



Baby Pediatric Symptom Checklist (BPSC) Scoring Guide

Scoring Instructions:

1. Determine the BPSC total score by assigning a "0" for each "not at all" response, a "1" for each "somewhat" response, and a "2" for each "very much" response, and then summing the results.
2. For items where parents have selected multiple responses for a single question, choose the more concerning answer (i.e. "somewhat" or "very much") farthest to the right.
3. A missing item counts as zero

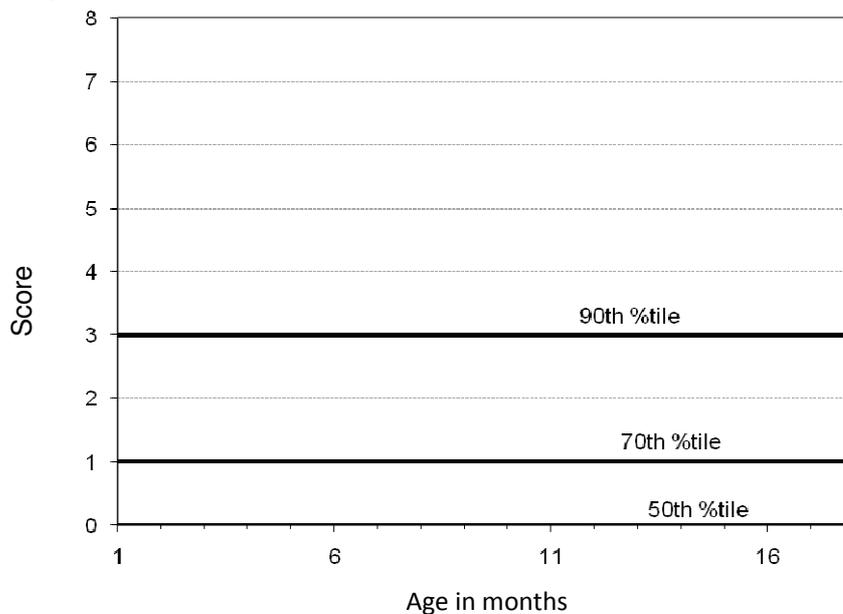
Interpretation:

BPSC scores are sensitive to age. We recommend tracking children's scores longitudinally using the attached charts. As a proxy, any score of 3 or more on any of the three scales can be considered positive.

Note: In our preliminary study, 79% of children with behavioral risk according to the ASQ-SE were also identified on the BPSC. However, 26% of children who had not been identified by the ASQ-SE were also detected. Validity data based on diagnoses was not available due to the small sample of diagnosed behavioral disorders for very young children. We therefore recommend interpreting results of this questionnaire with caution.

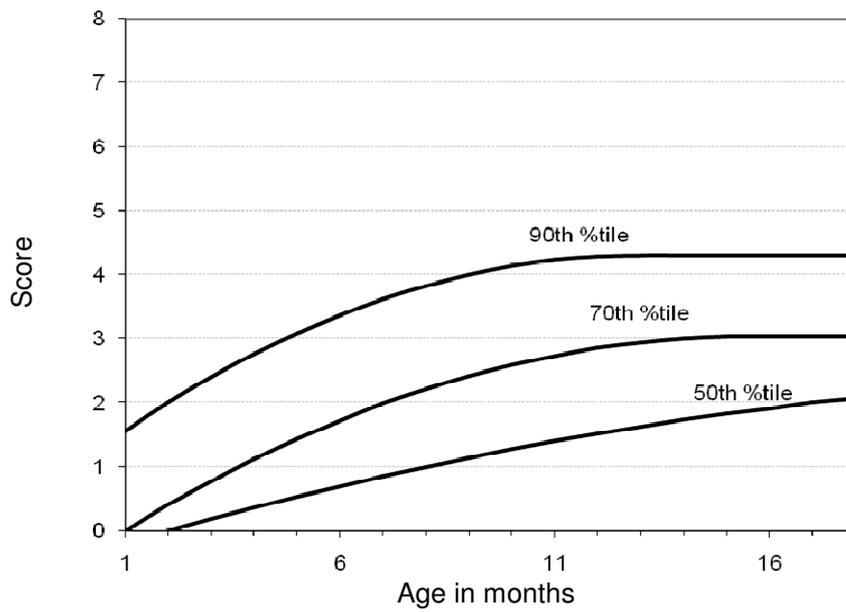
Normative curves for BPSC scales

Irritability

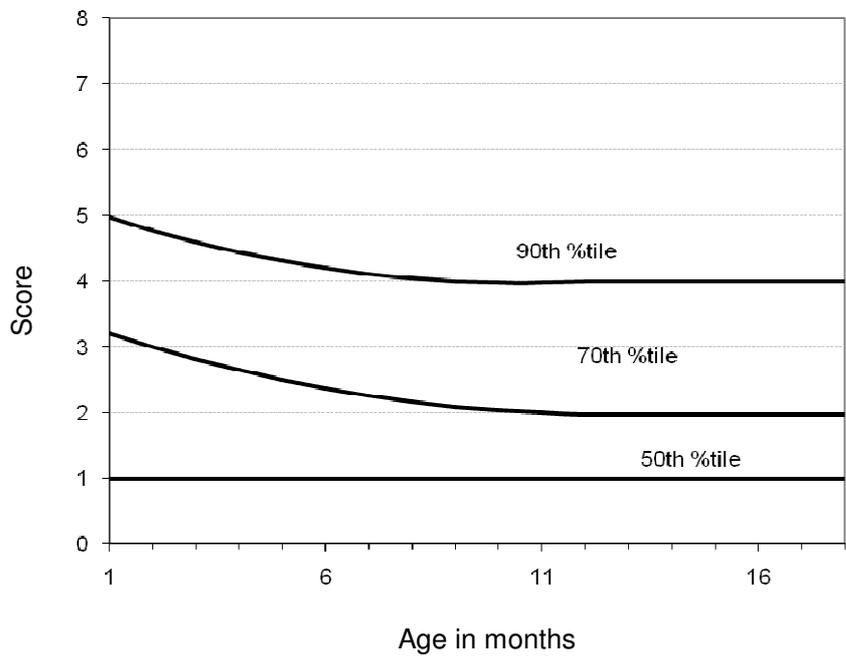


***** Please continue on the back *****

Inflexibility



Difficulty with routines



Technical Note: Curves are a function of age (months) and age². Constants, linear and quadratic coefficients for each curve are as follows: irritability_{50th}=[0,0,0]; irritability_{70th}=[1,0,0]; irritability_{90th}=[3,0,0]; inflexibility_{50th}=[-.393,.204,-.004]; inflexibility_{70th}=[-.432,.446,-.014]; inflexibility_{90th}=[1.086,.495,-.019]; routines_{50th}=[1,0,0]; routines_{70th}=[3.426,-.231,.009]; routines_{90th}=[5.2,-.233,.011]



Preschool Pediatric Symptom Checklist (PPSC) Scoring Guide

Scoring Instructions

1. Determine the PPSC total score by assigning a "0" for each "not at all" response, a "1" for each "somewhat" response, and a "2" for each "very much" response, and sum the results.
2. For items where parents have selected multiple responses for a single question, choose the more concerning answer (i.e. "somewhat" or "very much") farthest to the right.
3. A missing item counts as zero.

Interpretation:

A PPSC total score of 9 or greater indicates that a child is "at risk" and needs further evaluation.

Note: In our preliminary study, 85% of children with a behavioral disorder were also identified on the PPSC. However, 18% of children who had not been diagnosed with a behavioral disorder were also identified. We therefore recommend interpreting results of this questionnaire with caution.

Version 1, 9/5/2013



Milestones Scoring Guide

The Milestones is one element of the Survey of Wellbeing of Young Children (SWYC), a brief but comprehensive screening instrument for children under 5 years. The Milestones are a set of evidence-based items that are appropriate for pediatric surveillance or for first level developmental screening.

There is a Milestones form for each visit on the pediatric periodicity schedule through 5 years. Use the chart below to select the appropriate form:

<u>FORM</u>	<u>Minimum age</u>	<u>Maximum age</u>
2	1 month, 0 days	3 months, 31 days
4	4 months, 0 days	5 months, 31 days
6	6 months, 0 days	8 months, 31 days
9	9 months, 0 days	11 months, 31 days
12	12 months, 0 days	14 months, 31 days
15	15 months, 0 days	17 months, 31 days
18	18 months, 0 days	22 months, 31 days
24	23 months, 0 days	28 months, 31 days
30	29 months, 0 days	34 months, 31 days
36	35 months, 0 days	46 months, 31 days
48	47 months, 0 days	58 months, 31 days
60	59 months, 0 days	65 months, 31 days

Scoring Instructions:

- Each form includes 10 items. Score each item using these values:
Not yet=0; Somewhat=1, Very Much=2.
- Add up all 10 item scores to calculate the total score. If answers are missing, reevaluate if possible. Otherwise, missing items count as zero.
- On the Milestones Scoring Chart, the child's age in months is indicated in the far left column. Check to be sure that the parent completed the correct form for the child's age (second column). If not, the score will be misleading.
- Following along the appropriate age row, try to find the number corresponding to the child's total score. If you find the appropriate number, circle it. Otherwise:
 - If the total score is less than any of the numbers in the row, circle the minus sign ("-") to the left.
 - If the total score is greater than any of the numbers that appear in the row, circle the plus sign ("+") to the right.
- Repeat this process at every pediatric visit in order to monitor the child's developmental status. Note that all SWYC Milestones results can be recorded on a single copy of the SWYC Milestones Scoring Chart, thus facilitating comparisons across visits.

Interpretation:

If a child scores in the 'Below Average for Age' range, we recommend further evaluation or investigation.

Name:		MR#:		DOB:																			
SWYC Milestones Scoring Chart																							
Age (months)	Form	Below average range: further investigation recommended					Average Range																
		4	4m	-	12	13		14	15	16		17											
5		-	14	15		16	17			18													+
6		-	10	11		12	13	14	15	16			17										+
7	6m	-	12	13	14		15	16	17	18													+
8		-	14	15	16		17	18	19														+
9		-	9	10	11		12	13	14	15			16							17			+
10	9m	-	11	12	13		14	15	16	17											18		+
11		-	12	13	14		15	16	17				18										+
12		-	10	11	12		13	14	15	16			17										+
13	12m	-	11	12	13		14	15	16	17			18										+
14		-	12	13	14		15	16	17	18													+
15		-		10		11	12	13	14	15	16	17								18			+
16	15m	-		10	11	12		13	14	15	16	17			18								+
17		-	10	11	12	13		14	15	16	17	18								19			+
18		-	5	7	8	9	10	11	12	13	14	15	16	17					17			18	+
19		-	6	7	8	9	10	11	12	13	14	15	16	17						18			+
20	18m	-	7	8	9	10	11	12	13	14	15	16	17							18			+
21		-	8	9	10	11	12	13	14	15	16	17	18									19	+
22		-	9	10	11	12	13	14	15	16	17	18									19		+
23		-	6	7	8	9	10	11	12	13	14	15	16	17							18		+
24		-	8	9	10	11	12	13	14	15	16	17								18			+
25	24m	-	8	9	10	11	12	13	14	15	16	17	18										+
26		-	9	10	11	12	13	14	15	16	17	18										19	+
27		-	10	11	12	13	14	15	16	17	18										19		+
28		-	11	12	13	14	15	16	17	18											19		+
29		-		7	8	9	10	11	12	13	14	15	16	17						18			+
30		-	6	7	8	9	10	11	12	13	14	15	16	17						18			+
31	30m	-	7	8	9	10	11	12	13	14	15	16	17	18								19	+
32		-	8	9	10	11	12	13	14	15	16	17	18								19		+
33		-	8	9	10	11	12	13	14	15	16	17	18								19		+
34		-	9	10	11	12	13	14	15	16	17	18	19										+
35		-	6	7	8	9	10	11	12	13	14	15	16	17								18	+
36		-		8	9	10	11	12	13	14	15	16	17								18		+
37		-	8	9	10	11	12	13	14	15	16	17									18		+
38		-	8	9	10	11	12	13	14	15	16	17									18		+
39		-	9	10	11	12	13	14	15	16	17	18											+
40	36m	-	10	11	12	13	14	15	16	17	18											19	+
41		-	10	11	12	13	14	15	16	17	18											19	+
42		-	11	12	13	14	15	16	17	18												19	+
43		-	12	13	14	15	16	17	18													19	+
44		-	12	13	14	15	16	17	18													19	+
45		-	13	14	15	16	17	18	19														+
46		-	14	15	16	17	18	19															+
47		-	9	10	11	12	13	14	15	16	17											18	+
48		-	10	11	12	13	14	15	16	17												18	+
49		-	10	11	12	13	14	15	16	17												18	+
50		-	11	12	13	14	15	16	17	18													+
51		-	11	12	13	14	15	16	17	18													+
52	48m	-	11	12	13	14	15	16	17	18												19	+
53		-	12	13	14	15	16	17	18													19	+
54		-	12	13	14	15	16	17	18													19	+
55		-	13	14	15	16	17	18														19	+
56		-	13	14	15	16	17	18														19	+
57		-	13	14	15	16	17	18														19	+
58		-	14	15	16	17	18	19															+

We urge caution in interpreting total scores for the 2-month and 60-month forms. They are useful for surveillance, but the scores should be considered imprecise. For this reason, we excluded these forms from our primary scoring table. If you are interested in using these forms, we have provided a separate table:

Supplemental Tables: 2 and 60 Month Scoring												
Name:				MR#:				DOB:				
Age (months)	Form	Below average range: further investigation recommended					Average Range					
		2	2m	-	12		13		14		15	
3		-				16		17			18	+
59		-	11	12	13	14	15	16	17	18		+
60		-	11	12	13	14	15	16	17	18		+
61		-		12	13	14	15	16	17	18	19	+
62		-	12	13	14	15	16	17	18		19	+
63		-	12	13	14	15	16	17	18		19	+
64	60m	-		13	14	15	16	17	18		19	+
65		-	13	14	15	16	17	18	19			+
66		-	13	14	15	16	17	18	19			+
67		-		14	15	16	17	18	19			+
68		-	14	15	16		17	18	19			+
69		-	14	15	16	17		18	19			+
70		-		15	16	17		18	19			+

Example Milestones Scoring

Keep a copy of the Milestones scoring sheet in your patient's file. At each well-child visit, mark the child's screening score on this sheet. By using the same scoring sheet over time, you will be able to see trends in your patient's developmental growth.

Name:		MR#:		DOB:																																																				
Age (months)	Form	Below average range: further investigation recommended					Average Range																																																	
		4	4m	-	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58				
5	4m	-	14	15		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58								
6	6m	-	10	11		12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58				
7	6m	-	12	13	14		15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58						
8	6m	-	14	15	16		17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58								
9	9m	-	9	10	11		12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58			
10	9m	-	11	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58					
11	9m	-	12	13	14		15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58						
12	12m	-	10	11	12		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58				
13	12m	-	11	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58					
14	12m	-	12	13	14		15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58						
15	15m	-	10	11	12		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58				
16	15m	-	10	11	12		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58				
17	15m	-	10	11	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58				
18	18m	-	5	7	8		9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
19	18m	-	6	7	8	9	10		11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
20	18m	-	7	8	9	10	11		12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	
21	18m	-	8	9	10	11	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58		
22	18m	-	9	10	11	12	13	14		15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58			
23	24m	-	6	7	8	9	10		11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
24	24m	-	8	9	10	11	12		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58		
25	24m	-	8	9	10	11	12		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58		
26	24m	-	9	10	11	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58			
27	24m	-	10	11	12	13	14		15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58				
28	24m	-	11	12	13	14	15		16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58					
29	30m	-	7	8	9	10		11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	
30	30m	-	6	7	8	9	10		11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58
31	30m	-	7	8	9	10	11		12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	
32	30m	-	8	9	10	11	12		13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58		
33	30m	-	8	9	10	11	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58		
34	30m	-	9	10	11	12	13		14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58			
35	36m	-	6	7	8	9	10		11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	



Parents' Observation of Social Interaction (POSI) Scoring Guide

Scoring Instructions:

1. Determine the number of items on which parents have answered using responses in the 3 most-concerning categories (i.e. the last 3 column response options, see figure).
2. For items where parents have selected multiple responses for a single question, choose the more concerning answer (i.e. lower-functioning behavior) farthest to the right.
3. Missing items count as zero.

Interpretation:

3 or more answers in the last 3 columns indicates that the child is "at risk" and needs further evaluation.

Note: In our preliminary study, 83% of children with an ASD diagnosis were detected by the POSI. However, 26% of children who had not been diagnosed with autism were also detected. Of the children who scored positive on the POSI but did not have ASD, 49% had developmental delay (n=28). We therefore recommend interpreting results of this questionnaire with caution.



SWYC:

18 months, 0 days to 34 months, 31 days

Three or more responses in these three columns

| | |

PARENT'S OBSERVATIONS OF SOCIAL INTERACTIONS (POSI)					
Does your child bring things to you to show them to you?	Many times a day	A few times a day	A few times a week	Less than once a week	Never
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Is your child interested in playing with other children?	Always	Usually	Sometimes	Rarely	Never
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you say a word or wave your hand, will your child try to copy you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look at you when you call his or her name?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Does your child look if you point to something across the room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How does your child <u>usually</u> show you something he or she wants?	Says a word for what he or she wants	Points to it with one finger	Reaches for it	Pulls me over or puts my hand on it	Grunts, cries or screams
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(please check all that apply)					
What are your child's favorite play activities?	Playing with dolls or stuffed animals	Reading books with you	Climbing, running and being active	Lining up toys or other things	Watching things go round and round like fans or wheels
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(please check all that apply)					

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Family Questions Scoring Guide

Scoring Instructions:

Question 1. The single-item screen for tobacco use has been found to be a valid way to screen for tobacco use in pediatric populations.

Questions 2, 3, and 4. At least one positive response on the Two-item Conjoint Screener (TICS) has been found to detect substance abuse disorders with adequate sensitivity and specificity (nearly 80% or higher). In addition, we have included the question “Has a family member’s drinking or drug use ever had a negative effect on your child?”

Question 5. We have incorporated one question based on the Children’s Sentinel Nutrition Assessment Program (C-SNAP): In a study of 2216 children, this question identified food-insecure families with 99% sensitivity and 82.5% specificity.

Questions 6 and 7. Domestic Violence: The short version of the Woman Abuse Screening Tool (WAST-Short) is considered positive if the most extreme choices, "a lot of tension" for question 8 and "great difficulty" for question 9, are endorsed on either or both of the items.

Interpretation:

Positive endorsement of items on this list indicate a child should be monitored further. If a parent endorses items such that a pediatrician believes a child or family member may be at immediate risk of harm, appropriate steps should be taken to refer the child and/or family for help as soon as possible.

Edinburgh Postnatal Depression Scale Scoring

Postpartum depression is the most common complication of childbearing. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for postpartum depression. The EPDS is easy to administer and has proven to be an effective screening tool. Parents who score 10 or greater may be suffering from a depressive illness. Those who score 13 or greater are likely to be suffering from a depressive illness. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the parent has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

Parents with postpartum depression need not feel alone. We recommend letting parents know that getting help is the best thing that they can do for themselves and their baby. We also recommend referring them to the MCPAP for Moms website, which includes useful information and an option to search for support groups throughout the state (<https://www.mcpapformoms.org/>).

SCORING

QUESTIONS 1, 2, & 4 (without an *) are scored 0, 1, 2 or 3 with the far left response bubble scored as 0 and the far right response bubble scored as 3.

QUESTIONS 3, 5, 6, 7, 8, 9, 10 (marked with an *) are reverse scored, with the far left response bubble scored as a 3 and the far right response bubble scored as 0.

Maximum score: 30

Possible Depression: 10-12

Probable Depression: 13 or greater

Always look at item 10 (thoughts of self harm)

INSTRUCTIONS FOR USING THE EPDS

1. The parent is asked to check the response that comes closest to how s/he has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the parent discussing his/her answers with others. (Answers come from the parent)
4. The parent should complete the scale him/herself, unless s/he has limited English or has difficulty with reading.

1. Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

2. Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression *N Engl J Med* vol. 347, No 3, July 18, 2002, 194-199

Postpartum Depression Screening Algorithm for Pediatric Providers During Well-Child Visits (with suggested talking points)

We encourage all providers to use the S3005 billing code that allows the Dept of Public Health to track screening across specialties and regions.

Parent completes the PHQ-2, PHQ-9 or EPDS screen during the following well child visits and during other visits as indicated:

- Within first month
- 2 month visit
- 4 month visit
- 6 month visit
- 9-12 month visit

If first screen for depression

If subsequent screen for depression

Clinical support staff explains screen

Emotional complications are very common during pregnancy and or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact you and your baby's health. Dads can also experience depression or anxiety before or after the baby is born. We will be seeing you and your baby a lot over the next few months/years and want to support you.

Give screen to parent to complete in the waiting room or in a private exam room.

Parent completes the **PHQ-2, PHQ-9 or EPDS** screen. Provider/nurse tallies score.

Give screen to parent to complete in the waiting room or in a private exam room.

PHQ-2 ≥ 3

Administer PHQ-9 or EPDS

PHQ-2 < 3; PHQ-9 or EPDS < 10

PHQ-9 or EPDS ≥ 10

Score does not suggest depression

Clinical support staff educates parent about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every parent deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Score suggests depression

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

If positive score on self-harm question

For all positive screens

Suggests parent may be at risk of self-harm or suicide

It sounds like you are having a lot of strong feelings. It is common for parents to experience these kinds of feelings. Many effective support options are available. I would like to talk to you about how you have been feeling recently.

Do NOT leave parent/baby in room alone until further assessment or treatment plan is established. **Immediately assess further:**

1. In the past two weeks, how often have you **thought** of hurting yourself?
2. Have you ever **attempted** to hurt yourself in the past?
3. Have you thought about how you could harm yourself?

If concerned about the safety of parent/baby: *You and your baby deserve for you to feel well. Let's talk about ways that we can support you.*

If there is a clinical question, call MCPAP regional hub. For safety concerns, refer to emergency services. Document in medical record.

1. If parent is already in mental health treatment, refer to/notify* parent's provider.
2. Give parent community resource information (e.g., MCPAP for Moms card, and website)
3. Refer to/notify* parent's PCP and/or OB/GYN for monitoring and follow-up.
4. Engage natural supports* and encourage parent to utilize them.

*Obtain parent's consent

Provider steps for positive screens

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.

If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.

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If first screen for depression

If subsequent screen for depression

Clinical support staff explains screen
 Give screen to parent to complete in the waiting room or in a private exam room.

Parent completes the **PHQ-2, PHQ-9 or EPDS** screen.
 Provider/nurse tallies score.

Give screen to parent to complete in the waiting room or in a private exam room.

PHQ-2 ≥ 3

Administer PHQ-9 or EPDS

PHQ-9 or EPDS ≥ 10

PHQ-2 < 3; PHQ-9 or EPDS < 10

Score does not suggest depression
 Clinical support staff educates parent about the importance of emotional wellness.
 Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

If positive score on self-harm question

Score suggests depression

For all positive screens

1. If parent is already in mental health treatment, refer to/notify* parent's provider.
 2. Give parent community resource information (e.g., MCPAP for Moms card, and website)
 3. Refer to/notify* parent's PCP and/or OB/GYN for monitoring and follow-up.
 4. Engage natural supports* and encourage parent to utilize them.
- *Obtain parent's consent

Provider steps for positive screens

Suggests parent may be at risk of self-harm or suicide
Do NOT leave parent/baby in room alone until further assessment or treatment plan has been established. **Immediately assess further.**
 If there is a clinical question, provider calls MCPAP regional hub. For safety concerns, refer to emergency services. Document the assessment and plan in medical record.

Provider documents clinical plan based on screening results. Not required to include screen as part of the medical record.

If there are clinical questions (including questions about medications that may be taken during lactation), call MCPAP for Moms.