

Children's TiPS

Psychiatry: Screening for Postpartum Depression in Pediatric Primary Care

By: Dr Eydie Moses-Kolko

Approximately 15% of new mothers will experience depression within 3 months postpartum (Postpartum depression; PPD). Twice as many minority and low-income mothers will experience postpartum depression. Some will have symptom severity that reaches the threshold of a major depression episode, which is defined by the presence of at least low mood or lack of interest for 2 weeks accompanied by hyperphagia or anorexia, hypersomnia or insomnia, fatigue, restlessness or slowing, inappropriate guilt, poor concentration, and recurrent thoughts of death or suicide. Other mothers will only have a couple of these symptoms, indicative of a milder syndrome. Intervention even for mild symptoms can be extremely effective in preventing further worsening. Common sense strategies to reduce stress and to facilitate adjustment to motherhood include increasing social and material support, taking breaks from childcare to take care of oneself, optimizing sleep, and increasing pleasurable activities. Fathers and partners often benefit from support themselves, given the high correlation of depressive symptom between mothers and their partners.

Anxiety is a common feature of PPD and is more prevalent in postpartum women than in the general population. Women often complain that their "brain won't shut off" due to incessant worry. This can be associated with panic symptoms and insomnia even when the baby is sleeping. Obsessions that may not meet the severity threshold for Obsessive Compulsive Disorder (OCD) are present in 25% of new mothers and often take the form of intrusive, irrational fears of harm coming to their children or other loved ones with compensatory compulsive checking on their welfare, irrational aggressive thoughts directed toward their children, or compulsive, ritualistic routines for pumping and storing breastmilk, and for avoiding contact with



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germs or contaminants. Any aggressive thoughts must be evaluated by the clinician to confirm that the mother finds the aggressive thoughts distasteful (ego dystonic) and that there is no risk of harm to the infant.

Post-traumatic stress disorder (PTSD) is a common underlying cause of anxiety which occurs following exposure to actual or threatened death or serious injury to oneself or a loved one, and includes intrusive memories during sleep or while awake, avoidance of memories, changes in cognitions and mood, and changes in arousal and reactivity. PTSD affects 20% of women who experience high risk deliveries, which can include a difficult birth, emergency c-section, fear of birth, history of sexual or physical abuse, very low birth weight babies, preterm birth, fetal anomalies, perinatal loss, and pregnancy medical complications (ie: hyperemesis gravidarum, pre-eclampsia, and HELLP). It is beneficial to identify the presence of PTSD, as affected women may benefit from specialized behavioral treatments, such as prolonged exposure and trauma-focused CBT.

Postpartum psychosis, a much different and more serious illness, usually begins within 2 weeks postpartum and is characterized by profound insomnia, confusion, disorientation, agitation or stupor, hallucinations, and delusions. Postpartum psychosis occurs in 0.3-0.6/1000 births and is a medical emergency that requires urgent psychiatric hospitalization and treatment with mood stabilizer medication (ie: Lithium or antipsychotic medications).

Screening for depression during pregnancy and after delivery is an important public health method to increase identification of mothers with PPD. The most commonly used screening instrument for PPD is the Edinburgh Postnatal Depression Scale (EPDS). Scores ≥ 10 are suggestive of milder depression, whereas scores ≥ 13 (postpartum) and ≥ 15 (antenatal) confer greater specificity for a major depressive episode. Research demonstrates that when screening is implemented into the workflow of a clinic, more depressed mothers are identified, and the practitioners are 2x more likely to refer such women for treatment. It is important for the clini-

cian to review responses with the mother, and to specifically look at the response to item 10 to assess for mothers' safety. In women who reports thoughts to harm themselves, assess suicide directly and specifically and get input from family members. Download a card that summarizes the gold standard for suicide assessment so that you feel prepared <http://www.sprc.org/resources-programs/suicide-assessment-five-step-evaluation-and-triage-safe-t-pocket-card>.

On the EPDS, a score greater than 12 in new mothers for whom the clinician is also alarmed by the clinical presentation or intent/plan for self harm, suicide, or harm to others, must get urgent evaluation in an ER. When such urgency is not present, a referral for a psychiatric evaluation and psychotherapy, and a follow-up phone call are effective. For scores 10-12, (concern for minor depression), the clinician can discuss stress relief, coping strategies, self-care, and sleep hygiene with the mother, in addition to following-up at the next appointment. For women who score less than 10, screening provides an opportunity for education about warning signs of depression. Clinics can be best prepared by creating a detailed resource list, organized by county, including both emergency and non-emergency services, for mothers with postpartum mood disorders.

Over 50% of women with postpartum depression (PPD) have experienced mood disorder symptoms during pregnancy or prior to conception. As such, PPD is generally a manifestation of a recurrent mood disorder and should be treated using the common paradigm of psychotropic medications in combination with behavioral treatments. Primary care and OB-GYN practitioners are increasingly experienced in prescribing SSRIs and may constitute the best referral plan for some mothers. PPD is treatable. Antidepressants yield an approximately 50% remission rate. The best studied medications include Fluoxetine, Sertraline, and Nortriptyline, with smaller positive studies of Paroxetine, venlafaxine, escitalopram, and bupropion. In studies of mother to infant transfer of drug through

Psychiatry (cont.)

lactation, all antidepressants yield less than a 10% relative infant dose and most yield less than a 4% relative infant dose. Behavioral interventions yield an approximately 40% remission rate. The best studied interventions include Home visitors, Interpersonal psychotherapy and Cognitive Behavioral Therapy.

Postpartum depression is a mental health disorder that has gained increasing attention over the recent decades. Progress in medical research, advocacy, as well as grassroots support networks for new mothers has increased opportunities for women to get help. Below are websites to provide further information and referral resources.

www.postpartumpgh.org

<http://www.postpartum.net/>

Yearly TiPS Survey

Dear Primary Care Clinicians:

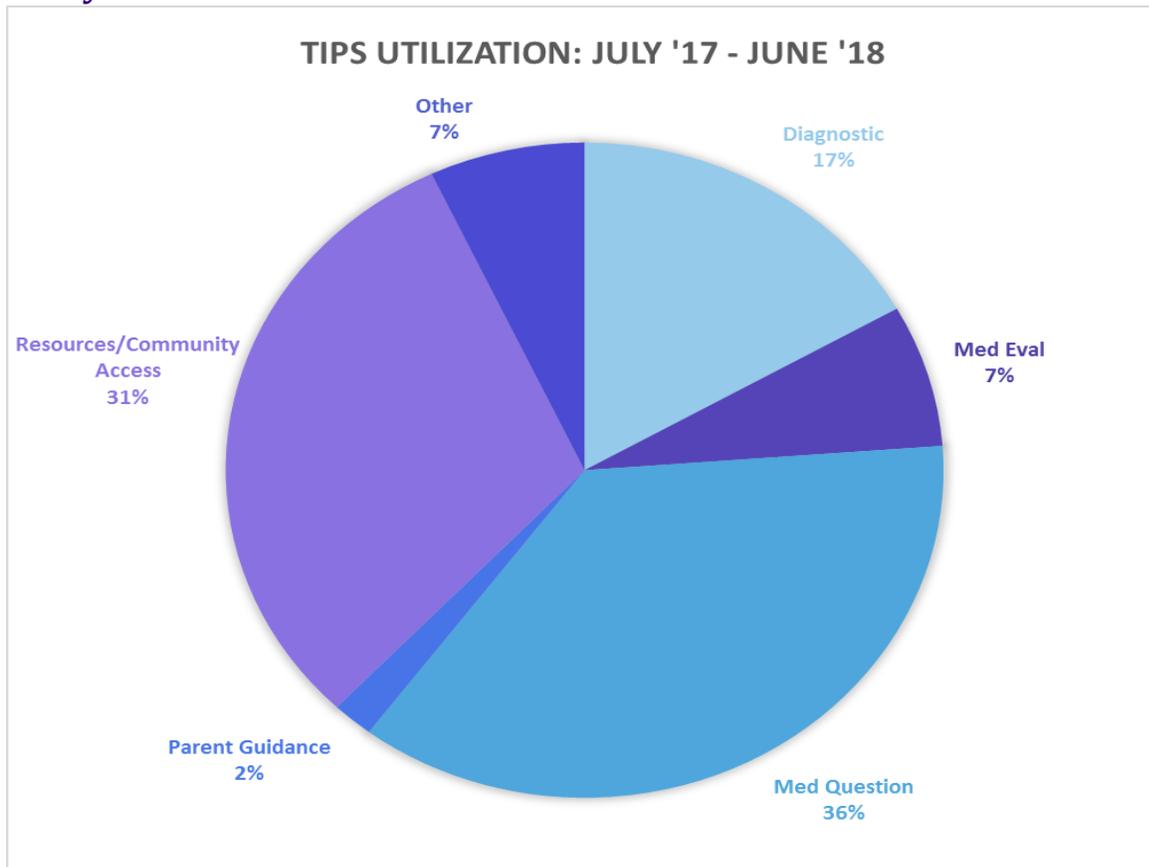
It's hard to believe that it's been two years since the start of Children's TiPS. We have learned so much about this model from you, our referring providers. We hope that having access to experts in child psychiatry has increased your knowledge on behavioral health conditions and medications; provided you with additional support; and enhanced the care of children and adolescents at your practice. As we enter our third year, we'd love to hear from you about how we are doing and how we can improve our services. Your honest feedback is valued and appreciated! Please take a few minutes to complete our annual survey:

<https://www.surveymonkey.com/r/TiPS2018AnnualSurvey>

Thank you,

Colleen Gianneski, LCSW
Children's TiPS Program Manager

Yearly TiPS Data



*Other includes: (Collateral contact, crisis, follow up, parent guidance, school issues, second opinion, and non-member specific data - all less than 5%)

TiPS Conference

Save the Date:

TiPS Conference

Friday, March 22, 2019

Location: Hilton Garden Inn at
Southpointe

Congratulations

Congratulations to TiPS Care Coordinator, Taylor Naus, LCSW on receiving the UPMC ACES award (Award for Commitment and Excellence in Service)

Welcome

Children's TiPS would like to give a warm welcome to our new team member:

- TiPS Therapist - Shelley Wikert, LPC

For Enrolled Practices

We will be reaching out to the following practices to set up a yearly practice visit:

- CCP Mt. Lebanon
- Hope Pediatrics – Seneca, PA
- Kids Plus Pleasant Hills
- CCP Allegheny
- Kids Plus – Cranberry
- Premier Medical – Monroeville
- Westmorland Family Medicine
- Forbes Family Medicine Residency
- Kids Plus – Squirrel Hill
- Cherry Tree Pediatrics

Care Coordination



By: Nanelle Florence, MSW

Being a new mom can be a very wonderful and challenging experience. Having a baby, for many women, can be one of the biggest joys of their lives. However, for some women instead of feeling overjoyed they may feel sad, anxious, or depressed. It's important for new mothers and those who love them to understand the symptoms of postpartum depression and the resources that are available to them.

Here are some useful resources for mother's experiencing postpartum depression:

Postpartum Support Coordinator: Coordinators offer caring and informed support and resources to moms and their families. They also provide information and resources for area providers who are caring for pregnant and postpartum families.

JODIE HNATKOVICH
Pittsburgh
412-605-4211 TEXT OR CALL
jodie.hnatkovich@gmail.com

JENNIFER COCCARO
Greater Pittsburgh Area
jennifercoccaro1@gmail.com

ERIN SADDIC
Greater Philadelphia Area
610-931-5547 TEXT OR CALL
erinsaddic4@gmail.com

PERRI SHAW BORISH
Greater Philadelphia Area
215-840-3554 TEXT OR CALL
perrishawborish@gmail.com

TRICIA STEELE
Central PA
570-560-4715
tltsteele@gmail.com

APRIL GABRIEL-FERRETTI

NICOLE MOORE
NW Pennsylvania
814-580-6259 TEXT OR CALL
psi.nicolemoore18@gmail.com

Websites:

<http://www.postpartum.net/learn-more/useful-links/>

<http://www.postpartum.net/learn-more/help-for-moms/>

<https://store.samhsa.gov/shin/content/SMA14-4878/SMA14-4878.pdf>

<https://www.alexisjoyfoundation.org/perinatal-disorders.html>

Follow up on Autism: An Exciting Training Opportunity!

Clinicians at the Center for Autism and Developmental Disorders are inviting physicians to join a grant-funded service that is improving care for patients with autism spectrum disorder. We are sure you have children in your practice with ASD and would like to become even more proficient in making decisions about their healthcare, including screening, diagnosing, and treatment of ASD. ECHO (Extension for Community Healthcare Outcomes) Autism, aims to increase provider confidence and assurance when treating patients with ASD and supporting their families. The Center for Autism & Developmental Disorders at UPMC Western Psychiatric Hospital is recruiting providers to attend our on-line clinic over a six-month period. Participating providers will learn the latest approaches to identify children with autism and manage their comorbidities.

If you have any questions regarding this program or if you or someone in your practice is interested in learning more, please feel free to contact our lead clinician at 412-235-5447 or at kdalope@upmc.edu.

Meet the TiPS Team—Staff Highlight

Anna Jolliffe, MD

Your Job Title/Location:

Child and Adolescent Psychiatrist:

- I work with residents, psychologists and psychology trainees on the Behavioral Health Consult Liaison service at Children's Hospital
- I see children and adolescents at the Child and Family Counseling Center at Children's South in Bridgeville
- I provides phone and in person psychiatric consultations for TiPS

Education:

- Undergraduate: Shepherd University
- Medical School: West Virginia School of Osteopathic Medicine
- Residency: Triple Board Residency (combined training in Pediatrics, Psychiatry and Child and Adolescent Psychiatry) at the University Of Utah
- Fellowship: Psychosomatic Medicine (Consult Liaison Psychiatry) at the National Institutes of Health/MedSTAR Georgetown University Hospital

Certifications:

American Academy of Pediatrics

About You:

I am originally from West Virginia. I trained in Salt Lake City and Washington, DC and came to Pittsburgh last year to be closer to family again. I am still learning the city and figuring things out.

Your Favorite Food:

Indian and Thai food

About Your Job:

I love working with children and families. Through my training I specialize in medically complex children with psychiatric needs or presentations on the border of medicine and psychiatry but I really enjoy seeing my general behavioral health patients as well.

What do you like to do in your free time:

I love to travel, learn new things and experience different cultures. I enjoy hiking, trail running and spending time with my family and obnoxious dog.



Contact Us

Phone: 1-844-972-8477

Email: wpatips@chp.edu

Website: www.chp.edu/tips

Children's TiPS

Our provider-to-provider service gives primary care clinicians (PCCs) access to on-call psychiatrists, Monday through Friday, 9 a.m. to 5 p.m. When a PCC calls, the Children's TiPS team will connect him or her with a child and adolescent psychiatrist within the same day, often within thirty minutes. Our TiPS psychiatrists can answer questions about medications, diagnoses, screening tools, resources, and other topics. TiPS psychiatrists can also refer patients to our care coordinators or licensed therapists if needed.



Children's TiPS

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A Behavioral Health Newsletter for Pediatric Primary Care Clinicians

PLEASE
PLACE
STAMP
HERE

