

Choosing Well-Child Visits for Postpartum Depression and Anxiety Screening

The best option for screening mothers for postpartum depression and/or anxiety (PPD/A) is to screen at all well child checks within the first year, or at least up to and including the 6 month check. In Minnesota, a maternal depression screen at a well child check in the first 12 months is billable, up to three times in a calendar year. It is a recommended part of a complete Child and Teen Check Up (Minnesota’s Early and Periodic Screening, Diagnostic, and Treatment) in visits within the first year.

Some pediatric clinics choose specific well child checks at which to do the PPD/A. This may be useful for clinics who have significant differences between visits (i.e. other screens only done at certain visits) and but may not be helpful for clinics with patients who came for well child checks in a less than regular fashion. A practical suggestion: if you must pick only one visit (*not recommended*) than do it at the 2 month – unless you know all your moms are attending and getting screened at their 6 week postpartum visit, then do it at the 4 month.

Here are some things to consider in deciding which well child visits to do PPD/A screening at:

Visit	Advantages	Disadvantages	Data
1 or 2 week (new born)	If there is a concern, it is best to catch it as early as possible.	Most parents are still in the middle of major adjustment to the hormonal changes and generally having a baby. Concerns over anxiety or depression are expected and not out of the ordinary.	Psychosis presents itself within two weeks in 65% of all cases of postpartum psychosis. (Heron, 2007) (MGH Center, 2008) (Scotland, 2012)
2 month	<ul style="list-style-type: none"> • Most important time to catch this with a caregiver. • The initial “baby blues” have passed and this is the point where depression/anxiety will start to have an effect on the child. • Anxious or depressed moms and moms in low-income communities are less likely to attend their 6 week check. 	Many mothers will also attend their 6 week postpartum visit, where they will (hopefully) be screened.	<p>Children who are younger when first exposed to their mother’s depression may be more vulnerable to the development of psychopathology than children not exposed until later (Goodman, 2011)</p> <p>AAP recommendation (below)</p>

<i>Visit</i>	<i>Advantages</i>	<i>Disadvantages</i>	<i>Data</i>
4 or 6 month	<ul style="list-style-type: none"> • If it hasn't been caught yet, this may be the last good chance to catch it and start to address the effect upon the baby. • No verified differences in screening at 4 or 6 month. 	Late, so if screening here, should also be screening earlier.	<p>There is a strong body of research on the impact of a depressed parent on children. Effects include increased risk of mood disorder in children, impaired cognitive functioning, and poor language development (Conroy, 2012) (Grace, 2003) (Zajicek-Farber, 2009) (Scotland 2012) (AAP 2010)</p> <p>One study suggests screening at 6 month is better than 4 (Sheeder, 2008)</p> <p>One study notes no significant difference (Whichman 2010)</p>
All visits	<ul style="list-style-type: none"> • Don't have to remember which visit it is. • More chances to find caregivers with concerns. 	Caregiver may tire of the screen (no clear research to support this concern)	

Additional Screening Advice:

- Parents with a previous mental health history should be screened at every well-child visit.
- Parents with PPD/A symptoms should be screened at every well-child visit.

If the provider suspects PPD/A parent should be screened at every well-child visit. (Heron , Robertson Blackmore, McGuinness, Craddock, & Jones, 2007)

Notes from Studies

From Massachusetts General Hospital: Center for Women's Mental Health

When is the best time to screen?

Mood fluctuations are extremely common during the first postpartum week, with approximately 60%-85% of women reporting mild to moderate mood symptoms, or “the blues”. While this may complicate screening, studies which have used the EPDS to screen for depressive symptoms within the first postpartum week suggest that the EPDS may be used to predict which women will go on to have postpartum depression. In this study, women who scored 9 or greater on the EPDS were about 30 times as likely to have postpartum depression at week 4 than women with lower EPDS scores. Similar results were observed when the EPDS was administered at 2-3 days postpartum.

From: Identifying Postpartum Depression: A Three Question Screening Tool

By [MGH Center for Women's Mental Health: 2008](#)

(<http://womensmentalhealth.org/posts/identifying-postpartum-depression-a-three-question-screening-tool/>)

From Scottish Intercollegiate Guidelines network (SIGN) UK

Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at four to six weeks and three to four months.\

For women regarded to be at high risk (those with previous or current depressive disorder), enquiry about depressive symptoms should be made at each contact.

Where there are concerns about the presence of depression, women should be re-evaluated after two weeks. If symptoms persist, or if at initial evaluation there is evidence of severe illness or suicidality, women should be referred to their general practitioner or mental health service for further evaluation.

By [Healthcare Improvement Scotland, 2012](#)

(<http://www.sign.ac.uk/pdf/sign127.pdf>)

Further Information from [MedEd: Postpartum Depression, Screening Guidelines](#)

(<http://www.mededppd.org/guidelines.asp?source=banner>)

From The AAP Report—Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice

The new *Bright Futures* guidelines include surveillance regarding parental social-emotional well-being. The US Preventive Services Task Force has endorsed the Edinburgh Postnatal Depression Scale as well as the general 2-question screen for depression.^{2,41} Given the peak times for postpartum depression specifically, the Edinburgh scale would be appropriately integrated at the 1-, 2-, 4-, and 6-month visits. The *Current Procedural Terminology* (CPT) code 99420 is recommended for this screening, recognizing the Edinburgh scale as a measure for risk in the infant's environment, to be appropriately billed at the infant's visit.

From: [The AAP Report](#)

(<http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348.full.pdf+html>)

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Minnesota Department of Health, Maternal and Child Health Section
PO Box 64882, St. Paul, MN 55164-0882
651-201-3625
<http://www.health.state.mn.us/divs/cfh/topic/pmad/>

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