Position statement: screening for perinatal depression & anxiety

This Utah Women and Newborns Quality Collaborative (UWNQC) position statement explores the rationale and recommended plan for routine screening of pregnant and postpartum women for perinatal mood disorders including depression and anxiety.

Perinatal mood and anxiety disorders include major depression, generalized anxiety disorder, panic disorder, obsessive compulsive disorder (OCD), post-traumatic stress disorder (PTSD), bipolar I and II, and psychosis. Although these conditions are not uncommon in the general population, they may go undetected or improperly treated due to their unique presentation in the perinatal period. For example, perinatal depression often includes an agitated or anxious component, intrusive thoughts that may not meet the criteria for OCD, as well as anger and rage. Women may think that excessive worry is "normal." Their symptoms may be dismissed merely as normal new parent worries or even the "baby blues" (which occurs in about 80% of women, and only lasts for 2 weeks or less after delivery or postpartum).

Mental health conditions, including depression and anxiety, are the leading complication of childbirth (Gavin et al., 2005; Wisner et al., 2006). When left untreated, they can have a significant negative impact on pregnancy and birth outcomes, maternal mortality and morbidity, infant and child development, and overall family life.

Unfortunately, perinatal mood and anxiety disorders are often missed or improperly diagnosed and subsequently, left untreated. Screening for these conditions is recommended by all major health authorities including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, United States Preventative Services Task Force, and Centers for Disease Control and Prevention. Screening and proper treatment improves health outcomes for moms and babies.

In Utah, pregnancy and the birth of a child are of special importance as Utah has the highest childbirth rate in the nation per capita (U.S. Census Bureau)— at around 50,000 births each year in Utah.

Providers have a responsibility to:

1. **Educate families on mental and emotional health—and that perinatal mood disorders are common and treatable.**
2. **Help women identify if and when they are not feeling like themselves.**
3. **Seek appropriate, timely help to minimize the duration and impact of maternal mental health conditions on their patients.**

Providing education and open, judgment-free conversations with patients and their families can help us collectively address the stigma around perinatal mental health. We can systematically begin to help families prevent and self-identify maternal mental health issues as well as create safe environments for them to openly ask for help.

Misconceptions about perinatal mood disorders by both providers and families may delay or interfere with adequate treatment. Additionally, stigma around mental and emotional health; lack of access to care with long wait times and lack of specialists; dismissive messages from community members, peers, and family; and the fear that a child could be removed from the mother or family are additional barriers to help-seeking.

The Pregnancy Risk Assessment and Monitoring System (PRAMS) surveys women who have recently given birth in Utah.

One respondent to the Pregnancy Risk Assessment and Monitoring System (PRAMS) Survey said,

"I would like to have [my] Dr. more open about being depressed or anxiety issues. It's hard as a woman/person to break down & admit they are having these feelings or issues. I felt dumb and that my feelings and thoughts would get better by the way I was brushed off...I think more women suffer with this and are afraid to say something & when you build up the nerve to finally say something and not feel heard, it was hard."

Diagnostic limitations abound, as current coding systems allow for only the first 6 weeks postpartum to meet criteria for "with postpartum onset." Despite this, perinatal experts agree that the postpartum period extends to at least 1 year after delivery and through weaning if the person is breastfeeding due to the potential hormonal implications of lactation. A recent study[1] showed that maternal depression persisted up to 3 years postpartum in one-fourth of the moms who participated in the study. A report from the Utah Perinatal Mortality Review Committee shows the majority of maternal deaths occurred between 43 and 365 days postpartum, and unsurprisingly, a history of mental illness was present in 75% of deaths during that time period.[2] For this reason, primary care and public health settings must be equipped to identify, screen, and treat these common illnesses. These conditions are treatable and patients respond well to appropriate treatment.

This toolkit includes Utah-specific materials as well as nationally recognized tools and recommendations, borrowed with permission by other experts. It also provides clinical information and considerations as well as links to resources for creating a workflow that is manageable in a variety of settings.

Facts to keep in mind as you develop a screening system in your office:

- Depression is the #1 complication of childbirth, affecting 1 in 7 women nationally with around 40% beginning during pregnancy.[3, 4]
- Accidental drug overdose and suicide are the top leading causes of death for Utah women during the perinatal period.[2]
- Only about half of Utah women who have perinatal anxiety will receive the help they need (PRAMS).
- The impact of untreated depression or anxiety during pregnancy includes higher rates of premature labor, cesarean sections, preeclampsia, and lower Apgar scores.[4, 5, 6]
- Perinatal mental illness negatively impacts infant, child, and adolescent development as well as mental health in adulthood.[7]
- Of depressed perinatal women, up to one in five may have thoughts of harming themselves.[3]
- In the largest study thus conducted with a clinical assessment of perinatal women, 20. percent of the group studied was diagnosed with bipolar disorder.[3]
- Untreated maternal depression can be long lasting and may not resolve on its own.
- Half of the Utah women diagnosed with perinatal depression have never experienced mental illness before in their life (PRAMS).
- More women will suffer from postpartum anxiety and depression in a year than the combined number of new cases for men and women of Tuberculosis, Leukemia, Multiple Sclerosis, Parkinson's Disease, Alzheimer's Disease, Lupus, and Epilepsy (The Bloom Foundation).

Other clinical considerations:

We cannot tell the mental health status of a woman by looking at someone; screening is necessary.

Disturbing or intrusive thoughts about the baby being harmed are common, and are most often not psychosis or a child endangerment issue. In fact, some studies suggest intrusive thoughts occur to as many as 90% of moms, but psychosis only occurs to one in every 1,000 women who will have a baby. Staff education is crucial to avoid traumatization through unnecessary child welfare involvement.

Inappropriate treatment of bipolar illness with a selective serotonin reuptake inhibitor (SSRIs) (SSRI) may trigger a manic episode, which is correlated with postpartum psychosis.[5]

Culturally relative treatment is essential. Studies suggest complaints about physical symptoms like pain or feeling tired may be more common than complaints about emotional symptoms among Latina or African American women due to stigma.[6]

Crisis response planning is an effective approach for lowering suicide risk when anything other than 0 is scored for item 10 on the Edinburgh Postnatal Depression Scale.

Perinatal mental illness can affect anyone including LGBTQIA+ individuals and couples, fathers, adoptive parents, those suffering from infertility issues, people who have experienced a pregnancy termination, those who have experienced infant loss and miscarriage, and grandparents. All caretakers should be screened and referred to help.

Disclaimer: The Utah Women's Newborn Quality Collaborative (UWNQC) understands and recognizes that not all people who have been pregnant or given birth identify as being a "woman." This toolkit uses the term "women" instead of "people" or "persons" as an intentional device to highlight the vulnerability of people who society typically identifies as being female. The use of "women" is not intended to exclude or silence those who do not identify as female, but to draw attention to the ways pregnant or postpartum people may be discriminated against because of their female gender assignment at birth. We acknowledge all pregnant people experience mental health complications during the perinatal period, and include all parent populations when we talk about moms.

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