The Texas Clinician's Postpartum Depression Toolkit

Volume 1

A resource for screening, diagnosis and treatment of postpartum depression

TEXAS
Health and Human Services

Table of Contents

1. Introduction

Definition and Prevalence

Although the term "postpartum depression" is commonly used, it is important to note that depression can occur during pregnancy as well as after the baby is born, leading some authors to prefer the term "perinatal depression," or simply "maternal depression." The term used, its precise definition, and prevalence of the condition vary in the literature. Prevalence is greater if both major and minor depressive episodes are included than if only major depressive episodes are considered.

As many as 80 percent of new mothers experience a brief episode of the "baby blues" beginning in the first few days after childbirth and lasting up to about 10 days (Hirst & Moutier, 2010, Langan & Goodbred, 2016). Symptoms are generally mild and self-limited, and include such things as poor sleep patterns, irritability, and brief crying episodes. Thoughts of suicide do not occur. Treatment includes reassurance and support of the mother. This should not be confused with postpartum depression, which is more serious and may require additional treatment.

As stated, the definition and prevalence vary by source as noted below:

The American College of Obstetricians and Gynecologists (ACOG, 2015), defines perinatal depression as any major or minor depressive episode with onset during pregnancy or in the first year after childbirth. It is estimated to occur in approximately one woman in seven.

*The Diagnostic and Statistical Manual of Mental Diso*rders (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) does not define depression that occurs in the perinatal period as a separate disorder, but includes "with peripartum onset" as a specifier for an episode of depression that occurs during pregnancy or in the first 4 weeks after delivery. The authors note that 3 to 6 percent of women will experience a major depressive episode during pregnancy or after delivery, and that one-half of so-called "postpartum" major depressive episodes actually have their onset before delivery.

Meltzer-Brody & Jones (2015) cite a postpartum depression prevalence of 10-15 percent without providing a precise definition.

Scope

ACOG (2015) recommends that all women undergo screening for perinatal depression at least once during the perinatal period, using a validated screening tool. While it is well accepted that an episode of depression may begin during the pregnancy as well as after delivery, the scope of this toolkit is restricted to the screening, diagnosis, and treatment of depression in postpartum women. The target audience is all clinicians who provide care to women in the postpartum period. Providers who care for pregnant women are strongly encouraged to be mindful of the possibility of depression occurring during pregnancy and to take necessary steps to evaluate and manage this appropriately.

Risk factors

Women with a history of anxiety or mood symptoms during the pregnancy, or an episode of the "baby blues" following delivery, are at increased risk of a major depressive episode in the postpartum period (APA, 2013). The single greatest risk factor for postpartum depression is a prior history of depression (Langan & Goodbred, 2016). It is important to note, however, that a woman without any known risk factors may develop postpartum depression.

Other risk factors include, but are not limited to, all of the following (ACOG, 2015; ACOG, 2016; Langan & Goodbred, 2016; Norhayati, *et al*., 2015):

- Symptoms of depression (especially in the third trimester) or anxiety during the pregnancy
- Prior psychiatric illness or poor mental health, especially postpartum depression with a prior pregnancy
- A history of physical, sexual, or psychological abuse; domestic violence
- Family history of depression, anxiety, or bipolar disorder
- Lack of social support
- Low socio-economic status or educational level
- Immigrant from another country
- Medicaid insurance
- Poor income or unemployment

- Intention to return to work
- Single parent status
- Poor relationship with a partner or the father of the baby
- Unintended pregnancy or a negative attitude toward the pregnancy
- Traumatic childbirth experience
- Stress related to child care issues
- Medical illness, neonatal intensive care unit admission, or prematurity in the infant
- Difficulties with breastfeeding
- A temperamentally difficult infant
- A recent stressful life event or perceived stress
- Smoking
- A history of bothersome premenstrual syndrome

2. Screening and Diagnosis of Postpartum Depression

Screening tools

Postpartum depression is a common, potentially serious, and sometimes life-threatening condition. All mothers should undergo screening for depression at the postpartum visit. It is important to note as well that, because common symptoms of depression overlap considerably with those of normal pregnancy and postpartum periods (eg, changes in appetite, sleep patterns, and libido), perinatal depression often goes unrecognized.
For those who screen negative initially, repeat screening should be considered at a later visit or when the mother takes her baby in for a checkup. Baby checkup visits offer a good opportunity to screen mothers who missed their postpartum visit, those who might benefit from repeat screening, and those who failed to undergo earlier screening for any reason (Earls & American Academy of Pediatrics [APA] Committee on Psychosocial Aspects of Child and Family Health, 2010).

A standardized self-administered screening tool, followed by a review of the patient's responses and follow-up questions in a face-to-face interview with the provider, will ensure consistency and efficiency in the screening process (ACOG, 2015; Myers, et al., 2013; Langan & Goodbred, 2016; Norhayati, et al., 2015; O'Connor, et al., 2016; O'Hara & Scott).

The following postpartum depression screening tools have been validated for use in postpartum patients:

- Edinburgh Postnatal Depression Scale (EPDS; Cox, *et al.*, 1987)
- Patient Health Questionnaire-9 (PHQ-9; Yawn, *et al*., 2009)
- Postpartum Depression Screening Scale (PDSS; Beck & Gable, 2000)

To help mothers receive screening without undue interruption of a clinic workflow, the following methods could be used as a convenient approach to screening:

- Give each postpartum woman a screening tool to complete, in the form of a printed sheet with a clipboard, while she waits for her visit with the clinician.

- Score the completed tool, according to the standards provided for each tool, and assess whether the screen is positive or negative (O'Hara & Scott):
  - EPDS: A 10-item tool to screen for postpartum depression available at the link provided above. A score of 10 or more suggests depressive symptoms. A score of 13 or more indicates a high likelihood of major depression. A score of 1 or more on question #10 is an automatic positive screen because it indicates possible suicidal ideation and requires immediate further evaluation.
  - PHQ-9: A 9-item tool available free of charge in multiple languages at the link provided. A score of 10 or more indicates a high risk of having or developing depression. A score of 2 or more on question #9 is an automatic positive screen because it indicates possible suicidal ideation and requires immediate further evaluation.
  - PDSS: A tool to screen for postpartum depression available in long and short versions for purchase from multiple vendors.
    - PDSS Full form (35-item version): A score of 60 or more suggests depressive symptoms; a score of 81 or more indicates a high likelihood of major depression. A score of 6 or more on the SUI (suicidal thoughts) subscale is an automatic positive screen because it indicates possible suicidal ideation and requires immediate further evaluation.
    - PDSS Short form (7-item version): A score of 14 or more indicates a high risk of major depression. A score of 2 or more on question #7 is an automatic positive screen because it indicates possible suicidal ideation and requires immediate further evaluation.
- The tool can be scored by a nonclinical staff person.
- A clinician with appropriate training should review the screen, discuss it with the woman, and ask follow-up questions to evaluate her risk of having postpartum depression.

Screening for suicide risk

In a study of women who screened positive for depression, either early in the third trimester or at the postpartum visit, approximately 3.8 percent reported suicidal ideation (Kim, *et al*., 2015). Among women with suicidal ideation, approximately 1.1 percent also reported having a plan, the intent, and access to the means to carry it out. Single relationship status, non-

white ethnicity, non-English speaking, and severe vaginal laceration at delivery were associated with suicidal ideation. Immigrant Hispanic women may be at higher risk for postpartum depression and suicidal ideation (Shellman, *et al*., 2014).

The *DSM-5* notes that suicidal behavior may occur with any major depressive episode, and the most commonly cited risk factor is a prior suicide attempt or threat (APA, 2013). However, most completed suicide attempts are not preceded by a failed attempt, so women with no prior suicide attempt should not be automatically considered free of suicide risk. Other risk factors for a completed suicide in the setting of a major depressive episode are single status, living alone, and prominent feelings of hopelessness. In general, women are more likely than men to attempt suicide, but less likely to complete a suicide attempt.

Any patient with a positive response to questions related to suicide risk on the screening tool, and any patient who expresses or is suspected of having suicidal thoughts or ideas, should immediately undergo a thorough suicide risk assessment (Zero Suicide Advisory Group, 2015). For information on how to conduct a suicide risk assessment, and best practices for preventing suicide and treating a person at risk of suicide, see the ZERO Suicide web site.

Any patient who is felt to be acutely at risk of suicide or infant harm should be referred for emergent evaluation and/or hospitalization as indicated (Langan & Goodbred, 2016).

Diagnosis

For women with a positive postpartum depression screen, the diagnosis of postpartum depression is based on the diagnostic criteria for major depressive disorder in the *DSM-5*, which requires the presence of 5 of the 9 diagnostic criteria listed in Table 1 for 2 weeks or more (APA, 2013).

Symptom one or two in Table 1 must be present for a diagnosis of postpartum depression. Additionally, to be counted toward the diagnosis, symptoms other than suicide must be present and prominent on most days. Symptoms five through eight in Table 1 may overlap with normal postpartum symptoms.

Table 1. Symptoms of Major Depressive Disorder, DSM-5[i]

1. Depressed mood most of the time on most days, either by subjective report (eg, feelings of sadness, hopelessness, or emptiness) or by observed behavior (eg, tearfulness)
2. Substantially decreased interest or ability to enjoy all or most activities (may be reported subjectively or observed)
3. Psychomotor retardation or agitation
4. Feelings of worthlessness or guilt
5. Indecisiveness or difficulty concentrating
6. Significant change in weight (gain or loss) or appetite (increase or decrease)
7. Insomnia or hypersomnia
8. Decreased energy or excess fatigue
9. Frequent thoughts of death (not just fear of death), suicide attempt, or suicidal thoughts (with or without a plan)

[i] Hirst & Moutier, 2010, Langan & Goodbred, 2016

The diagnosis of depression in a postpartum woman presents several challenges (Hirst & Moutier, 2010). For example, fatigue and difficulty sleeping may be a normal response to the demands of a new baby. Asking her if she has difficulty sleeping even when her baby is asleep can help to identify sleep difficulty related to depression. Similarly, occasional problems concentrating can be normal, but persistent difficulty with thinking and concentration is more likely to relate to depression.

Women with postpartum depression are less likely to report feelings of sadness than other persons with depression; rather, they commonly have prominent feelings of guilt or worthlessness, and experience a loss of enjoyment of usually pleasurable activities (Hirst & Moutier, 2010). They frequently have thoughts of aggression focused on the infant, which may result in an attempt to avoid the infant in order to minimize these thoughts. They may not report this experience to the provider due to feelings of guilt or shame. It is important to inquire about such symptoms in a

nonjudgmental fashion, explaining that such thoughts are common in postpartum depression and do not reflect on the woman herself.

Severity of the depression is based on the number of symptoms present from Table 1, their severity, and the degree of resulting impairment (APA, 2013):

- Mild depression is characterized by the presence of relatively few symptoms that cause a manageable amount of distress and only limited impairment of social or work function.
- Severe depression is associated with the presence of many more symptoms than the minimum required to make the diagnosis, together with substantial distress and impairment of social or work function.
- Moderate depression is characterized by a state between that of mild and severe depression.

Providers should inquire about any history of bipolar disorder or manic symptoms, as women with bipolar disorder are at increased risk of postpartum depression. For any woman with suspected manic symptoms or bipolar disorder, or any history of a psychotic disorder, referral to a mental health professional for evaluation and treatment should be considered, as the management of these conditions may be complex (Hirst & Moutier, 2010; Langan & Goodbred, 2016).

Although postpartum psychosis is uncommon, approximately one-half of such episodes represent the initial manifestation of a severe psychiatric disorder. Any woman with psychotic symptoms at the time of evaluation or in the recent past (either self-reported or observed by another person) should be referred for emergent psychiatric evaluation and consideration of hospitalization, as her condition may deteriorate very rapidly (Langan & Goodbred, 2016; Meltzer-Brody & Jones, 2015).

Laboratory testing

For women with postpartum depression, a thyroid-stimulating hormone (TSH) level should be obtained to evaluate possible hypothyroidism, which can mimic symptoms of depression (Hirst & Moutier, 2010).

3. Treatment of Postpartum Depression

Nonpharmacologic treatment

First-line treatment of mild-to-moderate postpartum depression includes psychological and behavioral therapies, such as individual or group counseling, interpersonal psychotherapy (IPT), and partner-assisted IPT (Hirst & Moutier, 2010; Langan & Goodbred, 2016; Meltzer-Brody & Jones, 2015). The choice of intervention should be dictated by the predominant symptoms. For example, a woman experiencing primarily psychosocial difficulties might benefit most from an IPT intervention with motivational interviewing and collaborative problem solving (Grote, *et al*., 2009). A visiting nurse with specialized training in recognition of postpartum depression and appropriate counseling has demonstrated greater benefit than untrained health care visitors (Langan & Goodbred, 2016).

Mild postpartum depression may respond well to cognitive behavioral interventions (eg, stress management, problem solving, goal setting), provided in individual or group settings (O'Connor, *et al*., 2016). The provider might work with the patient to develop a Postpartum Depression Action Plan and see her again in a week to assess response to the intervention. Response can be assessed by repeating the screening tool to see if the score improves over time. If no improvement is seen, or if symptoms worsen, consideration should be given to initiating pharmacologic therapy.

Pharmacologic treatment

For patients with more severe symptoms and those who do not respond to non-pharmacologic therapy, medication therapy may be appropriate. Selective serotonin reuptake inhibitors (SSRIs) are one class of drugs commonly used to treat postpartum depression (Hirst & Moutier, 2010, Langan & Goodbred, 2016). There is no evidence that one agent is superior to any other. If the patient has taken an antidepressant in the past with good result, that agent would be a logical choice to initiate therapy in the absence of contraindications.

Table 2 provides common initial, treatment, and maximum doses for antidepressant medications (some SSRIs and Bupropion) commonly used to treat postpartum depression.

Table 2. Common Dosing Regimens for Antidepressants in Women with Postpartum Depression[ii]

Drug	Starting dose	Typical treatment dose	Maximum dose
Sertraline	25 mg	50-100 mg	200 mg
Fluoxetine	10 mg	20-40 mg	80 mg
Escitalopram	5 mg	10-20 mg	20 mg
Citalopram	10 mg	20-40 mg	60 mg
Bupropion, sustained release	100 mg	200-300 mg (divided dose)	450 mg

[ii] Hirst & Moutier, 2010

It is generally prudent to start with a low dose and increase as needed, since the side effects of antidepressants can be a barrier to compliance, and because the lowest effective dose is preferred in the breastfeeding mother (Hirst & Moutier, 2010). The response to treatment can be assessed by repeating the screening tool used initially. When remission of symptoms is achieved, treatment is generally continued for a period of time (eg, 6 to 9 months) and then discontinued (Langan & Goodbred, 2016). To minimize the side effects of suddenly discontinuing therapy, the dose can be tapered over a period of two weeks.

Adverse effects that have been associated with SSRIs include headache, diarrhea, nausea, insomnia, sedation, nervousness, tremor, decreased libido, delayed orgasm, and sustained hypertension. Adverse effects of bupropion include seizures (0.4 percent), agitation, dry mouth, nausea, and sweating (Hirst & Moutier, 2010).

Breastfeeding

Relatively little data is available to evaluate the effect of antidepressant medications on breastfeeding and the breastfed infant, and most of the available evidence centers on measurement of drug levels in breast milk and infant serum. In breastfeeding mothers taking antidepressant medication and their infants, concentrations of drug and metabolites in breast milk and infant serum vary widely. The measurement of drug levels in breast milk is influenced by maternal medication dose, maternal plasma drug level, and time since maternal dosing, among other things. In many cases, the active metabolite is present in measurable amounts even when the parent drug is undetectable (Weissman, et al, 2004).

In some reports, breastfed infants of mothers taking antidepressants had serum levels of paroxetine, sertraline, or nortriptyline that were largely undetectable. In infants of mothers taking fluoxetine or citalopram, drug was detectable in the infant's serum at a milk-to-plasma ratio below 0.1 (Hirst & Moutier, 2010).

The LactMed® database provides reviews of safety information on a wide variety of drugs that may be taken by women who are lactating, including antidepressant medications. Measurement of drug levels in breast milk or the serum of breastfed infants is not recommended (ACOG, 2008).

Limited data from prospective cohort studies suggest an association between early cessation of breastfeeding or not breastfeeding, and postpartum depression; however, a causal relationship has not been established (Ip, et al, 2007).

Postpartum depression and treatment with antidepressant medications are not contraindications to breastfeeding. Women who wish to breastfeed while taking antidepressants should be counseled on the benefits of breastfeeding, the value of treating postpartum depression (including the risk of untreated depression), the potential risk of exposure of the infant to the medication or its metabolites, and the limitations of evidence related to the effects on the infant (Sachs & APA Committee on Drugs, 2013). Those who choose to breastfeed should receive encouragement and support to overcome challenges and obstacles that may be present (Sriraman, et al., 2015), and providers should consider monitoring the growth and neurodevelopment of the infant (Sachs & APA Committee on Drugs, 2013).

Contraception

Women being treated for postpartum depression, whether they are taking antidepressant medications or not, should be offered a reliable contraceptive method to prevent an unplanned pregnancy, and to allow them the control to space pregnancies in the way most acceptable to themselves .

4. Coverage and Reimbursement for Postpartum Depression

Coverage for screening and treatment for uninsured and underinsured Texas women

All women should undergo screening for postpartum depression at the postpartum visit.

Medicaid and CHIP

Women who receive prenatal care through Medicaid for Pregnant Women remain eligible for Medicaid benefits for 60 days after the birth of the baby. During this time, Medicaid will cover the postpartum visit(s) as well as medications and follow-up necessary for women who are diagnosed with postpartum depression.

Women who receive prenatal care through the CHIP-Perinatal program are eligible for two postpartum visits under the global prenatal care service package.

Women who remain eligible for Medicaid when they are not pregnant may receive provider services and medications through the Medicaid program.

Healthy Texas Women

When coverage under Medicaid for Pregnant Women ends, a woman will transition to the Healthy Texas Women (HTW) Program if she meets eligibility requirements. In addition, any woman who meets eligibility requirements may enroll directly in the HTW Program. The HTW Program covers diagnostic evaluation, medications, and follow-up visits for women with a diagnosis of postpartum depression.

For a list of medications covered under the HTW Program go to the Texas Medicaid/CHIP Vendor Drug website.

Family Planning Program

The Texas Family Planning Program covers screening and diagnosis of postpartum depression for women who meet income eligibility requirements and do not qualify for other similar coverage.

To find out more about Healthy Texas Women and the Family Planning Program, or to locate a provider, go to the Healthy Texas Women website or call 2-1-1.

Referral for additional treatment

Women in need of more intensive treatment for postpartum depression should be referred to a provider of behavioral health services. For information on local behavioral health care providers, refer to the website of the Office of Mental Health Coordination of the Texas Health and Human Services Commission, or call 2-1-1.

Coding for services

Coding for healthcare services is complex and this toolkit is not intended to provide a thorough treatment of the topic. Below is a brief description of codes that might be used for providing services to patients with signs and/or symptoms of postpartum depression. The codes used should reflect the patient's actual diagnosis and the level and type of services provided. Providers are referred to appropriate coding textbooks and recognized resources for a more detailed discussion.

Diagnosis coding

Table 3 provides a listing of ICD 10-CM diagnosis codes and their descriptions commonly used for women with signs and/or symptoms of postpartum depression (Holden, et al [AMA], 2015). Depending on the precise presentation and patient history, other codes may be more appropriate to use. Documentation in the medical record should support the specified diagnosis. It is important to use the code that most closely represents the patient's diagnosis, particularly if the patient requires referral to a mental health professional, because patients with a diagnosis of major depressive disorder or other serious psychiatric disorder are sometimes given priority in scheduling.

Table 3. Common Diagnosis Codes and Descriptions[iii]

ICD 10-CM Code	Description
O90.6	Postpartum mood disturbance, postpartum blues, "baby blues," postpartum sadness, postpartum dysphoria
F53	Puerperal psychosis, postpartum depression
F32.9	Major depressive disorder, single episode, unspecified

[iii] Holden, *et al* [AMA], 2015

Procedure coding and medical record documentation

To code services provided in the clinic or provider's office, an Evaluation & Management (E&M) code appropriate for the level of service provided should be used. The level of service is based on the complexity of the history, examination, and medical decision making required, and is generally reflected in the amount of time spent face-to-face with the patient (OPTUM, 2016). Documentation in the patient's medical record should clearly demonstrate the level of service provided and time spent with the patient.

For patients who require referral to a mental health professional, a full psychiatric diagnostic evaluation may be appropriate at the initial visit (North & Yutzy, 2010). For the psychiatric diagnostic evaluation codes (ie, 90791 and 90792), the findings of the initial interview and recommended treatment plan, sometimes called a psychiatric report, should be thoroughly documented in the medical record. Continuing services should then be coded with the established patient E&M code appropriate for the level of service provided.

Table 4 provides a listing of Common Procedural Terminology (CPT) codes that may be used for these services provided to patients with signs and symptoms of postpartum depression (OPTUM, 2016).

Table 4. Common Procedural Terminology Codes Used for Services Provided to Patients with Signs and Symptoms of Postpartum Depression[vi]

CPT Code	Description
99201-99205[iv]	Outpatient evaluation and management service for a new patient
99211-99215[v]	Outpatient evaluation and management service for an established patient
90791	Psychiatric diagnostic evaluation without medical services
90792	Psychiatric diagnostic evaluation with medical services

[iv] Higher numbers reflect a higher level of service.
[v] Higher numbers reflect a higher level of service.
[vi] OPTUM, 2016

References

American College of Obstetricians and Gynecologists. (2016). Committee Opinion no. 658. Optimizing support for breastfeeding as part of obstetric practice. *Obstet Gynecol*, 127(2), 420-421. Available at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice

American College of Obstetricians and Gynecologists. (2015). Committee Opinion no. 630. Screening for perinatal depression. *Obstet Gynecol,* 125, 1268-1271. Available at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

American College of Obstetricians and Gynecologists. (2008). Practice Bulletin no. 92. Use of psychiatric medications during pregnancy and lactation. *Obstet Gynecol*, 111, 1001-1020.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

Beck, C.T., & Gable, R.K. (2000). Postpartum depression screening scale: Development and psychometric testing. *Nurs Res*, 49(5), 272-282.

Cox, J.L., *et al*. (1987). Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry*, 150, 782-786.

Earls, M.F. & American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. (2010). Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*. 126(5), 1032-1039. Available at http://pediatrics.aappublications.org/content/126/5/1032

Grote, N.K., *et al*. (2009). A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. *Psychiatr Serv*, 60(3), 313-21.

Hirst, K.P., & Moutier, C.Y. (2010). Postpartum major depression. *American Family Physician,* 82, 926-933. Available at http://www.aafp.org/afp/2010/1015/p926.html

Holden, K., Schmidt, A., & Willard, P. (Eds.). (2015). *ICD 10-CM: The complete official draft codebook (15th ed.)*. USA: American Medical Association (AMA).

Ip, S., *et al*. (2007). Breast feeding and maternal and infant outcomes in developed countries. Evidence Report/Technology Assessment No. 153. Prepared for the Agency for Healthcare Research and Quality, Rockville, MD. Available at https://archive.ahrq.gov/clinic/tp/brfouttp.htm

Kim, J.J., *et al*. (2015). Suicide risk among perinatal women who report thoughts of self-harm on depression screens. *Obstet Gynecol*, 125(4), 885-93.

Langan, R.C., & Goodbred, A. J. (2016). Identification and management of peripartum depression. *American Family Physician*, 93(10), 852-858.

Meltzer-Brody, S., & Jones, I. (2015). Optimizing the treatment of mood disorders in the perinatal period. *Dialogues in Clinical Neuroscience*, 17(2), 207-218. Available at http://www.dialogues-cns.org/publication/optimizing-the-treatment-of-mood-disorders-in-the-perinatal-period/

Myers, E.R., *et al*. (2013). Efficacy and safety of screening for postpartum depression. Comparative effectiveness review 106. Prepared for the Agency for Healthcare Research and Quality, Rockville, MD. Available at https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=1438
Accessed 7/29/2016 from http://www.effectivehealthcare.ahrq.gov/index.cfm/search-for-guides-reviews-and-reports/?producttypes=&search=&trackID=&language=1&methodCategory=&category=&statusType=3&agencyType=2&sortBy=topicDate.

Norhayati, M.N., *et al*. (2015). Magnitude and risk factors for postpartum symptoms: A literature review. *J Affect Disord*, 175, 34-52.

North, C. S., & Yutzy, S. H. (2010). *Goodwin and Guze's Psychiatric Diagnosis* (6th ed.). New York, NY: Oxford University Press.

O'Connor, E., *et al*. (2016). Primary care screening for and treatment of depression in pregnant and postpartum women: Evidence report and systematic review for the US Preventive Services Task Force. *JAMA*, 315, 388-406.

O'Hara, M., & Scott, S. *STEP-PPD: Support and training to enhance primary care for postpartum depression* [Online course]. Retrieved from Danya International, Inc. Web site: http://www.step-ppd.com/step-ppd/Home.aspx

OPTUM™ CPT® Data Files. (2016) Salt Lake City, UT. Optum Coding - Ingenix. STAT!Ref Online Electronic Medical Library. Retrieved from http://online.statref.com/Document.aspx?fxId=24&docId=1 on 8/18/2016.

Sachs, H.C. & American Academy of Pediatrics Committee on Drugs. (2013). The transfer of drugs and therapeutics into human breast milk: An update on selected topics. *Pediatrics*, 132(3), e796-809. Available at http://pediatrics.aappublications.org/content/132/3/e796.long

Shellman, L., *et al*. (2014). Postpartum depression in immigrant Hispanic women: A comparative community sample. *J Am Assoc Nurse Pract*, 26(9), 488-97.

Sriraman, N.K., *et al*. (2015). ABM Clinical Protocol #18: Use of antidepressants in breastfeeding mothers. *Breastfeeding Medicine*, 10(6), 290-299.

Weissman, A.M., *et al*. (2004). Pooled analysis of antidepressant levels in lactating mothers, breast milk, and nursing infants. *Am J Psychiatry*, 161, 1066-1078.

Yawn, B.P., *et al*. (2009). Concordance of Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire (PHQ-9) to assess increased risk of depression among postpartum women. *J Am Board Fam Med*, 22(5), 483-491. Available at http://www.jabfm.org/content/22/5/483.long

Zero Suicide Advisory Group (2015). *Zero suicide toolkit*. Retrieved from http://zerosuicide.sprc.org/

Resources for Patients and Providers

American Academy of Family Physicians. Postpartum Depression web page. Information for patients and providers on postpartum depression. Available at http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression.html

American Academy of Family Physicians. Postpartum Depression Action Plan. Available at http://familydoctor.org/familydoctor/en/diseases-conditions/postpartum-depression/treatment/postpartum-depression-action-plan.html

American Congress of Obstetricians and Gynecologists. Depression and postpartum depression: Resource overview web page. Available at http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression

American Psychological Association. Postpartum Depression web page. Includes patient education brochures in English, Spanish, French, and Chinese as well as links to resources on postpartum depression for new mothers and new fathers. Available at http://www.apa.org/pi/women/resources/reports/postpartum-dep.aspx

Eunice Kennedy Shriver National Institute of Child Health and Human Development National Child & Maternal Health Education Program. Moms' Mental Health Matters website. Provides information for mothers and mothers-to-be on depression and anxiety, and how to find help. Available at https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms/pages/default.aspx

Healthy Texas Women web site. Provides links to information for patients and providers on the Healthy Texas Women and Texas state Family Planning Programs. Available at https://www.healthytexaswomen.org/

Healthy Texas Women Drug Formulary. For a list of medications covered under the HTW Program go to the Texas Medicaid/CHIP Vendor Drug website.

National Library of Medicine Toxnet Toxicology Data Network. LactMed drugs and lactation database website. Provides information on safety of drugs in breastfeeding mothers, including infant serum drug levels, effects in

breastfed infants, effects on breastmilk and lactation, and alternative medications to consider. Available at https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

Office of Mental Health Coordination website, Texas Health and Human Services Commission. Provides links to information for providers and patients in Texas on a variety of behavioral health topics, and a link to the Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health treatment services locator. Available at http://mentalhealthtx.org/

STEP-PPD: Support and training to enhance primary care for postpartum depression [Online course]. Retrieved from Danya International, Inc. Web site: http://www.step-ppd.com/step-ppd/Home.aspx

Texas Medicaid/CHIP Vendor Drug Program Formulary Information web page. Provides links to information on the formulary benefits for multiple state-administered healthcare programs, as well as interactive drug and product look-up tools. Available at http://www.txvendordrug.com/formulary/index.asp

ZERO Suicide in Health and Behavioral Health Care web page. Provides resources, organizational self-study materials, and toolkit for developing and implementing a comprehensive organizational program to recognize and treat suicide and suicidal risk across the health care continuum, with a goal of preventing all suicide. Available at http://zerosuicide.sprc.org/