ANNALS OF FAMILY MEDICINE

Online Supplementary Material

Yawn BP, Dietrich AJ, Wollan P, et al. TRIPPD: A practice based network effectiveness study of postpartum depression screening and management. *Ann Fam Med*. 2012;10(4):320-329.

http://www.annfammed.org/content/10/4/320/suppl/DC1

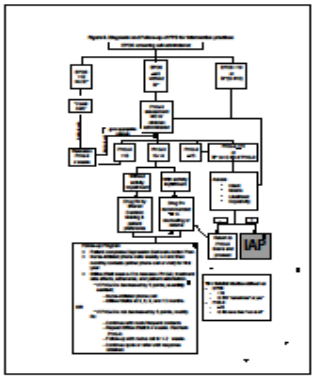
Supplemental Appendix 1. Tools to Facilitate Diagnosis, Follow-Up, and Management of Postpartum Depression

Note: The figure below is available in the full article at http://annfammed.org/content/10/4/320.

This form will be individualized to each site based on state laws and regulations and will be tailored to each practice.

IMMEDIATE ACTION PROTOCOL (IAP)

Use this action plan if any of the following:



a. The EPDS score > 19.
b. The answer to EPDS Q #10 (The thought of harming myself has occurred to me) is "sometimes" or "yes, quite often".
c. The PHQ-9 score is ≥15.
d. The answer to PHQ-9 Q #9 (Thoughts that you would be better off dead or of hurting yourself in some way) is greater than "not at all".
e. Clinical judgment suggests concern about suicide.

First step: Assess suicidal risk:

-This can be done by the primary care physician using the Suicide Risk Assessment Questions below.

Or

-By immediate (same day) referral to a mental health professional who has access to an inpatient psychiatric facility or referral to an emergency department. Establish a verbal "No Suicide Contract" for at least 24 hours. (See reverse side for Immediate Referral Resources.)

Suicide Risk Assessment: Examples of questions.

a. Intent – *You have said that you think about killing or harming yourself. Have you made any plans?* (Use the answers on the EPDS or PHQ-9 to lead into the first question.)
b. Means – Can you *describe your plans?*. Or *How have you thought about killing yourself (your infant)? (You will want to assess access to weapons, drugs or other methods she has concerned)*
c. Likelihood – *Do you think you would actually harm or kill yourself?* (May be especially useful in those who state they think about but would never do it because it would leave their children without a mother or such reasons or those who report no social support.)
d. Impulsivity – *Have you tried before?* Factors such as alcoholism, drug use, or a history of previous attempts that suggest impulsive behavior or episodes of reduced control.

If the response to any of these is positive then referral to inpatient management is strongly recommended. Also establish a verbal "No Suicide Contract" for at least 24 hours. (See reverse side for Next Step Referral Resources.)

Patient not in the office:

If the clinician has a concern about active suicidal thought but the patient is not in the office:
-Ask to speak with another adult in the house to alert them to the situation.
-If no other person is available in the house and there is an immediate concern, keep the person on the phone and notify another staff member to dial 9-1-1.
-Do not disconnect the phone.
-Dispatch an ambulance/police and stay on the phone until someone arrives.
-Establish a verbal "No Suicide Contract" for at least 24 hours.

Names, addresses and telephone numbers for referral and support are on the reverse side.

Nurses follow-up call form (Study #_____)

Clinic Name:_____

Patient's Name: _____ Date of call: __/__/____

Name of person making call: _____

Medication name: _____

Fax to: 507.287.2722

- Has the woman gotten her medication prescription filled?
  - Yes___ No___---any problems doing so?_____
    _____
- Has she started taking the medication?
  - Yes___ No___--reasons_____
- Any medication side effects or concerns she has?
  - None___ Concerned about_____
- If she was referred for counseling or treatment----has she been to a visit recently and when is the next appointment scheduled?
  - Yes made visit _____
  - Yes, next visit_____
  - Not made visit or appointment ---reasons_____
  - _____
- Has the woman been able to do any of the things she agreed to do on the Depression Self-Care Action Plan?
  - Yes, what _____ (praise and ask if ready for next step)—If so, what will she do _____
  - No—reasons or needs help_____
- Is her follow-up visit scheduled?
  - Yes, when_____
  - No, _____. Can you schedule it now or problems _____
    _____
- Does she have any questions for the doctor?
  - _____

Reviewed by physician (clinician) _____ **Date** __/__/____

Immediate Referral Resources:

Referral for immediate (same day) assessment for suicidal risk:

Outpatient _____
Name of Clinic Telephone # Address

Inpatient _____
Name of Clinic Telephone # Address

Mental Health Center _____
Name of Center Telephone # Address

Crisis Facility _____
Facility Name Telephone # Address

Emergency Department _____
Name of ED Telephone # Address

Other _____
Name Telephone # Address

Next Step Referral Resources:

When the primary care physician has determined the woman is at risk for suicide (see Suicide Risk Assessment):

Local Psychiatrist/Mental Health Professional _____
Name Telephone # Address

Local Hospital _____
Hospital Name Telephone # Address

Local ED for Admission _____
Name of ED Telephone # Address

Suicide Helpline _____
Name Telephone # Address

Distant Psychiatrist Consultation _____
Name Telephone # Address

Other _____
Name Telephone # Address

Transportation Resources:

If the woman/patient is resistant to inpatient management, transportation may better be accomplished by using non-family transportation.

Police _____
Telephone #

Ambulance _____
Telephone #

Other _____
Name Telephone #

In most states physicians have the legal right and obligation to assure the suicidal patient is protected from self-harm. This usually includes the legal right to initiate a 24 to 72 hour involuntary "hold" for inpatient mental health assessment.

Research Response:

Immediately notify central site of admission: 1-888-292-7164

Date Adverse Event Registry form completed: (Date) __/__/__

Date Adverse Event Form sent to Central Site: (Date) __/__/__

Physician to Nurse Referral Form

Patient's Name:_____

TRIPPD Study #:_____

Phone Number: _____

Circle Preferred Day of Week: M TU W TH F

Preferred Time: _____

Referral Date: _____

Referring Clinician: _____

FAX to 507-287-2722

- ❑ PHQ-9 Score: _____
- ❑ Suicide Score: (Q# 9) Positive? **Yes** ____ **No**_____
- ❑ Functioning Score: (Q #B) Impaired? **Yes** ____ **No** _____
- ❑ Medication/dose ordered:_____
- ❑ Self-Care Action Plan completed? **Yes**_____ **No** _____
  If yes, plans_____
- ❑ Referred for Counseling? **Yes**_____ **No**_____
  If yes, to whom:_____

Date of Next Appointment: **1 week / 2 weeks / 4 weeks**
(circle one)

Comments:_____

Phone and Visit Follow-up Depressed Women

Key
☎ = Nurse phone call
= Office Visit

CAN MAKE ADDITIONAL VISITS OR CALLS AS REQUIRED

Week 0	Enroll and Diagnose	
Wk 1	☎	
Wk 2	☎ OR	
Wk 4	Assess using PHQ-9, as well as side effects, adherence and satisfaction.	
	DOING WELL PHQ-9 drops by 4-5 points means woman is responding, continue therapy or increase dose if necessary.	**NOT DOING WELL** PHQ-9 has dropped by only 1-3 points means that the woman is not responding. ✓diagnosis-reassess, ↑ medication to full therapeutic dose, if 4wks at full therapeutic dose, consider changing medications. If available, consider adding CBT.
Month 2	☎	☎ Call at week 6 Visit at 8 weeks to recheck PHQ-9 as well as side effects, adherence and satisfaction
Month 3	Assess PHQ-9, as well as side effects, adherence and satisfaction **DOING WELL** PHQ-9 drops to 50% of initial score or to <5. She is recovering. Maintain therapy. If PHQ-9 falling but has not reached recovery levels, modify therapy.	**NOT DOING WELL** PHQ-9 is not down to 50% of initial score or to <5. Reassess diagnosis Change therapy Consider referral If the woman is not referred continue monthly visits to follow PHQ-9, adherence, side effects and satisfaction
Month 4	☎	
Month 5	☎	
Month 6	Assess using PHQ-9, as well as side effects, adherence and satisfaction. Assess parenting and relationships. If problems move to R side of sheet. If doing well continue as below.	If woman is not referred then continue to treat women for depression and do MONTHLY visits. Phone calls should be done to follow up on any missed visits. Check PHQ-9 at each monthly visit. If PHQ-9 does not return to <5 or 50% or less of initial high score, consider referral.
Month 7	☎ if needed	
Month 8	☎ if needed	
Month 9	Assess using PHQ-9, as well as side effects, adherence and satisfaction. If problems move to R side of sheet. If doing well continue as below.	
Month 10	☎ if needed	If PHQ-9 begins to fall or is <5 or 50% of initial score then move to the left side of the sheet.
Month 11	☎ if needed	
Month 12	Assess readiness to discontinue therapy.	

Each visit: Assess suicide risk

Medication Chart

Table for anti-depressants

Brand Name	Generic Name	Class	Dosage	In breast milk	Major side effects in mothers	Major side effects in babies if mothers are breastfeeding	Use during breastfeeding	FDA Pregnancy Grade
PAXIL PEXEVA PAXIL CR	PAROXETINE	SSRI	Start10 mg daily X 3 days Increase to 25 mg/day weekly Maximum dose is 37.5 mg daily	YES*	sleepiness, sexual dysfunction	uneasy sleep, irritability, poor feeding/sucking	No effect on development and weight	D
ZOLOFT	SERTRALINE	SSRI	Start 25 mg daily X 4-5 days Increase by 25 mg/day weekly Maximum dose is 100mg daily	YES*	poor appetite, agitation and sexual dysfunction	uneasy sleep, irritability, poor feeding/sucking	No effect on development and weight	C
PROZAC SARAFEM	FLUOXETINE	SSRI	Start 10 mg daily X 3 days Increase by 10mg/day weekly Maximum dose 40 is mg daily	Yes	insomnia, anxiety, nervousness, sexual dysfunction	colic, irritability feeding and sleep disorder	Use only when potential benefit outweighs the risk	C
PROZAC WEEKLY			Start 90 mg weekly tablet or convert from equivalent daily dose to weekly	Yes				
LUVOX	FLUVOXAMINE	SSRI	Start 50 mg qhs X 4 to 7 days Increase by 50 mg/day weekly Maximum dosage 300 mg daily	Yes	headache, insomnia, dizziness, weakness, palpitation, vomiting	Not recommended	Not recommended	C
CELEXA	CITALOPRAM	SSRI	Start 10-20 mg/day X 7 days Increase by 10 mg/day weekly Maximum dose is 40mg/day--highest dose for nonresponders	Yes	insomnia, anxiety, nervousness, sexual dysfunction, marked weakness	excessive somnolence, decreased feeding	Use only when potential benefit outweighs the risk	C
LEXAPRO	ESCITALOPRAM	SSRI	Start 10mg/day X 7 days Maximum dose is 20 mg daily	Yes	somnolence, agitation, sexual dysfunction, rare chest pain	excessive somnolence, decreased weight gain	Use only when potential benefit outweighs the risk	C
EFFEXOR	VENLAFAXINE	SNRI	Start 25 mg/day X 4-5 days Increase by 25 mg/day weekly Optimal dosage is 75 mg. Maximum dose is 225 mg daily	Yes	somnolence, agitation, sexual dysfunction, nausea, dizziness	Not recommended	Not recommended	C
WELLBUTRIN	BUPROPION	DRI	Start 100 mg/day X 4-5 days Increase by 100 mg/day weekly Maximum dose is 300mg daily	Yes	nausea, headache, insomnia	poor weight gain, irritability	Use only when potential benefit outweighs the risk	B
WELLBUTRIN SR	BUPROPION	DRI	Start 150 mg/day in AM X 7d Increase by 50 mg/day weekly Maximum dose is 300mg daily	Yes	nausea, headache, insomnia	poor weight gain, irritability	Use only when potential benefit outweighs the risk	B
WELLBUTRIN XL	BUPROPION	DRI	Start 150 mg/day in AM X 7 Increase by 50 mg/day weekly Maximum dose is 450mg daily	Yes	nausea, headache, insomnia	poor weight gain, irritability	Use only when potential benefit outweighs the risk	B

Medication Chart, continued

Brand Name	Generic Name	Class	Dosage	In breast milk	Major side effects in mothers	Major side effects in babies if mothers are breastfeeding	Use during breastfeeding	FDA Pregnancy Grade
SERZONE	NEFAZODONE	SIA	Start 50 mg/day qhs X 7 days Increase by 50mg/day weeekly Maximum dose is 200 mg daily	Yes	drowsiness, agitation, insomnia, dizziness	poor weight gain, irritability, lethargy, difficulty maintaining body temperature	Use only when potential benefit outweighs the risk	C
REMERON	MIRTAZAPINE	ALFA 2 A	Start 15 mg/day qhs X7 days Increase by 15 mg/day weekly Maximum dose is 45 mg daily	Yes	somnolence	somnolence	Not recommended	C
REMERON SOL TAB	MIRTAZAPINE	ALFA 2 A	Start 15 mg/day qhs X7 days Increase by 15 mg/day weekly Maximum dose is 45 mg daily	Yes	somnolence	somnolence	Not recommended	C
CYMBALTA	DULOXETINE	SNRI	Start 40 mg/day X 4-5 days Increase to 60 mg/day weekly Maximum dose 60 mg daily	Yes	insomnia, dizziness, nausea	Not recommended	Not recommended	C
TOFRANIL	IMIPRAMINE	HTC	Start 25 mg BID X 4-5 days Increase by 25 mg/day weekly Maximum dose is 300 mg daily	Yes	tachycardia, arrhythmia, drowsiness	Not recommended	Not recommended	D
TOFRANIL PM	IMIPRAMINE	HTC	start 75 mg/day qhs X7 days Increase by 50 mg/day weekly Maximum dose is 300 mg daily	Yes	tachycardia, arrhythmia, drowsiness	Not recommended	Not recommended	D
ELAVIL	AMITRIPTYLINE	HTC	Start 25 to 50 mg/day X7 days Monitor closely before Increasing dosage Maximum dose 300mg daily	Yes	tachycardia, arrhythmia, drowsiness	Not recommended	Not recommended	C
NORPRAMIN	DESIPRAMINE	HTC	Start 25 mg/day X 2-3 days Increase by 25 mg/day weekly Maximum dose is 300 mg daily	Yes	tachycardia, arrhythmia, drowsiness	Not recommended	Not recommended	C
PAMELOR	NORTRIPTYLINE	HTC	Start 25 mg/day X 2-3 days Increase by 25 mg/day weekly Maximum dose is 75 mg daily	Yes	tachycardia, arrhythmia, drowsiness	Not recommended	Not recommended	D

*Lattimore K, Donn S, Kaciroti N, et al. State of the Art - Selective Serotinin Reuptake Inhibitor (SSRI) Use during Pregnancy and Effects on the Fetus and Newborn: A Meta-Analysis. *Jrnl of Perinatology*.

*Oystein Berle J, Steen V, Aamo O, et al. Breastfeeding During Maternal Antidpressant Treatment With Serotonin Reuptake Inhibitors: Infant Exposure, Clinical Symptoms, and Cytochrome P450 Genotypes. *J Clin Psychiatry*. 2004;65:9.

*Gjerdingen D. The Effectiveness of Various Postpartum Depression Treatments and the Impact of Antidepressant Drugs on Nursing Infants. *Jrnl of the Am Brd of Fam Pract*. 2003;16:372-382.

ATIVAN

Brand Name	Generic Name	Class	Dosage	Drug in breast milk	Major side effects in mothers	Use when breast feeding	FDA Pregnancy Grade
DESYREL	TRAZODONE	SRA	Start 25 to 50 mg/day qhs Maximum dose 100mg/day qhs This drug is an antidepressant used to treat insomnia	Yes	sedation, sleepiness, confusion, fatigue	Not recommended	C
KLONOPIN	CLONAZEPAM	BZD	Start 1.5 mg BID or TID for anxiety or 2-4 mg qhs for insomnia	Yes	sedation, sleepiness	Not recommended	D
ATIVAN LORAZEPAM INTENSOL	LORAZEPAM	BZD	Start 1.5 mg BID or TID for anxiety or 2-4 mg qhs for insomnia	Yes	sedation, sleepiness	No data on clinical effects in infants available Monitor infant closely Somnolence	D

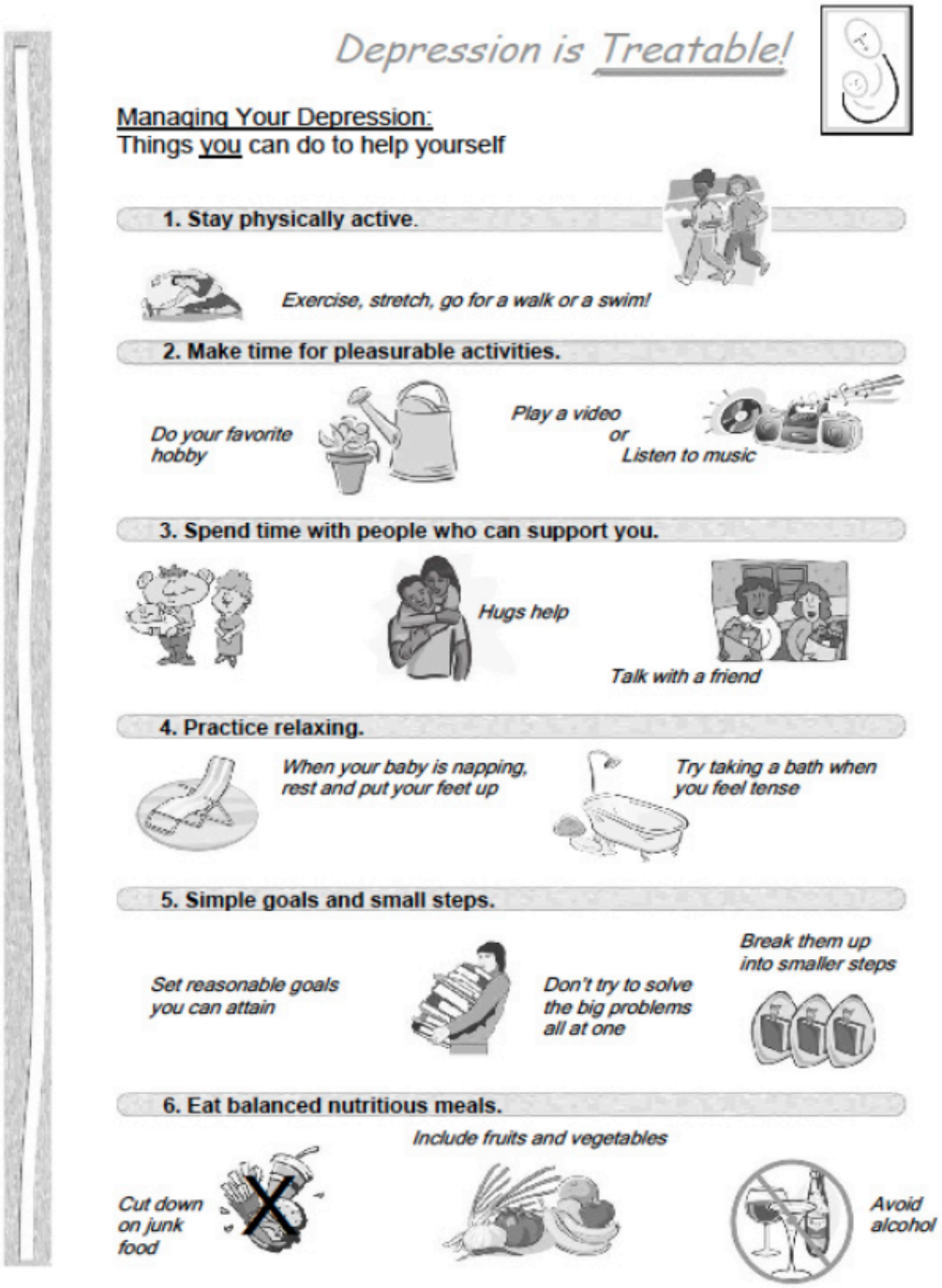
Sheet of Medication Side Effects for Nurses

Common Side Effects of Antidepressants

SIDE EFECT	SSRIs & EFFEXOR CYMBALTA (SNRI)	HETEROCYCLICS (HTC) (nortriptyline, amitriptyline, imipramine)	BUPROPION (DRI)	MIRTAZAPINE (Alpha 2A)	MANAGEMENT STRATEGY
Sedation	+/-	++	-	-	*Give medication at bedtime. *Try caffeine.
Anticholinergic-like symptoms Dry mouth/eyes, Constipation, Urinary retention, Tachycardia	+/-	+++	-	+/-	*Increase hydration. *Sugarless gum/candy. *Dietary fiber. *Artificial tears *Talk to FP about temporarily lowering dose.
GI distress, Nausea	++	-	+	+/-	*Often improves in 1-2 weeks. *Take with meals. *Consider antacids – Maalox, Rolaids, Tums.
Restlessness, Jitters/Tremors	+	+/-	++	-	*Talk with FP about temporarily lowering dose.
Headache	+	-	+	-	*Acetaminophen. *Talk with FP about temporarily lowering dose.
Insomnia	+	-	+	-	*Take medication in A.M. *Talk to FP if no improvement.
Sexual Dysfunction	++	-	-	-	*May be part of depression or medical disorders. *Decrease dose. *Talk to FP about lowering dose or ask at your next visit.
Weight gain	+/-	+/-	+/-	++	*Exercise. *Diet. *Ask at next visit about considering changing medications.

KEY: - Very unlikely +/- Uncommon + Mild ++ Moderate

Self-Help Sheets



Fathers' Sheets (English & Spanish)

Information for Fathers & Partners

The postpartum adjustment for all family members is often an overwhelming and confusing experience. Though a happy and joyful event, the welcoming of a newborn into your family, may also be a source of stress and anxiety during this time.

You may be the first one to recognize that your partner is exhibiting signs of a Postpartum Anxiety or Depression (PPD), and you will become her life-line toward treatment and support. PPD often inhibits the mothers' ability to care for herself and the baby. She has no control over her self-doubts, fears and emotional upset. You will need to provide the family leadership for the baby's and mother's health and safety.

Help is available through your family physician, the doctor who delivered your baby, or the baby's doctor. Reach out and ask for help. Resources are also available on our Postpartum Depression website. It may take some time for the combination of medication and psychotherapy to work effectively to control the symptoms of Postpartum Anxiety and Depression.

Here is what you can do to help your partner until she feels like herself again:

- BE EMPATHIC – Show love and compassion, not anger or impatience.
- BE NON-JUDGEMENTAL – Reassure, don't criticize.
- BE OBSERVANT – Report what you observe to the doctors and nurses.
- BE AWARE – Of your partner's concerns and feelings.
- BE AVAILABLE – Be present and actively involved with your newborn.
- BE PATIENT – This will go away. It will get better.
- BE COLLABORATIVE – Work with our resources toward shared goals.
- BE A FATHER – Active interest and participation prevents isolation.

The leadership you provide for your family during this difficult adjustment will empower all of you toward health, happiness, and strong family relationships.

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Información para padres y parejas

El periodo de ajuste después del nacimiento de un bebé puede ser una experiencia muy abrumadora y confusa para todos los miembros de la familia. Aunque es cierto que la llegada del bebé es un acontecimiento hermoso y lleno de alegría, también es cierto que puede ser una fuente de estrés y ansiedad.

Usted puede ser la primera persona en darse cuenta de que su pareja está sufriendo de ansiedad o de depresión posparto, y debe convertirse en su enlace vital para que ella reciba tratamiento y apoyo. Generalmente la depresión posparto dificulta la capacidad de la madre para cuidarse a ella misma y al bebé. En esas condiciones ella no puede controlar sus sentimientos de falta de capacidad, sus temores y sus emociones. A usted le toca asumir el papel de guía para velar por la salud y la seguridad de la madre y del bebé.

Puede conseguir ayuda a través de su médico familiar, del médico que atendió el parto o del pediatra. Pregunte, pida ayuda. Encontrará una variedad de recursos en nuestro sitio web de Depresión Posparto. Es posible que transcurra cierto tiempo para que la combinación de medicamentos y psicoterapia comience a surtir efecto para controlar los síntomas de la ansiedad y depresión posparto.

A continuación le damos algunas ideas para ayudar a su pareja a volver a la normalidad:

- MUESTRE EMPATÍA: demuéstrele amor y compasión, no enojo ni impaciencia.
- NO LA JUZGUE: tranquilícela, no la critique.
- OBSÉRVELA CON ATENCIÓN: comente sus observaciones a los médicos y enfermeras.
- ESTÉ PENDIENTE: de las inquietudes y sentimientos de su pareja.
- ESTÉ DISPONIBLE: esté presente, participe activamente en la vida diaria del bebé.
- TENGA PACIENCIA: este problema se va a solucionar, va a mejorar.
- COLABORE: aproveche nuestros recursos para lograr metas compartidas.
- ASUMA SU PAPEL DE PADRE: si muestra interés y participa, evitará que ella se sienta sola.

La guía que usted ofrezca a su familia durante esta difícil etapa de ajuste fortalecerá las relaciones familiares y ayudará a la salud y felicidad de todos.

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