First prenatal or program visit
Give/review handout “Are you at risk for Perinatal Depression and Anxiety?”
Administer * PHQ-2

*PHQ-2
1. Over the past two weeks, have you ever felt down, depressed, or hopeless?
2. Over the past two weeks, have you felt little pleasure or interest in doing things?

PHQ-2 score ≥ 1 yes answer?

no

(Negative Screen)
Routine care

yes

(Please Screen)
Ask client to complete EPDS

28 to 36 wks gestation

Implement agency guidelines for crisis/suicide/self harm
Do not leave client by herself or alone with baby
Assess/engage client’s support system and develop safety plan
As needed call:
Crisis line 1-866-638-7103
and/or
Child protection 1-541-693-2700

EPDS Score ≥20, positive item #10, or psychosis concern

no

EPDS score ≥10?

no

(Negative. Screen)
Give/review MMH brochure,

yes

(Please Screen)
Discuss results/plan with client, If PCP, assess need for medication or refer to PCP, Give/review MMH brochure
Assess client support system
Refer for support/counseling:
PSI warm line 541-728-3427

no

Next appointment

client accessed services?

yes

Routine Care, Rescreen as indicated

Facilitate access referrals
Care/Rescreen as indicated

no

Day following appointment

Abbreviations
EPDS: Edinburgh Postpartum Depression Screen
PHQ-2: two question depression screen
PSI: Postpartum Support International
MMH: Maternal Mental Health
PCP: primary care provider
PP: postpartum