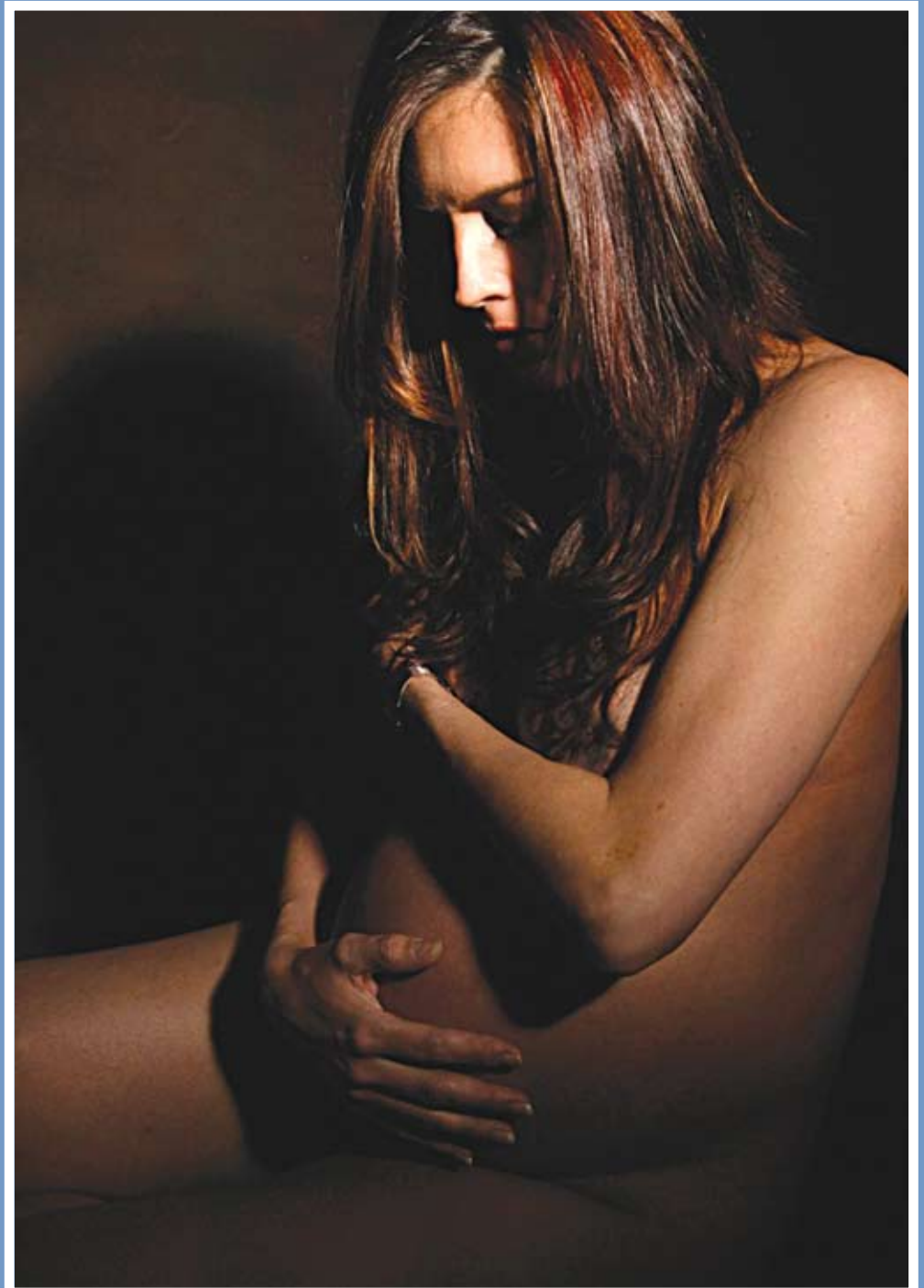


Perinatal Depression Screening:

Tools for
Obstetrician-
Gynecologists



American College
of Obstetricians and
Gynecologists, District II/NY



Dear Member,

On behalf of the American College of Obstetricians and Gynecologists, District II/ NY (ACOG), we are pleased to provide you with *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists*, a toolkit offering relevant provider education regarding perinatal depression. The toolkit includes the following:

- Perinatal Depression Screening Tool
- Assessment and Management Strategies
- Pharmacologic Chart
- List of Relevant Provider and Patient Resources

After reading this toolkit, you may obtain CME credit by completing the quiz on page 25.

As many as 14.5% of new mothers in the United States suffer from major depression and nearly 80% experience some form of 'baby blues'. There is an urgent need to identify and care for these women. Obstetrician-gynecologists (ob-gyns) and women's health care providers are in an optimal position to screen, assess and manage perinatal depression because they see women during pregnancy, labor and delivery and postpartum. Unfortunately, many barriers make perinatal depression screening difficult to carry out in the ob-gyn practice setting. The goal of this toolkit is to alleviate barriers and implement routine perinatal depression screening into practice.

We would like to extend our appreciation to the task force of medical experts who offered their expertise throughout the creation of this toolkit. Their knowledge and dedication was invaluable.

If you have any questions regarding the toolkit or ACOG's initiatives, please contact the ACOG District II office at: info@ny.acog.org or (518) 436-3461.

Sincerely,

Richard N. Waldman, MD, FACOG
Chair, ACOG District II/NY

Renée Samelson, MD, MPH, FACOG
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*As many as
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Learning Objectives:

This toolkit is designed to enable participants to:

- Establish a routine perinatal depression assessment in the practice setting.
- Screen and diagnose patients with baby blues, perinatal depression or other depressive disorders.
- Describe different treatment options and the benefits and limitations of each.

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ACCME Accreditation

The American College of Obstetricians and Gynecologists (ACOG) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. (Continuing medical education credit for *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists* will be available through November 2009)

AMA PRA Category 1 Credits(s)™ or ACOG Cognate Credits(s)

The American College of Obstetricians and Gynecologists (ACOG) designates this education activity for a maximum of 2 AMA PRA Category 1 Credits™ or up to maximum of 2 Category 1 ACOG Cognate Credits. Physicians should only claim credit commensurate with the extent of their participation in the activity.

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In accordance with ACOG policy, all authors, reviewers and contributors have signed a conflict of interest statement in which they have enclosed any significant financial interests or other relationships with industry relative to topics they will discuss in this enduring material. The authors, reviewers, and contributors have made the following disclosure.

Conflict of Interest Disclosure:

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Introduction:

Since 2006, ACOG District II/NY has worked towards increasing awareness of perinatal depression, which affects as many as 20% of pregnant women and mothers. ACOG's goal is to educate ob-gyns and other health care providers about the clinical elements of this debilitating disease. Overcoming current barriers to care will improve the capacity of health care professionals to screen, assess and manage perinatal depression and, ultimately, positively impact the overall mental health of New York's women.

A two-year District II initiative was undertaken to pilot routine perinatal depression screening using the Edinburgh Postpartum Depression Scale (EPDS). This 10-question screening tool has been validated in numerous countries, including the United States, and in several different languages. Within the District II initiative, the following six ob-gyn practices from across New York State utilized the EPDS in routine perinatal care for one year.

- Jacobi Medical Center, Bronx
- Kliot Obstetrics and Gynecology, Brooklyn
- Mohawk Valley Women's Health Associates, Rome
- Northern Dutchess Ob-Gyn, Kingston and Rhinebeck
- Upstate Ob-Gyn Associates, PC, Albany
- Women and Children's Hospital of Buffalo, Buffalo

ACOG District II/NY utilized the lessons learned in this one year pilot to revise this toolkit and develop a grand rounds curriculum. The perinatal depression grand rounds curriculum was delivered at hospitals across New York State during 2008.

The American College of Obstetricians and Gynecologists (ACOG) does not endorse a specific perinatal depression screening tool. For the purposes of this toolkit, the Edinburgh Postnatal Depression Scale was selected due to its high specificity, high predictive value and its validation in numerous countries and languages. During the pilot study, the overwhelming conclusion of participating ob-gyn practices was that the EPDS was useful, efficient and effective.

Ob-gyns and other providers see women regularly during the perinatal period. Therefore, they are in an optimal position to screen, assess and manage perinatal depression. This CME-accredited toolkit offers the background and tools necessary to help providers implement routine perinatal depression screening into their practice setting.

The EPDS is a screening tool and should never override clinical judgment. A careful clinical assessment should be carried out to confirm a diagnosis. The scale will not detect patients with anxiety neuroses, phobias or personality disorders.

It is important to note that the EPDS is only a screening tool and should not override clinical judgment. While the EPDS has its merits, numerous screening tools exist. Providers should select a validated tool that fits best in their practice and use it to screen perinatal patients routinely for depression.

About the Edinburgh Postpartum Depression Scale (EPDS): In 1987, the EPDS was developed at health centers in Scotland by John L. Cox, Jenifer M. Holden, and Ruth Sagovsky to identify depression in postpartum women. Poor validity for postpartum women on existing depression scales, such as the Anxiety and Depression Scale, prompted Cox and colleagues to develop the EPDS, a specialized 10-question screening tool¹.

Cox and colleagues originally validated the EPDS among 84 postpartum women living in Edinburgh and Livingston. It has since been validated in numerous countries, including the United States, and in several different languages.²

The EPDS consists of ten short statements with four possible responses. The patient circles the response that is closest to how she has been feeling in the previous seven days. Most patients complete the scale without difficulty in less than five minutes. The EPDS was originally used in the postpartum period only. Since then, numerous studies have validated its use throughout the perinatal period, including the first trimester. For example, a French study tested the EPDS on 60 high-risk pregnant women living in Paris. The EPDS correctly identified depressed patients in their third trimesters at an 11.5 threshold (Sensitivity 0.80; Specificity 0.08) and was validated among that population³.

Edinburgh Postnatal Depression Scale (EPDS)

Instructions

Remember - The EPDS is a screening tool and should never override clinical judgment. A careful clinical assessment should be carried out to confirm a diagnosis. The scale will not detect patients with anxiety neuroses, phobias or personality disorders.

Administration

1. Ask the patient to circle the response that comes closest to how she has been feeling in the **previous 7 days**.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the patient discussing her answers with others. (Answers come directly from the patient, whether pregnant or postpartum.)
4. The patient should complete the EPDS herself, unless she has limited English proficiency or has difficulty with reading. If the patient has a comprehension problem, the provider must make a decision as to how to best administer the EPDS. Ideally, a trained medical interpreter, not a family member, serves as the translator.

Scoring

Each question is scored with a 0, 1, 2 or 3. The higher a score is, the more likely the woman is experiencing some level of perinatal depression. Cox and colleagues recommend a total score of 12 or greater as an indicator of possible depression⁴. Threshold scores, of 9, 10 and 11.5, have also been suggested when the scale is used routinely⁵. When piloting the EPDS in New York ob-gyn offices, the District II task force used a threshold of 10 in an effort to identify many potential cases. Your practice may set its own threshold score; however, setting it lower allows your practice to capture more women with possible depression.

Question 10 on the EPDS tool addresses suicidal ideation. If a patient scores higher than zero (0) specifically on question 10, immediate action is needed. An immediate emergency referral to a mental health professional may be the most appropriate next step if a patient has suicidal ideation.

The EPDS serves to guide best practices. However, **the most essential best practices are recognizing the need to evaluate each patient individually and always utilizing sound clinical judgment**. The EPDS is only a screening tool and should never override clinical judgment.

Edinburgh Postnatal Depression Scale

Instructions

Please circle the response that comes closest to how you have been feeling IN THE PAST 7 DAYS. Please answer all questions.

Here is an EXAMPLE already completed.

I have felt happy:

0 Yes, all the time

1 Yes, most of the time

2 No, not very often

3 No, not at all

This would mean: "I have felt happy most of the time" during the past week.

Please complete the other questions in the same way.

Please answer all questions below:

(Circle one answer in each question)

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, quite a lot
2 Yes, sometimes
1 No, not much
0 No, not at all
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, quite often
2 Sometimes
1 Hardly ever
0 Never

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For Office Use Only	Screen Administration	Screened During	Score
Patient # _____	Self Administered: _____	Week/Date: _____	Total: _____
Administered/Reviewed by _____	Assisted: _____	Week/Date: _____	#10 Score: _____
		Week/Date: _____	

Source: Cox, J.L. Holden J.M. and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

Source: K.L Wisner, B.L Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199.

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Counseling Your Patients on Perinatal Depression

Clinical judgment is most important when counseling patients. Conversations with your patients about sensitive topics, such as perinatal depression, can be difficult and awkward. The following scripts about introducing the EPDS, counseling patients about perinatal depression and prescribing treatment options have been successfully used by other depression screening programs.

Introducing the EPDS to Your Patients

Patients may wonder why they are being asked to complete the EPDS. Pregnancy is supposed to be a joyous occasion. Some patients may feel that they are, or are going to be bad mothers, if they are depressed. It is important for apprehensive patients to understand what perinatal depression is, to know that many women experience similar feelings and to realize that untreated perinatal depression may have adverse effects on women's health and their children.

The following suggested scripts have been used to reduce potential patient apprehension regarding the EPDS.

Prenatal Visit:

- *I'd like to check in with you to hear about how you are feeling since you've become pregnant. Please take a few minutes to fill out this short survey.*
- *Since you are now in the third trimester of your pregnancy and getting closer to your delivery, I'd like to check in with you and hear about how you are feeling lately. Please take a few minutes to fill out this short survey.⁶*

Postpartum Visit:

- *Now that you have had your baby, I would like to know how you are feeling and how you have been coping lately. Please take a few minutes to fill out this short survey.⁷*

Counseling Scripts Based on a Total EPDS Score above Threshold

(See EPDS Instructions on Page 6 about setting a threshold)

Transition from EPDS Score to Counseling:

From the survey you just filled out, it appears as though you are feeling down or depressed. I'd like to ask you a little more about your history and how you're doing now.

Addressing Past History

- *Your answers suggest that your mood is down. Can you tell me how you have been feeling? How long have you been feeling this way?*
- *Have you ever felt like this before? For more than a few days?*
- *Have you felt these symptoms with previous pregnancies? Did these symptoms last longer than two weeks?*
- *Have you ever had treatment for depression or other emotional illness?*
- *Have you ever intentionally hurt yourself?*
- *Have you ever seen a counselor or social worker or other mental health professional at any time, even for one or two visits?*

Current Emotional State

Let's talk a little more about what your life is like now...

- *How do you feel about your pregnancy/motherhood?*
- *What concerns do you have about your pregnancy/motherhood?*
- *How is your relationship with the father of the baby? (Is your partner supportive?)*
- *Who are the friends or family who help you during this time?*
- *How is your living situation?⁸*

Transition from Counseling to Diagnosis Script:

It is common for women during and after pregnancy to feel down or depressed. It is very important to address these feelings to ensure your health and your baby's health...

Baby Blues (feelings of sadness, fear, anger or anxiety that typically occur within 48 hours after birth and usually fade within 1-2 weeks):

Baby Blues Script 1 (No Treatment Needed):

...Some call these feelings the baby blues. Women may have feelings of sadness, fear, anger or anxiety that usually fade within 1-2 weeks. I'd like to give you some brochures and information about local resources. I can have the office call you in about one week to see how you are doing and you are welcome to call the office if you have questions or if your mood or anxiety becomes worse.

Baby Blues Script 2 (Treatment Needed):

...Some call these feelings the baby blues. Women may have feelings of sadness, fear, anger or anxiety that usually fade within 1-2 weeks. I would like to discuss different treatment options with you. (See Page 11- Counseling Scripts for Treatment Options).

Perinatal Depression (intense feelings of sadness, anxiety or despair before or after childbirth that interfere with the patient's ability to function and do not go away after a few weeks):

Perinatal Depression Script:

...Some call these feelings postpartum or perinatal depression. Women may have intense feelings of sadness, anxiety or despair before or after childbirth that interfere with her ability to function. If these feelings are not going away, treatment is needed. Options for treatment include medication, talk therapy or counseling, or both, depending upon the severity. Increasing healthy life behaviors is also

helpful, like getting enough sleep, eating healthier foods, time for walking, and so on. I would like to discuss these treatment options with you. (See below - Counseling Scripts for Treatment Options).

Counseling Scripts for Treatment Options

Transition from Counseling/Diagnosis to Discussing Treatment Options:

From talking with you, I think you would benefit from treatment for anxiety or depression. The two most common forms of treatment are talk therapy or counseling (psychotherapy) and medication. Let's talk about the benefits, risks, and alternatives of the various treatment options.

Transition from Counseling/Diagnosis to Referring:

I would like you to speak with someone more about your feelings. This referral will help you take care of your health and your baby's health.

If patient is reluctant to take referral for counseling:

Many women experience some anxiety or depression during or right after pregnancy. This referral does not mean that you are or will be a bad mother. However, not getting treatment could have adverse effects on your health and your child. I am concerned for your health and want you to speak with someone.

Transition from Counseling/Diagnosis to Prescribing Medications*:

I want to discuss medications that could improve your mood. Have you taken medication in the past for anxiety or depression?

IF YES-

- *Was the medication effective?*
- *From the conversation we just had, I'm going to prescribe _____ for you. Let's discuss this medication's side effects, especially how it may impact your pregnancy and ability to breastfeed...*
- *Please remember that the medication you will be taking works gradually and may not take effect for several weeks.*

IF NO-

- *There are many choices for medications. The medication I am going to prescribe, _____, should effectively treat your depression. Most babies of mothers who required antidepressant medication during pregnancy and/or post partum experience no ill effects. I'd be happy to talk about rare effects some medications could have on your baby. However, it is important to remember that not treating maternal depression has a harmful effect on pregnancy and development of the baby. Mothers who require medication to treat depression can often safely and successfully breastfeed*.*
- *Please remember that the medication you will be taking works gradually and may not take effect for several weeks.*

If patient is reluctant to take medication:

I am concerned for your health. Many women experience some anxiety or depression during or right after pregnancy. Medication can help you cope and lessen the harmful effects of depression on you and your baby.

*See Provider Medication Information Chart on pages 14 & 15.

Leaving your feelings untreated could have adverse effects on your health and your child. I can refer you to a mental health professional for treatment options. However, I want to make sure you do address your feelings.

Transition from Providing Treatment to Patient Follow-Up:

I'd like to give you some brochures and information about local resources. I can have the office call you in a few weeks to see how you are feeling. In the meantime, you are welcome to call the office if you have questions or if your mood or anxiety becomes worse.

Counseling Scripts Based on an EPDS Score of 1 or More on Question 10

Question 10 assesses patient thoughts of harming themselves. Treatment decisions should only be made after a discussion with your patient.

Immediate emergency referral to a mental health professional may be the most appropriate next step if the patient has suicidal ideation.

This referral may require the assistance of the partner, a family member or friend to accompany the patient to the emergency room or mental health professional's office where a complete suicide risk assessment and treatment can be accomplished, generally within 24 hours. Alternatively, you may need to call the community mobile crises unit to come get the patient.

Transition from EPDS Score to Counseling:

From the survey you filled out, you responded that you've had thoughts of harming yourself on question 10.

Immediate emergency referral to a mental health professional may be the most appropriate next step if the patient has suicidal ideation.

- Do you currently feel as if you do not want to live?*
- Have you made a plan?*
- Can you tell me what it is?*
- Do you have the means (pills, a weapon, a car, etc.) to carry out that plan?*
- Have you tried to hurt yourself in the past?*

**** If an emergency referral is needed, please take immediate action. ****

Please continue to Page 11 for *Counseling Scripts for Treatment Options* if patient needs some form of treatment other than or in addition to an emergency referral.

Emergency Telephone Numbers:

Suggestions for Managing Perinatal Depression

In order to determine the best treatment for a depressed woman, she and her doctor must evaluate the benefits, risks, and alternatives of treatment options. This evaluation must include both the effects of specific treatments on the woman and fetus or baby. The two most common forms of treatment for perinatal depression are psychotherapy and/or medication. These methods are not always equally effective. The choice of treatment depends on the seriousness of the depression, the individual woman's needs and preferences and availability of services.

Psychotherapy (counseling or talk therapy):

Different types of psychotherapy, also called counseling or talk therapy, have been successfully used to treat depression. Psychotherapy focuses on changing faulty behaviors, thoughts, perceptions, and emotions that may be associated with specific disorders. Talk therapy can be utilized either by itself or in conjunction with medications. Psychotherapy should be provided by a qualified mental health professional. Providers should have knowledge about their local mental health resources and their accessibility to ensure appropriate patient referrals.

Medication:

Appropriate pharmacologic treatment is available for most pregnant and breastfeeding women. The benefits, risks, and alternatives of the medications need to be discussed with the patient. If your patient is pregnant, plans to breastfeed or is breastfeeding, a qualified provider who is knowledgeable about antidepressant medications should be consulted prior to prescribing medications. Maternal-fetal medicine specialists can assist in providing consultation by weighing the risks, benefits, and alternatives of medication. It is ideal to speak with the patient's mental health provider or primary care physician if possible. Provider hotlines, such as the University of Illinois at Chicago (UIC) Perinatal Depression Project (1-800-573-6121), can also be a valuable resource. The UIC Perinatal Depression Project has also developed medication lists to aid physicians.

Supplemental Options:

Support groups may help a depressed woman talk with others who share similar feelings. Encouraging lifestyle interventions may also be helpful for a depressed woman. Such interventions include:

- Rest
- Exercise
- Change in diet
- Assistance with childcare

Remember, women with perinatal depression deserve treatment. Women who have poorly managed perinatal depression may suffer disturbed relationships with their infant and other family members.

Provider Medication

Information for Physicians on Prescription Products

Treatment decisions should be based on patient characteristics and clinical judgment.

For questions or to check for updates, call the UIC Perinatal Mental Health Project at 1-800-573-6121.

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Anti-depressants	Advantages During Pregnancy	Disadvantages During Pregnancy
Bupropion (Wellbutrin [®])	<ul style="list-style-type: none"> •No sexual side effects •No excess weight gain •Helps with smoking cessation 	<ul style="list-style-type: none"> •Limited data available •No behavioral studies in human pregnancy •Lowers seizure threshold •Can cause insomnia •May increase risk of miscarriage
Citalopram (Celexa [®])	<ul style="list-style-type: none"> •Few interactions with other medications 	<ul style="list-style-type: none"> •Limited data available •No behavioral studies in human pregnancy
Desipramine (Norpramin [®])	<ul style="list-style-type: none"> •More studies in human pregnancy, including neurodevelopmental follow-up 	<ul style="list-style-type: none"> •Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) •Orthostatic hypotension, risking decreased placental perfusion •Fetal and neonatal side effects: tachycardia, urinary retention
Duloxetine (Cymbalta [®])	<ul style="list-style-type: none"> •Also treats diabetic peripheral neuropathic pain •Balanced antidepressant; may be effective when selective agents are not 	<ul style="list-style-type: none"> •No systematic studies in human pregnancy
Escitalopram (Lexapro [®])	<ul style="list-style-type: none"> •Few interactions with other medications 	<ul style="list-style-type: none"> •No systematic studies in human pregnancy
Fluoxetine (Prozac [®])	<ul style="list-style-type: none"> •More studies in human pregnancy, including meta-analysis and neurodevelopmental follow-up 	<ul style="list-style-type: none"> •More reports of neonatal side effects than some other antidepressants
Mirtazapine (Remeron [®])	<ul style="list-style-type: none"> •No sexual side effects •Helps restore appetite in women who are not gaining weight •Less likely to exacerbate nausea and vomiting 	<ul style="list-style-type: none"> •Limited data available •No behavioral studies in human pregnancy •Can cause excessive weight gain •Tends to be sedating •May increase risk of preterm birth
Nortriptyline (Pamelor [®])	<ul style="list-style-type: none"> •More studies in human pregnancy, including neurodevelopmental follow-up •Balanced antidepressant; may be effective when selective agents are not 	<ul style="list-style-type: none"> •Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) •Orthostatic hypotension, risking decreased placental perfusion •Fetal and neonatal side effects: tachycardia, urinary retention
Paroxetine (Paxil [®])	<ul style="list-style-type: none"> •None 	<ul style="list-style-type: none"> •No behavioral studies in human pregnancy •Specific association with cardiovascular malformations •More reports of neonatal side effects than most other antidepressants
Sertraline (Zoloft [®])	<ul style="list-style-type: none"> •Relatively well-studied in human pregnancy •Fewer reports of neonatal side effects than other antidepressants 	<ul style="list-style-type: none"> •Possible specific association with omphalocele and septal defects*
Venlafaxine (Effexor [®])	<ul style="list-style-type: none"> •Balanced antidepressant; may be effective when selective agents are not 	<ul style="list-style-type: none"> •Limited data available •No behavioral studies in human pregnancy

* Absolute risk is small

** These are weight-adjusted estimates that include the agent and its active metabolites.

*** These are based on case reports; this does not mean that it is confirmed to be due to the medication.

Physicians may consider initiating treatment with these agents at half of the lowest recommended therapeutic dose. Treatment decisions should be based on patient characteristics and clinical judgment. Recommended dosages can be found in the Physician's Desk Reference, 60th ed. Table based on Wisner et al Postpartum Depression Article in N Eng J Med, Vol. 347, No. 3, July 18, 2002, pg. 196 and related articles. For other references, call the UIC Perinatal Mental Health Project at 1-800-573-6121.

General notes:

- Risks of antidepressants during pregnancy and lactation must be weighed against risks of untreated symptoms and treatment needs to be individualized.
- All antidepressants, if abruptly discontinued during pregnancy or at the time of birth, can lead to discontinuation side effects in the fetus or neonate. These signs can include respiratory distress, excessive crying, changes in sleep and behavioral state, difficulty feeding, increased or decreased tone, hyperreflexia, seizures or cardiac arrhythmias. Discontinuation side effects can be minimized by a partial dose taper during the last month of pregnancy, if the patient is asymptomatic, with a return to full dose after delivery to prevent postpartum recurrence.

Information Chart

to Treat Perinatal Depression - September 2007

patient characteristics and clinical judgment.

1-800-573-6121 or visit <http://www.psych.uic.edu/research/perinatalmentalhealth/>

Estimated % of Maternal Dose to Breastfeeding Baby**	Reported Side Effects to Breastfeeding Babies***	Teratogenicity
2%	Seizures	Morphologic - none found Behavioral - unknown
0.7% -9.0%	Uneasy sleep, drowsiness, irritability, weight loss	Morphologic - none found Behavioral - unknown
1.0%	None	None found
Unknown	Unknown	Unknown
3.9% - 7.9%	Enterocolitis	Unknown
1.2% - 12.0%	Excessive crying, irritability, vomiting, watery stools, difficulty sleeping, tremor, somnolence, hypotonia, decreased weight gain, hyperglycemia	None found
0.6% - 2.8%	None	Morphologic - none found Behavioral - unknown
1.3%	None	None found
0.1% -4.3%	Irritability, sleepiness, constipation, SIADH	Morphologic - Possible increased risk of cardiovascular malformations Behavioral - unknown
0.4% -2.3%	Benign sleep myoclonus, agitation	Morphologic - possible increased risk of omphalocele and septal defects Behavioral - none found
5.2% -7.6%	Decreased weight gain	Morphologic - none found Behavioral - unknown

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All SSRI antidepressants (citalopram, escitalopram, fluoxetine, paroxetine, sertraline) may be associated with the following risks: possible increased risk of miscarriage, gestational age decreased by an average of 1 week, possible increased risk of persistent pulmonary hypertension in the newborn with exposure after 20 weeks gestation, although no teratogenicity has been found in prospective, controlled studies or meta-analyses, one case-control study found a possible increased risk of anencephaly, craniosynostosis and omphalocele, and a retrospective prescription events monitoring study found an increased risk of anomalies in general; absolute risks were small.

• Medications vary in the amount and quality of data available about effects in human pregnancy. A better-studied medication may have more reported side effects than a less-studied medication because

more is known about it, not necessarily because it is riskier.

- Data presented here are based on studies during human pregnancy. The Food and Drug Administration's Pregnancy Risk Categories, as found in the Physician's Desk Reference, are based on a combination of animal and human studies.

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A Follow-Up Plan Should Be Developed:

It is important to follow-up with patients regardless of what treatment options are chosen in order to ensure on-going care for each patient. Depending upon the severity of the patient's depression, the following options or combination of options could be utilized:

- A follow-up telephone call shortly after the initial EPDS that scored over the set threshold or 1 or more on question 10.
- An initial follow-up appointment within a few weeks of the EPDS that scored over the set threshold or 1 or more on question 10.
- Follow-up appointments or telephone calls every few weeks until the patient is stable or improving.
- Regular follow-up appointments or telephone calls until the first postpartum year is completed.

During the follow-up appointments or telephone calls, the EPDS may be used to re-screen your patient. It is appropriate to ask your patient about her progress, especially if she is taking medication or participating in psychotherapy. These follow-up appointments will help providers evaluate their patients' progress and adjust their care plan if needed. If possible, conversation with the patient's mental health professional may also be helpful.

References

- ¹ Cox, J.L., Holden, J.M. and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.
- ² Garcia-Esteve, L., Ascaso, C., Ojuel, J. And Navarro, P. 2003. Validation of the Edinburgh Postnatal Depression Scale (EPDS) in Spanish Mothers. *Journal of Affective Disorders* 75: 71-76.
- ³ Adouard, F., Glangeaud-Freudenthal, N.M.C., and Glose, B. 2005. Validation of the Edinburgh postnatal depression scale (EPDS) in a sample of women with high-risk pregnancies in France. *Archive of Women's Mental Health* 8: 89-95.
- ⁴ Cox, J.L., Holden, J.M. and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.
- ⁵ Adouard, F., Glangeaud-Freudenthal, N.M.C., and Glose, B. 2005. Validation of the Edinburgh postnatal depression scale (EPDS) in a sample of women with high-risk pregnancies in France. *Archive of Women's Mental Health* 8: 89-95.
- ⁶ "Behavioral Risk Factor (BRF) Screen and A.L.E.R.T. Brief Intervention," Medical and Health Research Association of New York City, Inc.
- ⁷ Ibid.
- ⁸ Ibid.

Developing an Office Protocol

Starting a new protocol in your practice can be challenging. It takes time to train staff and divide tasks. Please use this check list to develop an EPDS implementation strategy that best fits your practice.

Task	Staff Member Responsible for Task
<p>Chart Preparation:</p> <p>Select a paper color for the EPDS tool and use that paper color consistently.</p> <p>Individual patients may be screened more than once using the EPDS, so you may want to include multiple copies of the scale along with the instructions in each patient's medical chart.</p> <p>If your practice uses Electronic Medical Records (EMR), please include an electronic copy (or multiple copies) of the EPDS tool and a set of instructions in each patient's EMR.</p>	
<p>Every time an EPDS is administered and collected from a patient, add up the score and place the finalized document in the patient's medical chart.</p>	
<p>Review scored EPDS with patients as deemed necessary. Counsel, refer and write prescriptions as needed.</p>	
<p>Document all conversations with individual patients in their medical charts.</p>	
<p>Flag specific patients and follow-up with them as needed.</p>	

Mental Health Professional Referral List

Please list all mental health professionals whom your practice/institution refers patients to for perinatal depression and assistance with emergency referrals. Keep this completed list in a central location at your practice/institution and use as needed.

Name	Organization	Address	Telephone	Fax	Email	Comments



Referral Form for Perinatal Depression

Instructions: Please complete the top portion of this form and fax it to a mental health professional. The bottom portion of this form should be completed by the referred mental health professional and a copy sent back to the referring ob-gyn office.

Referral to: _____
Address: _____
Phone: _____
Fax: _____

Referral from: _____
Address: _____
Phone: _____
Fax: _____

Patient: _____
DOB: _____
Address: _____
Telephone: Home: _____
Work: _____
Cell: _____

Contact Person (if not patient):
Name: _____
Relationship with Patient: _____
Telephone: Home _____
Work: _____
Cell: _____

Insurance Carrier: _____
Policy ID#: _____
Plan Authorization#: _____

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- Reasons for Referral:** _____
____ EPDS Score: _____
____ Answer on EPDS Question 10: _____
____ Prior history of Perinatal Depression
____ Prior history of Depression

Additional Comments: _____

Due date or date of delivery _____

Date of Referral

- Relevant Psychosocial Risk Factors:**
- ____ Barriers to Care
 - ____ Unstable Housing
 - ____ Unintended Pregnancy
 - ____ Communication Barriers
 - ____ Poor Nutrition
 - ____ Tobacco Use
 - ____ Substance Use
 - ____ Depression
 - ____ Lack of Safety
 - ____ Intimate Partner Violence
 - ____ Stress
 - ____ Pregnancy or delivery complication
- Other: _____

Signature of Referring Ob-Gyn



To Referring Ob-Gyn: The above patient has been scheduled for perinatal depression counseling.
This appointment is scheduled with the following mental health professional:
_____ on _____ at _____ AM/PM
Location: _____



Coding for Perinatal Depression

Screening for depression:

If a physician is providing the global obstetrical service (and reporting a global code), the payer may consider this part of the global service and not reimburse additionally for the service. This is particularly true if the physician screens every patient for depression (even patients without signs or symptoms). However, some payers may reimburse for this service. Physicians should check with their specific payers.

Treatment for patients with signs and symptoms:

If the patient has signs or symptoms of depression (with an appropriate diagnosis code), then the service should be reimbursed.

Diagnosis coding - Mental disorders codes are found in the 290- 319 section of ICD-9-CM. Note that many payers will only reimburse a psychiatrist or psychologist for services linked to a diagnosis in the mental disorders chapter. Possible diagnosis codes are:

293 Transient mental disorders due to conditions classified elsewhere
296 Episodic mood disorders
300.4 Anxiety depression
311 Depression

Symptoms codes are found in the section 780-799. Possible diagnosis codes are:

780.5 Sleep disorders
780.79 Malaise, lack of energy
799.2 Nervousness

Procedure coding - The correct Evaluation and Management (E/M) code will depend on whether the encounter was for screening or treatment of depression.

If the encounter was for screening for a patient without symptoms, report a preventive medicine code. These codes are selected according to the time spent in face to face counseling with the patient. Whether or not these codes will be reimbursed by the payer will vary. Possible procedure codes are:

99401-99404 Preventive medicine, individual counseling
99411-99412 Preventive medicine, group counseling

If the encounter was for treatment for a patient with a diagnosis of depression or documented symptoms of depression, report an outpatient E/M code. These codes list a “typical time” in their code descriptions. This time spent face to face counseling the patient must be documented in the medical record. The record must document that either all of the encounter or more than 50% of the encounter was spent counseling the patient. Possible procedure codes are:

99201-99205 New patient, office or other outpatient services
99211-99215 Established patient, office or other outpatient services

Please email any coding questions to ACOG’s Coding Department: coding@acog.org

Compiled in August 2008

Perinatal Depression Resources

For Providers:

Perinatal Depression Project

University of Illinois at Chicago
(Provides a Perinatal Consultation Service for Health Care Providers)
1-800-573-6121
www.psych.uic.edu/research/perinatalmentalhealth

Perinatal Depression- Awareness in Action, Making a Difference
(Provides the EPDS in 11 different languages)
www.perinataldepression.org

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Provider References:

Adouard, F., Glangeud-Fredenthal, N.M.C., and Golse, B. 2005. Validation of the Edinburgh Postnatal Depression Scale (EPDS) in a sample of women with high-risk pregnancies in France. *Archives of Women's Mental Health* 8:89-95.

Cox, J.L., Holden, J.M. and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

Garcia-Esteve, L., Ascaso, C., Ojuel, J., and Navarro, P. 2003. Validation of the Edinburgh Postnatal Depression Scale (EPDS) in Spanish mothers. *Journal of Affective Disorders* 75: 71-76.

Gordon TEJ, Cardone IA, Kim JJ, Gordon SM, Silver RK. Universal Perinatal Depression Screening in an Academic Setting. *American College of Obstetricians and Gynecologists. Obstet Gynecol* 2006;107:342-347.

Psychosocial Risk Factors: Perinatal Screening and Intervention. ACOG Committee Opinion No. 343. *American College of Obstetricians and Gynecologists. Obstet Gynecol* 2006;108:469-77.

Use of Psychiatric Medications During Pregnancy and Lactation. ACOG Practice Bulletin No. 92. *American College of Obstetricians and Gynecologists. Obstet Gynecol* 2008;111:1001-20.

Understanding Maternal Depression: A Fact Sheet for Care Providers.
www.health.state.ny.us/community/pregnancy/health_care/perinatal/maternal_factsheet.htm

For Providers and Patients:

American College of Obstetricians and Gynecologists
www.acog.org
1-800-673-8444

American Psychological Association
www.apa.org
1-800-374-2721

County Mental Health Offices
www.clmhd.org/about/countydirectory.aspx

Growing-Up Healthy Hotline
(to locate a local mental health professional)
www.health.state.ny.us/nysdoh/perinatal/en/guh.htm
1-800-522-5006

Mental Health Association of New York State, Inc.
www.mhanys.org
518-434-0439

National Institute of Mental Health
www.nimh.nih.gov
866-615-6464

New York State Department of Health
www.health.state.ny.us

Postpartum Education for Parents
www.sbpep.org
805-564-3888

Postpartum Resource Center of New York, Inc.
www.postpartumny.org
631-422-2255

Postpartum Support International
www.postpartum.net
805-967-7636

The National Women's Health Information Center
www.4woman.gov
800-994-9662

The Postpartum Stress Center
www.postpartumstress.com
610-525-7527

For Patients:

Hopeline
1-800-SUICIDE (784-2433)

Mental Health Association of New York City
1-800-Lifenet

CME Accreditation

Test Your Skills- And Earn CME Credits

Complete the answer sheet and program evaluation on pages 27 and 28 of this toolkit and return both to ACOG, District II/NY to receive Continuing Medical Education credits.

The answers appear at the end of this test. **Directions: Select the 1 best answer.**

1. A patient who scores high on the EPDS is less likely to be experiencing some level of perinatal depression.
 - a. True
 - b. False

2. What is the EPDS?
 - a. A 20-question depression screening tool used in the postpartum period only
 - b. A 10-question tool that screens for perinatal depression and is only available in English
 - c. A 10-question tool that screens for perinatal depression
 - d. A 10-question depression screening tool used in the third trimester only

3. If a patient scores higher than zero on question 10 of the EPDS, immediate action is required.
 - a. True
 - b. False

4. What is Perinatal Depression?
 - a. When a mother feels sad, afraid, angry, or anxious within 48 hours after birth and typically fades within 1-2 weeks
 - b. When a woman has intense feelings of sadness, anxiety or despair before or after childbirth that interfere with her ability to function and does not go away after a few weeks
 - c. A psychological disorder that only affects first-time mothers
 - d. B and C only

5. When managing perinatal depression, psychotherapy and medication are:
 - a. The most common forms of treatment and are not always equally effective
 - b. The most common forms of treatment, and should be used over other treatment options
 - c. Never safe to prescribe to a patient who is pregnant, and may cause additional stress and danger to the fetus
 - d. None of the above

6. What are the Baby Blues?
- a. When a mother feels sad, afraid, angry, or anxious within 48 hours after birth and fades within 1-2 weeks
 - b. When a mother has intense feelings of sadness, anxiety or despair before or after childbirth that interfere with their ability to function and does not go away after a few weeks
 - c. Newborns with cyanotic conditions
 - d. None of the above

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7. Some women with perinatal depression may benefit from participating in support groups and/or lifestyle interventions. Such interventions can include:
- a. Exercise
 - b. Sleep Deprivation
 - c. Assistance with childcare
 - d. A and C only

8. When completing the EPDS, you should ask the patient to circle the response that comes closest to how she has been feeling in the previous 30 days.
- a. True
 - b. False

9. Ultimately, the EPDS is only a screening tool and should not override clinical judgment.
- a. True
 - b. False



Perinatal Depression Screening: Tools for Obstetrician-Gynecologists

Test Your Clinical Skills- and Earn CME Credits

Answer Sheet

ACCME Accreditation

The American College of Obstetricians and Gynecologists (ACOG) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. (Continuing medical education credit for *Perinatal Depression Screening: Tools for Obstetrician-Gynecologists* will be available through November 2009.)

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AMA PRA Category 1 Credits(s)™ or ACOG Cognate Credits(s)

The American College of Obstetricians and Gynecologists (ACOG) designates this education activity for a maximum of 2 AMA PRA Category 1 Credits™ or up to maximum of 2 Category 1 ACOG Cognates Credits. Physicians should only claim credit commensurate with the extent of their participation in the activity. To obtain credits, complete and return this answer sheet to the address or fax shown below (Only original answer sheets will be accepted for credit).

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

ACOG ID Number _____

Name _____

Address _____

City _____

State/Zip _____

Phone _____

Return completed evaluation to:

ACOG District II/NY

Attn: Medical Education Department

152 Washington Avenue

Albany, NY 12210

FAX: 518-426-4728

Program Evaluation

Please mark your responses to the following statements in the Evaluation Response Grid below.
Return completed evaluations to the address at the bottom of the page.

1. The program provided me with relevant information on perinatal depression screening, diagnosis and management.
2. The program reinforced the importance of routine screening for perinatal depression in ob-gyn practice.
3. The program covered the basics of different treatment options and the benefits and limitations of each.
4. The program met its educational objectives.
5. The program was free of commercial bias.
6. The quality and organization of the content was good.
7. The program content was evidence-based.
8. The content was applicable to my responsibilities.
9. I would recommend this program to my peers.

Evaluation Response Grid

	Strongly Agree	Agree	Disagree	Strongly Disagree
Q.1	1	2	3	4
Q.2	1	2	3	4
Q.3	1	2	3	4
Q.4	1	2	3	4
Q.5	1	2	3	4
Q.6	1	2	3	4
Q.7	1	2	3	4
Q.8	1	2	3	4
Q.9	1	2	3	4

Return completed evaluation to:

ACOG District II/NY
Attn: Medical Education Department
152 Washington Avenue
Albany, NY 12210
FAX: 518-426-4728



Perinatal Depression Screening: Tools for Obstetrician-Gynecologists

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