Incorporating Perinatal Depression Screening into Practice

FELLOWS OF AMERICAN COLLEGE OBSTETRICIANS AND GYNECOLOGISTS

2008
This initiative is supported by a grant funded by the Aetna Foundation, Inc.
Objectives

• Learn about the ACOG Perinatal Depression project and resources
• Understand clinical elements of perinatal depression
• Incorporate use of EPDS into perinatal care
• Become familiar with treatment options during the perinatal period.
The ACOG Perinatal Depression Project -
Enhancing Early Identification, Diagnosis and Treatment of Perinatal Depression: Education and Resources for Women’s Healthcare Providers

Goal:
• Improve ob-gyns capacity to screen, assess and manage perinatal depression through the provision of education, tools and resources.
ACOG Project Objectives

- Evaluate existing perinatal depression practice patterns among Ob-Gyn’s.
- Develop education and resources to improve ‘screening, assessment and management of perinatal depression
- Evaluate education and resources with 6 ob-gyn sites
- Deliver education to Ob-Gyn’s through resource guide and grand rounds series.
Creation of Resource Guide

• The taskforce utilized the ACOG evaluation results and other perinatal depression materials.

• Six sites implemented use of the Edinburgh Postnatal Depression Scale (EPDS) into perinatal care for 12 months.

• Through quarterly evaluation and focus groups with the six sites, ACOG staff will revise resource guide and distribute it to ACOG District II membership.

* District-wide distribution of the resource guide will occur in Summer 2008
Criteria Used for Selection of Six NY Sites

- Practice type
- Number of annual deliveries
- Diversity of patient population
- Insurance coverage of patient populations
- Geographic location
- Access to mental health resources
Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Name: ___________________________  Address: ___________________________

Your Date of Birth: ___________________  ___________________________

Baby’s Date of Birth: ___________________  Phone: ___________________________

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*10  The thought of harming myself has occurred to me
- Yes, quite often
- Sometimes
- Hardly ever
- Never
Preliminary Findings

• Number of screens: 2,307
• Number of women who scored a 10 or higher: 378
  – 11 of these women scored a 10 or higher twice.
• Number of women who scored 1 or more on Question 10: 79
Gender Differences in Prevalence of Major Depression

Women: 1.5-2.5 X rate relative to men

Kessler et al 1993
Postpartum Depression Onset

- N=209 MDD
  - 24 (11.5%)
    » onset in pregnancy (x=22 weeks)
  - 46 (22%)
    » late postpartum onset (13 weeks)
  - 139 (66.5%)
    » early postpartum onset (2 weeks)
    » (Stowe et al; 2005)
Antepartum Depression Symptoms

- Poor Appetite; ↓ Weight
- Insomnia
- Poor Prenatal Care
- Nicotine, Drugs and Alcohol
- Low birth weight
- Prematurity
- Developmental delay

Postpartum Depression

• Prevalence: 20% (2 in 10 women)
  • (Kumar 1994)

• Risk Factors:
  • Personal and Family H/O depression
  • Depression during pregnancy
  • Change in hormone levels
  • Difficult pregnancy
  • Medical problems
  • Previous postpartum depression
  • No family support
  • High stress

(DOH;OMH 2005; Flynn, 2005)
Postpartum Depression Symptoms

- Feeling irritable, angry, nervous, exhausted
- Not enjoying life
- Feeling guilty or worthless
- Lack of interest in baby, friends and family
- Crying uncontrollably
- Trouble concentrating
- Change in appetite ---- eating too much or too little
- Low energy

- Anxiety as bizarre thoughts and fears
- Feelings of being a bad mother
- Inability to sleep when infant sleeps
- Feel anxiety with distressing thoughts about infant safety
- Poor bonding, feel “detached” “numb”

- Thoughts of death or suicide

(DOH;OMH 2005; Flynn, 2005)
Perinatal Mood Changes

- Perinatal Blues
- Perinatal Depression
- Perinatal Psychosis
Management Options

• Mild Depression
  – Healthy Behaviors
  – Support Groups

• Moderate Depression
  – Interpersonal Psychotherapy
  – Cognitive Behavioral Therapy
  – Light Therapy
  – Medication

• Severe Depression
  – Medication
  – Electroconvulsive Therapy
  – Hospitalization
Antidepressant Drugs

SSRIs

• Citalopram   (Celexa)
• Escitalopram  (Lexapro)
• Paroxetine   (Paxil)
• Sertraline    (Zoloft)
• Fluoxetine    (Prozac)
Antidepressant Drugs (Non-SSRIs)

- Bupropion (Wellbutrin Zyban)
- Venlafaxine (Effexor)
- Mirtazapine (Remeron)
- Desipramine (Norpramin)
- Nortiptyline (Pamelor)
Discontinue medication at conception?

<table>
<thead>
<tr>
<th>Group</th>
<th>Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discontinued</td>
<td>44/65 (68%)</td>
</tr>
<tr>
<td>Maintained</td>
<td>21/82 (25%)</td>
</tr>
</tbody>
</table>

Time to recurrence:
50% in 1\textsuperscript{st} TM / 90% in 2\textsuperscript{nd} TM

(Cohen et al; JAMA, 2006)
SSRIs Effect: Newborn

- Not a major teratogen
- Individual SSRIs may increase risk slightly—but not clearly established
- Neonatal behavioral syndrome
- Pulmonary hypertension

Alwan et al: NEJM; June 2007
Louik et al: NEJM; June 2007
Chambers et al: NEJM; February 2006
Moses-Kolko et al: JAMA; May 2005
Absolute Risk of PPHN*

• Limitations:
  – supports association; no cause effect relationship
  – small Ns
  – retrospective

\[
RR = 6.1 \text{ (95\% CI, 2.2-16.8)}
\]

\[
\text{Absolute Risk} = 6-12/1000 \text{ births (0.6-1.2\%)}
\]

Therefore 99\% of women treated with an SSRI delivered infants without PPHN*

*persistent pulmonary hypertension of the newborn
Breastfeeding Mothers and Depression

• Incidence
• Screening – importance of lactation consultants
• Impact
Effect of Breastfeeding on Maternal Depression

• Overall positive effect on mother
  – Positive impact of oxytocin and prolactin hormones
  – Sense of accomplishment, bonding

• Sleep interruption

• Impact of weaning
Breastfeeding and Antidepressants

- **SSRIs: first line**
  - Few adverse effects to date
    - **Sertraline (Zoloft)**
      - usually yields undetectable infant serum levels
      - No adverse effects (Epperson 2003)
    - Infant serum: minimal or no drug or metabolite***
    - **(Celexa)** - Elevated infant levels
    - **Prozac (Fluoxetine)**
      - long T ½: accumulation infant serum - Immature infant enzymes
        - ***Does not apply to fluoxetine/ venlafaxine**
Guidelines for Medicating During Lactation

• Avoid polypharmacy
• Monitor infant sleep, feeding
• Bottle feed if sick
• Lowest effective dose
• Collaboration with Pediatrician
• All pass to breast milk
  – depends on drug and metabolite
  – outcome on physiology, behavior and development
Recommendations for Medicating during Lactation (1)

- Use drugs with published data and a track record on the market
- Use more caution with premature infants, neonates, and compromised infants
- Be cautious of drugs shown to accumulate in neonates
Recommendations for Medicating during Lactation (2)

- Avoid use of herbal preparations
- Choose drugs with high protein binding or low bioavailability in the presence of food or calcium
- Choose drugs with high molecular weights
- Attempt to modify schedules to continue breastfeeding
Case Vignette #1

M.J.- 35 y/o G3P2002 28 weeks gestation, screened yes for #10 with total score 18.

• What are the counseling points for this patient?
• How does prenatal care provider give emergency treatment?
• What resources are available in the patient’s community?
• How should the patient be followed up?
Case Vignette #2

L.M.- 24 y/o woman G1 10 weeks gestation taking paroxetine for two years after a hospitalization for a suicide attempt. She read on the internet last week that the drug may harm her fetus, and stopped her medication.

• What are the risks of restarting/not restarting this medication at this time in the pregnancy?
• What are the benefits of starting/restarting this medication at this time in the pregnancy?
• Would you restart her?
• What are the alternatives?
• How would you follow up with this patient?
• What resources are available?
Case Vignette #3

P. K.- 32 yo woman gravida P2122, non-english speaking, seeking preconception counseling, history of miscarriages and depression, no hospitalizations.

• What translation services and other resources are available?

• What management plan could be available?

• What are the preconception counseling points for the patient?
Case Vignette #4

W.S.- 23 yo G1P1001, brought in by her mother-in-law with suicidal ideation and admits to thoughts of harming her infant 3 months PP. Was screened for depression during preg. and at 6 week pp visit. Breastfeeding. Many hours spent to coordinate/arrange emergency admission into psych unit. Much of hospitalization was not covered by insurance. Breastfeeding was discontinued upon admission to hospital.

- Could a provider have detected postpartum depression in this new mother, taking into account the late presentation of symptoms?
- What resources exist to private offices who lack on-site services such as social workers to facilitate/arrange for referrals?
- Could/should breastfeeding have been preserved?
- Are ethical issues challenged with family members exposing mental health issues without consent of patient?
Supporting Maternal Wellness

- Assure adequate sleep for the new mother
- Assure adequate exercise; yoga; walking outside
- Assure nutritious eating
- Assure support from family and friends
- Assure time alone for the new mother to rest or do something fun or creative
- Avoid isolation – talk openly about feelings
- Cultivate activities & attitudes that bring joy
- Support breastfeeding
Take Away Points (1)

- Support maternal wellness.
- Know your communities perinatal and mental health resources.
- Consider identifying by name mental health professionals in your community.
- Contact OB coordinator at insurance plans to get assistance.
- Be comfortable prescribing one/two medications.
Take Away Points (2)

• Obtain more than one contact information per patient to improve follow-up success.
• Know who to call in a mental health emergency.

REMEMBER: Not identifying depression is more egregious than identifying and being unable to find referral care.
Insurance

• **Timothy’s Law**- New Yorkers with group insurance health coverage may receive improved mental health benefits due to 2007 state legislation entitled Timothy’s Law. (Not applicable to Healthy New York, Child Health Plus or Individual Insurance Market)

• **Medicaid Managed Care**- covers mental health services- to what level will vary amongst insurance carriers.
Obstetric Global Packages: Insurers may consider perinatal depression screening and discussion part of comprehensive prenatal care.

What is covered under an obstetric global package for comprehensive prenatal care varies depending on the insurer.
Billing Information (2)

Billing may be possible using E&M codes if a brief intervention occurs as a result of screening for depression.

If the visit is considered a comprehensive visit with moderate or high complexity and a moderate to high severity of problem, the following E&M codes may be used:

• **New Patients:** 99204 or 99205
• **Established Patients:** 99214 or 99215
• **For time spent over 30 minutes and under 75 minutes:** 99354
If the patient is seen more frequently than the usual 13 antepartum visits for depression, the additional visits may be reported using E/M codes, but they are not reported to the insurer until the patient delivers.

**Notes:**
- ICD-9-CM diagnosis code(s) must be used to establish the medical necessity of the extra visits and any extra diagnostic tests.
- Many payers require that E/M services for mental health diagnoses be performed only by a psychiatrist or psychologist.
Websites for Providers

• Clinical practice guidelines of APA – http://www.psych.org

• UIC Perinatal Depression Project: http://www.psych.uic.edu/clinical/HRSA/

• Perinatal Depression (VA DOH): http://www.perinataldepression.org/

• Mother Risk: www.motherisk.com

• Otis pregnancy registry: www.otispregnancy.com

• Maternal Depression and Breastfeeding: http://www.albany.edu/sph/coned/bfgr07.htm

• North American Society for Psychosocial Obstetric and Gynecologic practice: http://naspog.org/
## Websites for Patients

- National Women’s Health Information Center: [http://www.4woman.gov](http://www.4woman.gov)
- Postpartum Support International: [http://www.chss.iup.edu/postpartum](http://www.chss.iup.edu/postpartum)
- Postpartum Depression Foundation: [http://www.ppdchicago.org](http://www.ppdchicago.org)
- Medical education postpartum depression from NIH: [www.medEdppd.org](http://www.medEdppd.org)
- Reproductive Toxicology Center [www.reprotox.org](http://www.reprotox.org)
Telephone Hotlines

• Growing Up Healthy:
  1-800-522-5006 (TTY:1-800-655-1789)

• National Suicide Prevention: 1-800-273-TALK

• Speak Up When you are Down – NJDOH: 1-800-328-3838
  www.njspeakup.gov

• Office of Mental Health NYS
  www.omh.state.ny.us