

Developing a Postpartum Depression Screening and Referral Procedure in Pediatric Primary Care

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ABSTRACT

Introduction: Postpartum depression affects approximately 10% to 20% of mothers and impairs a mother's ability to engage with her child at an emotional and cognitive level, placing the child at greater risk for impaired development. Early diagnosis and management can reduce its negative impacts. Despite mothers being receptive to screening, screening rates are less than 50%.

Methods: This article provides an appraisal of the current state of the evidence on implementing screening for postpartum depression in pediatric primary care. It describes how to use a clinical decision support algorithm for screening and follow-up and the process of developing an accompanying referral/resource list.

Results: Evidence supports the use of clinical decision support algorithm and the need for having local resources and referrals available at the point of care.

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Conflicts of interest: None to report.

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0891-5245/\$36.00

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<https://doi.org/10.1016/j.pedhc.2017.11.002>

Discussion: Screening for postpartum depression in the pediatric primary care setting is feasible and can be adapted to the local setting. *J Pediatr Health Care.* (2017) ■■, ■■-■■.

KEY WORDS

Postpartum depression, screening, primary care pediatrics, decision support, algorithm

INTRODUCTION AND BACKGROUND

Postpartum depression (PPD) affects approximately 10% to 20% of women, and it is not accurately known how many of those women go undiagnosed (Gjerdingen & Yawn, 2007; Sriraman, 2012). The latest prevalence rates for self-reported postpartum depressive symptoms are 11.5% from the Pregnancy Risk Assessment Monitoring System (27 states reporting, accounting for 41% of all U.S. births; Ko, Rockhill, Tong, Morrow, & Farr, 2017). PPD negatively affects a mother's ability to engage with her family and child at an emotional and cognitive level, placing the child at greater risk for impaired development (Milap Kumar et al., 2012). In fact, a recent comprehensive review on PPD reports a negative relationship between PPD and language development, cognitive development, and physical health for children (O'Hara & McCabe, 2013). Despite the long-term consequences of PPD for both mothers and families, early diagnosis and management can reduce the negative impacts. In light of this, the American College of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms. Furthermore, in recognizing that screening alone is insufficient to improve outcomes, ACOG recommends appropriate follow-up and treatment,

and clinicians should be prepared to initiate antidepressant medication and/or refer patients to appropriate behavioral health resources (American College of Obstetricians and Gynecologists, 2015). In 2010, the American Academy of Pediatrics (AAP) issued a clinical report encouraging pediatric practices to screen for PPD, use community resources for referral and treatment for those women experiencing depressive symptoms, and provide support for the mother–child relationship (Earls, 2010). The National Association of Pediatric Nurse Practitioners (NAPNAP) position statement also recommends screening mothers for depression in the child's first year of life (National Association of Pediatric Nurse Practitioners, 2011).

However, making a recommendation is perhaps much easier than implementing a recommendation. Typically during the postpartum period, women have one or two postpartum visits with an obstetrician or primary care provider, limiting the opportunity for screening to a very narrow window. A pediatric primary care provider sees a mother as frequently as eight times within the first 6 months of her child's life, placing pediatric providers in a strategic position to screen for PPD (American Academy of Pediatrics & Bright Futures, 2017; Sriraman, 2012). This position, though strategic, faces several barriers.

In a recent systematic review of the literature, Evans, Phillippi, and Gee (2015) examined the PPD screening practices of primary care providers. They looked specifically at research studies that involved the screening practices of pediatricians, obstetrician-gynecologists, and family practitioners. They found that although most pediatricians felt a responsibility for identifying PPD, pediatricians were the least likely of the three provider groups included to use a screening tool to assess for PPD, at 7%, compared with 31% for family physicians and 36% for obstetrician-gynecologists. Pediatricians were also the least confident in their skills to recognize PPD yet were the most likely to rely on their own clinical judgment rather than a screening tool to detect PPD. The review goes on to identify time constraints as the barrier most frequently cited by pediatricians (66%). The next most frequently reported barrier was inadequate training, skills, or knowledge needed to screen for PPD (60%). Other perceived barriers included a lack of mental health services for referral, issues of liability, lack of financial incentives, perceived ineffectual treatment, and

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the perception that mothers did not want to discuss PPD.

Much of the present literature reflects the position of the AAP, ACOG, and NAPNAP that screening for PPD is best practice and encourages pediatric primary care providers to implement screening (Byatt, Biebel, Friedman, Debordes-Jackson, & Ziedonis, 2013; Earls, 2010; Garg, Toy, Tripodis, Cook, & Cordella, 2016; Olin et al., 2015). However, there is a gap in the evidence with regard to how pediatric providers are meeting this recommendation in light of the barriers described previously and what is or can be done to overcome barriers to screening and subsequently respond to mothers who have positive screening results for symptoms of PPD. Therefore, the purpose of this article is threefold: (a) to review the current state of the evidence related to the processes being used in pediatric primary care to incorporate screening for PPD, (b) to describe how to develop a decision support algorithm for consistent screening and responding to risk for PPD, and (c) to describe the process of developing an accompanying referral and resource list by examining the approach used with a children's developmental services agency (Beeber et al., 2016).

CURRENT STATE OF THE EVIDENCE

The electronic databases PubMed, CINAHL, and PsychInfo were searched for reports published after 2010. This date was selected because the AAP published their recommendation for PPD screening in 2010. Ultimately, however, three articles with publication dates before 2010 were included because they met all other criteria. The search included the following key words: *maternal depression, postpartum depression, postnatal depression, screen*, test*, tool*, scale*, instrument*, determin*, assess*, identif*, recogn*, primary care, pediatric*, nurse practitioner, and nurse practitioners.*

Reports were included if they described the implementation of PPD screening in a pediatric primary care setting and the results thereof. Reports were excluded if the research was conducted outside the United States and if the article was written in a language other than English. No study designs were excluded. Only seven reports met the inclusion criteria of describing the implementation and outcomes of PPD screening in the pediatric primary care setting.

RESULTS

Although the purpose and aims of each study varied slightly, overarching each was a desire to implement and evaluate the feasibility and effectiveness of PPD screening in a pediatric primary care setting. The body of evidence was graded using the Grading of Recommendation Assessment, Development and Evaluation (i.e., GRADE) criteria. GRADE rates evidence

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