Screening for Postpartum Depression and Anxiety: A Perfect Pediatric Opportunity!

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(Recent efforts by the American Academy of Pediatrics, New York, Chapter 2, as well as other pediatric advocates, have worked to make screening for postpartum depression in the pediatric office more convenient. Two years ago, the New York State Legislature passed a bill expanding pediatric scope of practice in the state to specifically include screening for this common condition. However, regulation and insurance issues were interpreted as requiring a separate chart for the mother solely for this screening, which impeded many practices from implementing this important work. Last year, your chapter worked with a coalition to ensure maternal postpartum depression can be included in the infant's chart. In this blog post, Dr. Jack Levine, MD FAAP, Chairman of Developmental Behavioral Pediatrics/Children with Disabilities Committee for AAP NYS Chapter 2 and an Executive Committee member of National AAP Section on Developmental Behavioral Pediatrics, provides insights into how, why and when to screen.)

2017 is the perfect time to begin screening for postpartum depression in your office! According to the American Academy of Pediatrics, pediatricians can now use CPT code 96161 and bill with the infant's visit. New York State Medicaid billing guidance can be found at https://www.health.ny.gov/health_care/medicaid/program/update/2016/aug16_mu.pdf. Pediatricians see new mothers earlier and more frequently than other physicians, giving us multiple opportunities to assess and screen parental mental health.

Perinatal Mood and Anxiety Disorders: The new Terminology

Anxiety is a common characteristic of mothers' feelings both during and after pregnancy and is very common in postpartum depression. Additionally depression can effect up to 20% of pregnant woman. Along with "baby blues" and postpartum depression and anxiety disorders there is also psychosis, obsessive-compulsive disorder and PTSD. Fathers may also develop postpartum depression.

Why screen?

Postpartum depression is common (8%-25%) and in some low income populations may include close to 50% of all new mothers! It is the most common cause of infant toxic stress in the United States. There are significant and highly detrimental effects to developing infants (Table 1). Screening helps us assess the baby's environment and to establish a positive helpful relationship with the family.

Table 1. Effects of Postpartum Depression on Infants

Decreased breastfeeding	Mental health concerns
Failure to thrive	Social withdrawal
Developmental delay	Fussy, irritable
Cognitive deficits	Poor self control, impulsivity
Less language stimulation	Anxiety/depression
Less play time	Attachment disorders
Less reading stimulation	Aggression
Less engagement with mother	Poor safety: car seats, plug covers, sleep
School problems	Over/under use of health care and ER
Sleep problems	Difficulty managing health conditions

What to ask at every visit?

Assessing the risk factors for postpartum depression should be part of every well visit (Table 2). Maternal history of mood disorders and/or anxiety is an important risk factor and should be carefully assessed. Discontinuation of anti-depressant medication during pregnancy is a particularly important risk factor.

Table 2. Risk Factors for Postpartum Depression

Psychosocial Risk Factors

- Poverty
- Maternal chronic illness
- History of depression, anxiety, mood disorder, substance abuse
- Adolescent pregnancy
- Social isolation
- Stressful life events, miscarriage

Infant behavior

- Decreased activity
- Increased crying
- Poor feeding
- Failure to thrive
- Sleeping problems
- Increased accidents

Maternal behavior (observed or expressed by mother, father, grandparents)

- Depressed affect
- Sleeping more or trouble sleeping
- Lack of enjoyment of usual activities/avoidance of usual activities
- Withdrawal from family
- Neglect of newborn or other children
- Questions reflecting self-doubt/ severe anxiety
- Inaccurate expectations of behavior and/or development
- Punitive child rearing attitudes or discipline
- Irritable/disruptive in office/frequent visits

Infant risk factors

- Prematurity
- Congenital problems
- "Vulnerable child" syndrome
- Fussy temperament

When should I screen and what tools are available?

Depressive symptoms peak at 6 weeks, 2-3 months and 6 months. "Baby blues" usually resolve by two weeks so that earlier screening may over identify, but post-partum depressive symptoms can be delayed or persist for up to one year or longer! Screen at 2 weeks, 2 months, 6 months and one year. One month and 4 month screens can be added. The Patient Health Questionnaire (PHQ-2, PHQ-9) or the Edinburgh Postnatal Depression Scale (EPDS) are commonly used, readily available, well researched, easy to administer, free, and have been translated into many languages (See References).

The EDPS has 10 questions and includes both anxiety and suicidal intent. The PHQ-2 is brief and contains only two questions. The PHQ-9 (which also includes suicidal intent but not anxiety) can be given alone or with the PHQ-2 to determine the extent of depression.

Remember: Whenever inquiring about postpartum depression there must be a determination of suicide intent and safety of the mother and infant.

What are available resources?

Treatment for postpartum depression must include both treatment for the mother and the mother-infant dyad. Reassurance and parent education can be provided along with specific referrals. Medication is usually not needed but can be provided by obstetricians, internists or psychiatric providers. A pediatric office should have plans available for the rare event of emergency referral (911) or in case of safety issues. Resources and guidance for both providers and parents are available through the Postpartum Resource Center of NY www.postpartumny.org and Postpartum Support International www.postpartum.net. Programs are available at most local hospitals in the Chapter 2 area. Resource material should be available for immediate referrals (See Figure). Appointments should be confirmed in the pediatric office and frequent follow-up provided. Early treatment results in the best outcomes for mother and baby and should be obtained as quickly as possible (within a day or two).

Identifying and treating postpartum depression are effective ways to ensure optimal early infant brain development – which is after all, why we all do what we do!!!

References:

1. Earls, M et al. Clinical Report: Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice. Pediatrics. 2010;126(5):1032–1039. Reaffirmed December 2014)
2. PHQ-2 download: http://health.utah.gov/mihp/pdf/PHQ-9%20two%20question.pdf
3. PHQ-9 download: https://www.cappcny.org/home/media/phq9_adult.pdf
4. Edinburgh Postnatal Depression Scale download: https://www.cappcny.org/home/media/Edinburgh_Postnatal_Depression_Scale.pdf

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North Shore Child & Family Guidance Center
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