Randomised controlled trial

Primary care-based screening, diagnosis and management of postpartum depression effective for improving symptoms

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10.1136/eb-2012-100972

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Commentary on: **Yawn BP**, Dietrich AJ, Wollan P, *et al.* In collaboration with the TRIPPD practices. TRIPPD: a Practice-Based Network Effectiveness Study of Postpartum Depression Screening and Management. *Ann Fam Med* 2012;**10**:320–9.

Context

Postpartum depression (PPD) is a debilitating mental health disorder that negatively affects maternal functioning and child outcomes. Prevalence rates demonstrate that up to 19.2% of women will develop a major or minor depressive episode within the first 3 months postpartum.[1] Depression places the second greatest burden on the health of childbearing women worldwide. Despite the prevalence and negative consequences of PPD, it is a condition that has been under-recognised and undertreated in primary care settings. Universal screening efforts have been implemented in multiple medical and community settings. However, there are drawbacks to universal screening and limited empirical data demonstrating its effectiveness. A major criticism of universal screening is the availability and capacity to provide treatment for postpartum women identified as having high levels of depressive symptoms. Extensive literature documents the barriers to treatment for PPD. There are personal, logistical and institutional barriers, such as lack of insurance, stigma, fear of mental health systems and limited mental health services.[2] Mental health treatment utilisation is low for postpartum women with depression, which indicates a significant unmet need.

Methods

Translating Research into Practice for Postpartum Depression (TRIPPD) effectiveness study included screening, diagnosis and management of PPD within a national sample of family medicine practices. Practices were randomised into the intervention or usual care. The intervention involved a multiple step process in PPD identification and treatment. English and Spanish speaking women 18 years or older, who were 5–12 weeks postpartum and receiving continuing care at the practice, were initially screened using the Edinburgh Postnatal Depression Screening Scale (EPDS). Women screening positive on the EPDS were administered the Patient Health Questionnaire and given a physician evaluation to determine diagnosis. Management involved guidance for follow-up visits, medication, nursing follow-up calls and information about therapy. The intervention practices received training and tools for the multiple step process, while the usual care practices received a brief training about PPD. Data were collected at 6 and 12 months postpartum through self-report questionnaires (depression, parenting stress and dyadic satisfaction) and systematised medical records review (diagnosis and treatment utilisation). Generalised linear mixed effects models were used to test group differences on primary and secondary outcomes.

Findings

Twenty-eight practices completed the study with a total of 2343 women enrolled. Of these participants, 80% (1897) completed at least one of the questionnaires to be included in the analyses. Despite randomisation, there were group differences between the intervention and usual care groups. Women in the intervention group had lower income, less education and were less likely to be married than usual care women. Among the sample, 34.5% screened positive for PPD. Of those screening positive, women in the intervention group were more likely to be diagnosed with PPD, to be treated with medication and to receive counselling than the women in the usual care group. Additionally, the intervention group had less depressive symptoms at 6 and 12 months postpartum compared to the usual care group. PPD diagnosis was associated with depression improvement, while elevated parenting stress was negatively associated with depression improvement.

Commentary

Primary care offers a unique opportunity to identify and treat PPD in an environment that the mothers already routinely attend. TRIPPD showed that screening, evaluating and managing PPD through medication, nursing follow-up and mental health referral can be effectively implemented within family medicine practices and have benefits to depressive symptoms. This is a significant finding lending support to universal screening with a systematic process to diagnose, treat and refer. The study has a sound design with a sufficient sample size. Nursing follow-up calls were difficult to implement due to staff and participant availability. Finding novel ways for follow-up, such as technology, should be explored. The exclusion of teenage mothers is a limitation, as this is a particularly vulnerable group for PPD. Other vulnerable groups are postpartum low income and ethnic minority women, who have an increased risk for PPD but less access to mental health treatment. The strength of TRIPPD is that the intervention group showed improvement while including a greater percentage of women with lower resources; nonetheless, ethnicity was not examined. Effective depression treatment for postpartum mothers is a critical first step, but it may not be sufficient as the parenting role is not addressed.

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Parenting stress was associated with a poor treatment response, suggesting that parenting resources would be an important component to include in an intervention with postpartum mothers. As a result of the generational impact, longer follow-up of intervention effects on mother and child is warranted.

Competing interests None.

References

1. **Gavin NI,** Gaynes BN, Lohr KN, *et al*. Perinatal depression—a systematic review of prevalence and incidence. *Obstet Gynecol* 2005;**106**:1071–83.
2. **Boyd RC,** Mogul M, Newman D, *et al*. Screening and referral for postpartum depression among low-income women: a qualitative perspective from community health workers. *Depress Res Treat* 2011;**2011**:320605.

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