# Statement of Clinical Protocol

| Section | Antepartum, Postpartum | Sub-Section | Mental Health |
|---|---|---|---|
| Protocol | Screening of Mood and Anxiety Disorders in Pregnancy and Postpartum | Protocol # | 2.2 |
| Distribution | Practice Directors, Registered Midwives of Diversity Midwives (Staff Midwives), Administrative Staff Team, Students at Diversity Midwives | Page(s) | 5 |
| Approved | October 20, 2020 | Due to be reviewed | October 2022 |
| Effective | November 2020 | Revision | NA |

## 1.0 **Purpose:**

In Canada, approximately 20% of women (about one in five) have depressive symptoms during pregnancy. The prevalence of a major depressive episode is 12.4% (or about 1 in 10). In addition, up to half of women with clinically significant depression in pregnancy or postpartum have concurrent symptoms of anxiety. (1)

Anxiety in pregnancy is not as well studied as depression. About 8.5% of women have a clinically significant level of worry or "what if" concerns in their third trimester and this rate remains about the same in the postpartum period. However, a much larger group of women (up to 30%) can have symptoms of anxiety. (1) The incidence of anxiety in the postpartum period is about 10%. However, in contrast to depression, anxiety may increase over time.

Reluctance to disclose symptoms, perceived stigma, and diagnostic uncertainty are some of the challenges facing healthcare professionals trying to identify and help clients with perinatal mood disorders. Consequently, pregnant people are less likely than non-pregnant people to be diagnosed with depression, and less than half of those diagnosed receive appropriate treatment. In Ontario, 1 out of every 19 perinatal maternal deaths is attributable to suicide (1).

While the SOGC does not have a guideline on the assessment of perinatal mood disorders in pregnancy, the ACOG, RCOG, RCM, ACNM, RNAO, NICE and the BC Health Authority all have guidelines or position statements. At a minimum, it is recommended that all pregnant people be screened at least once during the antenatal or postpartum period. (2,3,4,5,6,7,8)

2.0 **Background:**

3.0 **Protocol:**
(Suggested headers, revise as appropriate for issue addressing)

3.1 HISTORY/RISK FACTORS

The User Guide to the Ontario Perinatal Record (OPR) states that "anxiety, depression or other conditions are common and may develop or worsen during pregnancy. Review signs and symptoms, resources and when to seek care with EVERYONE. Mental health assessment should be an ongoing process and the screening tools in the OPR 4 can be used at any time throughout pregnancy." (9)

Risk Factors:

- Past history or current anxiety, depression, PTSD, bipolar disorder or psychotic disorder
- Past history or current use of psychotropic medication
- Past history or current mental health treatment
- Past history of psychiatric hospitalization

3.2 MIDWIFERY ASSESSMENT

- Screening for depression and anxiety will be offered with the screening tools available on Page 4 of the Ontario Perinatal Record (OPR):
    - Generalized Anxiety Disorder scale (GAD-2): The GAD-2 is a validated screening tool for generalized anxiety disorder as well as panic disorder, social anxiety, and post-traumatic stress disorder. A score of 3 or more merits consideration of further assessment by the more comprehensive GAD-7 or a referral. (9)
    - Patient Health Questionnaire-2 (PHQ-2): The PHQ-2 is a validated screening tool for depression. A score of 3 or more merits consideration of further assessment by tools such as the PHQ-9 or the EPDS or a referral. (9)
    - Edinburgh Perinatal/Postnatal Depression Scale (EPDS): The EPDS is a validated screening tool for perinatal depression. Initially developed for diagnosis of postpartum depression, it has been validated for use in pregnancy as well. It is available in multiple languages. A score of 13 or more merits more comprehensive assessment. Any positive response to question 10 (self-harm) requires immediate mental health assessment. (9)

3.3 MANAGEMENT

**Antenatal**

- All clients should be offered screening for depression and anxiety during the antenatal period.
- All clients should be screened at the **Booking Appointment** and at **28 weeks**:
    - Clients should be screened using the GAD-2 for Anxiety, the PHQ-2 for Depression and the EPDS (Edinburgh Perinatal Depression Scale) available on Page 4 of the OPR.

- Clients identified as requiring follow-up regarding anxiety or depression should be referred to the most responsible primary care provider for appropriate medical treatment.

**Immediate Postpartum**

- **Hospital Birth:** The primary midwife will consult with the on-call psychiatrist. The on-call psychiatrist will assess for 5 day/5 night stay in the hospital.
- **Out-of-Hospital Birth:** The primary midwife will have an informed choice discussion regarding the client's history of mental health concerns and recommendation for hospital birth to ensure rapid access to the on-call psychiatrist.
    - If the client chooses an out-of-hospital birth, the primary midwife should ensure that a referral is made to outpatient psychiatry at our privileging hospital in a timely manner.

**Postpartum**

- All clients should be screened at **TWO WEEKS POSTPARTUM:**
    - Clients should be screened using the GAD-2 for Anxiety, the PHQ-2 for Depression and the EPDS (Edinburgh Perinatal Depression Scale) available on Page 4 of the OPR.
- Clients identified as requiring follow-up regarding anxiety or depression should be referred to the most responsible primary care provider for appropriate medical treatment.

### 3.4 CONSULTATION/TRANSFER OF CARE

**Consultation**

- Significant mental health concerns that are present or become worse during the antenatal period require consultation with a physician. (11)
- Significant mental health concerns, i.e., postpartum depression, postpartum anxiety or signs and symptoms of postpartum psychosis require consultation with a physician, preferably psychiatry. (11)

**Transfer of Care**

- Postpartum psychosis is an indication for transfer of care to a mental health specialist. The primary midwife will remain the obstetrical MRP, within her scope of practice, if it is possible/safe to do so. (11)

## 4.0 **Policy Changes:**

| Policy # | Approval Date | Describe Change(s) |
|---|---|---|
| TBD | October 20, 2020 | First Version of this policy |
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## 5.0 **References:**

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