ONLINE EXCLUSIVE

Should you screen for postpartum depression?

Yes. Evidence suggests that screening new moms for depression leads to better outcomes, and should be routine.

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PRACTICE CHANGER

Make depression screening a routine part of the postpartum visit.[1]

STRENGTH OF RECOMMENDATION

B: Based on a single blinded randomized controlled trial (RCT).

Yawn BP, Dietrich AJ, Wollan P, et al. TRIPPD practices. TRIPPD: a practice-based network effectiveness study of postpartum depression screening and management. *Ann Fam Med*. 2012;10:320-329.

ILLUSTRATIVE CASE

A 20-year-old patient comes in at 6 weeks' postpartum for routine care. Should you screen her for postpartum depression?

The incidence of depression in the first 3 months' postpartum is estimated at about 14%,[2,3] and the consequences can be severe. A new mom with a mood disorder in the first year of her child's life can disrupt the mother-infant relationship, thereby contributing to both short- and long-term adverse outcomes for the child. These include behavior problems, low self-esteem, poor self-regulation, and an increased risk of impaired mental and motor development.[4,5]

Postpartum depression often goes undetected

Despite this correlation, postpartum depression is both under-recognized and undertreated.[6] A prospective randomized study of 5169 women who were screened for postpartum depression bears this out. Researchers found that about one in 4 (26%) of the 674 mothers who had positive screens were not asked about their emotional state by their clinicians.[2]

This may be due to a lack of evidence of the efficacy of screening for postpartum depression. In the Healthy Start Depression Initiative (n=1336), universal screening—with referrals to mental health care outside of the primary care physicians' offices—did not alter either the level of depressive symptoms over a 10-month period or depression treatment.[7]

The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice noted in 2010 (and reaffirmed in 2012) that there is insufficient evidence to support a firm recommendation for universal postpartum screening for depression.[8] Neither the US Preventive Services Task Force nor the American Academy of Family Physicians has a specific recommendation regarding postpartum depression.

STUDY SUMMARY

Screening—with follow-up—leads to better outcomes

The study by Yawn et al included 28 family medicine practices in 21 states, randomized to either usual care or intervention.[1] Eligible practices had to have provided well-baby or maternity care to more than 30 patients in the previous year, but not to routinely screen

for postpartum depression. A total of 2343 women aged 18 years or older—all of whom were between 5 and 12 weeks' postpartum and planning on continuing care at the family medicine practice at the time they entered the study—were enrolled.

Staff at the 14 intervention sites received training in postpartum depression screening and diagnosis. They were also given a set of tools to facilitate management of postpartum depression, including an outline for follow-up visits and scripts for nurses to use for telephone calls relating to antidepressants. Therapy options were left to the discretion of the physician and the patient, with the help of tools that detailed the doses and adverse effects of various medications and described cognitive behavioral therapy.

At the start of the study, participants at all 28 sites were given survey packets containing the Edinburgh Postnatal Depression Scale (EPDS) and the 9-item Patient Health Questionnaire (PHQ-9). Patients subsequently received surveys by mail at 6 and 12 months' postpartum for self-reported outcomes. Clinicians at the intervention sites had routine access to the EPDS and PHQ-9 scores; those at the usual care sites did not.

The primary outcome was ≥5 point drop in the PHQ-9 score from baseline at 6 or 12 months' postpartum, considered to be an indicator of clinical improvement and/or response to therapy. The PHQ-9 is a validated measure of depression severity, with the proven ability to detect changes over time.[9,10]

Of the 2343 women initially enrolled in the study, 1897 (81%) provided outcome information and were included in the analysis. The rates of women with elevated depression scores (EPDS and/or PHQ-9 ≥10) at the start were comparable between the intervention and usual care groups (29.5% vs 25.8%, respectively).

Of those whose scores were initially elevated, 219 women in the intervention group and 178 women in the usual care group returned surveys at 12 months and were included in the final analysis. The results: 45% of those in the intervention group met the primary outcome—a decline in self-reported depressive symptom levels, as indicated by a PHQ-9 decrease ≥5 points—compared with 35% of the women in the usual care group (odds ratio, 1.8; 95% confidence interval, 1.14-2.9; *P*=.001). Not surprisingly, medical record review also indicated that those in the intervention group who initially had elevated depression scores were more likely to have received a diagnosis (66% vs 41%; *P*=.0006) and therapy (20% vs 11%; *P*=.02) for postpartum depression.

Low socioeconomic status has been shown to be a strong risk factor for the development of postpartum depression.

WHAT'S NEW?

We now have evidence of the efficacy of postpartum screening

This is the first large study of a primary care-based approach to screening, diagnosis, and management of postpartum depression to show any improvement in maternal outcomes at 12 months. Prior universal screening and referral support in the Healthy Start program was done by paraprofessionals, who referred women with positive screens for mental health care outside of the primary care setting and did not reduce the rate of depression in perinatal women.[7]

CAVEATS

Dropout rate, socioeconomic status may affect results

Among the women who initially were found to be positive for postpartum depression, 38% did not return questionnaires at 12 months' postpartum. While this loss to follow-up is high, it is comparable to that of most effectiveness trials[11] with similar rates in the intervention and usual care groups.

Within the intervention group, there was no statistical difference between women who did and did not return the questionnaires with regard to marital status, history of depression, income, or uninsured status. However, women in the usual care group who did not return the 12-month questionnaire were more likely to be poor (89% vs 57%; *P*<.01) and uninsured (49% vs 29%; *P*<.01) than those who did return the questionnaire.

The impact of these differences and the loss to follow-up in this study is unknown. However, low socioeconomic status has been shown to be a strong risk factor for the development of postpartum depression.[12] The

authors of the study suggest (and we agree) that the difference in socioeconomic status in women who did not return the questionnaire may underestimate the positive impact of this screening approach.

CHALLENGES TO IMPLEMENTATION

Screening requires extra work

Personnel at the intervention sites received a half day of training in postpartum depression screening, diagnosis, and nursing telephone follow-up. The workload at these sites also increased, as most women found to have postpartum depression received one to 2 follow-up telephone calls and an average of one to 2 follow-up visits after the start of therapy. These measures, while seemingly modest, could pose a challenge to implementation. This could potentially be alleviated by the additional payments for care coordination promised in the Patient Protection and Affordable Care Act.[13] JFP

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