CARE FOR KIDS

Early & Periodic Screening, Diagnosis & Treatment

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Coming Your Way...

Proposed Minimum Standards

for the identification of developmental, social, emotional, and behavioral concerns in children age birth through three years

Iowa Medicaid, through Iowa's Assuring Better Child Health and Development II (ABCD II) Initiative, is moving to infuse best practices for the healthy mental development of young children into Iowa's current Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Care for Kids system.

Proposed minimum standards of care. To facilitate this, an ABCD II Clinical Advisory Panel composed of key Iowa private and public health associations has proposed a set of minimum standards for Iowa health providers to use to identify developmental, social, emotional, and behavioral concerns in children birth through age three who participate in Medicaid (see page 5).

Recommended screening tools. The panel has also developed a list of recommended screening tools (see page 5) to help providers identify needs as a part of the provision of three levels of developmental care. These proposed standards and recommended tools are now being tested in an urban pediatric practice and a rural family practice in Iowa.

Evaluation of standards. These sites are also testing the use of a public-private partnership model to facilitate connecting families to community resources, and then communicating referral results back to the health provider. An evaluation process is looking at the number of children identified, referred, and connected to services before and after implementation of the standards. Evaluation, which will be completed this spring, is also assessing ease of use of the standards, provider satisfaction with the standards, and billing considerations.

Your input is invited.

The ABCD II Board and Clinical Advisory Panel will use what is learned from these evaluations and from comments from health providers like you to finalize a set of minimum standards for the identification of developmental, social, emotional, and behavioral concerns in children 0-3 years. Your input is an important part of this process. See page 6 for information on how to provide input via mail or the web.

For more information about the ABCD II Initiative and the proposed standards, visit **www.IowaEPSDT.org**.

Maternal Depression and Its Effects on Children

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Children of depressed mothers are at increased risk for impaired functioning in a number of domains. The types of adjustment difficulties vary depending on the child's age, and typically reflect the developmental tasks associated with that age. For example, children of depressed mothers begin to exhibit social, emotional, and cognitive problems during infancy, but do not exhibit increased rates of depression until adolescence.

Child problems

Children of depressed mothers cry more and are more difficult to soothe, according to reports of their mothers and independent observers.

Infants of mothers who receive anti-depressants for clinical depression during pregnancy or are clinically depressed during the postpartum period are less likely to develop secure infant-mother attachment relationships. Such relationships typically develop as mothers respond sensitively to their infant's distress signals (i.e., crying) and positive bids for interaction (smiling, reaching out).

Development of a secure attachment relationship by the end of the first year of life is an important milestone associated with positive emotional functioning at later ages.

Maternal depression is also associated with delays in cognitive, motor, and language development during infancy and early childhood. This is especially true when maternal depression is chronic or accompanied by additional risk factors such as low socioeconomic status or impaired mother-infant interaction. Some studies have found that

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Children of depressed mothers

- Cry more and are harder to soothe
- Are less likely to form secure infant-mother attachments
- Are at risk for delays in cognitive, motor, and language development
- Are at risk for aggressive and oppositional behaviors in childhood, and for depression in adolescence

these delays persist for several years after the maternal depression resolved.

During childhood, children of depressed mothers are at increased risk for aggressive and oppositional behavior. Sons of depressed mothers are at greater risk for these types of problems than daughters. In adolescence, depression and anxiety disorders are more common among children of depressed mothers, and daughters are at greater risk than sons.

Parenting difficulties

A lack of confidence in the ability to carry out parenting tasks is often associated with maternal depression, and may be one of the first indicators observed by healthcare providers. Providers may be understandably hesitant to ask about maternal depression in the context of assessing and treating children, for mothers struggling with depression and feeling demoralized about their parenting abilities may become defensive if concerns are raised about their mental health. The stigma associated with mental health concerns can make it difficult for providers to inquire about maternal depression, and for mothers to acknowledge depressive symptoms. By openly and matter-of-factly asking mothers about their stress levels and mental health, healthcare providers can make mental health concerns, including maternal depression, a little less frightening. A dialogue about maternal mental health might begin with a reference to the relationship between child functioning and maternal depression. For example, "Parents often find it really stressful to deal with a new baby who cries a lot. How are you doing?"

Maternal depression in Iowa

A 2004 survey distributed to all Iowa maternity hospitals found that an average of 13% of new mothers reported feeling "sad or miserable much of the time over the past two weeks":

- Cedar Rapids **11%**
- Sioux City **17%**
- Davenport **14%**
- Waterloo **14%**
- Des Moines **12%**

Barriers to Prenatal Care Project, UNI Center for Social and Behavioral Research, and the Iowa Department of Public Health

As they talk with parents, providers can educate them about the relationship between maternal mental health and child functioning. Mothers may be relieved to find out that their depressive symptoms and parenting difficulties are not unique, and that there are effective treatments to reduce maternal depression and improve mother-child interactions.

Resources

Postnatal depression and infant cognitive and motor development in the second postnatal year, *Inf Behav & Dev (2005)* 28:407-17.

Two approaches to maternal depression screening during well child visits, *J Dev & Behav Peds* (2005) 26(3):169-76.

Relations among postpartum depression, maternal adjustment, contextual risk, and the attachment bond. Marce Soc Internat'l Biennial Scientific Mtg, Oxford, UK (2004)

The Identification and Treatment of Postpartum Depression

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Iowa Depression and Clinical Research Center

Experts agree that about one mother in ten experiences postpartum depression. Despite the high incidence of postpartum depression, however, it remains largely unrecognized -- both by affected women and by their health care providers. In one study, 97% of women with postpartum depression reported that they felt there was "something wrong," but only 32% believed they were suffering from depression. Many felt their symptoms were either not severe enough to merit treatment or attributed them to family or child care difficulties. Most strikingly, only 10% discussed their symptoms with a health care professional. Current research indicates that standardized screening of all postpartum women is essential in order to increase identification and treatment of postpartum depression.

Identifying postpartum depression

Primary care providers, particularly family practitioners, obstetricians, and pediatricians, play a key role in recognizing postpartum illness. As many new mothers will have little contact with their obstetricians after the first six weeks postpartum, it is often physicians caring for newborns who have the most contact with these women. All postpartum women should be screened for depression; instruments such as the Edinburgh Postnatal Depression Scale (http://www.vh.org/adult/provider/ psychiatry/postpartumdepression/evalmentalhealth.html) are easy to use and have been validated for this purpose. A recent study reported an increase in detection rates from 3.7% to 10.7% after one year of universal screening.

No evidence exists for major qualitative differences between postpartum depression and other types of depression. Recognition of postpartum depression, however, is often more difficult. Many of the changes that occur normally during the postpartum period, such as fatigue and sleep disruption, are similar to those that signal depression. Physicians should be alert to the physical symptoms of postpartum depression while also carefully assessing psychological symptoms.

Symptoms of postpartum depression include:

- Depressed mood
- Lack of interest or pleasure in activities
- Changes in appetite
- Sleep disruption
- Fatigue
- Lack of motivation
- Feelings of guilt or worthlessness
- Poor concentration
- Persistent anxiety
- Irritability
- Thoughts of death or suicide

New mothers who are depressed often report feelings of guilt about their ability to care for their newborns, or a lack of enjoyment, particularly with their children. Any tendency toward suicidal impulse must be carefully evaluated as well. Thoughts of harm towards the newborn, though rare, must also be assessed.

Treating postpartum depression

Medication. Any of the commonly used antidepressant medications for postpartum depression may be prescribed for new mothers with postpartum depression who are not breastfeeding. If there is a history of depression, the choice of medication should be based on the woman's previous response to medication or her family's history of response to treatment. When considering the treatment of de-

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Proposed Minimum Standards

Identifying developmental, social. emotional, and behavioral concerns in children from birth through three years

Iowa's ABCD II Initiative has proposed a set of minimum standards to help providers identify concerns that may arise in children from birth through 3 years who participate in Medicaid.

Level 1 The standard for screening of all children

Level 2 For children at risk

Level 3 For children who have developmental, social, or emotional concerns

(For information on billing developmental testing separate from the EPSDT screening exam, visit www.IowaEPSDT.org.)

LEVEL 1 *Screening for all children*

STANDARD: Every regular EPSDT screening for a child 0-3 years must include a review of cognitive, motor, language, adaptive, social, and emotional development. Each screening shall address parental concerns about the child's growth and development, and review:

- Developmental milestones
- Social, emotional, and behavioral health, including early signs of autism
- Family risk factors, including parental stress and maternal depression

Screen all children using ONE of the two options below:

OPTION 1

At each EPSDT well-child screening, a physician, nurse practitioner, physician assistant, or nurse completes the appropriate Iowa Health Maintenance Clinical Notes (HCMN) form (available at http://www.IowaEPSDT.org/clinNotesForms.htm). If a nurse completes the form, a physician, nurse practitioner, or physician assistant then reviews it.

OR

OPTION 2

Review all three domains below
during **EPSDT well-child screening** at designated intervals

1 DEVELOPMENT

Use **ONE** of these parent questionnaires at least three times before the child is 4 years old

Recommended screening tools for Level 1:

- Parent's Evaluation of Developmental Status (0-8 years) (1998)
- Ages and Stages Questionnaires (2 months-5 years) (2002)
- Child Development Review (3 months-6 years) (1994)

2 SOCIAL, EMOTIONAL, AND BEHAVIORAL HEALTH

Use **ONE** of these screening questionnaires at intervals you determine

Recommended screening tools for Level 1:

- Ages and Stages Questionnaires: Social-Emotional (2 months to 5 years) (1999)
- Brief Infant-Toddler Social and Emotional Assessment (2000)
- Child Development Review and Infant Development Inventory (1994)

3 FAMILY RISK FACTORS, PARENTAL STRESS, MATERNAL DEPRESSION

Recommended screening tools for Level 1:

- First visit: Complete Pediatric Intake Form from *Bright Futures*
- Subsequent visits: Complete shorter version of the PIF annually

Levels 2 and 3 on back

LEVEL 2 *Screening children at risk*

STANDARD: Every child 0-3 years old who is identified as at risk in any domain during the initial screening, as well as children the health care provider feels need additional developmental, social, emotional, or behavioral screening, must receive Level 2 screening. This screening may be completed in the health provider's office by the physician, nurse practitioner, or physician assistant, or by a paraprofessional so long as the primary health care provider reviews the results.

A provider may also refer the child to another community agency for Level 2 screening, or refer the child directly to another professional for Level 3 follow-up assessment and evaluation.

Review the four domains below

1 DEVELOPMENT

Recommended screening tools for Level 2:

- Ages and Stages Questionnaires http://www.pbrookes.com(2002)
- Brigance Infant and Toddler Screen (0-23 months) (2002)
- Bayley Infant Neurodevelopmental Screener (3-24 months) (1995)
- Denver Developmental Screening Test (Denver II, 0-6 years) (1992; this test has been shown to have lower specificity than other tests)

Special note: Any child with speech delay or suspected hearing impairment requires prompt referral for audiological evaluation.

2 SOCIAL, EMOTIONAL, AND BEHAVIORAL HEALTH

Recommended screening tools for Level 2:

- Brief Infant-Toddler Social and Emotional Assessment (2000)
- Child Development Review and Infant Development Inventory (2000)
- Ages and Stages Questionnaires: Social-Emotional (1994)

3 PDD AND AUTISM

Recommended screening tools for Level 2:

- Modified Checklist for Autism in Toddlers (2001)
- Pervasive Developmental Disorders Screening Test II, Stage 1 (2004)

4 FAMILY RISK FACTORS, PARENTAL STRESS, MATERNAL DEPRESSION

Recommended screening tools for Level 2:

- Edinburgh Postnatal Depression Scale (1987)
- Parenting Stress Index Short Form (1995)

LEVEL 3 *Follow-up assessment and evaluation for the diagnosis and treatment of children with developmental, social, emotional, or behavioral concerns*

STANDARD: Children who need further evaluation must be referred for systematic, comprehensive assessment specific to the areas of concern. Professionals, as authorized by their scope of practice, will determine the domains to be tested. Assessment should include standardized measures of the functioning of the child and the family. What is learned will guide the creation of the child's treatment plan as well as provide diagnostic information.

Developmental screening for Iowa children is a key component of good health care.

We'd like to hear from you. The proposed minimum standards above are a work in progress. Are they:

- Something you can apply in your day-to-day work?
- Comprehensive enough?
- Easy to understand?
- What do you need to implement these standards in your practice?

Please – let us know what you think. Complete our web survey at http://www.IowaEPSDT.org/standardsInput.htm

Or mail your comments to:

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Thanks for helping to make *Iowa EPSDT Care for Kids* even better!

The Identification and Treatment of Postpartum Depression

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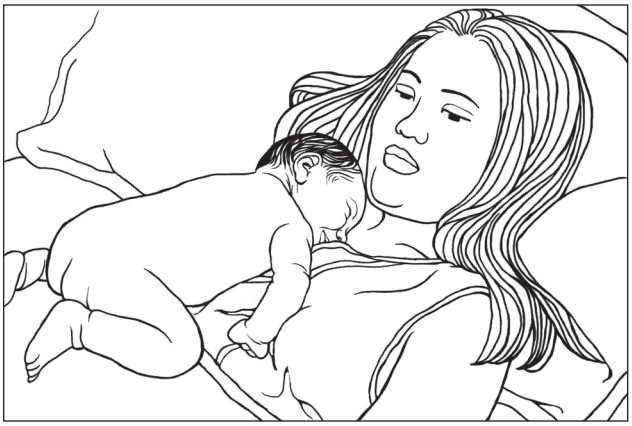
pression in women who breastfeed, it is important to be aware of the risks posed by untreated depression, especially the adverse effects it can have on child development (see page 2).

The risks of medication and the benefits of treatment should be carefully weighed. Experts agree that moderate to severe depression in nursing mothers should be treated with medication.

Current data suggest that the use of tricyclic antidepressants and the selective serotonin re-uptake inhibitors (SSRIs) is relatively safe for the breastfeeding infant. A recent analysis of antidepressant levels in lactating mothers suggests that nortriptyline, paroxetine, and sertraline may be the preferred choices for breastfeeding women. The general opinion of experts in the field is that fluoxetine should be avoided while breastfeeding due to its long half- life, unless a woman has responded well to treatment with fluoxetine previously.

Though fewer women have been treated postpartum with the new generation antidepressants, these medications also appear to be relatively safe during breastfeeding. Electroconvulsive therapy can be safely used for women with psychotic depression, and for those who do not respond to other treatments.

In sum, the current clinical consensus is that antidepressants can and should be used with breastfeeding women who have moderate to severe depression. Because commonly used antidepressant medications appear safe, the guidelines for selection of medication described above (such as previous response or family history of response to treatment) should be used. Supplementation of breastfeeding with bottle feeding during times of peak exposure may also reduce risks to infants.



Psychotherapy. Despite data supporting the relative safety of antidepressant medications during breastfeeding, many women are wary of their use. In one study, only 20% of women with postpartum depression said that they would consider using antidepressant medications. Psychotherapy is an effective and empirically validated alternative for women who do not want to use medications while breastfeeding. The use of interpersonal psychotherapy over 12 to 16 weeks has been shown by University of Iowa investigators to be of great benefit for depression; cognitive, group, family, and mother-infant therapy may also be helpful.

Conclusion

The value of screening for maternal postpartum depression has been clearly demonstrated. Women who are depressed can be identified either through health clinics or during visits by home health care providers. Once identified, women with MPD are often willing to engage in acute treatment. Given the implications of untreated postpartum depression for women and their children, screening should be considered to be a necessary part of all postpartum visits.

Resources

Stuart S (editor): *Postpartum Depression*. Psych Ann 35: 2005.

Iowa Depression and Clinical Research Center, http://www.psychology.uiowa.edu/labs/idcrc/, 319-335-0307.

EPSDT Care for Kids Provider Web Site

A great resource for all of you who care for children participating in Medicaid. Here you can get information on:

- **Periodicity schedules** for required exam components, such as physicals and immunizations
- **Developmental screening** standards and exam guides
- **Local EPSDT care coordinators** who can help with referrals
- **Medicaid billing information**

Visit today!

http://www.IowaEPSDT.org

What's in this issue

If you have questions about **billing**
related to EPSDT Care for Kids services, please call
Provider Services: **1-800-338-7909**

If you have questions about **clinical issues**
and EPSDT Care for Kids services, please call
1 -800-383-3826

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