PREGNANCY RISK ASSESSMENT MONITORING SYSTEM
A survey for healthier babies in New Jersey

NJ.gov/health/fhs/professional/PRAMS.shtml

Post-Partum Depression In New Jersey (January 2014)

Major depression with postpartum onset (PPD) is defined as onset of a depressive episode within the first 4 weeks after childbirth. In 2006, New Jersey enacted a law (N.J.S.A. 26: 2-175 et seq.) that directs prenatal care providers to provide education about postpartum depression, and licensed health care professionals providing postnatal care to screen new mothers for postpartum depression symptoms prior to discharge from the birthing facility *and at the first few postnatal check-up visits*. All New Jersey delivery hospitals comply with the initial screening mandate, most using the Edinburgh Postnatal Depression Scale (EPDS). Later re-screening is hard to document.

NJ-PRAMS is a joint project of the New Jersey Department of Health and the Centers for Disease Control and Prevention (CDC). Information from PRAMS is used to help plan better health programs for New Jersey mothers and infants—such as improving access to high quality prenatal care, reducing smoking, and encouraging breastfeeding. ▫ One out of every 50 mothers are sampled each month, when newborns are 2-6 months old. Survey questions address their feelings and experiences before, during and after their pregnancy. ▫ From 2002 to 2011, over 17,000 mothers were interviewed with a 72% response rate.

The timing of the PRAMS survey—typically around three months post-partum—is valuable for assessing the incidence of later developing depressive symptoms. Since 2009, the questionnaire presents three statements:

"I have felt down, depressed or sad."
"I have felt hopeless."
"I have felt slowed down physically."

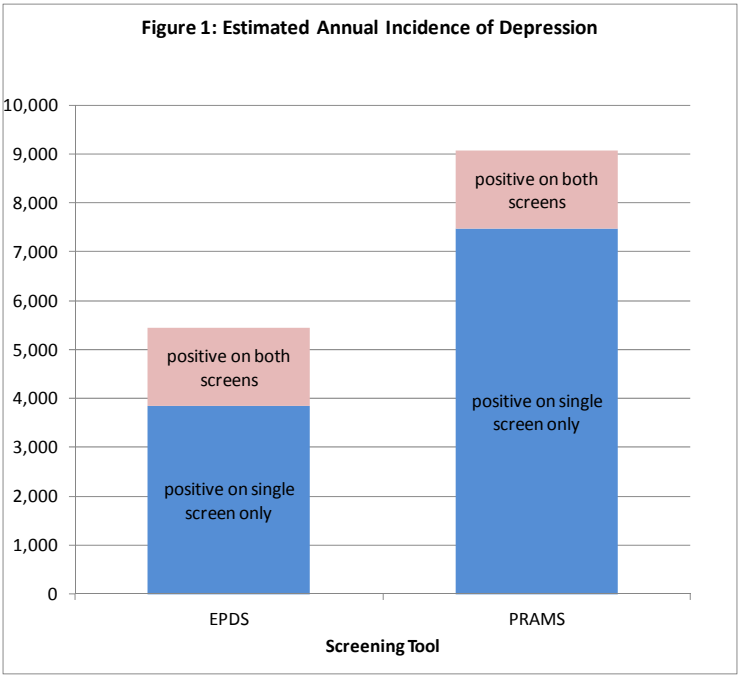
Responses listed are never, rarely, sometimes, often or always. We consider a combination of responses that exceeds three "sometimes" as a positive screening result. The sensitivity and specificity of this algorithm for PPD has been reported as 57% and 87%, respectively, compared to 86% and 78% for a similar scoring of the more extensive Edinburgh Scale. Thus the PRAMS screening measure is more conservative for individual screens but potentially more reliable for population estimates. (It is important to recognize that both the Edinburgh Scale used in hospitals and the PRAMS scale are screening tools, and not full diagnostic assessments.)

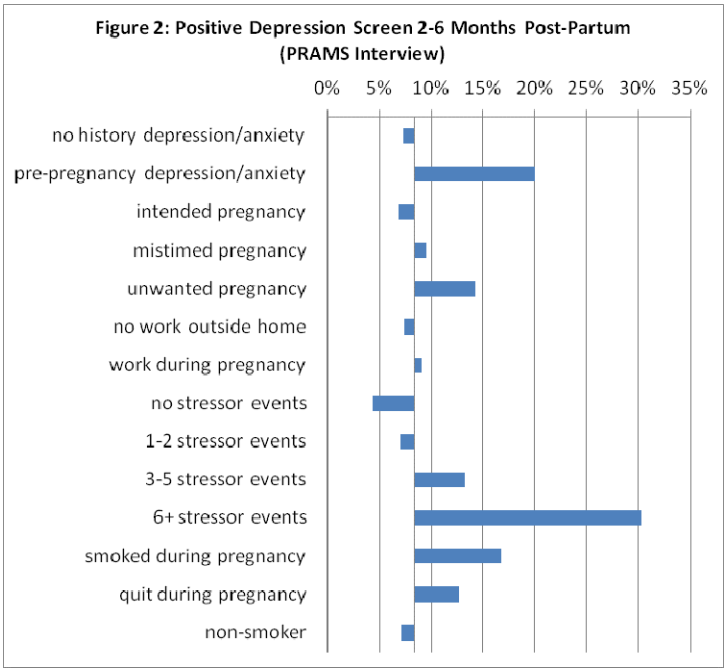
Combining PRAMS survey data from 2009 through 2011, the overall incidence of a positive depression screening result is 8.4%, averaging 7,946 post-partum New Jersey resident mothers per year. For a matched sample in 2009-2010, the EPDS screening at delivery yielded a 5.5% positive incidence of depressive symptoms.

Screening results from each tool do not strongly agree for individual women. Only 29% of women who screen positive for depression at delivery are also positive at the PRAMS interview. Also, about 82% of women who screen positive at the PRAMS interview scored a negative screen at delivery. (See Figure 1.) The lack of concordance may be due to measurement, the delayed onset typical of PPD, or differences in the nature of depressive states immediately postpartum and later.

Positive screens for depression at the two time points also appear to relate to different risk factors. Unwanted pregnancy, stressful events during pregnancy, work outside the home, and smoking predicted more frequent positive depression screens at the PRAMS interview (Figure 2). In contrast, Asian or Hispanic mothers, those who never

Figure 1: Estimated Annual Incidence of Depression





attended college, and those whose infants were admitted to NICU had more frequent positive depression screens at delivery (data not shown). Women who reported a pre-pregnancy history of counseling for depression and/or anxiety were more likely to screen positive on both assessments.

We estimate that 87.7% of new mothers attend their six-week post-partum OB visit, and 97.6% attend at least one well-child pediatric visit (averaging 2.7 visits by the time of the PRAMS interview). Fewer than 1% of new mothers miss both of these opportunities for further screening, although 1.6% of those with a positive depression screen from PRAMS miss both. These lost opportunities notwithstanding, we estimate that 6,582 women each year experience significant PPD that was not detected at delivery and would benefit from follow-up screening and possible treatment.

According to state law, pregnant women should receive PPD education during prenatal care. Overall, 68% recalled having such information presented. Women who screened positive at the PRAMS interview were slightly *less* likely to recall such education (63.3%).

Agenda for Action

Depression after childbirth can be debilitating for women and may have adverse consequences for maternal-infant bonding and infant development. Although common, it is estimated that half of depressed women of reproductive age nationally do not receive a diagnosis or treatment.

New Jersey's established mandates for prenatal education and postpartum screening have produced broad acceptance—some hospitals report 95% adherence to screening protocol at discharge. But while PRAMS data show the importance of post-discharge screening, there is not currently a mechanism to track whether and for whom such screening occurs. Until more is known about population distribution and etiology of perinatal mood disorders, universal and repeated screening remains vitally important. The six-week postpartum OB visit and multiple pediatric visits offer important opportunities to further educate and screen.

ACOG recognizes the value to women and families of screening during and after pregnancy (ACOG Opinion 453, below). Special vigilance for women with a history of depression is recommended. Several screening instruments, including the EPDS (i.e., the "Edinburgh") take less than five minutes for a patient to complete.

Pediatricians are not included in the current law. An AAP report (Earls, et al. below) found that "The majority of pediatricians agree [in a survey] that screening for perinatal depression is in the scope of pediatric practice…" The report also contextualizes the pediatrician's role:

> Screening for postpartum depression does not require that the PCP treat the mother. The infant is the PCP's patient. However, the PCP has a role in supporting the mother and facilitating her access to resources to optimize the child's healthy development and the healthy functioning of the family.
>
> The US Preventive Services Task Force has endorsed the Edinburgh Postnatal Depression Scale as well as the general 2-question screen for depression. 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 2-question screen for depression is:
>
> *Over the past 2 weeks:*
> *Have you ever felt down, depressed, or hopeless?*
> *Have you felt little interest or pleasure in doing things?*
>
> One 'yes' answer is a positive screening result, [requiring further assessment/intervention].

Resources

New Jersey Department of Health, "Speak Up When You're Down." http://nj.gov/health/fhs/postpartumdepression

Farr SL, Bitsko RH, Hayes DK, Dietz PM. Mental health and access to services among US women of reproductive age. Am J Obstet Gynecol 2010 Dec;203(6):542-9.

Committee opinion no. 453: Screening for depression during and after pregnancy. Obstet Gynecol 2010 Feb;115(2 Pt 1):394-5

Earls MF. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. Pediatrics 2010 Nov;126(5):1032-9.

Screening for depression in adults: U.S. preventive services task force recommendation statement. Ann Intern Med 2009 Dec 1;151(11):784-92.