Promoting Maternal Mental Health During and After Pregnancy

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1 in 7 women suffer from perinatal depression

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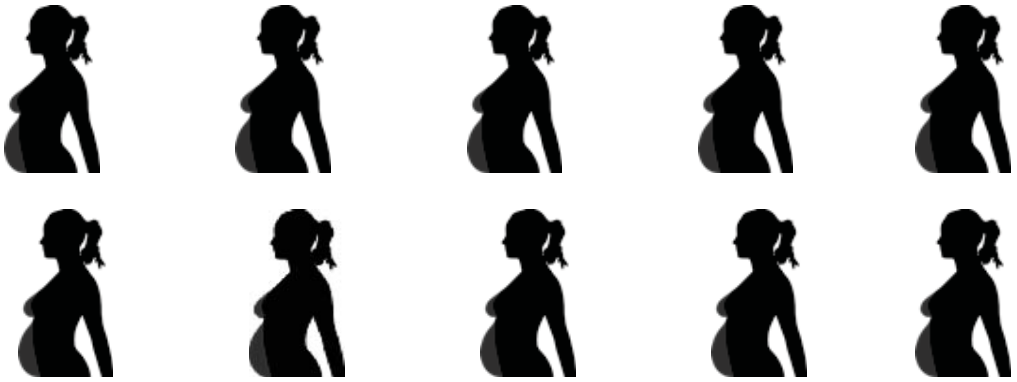
Gavin et al. Ob Gyn 2005, Vesga-Lopez et al. Arch Gen Psychiatry 2006.

Perinatal depression is twice as common as gestational diabetes

Depression
10 – 15 in 100



Diabetes
3 -7 in 100

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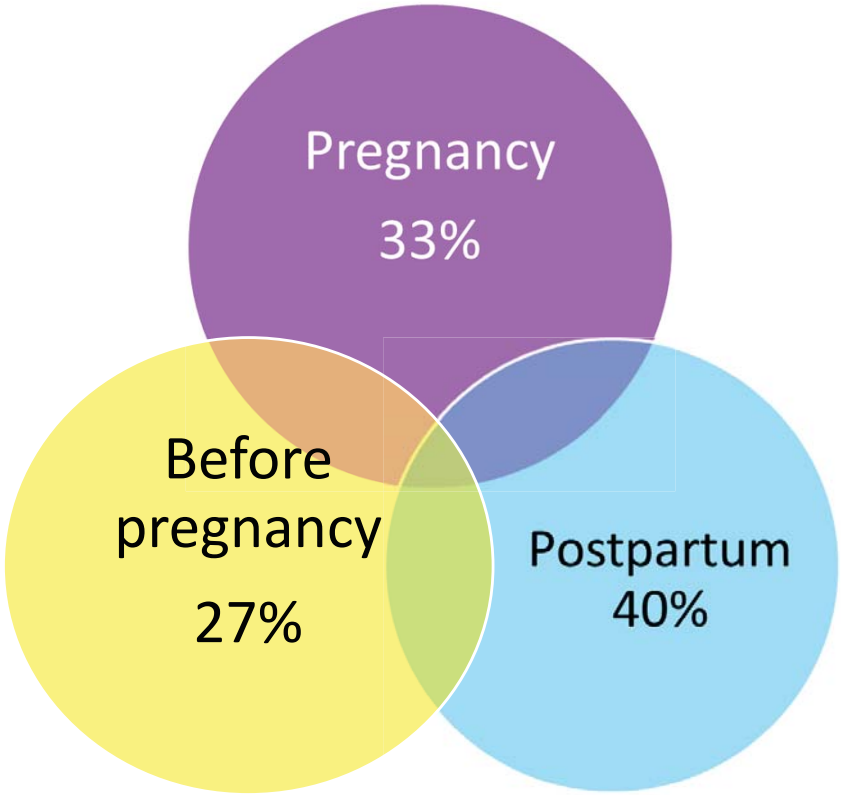
Gavin et al. Ob Gyn 2005, Vesga-Lopez et al. Arch Gen Psychiatry 2006. ACOG Practice Bulletin 2013.

Two – thirds of perinatal depression begins before birth



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Wisner et al. JAMA Psychiatry 2013

1 in 3 fathers in families struggling with maternal depression experience postpartum depression

Depression in fathers may present differently than in mothers
-Substance use, change in work or social functioning

Adoptive parents have similar rates of PPD as birth parents

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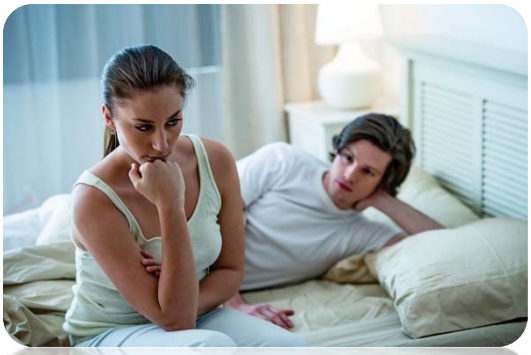
Ramchandani et al. The Lancet. 2005

Perinatal depression effects mom, child & family

Poor health care
Substance abuse
Preeclampsia
Maternal suicide



Low birth weight
Preterm delivery
Cognitive delays
Behavioral problems

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Bodnar et al. (2009). *The Journal of clinical psychiatry*. Cripe et al. (2011). *Paediatric and perinatal epidemiology*, Flynn, H. A., & Chermack, S. T. (2008). *Journal of Studies on Alcohol and Drugs*,.; Forman et al. (2007). *Development and psychopathology*, Grote et al. (2010). *Archives of general psychiatry*,.; Sohr-Preston, S. L., & Scaramella, L. V. (2006). *Clinical child and family psychology review*,. ; Wisner et al. (2009). *The American journal of psychiatry*,

PPD is leading cause of toxic stress

Importance of toxic stress from ACE study

- **Key cause of intergenerational transmission of heath risk and disparity**
- **Adverse Childhood Experiences (ACEs) are the most basic causes of adult health risk behaviors, morbidity, disability, mortality, and health care costs**

Toxic stress occurs when absence of social-emotional buffering such as with PPD

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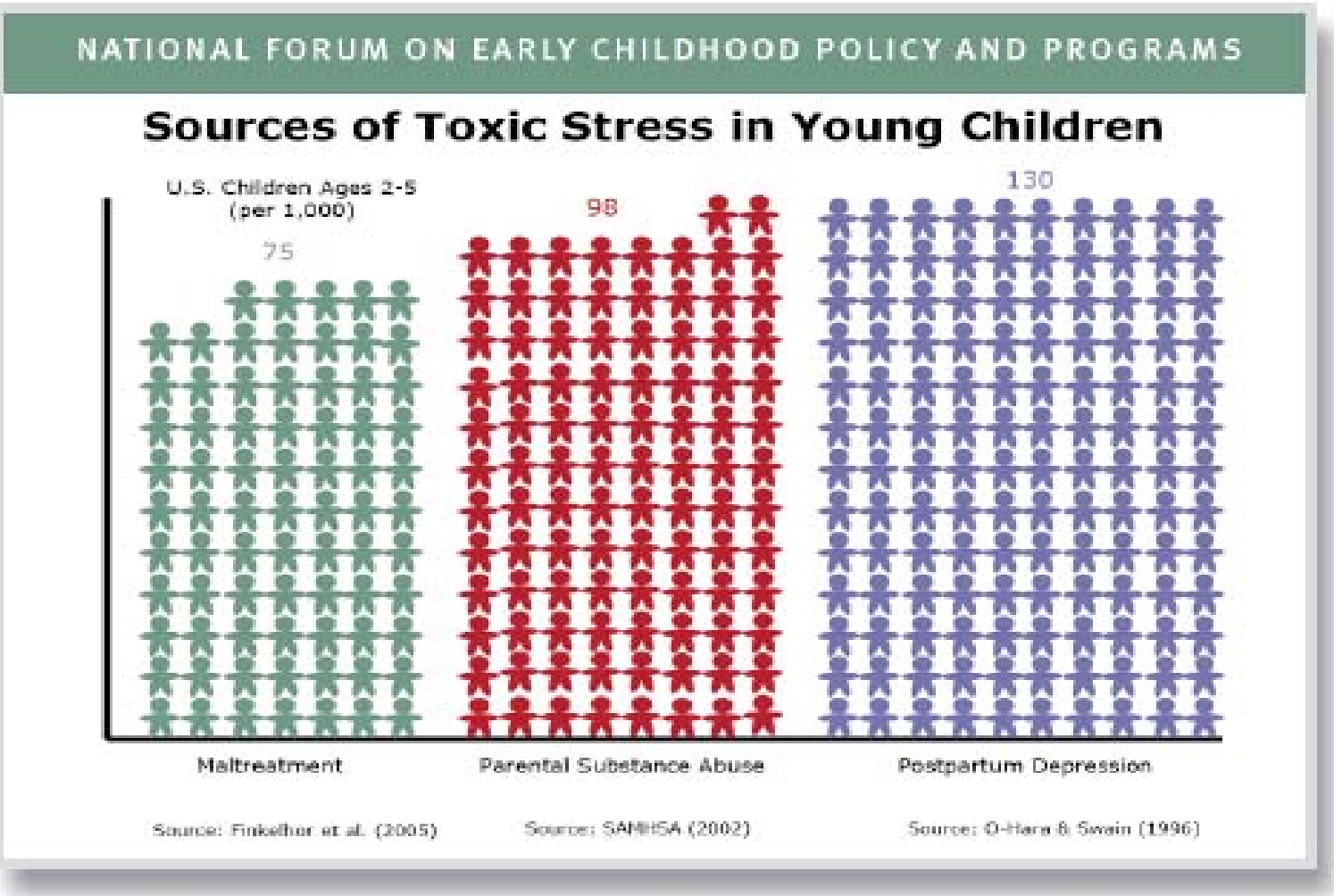
Felliti et al, 2005



Providing supportive relationships and safe environments can improve outcomes for all children, but especially those who are most vulnerable. Between 75 and 130 of every 1,000 U.S. children under age 5 live in homes where at least one of three common precipitants of toxic stress could negatively affect their development.

Treating maternal depression is associated with improved depression and other disorders in her child

STAR*D-Child : 151 mother-child pairs in 8 primary care and 11 psychiatric outpatient clinics across 7 regional centers in the US

"Continued efforts to treat maternal depression until remission is achieved are associated with decreased psychiatric symptoms and improved functioning in the offspring."

Treating Mother-Child Dyad shows promise of even better child outcomes

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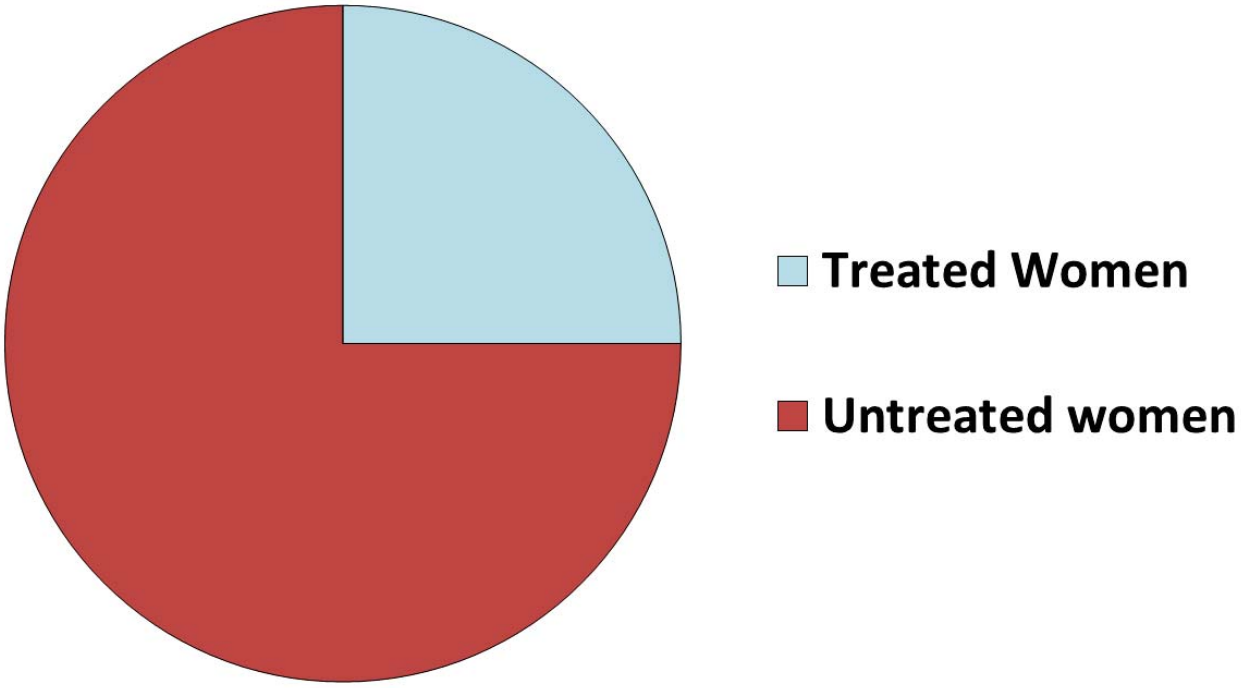
Pilowsky et al. 2008, *Am J Psychiatry*. Forster et al. 2008, J *Clin Adolesc Psychol*.

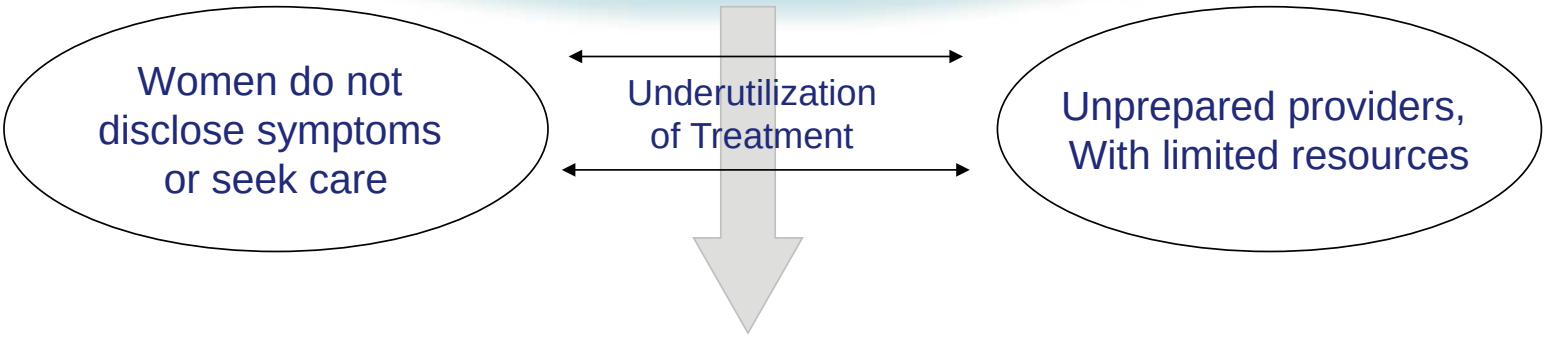
Perinatal depression is under-diagnosed and under-treated



Carter et al. (2005). Australian and New Zealand Journal of Psychiatry, 39(4), 255–261; Marcus et al. (2003). Journal of womens health 2002, 13(1), 373–380. Smith et al. (2009). General hospital psychiatry, 31(2), 155–62.

Barriers to Treatment

Patient	Provider	Systems
Lack of detection	Lack of training	Lack of integrated care
Fear/stigma	Discomfort	Screening not routine
Limited access	Few resources	Isolated providers



Poor Outcomes

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www.chroniccare.org

Optimizing perinatal mental health could break the transgenerational impact of maternal depression

Generation 0 Childhood impact
Maternal depression

Generation 1
Childhood impact

Maternal depression

Generation 2
Childhood impact

Maternal depression

Generation 3
Childhood impact

Maternal depression

Generation 4
Childhood impact

Maternal depression

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Adapted from slide created by Allain Gregoire, DRCOG, MRCPsych

The perinatal period is ideal for the detection and treatment of depression

80% of depression is treated by primary care providers

Regular opportunities to screen and engage women in treatment

Front line providers of all types have a pivotal role

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Transforming obstetrical and pediatric practice to include depression care could provide a solution

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In 2010, Massachusetts passed a Postpartum Depression Act

PPD Commission

PPD Screening Regulation
(if screen must report CPT S3005, 0-6 months)

MCPAP for Moms Funding

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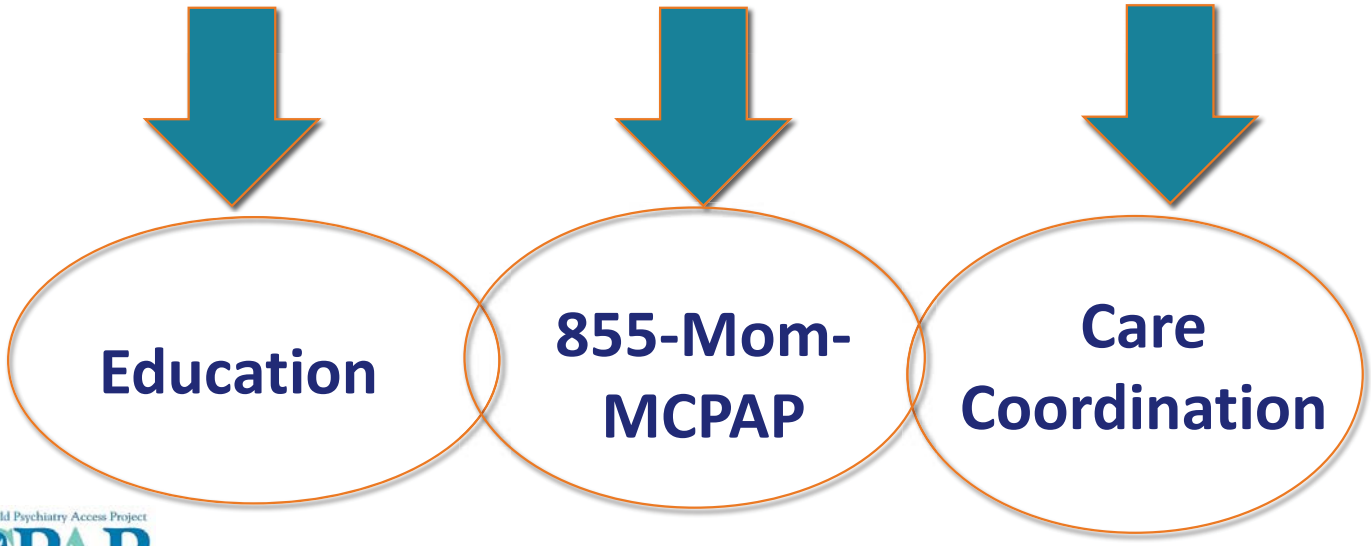

Telephone Consultation

Obstetric providers/ Midwives	Family Medicine	Psychiatric providers	Primary care providers	Pediatric providers

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What Can You Do?

Encourage mom and family members to visit www.mcpapformoms.org "For Moms and Families" resources

Encourage mom to contact her primary care or obstetric provider and ask them call MCPAP for Moms

With permission, contact mom's primary care or obstetric provider and recommend they call MCPAP for Moms

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1-855-Mom-MCPAP

Telephone Consultation

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MCPAP for Moms encourages all obstetric and pediatric providers to screen for depression

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Ramchandani et al. The Lancet. 2005

Administer Edinburgh Postnatal Depression Scale

Administer EPDS for high-risk patients

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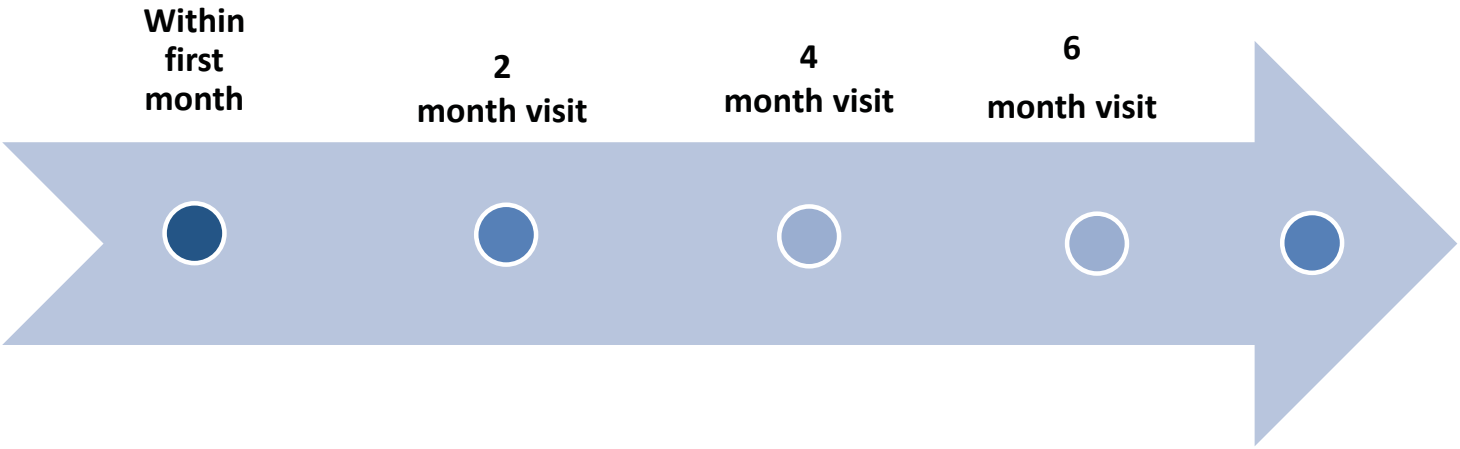

SWYC/MA (Massachusetts Survey of Wellbeing of Young Children)

OR

EPDS or PHQ-9

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Download SWYC/MA at www.MCPAP.org

Screening is reimbursed once during pregnancy and once postpartum for MassHealth patients

Use Code S3005

- Behavioral health need is identified

Modifier U3

Use Code S3005

- No Behavioral health need is identified

Modifier U4

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Bidirectional relationship between depression and infertility likely exists

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Freeman et al. Annals of Clinical Psychiatry. 2013

Preconception planning is critical

Attempting conception and being pregnant can be (often are) stressful

Therapy is evidence based treatment for depression and anxiety

If on psychiatric medication, preconception is an opportunity to plan and streamline treatment

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Duration and number of depressive episodes is the #1 risk factor for relapse during pregnancy

Other risk factors of perinatal depression:

- Personal history of postpartum depression
- Family history of postpartum depression
- History of mood changes related to hormonal changes (e.g. hormonal contraception, PMS/PMDD)

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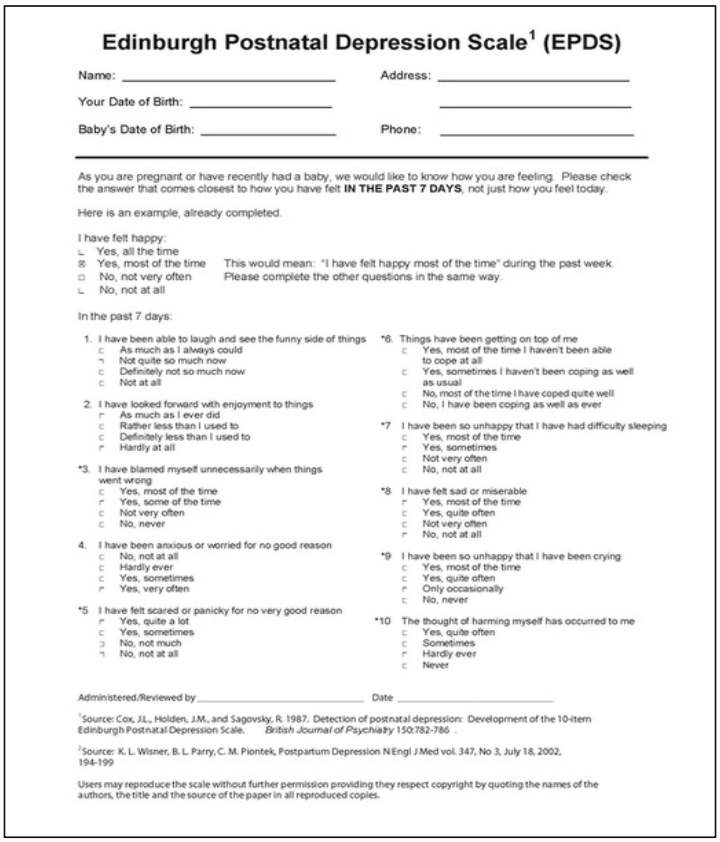
Edinburgh Postnatal Depression Scale (EPDS)

Validated in pregnancy and postpartum

10 items

Asks about self-harm



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all
2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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EPDS scores range 0 - 30

< 10	• Depression unlikely
≥10	• Possible depression
≥ 13	• Probable depression

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Source: Cox, J.L, Holden, J.M., and Sagovsky, R. 1987. British Journal of Psychiatry 150:782-786. Source: K.L. Wisner, B.L. Parry, C.M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002.

Baby Blues

≤ 2 wk

Mood lability

High emotionality

Depression

≥2 wks

Guilt, feeling worthless

Suicidal thoughts

Impacts functioning

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Mild depression

No suicidal ideation

Able to care for self/baby

Engaged in psychotherapy

Depression has improved with psychotherapy in the past

Strong preference and access to psychotherapy

Moderate/severe depression

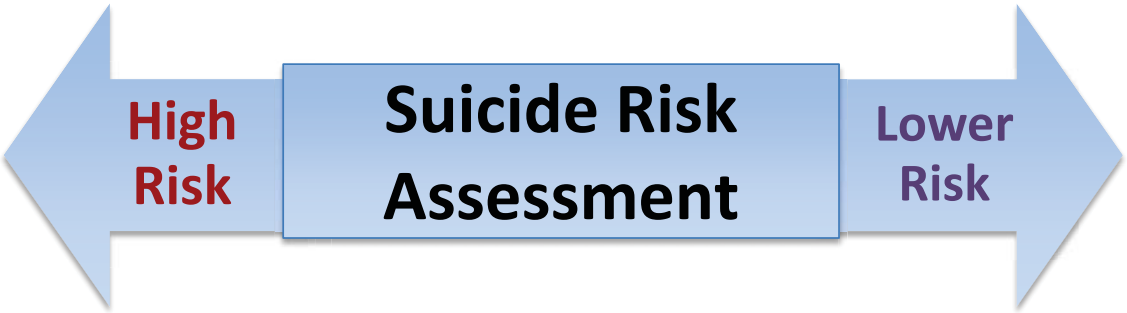
Suicidal ideation

Difficulty functioning caring for self/baby

Psychotic symptoms present

History of severe depression and/or suicide ideation/attempts

Comorbid anxiety



High Risk	Lower Risk
History of suicide attempt	No prior attempts
High lethality of prior attempts	If prior attempts, low lethality & high rescue potential
Recent attempt	
Current plan	No plan
Current intent	No intent
Substance use	No substance use
Lack of protective factors (including social support)	Protective factors

Risk of harm to baby

OCD/anxiety	Postpartum Psychosis
• Good insight • Thoughts are intrusive and scary • No psychotic symptoms • Thoughts cause anxiety	• Poor insight • Psychotic symptoms • Delusional beliefs or distorted reality present
Low risk	**High risk**

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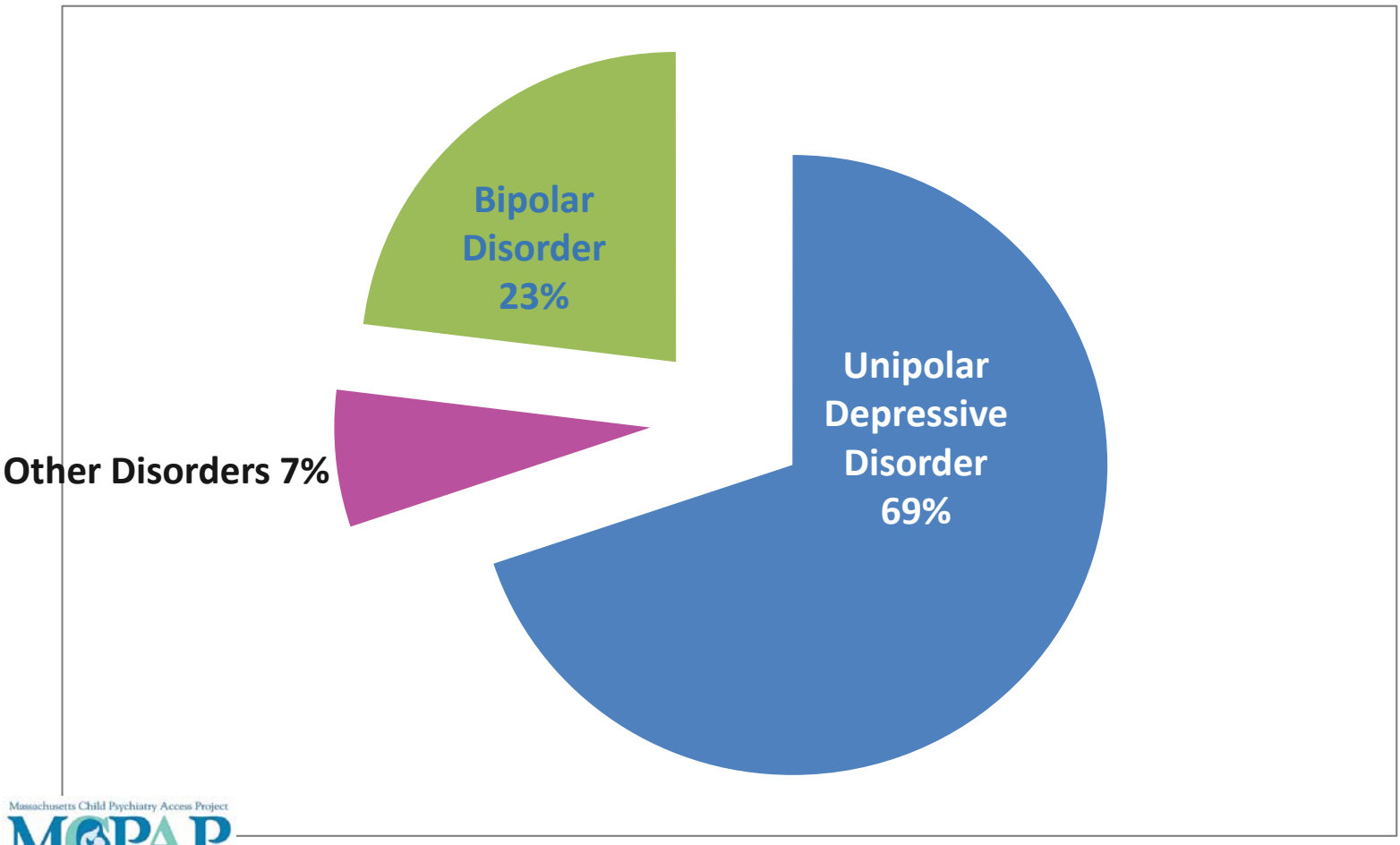
Imperative to address bipolar disorder



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Wisner et al. JAMA Psychiatry 2013

Bipolar disorder increases risk of postpartum psychosis

- 1-2/1000 women
- >70% bipolar disorder
- 24 hrs – 3 weeks postpartum
- Mood symptoms, psychotic symptoms & disorientation
- R/o medical causes of delirium
- Psychiatric emergency
- 4% risk of infanticide with postpartum psychosis

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EPDS or PHQ-9 ≥10

Score suggests depression

Perform a brief assessment of risk

Practices with co-located behavior health clinicians may want their clinician to do this task

Refer parent to previous mental health provider if there is one

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If there is a positive score on the self-harm/suicide question…

Refer to parent's local emergency service. For MassHealth members, contact local Emergency Services Program at 1-877-821-1609.

As best as possible, mom and baby should have someone else in room at all times

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EPDS or PHQ-9 ≥10 but < 13
or
Parent seems able to manage on their own

Give mom info about community resources/support groups. Order MCPAP for Moms resource cards. Refer to website, www.mcpapformoms.org.

Provide names of mental health providers in area who treat PPD. Encourage providers to call MCPAP for Moms and patients to visit www.mcpapformoms.org

Refer and with consent notify parent's PCP/OB for monitoring and follow-up. PCP can call MCPAP For Moms with questions. "Close the loop."

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Parent meets any of above criteria

or

You are concerned about safety

Contact patient's provider and recommend they call MCPAP for Moms (866-666-6272) for consultation and care coordination

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Engage Natural Supports

You will most likely only be with one parent when a screen is positive

If parent alone or feeling alone, higher risk of suicide

Seek parent's permission to notify natural support

Screen for domestic violence

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Education about various treatment and support options is imperative

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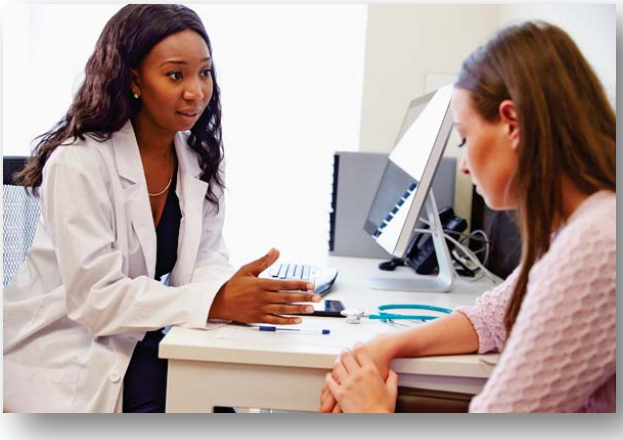
Ask women what type of treatment they prefer

There are effective options for treatment during pregnancy and breastfeeding.

Depression is very common during pregnancy and the postpartum period.

There is no risk free decision.

Women need to take medication during pregnancy for all sort of things.



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Linkages with support groups and community resources

Support the wellness and mental health of perinatal women

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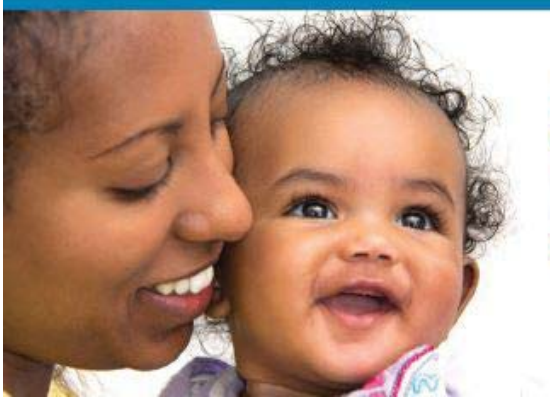
Having a baby is challenging.



Every woman deserves support.

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Go to www.mcpapformoms.org and visit the "For Mothers and Families" tab for information on resources for emotional support

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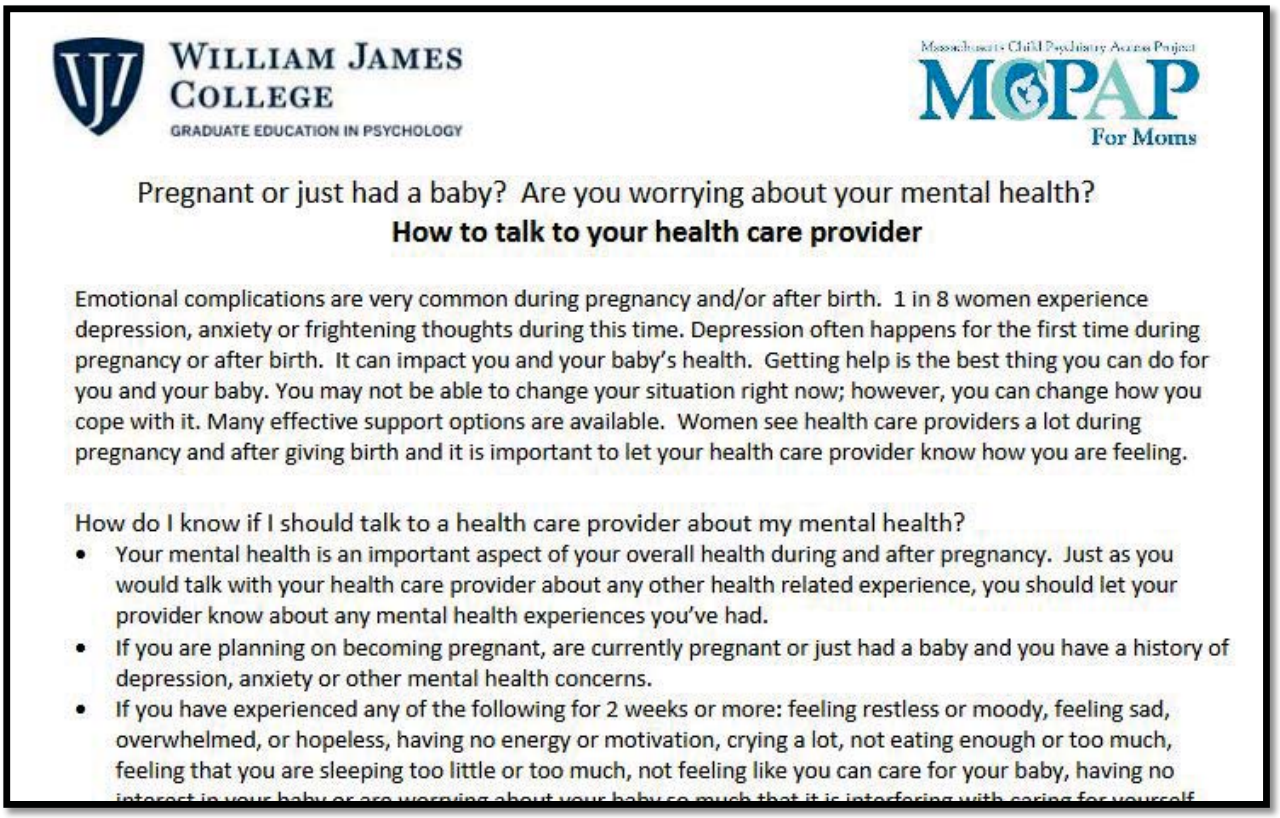
Can refer moms to www.mcpapformoms.org



William James College
GRADUATE EDUCATION IN PSYCHOLOGY

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Pregnant or just had a baby? Are you worrying about your mental health?

How to talk to your health care provider

Emotional complications are very common during pregnancy and/or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. Depression often happens for the first time during pregnancy or after birth. It can impact you and your baby's health. Getting help is the best thing you can do for you and your baby. You may not be able to change your situation right now; however, you can change how you cope with it. Many effective support options are available. Women see health care providers a lot during pregnancy and after giving birth and it is important to let your health care provider know how you are feeling.

How do I know if I should talk to a health care provider about my mental health?

- Your mental health is an important aspect of your overall health during and after pregnancy. Just as you would talk with your health care provider about any other health related experience, you should let your provider know about any mental health experiences you've had.
- If you are planning on becoming pregnant, are currently pregnant or just had a baby and you have a history of depression, anxiety or other mental health concerns.
- If you have experienced any of the following for 2 weeks or more: feeling restless or moody, feeling sad, overwhelmed, or hopeless, having no energy or motivation, crying a lot, not eating enough or too much, feeling that you are sleeping too little or too much, not feeling like you can care for your baby, having no interest in your baby or are worrying about your baby so much that it is interfering with caring for yourself

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Case of Ms. Y

Vs.

Need to balance and discuss the risks and benefits of medication treatment and risks of untreated depression or other mental illness

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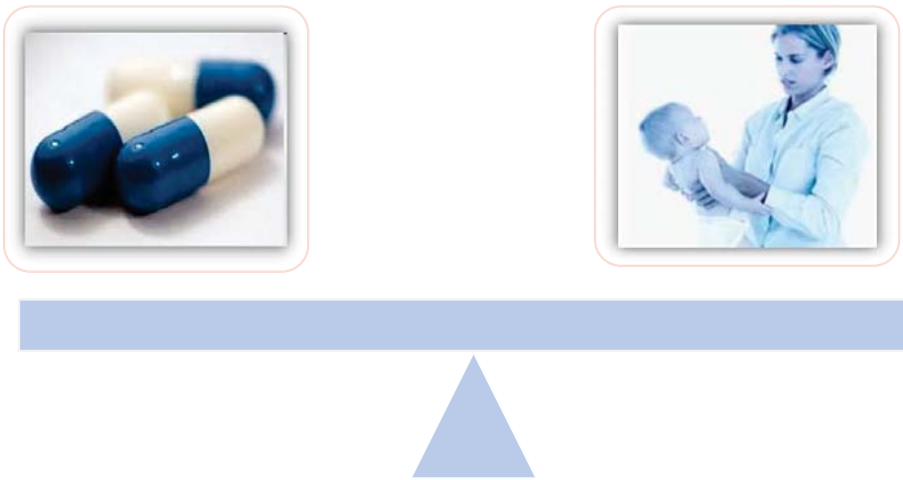
Byatt et al. Acta Psych Scand 2013.

No choice is completely free of risk



Need to balance and discuss the risks and benefits of medication treatment and risks of untreated depression or other mental illness. You can always call MCPAP for Moms.

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Breastfeeding generally should not preclude treatment with antidepressants

SSRIs and some other antidepressants are considered a reasonable option during breastfeeding

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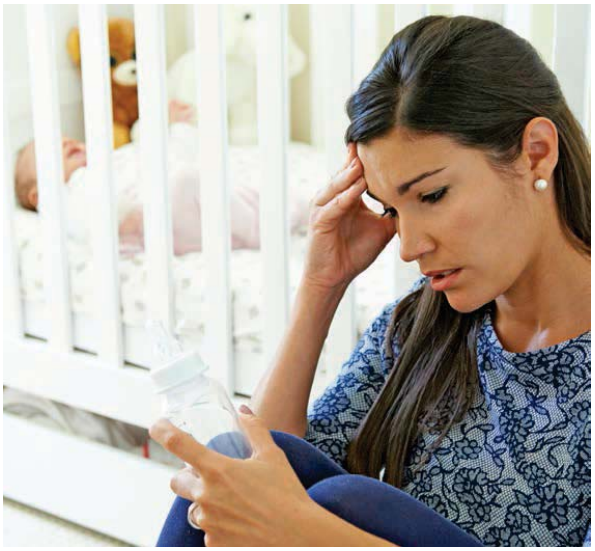
Questions?

In summary, our aim is to promote maternal and child health by building the capacity of front line providers to address perinatal depression



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Call 1-855-Mom-MCPAP

www.mcpapformoms.org

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Thank you!