PERINATAL DEPRESSION
OVERVIEW

What is Perinatal Depression?

Perinatal depression (PND) is depression that occurs during pregnancy and after childbirth. It is among the most common health challenges women face during pregnancy and is often underdiagnosed. For most women, having a baby is an exciting time, and can cause some anxiety. However, for women suffering from perinatal depression, this time can be very distressing and difficult.

Perinatal depression is a serious, but treatable medical illness involving feelings of extreme sadness, indifference and/or anxiety, as well as changes in energy, sleep and appetite. Pregnancy and the period after delivery is a particularly vulnerable time for women. Mothers often experience biological, emotional, financial and social changes during this time which can increase the risk for developing mental health problems, particularly depression and anxiety.

Perinatal depression is different from the “baby blues,” which affects up to 70 percent of all new mothers and is a short-lasting condition that doesn’t require medical attention. Perinatal depression is an emotionally and physically debilitating condition that may continue for months or more.

This condition carries risks for the mother and child. Studies have shown that perinatal depression results in:

- Expensive medical care
- Infants receiving improper care
- Failure to breastfeed
- Relationship issues within the family
- Increased risk of mistreatment with the child and others in the family
- Poor bonding of mother to baby

The crucial period of early brain development in infants is also at risk when perinatal depression is present and can lead to adverse childhood experiences. Children of mothers with perinatal depression are at greater risk for cognitive, emotional, developmental and verbal deficits, and impaired social skills.

Getting treatment is important for both the mother and child. It is critical that providers include perinatal depression screenings as part of their office visit routine with pregnant women and women who have delivered within the last year.

CareSource®

Key Facts

Prevalence

- Perinatal depression affects one in seven women – this includes minor and major depressive episodes that occur throughout pregnancy or within the first 12 months after childbirth
- Nearly two-thirds of women with perinatal depression also have an anxiety disorder
- Up to 70 percent of all new mothers experience the “baby blues” with changes in emotional, mental and physical states related to the pregnancy
- An estimated 4 percent of fathers experience depression in the first year after their child’s birth

General Symptoms

A woman experiencing depression usually has several symptoms with changing severity over the course of the condition. The symptoms may cause new mothers to feel isolated, guilty or ashamed. To be diagnosed with perinatal depression, the symptoms listed below must begin within four weeks following the delivery; however, symptoms of depression may occur at any time:

- Sluggishness, fatigue
- Feeling sad, hopeless, helpless, or worthless
- Difficulty sleeping/sleeping too much
- Changes in appetite
- Difficulty concentrating/confusion
- Crying for no reason
- Lack of interest in the baby; not feeling bonded to the baby or feeling very anxious about the baby
- Feelings of being a bad mother
- Fear of harming the baby or oneself
- Loss of interest or pleasure in life

Many women with perinatal depression also experience anxiety. Any woman who experiences the symptoms of perinatal depression should seek an evaluation by a medical provider.

Women in the postpartum phase should seek medical help if:

- They are experiencing several of the symptoms above for more than two weeks
- They have thoughts of suicide or of harming the child
- Their depressed feelings are getting worse
- They are having trouble with daily tasks or taking care of the baby

Risk Factors

Any new mother can experience the symptoms of peripartum depression or other mood disorder. Women are at increased risk of depression during or after pregnancy if they have previously experienced (or have a family history of) depression or other mood disorders, if they are experiencing particularly stressful life events in addition to the pregnancy, or if they don’t have the support of family and friends.

Research suggests that a dramatic drop in hormones (estrogen, progesterone), and low levels of thyroid after delivery have a strong effect on moods, leaving mothers feeling tired and sluggish and may contribute to perinatal depression. Other factors that may contribute include physical changes with pregnancy, lifestyle factors, worries about parenting, and lack of sleep.

Fathers: Pregnancy/Childbirth and Depression
New fathers can also experience symptoms of perinatal depression. Symptoms may include fatigue and changes in eating or sleeping. An estimated 4 percent of fathers experience depression in the first year after their child’s birth. Younger fathers, fathers with history of depression and fathers with financial difficulties are at increased risk of experiencing depression.

Assessment & Screening

An assessment should include a medical evaluation and psychiatric evaluation to rule out physical problems that may have symptoms similar to depression (such as thyroid problems or vitamin deficiencies).

Screening Tools

General depression assessment tools include the Patient Health Questionnaire (PHQ) and the Beck Depression Inventory Scale.

For depression related to pregnancy and perinatal, the following is used:

- **Edinburgh Depression Scale (EDS)** – a 10-item self-report measure designed to screen women for symptoms of emotional distress during pregnancy and the postnatal period

It is recommended that an OB-GYN or other obstetric care provider screen at least once for depression and anxiety using one of the validated instruments for each patient during pregnancy. During perinatal visits, a validated screening tool should be used to complete the assessment of the patient's mood and emotional well-being. Providers should also give ongoing oversight for patients with a history of mood disorders or suicidal thoughts. Recommendation by the American Academy of Pediatrics (AAP) And the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Provider Reference Module include integrating perinatal depression surveillance and screening at the first, second, fourth and sixth month well-child visits. Routine screening for perinatal depression should occur during well-child visits.

Importance of Screening

According to an analysis of National Ambulatory Medical Care Surveys, provider screening for depression is extremely low despite the high prevalence of depression in primary care. Approximately 10 to 12 percent of patients have some form of depression, yet screening for depression only occurs with 2 to 4 percent of patients. In 2016, the U.S. Preventive Services Task Force changed its recommendation for routine depression screening to an endorsing depression screening in the general adult population, including pregnant and perinatal women. It is difficult to distinguish the effect solely due to screening or screening combined with some type of intervention. Nevertheless, follow up of these patients several weeks to months later demonstrated an absolute risk reduction in depression prevalence of as much as 9%.

Treatment Practices

Many women may suffer in silence, dismissing their struggles as a normal part of pregnancy and childbirth and do not seek care. However, treatment for depression during and after pregnancy is essential and should be considered seriously. Greater awareness and understanding can lead to better outcomes for women and their babies. The following treatment practices are recommended for perinatal depression:

- **Psychotherapy** – Like other types of depression, peripartum depression can be treated with psychotherapy (talk therapy), medication, lifestyle changes and supports, or a combination of these. Women who are pregnant or nursing should discuss the risks and benefits of medication with their doctors. In general, the risk of birth defects to the unborn baby are low, and the decision should be made based on the potential risks and benefits. American Psychiatric Association (APA) guidelines for treating women with major depressive disorder who are pregnant or breastfeeding recommend psychotherapy without medication as a first-line treatment when the depression or anxiety is mild.
- **Medication** – For women with moderate or severe depression or anxiety, antidepressant medication should be considered as a primary treatment, according to the guidelines.

  Antidepressant options during pregnancy:
  - Selective serotonin reuptake inhibitors (SSRIs): work with a physician, but note that some SSRIs have been associated with a rare but serious lung problem in newborn babies (persistent pulmonary hypertension of the newborn)
  - Serotonin and norepinephrine reuptake inhibitors (SNRIs)
  - Bupropion (Wellbutrin)
  - Tricyclic antidepressants (TCAs)

  For more information on pregnancy/depression and psychiatric medications, see the MotherToBaby website from the Organization of Tetratology Information Specialists, and the Breastfeeding and Psychiatric Medications website from Massachusetts General Hospital, Center for Women's Mental Health.

  With proper treatment, most new mothers find relief from their symptoms. Women who are treated for peripartum depression should continue treatment even after they feel better. If treatment is stopped too soon, symptoms can reoccur.
- **Self-Help and Coping** – The support of family and friends, joining a mom's support group, and good nutrition and exercise can be helpful. Other suggestions for helping to cope with depression around pregnancy include resting as much as you can (sleep when your baby sleeps) and make time to go out or visit friends.

Related Conditions

(During pregnancy and after childbirth)

- Peripartum anxiety – although estimates vary, a recent study found that about 16 percent of women experience an anxiety disorder during pregnancy and about 17 percent during the perinatal period. After giving birth, some women develop intense anxiety, with rapid heart rate, a sense of impending doom and irrational fears and obsessions. Feeling guilty and blaming oneself when things go wrong, worrying and feeling panicky for no good reason are signs of anxiety in the perinatal period.

  Treatment may include medication and therapy, alone or in combination.
- Peripartum bipolar disorder – Bipolar disorder has two phases, the depression phase (the lows) and the manic phase (the highs). When the lows and highs happen at the same time, it is considered a mixed episode. Bipolar illness can emerge during pregnancy or the perinatal period. Risk factors include a previous mood disorder and family history of mood disorders.

  Symptoms of depression and mania:
  - Severe sadness and irritability
  - Elevated mood
  - Rapid speech and racing thoughts
  - Little or no sleep and high energy
  - Impulsive decisions and poor judgement
  - Delusions that can be grandiose or paranoid
  - Hallucinations – seeing or hearing things that are not present

  Treatment can include mood stabilizers and antipsychotic medications along with therapy.

- Perinatal psychosis – perinatal psychosis is an extremely rare but serious condition. It occurs in only one or two out of every 1,000 deliveries. The symptoms of perinatal psychosis are extreme and may include insomnia, excessive energy, agitation, hearing voices, and extreme paranoia or suspiciousness. Many women with perinatal psychosis have a personal or family history of bipolar disorder. Symptoms of perinatal psychosis can be a serious medical emergency and require immediate attention.

Referrals

It is important that primary care and other health care providers refer to behavioral health therapy or additional treatment for patients who screen in need of additional mental health services. Initiation of treatment or referral to mental health care providers offers the greatest benefit for women suffering from perinatal depression. Fathers can also receive screenings and referrals.

Billing & Coding

Below lists the CPT and HCPCS coding for assessment and screening of depression.

Individual Codes	Definition
CPT 96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
CPT 96127	Brief emotional and behavioral assessment
CPT 96156	Health behavior assessment, or re-assessment
HCPCS G0444	Annual depression screening

Please note: These codes are examples of codes typically billed for this type of service and are subject to change. Billing these codes does not guarantee payment.

Medicaid providers should check the Indiana Medicaid Fee Schedule prior to claim submission at www.in.gov/medicaid/providers/index.html.

Marketplace providers should refer to the Centers for Medicare and Medicaid Services (CMS) Fee Schedule prior to claim submission at the Myers and Stauffer website

CareSource Resources

Referring to Provider

Your patients experiencing depression who are CareSource members can get help when they need it by seeing a mental health professional or going to any provider in our network. If a screening is positive for depression, the provider can outreach to a behavioral health provider within the CareSource provider network. Indiana Medicaid members can see any Indiana Health Coverage Programs (IHCP) psychiatrist with no referral. All other Indiana behavioral health providers must be in-network and can be self-referred. Providers can refer patients to care management by calling CareSource Member Services at 1-844-607-2829 (TTY: 1-800-743-3333 or 711). CareSource members can also find a provider close to them by calling Member Services.

The CareSource Find-a-Doc tool helps find a variety of health professionals, including: marriage and family therapists, substance use counselors, social workers, community mental health centers and more: Caresource.com/providers/Indiana

If your patient is having suicidal thoughts, they may contact the Suicide Prevention Lifeline at 1-800-273-TALK (8255).

Care Management

A Care Manager can help members find the resources needed to be healthy. If a member does not have a Care Manager, they can request one by calling Member Services at 1-844-607-2829 (TTY: 1-800-743-333 or 711).

MyStrength

CareSource members can access the myStrength tool for personalized support to help improve mood and engage in online activities that include:

- Learning about depression, anxiety and substance abuse
- Using empowering self-help tools like mood trackers, thought and feeling logs
- Accessing wellness resources such as mindfulness exercises, parenting tips, weigh and stress management
- Review inspirational daily quotes
- Establishing goals and earning badges when goals are met
- Reviewing articles and videos on a variety of topics

Members can visit myStrength.com and complete the registration process to create a personal profile and access the benefits of the tool.

Depression Toolkit

CareSource has developed an online Depression Toolkit with information and resources that help with identifying patients with depression and understanding next steps for patients with depression. These resources can be incorporated into your everyday practice to ensure continuity of care and coordination for your patients with mental health issues.

- Major Depressive Disorder Overview
- Major Depressive Disorder Interventions Fact Sheet
- Major Depressive Disorder Clinical Practice Guideline
- PHQ-9 Screening Tool & Instructions
- Beck Depression Inventory Screening Tool & Instructions
- Perinatal Mood Disorder Overview
- Perinatal Mood Disorder Clinical Practice Guideline
- Edinburgh Postnatal Depression Scale Tool & Instructions

Source Citations

American Psychiatric Association, What is Depression?
American Academy of Family Physicians (https://www.aafp.org/home.html)
American College of Obstetricians and Gynecologists (www.ACOG.org)
Beck Depression Inventory (https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/beck-depression)
Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition TR (2013).
Division of Mental Health and Addictions (https://www.in.gov/fssa/dmha/index.htm)
Edinburgh Postpartum Depression Scale (http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf)
Mental Health America of Indiana (https://arc.mhanational.org/user/mhaindiana&quot)
Office on Women's Health, U.S. Department of Health and Human Services (www.womenshealth.gov)
PHQ-9 (https://med.stanford.edu/fastlab/research/imapp/msrs/_jcr_content/main/accordion/accordion_content3/download_256324296/file.res/PHQ9%20id%20date%2008.03.pd)
Perinatal Depression Screening Scale (https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf)
Perinatal Support International (www.postpartum.net)

Disclaimer: Recommendation of treatment does not guarantee coverage of services

IN-MED-P-95256a | Issued Date: 3/22/21 | OMPP Approved: 3/22/21

CareSource®