Promoting Maternal Mental Health During and After Pregnancy

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1 in 7 women suffer from perinatal depression

Perinatal depression is twice as common as gestational diabetes

Depression
10 – 15 in 100

Diabetes
3 -7 in 100

Two-thirds of perinatal depression begins before birth

- Pregnancy: 33%
- Before pregnancy: 27%
- Postpartum: 40%

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

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

PPD is leading cause of toxic stress

Importance of toxic stress from ACE study

- Key cause of intergenerational transmission of health 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
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

Perinatal depression is under-diagnosed and under-treated

Barriers to Treatment

Patient
- Lack of detection
- Fear/stigma
- Limited access

Provider
- Lack of training
- Discomfort
- Few resources

Systems
- Lack of integrated care
- Screening not routine
- Isolated providers

Women do not disclose symptoms or seek care

Underutilization of Treatment

Unprepared providers, With limited resources

Poor Outcomes

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

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
Transforming obstetrical and pediatric practice to include depression care could provide a solution
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
Massachusetts Child Psychiatry Access Project

MCPAP

For Moms

Education

855-Mom-MCPAP

Care Coordination
<table>
<thead>
<tr>
<th>Obstetric providers/Midwives</th>
<th>Family Medicine</th>
<th>Psychiatric providers</th>
<th>Primary care providers</th>
<th>Pediatric providers</th>
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*Telephone Consultation*
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
1-855-Mom-MCPAP
1-855-Mom-MCPAP
MCPAP for Moms encourages all obstetric and pediatric providers to screen for depression

Ramchandani et al. The Lancet. 2005
Administer Edinburgh Postnatal Depression Scale

Administer EPDS for high-risk patients
SWYC/MA (Massachusetts Survey of Wellbeing of Young Children)  
OR  
EPDS or PHQ-9  
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
Bidirectional relationship between depression and infertility likely exists
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.
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)
Edinburgh Postnatal Depression Scale (EPDS)

Validated in pregnancy and postpartum

10 items

Asks about self-harm
EPDS scores range 0 - 30

- **< 10**: Depression unlikely
- **≥10**: Possible depression
- **≥ 13**: Probable depression

Baby Blues

≤ 2 wk

Mood lability

High emotionality

Depression

≥2 wks

Guilt, feeling worthless

Suicidal thoughts

Impacts functioning
Meds not indicated

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

Meds indicated

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
Suicide Risk Assessment

High Risk
- History of suicide attempt
- High lethality of prior attempts
- Recent attempt
- Current plan
- Current intent
- Substance use
- Lack of protective factors (including social support)

Lower Risk
- No prior attempts
- If prior attempts, low lethality & high rescue potential
- No plan
- No intent
- No substance use
- Protective factors
Risk of harm to baby

**OCD/anxiety**
- Good insight
- Thoughts are intrusive and scary
- No psychotic symptoms
- Thoughts cause anxiety

**Postpartum Psychosis**
- Poor insight
- Psychotic symptoms
- Delusional beliefs or distorted reality present

Low risk  High risk
Imperative to address bipolar disorder

- **Unipolar Depressive Disorder**: 69%
- **Bipolar Disorder**: 23%
- **Other Disorders**: 7%

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


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.”
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
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
Education about various treatment and support options is imperative
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.
Linkages with support groups and community resources

Support the wellness and mental health of perinatal women
Having a baby is challenging.

Every woman deserves support.

Go to www.mcpapformoms.org and visit the “For Mothers and Families” tab for information on resources for emotional support.
Can refer moms to www.mcpapformoms.org
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 eating for yourself.
Case of Ms. Y
Need to balance and discuss the risks and benefits of medication treatment and risks of untreated depression or other mental illness
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.
Breastfeeding generally should not preclude treatment with antidepressants

SSRIs and some other antidepressants are considered a reasonable option during breastfeeding
Questions?
In summary, our aim is to promote maternal and child health by building the capacity of front line providers to address perinatal depression.
Call 1-855-Mom-MCPAP
www.mcpapformoms.org

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Thank you!