What's The Problem?

- Up to 1 in 5 women will experience a maternal mental health (MMH) disorder during pregnancy and/or postpartum.
- The most common complication of pregnancy in the US, surpassing gestational diabetes and preeclampsia combined.
- Prevalence higher among women living in poverty (up to 1 in 2 women) due to social determinates of health.
- Most never diagnosed or treated.
- Untreated, MMH disorders devastate women, impact family stability, affect the wellbeing of children, and can have life long consequences.

What Is the Impact?

- Annual births in CA approximately 500,000 (4.8 US infants).
- Untreated depression and anxiety increase the risk for preterm birth and low birthweight babies.
- Exposure to maternal depression in utero associated with changes in the fetal brain and associated with alteration of fetal DNA.
- Maternal depression and anxiety are stronger risk factors for childhood behavioral problems than smoking, drinking or domestic violence.
- Impaired maternal bonding associated with negative childhood outcomes with respect to learning, health, and adulthood functioning.
- Low income families disproportionately affected, with higher prevalence of MMH disorders and lower likelihood of treatment, compounding negative outcomes of poverty.
Range of Maternal Mental Health Disorders

![Diagram showing categories of mental health disorders: Baby Blues, Depression, Anxiety Disorders, Bipolar, Postpartum Psychosis, OCD, Panic Disorders, PTSD]

8/3/2018

Reported Prevalence of Maternal Mental Health Disorders

<table>
<thead>
<tr>
<th>MMH Disorder</th>
<th>Pregnancy Prevalence</th>
<th>Postpartum Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Depression</td>
<td>5.6%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Minor Depression</td>
<td>7.3%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Generalized Anxiety</td>
<td>0 - 11%</td>
<td>6 - 10%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>0.2 - 5.7%</td>
<td>1.4 - 10.9%</td>
</tr>
<tr>
<td>OCD Disorder</td>
<td>0 - 5.2%</td>
<td>2.7 - 3.9%</td>
</tr>
<tr>
<td>Perinatal PTSD</td>
<td>NA</td>
<td>3.1%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>2.8%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Postpartum Psychosis</td>
<td>NA</td>
<td>0.1 - 0.2%</td>
</tr>
</tbody>
</table>

What Are the Risk Factors?

**Reproductive Health Related**
- Prior birth loss
- Unintended pregnancy (4x risk)
- History of Premenstrual Syndrome (PMS)
- Single relationship status, poor quality relationship, incarcerated partner
- Multifetal births
- Breastfeeding difficulties
- Infant with colic/significant fuss patterns
- Preterm infant and/or admission to the NICU
- Traumatic birth experience
- Stressful life event during the perinatal period

**Other/General (Psychologic, Social)**
- Personal or family history of depression
- Major life changes, trauma, or stress
- Lack of social support
- History of domestic violence
- Poor health and/or chronic conditions prior to pregnancy, especially for women of color
- Perfectionism/fear of making a mistake
- Adverse childhood experiences (ACE)
- African-American women
- Poverty (4 in 10 CA residents)
Prevalence of Perinatal Depression and Distribution of Population by Income, California: 2012-213


- 2014: Assembly Concurrent Resolution (ACR) 148 passed in CA after introduction by the CA Legislative Women’s Caucus
- Task force on MMH convened as a result of ACR 148
- 2015 - 2016:
  - Multi-disciplinary and cross-sector stakeholders
  - Work products included
    - Provider Core Competencies for different types of providers
    - Continuum of Care Reference summarizing critical time frames when MMH should be addressed
    - Cut-off Score Guidelines for most popular screening tools plus frequency/intervals
    - Menu of Prevention and Treatment Options
    - Call to Action for stakeholder groups with detailed road map for change


Report seeks to summarize California’s gaps in MMH care, identify strategies for improvement, and provide a clear call-to action and framework for coordinating stakeholder responsibilities
CA MMH Task Force: Identified Barriers

- Providers lack guidelines, referral pathways, capacity, and support to screen and treat
- Medical and mental health insurance and delivery systems and providers are not integrated
- Ob Gyn screening rates are not measured and reported
- Women don’t receive adequate MMH support and education
- Stakeholder groups lack a framework or roadmap for coordinated change

CA MMH Task Force: Identified Provider Barriers

- Fewer than ½ of ObGyns screen sometimes or always, and not necessarily with a validated tool
- Ob Gyns who don’t screen say they
  - Don’t have time to screen or manage cases
  - Aren’t qualified to screen
  - Don’t know where to refer patients for help
  - Have high levels of burnout
  - See patients infrequently in the postpartum period
- Pediatricians identify the impact of MMH disorders on infant and children health but cite the same barriers
  - Further, they report the mother isn’t their patient, the child is
- Studies suggest women prefer talk therapy over pharmacologic intervention during and after pregnancy. Ob Gyns and Family Practice providers prefer medication treatment over talk therapy by themselves or other providers
  - Patient fears of adverse impact of medication on their fetus/child

What Are the Barriers?

Mother’s

- Maternal Mental Health disorders increase isolation and/or avoidance, decreasing attendance and participation in healthcare and follow-up
- 40% of women don’t attend even 1 postpartum visit
- Lack of childcare, transportation, insurance, high out of pocket expenses
- Low health literacy
- Feelings of shame or previous experiences feeling judged by healthcare providers
- Women of color have lower rates of diagnosis despite higher rates of MMH disorders
What Are the Barriers?

Systemic

- Mental health provider shortages
- Reproductive psychiatrist shortages
  - A physician with special interest and skills in diagnosing and treating psychiatric disorders that may be related to a woman’s reproductive life cycle, including menstruation, pregnancy, and menopause.
  - Only 11 of 58 CA counties have at least one reproductive psychiatrist
- A physician with special interest and skills in diagnosing and treating psychiatric disorders that may be related to a woman’s reproductive life cycle, including menstruation, pregnancy, and menopause.
  - Most women with MMH disorders don’t qualify for care unless they have a chronic and persistently severe illness.
- Bifurcation of behavioral health services from health insurance plans
  - The California MMH Taskforce has called for medical insurers to bring mental health ‘in‐house’ to reimburse MMH services provided by Ob/Gyns, primary care providers and birthing hospitals
- In MediCal, “severe” mental illness is addressed through and is the financial responsibility of the departments of mental health throughout California’s individual counties and jurisdictions
  - A physician with special interest and skills in diagnosing and treating psychiatric disorders that may be related to a woman’s reproductive life cycle, including menstruation, pregnancy, and menopause.

How and Whom to Screen?

- Edinburgh Pregnancy/Postnatal Depression Scale (EDPS)
  - A 10-question survey to detect depression, includes 2 questions on anxiety
  - Cutoff of 10
  - Typically chosen by providers who focus on the perinatal period
- Patient Health Questionnaire (PHQ‐9)
  - A 9-question survey to detect depression
  - Cutoff of 10
- MDQ (Mood Disorders Questionnaire)
  - Used to detect bipolar disorder
  - ALL PREGNANT AND POSTPARTUM WOMEN!!!
    - ACOG (American College of Obstetricians and Gynecologists); May 2015
    - U.S. Preventative Services Task Force (USPSTF) recommendation January 2016
    - Council on Patient Safety in Women’s Health Care
    - American Academy of Pediatrics (AAP); integrated into the well‐child care schedule
    - CMS: Screening during the well‐child visit

Establish Context for Screening

- Establish trust
- Normalize prevalence of MMH disorders
- Raise awareness that treatment is available and that with treatment and support, women get better
- Perform universal screening using a validated tool
- Consider using screening tool at several points
  - Obstetric care intake/antenatal
  - Third trimester
  - Postpartum/Fourth trimester
- Use screening scores to open a conversation
“Menu” of Treatment Options for MMH

<table>
<thead>
<tr>
<th>Prevention Strategies &amp; Treatment Options</th>
<th>Limited to</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care, including sleep hygiene and grooming, nutrition</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Brain health, including omega-3 fatty acids, vitamin D, folate</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Exercise</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Transfer mother-in-law support for uncomplicated babies, meeting needs, finding providers</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Emotional</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Prescribing education for women and families outside of the home</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Education in nutrition and appropriate support</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Education in nutrition and appropriate support</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Provide support from/from* family, friends, or support groups in case of ongoing issues, home visits, and community</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Support groups for depression/anxiety</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Stress for mothers</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Therapy for mother</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Provide medication</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Consider pharmacologic treatment when safety or ability to care for self is a concern</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

What We Do: Preparation

- Educate ourselves
  - Continuing medical education
  - Online resources
    - Mom JPEG Group https://www.momjiep.org/
    - The Blue Dot Project https://www.thebluedotproject.org/
    - Præclarus Press http://praeclaruspress.com/whitepapers/
    - Maternal Mental Health Now https://www.maternalmentalhealthnow.org/
  - Educate our patients
    - NEST Welcome to the Practice Packet
      - Every new patient intake includes questions about personal history of depression and anxiety
      - Set expectation that we will be the woman’s home base throughout the perinatal period
  - Universal screening with EPDS
    - Simple and quick
      - Initially, screened just at first postpartum visit
      - Currently implementing "4th Trimester" approach to postpartum care
      - Currently done at first prenatal visit and 2 postpartum visits (first within 7 weeks of delivery)

What we Do: Discuss Self Care (NESTS)

- Nutrition
- Exercise
- Sleep and Rest
- Time for Self
- Support
What We Do: Identify our Resources

- Talk therapy specialists (social workers, psychologists, therapists) in our geographic area
- Postpartum Support International Resources [http://www.postpartum.net](http://www.postpartum.net)
- Maternal Mental Health Now [http://directory.maternalmentalhealthnow.org](http://directory.maternalmentalhealthnow.org)
- 2020 Mom [https://www.2020mom.org](https://www.2020mom.org)
- Support groups
  - Hospital based
  - Community based
- Lactation support
- Patient handouts/written materials

What We Do: Follow-up, Follow-up, Follow-up

- Plan to provide ongoing care until plan in place and continuity of care ensured
- Frequent appointments
- Disability paperwork when indicated
- Talk therapy may take days to authorize and weeks to initiate
- Patients typically take “baby steps” and need check back

- Prepare to initiate medication therapy (SSRIs) if indicated
- Provide counseling regarding lactation
- Need for ongoing medication management
- Medication therapy takes time to onset, may need dose escalation