



Postpartum Depression Screening & Treatment Guideline

During the postpartum period, women are at much higher risk for the development of psychiatric illness than at other times in their lives. Routine clinical examinations by family practitioners, obstetricians, and/or pediatricians often fail to notice depression in postpartum women.

Community Health Group supports the performance of universal screening for postpartum depression by primary care, pediatric, and obstetrical practitioners and, when identified, treatment appropriate to the Member's need.

OBJECTIVE:

To ensure that practitioners are screening new mothers for postpartum depression and, if a positive diagnosis is confirmed, treating the depression and/or referring for treatment.

GUIDELINES:

1. Screening for postpartum depression should be conducted and documented in the medical record for all new mothers.
2. The Edinburgh Postnatal Depression Scale should be utilized for postpartum depression screening. Studies have shown that the use of a standardized and validated screening instrument produces a more sensitive and specific result, and this scale has been demonstrated repeatedly to be highly predictive of postpartum depression.
3. Women with increased risk of postpartum depression should receive a more in-depth evaluation of mental health status, including those who have experienced:
 - Previous postpartum depression
 - Postpartum psychosis
 - Depression during pregnancy
 - Depression unrelated to pregnancy
 - Bipolar disorder
 - Severe premenstrual syndrome
 - A difficult marriage/relationship
 - Few family members or close friends with whom to talk/depend on
 - Stressful life events during the pregnancy or after delivery
4. Screening and/or evaluation resulting in positive findings should be documented and acted on. Women with postpartum depression will indicate, to a greater or lesser extent, that during the past seven days they have experienced:
 - Sluggishness, fatigue, exhaustion
 - Less energy and motivation to do things
 - Sadness, low mood, hopelessness
 - Poor concentration/memory loss
 - Over concern for the baby or excessive anxiety over child's health
 - Guilt, inadequacy, and worthlessness; esp. feeling a failure at motherhood
 - Fear of losing control or 'going crazy'
 - Lack of interest in the baby
 - Fear of harming the baby

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- Diminished libido
- Anxiety
- Obsessionality
- Crying/irritability
- Thoughts of harming self

Documentation for any positive findings should include:

- Diagnosis of postpartum depression
- Recommendation for mental health therapy
- Referral for treatment

5. If the diagnosing practitioner decides to commence treatment for postpartum depression, he/she should:
 - Record diagnosis of depression on encounter/claim for each visit, although not necessarily in the primary position
 - Document the treatment plan
 - If antidepressant medication is prescribed:
 - a) Schedule regular appointments – at least 3 within the first 3 months – to evaluate response and document:
 - Diagnosis of depression
 - Patient education about the medication
 - Rationale for changes in treatment
 - Progress/response to therapy using an objective measurement
 - b) Maintain patient on an antidepressant medication for a period of at least 9 months

REFERRAL AND TREATMENT

1. When a woman presents with signs and symptoms of depression and/or a high score on a screening tool, practitioners may start with saying something like, "Based on what you've told me and your score, I'm concerned that you have some symptoms of depression. It's hard to be going through this when you have a new baby. Remember, depression is partly due to an imbalance of the chemicals in your body and things that cause stress in your life. There are things to do to feel better. Let's talk about some ideas that might work for you."
2. Encourage nonclinical interventions: exercise, diet, rest, and rethinking of expectations.
3. Assess level of social support. It does not matter how many people are around her. What matters is the mother's *perception of actual support*. This support may be found among families and friends, as well as local and national telephone, group, and Internet support services. Helping a woman to identify her support during pregnancy or postpartum is an important psychosocial intervention.
4. Acknowledge depression's effect on relationships. Ask about family members. Include them in information and planning. Those close to someone with depression often feel helpless. The person they once knew is different and they can't fix the problem.

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5. Consider clinical therapies:
 - a) medication—antidepressants;
 - b) psychotherapy—individual, couples, group, and parent-infant.

Which treatment or treatments to use is a decision between the practitioner and the mother. The decision may be based on effectiveness, preference, and severity of the symptoms, cost, and availability.

6. Practitioners must evaluate the risk and benefit of treating with medication for both the mother and the baby. A practitioner who prescribes antidepressant medication for a postpartum woman should follow up with regularly scheduled medication checks to ascertain the response and side effects.
7. Assess the risk for harming herself or her infant. One way of approaching this is to ask first about feelings of hopelessness. The practitioner might say, "Sometimes mothers feel so down and depressed that they think life isn't worth living or that they would be better off dead. Have you had thoughts like that?" (Known as suicidal ideation). If she has such thoughts, assess whether she has a plan. So, determine the likelihood that the plan will be carried out. Does she have materials? Time? Opportunity? Reasons not to? Precipitating factors? If so, refer for psychiatric emergency services. *Thoughts of harming the infant in some way **without intent to do so** are common with postpartum depression.*
8. Treatment for prenatal or postpartum depression should be initiated and monitored by a practitioner with experience and expertise.
9. It is important for health care practitioners to become familiar with the health expectations and practices of those to whom they typically give care. For example, learning simple words and phrases about depression in a person's native language can help build a bridge to a woman's experience.
10. In a broader context, the practitioner recognizes that a person's socioeconomic status, race, ethnicity, and gender affect access to and availability of health care.
11. Health care practitioners should be aware that the postpartum period may be devoid of expected joy and lightheartedness or at best, characterized by ambivalence. A recently-published retrospective study found that new mothers who described themselves as very depressed in the weeks and months after delivery were statistically more likely to describe their pregnancies as "a very hard time" or "one of the worst times of my life." Saying, "Oh, what a beautiful baby! Isn't being a new mother great?" may stifle a woman's desire to say how she's really feeling. The practitioner can ask, "How are things going?" in an interested and engaging way or say, "I've learned over the years that having a new baby can be a struggle as well as a joy. How are things for you?" Leaving the door open for the possibility that she is sad, anxious, or irritable, has lost interest in things, has trouble concentrating, or feels little if any connection with her baby provides a context within which both the practitioner and woman can speak about depression.