Toolkit for Primary Care and Obstetric Providers Improving Identification and Response to Depression in Pregnancy and Postpartum

SUMMARY OF DEPRESSION

FAST FACTS

1. Eighty percent of new mothers experience a brief episode of the "baby blues" in the first few days after childbirth, lasting up to about ten days. Symptoms are mild and self-limited, including poor sleep patterns, irritability, and brief crying episodes. Thoughts of suicide do not occur.
2. The American College of Obstetricians and Gynecologists (ACOG, 2015) defines perinatal depression as any major or minor depressive episode with onset during pregnancy or in the first year after childbirth.
3. Perinatal depression occurs in one out of seven women.
4. 3 to 6 percent of women will experience a major depressive episode during pregnancy or after delivery, and one-half of "postpartum" major depressive episodes have their onset before delivery.
5. Low-income and teenage mothers report depressive symptoms at 40 percent to 60 percent.
6. The Texas Maternal Mortality and Morbidity Review Committee found that mental health conditions are one of Texas's leading causes of pregnancy-related deaths.
7. The Department of State Health Services (DSHS) found that suicide was the cause of death for 8.6 percent of deaths among mothers during pregnancy or within 365 days postpartum.
8. One-half of postpartum psychosis is the initial manifestation of a severe psychiatric disorder. Any woman with psychotic symptoms at the time of evaluation or in the recent past (either self-reported or observed by another person) should be referred for emergent psychiatric evaluation and possible hospitalization due to the risk of rapid deterioration.
9. ACOG recommends that all women undergo screening for perinatal depression and anxiety at the initial prenatal visit, later in the pregnancy and at a postpartum visit with a validated screening tool (ACOG 2023).
10. AAP recommends that infant primary care providers integrate postpartum depression screening into the well-child visits at one, two, four, and six months.

RISK FACTORS

1. Women with a history of anxiety or mood symptoms during the pregnancy or an episode of the "baby blues" following delivery are at increased risk of a major depressive episode in the postpartum period.
2. The single greatest risk factor for postpartum depression is a prior history of depression
3. Other risk factors include, but are not limited to, the following (ACOG, 2015; ACOG, 2016)
    - Symptoms of depression (especially in the third trimester) or anxiety during the pregnancy
    - Prior psychiatric illness or poor mental health, especially postpartum depression with a prior pregnancy
    - A history of physical, sexual, or psychological abuse; domestic violence
    - Family history of depression, anxiety, or bipolar disorder
    - Lack of social support
    - Low socio-economic status or educational level
    - Immigrant from another country
    - Medicaid insurance
    - Poor income or unemployment
    - Intention to return to work
    - Single parent status
    - Poor relationship with a partner or the father of the baby
    - Unintended pregnancy or a negative attitude toward the pregnancy
    - Traumatic childbirth experience
    - Stress related to childcare issues
    - Medical illness, neonatal intensive care unit admission, or prematurity in the infant
    - Difficulties with breastfeeding
    - A temperamentally difficult infant
    - A recent stressful life event or perceived stress
    - Smoking
    - A history of bothersome premenstrual syndrome

SCREENING AND DIAGNOSIS OF POSTPARTUM DEPRESSION

SCREENING TOOLS

- All mothers should undergo screening for depression at the initial pregnancy visit, again during the pregnancy, at the postpartum visit, and an infant checkup.
- Baby checkup visits are an excellent opportunity to screen mothers who missed their postpartum visit, those who might benefit from repeat screening, and those who failed to undergo earlier screening for any reason.
- The following validated postpartum depression screening tools are recommended in postpartum patients:
  1. **Edinburgh Postnatal Depression Scale** (EPDS; Cox, et al., 1987)
     https://perinatology.com/calculators/Edinburgh%20Depression%20Scale.htm
     Interpretation: A score of 10 or more suggests depressive symptoms. A score of 13 or more indicates a high risk of major depression. A score of one or more on question #10 is an automatic positive screen because it indicates possible suicidal ideation and requires immediate evaluation.
  2. **Patient Health Questionnaire-9** (PHQ-9; Yawn, et al., 2009)
     https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf
     Interpretation: A score of 10 or more indicates a high risk of having or developing depression. A score of two or more on question #9 is an automatic positive screen indicating possible suicidal ideation and requires immediate evaluation.
  3. **Postpartum Depression Screening Scale** (PDSS; Beck & Gable, 2000)
     Postpartum Depression Screening Scale (apa.org) and https://practicalpie.com/becks-depression-inventory/
     Interpretation: PDSS Full form (35-item version): A score of 60 or more suggests depressive symptoms; a score of 81 or greater indicates a high likelihood of major depression. A score of six or more on the SUI (suicidal thoughts) subscale is an automatic positive screen indicating possible suicidal ideation and requires immediate evaluation.

SCREENING FOR SUICIDE

1. In a study of women who screened positive for depression, either early in the third trimester or at the postpartum visit, approximately 3.8 percent reported suicidal ideation (Kim, et al., 2015).
2. Among women with suicidal ideation, approximately 1.1 percent also reported having a plan, the intent, and access to the means to carry it out.
3. Single relationship status, non-white ethnicity, non-English speaking, and severe vaginal laceration at delivery were associated with suicidal ideation.

4. Immigrant Hispanic women may be at higher risk for postpartum depression and suicidal ideation (Shellman, et al., 2014).
5. The DSM-5 notes that suicidal behavior may occur with any major depressive episode, and the most commonly cited risk factor is a prior suicide attempt or threat (APA, 2013).
6. Women are more likely than men to attempt suicide but less likely to complete a suicide attempt.
7. Any patient with a positive response to questions related to suicide risk on the screening tool and any patient who expresses or is suspected of having suicidal thoughts or ideation should immediately undergo a thorough suicide risk assessment (Zero Suicide Advisory Group, 2015). https://zerosuicide.edc.org/

DIAGNOSIS

- For women with a positive postpartum depression screen, the diagnosis of postpartum depression is based on the diagnostic criteria for major depressive disorder in the DSM-5, which requires the presence of five of the nine diagnostic criteria listed in Table 1 for two weeks or more (APA, 2013).

Table 1. Symptoms of Major Depressive Disorder, DSM-5*

1.	Depress mood most of the time on most days, either by subjective report (e.g., feelings of sadness, hopelessness, or emptiness) or by observed behavior (e.g., tearfulness)
2.	Substantially decreased interest or ability to enjoy all or most activites (may be reported subkectively or observed)
3.	Psychomotor retardation or agitation
4.	Feelings of worthlessness or guilt
5.	Indecisiveness or difficulty concentrating
6.	Significant change in weight (gain or loss) or appetite (increase or decrease)
7.	Insomnia or hypersomnia
8.	Decreased energy or excess fatigue
9.	Frequent thoughts of death (not just fear of death), suicide attempt, or suicidal thoughts (with or without a plan)

*** Hirst & Moutier, 2010, Langan & Goodbred, 2016**

- Mild depression is characterized by relatively few symptoms that cause a manageable amount of distress and only limited impairment of social or work function.

- Severe depression is associated with the presence of many more symptoms than the minimum required to make the diagnosis, together with substantial distress and impairment of social or work function.
- Moderate depression is characterized by a state between mild and severe depression.
- Providers should inquire about any history of bipolar disorder or manic symptoms due to their increased risk of postpartum depression.
- Although postpartum psychosis is uncommon, approximately one-half of episodes represent the initial manifestation of a severe psychiatric disorder either at the time of evaluation or in the recent past (either self-reported or observed by another person) and should be referred for emergent psychiatric evaluation and consideration of hospitalization due to the association of rapid deterioration.
- A thyroid-stimulating hormone (TSH) level should be obtained to evaluate possible hypothyroidism, which can mimic symptoms of depression.

TREATMENT OF POSTPARTUM DEPRESSION

NONPHARMACOLOGIC TREATMENT

- First-line treatment of mild-to-moderate postpartum depression includes psychological and behavioral therapies, such as individual or group counseling, interpersonal psychotherapy (IPT), and partner-assisted IPT
- A visiting nurse with specialized training in recognition of postpartum depression and appropriate counseling has demonstrated greater benefit than untrained healthcare visitors.
- Mild postpartum depression may respond well to cognitive-behavioral interventions (e.g., stress management, problem-solving, goal setting) provided in individual or group settings (O'Connor, et al., 2016).
- The provider might work with the patient to develop a Postpartum Depression Action Plan and see her again in a week to assess her response to the intervention. Action Plan: http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression/treatment/postpartum-depression-action-plan.html
- A response to treatment can be assessed by repeating the screening tool to see if the score improves over time. If there is no improvement or symptoms worsen, pharmacologic therapy should be considered.

PHARMACOLOGIC TREATMENT

- Medication therapy may be appropriate for patients with more severe symptoms and those who do not respond to non-pharmacologic therapy.
- Selective serotonin reuptake inhibitors (SSRIs) are one class of drugs commonly used to treat postpartum depression
- ACOG Recommendations (June 2023 Guideline)
  - Use the lowest effective dose
  - Avoid Polypharmacy
  - Minimize switching medications
  - Consider untreated or inadequately treated other mental health disorders

Table 2. Common Dosing Regimens for Antidepressants in Women with Postpartum Depression**

Drug	Starting dose	Typical treatment dose	Maximum dose
Sertaline	25 mg	50-100 mg	200 mg
Fluoxeting	10 mg	20-40 mg	80 mg
Escitalopram	5 mg	10-20 mg	20 mg
Citalopram	10 mg	20-40 mg	60 mg
Bupropion, sustained release	100 mg	200 -300 mg (divided dose)	450 mg

**** Hirst & Moutier, 2010**

- Start with a low dose and increase as needed
- The response to treatment can be assessed by repeating the screening tool used initially. When remission of symptoms is achieved, treatment is generally continued for a period (e.g., six to nine months) and then discontinued. To minimize the side effects of suddenly discontinuing therapy, the dose can be tapered over two weeks.

BREASTFEEDING

- Postpartum depression and treatment with antidepressant medications are not contraindications to breastfeeding (Sachs & APA Committee on Drugs, 2013).
- In breastfeeding mothers taking antidepressant medication and their infants, concentrations of drug and metabolites in breast milk and infant serum vary widely.
- The LactMed® database provides reviews of safety information on a wide variety of drugs that may be taken by women who are lactating, including antidepressant medications. https://www.ncbi.nlm.nih.gov/books/NBK501922/
- Measurement of drug levels in breast milk or the serum of breastfed infants is not recommended (ACOG, 2008).
- Postpartum depression and treatment with antidepressant medications are not contraindications to breastfeeding.
- Women who wish to breastfeed while taking antidepressants should be counseled on the benefits of breastfeeding, the value of treating postpartum depression (including the risk of untreated depression), the potential risk of exposure of the infant to the medication or its metabolites, and the limitations of evidence related to the effects on the infant.

CONTRACEPTION

- Providers should explain the risks, benefits, and considerations regarding contraceptive methods for breastfeeding women.
- See the HHS Long-Acting Reversible Contraception (LARC) Toolkit for information about highly effective, reversible contraceptive methods. https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/women/texas-larc-toolkit.pdf

COVERAGE AND REIMBURSEMENT FOR POSTPARTUM DEPRESSION

MEDICAID AND CHIP

- Women who receive prenatal care through Medicaid for Pregnant Women remain eligible for Medicaid benefits for 90 days after the baby's birth and can be expanded to one year with enrollment in the Healthy Texas Woman Program Healthy Texas Women | Healthy Texas Women.
- Medicaid will cover the postpartum visit(s) as well as counseling, medications, and follow-up necessary for women diagnosed with postpartum depression.
- Women who receive prenatal care through the CHIP-Perinatal program are eligible for two postpartum visits under the global prenatal care service package.
- Medications are covered by the HTW program.

HEALTHY TEXAS WOMEN

- When coverage under Medicaid for Pregnant Women ends, a woman who meets eligibility requirements will transition to the Healthy Texas Women (HTW) program. https://www.healthytexaswomen.org/provider-resources/healthy-texas-women-provider-resources
- The HTW program covers diagnostic evaluation, medications, and follow-up visits for women with a diagnosis of postpartum depression.
- To find a provider for the family planning program and Healthy Texas women, visit https://www.healthytexaswomen.org/ .
- For information on local behavioral health care providers, refer to the Office of Mental Health Coordination of the Texas Health and Human Services Commission website, or call 2-1-1. To find a local behavioral health care provider visit http://mentalhealthtx.org/.

SCREENING DURING THE INFANT'S TEXAS HEALTH STEPS CHECKUP

- AAP recommends that the infant's provider screen mothers for postpartum depression within the first few months following birth and up to the infant's first birthday (AAP, 2017).
- The Medicaid Texas Health Steps (THSteps) program allows postpartum depression screening coverage for the infant during a THSteps checkup or follow-up visit completed by the infant's first birthday.
- Coding for postpartum depression screening at the infant's checkup follows standard coding and billing requirements for all THSteps checkups.
- The infant's medical record should include documentation of postpartum depression screening.
- Detailed information on THSteps checkups and postpartum depression screening can be found in the Texas Medicaid Provider Procedures Manual (TMPPM) on the Texas Medicaid & Healthcare Partnership (TMHP) website. http://www.tmhp.com/Manuals_HTML1/TMPPM/Current/index.html

CODING FOR SERVICES

Table 3. Common Diagnosis Codes and Descriptions***

ICD 10-CM Code	Description
090.6	Postpartum mood disturbance, postpartum blues, "baby blues", postpartum sadness, postpartum dysphoria
F53	Puerperal psychosis, postpartum depression
F32.9	Major depressive disorder, single episode, unspecified

***** Holden, et al [AMA], 2015**

Table 4. Common Procedural Terminology Codes Used for Services Provided to Patients with Signs and Symptoms of Postpartum Depression

CPT CODE	Description
99201-99205	Outpatient evaluation and management service for a new patient
99211-99215	Outpatient evaluation and management service for an established patient
90791	Psychiatric diagnostic evaluation without medical services
90792	Psychiatric diagnostic evaluation with medical services

Table 5. Common Procedural Terminology Codes Used for Postpartum Depression Screening During THSteps Checkup or Follow-Up Visit*****

CPT CODE	Description
G8431	Screening for depression is documented as being positive and follw up plan is documented.
G8510	Screening for depression is documented as negative; a follow up plan is not required.

******* Texas Medicaid Provider Procedures Manual, Children's Services Handbook, Section 5.3.11.1.4**

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RESOURCES

- Edinburgh Postnatal Depression Scale https://perinatology.com/calculators/Edinburgh%20Depression%20Scale.htm
- Patient Health Questionaire-9 https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf
- American Academy of Family Physicians. Postpartum Depression web page. Information for patients and providers on postpartum depression. http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression.html http://www.aafp.org/afp/2010/1015/p926.html
- American Academy of Family Physicians. Postpartum Depression Action Plan. https://familydoctor.org/postpartum-depression-action-plan/
- American Congress of Obstetricians and Gynecologists. Depression and postpartum depression: Resource overview web page. http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression
- American Psychological Association. Postpartum Depression web page. Includes patient education brochures in English, Spanish, French, and Chinese as well as links to resources on postpartum depression for new mothers and new fathers. https://www.apa.org/search?query=postpartum%20depression%20resources
- Eunice Kennedy Shriver National Institute of Child Health and Human Development National Child & Maternal Health Education Program. Moms' Mental Health Matters website. Provides information for mothers and mothers-to-be on depression and anxiety, and how to find help. https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms/pages/default.aspx

- Healthy Texas Women web site. Provides links to information for patients and providers on the Healthy Texas Women and Texas state Family Planning Programs. https://www.healthytexaswomen.org/
- National Library of Medicine Toxnet Toxicology Data Network. LactMed drugs and lactation database website. Provides information on safety of drugs in breastfeeding mothers, including infant serum drug levels, effects in 26 breastfed infants, effects on breastmilk and lactation, and alternative medications to consider. https://www.ncbi.nlm.nih.gov/books/NBK501922/?report=classic
- Office of Mental Health Coordination website, Texas Health and Human Services Commission. Provides links to information for providers and patients in Texas on a variety of behavioral health topics, and a link to the Substance Abuse and Mental Health Services Administration behavioral health treatment services locator. http://mentalhealthtx.org/
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- Texas Health Steps, Texas Health and Human Services Commission. Integrating Postpartum Depression Screening into Routine Infant Medical Checkups. http://www.txhealthsteps.com/static/courses/ppd/sections/intro.html
- ZERO Suicide in Health and Behavioral Health Care web page. Provides resources, organizational self-study materials, and toolkit for developing and implementing a comprehensive organizational program to recognize and treat suicide and suicidal risk across the health care continuum, with a goal of preventing all suicide. Zero Suicide Institute | Solutions.edc.org

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