

Recent Policy Changes in Perinatal Depression Screening and Treatment

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ABSTRACT

Perinatal depression affects approximately 15%–20% of women who give birth, making it the most common postpartum complication. Symptoms may occur during pregnancy or the first year after childbirth. Untreated perinatal depression may have long-term effects on the mental and physical well-being of the woman, infant, and family. Early identification through screening and prompt treatment promotes optimal outcomes. Professional organizations and government agencies that provide services to women and children have created new policies on perinatal depression screening and treatment. The authors describe these policy changes and offer simple guidelines for implementing them into clinical settings.

Keywords: depression, mental health, perinatal, policy, screening

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INTRODUCTION

Perinatal depression (PD) is defined as a major depressive episode with symptom onset that begins during either pregnancy or the postpartum period.¹ Although discrepancies exist regarding prenatal and postpartum symptom onset, a growing body of research indicates depressive symptoms may occur during the first trimester through the first postpartum year.² With a prevalence rate of 15%–20%, PD is one of the most common perinatal health problems^{3–5} and is a significant public health concern for mothers, infants, and families.

When left untreated during the prenatal period, PD may lead to preterm birth, an increased risk for neonatal death, and lifelong health problems for the infant (eg, asthma, failure to thrive, eczema).^{6,7} Untreated maternal depression may lead to suboptimal parenting practices including frequent nonurgent visits to the emergency department, less frequent use of preventive health services (well-child visits and immunizations), and inadequate child safety practices.⁷ Children of mothers experiencing PD may experience poor maternal attachment and cognitive-behavioral problems that may persist into adolescence and affect the child's development and school performance.⁷ Maternal risks associated with untreated PD include poor adherence to prenatal

care, higher likelihood of substance use, marital relationship conflicts, suicide, and workplace difficulties.^{1,7,8} Early PD identification through screening, treatment, and referral can reduce symptoms and improve the health and well-being of perinatal women and their families.

Recently, policies have been created that more clearly define PD screening, treatment, and referral. However, inconsistencies within the policies may result in confusion among health care providers regarding when to screen, which screening tool to use, which health care provider should screen, and the overall referral process from primary care providers (PCP) to mental health care providers (MHCP). The purpose of this article is to provide an overview of current PD policies, compare and contrast the policies, provide implications for clinical practice, and offer recommendations to facilitate interdisciplinary screening and treatment in an effort to improve overall maternal and infant health.

BACKGROUND

Symptoms of PD, including frequent crying, irritability, inability to concentrate, sleep disturbance, and fearfulness, are similar to those of generalized depression in the nonpregnant or non-postpartum population. Some symptoms of PD may overlap with

those of normal physiological changes in the perinatal period. For example, weight loss and an increased need for sleep are common postpartum physiological changes that are common in both generalized depression and PD. Because of these overlapping symptoms, along with other normal physiologic changes, PD symptoms may go unrecognized by mothers, family members, or PCPs. Therefore, appropriate use of screening tools can accurately and promptly identify women at risk of developing PD. Although often easily treated when identified, only 20%–30% of women experiencing PD are identified or treated because of various provider barriers.^{9,10} Health care provider barriers to PD screening include inadequate education regarding administration, timing of screening, scoring questionnaires, selecting screening tools, treatment, access to referral resources, and follow-up care.¹⁰ Health care providers may be unsure of which screening tool to use and whether the screening should be completed by the PCP or through self-report. Additional confusion may result from the varying cutoff scores between tools and score modifications applied to high-risk populations, such as adolescents.

Other factors that contribute to low PD identification and treatment rates include a general lack of trained perinatal mental health professionals, poor insurance reimbursement for PD care, and lack of time to conduct clinical screening.^{11,12} Rampala and

coworkers¹³ examined PD screening practices among midwives in Oregon. Findings indicated most midwives provided PD screening and described lack of MHCP and reimbursement from third-party payors for PD screening as barriers to care. Recommendations based on study findings included incorporating a standardized PD screening questionnaire into the electronic health record and improved insurance reimbursement may improve PD screening rates.

In an effort to improve PD screening, identification, and treatment rates in childbearing women at all points of entry in the health care system, several organizations have developed policies, position statements, and recommendations regarding PD screening. These include the American Academy of Pediatrics (AAP),¹⁴ American College of Nurse-Midwives (ACNM),¹⁵ American College of Obstetricians and Gynecologists (ACOG),³ Mental Health America (MHA),¹⁶ Postpartum Support International (PSI),¹⁷ and the US Preventive Services Task Force (USPSTF)¹⁸ (see Table 1). It is important to note that each of these policies focuses on either a pediatric or maternal population, which further complicates the screening, treatment, and referral process. Discrepancies among these policies present challenges to PCPs in clinical settings that must be clarified and coordinated to promote early detection and prompt treatment of PD.

Table 1. Current Perinatal Depression Policies

Organization	Screening Frequency	Recommended Screening Tool(s)	Recommended Treatment
American Academy of Pediatricians	At Well-Child Visits: 1, 2, 4, and 6 months	PHQ-2, EPDS	Use community resources for treatment
Mental Health America	During pregnancy, postpartum, at well-child visits, emergency department visits, WIC visits, as condition of return to work	PHQ-9, EPDS	Co-location of mental health services in primary care tele-mental health
American College of Obstetricians and Gynecologists	At least once in perinatal period More frequently if symptomatic	PHQ-9, EPDS, others	Prompt treatment or referral
US Preventive Services Task Force	No specific frequency, must have adequate systems for treatment in place	PHQ-9, EPDS	Cognitive-behavioral therapy or other nonpharmacologic treatment before medication use in pregnancy

EPDS = Edinburgh Postnatal Depression Scale; PHQ-2 = Patient Health Questionnaire 2; PHQ-9 = Patient Health Questionnaire 9; WIC = Women, Infants, and Children.

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