

Postpartum Depression Screening at Well-Child Appointments: A Quality Improvement Project

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ABSTRACT

Introduction: The purpose of this quality improvement project was to implement and evaluate a postpartum depression screening program using the Edinburgh Postnatal Depression Scale (EPDS) during well-child appointments up to 1 year of age at a private, faith-based primary care clinic.

Method: The Plan–Do–Study–Act framework was used in this quality improvement project. The EPDS was administered to mothers ages 19 years and older at their infants' well-child appointments at a faith-based clinic in the Midwest. A score of 10 or higher was considered a positive result. The results were reviewed, and protocol changes were implemented every 2 weeks using the Plan–Do–Study–Act framework.

Results: A total of 35 mothers completed the EPDS during the 9-week implementation period. Of 37 mothers asked to participate, nearly all agreed (97.3%); there was one refusal (2.7%). Staff compliance rate with administering the EPDS was 78.7%; there were 10 missed opportunities (21.3%). There were five positive EPDS results (14.3%). Mothers who screened positive were between the ages of 20 and 44 years. Infant ages were between 2 weeks and 12 months.

Discussion: Screening mothers at well-child appointments can identify women with postpartum depression. Not doing so is a missed opportunity. The results of this project support the identification of postpartum depression by screening using the EPDS during well-child appointments up to 1 year of age. *J Pediatr Health Care.* (2016) ■, ■-■.

KEY WORDS

Appointments, depression, diagnosis, guidelines, outpatient, pediatric nursing, postpartum, postpartum depression, schedules, screening, standards, symptoms

Postpartum depression (PPD) is a manageable and treatable disease; however, it often goes unrecognized. PPD is the number one complication new mothers face after birth, and it affects one in seven women (American College of Obstetricians and Gynecologists [ACOG], 2015). Pediatric visits are an optimal screening time because of the opportunity for repeated assessments (Sheeder, Kabir, & Stafford, 2009). Mothers are able to form relationships with their child's health care providers (Sheeder et al., 2009), which may allow them to feel comfortable answering screening questions. Mothers are also more likely to take their children to well-child examinations than to make appointments for themselves (Sheeder et al., 2009).

The purpose of this quality improvement (QI) project was to implement and evaluate a PPD screening program using the Edinburgh Postnatal Depression Scale (EPDS) during well-child appointments up to 1 year of age at a private, faith-based primary care clinic. Outcomes measured included compliance of providers with screening, number of patients with PPD identified in the clinic population, and number of referrals.

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Conflicts of interest: None to report.

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BACKGROUND

The prevalence of PPD in the United States is 25%, with New Mexico having the highest rates (Centers for Disease Control and Prevention, 2015); some areas in the world report percentages as high as 39% (Goker et al., 2012). According to the U.S. Department for Health and Human Services, over 50% of patients with PPD go undetected (Agency for Healthcare Research and Quality [AHRQ], 2013). Suicide is the leading cause of death in postpartum women, occurring in up to 11 per 100,000 births (Roy-Byrne, 2016).

There are several factors that put new mothers at risk for developing PPD. One of the strongest risk factors for PPD is depression during any point in a woman's life (Roy-Byrne, 2016). Pregnant and parenting teenagers, as well as mothers with a low socioeconomic status, have a 60% increased risk of developing PPD (Earls, 2010). Additional factors putting mothers at higher risk for PPD include poor marital relationships, divorce, other mental health diagnoses, substance abuse, violence, low educational level, unwanted or unexpected pregnancy, complicated labor, obesity, and a weak support system (Goker et al., 2012).

The long-term effects that PPD has on a family are significant; marital relationships are negatively affected, mothers discontinue breastfeeding early, and development of the baby may be delayed because of insufficient maternal–infant interaction (Goker et al., 2012). Magnetic resonance imaging scans of infants whose mothers had PPD show adverse changes in early brain development during the first year of life (Earls, 2010). Mothers suffering from PPD spend less time with the infant, placing the infant at risk for attachment disorder (Earls, 2010). In addition to early cessation of breastfeeding, infants are more likely to be diagnosed with failure to thrive, which can be seen as early as 2 months of age (Earls, 2010).

A study of more than 10,000 children, ages 3.5 years old, found that emotional and behavioral problems were twice as likely to occur in children whose mothers suffered from PPD than in children whose mothers had not (Roy-Byrne, 2016). Follow-up of the same children at age 7 years found that psychiatric diagnoses were more common in children with depressed mothers than nondepressed mothers (Roy-Byrne, 2016).

Preschool-age children of mothers suffering from PPD have increased cortisol levels, which leads to increased anxiety, impaired social interaction, social wariness and withdrawal, attachment disorders, and depression (Earls, 2010). These children are at an increased risk of sleeping and eating difficulties, temper tantrums, hyperactivity, and delays in language and cognitive development (Roy-Byrne, 2016). Children of mothers with PPD and their siblings are 3 to 5 times more likely to have major depression themselves (Earls, 2010). They are also more likely to develop

attention deficit hyperactivity disorder at any age and be diagnosed with adolescent depression (Roy-Byrne, 2016).

When mothers are suffering from PPD, both parents are affected. Parents are less likely to implement injury prevention measures, such as putting babies on their backs to sleep (Earls, 2010). Parents are also more likely to struggle with managing chronic health conditions, such as asthma or any disabilities the child may have (Earls, 2010). Adverse outcomes of undiagnosed PPD range from impaired child development, as mentioned, to marital discord, suicide, and infanticide (Roy-Byrne, 2016).

SCREENING RECOMMENDATIONS

Screening at well-child appointments up to 1 year of life has led to significant increases in recognizing postpartum depression (Chaudron, Szilagyi, Kitzman, Wadkins, & Conwell, 2004). A random survey of new mothers showed that more than 85% reported that they welcomed a discussion of their health during their child's pediatric visit and that 75% believed it would have been a missed opportunity if they were not asked (Walker, Eun-Ok & Tyler, 2013).

Many countries have already implemented mandatory screening for PPD. In Australia, PPD screening practices have been in place for over 10 years (Armstrong & Small, 2010). In the United States, major organizations differ in recommendations regarding screening and treatment of postpartum mood disorders. The United States Preventive Services Task Force (USPSTF) recommends screening adults for depression when staff is in place to ensure accurate diagnosis, effective treatment, and follow-up (USPSTF, 2016). The USPSTF (2016) and Healthy People 2020 recommend screening for depression at well-child appointments (Office of Disease Prevention and Health Promotion, 2016).

Many countries have already implemented mandatory screening for PPD.

The Association of Women's Health Obstetric and Neonatal Nurses (AWHONN) recommends that providers treating pregnant women, new mothers, and newborns have routine screening protocols in place (AWHONN, 2015). They recommend that screening for depression and mood disorders begin during the woman's prenatal care and continue after the birth of the child (AWHONN, 2015). AWHONN also recommends implementing staff training and client education programs related to postpartum mood disorders and that health care providers be equipped with educational materials and be able to arrange for follow-up care for those with positive screening results.

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