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Certified Nurse-Midwives' Beliefs About and Screening Practices for Postpartum Depression: A Descriptive Study

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1	Certified Nurse-Midwives Beliefs About and Screening
2	Practices for Postpartum Depression:
3	A Descriptive Survey
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6	Sylva B. Zander
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10	Faculty Advisor: Arthur J. Engler, DNSc, RNC, APRN, Associate Professor

11 Abstract

Purpose

Defined as moderate to severe symptoms of major depression lasting greater than two weeks after delivery, postpartum depression (PPD) is a crippling mood disorder with extreme loss and incongruity in emotion. Despite the tools available for screening postpartum depression, there is a consensus that PPD continues to be underdiagnosed. Recent surveys assessing pediatricians and family physicians indicate that while practitioners believe that PPD is serious, they may not feel confident that they can recognize PPD, are unfamiliar with screening tools and under-estimate its incidence in their practice. This study was conducted to determine the knowledge and screening practices of PPD among certified nurse-midwives (CNMs).

Methods

A survey was distributed to 2100 CNMs attending the American College of Nurse-Midwives 50^{th} Annual Meeting. Of these, 8.3% (n = 174) responded. The 121 respondents who provide care to postpartum women and/or infants less than one year of age were included. The 114 respondents who screen for PPD sometimes, often, or always were analyzed for their knowledge and beliefs.

Results

Of the 121 who provide care at least 10 hours per week and see postpartum women and/or infants less than one year of age, 94.2% (n = 114) currently screen sometimes, often, or always. 84.2% (n = 102) of CNMs screen often or always.

Of the 114 respondents who currently screen, nearly all believe PPD is serious, common and treatable. Most believe that it would be feasible (91.2%) and that CNMs

should routinely screen for PPD (93.0%). But half of CNMs (45.6%) believed health insurance would not cover treatment for PPD for many of their patients, and the majority of respondents (74.6%) believed their communities do not have adequate resources available to treat PPD.

The majority of respondents had received formal training on postpartum depression in a variety of venues. However, only half (54.4%) of nurse-midwives reported the use of a specific screening tool or method, and nearly 60% estimated the incidence in their practice less than the published incidence (10-15%) in the general population. Over 30% are not confident that they would recognize PPD. In addition, less than two-thirds (65.8%) reported familiarity with available screening tools although 89.5% reported that they would use a brief self-administered screening tool to screen for PPD in their practice.

Estimated incidence of own practice and general population were positively correlated (r = 0.738, p<0.01) and age is inversely correlated with PPD reported in clinical practice (r = -0.229, p = 0.016).

The participants' narrative responses indicated that they most frequently ask informal, general questions about depression and observe patient behavior to assess for PPD. They will then follow-up with a screening tool if warranted. Several cited literacy, language and cost barriers to the use of self-administered screening tools. Conclusions and Implications

Nurse-midwives sampled believe PPD is serious and common, however their screening practices are irregular and they underestimate the incidence of PPD in their own practice. In addition, many are not aware of the available screening tools and are

likely to miss dimensions of PPD when they screen by interview. Efforts to improve PPD recognition and treatment should involve nurse-midwives in screening promotion and thorough education in the use of screening tools.

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Certified Nurse-Midwives Beliefs About and Screening Practices for Postpartum

Depression: A Descriptive Survey

Over the last two decades, there has been a widening public awareness and an increase in research on postpartum depression. Postpartum depression has been described as a thief that robs women of the happiness and love they expected to feel towards their infants (Beck, 1993). It is characterized as moderate to severe symptoms of major depression lasting greater than two weeks. There are many far-reaching effects of PPD, including depression and loss experienced by the mothers, negative changes in maternal-infant interactions, and fewer positive expressions in infant behavior (Beck, 1995). There are many effects that extend beyond infancy on children's attention and behavior problems, social patterns of play, IQ scores and difficulties in school (Murray & Cooper, 1997; Hayes, Muller & Bradley, 2001). Children have been found to have small but significant impairment in three areas of cognitive, language and emotional development (Beck, 1998; Grace, 2003).

Research has also demonstrated that postpartum depression affects 10 to 20 percent of all new mothers (Miller, 2002; O'Hara & Swain, 1996), and more than half will be experiencing symptoms a year later (Wisner, Parry, Piontek, 2002). Depression during pregnancy is highly correlated to postpartum depression, and in addition, women who experience PPD are more at risk for recurrent depression (Cooper & Murray, 1995). Despite this knowledge, research has shown that 50% of women experiencing PPD remain unidentified (Hearn, 1998).

PPD differs from major depression only in postnatal onset. The major predictor for PPD is a generalized history of depression, as well as depression

during pregnancy. Routine use of any screening tool has been shown to improve recognition of PPD (Georgiopoulos, 2001). To diagnose a patient, a more thorough evaluation is required if a patient screens positive on one of these tools (Seehusen, 2005).

With the increased awareness of PPD there has been the development of several short and easy-to-use validated screening tools such as the Edinburgh Postnatal Depression Scale, Beck's Postpartum Depression Screening Scale and the Postpartum Depression Checklist. Despite the accessibility of screening tools, PPD remains significantly underdiagnosed. Seehusen considers this may be because practitioners are not aware of the available screening tools, or they fear their use will be time-consuming and expensive (2005). Another reason may be the lack of referrals and resources for those who have high scores on a tool, or the unpaid time spent finding resources. In particular, there may be no resources available for Medicaid or other low-income patients.

A number of recent studies concerning postpartum depression have begun assessing practitioners' knowledge, adoption of screening tools and frequency of assessment. The United States Preventative Services Task Force recommends screening for depression in the general population (Pignone, 2002). Many authors support the routine screening of postpartum women (Georgiopoulos, 2001; Seehusen, 2005; Wiley, 2004),

Recently, several studies have been published regarding the current screening practices of several populations of health care providers (LaRocco, 2001; Seehusen, 2005; St. John, 1999; Wiley, 2004). These studies have examined the practices and

knowledge of family physicians, ob-gyns and pediatricians. Studies indicate that gender of practitioner, formal training in PPD, age, and years since graduating are all significantly associated with frequent or more frequent screening of PPD (Seehusen, 2005; Wiley, 2004). These studies are crucial to defining the future roles of health care practitioners in screening and diagnosing women with PPD. When performing a literature review, it was found that the screening practices and associated demographics of certified nurse-midwives (CNMs) have not yet been assessed. This survey was conducted to determine the postpartum depression screening practices of CNMs. It explores their beliefs, attitudes, and feelings concerning postpartum depression and their use of screening tools.

118 Methods

Instrument

We developed a 40-item self-administered questionnaire assessing knowledge and attitudes about postpartum depression and screening practices based on two previously published studies (Seehusen..., Wiley...). The original was based on surveys conducted by St. John (1999) and LaRocco (2001).

We provided the survey recipients with the following statement: "We define postpartum depression (PPD) as depressive manifestations of at least moderate severity lasting longer than 2 weeks after delivery. This can be distinguished from Baby Blues, which consists of milder manifestations that resolve by 14 days after delivery." We then asked the practitioners to complete the survey if they were practicing 10 or more hours per week. The survey asked nurse-midwives to estimate the incidence of PPD in the general population and in their own practices. We gathered demographic

data, information about practice, and sources of formal training in postpartum depression, as well as their attitudes, feelings and experiences with the identification and referral of mothers with PPD. The frequency of screening practices was measured win a 4-point Likert scale (never, sometimes, often, or always). Attitudes and beliefs were measured with a 5-point Likert scale of agreement (strongly disagree, disagree, neutral, agree, or strongly agree).

Human Subjects

The University of Connecticut Institutional Review Board approved this study.

The American College of Nurse-Midwives (ACNM) Board of Directors granted permission to conduct the study at their 50th Annual Conference in June 2005.

Sample

The ACNM has 9,371 members in all 50 states, Puerto Rico, Guam and the Virgin Islands. The survey was distributed to all 2100 CNMs, students, and other attendees of the American College of Nurse-Midwives 50th Annual Meeting, held in Washington DC on DATES. Of these attendees, 174 or 8.3% responded. Of the respondents, we excluded 53 because they did not provide care at least 10 hours per week to postpartum women and/or infants less than one year of age. We considered the remaining 121 the sample to assess screening practice. We then analyzed the surveys of the 114 who screen for PPD "sometimes", "often" or "always" for knowledge and screening practices.

Data Analysis

We used SPSS 14.0 (SPSS Inc., Chicago, IL) to analyze the data. Simple descriptive frequencies of participant demographics, practice type, training and beliefs

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about PPD were used to categorize the sample. Responses to belief statements were dichotomized: "Agree" and "Strongly Agree" were combined, and "Disagree," "Strongly Disagree," and "Neutral" were combined. Associations between belief statements and other variables were analyzed using Pearson correlations and Chi-square tests where appropriate. Statistical significance was set at p < .05.

Results 159

Demographics

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Of the sample of 114 surveys, 97.3% of the participants were female (n = 109) and 96.4% were white (n = 108) with a mean age of 46.4 years (SD = 10.36). See Table 1 for practice setting characteristics. WHERE DID MAJORITY PRACTICE? THEN SAY **SEE TABLE 1, ETC.**

Sources of PPD Education

__% of respondents had received formal training on PPD in a variety of venues. The most commonly reported source of training was nurse-midwifery school (92.9%). Over half indicated that they received formal PPD education through continuing education conferences and literature from midwifery, nurse-midwifery and medical sources. In addition, over half indicated receiving education about postpartum depression in nursing school. Seventy percent of those who received education from nurse-midwifery school also received training from medical education conferences.

Screening Tool Used

Sixty-two (54.4%) of the 114 participants indicated they used a specific screening tool or method, with 44 (38.6%) using a validated screening tool. The most commonly used screening tool was the Edinburgh Postnatal Depression Scale (EPDS) (41.9% or

26) reporting they used it most often. Second, a structured clinical interview was common, with 10 participants (16.1%) using this method most often. Many people stated in their comments that they use an informal interview or questions and observation rather than a screening tool. Other screening tools used were the Beck Depression Inventory (n = 8, 12.9%) and the Postpartum Depression Screening Scale (PDSS) (n = 7, 11.3%). The Hamilton and Zung Depression Scales were occasionally used. The Edinburgh Postnatal Depression Scale was used for 33.3% (n = 8), 55.6% (n = 10) and 61.1% (n = 11) of those who "sometimes", "often" and "always" used a formal tool to screen for postpartum depression.

Practices

Of the 121 participants who provide care at least 10 hours per week and see postpartum women and/or infants less than one year of age, 94.2% (n = 114) currently screen sometimes, often, or always, with 84.2% (n = 102) screening often or always. Beliefs

Nearly all participants recognized that postpartum depression is common, serious enough to warrant screening, and treatable. Of the 114 who screen sometimes, often, or always, all but one indicated that they believe PPD is a valid diagnosis. Most believe that it would be feasible for (91.2%) and that CNMs should routinely screen for PPD (93.0%). Most believe screening would not be very time consuming on their part (83.3%) or take too much effort (96.5%), but half of CNMs (45.6%) believed health insurance would not cover treatment for PPD for many of their patients, and the majority of respondents (74.6%) believed their community does not have adequate resources available to treat PPD (Table 4).

Participants overwhelmingly believed that PPD has lasting effects (97.4%), affects the spouses (97.4%) and children (96.5%) of affected women, and that women may not realize they are depressed (96.5%). Nearly 90% indicated that they would use a brief self-administered tool to screen for PPD in their practice, yet over one third were not familiar with available screening tools (Table 4).

Over half of the participants (56.6%) estimated the incidence of PPD in their own practice to be less than the published incidence (10-15%) in the general population. Over a quarter of participants estimated the incidence in the general population to be less than the published incidence of 10-15%, though nearly half (49.5%) of our sample estimated that the incidence of PPD in the general population was 10-15% (Table 4).

Over two-thirds (69.3%) of participants had confidence that they would recognize PPD, and over half (59.6%) of respondents stated they often encounter PPD in their clinical practice. Over three-quarters of nurse-midwives reported that they or someone close to them has been diagnosed with depression and some practitioners stated they would be unwilling to seek treatment for depression because of concern about stigma attached to the diagnosis (12.3%) and SOMETHING DELETED HERE? (Table 4).

Bivariate Statistics

Receiving education about PPD from medical literature and from online sources were each significantly associated with frequent screening at well-child visits, but not postpartum visits (Table 3). Specifically, 30% of those who received their PPD education via medical literature often or always screened for PPD during well-child visits during the first year of life, while only 12.5% of those who did not receive their PPD education this way often or always screened during newborn visits. Likewise, 47.6% of

those who received their PPD education via online education screened during well-child visits while only 16.7% of those who did not receive their PPD education this way screened during newborn visits.

No PPD beliefs were found to be associated with frequency screening at either postpartum or well-child visits during the first year of life (Table 4).

Narrative Findings

The narrative questions yielded a variety of answers. In response to the question, "How do you currently screen for PPD in your practice?" participants stated all of the following, and many responses were repeated at least once by another practitioner. A number of CNMs reported the use of a screening tool either once during her care, or multiple times, "at first prenatal visit, mid-pregnancy, 2 week checkup and/or 6 week checkup." The tool most often used was the Edinburgh Postnatal Depression Scale. One participant reported that the RN will ask, "are you having any issues with depression?" when checking in each patient. Others have the CNM or OB ask this question. (Nearly/Over) half reported that if the patient answers "yes", or the practitioner suspects they are experiencing PPD, they will then screen with a verified tool.

Other participants stated that they review warning signs with all patients, and many ask generalized or informal questions in order to assess for symptoms of PPD.

Each practitioner reported that they question patients about different combinations of the following topics: sleep disturbance, eating changes, emotions, crying, sadness, ability to care for self or child, worrying excessively, support, coping and exercise. One asks her patients about fearfulness and energy, another about suicidal ideation, and two participants questioned their patients for anhedonia. Some of these participants

reported that they follow up with a screening tool if they believe the patient's "verbal and non-verbal cues" warrant further assessment or "if I hear any triggers", without stating what these triggers were.

Several practitioners give the patients the surveys to fill out on their own, either by leaving copies in the waiting room, or by giving it upon hospital discharge and asking them to complete it and bring it to their 2-week visit. The latter commented, "Many don't bring it, and then we ask them general questions about mood".

Narrative about the tools themselves vary. One participant noted that the Edinburgh tool is "quick, easy for patient, a good way to start conversation [about PPD], patients are receptive, usually grateful that someone is paying attention". A number of nurse-midwives indicated that they or their OB/midwife group or clinic was excessively busy and there was "no time" to screen with a tool, but if there were a short, easy to administer tool they would begin. Others stated that language, literacy or culture barriers prevented them from providing a self-administered verified screening tool.

260 Discussion

Most participants our study were aware that PPD is both a valid and treatable diagnosis. They were also attentive to the far-reaching effects of PPD on the entire family unit. However, over half of the participants underestimated the incidence of PPD in their own practice and their screening methods were often informal irregular. Their use of screening tools was common but frequently used to confirm suspected postpartum depression rather than to recognize it. Many studies observe a distinct increase in the diagnosis of PPD with the use of a validated screening tool (Beck, 2002; Fergerson et al., 2002).

The narrative responses supported the lack of familiarity with available tools. The narrative areas of PPD that the nurse-midwives identified covered many of the seven dimensions of the experience of PPD, but it was found that they did not ask about the dimensions of loss of concentration, feelings of being all alone and the failure as a mother (Cognitive Impairment, Loss of Self, Guilt/Shame) (Beck, 2001). The EPDS also identifies guilt and shame, a topic that none of the nurse-midwives reported as part of their screening process (Beck, 2001).

There are a number of validated, short and easy-to-administer tools available. The instruments range from a 2-question structured interview asking about feelings of depression and anhedonia which is 97% sensitive and 67% specific for major depression and is reasonable for screening for PPD to the 7-question short version of the PDSS (Beck, 2001; Seehusen 2005; Wisner et al., 2002; Arroll, Kihn & Kerse, 2003). The EPDS itself is only 10-questions long (Cox, Holden & Sagovsky, 1987). To increase identification of mothers with postpartum depression, additional education is necessary as over a third of nurse-midwives are unfamiliar with available screening tools and a greater number lack confidence in their ability to identify postpartum depression. The use of a tool removes the dependence upon their ability to recognize PPD and instead increases likelihood of diagnosis, for several studies have found a strong correlation between use of screening tool and increased recognition of PPD (Cox et al., 1987; Beck, 2001).

Two recent studies of practitioner knowledge and screening practices by Seehusen and Wiley also recommend the increased education about available tools to increase and standardize diagnosis of PPD (Seehusen, 2005; Wiley, 2004).

Nearly a quarter (22.8%) of participants do not believe that mothers with PPD would be willing to discuss her signs and symptoms. Fewer nurse-midwives reported this obstacle than the majority of pediatricians in Wiley's study (2004), however it is still an obstacle to screening. Research has shown that providers are the ones uncomfortable discussing depression with their patients. A number of nurse-midwives (12.3%) stated that they would be unwilling to seek treatment for depression because of the concern of stigma. Olson found that many practitioners avoid the word "depression" when speaking with those they suspect to be depressed (Olson et al., 2002). Most interesting are the findings from Kahn indicating that more than 85% of mothers welcome and appreciate questions and referral for depression (Beck, 2002; Kahn, 1999).

303 Limitations

This study was limited by a low response rate and was was limited to the participants who attended the 50th Annual ACNM Conference in June 2005 (see demographics of their membership), however, the ACNM membership spreads all 50 states as well as Puerto Rico, Guam and the Virgin Islands. As the 50th Annual Conference, attendance was among the highest of all ACNM conferences (ACCORDING TO...). Finally, the self-selection process most likely resulted in a sample with greater interest in and knowledge of PPD than that of the general population.

Favorable attitudes to screening may be perceived as socially desirable and bias the results. This survey did not ask the CNM's demographic area of practice, or the years in practice as a CNM or other health professional.

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Another limitation was an error in our survey instructions that resulted in many people skipping the knowledge-based questions. As a result, we cannot assess all people's knowledge and experience, only those who, according to instructions, were asked to complete all questions. Therefore we cannot make conclusions about those who do not screen their patients or comparisons between those who do and don't screen.

Conclusions and Implications

Nurse-midwives sampled believe PPD is serious and common, however their screening practices are irregular and they underestimate the incidence of PPD in their own practice. They identified the lack of resources as barriers to treatment. Practitioners identified a barrier of cost of some screening tools as well as lack of referral providers available.

Efforts to improve PPD recognition and treatment should involve nurse-midwives in screening promotion and address the knowledge barriers.

329 References

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- 331 Table 1
- 332 Demographic Characteristics of Sample (N = XXX)

- 333 Table 2
- 334 CNM Beliefs about Postpartum Depression (N = XXX)

Table 3 335

Frequency of Screening for PPD by CNM Demographics, Practice Setting, and 336

337 Education Characteristics (N = 114)

Characteristic	Often or Always Screen		Often or Always Screen	P ²
	Women at Postpartum		Mothers at Well-Child	
	Visits		Visits	
Total (n = 114)	88.5		22.1	
Demographics				
Gender				
• Women (n =	88.0	NS	23.1	NS
95/25				
• Men (n = 3/0	100.0	NS	0.0%	NS
Age (yrs)				
• < 38 (n = 25/6)	85.2	NS	22.2	NS
• 38-47 (n =	84.6	NS	19.2	NS
22/5)				
• 48-53 (n =	96.3	NS	22.2	NS
26/6)				
• > 53 (n = 26/8)	86.7	NS	26.7	NS
Missing (n =	100.0	NS	0.0	NS
3/0)				

p = Pearson chi-square exact significance (1-sided)
p = Pearson chi-square exact significance (1-sided)

Characteristic	Often or Always Screen	p ¹	Often or Always Screen	P^2
	Women at Postpartum		Mothers at Well-Child	
	Visits		Visits	
Practice setting				
• Group (n =	66.3	NS	52.0	NS
98/25)				
Hospital (n =	27.6	NS	28.0	NS
(98/25)				
• Solo (n =	5.1	NS	12.0	NS
98/25)				
Other (n =	18.4	NS	24.0	NS
98/25)				
Education in PPD				
Nursing School				
• Yes (n = 61)	88.5	NS	27.9	NS
• No (n = 49)	87.8		16.3	
Midwifery School				
Yes (n = 103)	89.3	NS	22.3	NS
No (n = 7)	71.4		28.6	

Characteristic	Often or Always Screen	p ¹	Often or Always Screen	P^2
	Women at Postpartum		Mothers at Well-Child	
	Visits		Visits	
Modical				
Medical				
Conference				
o Yes (n =	91.7	NS	25.0	NS
72)	82.1		17.9	
o No (n = 39)				
Nursing				
Conference				
o Yes (n =	91.2	NS	24.6	NS
57)				
o No (n = 54)	85.2		20.4	
Lay Media				
o Yes (n =	90.9	NS	18.2	NS
30)				
o No (n = 68)	87.2		24.4	
Medical Literature				
o Yes (n =	92.1	NS	30.2	.022
63)				
o No (n = 48)	83.3		12.5	

Characteristic	Often or Always Screen	p ¹	p ¹ Often or Always Screen	
	Women at Postpartum		Mothers at Well-Child	
	Visits		Visits	
Nursing Literature				
o Yes (n =	92.1	NS	23.8	NS
63)	83.3		22.5	
o No (n = 48)				
Online Education				
o Yes (n =	81.0	NS	47.6	.004
21)				
o No (n = 90)	90.0		16.7	
Other				
o Yes (n =	90.9	NS	27.3	NS
22)	87.6		21.3	
o No (n = 89)				

Table 4
 Association between PPD Beliefs and Screening Practices (N = 114)

Statement	Often or Always	р	Often or Always	р
	Screen at		Screen at Well-Child	
	Postpartum Visits		Visits	
General beliefs about PPD				
PPD affects the spouses of				
affected women.				
• Agreed (n = 98/1)	89.1	NS	21.8	NS
● Did not agree (n = 2/24)	66.7		33.3	
PPD affects the children of				
affected mothers				
• Agreed (n = 97/23)	89.0	NS	21.1	NS
● Did not agree (n = 3/2)	75.0		50.0	
PPD causes no lasting				
effects.				
• Agreed (n = 0/0)	0.0		0.0	NS
• Did not agree (n = 100/25)	100.0		100.0	
PPD is not a valid diagnosis.				
• Agreed (n = 0/0)	0.0		0.0	
• Did not agree (n = 100/25)	88.5		88.5	

Statement	Often or Always	р	С	Often or Always	р
	Screen at		Scr	een at Well-Child	
	Postpartum Visits			Visits	
Therapy for PPD is effective.		1			
• Agreed (n = 89/23)		89.9	NS	23.2	NS
● Did not agree (n = 11/2)		78.6		14.3	
General beliefs about screening					
for PPD					
PPD is common enough to					
warrant screening.					
o Agreed (n = 97)					
o Did not agree (n = 11)					
PPD is a serious enough					
problem to warrant screening.					
• Agreed (n = 99/25)	90.8	.005	5	22.9	NS
● Did not agree (n = 1/0)	25.0			0.0	
Beliefs about screening women					
at postpartum visits					
Screening at every postpartum					
visit would not be effective.					
• Agreed (n = 96/2)					
• Did not agree (n = 4/23)	0.0	NS		50.0	NS
	22.1			21.1	

Statement	Often or Always	р	Often or Always	р
	Screen at		Screen at Well-Child	
	Postpartum Visits		Visits	
		l		
Screening at every postpartum				
visit would take too much effort.				
• Agreed (n = 98/24)	50.0	N	S 25.0	NS
• Did not agree (n = 2/1)	89.9		22.0	
Screening at every postpartum				
visit would be time-consuming.				
• Agreed (n = 15/6)	78.9	N	S 31.6	NS
• Did not agree (n = 85/19)	90.4		20.2	
Beliefs about screening mothers				
at well-child visits				
Screening at every well-child				
visit up to one year of age would				
take too much effort.				
• Agreed (n = 9/4)	75.0	N	S 33.3	NS
• Did not agree (n = 91/21)	90.1		20.8	
Screening at every well-child				
visit would not be effective.				

Often or Always	р	Often or Always	р
Screen at		Screen at Well-Child	
Postpartum Visits		Visits	
85.7	N	S 28.6	NS
88.7		21.7	
04.0	.	0 01.0	NO
81.3	N	S 21.6	NS
89.7		25.0	
	Screen at Postpartum Visits 85.7 88.7	Screen at Postpartum Visits 85.7 N 88.7	Screen at Postpartum Visits Screen at Well-Child Visits