Perinatal Mental Health

Jennifer McNulty MD

Clinical Professor, University of CA Irvine
Maternal Fetal Medicine
Long Beach Memorial Miller Children's and Women's Hospital

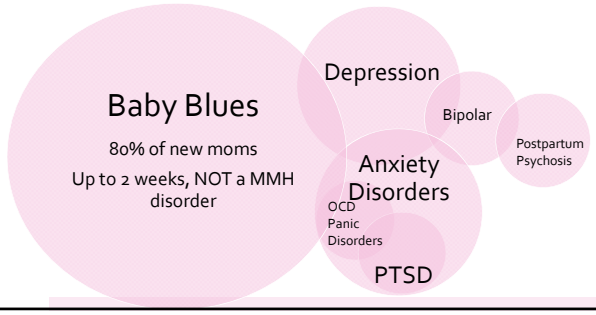
What's The Problem?

- 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 (1:8 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



Reported Prevalence of Maternal Mental Health Disorders

MMH Disorder	Pregnancy Prevalence	Postpartum Prevalence
Major Depression	5.6%	7.1%
Minor Depression	7.3%	12.1%
Generalized Anxiety	0 – 11%	6-10%
Panic Disorder	0.2 – 5.7%	1.4 – 10.9%
OCD Disorder	0 - 5.2%	2.7 – 3.9%
Perinatal PTSD	NA	3.1%
Bipolar Disorder	2.8%	2.8%
Postpartum Psychosis	NA	0.1 – 0.2%

Add a footer

What Are the Risk Factors?

Reproductive Health Related

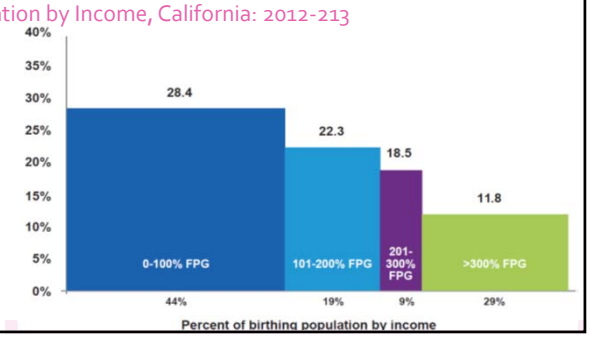
- Prior birth loss
- Unintended pregnancy (4x risk)
- History of Premenstrual syndrome (PMS)
- Single relationship status, poor quality relationship, incarcerated partner
- Multifetal birth
- Breastfeeding difficulties
- Infant with colic/significant fuss patterns
- Preterm infant and/or admission to 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)

Add a footer

Prevalence of Perinatal Depression and Distribution of Population by Income, California: 2012-213



A Report of the California Task Force on the Status of Maternal Mental Health Care: April 2017

- 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

CALIFORNIA TASK FORCE ON THE STATUS OF MATERNAL MENTAL HEALTH CARE

Add a footer

A Report of the California Task Force on the Status of Maternal Mental Health Care: April 2017

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

CALIFORNIA TASK FORCE ON THE STATUS OF MATERNAL MENTAL HEALTH CARE

Add a footer

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 road-map for coordinated change

CA MMH Task Force: Identified Provider Barriers

- Fewer than ½ of Ob Gyns 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 health care 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 of CA counties have at least one reproductive psychiatrist
- Bifurcation of behavioral health services from health insurance plans
  - The California MMH Taskforce has called for medical insurers to bring mental health 'in-house" and 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
  - Most women with MMH disorders don't qualify for care unless they have a chronic and persistently severe illness

How and Whom to Screen?

- Edinburgh Pregnancy/Postnatal Depression Scale (EDPS)
  - 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)
  - 9 questions 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

Prevention Strategies & Treatment Options[100]	Limited to no symptoms	Mild symptoms	Moderate symptoms	Severe symptoms
– Self-care, including sleep-hygiene and grooming, as desired	x	x	x	x
– Nutrition including adequate omega-3 fatty acids, vitamin D, folate	x	x	x	x
– Exercise	x	x	x	x
– Dyadic mother-baby support for dysregulated baby; crying, sleep, feeding problems	x	x	x	x
– Consider as augmentation: complementary/ alternative therapies (bright light therapy, acupuncture, massage, yoga, meditation)	x	x	x	x
– Reducing isolation by getting outdoors/outside of the home	x	x	x	
– Reducing isolation by socializing and community support (including receiving emotional support from partner, friends, family or others; attending support groups or new baby care/parenting classes, home visiting, community health workers)	x	x	x	x
– Practical support (from partner*, friends, family*, or postpartum doula with household duties and baby/child care)	x	x	x	x
– Support groups for depression/anxiety		x	x	x
– Therapy for mother		x	x	x
– Dyadic therapy for mother/baby		x	x	x
– Consider(x)/strongly consider(xxx) medication		x	xxx	xxx
– Consider inpatient hospitalization when safety or ability to care for self is a concern			x	x

What We Do: Preparation

- Educate ourselves
  - Continuing medical education
  - Online resources
    - 2020 Moms https://www.2020mom.org/
    - Blue Dot https://www.thebluedotproject.org/
    - Praeclarus Press http://praeclaruspress.com/white-papers/
    - Maternal Mental Health Now https://www.maternalmentalhealthnow.org/
    - California Maternal Mental Health Taskforce https://www.2020mom.org/ca-task-force/
- Educate our patients
  - Normalize
  - Handout in "Welcome to the Practice" Patient Packet
  - Every new patient intake includes questions about personal history of depression and anxiety
    - Used as an opportunity to educate about risk factors
    - Set expectation that WE will be the woman's home base if there are issues, throughout the perinatal period
- Universal screening with EDPS
  - Simple and quick
  - Initially, we 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 3 weeks of delivery)

What we Do: Discuss Self Care (NESTS)

- **N**utrition
- **E**xercise
- **S**leep and Rest
- **T**ime for Self
- **S**upport

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/
- Maternal Mental Health Now http://directory.meternalmentalhealthnow.org/
- 2020 Mom https://www.2020mom.org
- Support groups
  - Hospital based
  - Community based
- Lactation support
- Patient handouts/written materials

Add a footer

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

Add a footer