Perinatal Depression: Screening and Treatment

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- I have no financial interest or other conflict of interest in relation to this program/presentation

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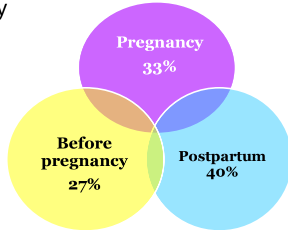
Objectives

- Understand the risk factors, prevalence and sequela of perinatal depression
- Review universal screening recommendations
- Discuss general treatment considerations
- Learn which medical options are best in pregnancy and breastfeeding

Definition

- Major or minor depressive episode during pregnancy or the first 12 months postpartum
- Symptoms may overlap with those of normal pregnancy



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Prevalence

- Estimates 5% - 25%
- One of the most common medical complications of pregnancy

Perinatal depression affects as many as
one in seven women.

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Gavin et al, Obstet Gynecol 2005
ACOG Committee Opinion Number 630

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Sequela

- Maternal
  - Inadequate prenatal care
  - Poor nutrition
  - Smoking
  - Substance abuse
- Obstetrical
  - Preterm birth
  - Low birth weight
- Infant
  - Poor maternal attachment
  - Missed peds visits
  - ED services
  - Insecurity in attachment
  - Risk of mental illness

Suicide is a leading cause of maternal mortality

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Metz et al, Obstet Gynecol 2016
Palladino et al, Obstet Gynecol 2011
Stewart , NEJM 2011
Wisner et al, Am J Psychiatry 2009

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Risk factors

- History of depression
- Low SES
- Family history of mental illness
- Low social support
- Unwanted pregnancy
- Low marital satisfaction
- Intimate partner violence

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Lee et al, Obstet Gynecol 2007

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Universal screening

- American Congress of Obstetricians and Gynecologists (ACOG):
  - clinicians screen all women at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool
- US Preventive Services Task Force:
  - level B
- Definitive evidence of benefit is limited

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ACOG Committee Opinion Number 630, 2015
Avalos et al, Obstet Gynecol 2016
Thombs et al, J Psychosom Res 2014

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Example Universal Screening

- Screening at least 3 times:
  - The first prenatal visit
  - 24-28 weeks
  - Postpartum
- Staff screening
  - Social work
  - Medical assistant
  - Nurse
  - Provider

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Universal screening

Screening Tool	Number of Items	Time to Complete (Minutes)	Sensitivity and Specificity	Spanish Available
Edinburgh Postnatal Depression Scale	10	Less than 5	Sensitivity 59–100% Specificity 49–100%	Yes
Postpartum Depression Screening Scale	35	5–10	Sensitivity 91–94% Specificity 72–98%	Yes
Patient Health Questionnaire 9	9	Less than 5	Sensitivity 75% Specificity 90%	Yes
Beck Depression Inventory	21	5–10	Sensitivity 47.6–82% Specificity 85.9–89%	Yes
Beck Depression Inventory-II	21	5–10	Sensitivity 56–57% Specificity 97–100%	Yes
Center for Epidemiologic Studies Depression Scale	20	5–10	Sensitivity 60% Specificity 92%	Yes
Zung Self-rating Depression Scale	20	5–10	Sensitivity 45–89% Specificity 77–88%	No

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Universal Screening - anxiety

Edinburgh Depression Scale

☐ First OB Visit ☐ Return Visit ☐ Postpartum Visit

Today's Date ____________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

In the past 7 days:

1. I have been able to laugh and see the funny side of things.
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all
2. I have looked forward with enjoyment to things.
   - 0 As much as I ever did
   - 1 Rather less than I used to
   - 2 Definitely less than I used to
   - 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong
   - 3 Yes, most of the time
   - 2 Yes, some of the time
   - 1 Not very often
   - 0 No, never
4. I have been anxious or worried for no good reason.
   - 0 No, not at all
   - 1 Hardly ever
   - 2 Yes, sometimes
   - 3 Yes, very often
5. I have felt scared or panicky for no very good reason.
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, never
6. Things have been getting on top of me.
   - 3 Yes, most of the time I haven't been able to cope at all.
   - 2 Yes, sometimes I haven't been coping as well as usual.
   - 1 No, most of the time I have coped quite well.
   - 0 No, I have been coping as well as ever.
7. I have been so unhappy that I have had difficulty sleeping.
   - 3 Yes, most of the time
   - 2 Yes, sometimes
   - 1 Not very often
   - 0 No, not at all
8. I have felt sad or miserable.
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Not very often
   - 0 No, not at all
9. I have been so unhappy that I have been crying.
   - 3 Yes, most of the time
   - 2 Yes, quite often
   - 1 Only occasionally
   - 0 No, never
10. The thought of harming myself has occurred to me.
    - 3 Yes, most of the time
    - 2 Yes, quite often
    - 1 Only occasionally
    - 0 No, never

Completed by: ____________ Date: ____________
Patient signature
Reviewed by: ____________ Date: ____________
Staff name & credentials

Universal Screening - suicide

Edinburgh Depression Scale

☐ First OB Visit ☐ Return Visit ☐ Postpartum Visit

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Patient signature
Reviewed by: ____________ Date: ____________
Staff name & credentials

Treatment

- Screening alone is insufficient
- ACOG Committee Opinion:
  - clinical staff in Ob/Gyn practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources, or both
  - systems in place to ensure follow-up

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Treatment

EPDS score	EPDS 0-8	EPDS 9-13	EPDS 14-18	EPDS ≥ 19
	Limited/no symptoms	*Mild symptoms*	*Moderate symptoms*	*Severe symptoms*
Medication		Consider medication	Recommend medication	Initiate medication
Additional treatment	Counseling therapy Community/social support Physical activity Self-care	Counseling therapy Community/ social support Physical activity Self-care	Counseling therapy Community/social support Physical activity Self-care	Refer for psychiatry consult in addition to counseling Community/social support Physical activity Self-care

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adapted from Byatt et al, MCPAP For Moms

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Antenatal medical treatment

- Rx medicines in pregnancy
- Teratogens
  - Sodium valproate
  - Carbamazepine
  - Lithium (?)
- Women who take antidepressants are more likely to
  - Smoke & drink alcohol
  - Be older
  - Take other rx drugs
  - Have higher BMI

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Yonkers et al, Annu Rev Clin Psychol 2014

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Antenatal medical treatment

- SSRIs first-line treatment
  - Sertraline (Zoloft)
  - Fluoxetine (Prozac)
  - Citalopram (Celexa)
  - Escitalopram (Lexapro)
- Not considered teratogens - with exception of paroxetine (Paxil)
- Persistent pulmonary hypertension of the newborn
- Neonatal withdrawal syndrome
- Very unlikely to be associated with autism spectrum disorder
- ? Effects on preterm birth and miscarriage

ACOG Practice Bulletin Number 92, 2008
Eke, BJOG 2016
McDonagh et al, Obstet Gynecl 2014
Yonkers et al for APA and ACOG, Obstet Gynecol 2014
Wisner et al, Am J Psychaitry 2009

Postpartum medical treatment

- Low levels of SSRIs in breast milk
- Breastfeeding is not contraindicated for *any* antidepressant
- If starting postpartum, choose:
  - Sertraline (Zoloft)
  - Paroxetine (Paxil)
  - Fluvoxamine (Luvox)

ACOG Practice Bulletin Number 92, 2008

Medical treatment

- If patient has a history of taking an antidepressant that helped, prescribe that antidepressant
- If no history of taking an antidepressant, use Zoloft (sertraline) as to date has the most literature and clinical experience
  - Therapeutic dose = 50 – 200 mg daily
- Start with ½ the recommended dose for 1 week, then increase to recommended dose as tolerated to minimize side effects
- Single medication at higher dose preferred over multiple medications
- If an antidepressant has helped during pregnancy, continue it during breastfeeding
- Screen for bipolar prior to starting monotherapy

Medical treatment

- Once treatment is initiated, reevaluate using the EPDS and clinical assessment
  - If no/minimal clinical improvement after 4-8 weeks:
    - If no/minimal side effects, increase the dose
    - If has been on therapeutic dose for ≥ 8 weeks without response, consider switching medication versus increasing dose
    - If patient has side effects, switch medication
  - If clinical improvement and no/minimal side effects:
    - Reevaluate every month and at PP visit
    - Refer to PCP or community psych provider for ongoing care at PP visit

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Resources

- ***Additional resources for providers and patients:***
  - *Massuchusetts Child Psychiatry Access Project (MCPAP) for Moms Provider Toolkit:* *https://www.mcpapformoms.org/Toolkits/Toolkit.aspx*
  - *MCPAP consultation 855-666-6272*
  - *NICHD Moms' Mental Health Matters:*
    - *https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms/Pages/default.aspx*
  - *Council on Patient Safety in Women's Healthcare:*
    - *http://safehealthcareforeverywoman.org/secure/maternal-mental-health.php*

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Council on Patient Safety in Women's Healthcare

PATIENT SAFETY BUNDLE

Maternal Mental Health

MATERNAL MENTAL HEALTH: PERINATAL DEPRESSION AND ANXIETY

READINESS

Every Clinical Care Setting

- Identify mental health screening tools to be made available in every clinical setting (outpatient OB clinics and inpatient facilities).
- Establish a response protocol and identify screening tools for use based on local resources.
- Educate clinicians and office staff on use of the identified screening tools and response protocol.
- Identify an individual who is responsible for driving adoption of the identified screening tools and response protocol.

RECOGNITION & PREVENTION

Every Woman

- Obtain individual and family mental health history (including past and current medications) at intake, with review and update as needed.
- Conduct validated mental health screening during appropriately timed patient encounters, to include both during pregnancy and in the postpartum period.
- Provide appropriately timed perinatal depression and anxiety awareness education to women and family members or other support persons.

RESPONSE

Every Case

- Initiate a stage-based response protocol for a positive mental health screen.
- Activate an emergency referral protocol for women with suicidal/homicidal ideation or psychosis.
- Provide appropriate and timely support for women, as well as family members and staff, as needed.
- Obtain follow-up from mental health providers on women referred for treatment. This should include the necessary release of information forms.

REPORTING/SYSTEMS LEARNING

Every Clinical Care Setting

- Establish a non-judgmental culture of safety through multidisciplinary mental health rounds.
- Perform a multidisciplinary review of adverse mental health outcomes.
- Establish local standards for recognition and response in order to measure compliance, understand individual performance, and track outcomes.

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Thank you

Questions or Comments?

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