Making the Legal and Ethical Case for Universal Screening for Postpartum Mood and Anxiety Disorders in Pediatric Primary Care

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Postpartum depression (PPD), part of a larger spectrum of perinatal mood and anxiety disorders, affects up to 15% of women following the birth of an infant. Fathers may also be affected. PPD not only affects caregivers, but also impacts infants through mechanisms such as inadequate caregiver–infant interactions and non-adherence to safety practices. The negative impact on infants may extend across the life course through adulthood. This article seeks to move the needle toward universal screening for PPD using validated tools in pediatric primary care settings for new caregivers by making the legal and ethical case for this course of action in a manner that is both compelling and accessible for clinicians. Toward this end, we summarize current literature as it applies to provider responsibilities, liabilities and perspectives; and caregiver autonomy, confidentiality, and privacy. We then assess utility by balancing the benefits and burdens of this approach to practices, providers, and caregivers; and take the analysis one step further by looking across multiple populations to assess distributive justice. We conclude that there is a strong ethical case for universal screening for PPD in pediatric primary care settings using validated tools when informed consent can be obtained and appropriate follow-up services are available and accessible. Clinical considerations, practical resources, and areas ripe for future research are also addressed.

Curr Probl Pediatr Adolesc Health Care 2017;47:267-277

Background

Overview of Postpartum Mood and Anxiety Disorders and Their Impact

Postpartum depression (PPD) affects up to 15% of women following the birth of an infant. PPD is a part of a larger spectrum of postpartum mood and anxiety disorders, or PMADs.[1,2] Postpartum anxiety is a separate condition that affects up to 18% of all mothers, making it equally worrisome, that can occur separately or combined with PPD.[3] The risk of PPD is more common within the first 4 months postpartum, but can occur anytime during the first year. Having a prior or family history of depression, being a teen mother or experiencing stressful situations, such as living in poverty or limited social support, are known risk factors of PPD. In a prospective cohort study, thoughts of death and dying or difficulty falling asleep at 1 month postpartum were associated with PPD at 4 months.[4] Fathers can also develop symptoms of PPD, but these often go undiagnosed.[5,6] PPD not only affects caregivers, but also frequently results in inadequate caregiver–infant interactions and non-adherence to safety practices.[7] The negative impact on infants may extend into early childhood,[8–10] resulting in a higher risk of developmental delays and behavioral issues. Exposure to parental mood disorders is one of ten known adverse childhood experiences, or ACEs,[11] that have been shown to be associated with poor health, social, and behavioral outcomes spanning the life course. It is, therefore, important to screen and identify at-risk individuals early, so caregivers experiencing PMADs can receive appropriate treatment and support in a timely manner.

Overview of Current Screening Practices and Tools

In the past, screening for PPD and other PMADs fell largely to adult medicine primary care providers including family practitioners, obstetricians, and

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Curr Probl Pediatr Adolesc Health Care 2017;47:267-277
1538-5442/$-see front matter
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http://dx.doi.org/10.1016/j.cppeds.2017.08.001

internists. In recent years, however, there has been increasing recognition that pediatric primary care providers have a unique opportunity to identify PMADs. Most of the research informing this recognition has been focused on mothers and PPD. It is recommended that at least 8 well-child visits occur during the first year of a child's life, resulting in earlier and more frequent interactions with new mothers.[12] Research also shows that women report a host of issues accessing health care for themselves, such that screening for PPD in pediatric settings may be the only way to catch them in the busy first year of their children's lives.[13] Although not all women are able to attend every recommended well-child visit, mothers may be more likely to seek care for their children than they would for themselves, and be more honest in their responses when screening is put in the context of benefiting their child's health.[14]

While many health care providers report feeling confident in their ability to identify PPD informally through conversations and general impressions,[15–17] surveillance of this nature has been found to be significantly less effective than screening with a validated tool.[17–19] Support for, and adoption of, screening for PPD by pediatric primary care providers using validated tools during well-child visits in the first year of life is increasing. A number of studies have demonstrated the feasibility and success of this approach[12,20–22] and several professional organizations and government agencies including the United States Preventive Services Task Force (USPSTF),[23] American Academy of Pediatrics (AAP),[12] and Centers for Medicare and Medicaid Services (CMS)[24] support this movement (Table 1).

The most commonly used tools for identifying symptoms of PPD are the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ-2 or PHQ-9). These instruments have been widely accepted, translated into more than twenty languages, and validated for a variety of patient populations including the EPDS for adolescent mothers[25] and fathers.[26,27] Either tool can reliably be used in the context of screening for PPD among postpartum mothers, as scores using the PHQ or EPDS have been shown to be concordant.[28] However, the EPDS specifically includes 3 items to capture anxiety symptoms (feeling scared/panicky, anxious or worried, and blamed self unnecessarily); whereas the PHQ is

TABLE 1. Support for screening in pediatric settings with validated tools

Organization	Recommendations/support	Tool endorsed
American Academy of Pediatrics/Bright Futures Guidelines[12,34]	Maternal depression screening at 1, 2, 4, and 6 mo visits	EPDS PHQ-2 PHQ-9
US Preventive Services Task Force Recommendation Statement[23,30]	Grade B recommendation: pregnant and postpartum women should be screened and supported with treatment and follow-up when necessary (support for this population to be screened in either obstetric or pediatric settings)	Provides evidence review for both EPDS and PHQ
Centers for Medicare & Medicaid Services (CMS)[24]	Some State Medicaid agencies cover PPD screening at well-child visits through either the mother's or child's Medicaid ID (via the Early and Periodic Screening, Diagnostic and Treatment component of Medicaid). Examples include: • Colorado[35] • Illinois[36] • Minnesota[37] • North Dakota[38] • Virginia[39]	Vary by state, but include EPDS, Beck Depression Inventory-II (BDI-II), Center for Epidemiological Studies Depression Scale (CES-D), PHQ-9, Parenting Stress Index (PSI)
National Association of Pediatric Nurse Practitioners (PNPs)[40]	States that PNPs are "skillful in screening mothers for risk of maternal depression" and supports early interventions to promote psychological well-being for parents	N/A
Mental Health America[41]	Supports screening for PMADS in a variety of settings including pediatrics. Also states that the cost of screening and follow-up care should be covered in all health plans and encourages the colocation of mental health professionals in settings where screenings occur	N/A

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