	5 mg daily x 7 days, then increase to 10 mg daily.	Increase to 20 mg daily.	10–20 mg

Note: Other SSRIs, such as citalopram and fluoxetine, may be clinically appropriate in certain circumstances. Other KP regions and other national guidelines include these medications as reasonable treatment options in pregnancy and breastfeeding. There is heterogeneity in which medications are listed as second line due to limited evidence. Use shared decision-making with OB provider.

Other treatment options

Herbal supplements

The safety and efficacy of herbal supplements for depression treatment in pregnant and breastfeeding women was not evaluated, as few animal or human studies have been conducted. Due to the lack of evidence and uncertainty in product quality, women who are pregnant, contemplating pregnancy, or lactating should generally be discouraged from using herbal treatments.

Bright light therapy

Moderate evidence suggests that the use of bright light therapy is not effective for perinatal depression.

Follow-up

See the [KPWA Adult and Adolescent Depression Guideline](#) for follow-up recommendations. The Mental Health Monitoring Tool should be used at every follow-up visit for depression after the baby's first birthday. The SmartPhrase .SMDEPFOLLOWUP may be used when scheduling follow-up visits.

Evidence Summary

This guideline was developed using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

External guidelines eligible for adapting/adopting

2023 ACOG Clinical Practice Guideline No. 5. Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum.

2023 ACOG Clinical Practice Guideline No. 4. Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum.

2022 A Review of Treatments and Clinical Guidelines for Perinatal Depression. McDonald et al.

Questions to the literature

1. In pregnant women with depression or potential postnatal depression what partner support interventions may prevent and /or improve the outcome of post-natal depression?

There is insufficient published evidence to determine partner support interventions that would prevent and /or improve the outcome of post-natal depression.

References

ACOG Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 5. *Obstet Gynecol.* 2023 Jun 1;141(6):1262-1288. doi: 10.1097/AOG.0000000000005202.

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Guideline Development Process and Team

Development process

The guideline team developed the Perinatal Depression Guideline using an evidence-based process, including systematic literature search, critical appraisal, and evidence synthesis.

This edition of the guideline was approved for publication by the Guideline Oversight Group in May 2024.

Team

The Adult & Adolescent Depression Guideline development team included representatives from the following specialties: adolescent medicine, family medicine, family medicine with OB, mental health and wellness, pediatrics, pharmacy, population health, and residency.

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