Screening and Addressing Postpartum Depression (PPD) in your practice

It takes a team

Helping women with PPD requires a team approach.

- Receptionists – help with screening
- Nursing staff – help with assessment and follow up
- Physicians/clinicians – help with diagnosis, therapy and follow up
Must have it all

- Find the women
  - Make the diagnosis
- Provide them options
  - Medications, counseling or both
- Support these options
  - Follow up visits and calls
- Prevent suicide
  - Identify warning signs

Why worry about PPD?

- PPD is common
  - 13% of all postpartum women
- PPD symptoms don’t just last a few days
  - 1/2 of women are symptomatic at 6 months
  - 1/3 of women continue to be symptomatic at 12 months
- Preliminary work suggests it is under-recognized and under-treated.

Perinatal Depression: AHRQ Evidence Report. Feb 2005
Impact of PPD

Potential impacts on:
- Baby
  - Delayed cognitive and psychological development
  - Fussier, vocalize less
  - Delayed motor skills
  - Increased health care resource use
- Marriage and Partnerships
  - Doubles risk of dissolution
- Depressive symptoms
  - Women clearly remember even 3 years later

How are we doing?
- Recognizing and diagnosing depression
  - Only 30% to 50% of cases are recognized during routine care
- Maintaining treatment
  - 50% of women drop treatment in 4 weeks or less
- Treating like a chronic disease
  - Planned care—follow up visits and calls
  - Written action plan
  - Education
  - Family involvement
Why aren’t we doing better?

- Don’t the women or partners recognize the depression?
  - Maybe, but
    - Think it is normal—prolonged baby blues
    - Afraid to comment
- Want to make correct diagnosis
  - Breastfeeding
  - Self image
  - Chronic management
  - Risk for PPD in future pregnancies

PPD identification and management

- Screen
  - A good start
- Diagnose
  - Must use another tool to make a diagnosis
  - Further assess suicidal ideation if present
- Treat
  - Emergency support for suicidal concerns
  - Medication
  - Counseling
- Follow up
  - Biggest problem is loss to follow up
  - Provide tools to make it easier
    - Nurse tools
    - Physician tools
Screening tool

- **EPDS (Edinburgh Postnatal Depression Scale)**
  - Specifically for PPD
  - It is sensitive but not specific
    - That means that it identifies almost all of the women who might be depressed but identifies some who are not depressed (false positives)
  - Scored by nurse or physician/reviewed by physician
  - Determines next steps in depression assessment:
    1. Risk of suicide
    2. PHQ-9
    3. Usual care

### Woman’s Feelings

**Instructions:**
Please read each sentence below. For each sentence, circle the number that best reflects your feelings. Then, write your total score at the end of the page.

1. **How much of the time did you feel loved?**
2. **How much of the time did you feel wanted?**
3. **How much of the time did you feel cared for?**
4. **How much of the time did you feel close to others?**
5. **How much of the time did you feel you belonged?**
6. **How much of the time did you feel safe?**
7. **How much of the time did you feel happy?**
8. **How much of the time did you feel worthwhile?**
9. **How much of the time did you feel loved?**
10. **How much of the time did you feel you belonged?**
11. **How much of the time did you feel close to others?**
12. **How much of the time did you feel you were needed?**

**Total Score:**
Results

Interpreting the scores

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 or less</td>
<td>low depression concerns</td>
</tr>
<tr>
<td>10 to 12</td>
<td>modest concern</td>
</tr>
<tr>
<td>13 to 18</td>
<td>moderate concern</td>
</tr>
<tr>
<td>19 and above</td>
<td>likely to have depression and worry about suicide risk</td>
</tr>
</tbody>
</table>

Diagnosis - PHQ-9 can help

- PHQ-9
  - Validated to show scores that are consistent with major depression and increased risk for suicide
  - Has unique functional status question
  - Based on the DSM-IV criteria for depression
    - Sad or depressed most of the day everyday
    - Diminished interest and pleasure
Diagnosis - continued

- PHQ-9: Must have 1 of 2 major symptoms circled:
  - Feeling down, depressed, or hopeless
  - Little interest or pleasure in doing things

- Plus enough minor to score >9:
  - Weight change
  - Insomnia or hypersomnia
  - Psychomotor retardation or agitation
  - Fatigue or loss of energy everyday
  - Feelings of worthlessness or guilt
  - Diminished ability to think or concentrate
  - Recurrent thoughts of death or suicide

**PHQ - 9 Symptom Checklist**

1. Over the last two weeks have you been bothered by the following problems?
   - Little interest or pleasure in doing things
   - Feeling down, depressed, or hopeless
   - Trouble falling or staying asleep, or sleeping too much
   - Feeling tired or having little energy
   - Poor appetite or overeating
   - Feeling bad about yourself, or that you are a failure . . .
   - Trouble concentrating on things, such as reading . . .
   - Moving or speaking so slowly . . .
   - Thoughts that you would be better off dead . . .

2. ... how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
   - Not difficult at all
   - Somewhat difficult
   - Very difficult
   - Extremely difficult

Subtotals: TOTAL:
Interpreting the Score: Severity Tool

- <5 normal
- 5-9 mild or minimal depression symptoms
- 10-14 moderate symptoms
- 15-19 moderately severe symptoms
- ≥ 20 severe symptoms

Diagnostic Interview

- R/O other potential causes
- Points of discussion/negotiation
  - Does the woman agree with symptoms?
  - How does she feel about “depression”?
  - What ideas does she have about treatment?
  - Does she accept the concept of chronic condition?
  - How does she feel about long term follow-up?

www.depression-primarycare.org
Treatment

- Self help
- Family support
- Medications—antidepressants
  - Consider desire to breastfeed
  - Use full range of doses—start low and increase
  - Side effects—consider timing and other changes
  - For other than mild
- Counseling
  - CBT
  - Supportive counseling
- Hospitalization for suicidal risk, severe depression or psychosis

Choosing an antidepressant

- Consider response to previous treatment
- Consider breast-feeding status
  - Paroxetine
  - Sertraline
- Use one you are comfortable with
- Begin low and increase
- Use the full range of doses if no side effects
- Give the medication time to work
- Follow with PHQ-9 for improvement
Antidepressant choice in nursing mothers

• Risk-benefit analysis *
  • Mother’s medical history
  • Mother’s response to treatment
  • Risks of untreated depression
  • Benefits of breastfeeding
  • Known/unknown risks of the medication to infant
  • Mother’s choice

* ABM Clinical Protocol #18: BREASTFEEDING MEDICINE volume 3, Number 1, 2008 p 44-52.

Antidepressant choice in nursing mothers –continued

• If no history of antidepressant use, paroxetine or sertraline having lower breastmilk and infant serum levels and few side effects are appropriate first choice. *

• For medication use during lactation: TOXNET lactmed at http://toxnet.nlm.nih.gov

* ABM Clinical Protocol #18: BREASTFEEDING MEDICINE volume 3, Number 1, 2008 p 44-52.
### Table for anti-depressants:

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Class</th>
<th>Dose</th>
<th>Monitoring</th>
<th>Major side effects</th>
<th>Major role effects in breastfeeding</th>
<th>Use during breastfeeding</th>
<th>FDA Pregnancy Grade</th>
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<tr>
<td>Downs</td>
<td>Fluoxetine</td>
<td>SSRIs</td>
<td>20 mg 1-3 times daily</td>
<td>Monitor for side effects</td>
<td>Nausea, insomnia</td>
<td>Can cause breast engorgement</td>
<td>Only if potential small outweighs the risk</td>
<td>C</td>
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<tr>
<td>DOWN</td>
<td>Sertraline</td>
<td>SSRIs</td>
<td>50 mg 1-3 times daily</td>
<td>Monitor for side effects</td>
<td>Nausea, insomnia</td>
<td>Possible increase in prolactin, breast engorgement</td>
<td>Only if potential small outweighs the risk</td>
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<td>PREV</td>
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<td>25 mg 1-3 times daily</td>
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<td>Only if potential small outweighs the risk</td>
<td>C</td>
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<td>SSRIs</td>
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<td>Monitor for side effects</td>
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<td>ZOLADIX</td>
<td>Difluoxetine</td>
<td>SSRIs</td>
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<td>Monitor for side effects</td>
<td>Nausea, insomnia</td>
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<td>APOCIN</td>
<td>Fluoxetine</td>
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<td>Monitor for side effects</td>
<td>Nausea, insomnia</td>
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### Beginning the antidepressant

- Lower dose for first 3 to 5 days then increase
- Monitor for side effects
- Nurse phone call and follow-up visits
- Critical stage
  - Time women often stop therapy
Postpartum psychosis

- Rare (0.1 to 0.2% of all pregnancies)
- Typical psychosis symptoms
  - Extreme restlessness, agitation, delusions
  - Hallucinations, suicidal or homicidal ideation
- Baby at high risk of harm or neglect
- Requires hospitalization
- Rarely compatible with breast feeding

Screening for manic-depression with DIGFAST

- Distractibility
- Indiscretions/Disinhibition
- Grandiosity
- Flight of Ideas
- Activities Increased
- Sleep: Decreased Need
- Talkativeness
Using CBT

- Cognitive behavioral therapy (CBT) is not the same as talk therapy.
- Shown to be as effective as antidepressants
  - Problem solving but the patient identifies the problems and the solutions
  - Long term
  - Requires 4 to 6 weeks to show response
  - May not be available in many rural sites or smaller communities.
- Can be useful addition to antidepressants

Self- help brochures

More Than Just The Blues

Do You Tend To...
- Be irritable or easily annoyed...
- Not be able to eat or lose or gain weight...
- Have trouble sleeping or falling asleep...
- Have physical symptoms such as headaches or stomachaches...
- Have difficulty concentrating or remembering...
- Have a change in appetite or making decisions...

Are You a Mom With a New Baby Who Is Feeling...
- Sad most of the time...
- Dulled...
- Worried...
- Alone...
- Helpless...
- Unable to pay attention...
- Irritated or irritated?

- Every day
- Most days
- Some days
- Rarely
- Never

Your baby is still very young. It is normal to feel some of these feelings. But it is not normal to feel sad all the time and to lose interest in other things. It may be a good idea to talk to someone about how you feel. It might be someone who is a friend or family member. Or, you could call your local doctors office or a local health clinic.
Congratulations for making a diagnosis and selecting therapy
BUT—you’ve only just begun

- Recognized
- Diagnosed
- Treated

but

Will she adhere?
Will she get better?
Will she stay better?
Multiple parts of follow-up

- Phone calls to assess:
  - Adherence
  - Side effects
  - Keeping in touch
- Visits to assess:
  - Improvement
  - Treatment modifications
- Consultations/referrals?

Critical junctures in follow up

- Initial visit
  - Engaging the woman
  - Treatment initiation
  - Taking treatment?
- 4-8 weeks
  - Should be showing a response to treatment
- Longer term
  - Staying the course
  - Maintenance of treatment
Nurse Call Content

Not therapy – are brief calls and focused on:

- Treatment
  - Medication adherence
  - Medication side effects/other barriers
- Counseling appointments made/kept
- Self-management
  - Confirm/reinforce commitment
  - Check progress/provide encouragement
- Next office visit scheduled

Follow-up depressed women protocol
How will the nurse know which patient needs to be called?

- The physician to nurse referral form
- It informs the nurse about:
  - The diagnosis of depression
  - What treatment was begun
  - When the next appointment is required
  - What the woman chose to do on the self management plan
- Nurse cannot get started without it

How will the physician know about the nurse calls?

- Nurse follow up call form
- Ask the physician to sign off
- Can be kept in the medical record as documentation
What to do at a follow up office visit

Assess:
• PHQ-9
• Side effects
• General life skills
• Parenting comfort
• Satisfaction with progress
• Concerns and fears
• Issues from relatives or others

How to interpret PHQ-9 on follow up visit

The PHQ-9 is a very useful way to guide therapy. Added to the side effects it can be the basis for your decisions. Works much better than questions like—“How are things going?”

• **Adequate**: ≥ 5 point drop
  • (Continue therapy and routine depression follow-up care)

• **Possibly inadequate**: 2 - 4 point drop
  • (Consider adjusting management)

• **Inadequate**: 1 point drop, no change or increased score
  • (Adjust management)
Follow up depressed women who are not doing well

- Close follow up
- Maximal doses of medication or change drugs
- Call within 2 weeks after changes in therapy
- Repeat visits
- Don’t give up
- Consider consultation or referral

What is the Immediate Action Protocol?

**Steps to assessing suicidal risk**

- You (primary care physician) can assess using the Suicide Risk Assessment Questions  OR
- You can immediately (same day) refer to a mental health professional who has access to an inpatient psychiatric facility or referral to an emergency department.
Suicide Risk Assessment

• Sample Questions: (use your own words)

  • **Intent** – On the questionnaire you said you think about killing yourself---do you have a plan?
  • **Means** – Can you tell me about the plan? (May want to assess access to any weapons or other means they mention such as “pills”.)
  • **Likelihood** – Do you think you would harm or kill yourself? (This is especially useful in those who state they think about but would never do it because it would leave their children without a mother or such reasons and in those with no social support.)
  • **Impulsivity** – Have you tried before? (Look for signs of alcoholism, drug use, or a history of previous attempts.)
  • If the answer to any of these is positive then referral to inpatient management is strongly recommended.

Summary

• PPD is common
• Screening will increase recognition
• Better outcomes will require:
  • Appropriate long term use of therapy
    • Medications
    • CBT
  • Follow up including
    • Nurse phone calls
    • Recurrent visits - reassess using PHQ-9
  • A team approach