Perinatal Depression Screening Rates at an Urban OBGYN Clinic

Paula Cortés Campos[1], Miriam Toaff[2], Alice Barr[2], Madelyn Hernandez[2], Jennifer Keller[2], Huynh-Nhu Le[1]

[1]Department of Psychology, [2]School of Medicine and Health Sciences

Introduction

- Perinatal depression (PD) is a significant public health problem with negative consequences for pregnant women, mothers, and families.
- One of the main risk factors for PD is depression that occurs during pregnancy.[1]
- The American College of Obstetricians and Gynecologists recommends that pregnant women be screened for depression at least once in both the prenatal and postpartum periods.[2]
- Obstetrics settings are ideal for implementing PD screening because women receive perinatal care across multiple visits.[2]
- In 2016, an obstetrics program in Washington, D.C. implemented universal screening for PD, in which women are screened at:
  - **T1**: their first prenatal appointment.
  - **T2**: their third trimester, at approximately 28 weeks.
  - **T3**: six weeks postpartum.
    - T3 was previously incorporated into visits at this clinic since 2014.

Purpose

To examine:

1. The prevalence of prenatal and postpartum depressive symptoms.
2. The rates of PD screening since the inception of the clinic's new prenatal screening procedure.
3. Whether women with high risk for depression were referred for or received mental health treatment.

Methods

Setting

- The site is an urban, group-practice OBGYN clinic that has three different locations in the Washington, D.C. metro area.
- Patients are treated by one or a combination of obstetricians, nurse practitioners, and midwives throughout their pregnancy and postpartum follow-up care.

Sample

- 301 out of 2,638 women seen at the OBGYN clinic during the study period (July 1, 2016 through June 31, 2017) were randomly selected for a retrospective medical chart review.

Data Collection

- Extracted data from electronic medical records (EMRs).
- Data collected include demographics, medical history, depression, and treatment and/or referral information.

Perinatal Depression Screening

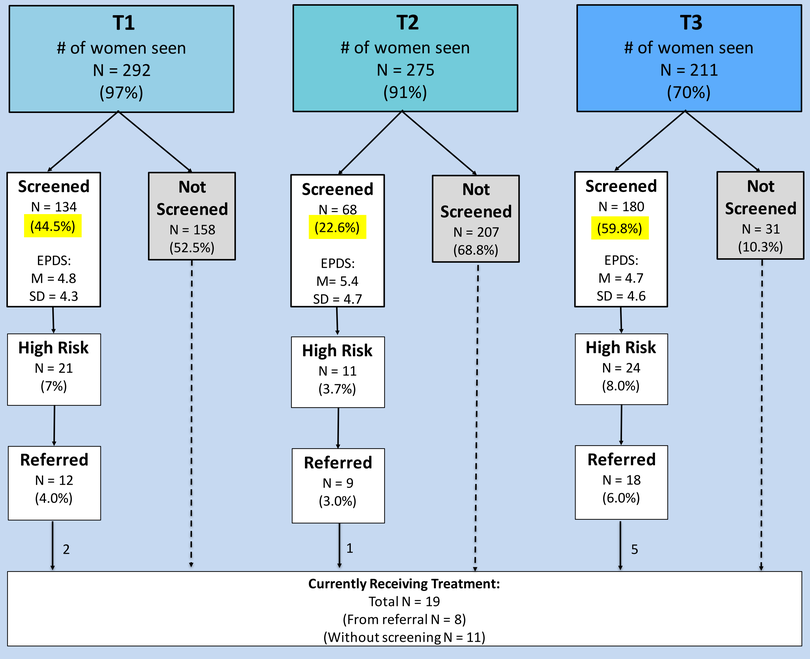
- The Edinburgh Posnatal Depression Scale is a widely validated self-reported 10-item Likert scale screener that asks women the extent to which they have experienced specific depressive symptoms within the past week.[3]
- Higher scores indicate greater severity of depressive symptoms.
- An EPDS score ≥ 10 indicates that a woman is at high risk of developing PD.

Results

Table 1: Sample demographics

Variable	Mean	SD	
Age	31.6	5.7	
Parity	2.8	5.8	
# of Children	1.8	1.1	
	Sub-group	**N**	**%**
Race/Ethnicity	African American	126	41.9
	White	113	37.5
	Latina	12	4.0
	Asian	18	6.0
	Other	16	5.3
Employment Status	Employed	179	59.5
	Unemployed	35	11.6
	Student	19	6.3
	Homemaker	17	5.6
Education	High school or less	65	21.6
	Undergraduate	67	22.2
	Graduate or Higher	96	31.9
Marital Status	Single	93	30.9
	Married/ Partnered	186	61.8
	Other	2	0.7
History of Mental Illness	Depression	11	3.7
	Anxiety	11	3.7
	Bipolar	3	1.0
	One or More Disorder	9	3.1
Insurance Status	Private	195	64.8
	Public	90	29.9
	Other	1	0.3
# of Times Screened with EPDS	1	137	45.5
	2	100	33.2
	3	15	5.0

Figure 1: Flowchart of perinatal visits, EPDS screening rates, depression risk, referral information, and current psychiatric treatment



Discussion

- The prevalence of PD symptoms was low in this sample across the three screening time points, ranging from 3.7 to 8.0%.
- Rates of screening ranged from 22.6% and 59.8% across the prenatal and postpartum periods.
- Although the OB clinic's intent was to implement universal screening for PD,
  - Less than half of the women were screened at T1.
  - Less than a quarter of the women were screened at T2.
    - This time point is especially important because rates of depression are substantial during the second and third trimesters.[4]
  - Few women (5%) were screened across all three time points.
  - Most women (60%) were screened at six weeks postpartum.
- To improve screening rates,
  - The EPDS could be embedded into standard intake forms in the EMR across all time points.
  - Increase providers' education and training about the importance of screening and follow-up for PD.
- Few women who were referred were currently receiving treatment.
- To improve referral rates, the EMR could be modified so that all relevant mental health data are recorded and stored in the same electronic location.

Limitations

- The sample was predominantly White and African American, highly educated and privately insured, so the results may not be generalizable.
- There is no feedback for mental health referrals made, to ensure that patients follow up and receive treatment.
- There are inconsistencies in the way in which providers collect, record, and store information on the EMR.

Future Research

- Analyze demographics data in order to determine if there are factors such as race, age, socioeconomic status, that may influence the likelihood of being screened for PD and being referred for mental health treatment.
- Assess whether certain providers and clinics are more likely to screen for PD and refer women for treatment.

References

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