TASK FORCE TO STUDY MATERNAL MENTAL HEALTH

December 6, 2016

The Honorable Lawrence J. Hogan, Jr.
Governor
State House
100 State Circle
Annapolis, Maryland 21401

The Honorable Thomas V. "Mike" Miller, Jr.
President
Senate of Maryland
State House, H-107
Annapolis, Maryland 21401

The Honorable Michael E. Busch
Speaker
Maryland House of Delegates
State House, H-101
Annapolis, Maryland 21401

Re: Senate Bill 74 (2015) Task Force to Study Maternal Mental Health

Gentlemen:

Pursuant to Chapter 6 of the Acts of 2015, the Task Force to Study Maternal Mental Health respectfully submits this final report. The report includes fifteen recommendations covering a range of issues, including patient, provider and public education; the expansion of psychiatric consultation programs; screening for perinatal mental illness; expanded peer support and navigation services; the increased use of evidence-based treatments and more.

If you have any questions, please call Dan Martin, staff to the Task Force, at (443) 901-1550 x208.

Sincerely,

Albert Zachik, M.D.
Chair

Enclosures

cc: Sarah Albert, Department of Legislative Services (5 copies)

REPORT OF THE TASK FORCE TO STUDY MATERNAL MENTAL HEALTH

Senate Bill 74 / Chapter 6 (2015)

December 2016

EXECUTIVE SUMMARY

One in seven women will experience depression during pregnancy or in the first 12 months after delivery, and more than 400,000 infants every year are born to mothers who are depressed, making perinatal depression the most underdiagnosed and untreated obstetric complication in the United States. This and other perinatal mood and anxiety disorders (PMADs) have been identified in women of every culture, age, income level and race. They can have very serious adverse effects on the health and functioning of the mother, her infant and her family, and although PMADs are treatable once recognized, 50 percent of all mothers who experience these disorders are never identified.

It is in this context that the Maryland General Assembly enacted legislation in 2015 establishing the Task Force to Study Maternal Mental Health ('Task Force'). Passed unanimously and signed into law by Governor Larry Hogan, Senate Bill 74 / Chapter 6 directed the Task Force to:

- Identify vulnerable populations and risk factors for maternal mental health disorders;
- Identify and recommend prevention, screening, identification and treatment strategies;
- Identify successful postpartum mental health initiatives in other states and strategies for implementing similar initiatives in Maryland;
- Identify and recommend evidence-based practices for health care providers and public health systems;
- Identify and recommend private and public funding models; and
- Make recommendations on legislation, policy initiatives, funding requirements, and budgetary priorities to address maternal mental health needs in Maryland, as well as any other relevant issues identified by the Task Force.

The Task Force[1] met eight times between September 2015 and November 2016. Notice of the meetings was posted in the Maryland Register and on the Maryland General Assembly website. Public comment was taken and considered at every meeting. The work of the Task Force was divided into five workgroups: Maryland Data, Provider Tools, Public Needs, Policy in Other States, and Co-Morbid Conditions. Each met multiple times to gather information, review relevant literature, share resources and develop recommendations to address the unmet maternal mental health needs in Maryland. The following report and recommendations are the result of that work.[2]

[1] See Appendix I for a complete list of Task Force membership.

[2] Charged with studying maternal mental health, the Task Force recognizes that, in order to be inclusive of all postpartum experiences, these recommendations should include the postpartum experiences of transgender and gender non-conforming individuals that carry pregnancies, chest feed, and can experience the same postpartum mood disorders as their cis counterparts. While currently a small population, the Task Force acknowledges that limitations exist when recommendations are created using gender binary, rather than its spectrum.

SUMMARY OF RECOMMENDATIONS

- **Improve early identification of postpartum depression and other perinatal mood and anxiety disorders** through increased screening and patient education. *(Recommendations 1-2)*

- **Develop continuing maternal mental health education for providers** who interact with women of a reproductive age. *(Recommendation 3)*

- **Expand psychiatric consultation programs** to assist obstetric, primary care, psychiatric and pediatric providers in addressing the emotional and mental health needs of pregnant and postpartum patients. *(Recommendation 4)*

- **Develop a Maryland Maternal Mental Health Initiative** to coordinate ongoing advocacy, education, awareness, and treatment efforts. *(Recommendations 5-8)*

- **Develop and expand peer support networks and navigation** to create opportunities for individuals with lived experience and to assist women and their families in maneuvering a complex system of care. *(Recommendations 9-10)*

- **Expand the array of maternal mental health services** by establishing specialized day and inpatient programs, including mother-baby units. *(Recommendation 11)*

- **Take steps necessary to address co-morbid maternal mental health conditions** including those related to substance use disorders, high risk pregnancies, perinatal loss and intimate partner violence. *(Recommendation 12-13)*

- **Expand access to paid family and medical leave** to provide flexibility in the balancing of work and family demands. *(Recommendation 14)*

- **Create a standing Maternal Mental Health Commission** to help guide state policy and decision-making. *(Recommendation 15)*

SCOPE OF NEED

Perinatal mood and anxiety disorders (PMADs) have been identified in women of every culture, age, income level, race and ethnicity. The term 'perinatal' generally refers to the time period of pregnancy through the first year postpartum.

Research has shown that **pregnancy is not protective against the development of psychiatric illness**. This is especially true for women with a history of psychiatric illness, including mood and anxiety disorders. As many as 50 percent of women with a previous diagnosis of a mood disorder report significant mood symptoms during the perinatal period. Further, the risk for psychiatric relapse during pregnancy increases in the setting of psychiatric medication discontinuation. Approximately 68 percent of women with major depression who discontinued their medications for pregnancy relapsed in one study, while in another, more than 80 percent of women with bipolar disorder who stopped their medications relapsed. During pregnancy and the postpartum, anxiety and related disorders are extremely common – and also under-recognized. Current research indicates that anxiety disorders are common in the perinatal period, and may even have their onset at this time. Phobias and generalized anxiety disorders are the most common, and up to 27 percent of perinatal women report some form of anxiety. In addition, pregnancy-specific anxiety is experienced by about 14 percent of women, and consists of specific worries about the baby or the pregnancy. Additionally, untreated mood disorders are associated with higher incidence of substance use disorders, an association often recognized as self-medication for untreated psychiatric illness.

Postpartum Mood Disorders. During the postpartum period, about 80 percent of women experience some type of mood disturbance. For most, the symptoms are mild and short-lived. However, 10 to 15 percent of women in the general population develop more significant symptoms of depression or anxiety. Perinatal psychiatric illness is typically divided into three categories along a continuum: (1) postpartum blues, (2) postpartum depression and anxiety, and (3) postpartum psychosis.

Postpartum blues, or "baby blues," is a common phenomenon, occurring in up to 80 percent of women, generally within a few days of labor and delivery. It is usually a self-limited process, resolving over the course of several days. Symptoms include tearfulness, mood lability, and feeling overwhelmed, but can also include more positive feelings of happiness or elation. Postpartum blues are thought to be related to the hormonal changes that women experience after giving birth and are generally self-limited with no intervention needed beyond emotional and social support.

Postpartum depression and anxiety in contrast, is less common, occurring in 10 to 15 percent of the general population. It lasts for at least two weeks and usually for much longer, particularly

without treatment. It is considered one of the most common medical complications during pregnancy and the postpartum period. Symptoms include intense and persistent sadness, feelings of hopelessness, worthlessness, inadequacy or guilt, and a range of somatic symptoms such as headaches and chest pains. Significant anxiety symptoms may also occur with some women developing recurrent feelings of intense worry or panic. The risk for postpartum depression is increased in women with a history of major depression, bipolar disorder, or a prior history of postpartum depression. While the etiology of postpartum depression is not known, it is likely to be multifactorial with psychological factors, biological factors including hormonal changes, and social factors all playing a role.

Postpartum psychosis is a rare phenomenon, occurring in approximately 0.1 percent of all births. It is more common in women with bipolar disorder, occurring in up to 30 percent of those who have children. Postpartum psychosis is considered a psychiatric emergency and resembles a manic episode with decreased sleep, psychosis, and agitation. Up to four percent of cases of postpartum psychosis commit infanticide, and five percent suicide. Any woman with suspected postpartum psychosis should seek emergency treatment and will almost always require hospitalization.

Effects of Perinatal Psychiatric Illness on Children. An area that is frequently overlooked is the risk to the fetus and newborn associated with untreated maternal psychiatric illness. There is a wealth of literature demonstrating that untreated maternal psychiatric illness during pregnancy is associated with poor outcomes for the exposed child. Depression during pregnancy has been associated with low maternal weight gain; increased rates of preterm birth; low birth weight; increased rates of cigarette, alcohol, and other substance use; increased ambivalence about the pregnancy; and overall worse health status, including higher rates of preeclampsia and gestational diabetes. Additionally, prenatal exposure to maternal stress has been shown to have consequences for the development of infant temperament. Children exposed to perinatal maternal depression have higher cortisol levels than infants of mothers who were not depressed, which continues through adolescence. Treatment of depression during pregnancy appears to help normalize infant cortisol levels. These findings may partially explain the mechanism for an increased vulnerability to psychopathology in children exposed to depression in utero.

It is also clear that untreated prenatal anxiety can have adverse effects on the fetus. Anxious women experience increased nausea and vomiting, higher alcohol and tobacco use, more frequent doctor visits, and poor maternal attachment. Like depression, prenatal anxiety has also been associated with low birth weight, preterm birth, difficult infant temperament, poor attention regulation, emotional and behavioral problems, alterations in adaptive immunity, poor cognitive and motor development, and an increased risk of subsequent anxiety and depression.

Untreated anxiety and depression during pregnancy is also one of the strongest risk factors for the development of postpartum depression. The literature regarding the effects of postpartum

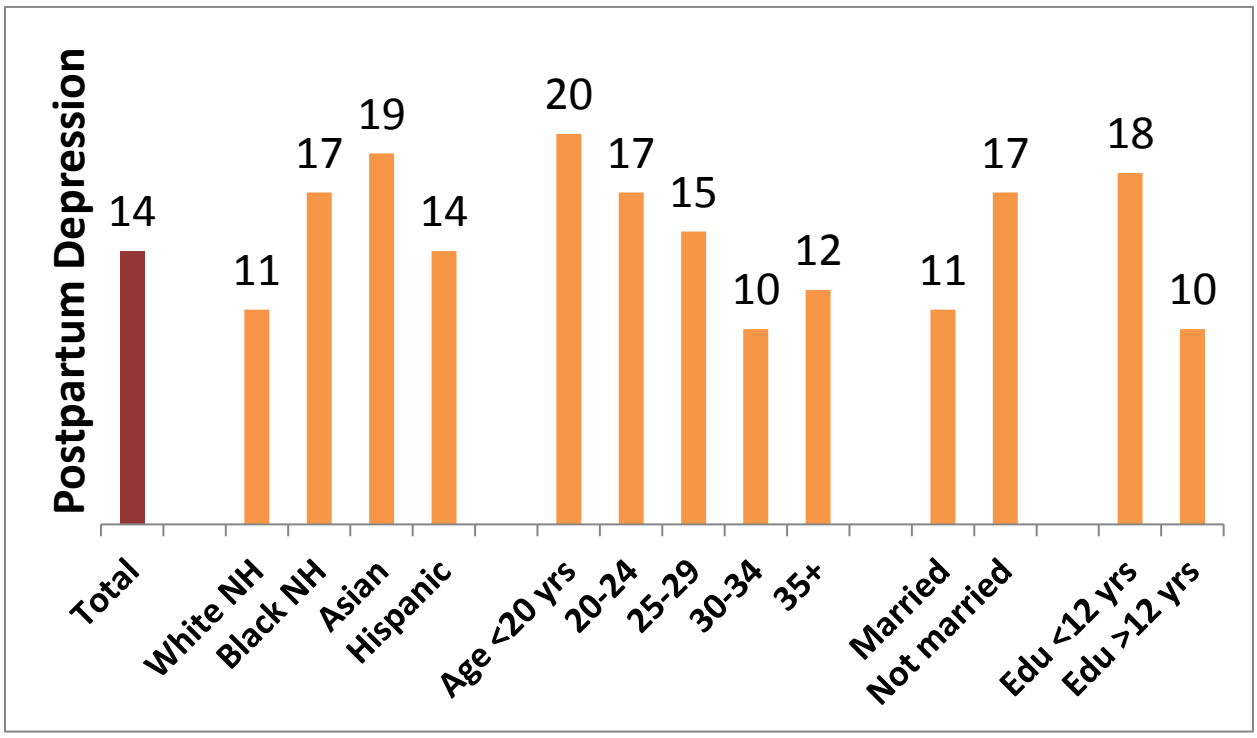
depression on the infant is quite clear, with adverse outcomes such as lower IQ, slower language development, increased risk of attention deficit disorder, and increased risk of behavioral issues and psychiatric illness in the exposed offspring. Postpartum depression also has potentially devastating consequences including suicide and infanticide. While the risk for completed suicides and suicide attempts is lower during and after pregnancy than in the general population of women, **suicides account for up to 20 percent of all postpartum deaths** and represent one of the leading causes of perinatal mortality.

In summary, psychiatric illness during pregnancy increases the risk for poor outcomes for the child as well as for postpartum psychiatric illness. Psychiatric illness during and after pregnancy should therefore be considered an exposure for the child in the same way that medication use during pregnancy is an exposure for the child. Many physicians remain unaware of the significant risks associated with untreated maternal psychiatric illness and may inappropriately recommend discontinuation of psychiatric medications during and after pregnancy or fail to screen and refer women with perinatal psychiatric illness. **Early identification, treatment resources and education for both the public and providers of prenatal and postpartum services about PMADs and their impacts is sorely needed.**

MARYLAND DATA

There are approximately **72,000 live births in Maryland every year**, and prevalence of PMADs is representative of the national averages. The Maryland Pregnancy Risk Assessment Monitoring System (PRAMS)[3] reports that, for mothers who delivered in 2004 through 2008 and 2012 through 2013, nearly **14 percent reported symptoms of postpartum depression**. As shown in Fig. 1 below, rates of postpartum depression were highest among Asian, black non-Hispanic (NH), young (less than 25 years of age), non-college educated and single mothers.

Fig. 1 – Postpartum Depression, Maryland PRAMS, 2004-2008 and 2012-2013



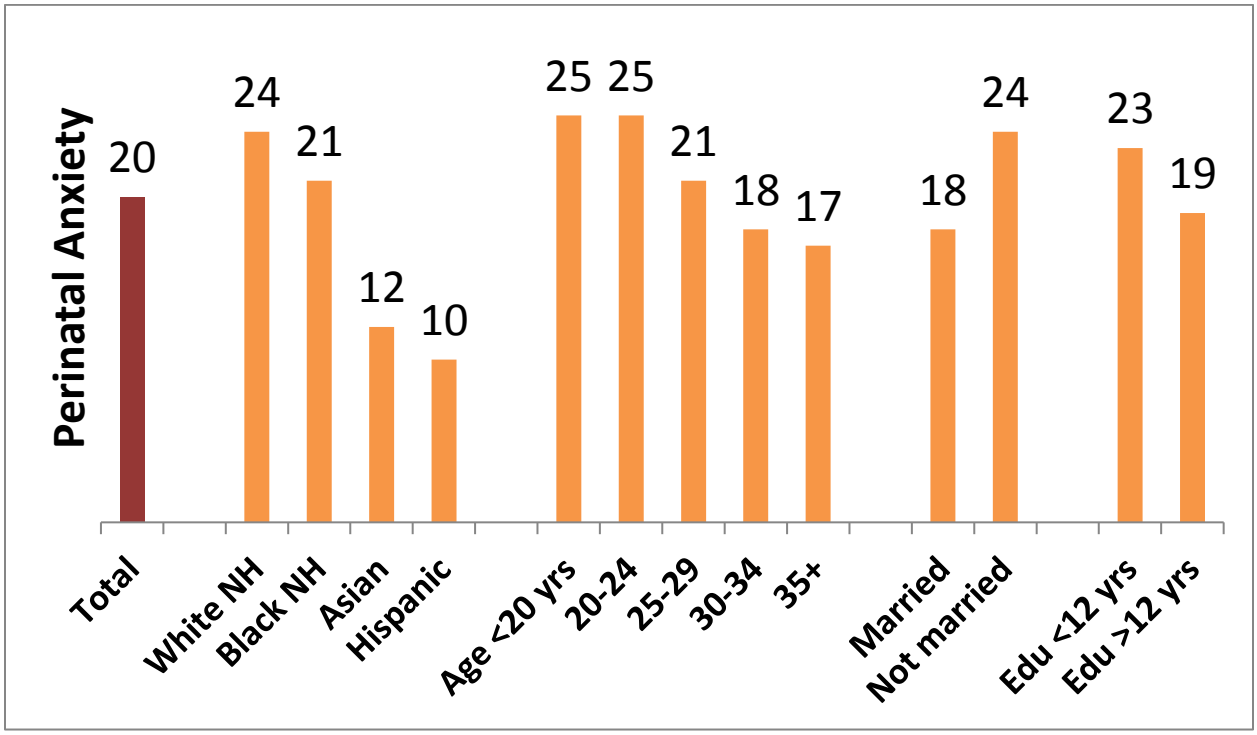
Note: Data from 2009 through 2011 births were not used due to different PRAMS postpartum depression questions which were not as valid.

Around **20 percent** of mothers who delivered in 2009 through 2013 reported symptoms of **perinatal anxiety**. Rates among various demographics were similar to those reported for

[3] Maryland PRAMS is a surveillance project supported by the Centers for Disease Control and Prevention (CDC). The Maternal and Child Health Bureau (MCHB), Vital Statistics Administration, and Maryland Department of Health and Mental Hygiene (DHMH) have a cooperative agreement with the CDC to participate in PRAMS. The project surveys new mothers randomly about their behaviors and experiences before, during and shortly after pregnancy. PRAMS findings may be used to guide recommendations for developing or modifying intervention programs or for securing resources for program changes.

postpartum depression, aside from a notable increase in prevalence among white non-Hispanic mothers (see Fig. 2).

Fig. 2 – Perinatal Anxiety, Maryland PRAMS, 2009-2013



Perceptions Among Providers and the Public

Notwithstanding the prevalence outlined above, a **significant stigma** persists around issues related to maternal mental health. There is a lack of understanding among providers and the public about effective treatment options and medications and – to the extent resources for the public do exist – there is little knowledge about their availability.

A series of focus groups commissioned by the Healthy New Moms campaign[4] revealed **frustrations among pregnant and new mothers** about the lack of PMAD-specific information and input received from their providers. Specifically, the focus group evaluation concluded that "pregnant and postpartum women expect to receive information and access to treatment from their medical

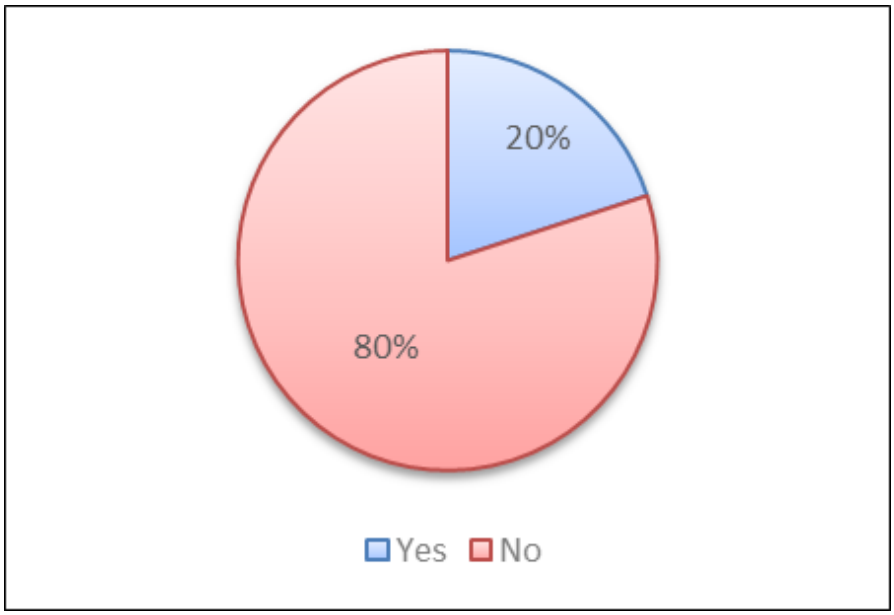
[4] The Healthy New Moms campaign, a program of the Mental Health Association of Maryland, works to raise awareness of PMADs and offer support and resources to providers and the public. Two consumer focus groups and one provider focus group were conducted over a two month period from February through April 2015. The consumer focus groups sought to determine public familiarity of maternal mental health issues and resources. The provider focus group was structured to elicit details on what information is routinely provided to pregnant and postpartum women, additional resource needs, and training and continuing education needs. The focus group report is included as Appendix II.

providers, but currently find little support." The report went on to cite a need for easily accessible and culturally competent information related to PMADs, suggested an expansion of maternal mental health peer groups to include connections to professional resources, and identified better communication between patient and provider as necessary to the healing process.

The focus groups exposed a **similar frustration among providers**. The participants reported that "there is little information available for providers, and even less training specific to PMADs." Further, the report found that "many are uncomfortable addressing mood disorders and are not familiar with resources that do exist, preventing them from feeling confident in addressing patients' needs."

These findings are reinforced by a recent provider survey conducted by the Johns Hopkins Women's Mood Disorders Center,[5] distributed online and targeted to OB/GYN providers at Hopkins and throughout Maryland. Of the clinicians surveyed, **80 percent reported they were not satisfied with the number and quality of psychiatric referral resources for their pregnant and postpartum patients** (Fig. 3).

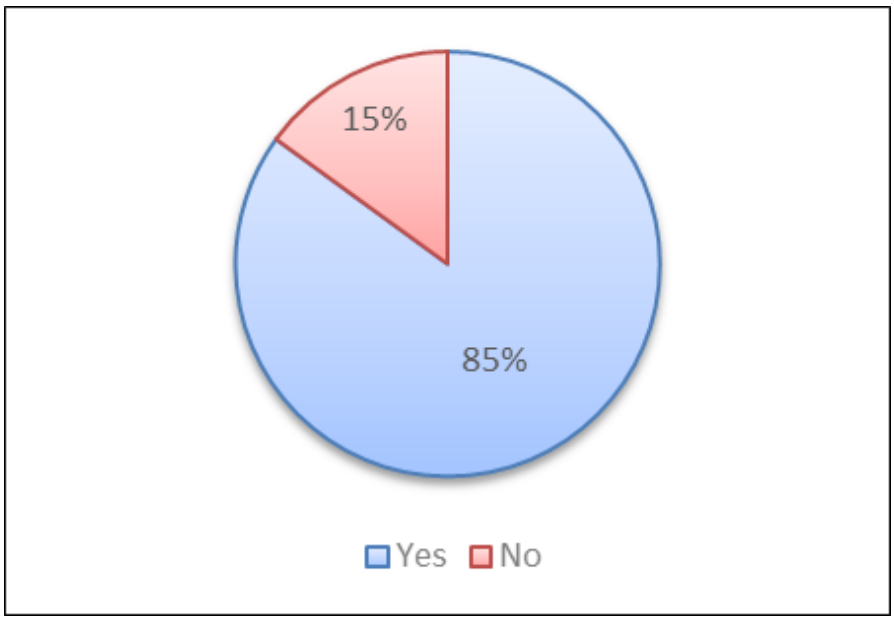
Fig. 3 – Are you satisfied with the number and quality of psychiatric referral resources for your patients?



Furthermore, **85 percent of the respondents indicated a strong desire for additional training and/or consultation in treating the mental health needs of these patients** (Fig. 4).

[5] The Women's Mood Disorders Center was established to study PMADs and provide expert evaluation of women experiencing PMAD symptoms. Complete survey results are included as Appendix III.

Fig. 4 – Would you be interested in receiving trainings and/or consultations about how to treat mental health in pregnancy and the postpartum?



The survey also revealed that **one in four OB/GYN providers lack confidence in their knowledge of psychiatric illnesses, medications and treatment** (Fig. 5), and **one in four providers have a low comfort level in treating depression and/or anxiety in pregnant patients** (Fig. 6).

Fig. 5 – To what degree do you feel confident about your knowledge of psychiatric illnesses, medications and treatment?

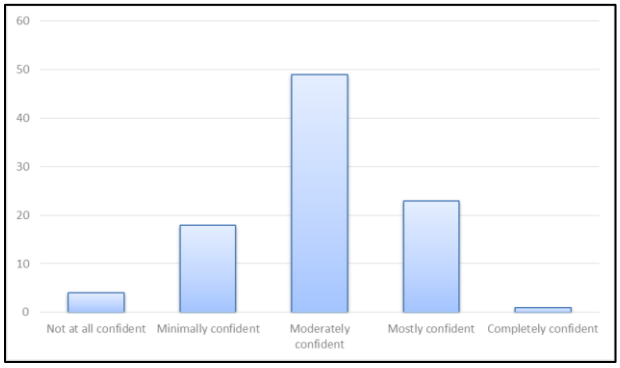
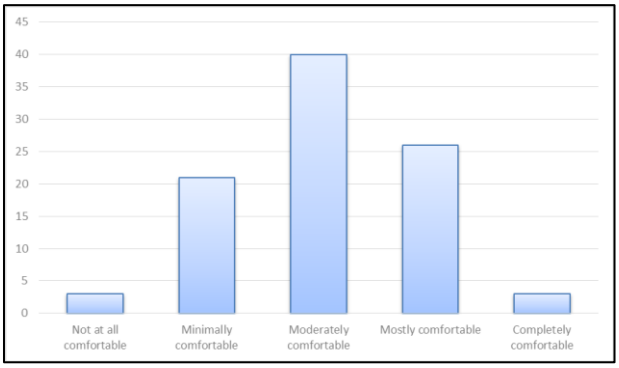


Fig. 6 – To what degree do you feel comfortable treating depression and/or anxiety in pregnant patients?



RECOMMENDATIONS

Improve Early Identification of Postpartum Depression and Other Perinatal Mood and Anxiety Disorders

Perinatal mood and anxiety disorders (PMADs) affect one in seven women, and although the conditions are treatable once recognized, 50 percent of all mothers who experience these disorders are never identified. The symptoms often go undetected because they closely resemble those generally associated with pregnancy and the postpartum period, and stigma may make women reluctant to report changes in their mood. As a result, postpartum depression and other PMADs are often left untreated, to the detriment of the mother and her entire family.

Recommendation 1: Require maternal mental health screening for all patients prenatally through the first year postpartum.

Screening and identification of PMADs greatly improves the likelihood of a quick recovery for the mother, supports healthy child development, and offers long-term health care cost savings. The United States Preventive Services Task Force (USPSTF)[6] recognized as much in January 2016, when it updated its recommendation for adult depression screening to specifically recommend screening for depression in pregnant and postpartum women. The panel gave its recommendation a "B" rating, meaning the service must be covered under the Affordable Care Act with no copayment, coinsurance or deductible. Additionally, recent guidance from the Centers for Medicare & Medicaid Services (CMS) discusses the importance of early screening for maternal depression and clarifies the role Medicaid can play in identifying and treating PMADs.[7]

Several states require some level of maternal mental health screening. West Virginia, for example, requires that licensed health care professionals providing prenatal, postnatal or pediatric care invite the mother to complete a questionnaire (i.e. an assessment tool[8]) to detect perinatal mental health disorders. Women typically visit their obstetrician and gynecologist during pregnancy and visit a pediatrician for infant check-ups more often than other health professionals, so these providers are in an ideal position to screen for PMADs.

[6] The U.S. Preventive Services Task Force is an independent, volunteer panel of experts in prevention and evidence-based medicine. The group works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services, and preventive medications.
[7] The May 11, 2016 CMS guidance is included as appendix IV.
[8] A commonly-used assessment tool is the Edinburgh Postnatal Depression Scale (EPDS), a 10-item questionnaire developed to identify women with postpartum depression. A sample EPDS is included as Appendix V.

However, as important as it is to ensure providers are detecting depression and other PMADs, it is equally critical that mothers and their families have the information necessary to recognize signs and symptoms when they occur. The more knowledge women have with regard to the prevalence of these illnesses, the more comfortable they will be discussing it with their providers, reducing stigma and improving early identification.

Recommendation 2: Require health care providers to offer maternal mental health information and resources for care to mothers and families at various times during the perinatal period.

Many states require this type of information distribution. Minnesota requires that information on postpartum depression be given to prenatal patients. West Virginia and Virginia require all hospitals to provide new mothers with PMAD materials prior to discharge. New York requires maternal mental health education as a routine aspect of postpartum care.

Develop Continuing Maternal Mental Health Education for Providers

Although screening is important for detecting perinatal depression and other PMADs, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated. The prevalence of the illness, combined with the potentially long-lasting and serious adverse effects on the health and functioning of the mother, her infant and her family, calls for the development of continuing medical education options to ensure a basic minimum level of understanding among certain healthcare providers about how to identify and treat PMADs.

Recommendation 3: Require development of free maternal mental health CME/CEU trainings, including online options.

At a minimum, available trainings should include information on signs and symptoms, perinatal medication usage, risk factors such as perinatal loss and high-risk pregnancies, how and when to screen for symptoms, brief intervention strategies, and evidence-based psychosocial treatments.

It is noteworthy that a portion of the Task Force supported a stronger recommendation in this area. While not a unanimous opinion, these members recommended a CME/CEU *requirement* for certain providers, such as pediatricians, internal/family medicine providers, obstetricians and psychiatrists. New York mandates the *availability* of provider education on PMADs, but no state mandates that providers complete CME credits related to maternal mental health. However, states do require CME for other practice areas. Florida requirements include the completion of CME courses in medical errors, HIV/AIDS and domestic violence. Most California-licensed physicians are required to complete CME on pain management and the appropriate treatment of the terminally ill. California also requires CME in the field of geriatric medicine for certain general internists and family physicians. The State of Maryland already requires a one hour CME in

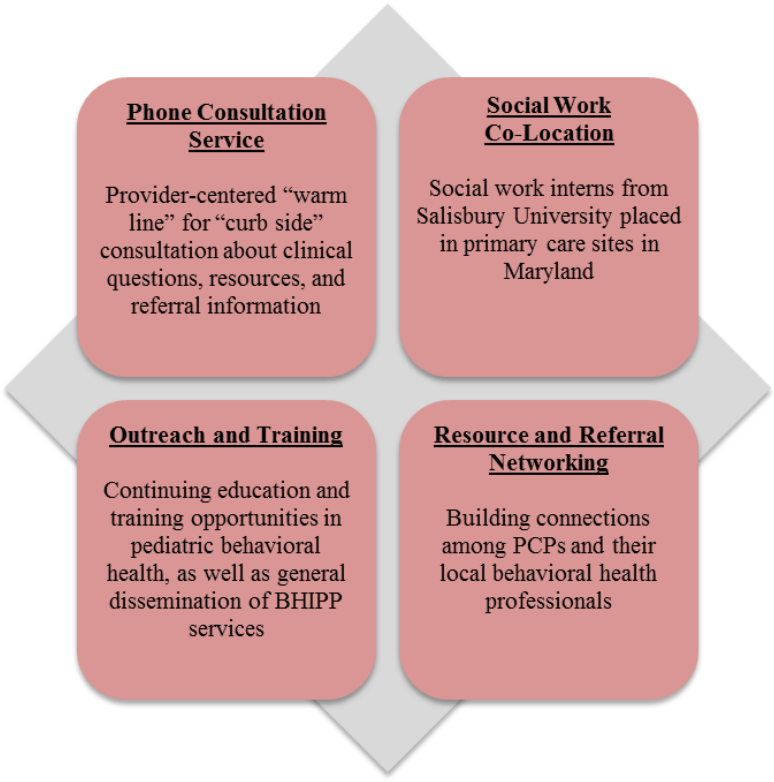
management of pain and opioid medications for physician license renewal, thus a requirement in this area would not be without precedent.

Expand Psychiatric Consultation Programs

The Maryland Behavioral Health Integration in Pediatric Primary Care program (BHIPP) is designed to support primary care providers in assessing and managing the behavioral health needs of their patients from infancy through young adulthood. Free of charge and regardless of a patient's insurance status, BHIPP offers an impressive array of services to primary care clinicians treating children (Fig. 7). The program is made possible through funding from the Maryland Department of Health and Mental Hygiene (DHMH) and the State Department of Education (MSDE), and is offered in collaboration with University of Maryland School of Medicine, Johns Hopkins Bloomberg School of Public Health, Salisbury University, and community and advocacy groups.

Recommendation 4: Expand BHIPP to assist obstetric, primary care, pediatric and other providers address the emotional and mental health needs of pregnant and postpartum patients.

Fig. 7 – Array of BHIPP Services



As noted in Fig. 4, Maryland providers treating pregnant and postpartum women indicate a strong desire for the same type of behavioral health consultation and support services now offered

through BHIPP to providers treating children. The Massachusetts Child Psychiatry Access Project (MCPAP) – the program on which BHIPP is modeled – has recently expanded its program in a similar way. *MCPAP for Moms* is a state-funded program open to all providers in contact with mothers prenatally through the first year postpartum. It includes real-time consultation with expert perinatal psychiatrists, includes screening and treatment toolkits for providers, helpful links for patients and the public, and assists both medical providers and families in connecting with community-based resources including therapy and support groups.

Develop a Maryland Maternal Mental Health Initiative

There is little understanding among providers and the public about maternal mental health issues, their impact and prevalence, effective PMAD treatment options and the availability of helpful resources. A dearth of information, confusion about where to turn for help and the lack of a coordinated statewide effort to increase awareness is feeding stigma and frustration.

Recommendation 5: Establish an Office of Maternal Mental Health and Substance Use Disorders to coordinate and implement ongoing advocacy, education, awareness, and treatment efforts.

Maryland must do more to address the service gaps and unmet need identified by providers and the public alike. An Office of Maternal Mental Health and Substance Use Disorders ('Office') in the Department of Health and Mental Hygiene would ensure a relevance and sustainability of efforts as the state moves proactively to tackle this issue. In addition to the overarching responsibilities outlined below, the Task Force envisions duties of the Office to include the approval and provision of training for peer support, frontline providers and perinatal navigators; the promotion of perinatal mental health policies at the state level; grant writing for maternal mental health initiatives; and acting as liaison to a newly expanded psychiatric consultation program.

Recommendation 6: Expand state maternal mental health public awareness campaign efforts.

As noted previously, focus groups identified education for the public as a critical unmet need. Many other states fund one or more public education efforts, including public awareness months and public service announcements (PSAs). The Task Force recommends the development of culturally competent PSAs to run on traditional media and online / social platforms, with particular attention to populations most at-risk. Pamphlets, posters, flyers and other resources should be made available in hospitals and provider waiting rooms. Sample materials are available in English and Spanish through the National Child & Maternal Health Education Program[9] website.

[9] The National Child & Maternal Health Education Program is the first national education program of the Eunice Kennedy Shriver National Institute of Child Health and Human Development. It provides a forum for reviewing, translating, and disseminating new research in the field of maternal and child health.

Certain groups across the state, including Heathy New Moms and Postpartum Support Maryland,[10] are already well organized and doing some of the outreach and education outlined here. Rather than reinvent successful ongoing efforts, it is recommended that the state coordinate and expand these efforts by expanding public-nonprofit partnerships with these and other organizations.

Recommendation 7: Develop, maintain and promote centralized, multicultural educational materials and resources for patients and families.

Consistent with the recommendation to increase public awareness is the need to ensure the availability of resources for those who may find themselves in need of maternal mental health services. A number of states have developed websites and hotlines to address this need, and Maryland should follow suit, leveraging existing programs such as the state's Crisis Hotline and websites like Healthy New Moms and Postpartum Support Maryland. Additional materials should include updated and regional lists of mental health providers and PMAD support groups, as well as helpful links and educational resources.

Recommendation 8: Create a centralized, multicultural online provider toolkit to assist in the identification and treatment of perinatal mood and anxiety disorders.

Equally as critical as the need to educate and empower the public is the need to assist frontline perinatal care providers in the prevention, identification and treatment of depression and other mental health concerns in pregnant and postpartum women. Maryland providers are frustrated at the lack of available information and are not familiar with existing resources. They are therefore uncomfortable addressing their patients' mood and anxiety disorders. Healthy New Moms has created an online resource for providers that includes prevalence and treatment information, assessment and screening tools, and a medication chart. Additional resources are needed.[11]

Develop and Expand Peer Support Networks and Navigation

Peer support programs provide an opportunity for communities of individuals who have lived with and significantly recovered from mental health disorders to use their experience to help others direct their own recoveries. Combined with skills often learned in formal training, peer supporters' experience and institutional knowledge put them in a unique position to offer support. Considered a best practice by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), peer support has been shown to reduce symptoms, hospitalizations, and costs of

[10] Postpartum Support Maryland works to provide resources to families suffering from postpartum depression and to raise awareness within the community.

[11] The MCPAP for Moms toolkit is illustrative, and is included as Appendix VI. See also, *Substance Use in Pregnancy: A Clinician's Toolkit for Screening, Counseling, Referral and Care*, available online at www.baltimorecountymd.gov/go/perinatal

services; increase social support and participation in the community; improve well-being, self-esteem and social functioning; and encourage more thorough and longer-lasting recoveries.

Recommendation 9: Expand maternal mental health and substance use disorder peer support training and infrastructure.

Although several maternal mental health and substance use disorder peer support programs are active in Maryland, the groups are operating with little or no resources. The services these programs provide – including support for new and expectant mothers and the provision of resources and information for families – are critical components of the Maryland system of care that should be expanded upon. The Task Force has identified the Massachusetts program *MotherWoman*[12] as a model and recommends that Maryland support and partner with existing efforts in the state to develop a similar peer support capacity here.

Similar in some aspects to the role of peer support specialists, perinatal navigators promote better health outcomes by helping obstetrical patients maneuver a complex system.

Recommendation 10: Further explore the use of maternal mental health navigators, including issues related to insurance reimbursement and incentives for providing the service.

Sometimes referred to as "women's wellness guides," perinatal navigators work to eliminate barriers to care by educating patients and assisting them in accessing essential health care monitoring and resources. These professionals play a critical role in cultivating relationships between the patient and their families, local and regional health care providers and other key players to ensure smooth transitions and timely access to care. The Task Force recommends further exploration into the use of maternal mental health navigators in Maryland, including consideration of methods to ensure that insurance carriers provide their consumers with coverage for perinatal navigation, and an examination into potential incentives for hospitals, clinics and other health care providers that offer this needed service to their patients.

Expand the Array of Maternal Mental Health Services

Specialized inpatient and day programs are quite common for a variety of illnesses and disorders. In Maryland and elsewhere, there are places people can go to address needs specifically associated with cancer, diabetes, post-traumatic stress disorder and many more. But there is nowhere in Maryland for pregnant women and new mothers to receive specialized treatment for postpartum depression and other PMADs.

[12] More information on MotherWoman is available at http://www.motherwoman.org/

Recommendation 11: Incentivize the use of evidence-based practices and the establishment of specialized maternal mental health outpatient and inpatient programs and mother-baby units.

At least six states have established perinatal partial hospitalization programs to treat the needs of pregnant women and new mothers with depression, anxiety or other emotional distress with their babies in a warm, nurturing setting. The nation's first such program, the Day Hospital,[13] opened in Rhode Island in 2000. In the Day Hospital, every woman's program is tailored to her unique needs and can include group, individual and family therapy; medication assessment; nutrition and lactation consultation; mother-baby bonding and connecting support; and personalized outpatient discharge planning. Like the programs in other states, the Day Hospital accepts health insurance and encourages inclusion of the infant in the treatment.

Available in only three states, specialized inpatient programs are less widespread but provide more intensive treatment. The newest of these programs opened earlier this year in New York when Zucker Hillside Hospital cut the ribbon on a 20-bed, single-gender inpatient unit dedicated to easing the burden of maternal depression. Like their day program counterparts, all of these inpatient programs encourage the presence of the infant and accept insurance.

It is worth noting that, although day and inpatient programs across the country allow for the infant to participate in treatment during the day, none allow for the child to stay overnight (i.e. joint admission). The United States has lagged behind Europe and Australia in this respect, where joint admission is now routine. These "mother-baby" units have many advantages, including the avoidance of breastfeeding disruption or cessation, direct observation of mother-infant interaction, and the promotion and modeling of a healthy maternal-child relationship. The Task Force also recommends the integration of evidence-based intervention and prevention strategies – including psychosocial group treatments for perinatal depression and anxiety – into settings that serve women and families, such as obstetrics and pediatrics.

Take Steps Necessary to Address Co-Morbid Maternal Mental Health Conditions

As complicated and debilitating as postpartum depression and other PMADs can be, the issues associated with these disorders may be compounded by the existence of co-morbid conditions, including those related to substance use disorders, perinatal loss, high-risk pregnancies and intimate partner violence. When implementing the recommendations outlined in this report, it is essential to remain cognizant of the unique needs of these women.

[13] More information on the Day Hospital is available at http://www.womenandinfants.org/services/behavioral-health/day-hospital.cfm

Recommendation 12: Ensure coordination and integration of treatment for both mental health and substance use disorders.

Substance-Use Disorders (SUDs) – Figures related to SUDs during pregnancy are startling. Eight to 10 percent of pregnant women continue to drink throughout their pregnancy. Four percent of pregnant women across the nation report a current use of illicit drugs. In Maryland, over five percent of female admissions to SUD treatment are pregnant. More than nine percent of Maryland women report tobacco use during pregnancy, and in the presence of an SUD that number can exceed 90 percent.

SUD-specific strategies include:

- Use evidence-based tools to screen for SUDs throughout the pregnancy
- Encourage brief intervention by prenatal providers as appropriate, guided by screening results
- Facilitate timely referral to SUD treatment for pregnant and postpartum women as needed
- Ensure that various treatment providers secure releases necessary to communicate with each other early in the pregnancy
- Encourage SUD treatment providers to incorporate both prenatal care and mental health care into their overall treatment plans
- Improve postpartum follow-up
- Implement the final recommendations of the Maryland Heroin & Opioid Emergency Task Force,[14] particularly those related to expanding access, enhancing quality, boosting overdose prevention efforts, and improving state support services

Recommendation 13: Adopt strategies to address the unique needs of pregnant women and new mothers with other co-morbidities.

Perinatal Loss – 15 to 20 percent of all recognized pregnancies end in miscarriage. Approximately 25 percent of bereaved parents demonstrate significant psychological difficulties during the first two years after perinatal losses. Strategies to address this issue include:

- Ensure expertise on management of perinatal loss at all delivering hospitals
- Provide outreach to parents remote from the loss
- Establish preconception counseling services for subsequent pregnancies

[14] The final report of the Maryland Heroin & Opioid Emergency Task Force is available at https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2015/12/Heroin-Opioid-Emergency-Task-Force-Final-Report.pdf

High-Risk Pregnancies and Deliveries – As many as six percent of women will experience a post-traumatic stress disorder (PTSD) following a complicated pregnancy or delivery. The risk for PTSD is much higher in pregnancies requiring an emergency cesarean section or an operative vaginal delivery, or for those where there is a general feeling of loss of control during delivery. Mothers whose babies require medical attention in neonatal intensive care units are also at significantly increased risk for depression, anxiety, and trauma-related symptoms.

The Task Force suggests that specific components related to high-risk pregnancies and the experience of having an infant with medical issues be incorporated into the training and provider toolkit recommendations above.

Intimate Partner Violence - Intimate partner violence is not uncommon during pregnancy and postpartum. Women who are at high risk for IPV are especially at risk for depression as well. Maryland PRAMS data indicates that four out of 10 women who reported physical abuse during pregnancy also reported symptoms of depression. In several studies, 30 to 60 percent of pregnant women with substance use disorder have a history of IPV and / or sexual abuse as a child. IPV has also led to multiple incidents of maternal homicide and suicide, as well as infanticide. In Maryland and across the country, homicide is a significant cause of maternal mortality and most of these deaths are perpetrated by a current or past intimate partner. Screening and counseling for current and past IPV needs to be integrated with maternal mental health and addiction treatment services to potentiate improvement in perinatal health.

Expand Access to Paid Family and Medical Leave

As important as these recommendations are, many will be limited in their effectiveness unless working mothers and their families have the time and flexibility to avail themselves of the services. The federal Family and Medical Leave Act (FMLA) allows eligible employees of covered employers to take unpaid, job-protected leave for specific family and medical reasons, but many in the workforce are not covered by FMLA, cannot afford to take unpaid leave, or need longer periods than are allotted to address their maternal mental health needs.

Recommendation 14: Support mothers and families by expanding access to paid family and medical leave in Maryland.

Paid family and medical leave programs have been associated with a range of positive effects on the health of the mother and her family. These benefits include lower infant and child mortality, better prenatal and postnatal care, an improvement in the child's cognitive and behavioral development, and an overall improvement in the mother's mental health over an extended period of time, including fewer and less severe depressive symptoms. Unfortunately, although 75 percent of women entering the workforce will become pregnant at least once, less than 20 percent of expecting mothers qualify for FMLA. Even fewer have access to *paid* family and medical leave.

Create a Standing Maternal Mental Health Commission

This Task Force has worked over the past year to shine a light on an issue that is too often suffered by many in silence. It has brought together dozens of individuals with varying expertise and lived experience in the development of a blueprint for tackling a critical unmet need. The recommendations outlined in this report are a starting point, but the work must continue.

Recommendation 15: Create a standing Maternal Mental Health Commission to guide state policy and decision-making.

As awareness and understanding of PMADs increases, and as the science evolves, it is important to ensure that state policy and decision-making are driven by best practices and current research. A Special Legislative Commission on Postpartum Depression has been meeting quarterly in Massachusetts since 2012 to provide continuing guidance and advice to the governor and legislature on "best and promising practices in the prevention, detection and treatment of postpartum depression." The group conducts public hearings and forums, sponsors state and regional conferences, and makes policy and legislative recommendations. Maryland would benefit from the establishment of a similar multidisciplinary commission to guide and oversee state maternal mental health efforts.

REFERENCES

Ashman SB, Dawson G, Panagiotides H, Yamada E, Wilkinson CW. Stress hormone levels of children of depressed mothers. *Development and psychopathology.* 2002;14(2):333-349.

Brennan PA, Pargas R, Walker EF, Green P, Newport DJ, Stowe Z. Maternal depression and infant cortisol: influences of timing, comorbidity and treatment. *Journal of child psychology and psychiatry, and allied disciplines.* 2008;49(10):1099-1107.

Brockington I. Postpartum psychiatric disorders. *Lancet.* 2004;363(9405):303-310.

Campbell SB, Cohn JF. Prevalence and correlates of postpartum depression in first-time mothers. *J Abnorm Psychol.* 1991;100(4):594-599.

Cohen LS, Altshuler LL, Harlow BL, et al. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA.* 2006;295(5):499-507.

Cox JL, Murray D, Chapman G. A controlled study of the onset, duration and prevalence of postnatal depression. *The British journal of psychiatry : the journal of mental science.* 1993;163:27-31.

Davis EP, Glynn LM, Dunkel Schetter C, Hobel C, Chicz-Demet A, Sandman CA. Corticotropin-releasing hormone during pregnancy is associated with infant temperament. *Developmental neuroscience.* 2005;27(5):299-305.

Diego MA, Field T, Hernandez-Reif M, Cullen C, Schanberg S, Kuhn C. Prepartum, postpartum, and chronic depression effects on newborns. *Psychiatry.* 2004;67(1):63-80.

Dunkel Schetter C, Tanner L. Anxiety, depression and stress in pregnancy: implications for mothers, children, research, and practice. *Current opinion in psychiatry.* 2012;25(2):141-148.

Essex MJ, Klein MH, Cho E, Kalin NH. Maternal stress beginning in infancy may sensitize children to later stress exposure: effects on cortisol and behavior. *Biological psychiatry.* 2002;52(8):776-784.

Field T, Diego M, Hernandez-Reif M. Prenatal depression effects on the fetus and newborn: a review. *Infant Behav Dev.* 2006;29(3):445-455.

Field T, Diego M, Hernandez-Reif M. Prenatal depression effects and interventions: a review. *Infant Behav Dev.* 2010;33(4):409-418.

Forray A, Focseneanu M, Pittman B, McDougle CJ, Epperson CN. Onset and exacerbation of obsessive-compulsive disorder in pregnancy and the postpartum period. *The Journal of clinical psychiatry.* 2010;71(8):1061-1068.

Frank E, Kupfer DJ, Jacob M, Blumenthal SJ, Jarrett DB. Pregnancy-related affective episodes among women with recurrent depression. *The American journal of psychiatry.* 1987;144(3):288-293.

Goodman JH, Guarino A, Chenausky K, et al. CALM Pregnancy: results of a pilot study of mindfulness-based cognitive therapy for perinatal anxiety. *Archives of women's mental health.* 2014;17(5):373-387.

Grace SL, Evindar A, Stewart DE. The effect of postpartum depression on child cognitive development and behavior: a review and critical analysis of the literature. *Archives of women's mental health.* 2003;6(4):263-274.

Halligan SL, Herbert J, Goodyer IM, Murray L. Exposure to postnatal depression predicts elevated cortisol in adolescent offspring. *Biological psychiatry.* 2004;55(4):376-381.

Kelly RH, Russo J, Katon W. Somatic complaints among pregnant women cared for in obstetrics: normal pregnancy or depressive and anxiety symptom amplification revisited? *Gen Hosp Psychiatry.* 2001;23(3):107-113.

Krans EE, Cochran G, Bogen DL. Caring for Opioid-Dependent Pregnant Women: Prenatal and Postpartum Care Considerations. *Clinical Obstetrics and Gynecology*. 2015;58(2):370-379.

Li D, Liu L, Odouli R. Presence of depressive symptoms during early pregnancy and the risk of preterm delivery: a prospective cohort study. *Hum Reprod.* 2009;24(1):146-153.

Lindahl V, Pearson JL, Colpe L. Prevalence of suicidality during pregnancy and the postpartum. *Archives of women's mental health.* 2005;8(2):77-87.

Norhayati MN, Hazlina NH, Asrenee AR, Emilin WM. Magnitude and risk factors for postpartum symptoms: a literature review. *Journal of affective disorders.* 2015;175:34-52.

Opioid abuwe, dependence, and addiction in pregnancy. Committee Opinion No. 524. American College of Obstetricians and Gynecologists. *Obstet Gynecol*. 2012;119:1070-6.

Orr ST, Blazer DG, James SA, Reiter JP. Depressive symptoms and indicators of maternal health status during pregnancy. *J Womens Health (Larchmt).* 2007;16(4):535-542.

Payne JL. The role of estrogen in mood disorders in women. *Int Rev Psychiatry.* 2003;15(3):280-290.

Payne JL, Roy PS, Murphy-Eberenz K, et al. Reproductive cycle-associated mood symptoms in women with major depression and bipolar disorder. *Journal of affective disorders.* 2007;99(1-3):221-229.

Viguera AC, Nonacs R, Cohen LS, Tondo L, Murray A, Baldessarini RJ. Risk of recurrence of bipolar disorder in pregnant and nonpregnant women after discontinuing lithium maintenance. *The American journal of psychiatry.* 2000;157(2):179-184.

Viguera AC, Whitfield T, Baldessarini RJ, et al. Risk of recurrence in women with bipolar disorder during pregnancy: prospective study of mood stabilizer discontinuation. *The American journal of psychiatry.* 2007;164(12):1817-1824; quiz 1923.

Wesseloo R, Kamperman AM, Munk-Olsen T, Pop VJ, Kushner SA, Bergink V. Risk of Postpartum Relapse in Bipolar Disorder and Postpartum Psychosis: A Systematic Review and Meta-Analysis. *The American journal of psychiatry.* 2016;173(2):117-127.

Zuckerman B, Amaro H, Bauchner H, Cabral H. Depressive symptoms during pregnancy: relationship to poor health behaviors. *American journal of obstetrics and gynecology.* 1989;160(5 Pt 1):1107-1111.

APPENDIX I. TASK FORCE MEMBERSHIP

Membership of the Task Force to Study Maternal Mental Health was defined in statute and established as follows:

Task Force Member	Affiliation / Task Force Role
Albert Zachik, M.D., Chair	Maryland Behavioral Health Administration
The Honorable Brian Feldman	Senate of Maryland
The Honorable Ariana Kelly	Maryland House of Delegates
Safiyyah Abdul-Rahman, M.D.	Reproductive Psychiatrist
Carolyn Atkins	Department of Public Safety and Correctional Services
Julie Bindeman, Psy-D.	Maryland Psychological Association
Diana Cheng, M.D.	Maryland Maternal and Child Health Bureau
Annie Coble	Maryland Medical Assistance Program
Deedra Franke	Perinatal Registered Nurse
Kari Gorkos	Mental Health Association of Maryland
Catherine Harrison-Restelli, M.D.	Maryland Hospital Association
Jessica Honke	Maryland Chapter – National Alliance on Mental Illness
Sara Jeurling, M.D.	Perinatal Mood and Anxiety Disorders Survivor
Jessica Katznelson, M.D.	Maryland Chapter – American Academy of Pediatrics
Katrina Mark, M.D.	Obstetrician
Ilise Marrazzo	Maryland Maternal and Child Health Bureau
Tamar Mendelson, Ph.D.	Reproductive Therapist
Lorraine Milio, M.D.	MedChi, the Maryland State Medical Society
Nadia Monroe	Postpartum Support Maryland
Ann Myers	Maryland Network Against Domestic Violence
Jennifer Payne, M.D.	Johns Hopkins Women's Mood Disorders Center
Debra Scrandis, Ph.D.	Nurse Psychotherapist
Erin Shaffer	Department of Public Safety and Correctional Services
Aashish Shah, M.D.	Health Insurance Industry Representative
Milena Smith, M.D.	Maryland Psychiatric Society
Stacey Stephens	Licensed Clinical Social Worker

Wendy J. Frosh
Healthcare Management Strategies

MENTAL HEALTH ASSOCIATION OF MARYLAND

HEALTHY NEW MOMS CAMPAIGN

FOCUS GROUP EVALUATION

APRIL, 2015

BACKGROUND

In 2005, with grant support from HRSA, the Mental Health Association of Maryland initiated a program consisting of outreach and education regarding postpartum depression (PPD). The program, Healthy New Moms, was structured as a campaign and targeted three distinct audiences: the general public; pregnant and postpartum women; and providers of health, mental health and support services.

To reach the general public, the campaign developed and disseminated articles highlighting the topic of PPD and advertisements in specific media outlets. For pregnant women and new mothers, brochures that discussed symptoms, screening and resources for treatment were created and distributed. Providers were targeted through hospital grand rounds, print materials and training programs – both in person and on line.

The effectiveness of the Healthy New Moms campaign was evaluated in 2007. With regard to consumers, the evaluation was specifically designed to determine if the campaign was reaching the desired audiences, and if there was a corresponding increase in the use of the Health New Moms website and PPD Hotline. On the provider side, campaign success was assessed in terms of the number of providers who participated in the education and training programs delivered across the state. This early evaluation showed that the campaign was on track in achieving its goals in outreach and education.

In 2014, MHAMD initiated an effort to further assess the impact and effectiveness of its campaign materials in preparation for a renewed and expanded organizational effort on maternal mental health. Structured as a qualitative evaluation, it consisted of a series of three focus groups – two with consumers and one with providers. The goal of the focus

10401 Grosvenor Place, Suite 1206
North Bethesda, MD 20852
301 564-0609
wjfrosh@wendyfrosh.com

21 Tidewater Farm Road
Greenland, NH 03840
603 770-8159

groups was to determine how familiar consumers were with PPD and with perinatal mood disorders (PMAD), where they would typically seek information, where they were currently getting information, how well the campaign materials met their purpose, and what other resources would be useful. [Attachment 1 contains the Consumer Focus Group Guide.] For providers, the focus group was structured to elicit information on what information was routinely provided to pregnant and postpartum women, additional resource needs, and training and continuing education needs and opportunities. [Attachment 2 contains the Provider Focus Group Guide.]

FOCUS GROUP FINDINGS

The focus groups were conducted over a two month period, from February through April, 2015. Participants for the consumer sessions were recruited through Postpartum Support Maryland for a session in Prince Georges County (16 women) and Johns Hopkins Women's Mood Disorders Center (18 women) for a session in the city of Baltimore.

The recruitment process for the consumer sessions was not designed to create a demographically representative sample. It was conducted through individual contact, posters, and outreach through the two programs' websites, and participants signed up on a first come – first served basis. Women were offered refreshments and a gift card as incentives to participate in the process.

Both consumer groups included individuals from diverse racial and ethnic backgrounds, although determination of diversity was visual and not confirmed by the participants. It was interesting to note that in both groups, women tended to cluster. Some of the women knew each other from the community and/or support group activity, and sat together through the session. Others seemed to connect more easily with racial and/or ethnic peers. While these observations are anecdotal, they underscore the need for the MHAMD to address the development of programs and materials for PMAD/PPD in a culturally sensitive and competent manner.

Participants for the provider session were recruited by MHAMD's Director of Youth and Family Programs, who oversees the Healthy New Moms program. While the 23 providers came from a wider geography, the session was held in Lutherville at the MHAMD offices.

Consumer Input

The two consumer focus groups were similar in terms of participants' knowledge and understanding of PMAD/PPD, and their access to information regarding those conditions. Clearly, as the recruitment was handled through channels that provide support for women with PMAD/PPD, the participants, although diverse, were not a random sample of the general population. The women in the focus groups were familiar with PMAD/PPD, and the majority reported experiencing symptoms during and/or after pregnancy. The women consistently reported that there was a dearth of information regarding PMAD/PPD, and very few of them had received what they considered adequate information from their providers during or after their pregnancies. They reported confusion regarding symptoms – what should I watch for; what is serious; how

would I know if I have PMAD/PPD? They also indicated that they, themselves, were afraid to answer "yes" to questions about symptoms.

> "I wondered what the symptoms were. I was a high risk pregnancy, but no one ever said anything about PPD."
>
> "Despite the fact that I was on antidepressants, my doctor never discussed it with me."
>
> "I'd heard of the 'baby blues', but from my sisters, not my doctor."

The participants described what they considered to be the continuing stigma around perinatal depression and anxiety, and strongly suggested that public awareness of PMAD/PPD, its symptoms and incidence be enhanced. As new mothers, they were expected to be happy and able to handle the role of motherhood, but they felt that the reality they experienced was far from those expectations. They described fears of feeling judged and inadequacy as they discussed their reactions to experiencing PMAD/PPD, but were most surprised by how unprepared they felt as their anxiety and depression took root.

> "I looked forward to having a baby, but I didn't realize how tough it would be. There's no 'out' now."
>
> "You judge yourself, and other people judge you. They say it was your choice, you should be joyous."
>
> "I didn't feel prepared to be a new mom, felt ashamed."

Many noted that their physicians and midwives never mentioned the possibility of PMAD/PPD, and downplayed symptoms that had begun to occur. Self-diagnosis was commonly reported, and information was gathered through discussion with friends and online searches. The lack of input from providers – obstetricians, pediatricians, midwives, lactation consultants, and hospital social workers among them – created additional anxiety, as these women described their own wariness of admitting that there were problems. It was noted that materials on breast feeding and shaken baby syndrome were routinely distributed and discussed in the media, but references to PMAD/PPD were not.

> "I cried at every appointment, but there was no intervention."

"After seven hospital admissions, I was finally diagnosed in the ED, even though I had given my doctor my history of PPD after my first pregnancy."

"Our pediatrician never acknowledged my concerns. I called the lactation consultant, and even she didn't have answers for me."

"I had to advocate for myself. That was hard given how depressed and ashamed I was."

When women had access to screening tools – mostly through online sources – again, they had a significant number of questions regarding the extent and severity of symptoms, and what constituted a condition for which medical/mental health care was warranted. Women who approached their caregivers for help and information were often shunted from one provider to another – obstetricians referring back to primary care, and vice versa. Several women described calling mental health provider systems, but never hearing back. The participants also found insurance coverage to be a barrier to care. When a provider with expertise in the field could be found, often that individual was not participating in the individual's insurance plan. Seeking referrals, using provider directories, and obtaining authorizations were all cited as obstacles to obtaining appropriate care.

Interestingly, there were several women who had given birth outside of Maryland – in Europe, Canada, and North Carolina – who had dramatically different and more positive experiences in those locations. While their experiences were not identical, they reported having had access to screening, information, referral and follow-up – a system of care that enabled them to deal more effectively with symptoms of PMAD/PPD. Several individuals referred to state requirements (New Jersey, for example) where screening is mandatory, as models for emulation.

After searching for resources, many participants predominantly found assistance and support from friends, family members and/or peer groups in an effort to cope with their symptoms. Some found specific groups that were targeted to women with PMAD/PPD, while others looked to on line chat rooms and Facebook. Still others sought help through neighborhood play groups, "new moms" groups, and La Leche league. The more focused these groups were to mood disorders, the more satisfied the participants were with the experience. In contrast, several women noted that joining "generic" new moms' groups added to their sense of stigma and shame, as their experiences were not common to the other members. But the majority felt that peer support groups were an excellent tool for addressing PMAD/PPD, and suggested that hospitals could build on the birthing class model and encourage postpartum reunions.

"I don't know what I would have done without my support group."

"Stories about other women, who were having the same experiences as I did, helped me feel less anxious."

"I felt isolated in the new moms' group, because everyone else was doing fine."

When asked where resources on PMAD/PPD should be available, the participants had numerous suggestions. There was a clear expectation that all providers – hospitals and hospital staff, obstetrical providers, etc. – who work with pregnant and postpartum women should be discussing mood disorders, risk factors, symptoms and signs. They should also be able to direct women to resources for screening, diagnosis and treatment. Many women noted that because they see pediatricians for routine follow up care for their children, these practitioners should have the knowledge base and tools to direct new mothers to appropriate intervention. They cited the need for direct communication by doctors, nurses, and/or social workers upon discharge from the hospital, noting that because of the volume of information given a new mother, pamphlets were not sufficient. They felt that a conversation about the appropriate response to mood changes should be a critical piece of the discharge process, and included in a routine follow up call or visit post-discharge.

Beyond the providers who routinely work with obstetrical patients and their children – obstetricians, midwives, pediatricians, etc. – participants suggested that they and their peers would benefit from and seek information through a variety of sources. These included community resources such as birthing classes, lactation programs, childcare centers, gyms, retailers and resellers in the baby/children business, community bulletin boards, faith-based organizations and public libraries; electronic media such as Facebook, on line chat rooms, and professional sites like WebMD; and hotlines sponsored by insurance companies and service organizations. But many of the participants felt that any and all of these resources should provide a pathway to personal contact and/or intervention. Other suggestions included providing respite daycare, bartering networks, classes for new mothers in Yoga, coping with sleep deprivation, and planning for what comes next. Because PMAD/PPD can be very isolating, it was suggested that having a place to go was very important. As one participant said, "It takes a village."

"It would be great if the hospital could give you a partner, a mentor, someone who's been through it when you start to come in for your regular

appointments. Women aren't always comfortable telling their doctors what's going on for fear of being judged."

"The OB should evaluate you at every visit. I like the idea of journaling – writing down my thoughts and feelings every day and bringing that with me to my appointments."

"Wouldn't it be great if we could have a bartering network? We could support each other and get things done that we can't do ourselves."

"How about a place, maybe the hospital, that offers respite daycare? When you're having a hard time, you could bring your baby somewhere that you know is safe, so you can have some time for yourself."

Another common theme was the importance of engaging spouses, partners, and family members in identifying and addressing PMAD/PPD. Participants felt that education and outreach to members of that "extended family" would help with early identification and intervention. They also felt that by preparing these significant others, stigma could be reduced, and outcomes improved. Including materials in FMLA packets distributed by human resources departments/professionals was another suggested means of reaching partners/spouses, in addition to pregnant women.

"It would have been so helpful if my husband had known what to look for, what to do. I felt so isolated."

"My family expected me to be so happy. They didn't know how to cope with my anxiety."

"The hospital should have a patients' library that has lots of resources for you on depression and anxiety. A place where you can easily sit and read and find what you need."

Participants were asked to review the MHAMD brochure, "Depression & New Moms" and discuss their reactions within the group. Overall, the women found the brochure to be out of date, both visually and content-wise. To many, the photographs were off-putting, and did not visually address the issues in the text. The stated campaign goal of "ending depression, during and after pregnancy" was viewed as unrealistic. The principal focus on depression was considered inadequate, failing to address the other common aspects of PMAD. Some felt that the term *anxiety* would be a better choice,

and resonate more effectively with the intended audience, as the term depression was considered "loaded". Additionally, by addressing only "new moms", many felt the brochure did not speak to the symptoms that may begin during pregnancy and/or continue for a significant period after delivery. Participants suggested that the language used in the brochure should focus on the theme "you are not alone" and "this is common", as they felt that the sense of isolation among those who experience PMAD/PPD can be intense.

There were strong reactions to the trajectory of the information in the brochure – warning signs to treatment – as the section on treatment focused principally on medication and only later touched on counseling as an adjunct to medication. Participants felt that there were many other approaches that should be presented in future publications. A list of resources would be a critical addition. Acknowledging that not everyone has access to computers, directing women to physical resources – hotlines, libraries, hospitals, etc. – would be very important. To the extent possible, any local information would be a priority, although keeping that updated was seen as a potential problem.

Participants had many suggestions as to where information should be distributed and available. Ensuring that OB/Gyn and pediatric practices and hospital maternity units have and distribute the material was their first priority, but there were a lot of other places that participants thought would help provide women with greater access. These included public libraries, childcare centers, birthing classes, lactation programs, WIC sites, retailers (such as Babies R Us, Target, IKEA), women's gyms, grocery store/community bulletin boards, EAP counselors, and employer human resources offices. The need for information in languages in addition to English that resonate with diverse audiences was also discussed.

At the close of both consumer group sessions, individuals engaged with each other and exchanged contact and resource information. It was clear that the opportunity to network and reach out to others who had experienced similar issues was welcome, as was the chance to broaden knowledge and understanding.

Provider Input

The provider focus group was very diverse, comprised of physicians, nurses, psychologists, social workers, lactation consultants and case managers. They represented several hospitals and private practices, as well as clinics and support groups. Many of the same themes that were evident in the consumer groups were raised by providers as well. Prominent among them were stigmatization of mental health problems including PMAD/PPD, a dearth of information directed to pregnant women and new mothers, an inadequately trained provider workforce, and a lack of a sufficient number of providers to address clients' needs vis a vis PMAD/PPD.

There was consensus in the group that there is a need to reach out to women during pregnancy to discuss PMAD/PPD signs and symptoms. Ensuring that the topic is discussed in prenatal classes was considered essential and engaging spouses/partners and other family members in that educational process was considered ideal. Many noted that when women did report problems, the concerns and presenting symptoms were more frequently tied to anxiety rather than to depression, but that overall, there was a good deal of denial regarding the need for intervention until/unless symptoms were dramatic. It was suggested that this was a result of the sense of stigma associated with PMAD/PPD as a mental health problem.

Those providers who were hospital-based reported that there was an effort to distribute material on PMAD/PPD to pregnant women who used their facilities. Many reported familiarity with the MHAMD brochures and distribute them to new mothers. Others indicated that a video on postpartum issues, including PMAD/PPD, was shown to women prior to discharge. While many of these facilities still offer birthing classes, currently they are not as popular as they were a decade ago. One facility representative did report that child birth classes for obstetrical patients are required. But it was noted that prior to delivery, women tend to be focused on preparing for birth, and do not show an interest in the potential problems that may come later, making discussion of PMAD/PPD difficult. Additionally, it was noted that the target population is not homogeneous, and thus, efforts to reach individuals need to be targeted to the specific audience. For some, pregnancy is a welcome life event, while for others, it is unintended and an additional stress in a difficult life. For those at high risk because of pre-existing mental health problems or complicated living circumstances, efforts to avoid stigmatization are crucial.

While statistically PMAD/PPD is not common, it would be optimal to include questions in the pre-admission intake form to screen for possible problems. Many providers indicated that problems begin during pregnancy, rather than postpartum, and so

screening and intervention should be available throughout pregnancy. One individual noted that the Edinburgh screening tool was used at her facility. There were significant concerns regarding physicians' knowledge base, about PMAD/PPD in general, and about treatment in particular. Many participants reported that obstetricians will take women off certain medications, including antidepressants, without consulting the prescribing psychiatrist, putting women with a history of depression and/or anxiety at risk for mood disorders.

Most attendees reported that there is little information available for providers, and even less training specific to PMAD/PPD. Many are uncomfortable addressing mood disorders and are not familiar with resources that do exist, preventing them from feeling confident in addressing patients' needs. It was the strong sentiment of the group that there is a need to create more opportunities for CE/CEU programming, both in-person and online, to educate providers on the screening and identification of mood disorders, as well as on treating identified problems.

In addition to formal training programs, creating a summary of existing literature for professionals was recommended. While it was initially suggested that MHAMD develop a directory of providers who focus on PMAD/PPD, it was the consensus that a directory might imply qualifications that would be beyond the organization's ability to monitor and certify. That said, however, attendees felt that there needed to be a way to link obstetricians and pediatricians with mental health providers who were competent and capable in the field. Utilizing information available through licensing boards was suggested as a means for reaching out to targeted provider groups.

Participants offered many suggestions regarding how to reach patients with information and resources on PMAD/PPD: creating or obtaining a video that could be played in physician waiting rooms; hospital-sponsored "baby showers" for new mothers; distributing information at WIC sites; including information in formula packaging; information developed and mailed to patients registered with OBs, clinics, etc.; using faith-based groups and parish nursing to distribute information; include material in health department "healthy start" programs; build into home visiting programs, specifically those that target women with a history of mental health, substance abuse and domestic violence issues; and including in "baby booster" programs run by local organizations.

While attendees felt that all these efforts would be useful, they circled back to the importance of de-stigmatizing mood disorders as a means to improve early detection and treatment. It was strongly suggested that all pregnant women and their families be introduced to the subject of PMAD/PPD through their medical and social service

providers, and the general public engaged through a public awareness campaign. But even as these professionals identified ways to reach the population with information about PMAD/PPD, they acknowledged that there was still a lack of workforce resources to treat identified problems.

The provider focus group had the unanticipated benefit of linking a diverse group of individuals engaged in working with pregnant and postpartum women. At the end of the session, participants requested that an attendance list with individuals' areas of expertise/specialization be developed and distributed. In turn, they offered to provide information regarding appropriate locations and sources for distribution of materials, at the time that they submit their professional details. Lastly, they also requested an updated list of resources be put on the MHAMD website, including information regarding training opportunities.

CONCLUSIONS

In spite of the diversity of the participants in the three focus groups, there were a number of broad, underlying commonalities.

- Participants – consumers and providers alike – believe that PMAD/PPD and mood disorders in general, are still seen as carrying significant stigma. In order for women to identify, acknowledge and address symptoms, the knowledge about PMAD/PPD needs to be elevated within the general public. Conveying information about the incidence and frequency of mood disorders would assist women greatly.

- Pregnant and postpartum women expect to receive information and access to treatment from their medical providers, but currently find little support. Providers also feel that they and their colleagues should be equipped to identify symptoms, as well as treat, or refer for treatment.

- There is a dearth of providers who have the knowledge basis to comfortably diagnose and treat PMAD/PPD. Efforts to provide training and disseminate knowledge need to be enhanced.

- Women find support through peer groups, both formal and informal, in person and online. It was suggested that these networks should be enhanced by connections to professional resources whenever possible, to maximize their efficacy.

- There is a need for easily accessible information on PMAD/PPD – signs/symptoms, when to seek help, resources for treatment. In addition to having this information available through "traditional" professional venues, ensuring that materials are disseminated through "local" channels such as libraries, bulletin boards, childcare centers and other community sites is critical to reaching women in need.

- These materials should also be available online, on websites, in chat rooms, on Facebook and Twitter, but it was noted that not all women have access to the internet.

- The need for culturally competent materials was also cited by consumers and providers alike.

Overall, the majority of women who participated in the consumer focus groups expressed a strong desire for resources that create personal contact, rather than just written or electronic information. The need to "connect" – with experts and with peers –

to talk about and address symptoms of mood change and mood disorder was a very deep underlying theme. For these women, overcoming the sense of isolation requires an opportunity for dialogue and personal contact. They repeatedly identified better communication between patient and provider, support groups, and access to talk therapy as necessary to the healing process.

The MHAMD has a unique opportunity to update and enhance its campaign, Healthy New Moms. Based on the feedback from three focus groups, there continues to be a need for significant public education to increase early identification and intervention for those who suffer with PMAD/PPD, as well as to reduce the stigma associated with these problems. Clearly, in order for women to have access to the services that they require, there is a corresponding need for a campaign among providers to enhance their knowledge base and level of comfort in diagnosing and treating these disorders. Finally, while access to written and electronic resources on PMAD/PPD is important, so too are opportunities for women to connect in structured settings, to share experiences and find support. The MHAMD is well positioned to undertake the challenge of continuing and expanding its comprehensive approach to addressing PMAD/PPD.

Johns Hopkins WMDC Survey Results

Jennifer L. Payne

Lauren O. Osborne

Conducted an online survey distributed in two waves:

Wave 1: Johns Hopkins OB/GYN Department

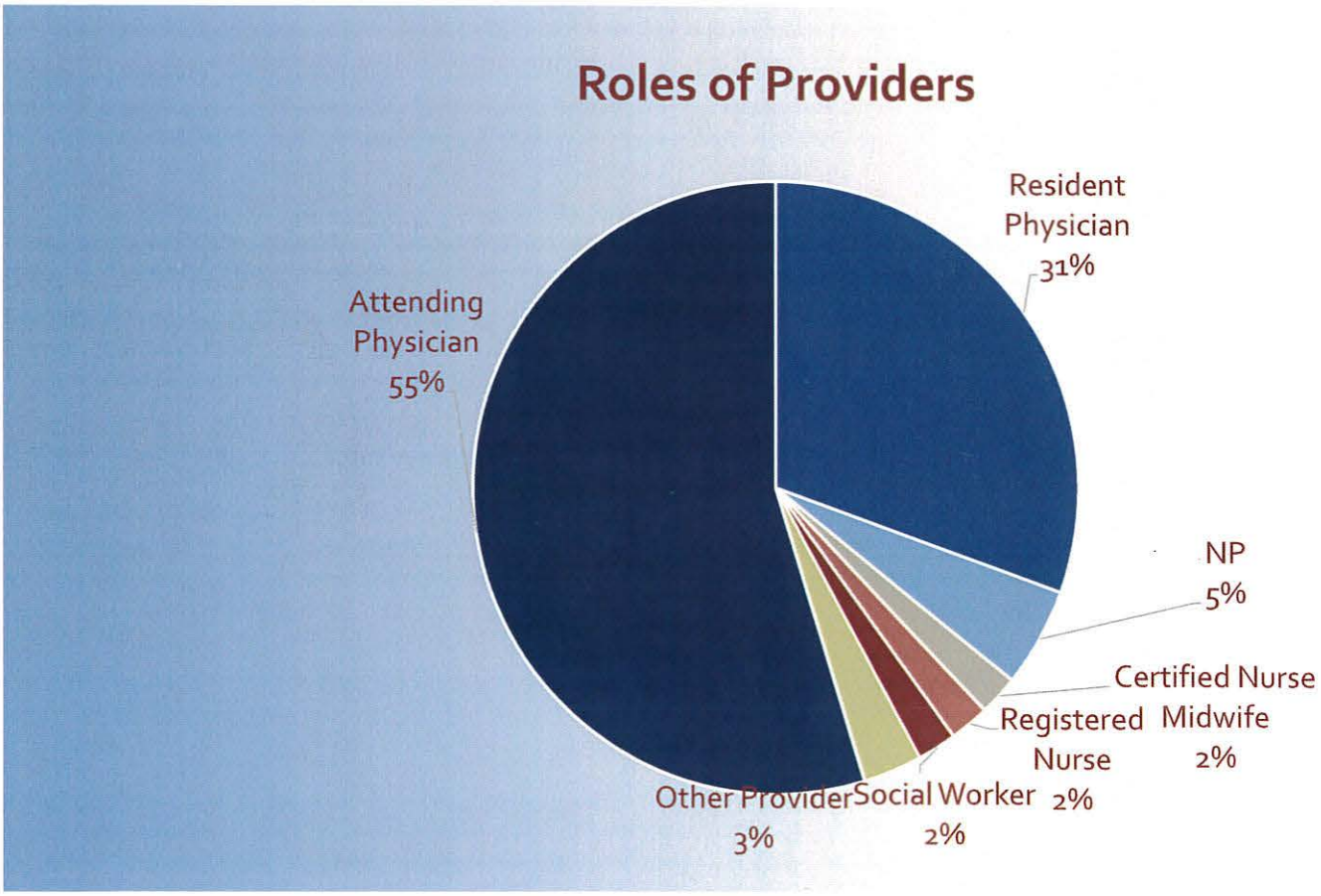
→ 53 responses

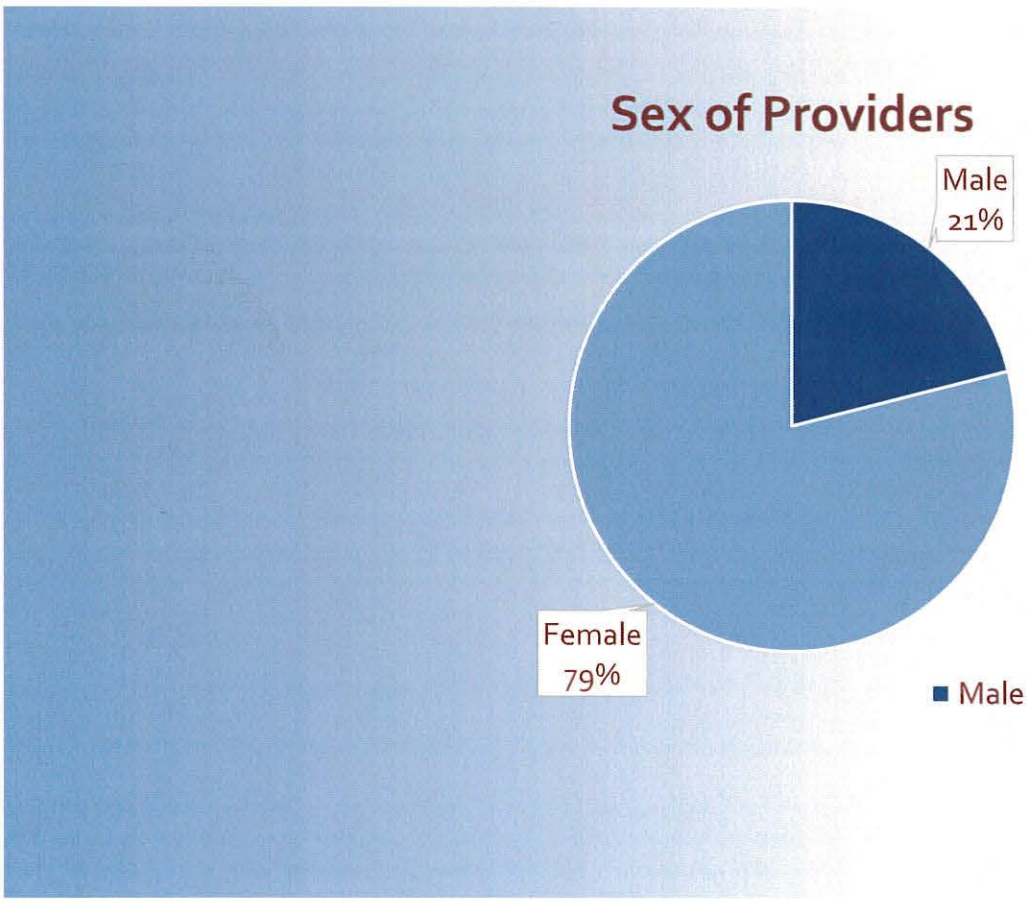
Wave 2: OB/GYN Providers in Maryland

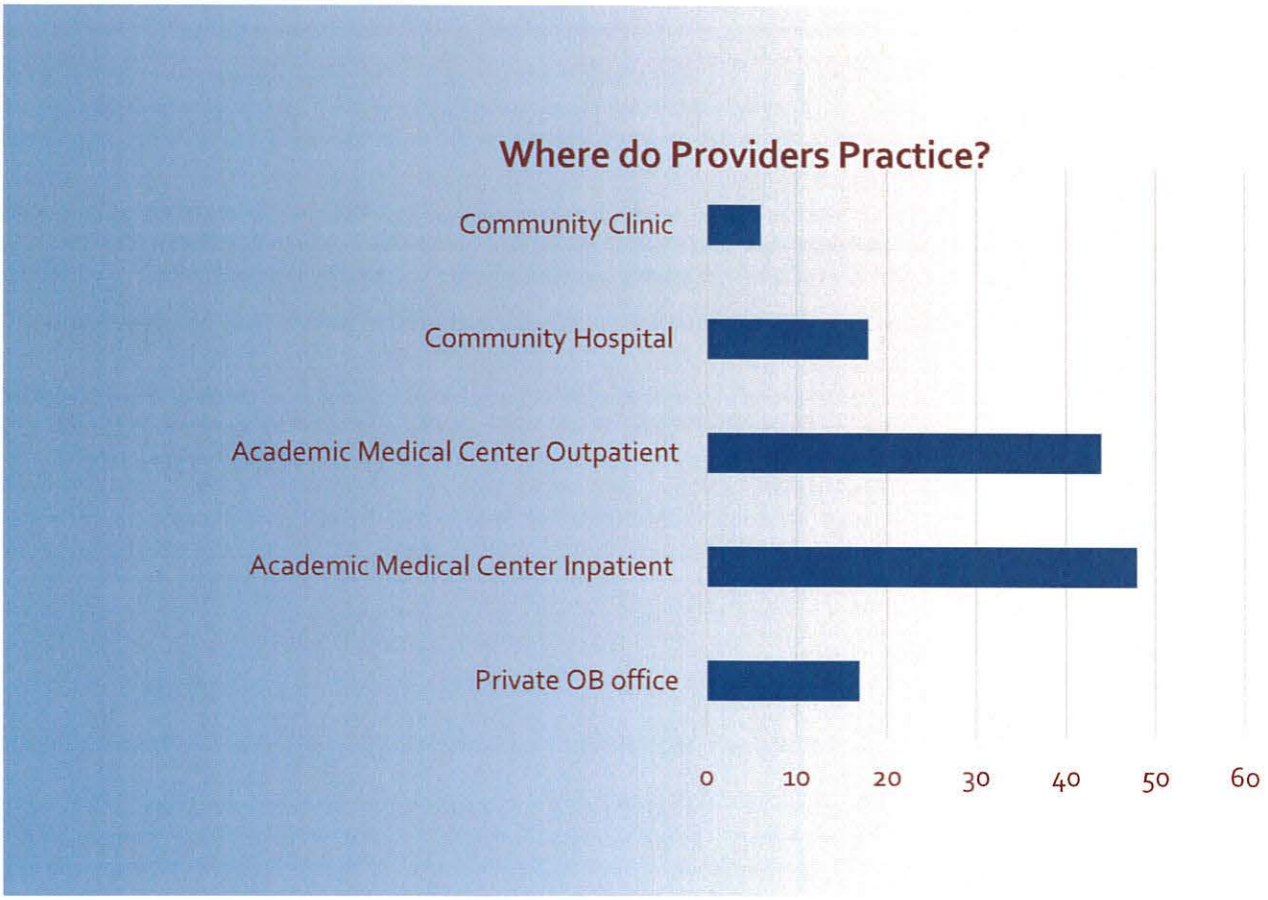
-Distributed via ACOG of MD

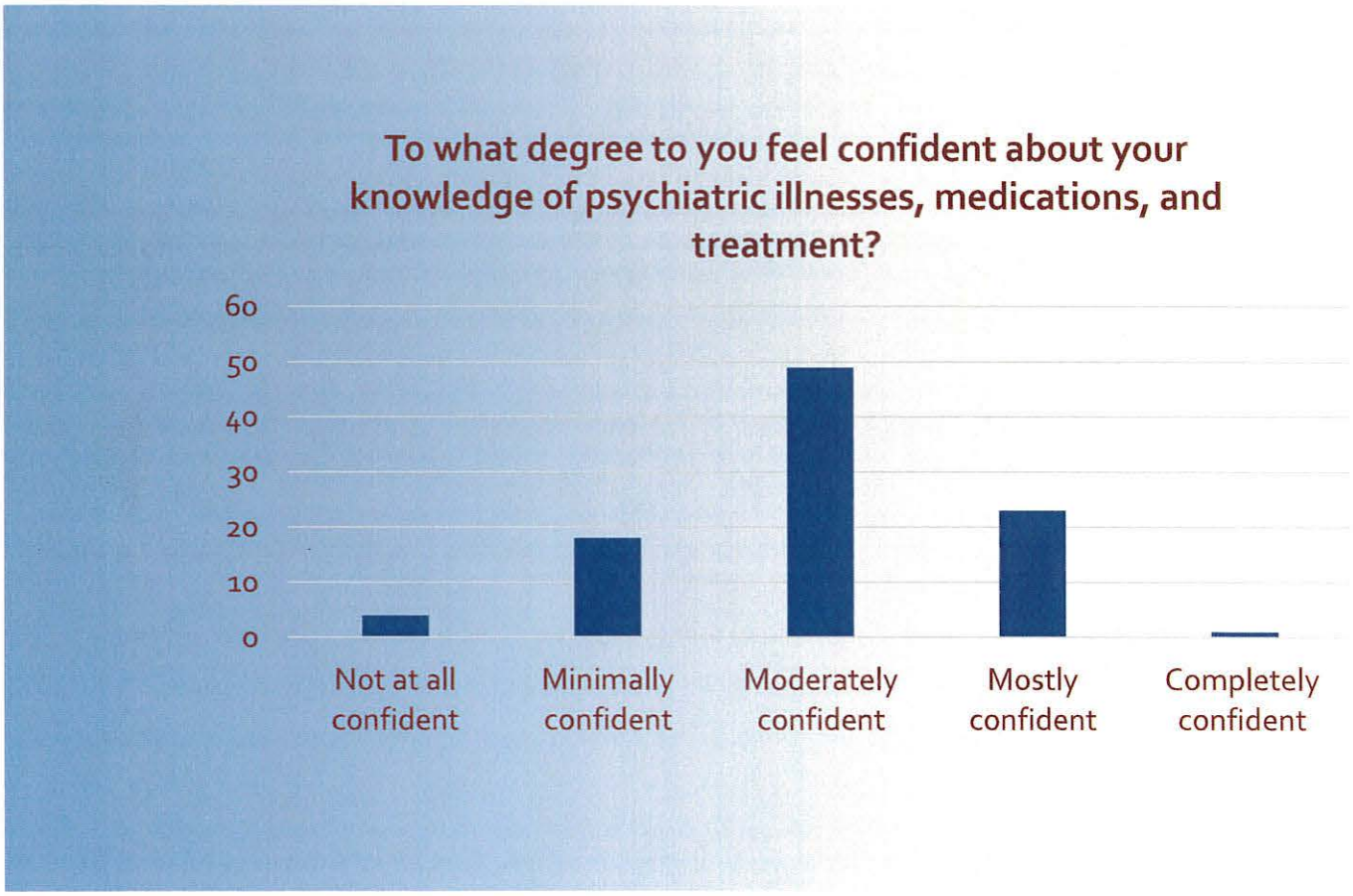
→ 42 responses

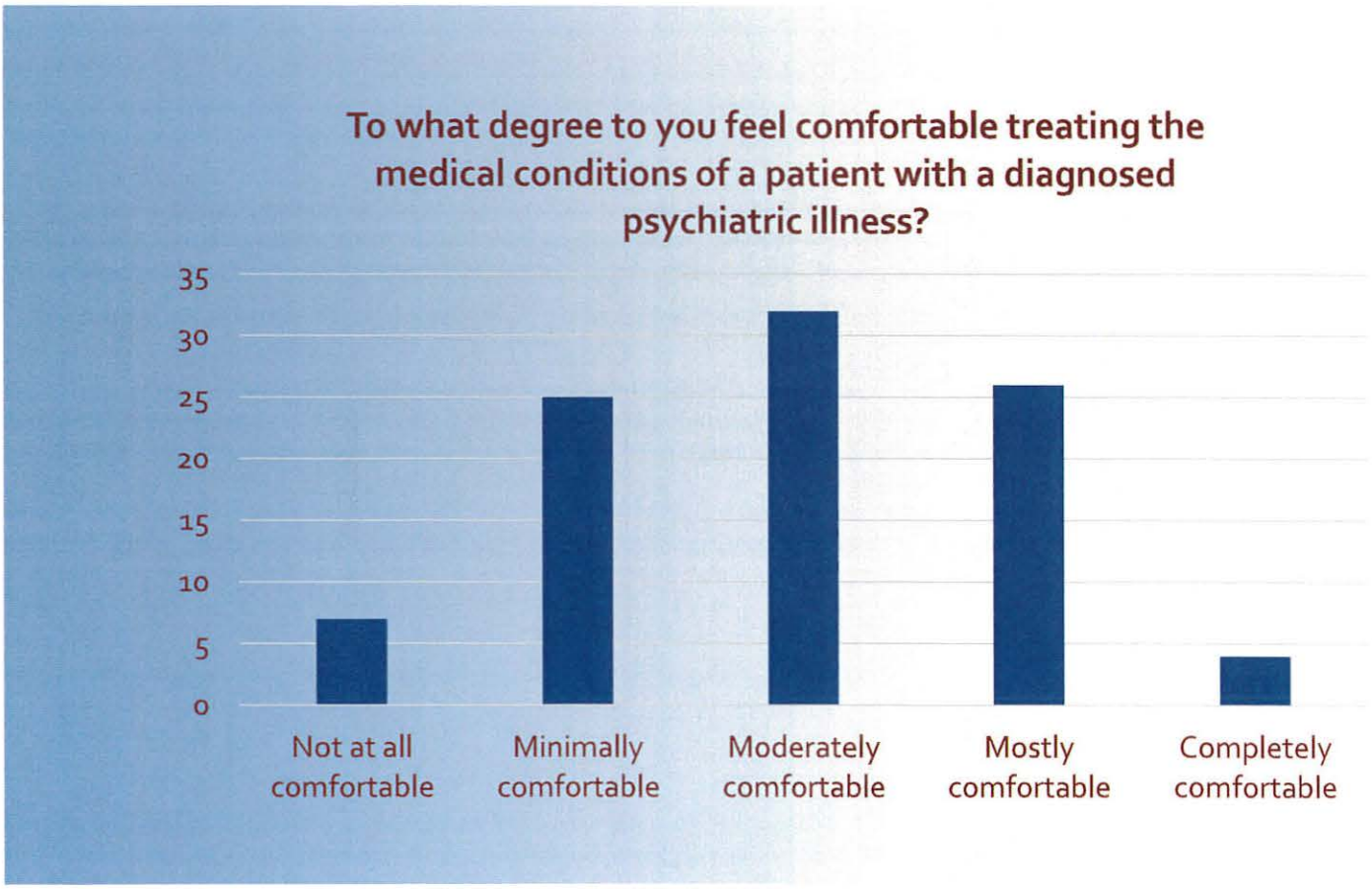
TOTAL: 95 Completed Surveys

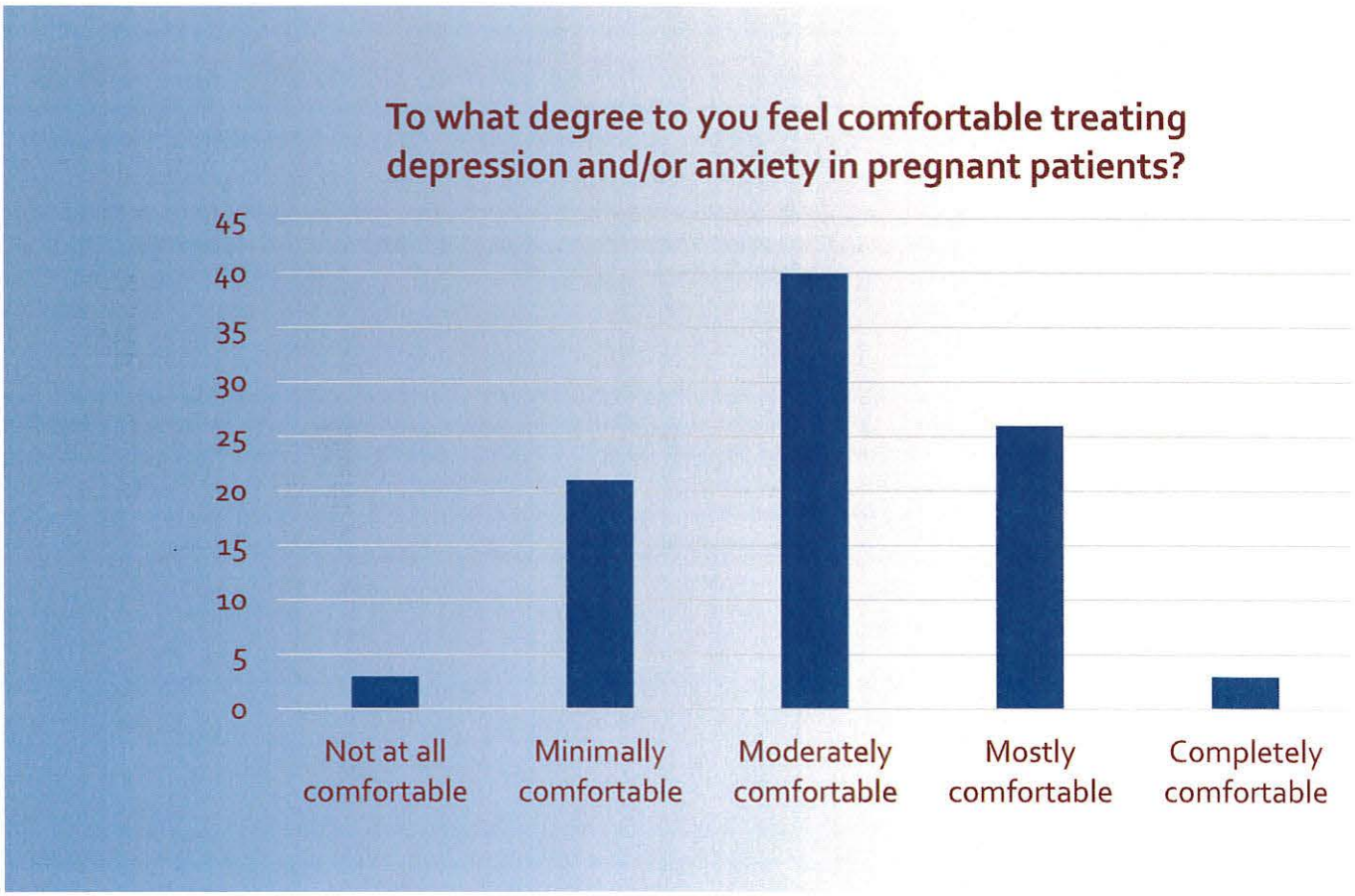

Roles of Providers
Resident Physician 31%
NP 5%
Certified Nurse Midwife 2%
Registered Nurse 2%
Social Worker 2%
Other Provider 3%
Attending Physician 55%

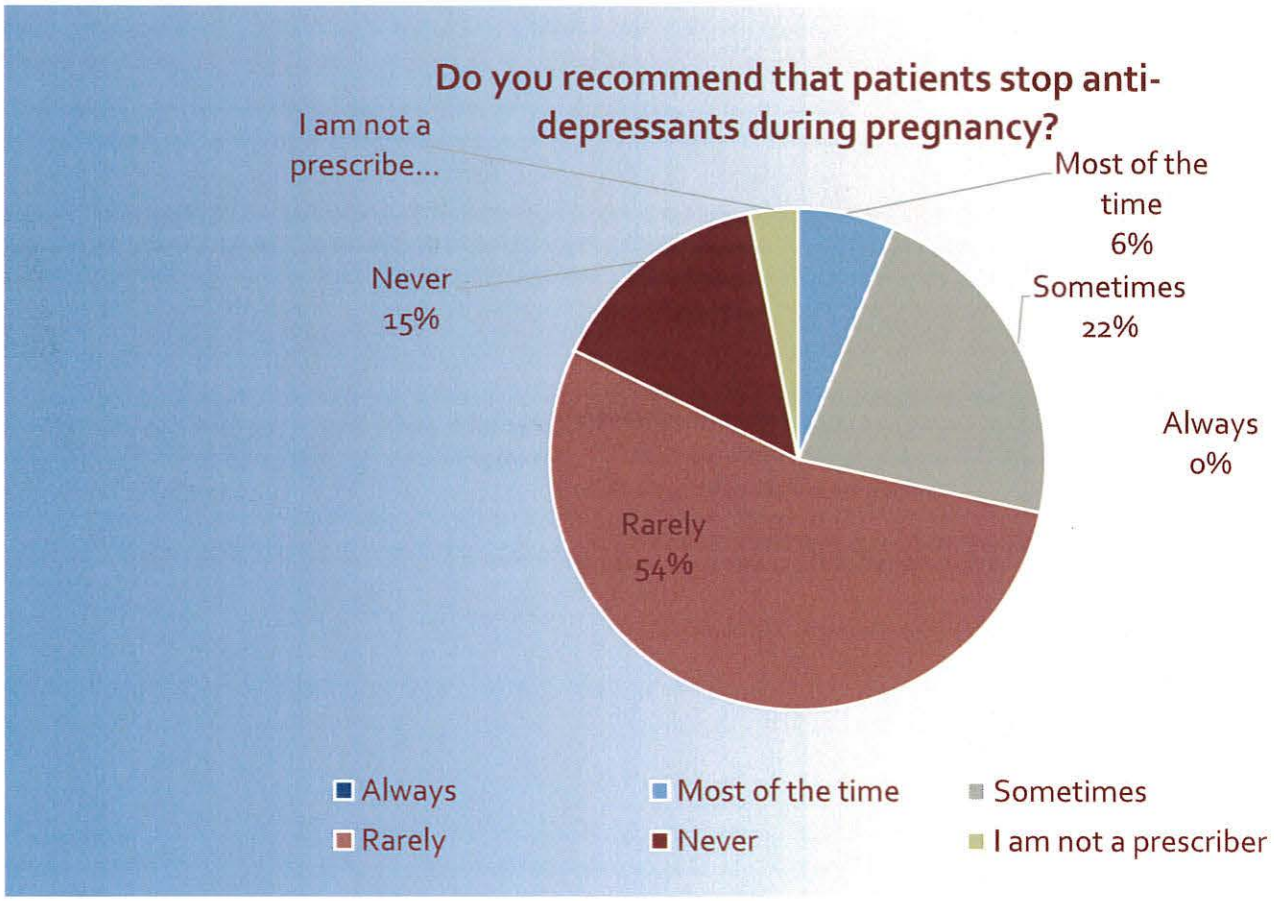

Sex of Providers
Male
21%
Female
79%
Male

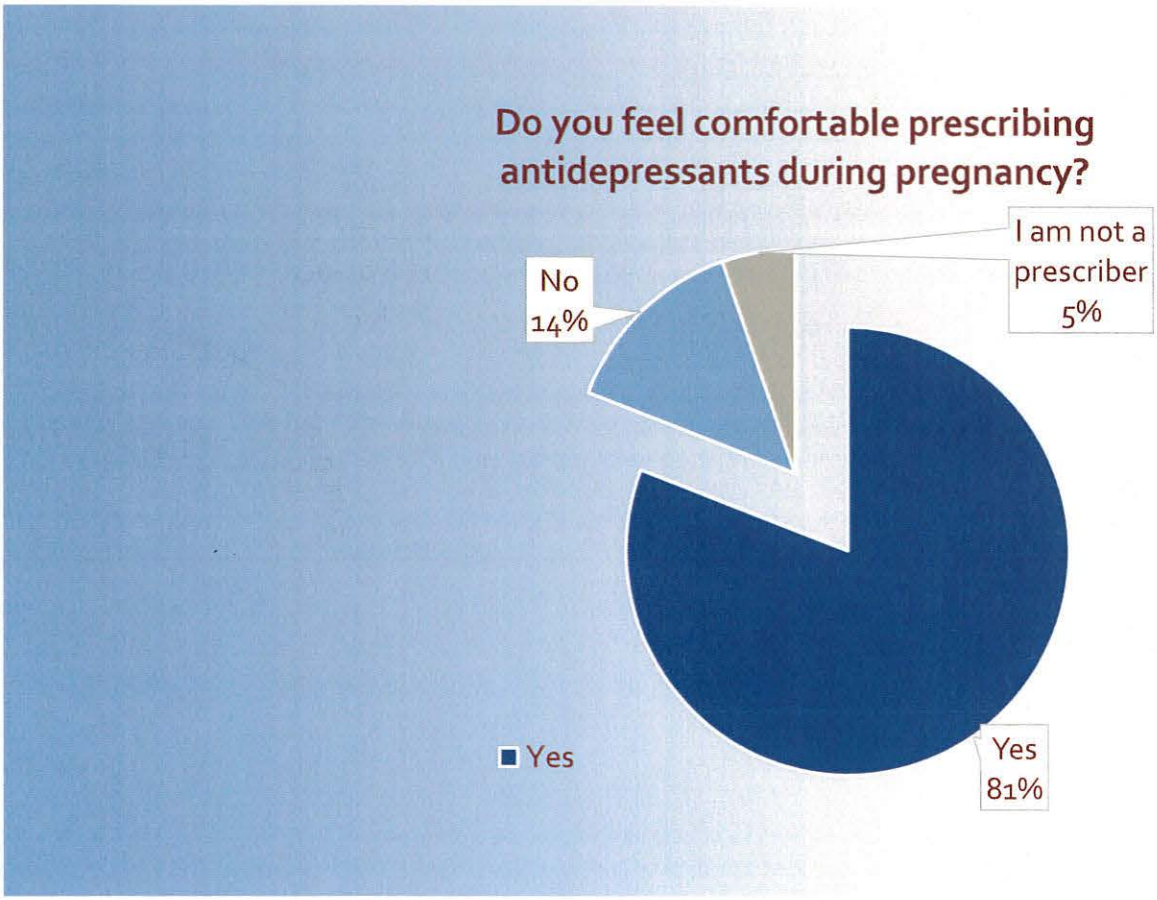

Where do Providers Practice?
Community Clinic
Community Hospital
Academic Medical Center Outpatient
Academic Medical Center Inpatient
Private OB office
0
10
20
30
40
50
60

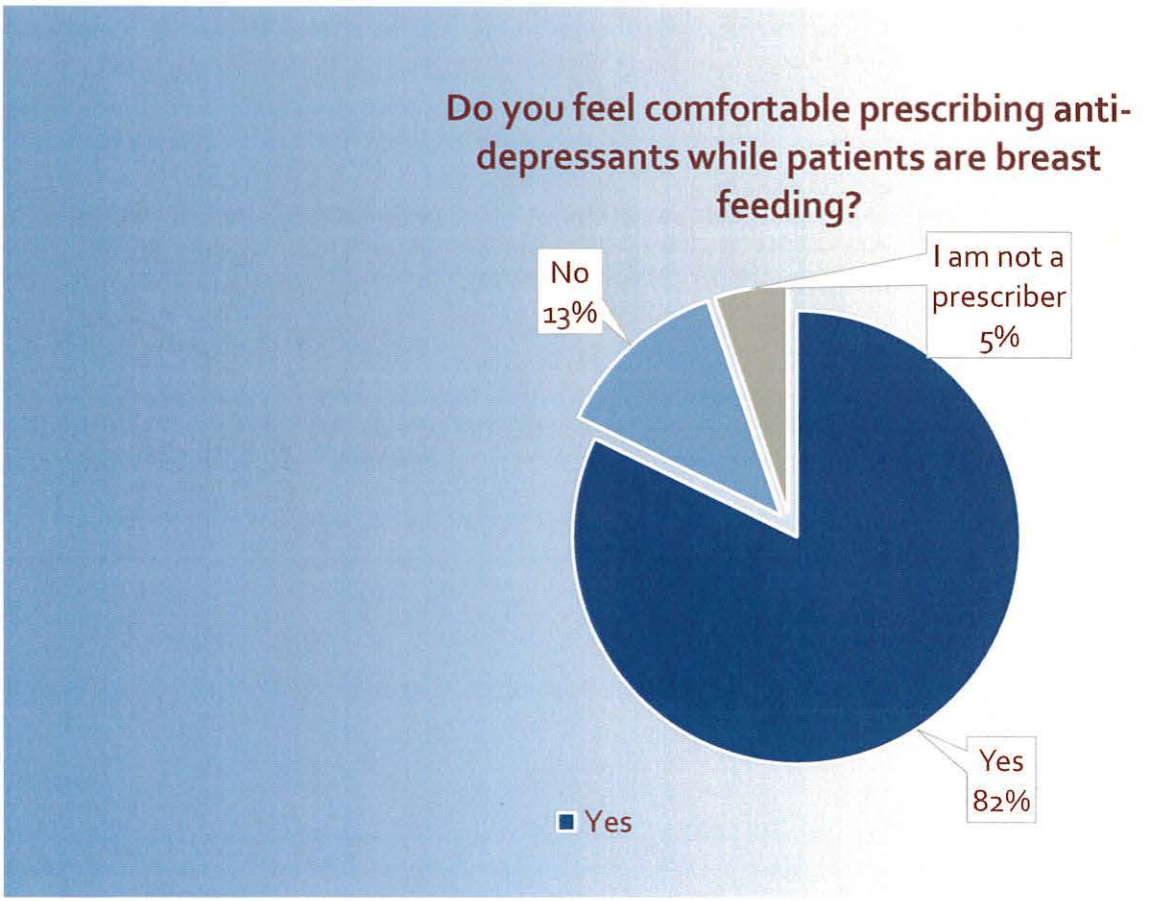

To what degree to you feel confident about your knowledge of psychiatric illnesses, medications, and treatment?
60
50
40
30
20
10
0
Not at all confident
Minimally confident
Moderately confident
Mostly confident
Completely confident


To what degree to you feel comfortable treating the medical conditions of a patient with a diagnosed psychiatric illness?
35
30
25
20
15
10
5
0
Not at all comfortable
Minimally comfortable
Moderately comfortable
Mostly comfortable
Completely comfortable

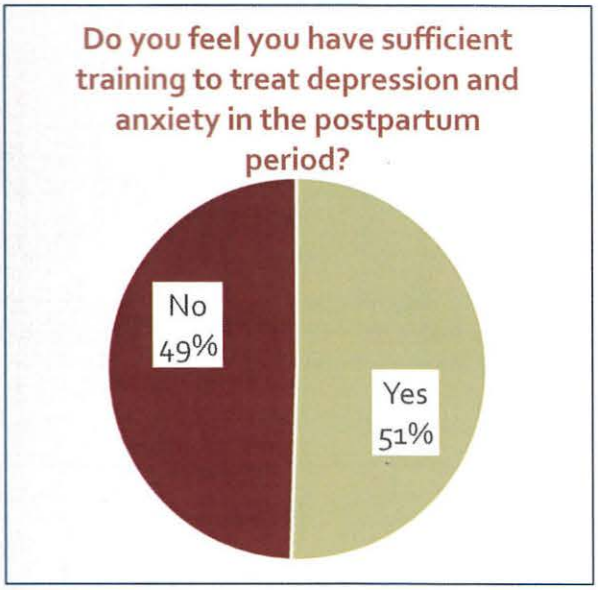

To what degree to you feel comfortable treating depression and/or anxiety in pregnant patients?
45
40
35
30
25
20
15
10
5
0
Not at all comfortable
Minimally comfortable
Moderately comfortable
Mostly comfortable
Completely comfortable


Do you recommend that patients stop anti-depressants during pregnancy?
I am not a prescribe...
Most of the time 6%
Never 15%
Sometimes 22%
Always 0%
Rarely 54%
Always
Most of the time
Sometimes
Rarely
Never
I am not a prescriber

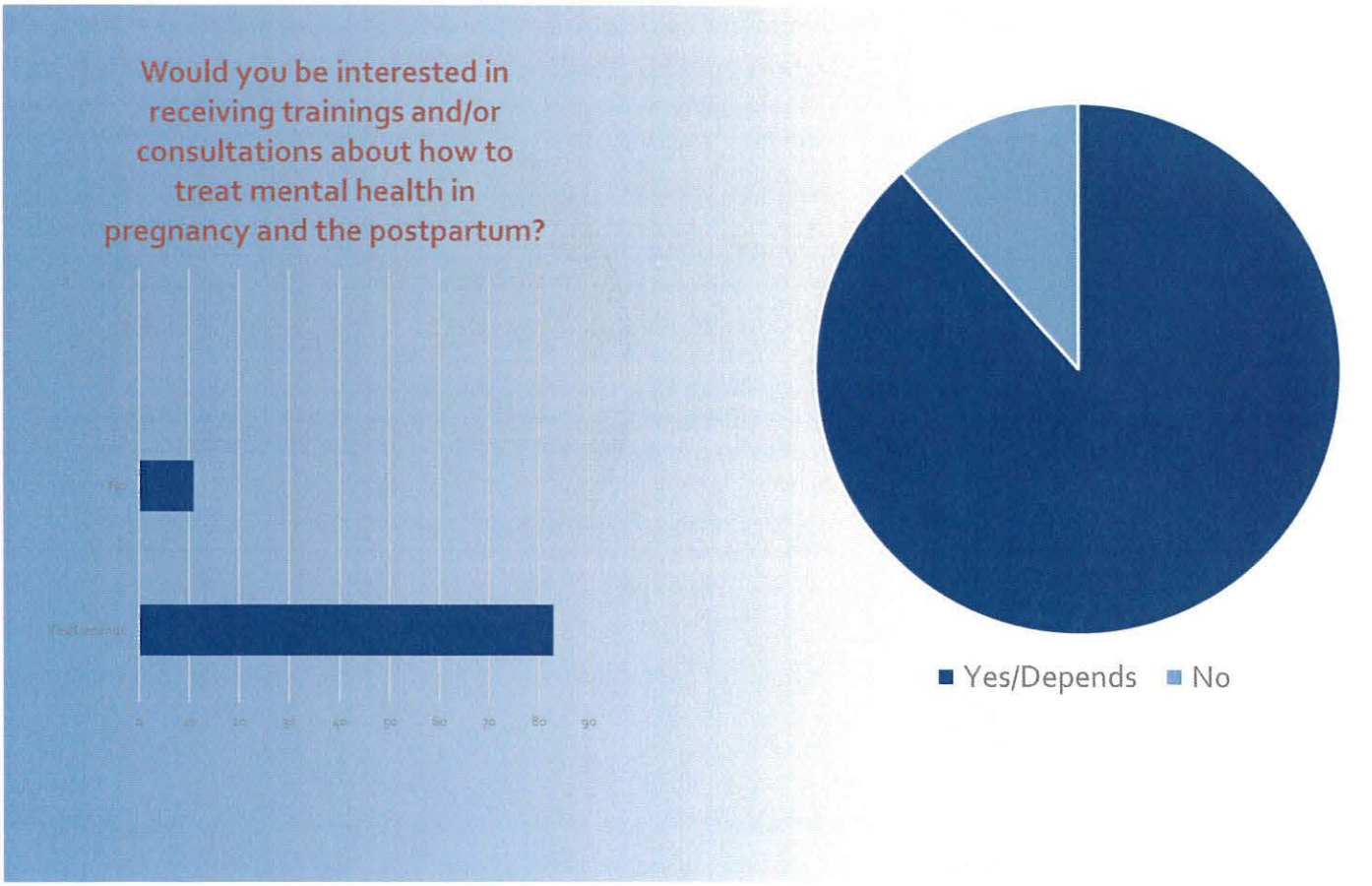

Do you feel comfortable prescribing antidepressants during pregnancy?
I am not a prescriber 5%
No 14%
Yes 81%
Yes

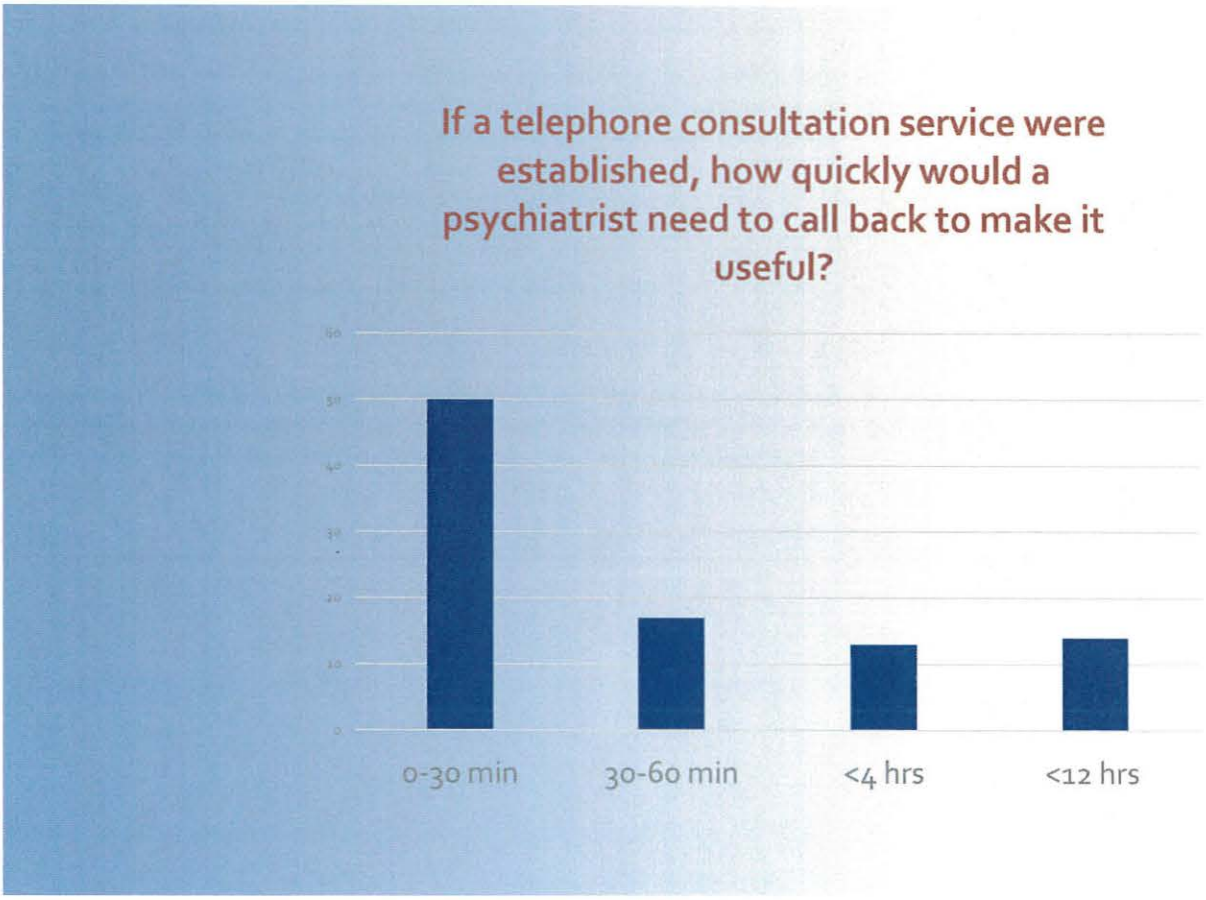

Do you feel comfortable prescribing anti-depressants while patients are breast feeding?
No 13%
I am not a prescriber 5%
Yes 82%
Yes

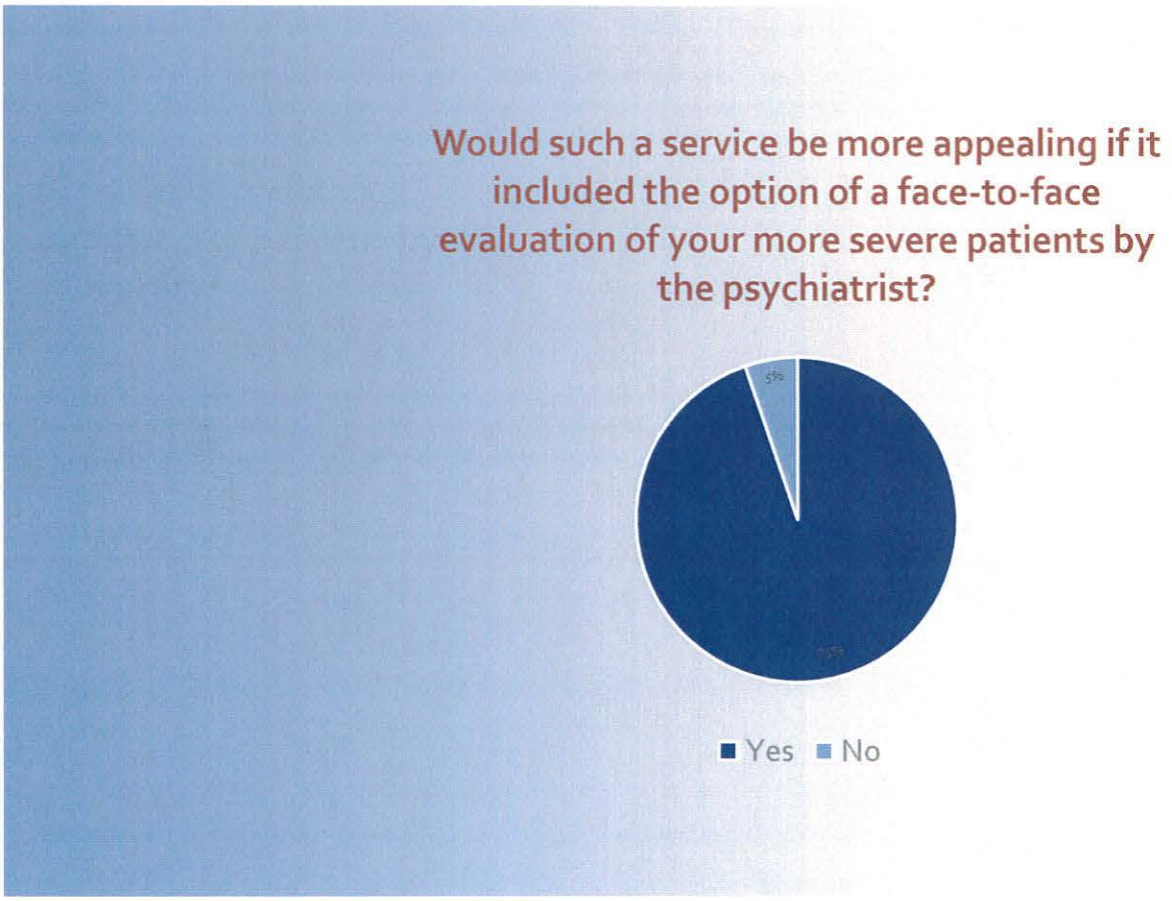

Do you feel you have sufficient training to treat depression and anxiety in pregnancy?
No 52%
Yes 48%


Do you feel you have sufficient training to treat depression and anxiety in the postpartum period?
No 49%
Yes 51%


Are you satisfied with the number and quality of psychiatric referral resources for your patients?
Yes
No


Would you be interested in receiving trainings and/or consultations about how to treat mental health in pregnancy and the postpartum?
No
Yes/Depends
No


If a telephone consultation service were established, how quickly would a psychiatrist need to call back to make it useful?
0-30 min
30-60 min
<4 hrs
<12 hrs


Would such a service be more appealing if it included the option of a face-to-face evaluation of your more severe patients by the psychiatrist?
5%
95%
Yes
No

How quickly would such face-to-face evaluation need to occur to make the service useful?

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: May 11, 2016

FROM: Vikki Wachino, Director
Center for Medicaid and CHIP Services

SUBJECT: **Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children**

Introduction

This Informational Bulletin discusses the importance of early screening for maternal depression and clarifies the pivotal role Medicaid can play in identifying children with mothers who experience depression and its consequences, and connecting mothers and children to the help they need. State Medicaid agencies may cover maternal depression screening as part of a well-child visit. In addition, states must cover any medically necessary treatment for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

Prevalence and Impact of Maternal Depression

Maternal depression is a serious and widespread condition that not only affects the mother, but may have a lasting, detrimental impact on the child's health. Maternal depression presents a significant early risk to proper child development, the mother-infant bond, and the family. Maternal depression screening and treatment is an important tool to protect the child from the potential adverse physical and developmental effects of maternal depression. According to the American Academy of Pediatrics (AAP), screening mothers for maternal depression is a best practice for primary care pediatricians caring for infants and their families[1] and can be integrated into the well-child care schedule, as well as included in the prenatal visit.

Maternal depression is characterized by a spectrum of severity: the common "maternity blues" or "baby blues" are usually gone after a few days or one to two weeks and are helped with reassurance and support for the mother. This is distinct from postpartum depression and post-partum psychosis (the most serious condition), which meet specific diagnostic criteria.[2] According to AAP, it has been estimated that 5 percent to 25 percent of all pregnant, postpartum and parenting women have some type of depression depending on the population surveyed. "Maternal depression" in this guidance encompasses the full spectrum of severity, not only the most severe diagnoses. Mothers who have low incomes are more likely to experience some form of depression than the general population of mothers. For low-income women, rates of depressive symptoms are reported to be between 40 percent and 60 percent.[3] There are estimates that 11 percent of infants in families with incomes below the federal poverty level live with a mother who has severe depression and that more than half (55 percent) of all infants living in poverty are being raised by mothers with some form of depression.[4]

In light of recent evidence that children living with mothers with depression may be at risk for long-term physical and behavioral health consequences, the importance of screening and treating

maternal depression is clear. As Harvard University's Center on the Developing Child indicated in 2009, children raised by a clinically depressed mothers may perform lower on cognitive, emotional, and behavioral assessments than children of non-depressed caregivers, and are at risk for later mental health problems, social adjustment difficulties, and difficulties in school.[5] The risk to the child may depend on the severity of the maternal depression, but timely screening and appropriate treatment can reduce maternal depression and its consequences.

According to the AAP, "If the maternal depression persists untreated and there is not intervention for the mother and the dyadic relationship, the developmental issues for the infant also persist and are likely to be less responsive to intervention over time." [6] Recent research shows promising results for intensive interventions that focus specifically on mother-child interactions, suggesting that treatments designed to improve child well-being must attend both to relieving the mothers' depression and focus on interactions with the child as central dimensions of the interventions. [7]

Medicaid's Role in Maternal Depression Screening and Treatment

Screening

Maternal depression screening is endorsed by several independent expert medical panels that impact services provided to Medicaid eligible children and adults. For example:

The AAP-endorsed Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents ™ is used by many states to implement their EPSDT well-child visits. Bright Futures includes recommendations for well-child visits at one week and one and two months of age, including a recommendation for "Parental (maternal) well-being," which includes a postpartum checkup, with depression and substance abuse screening. Any suggestion of depression should trigger screening questions and providers furnishing these services as part of a well-child visit are guided to refer the mother to her obstetrician or other health care professional and appropriate community-based mental health services. In terms of Medicaid coverage, covering Bright Futures recommended services as part of the preventive benefit strengthens access to these services.

In addition, the United States Preventive Services Task Force (USPSTF) recently published recommendations for screening for depression in the general adult population, including pregnant and postpartum women. [8] The recommendation was given a B grade, based on the quality and strength of the evidence about potential benefits and harm for screening for this purpose. For state Medicaid agencies, section 4106 of the Affordable Care Act (ACA) established a one percentage point increase in the Medicaid federal medical assistance percentage (FMAP) applied to expenditures for preventive services to states that cover all USPSTF grade A and B preventive services and the Advisory Committee on Immunization Practices (ACIP) recommended vaccines.

The EPSDT benefit is Medicaid's comprehensive child health benefit. Under the EPSDT benefit, eligible individuals under age 21 must be provided periodic screening services (well child exams).[9] One required element of this screening is a comprehensive health and developmental history, including assessment of physical and mental health development.

A maternal depression screening can be considered an integral part of a risk assessment for the child, in light of the evidence that maternal depression can place children at risk of adverse health consequences. There are several validated screening tools for depression which are simple to administer and can help identify maternal depression and potential risk to the child.[10] Some of these screening tools are specific to postpartum women and some are more general.

Some states cover maternal depression screening as part of a Medicaid well-child visit. These states may instruct providers to claim for this activity either as a service for the child or for the mother, depending on the mother's Medicaid eligibility. The Centers for Medicare & Medicaid Services (CMS) wishes to clarify that, since the maternal depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the EPSDT benefit. State Medicaid agencies have discretion to determine reimbursement approaches available to the pediatric provider for furnishing the maternal depression screening.

In keeping with the expert recommendations, several state Medicaid agencies have recognized the importance of the maternal depression screening and are allowing providers to perform and bill for this screening as part of the EPSDT well-child visit:

- *Colorado:* The Colorado Department of Health Care Policy and Financing issued Provider Bulletins with guidance on maternal depression screening. Starting January 2014, postpartum depression screening is covered as an annual depression screening and Medicaid primary care providers are encouraged to screen new mothers at a well-child visit using the mother's Medicaid ID number. To facilitate screening in more settings, providers seeing an infant for a well-baby visit are alternatively allowed to bill for the service using the Medicaid ID of the infant.[11]
- *Illinois:* The Illinois Department of Healthcare and Family Services (HFS) covers perinatal depression screening when an approved screening instrument is used. If the postpartum depression screening (for the woman) occurs during a well-child visit or episodic visit for an infant (under age one) covered by HFS' Medical Programs, the screening may be billed as a "risk assessment" under the infant's Medicaid identification number. Alternatively, if the woman is postpartum and covered by HFS' Medical Programs, the postpartum depression screening may be billed under the woman's identification number.[12]
- *North Dakota:* North Dakota Medicaid covers maternal depression screening as a separate service when performed in conjunction with a Health Tracks (EPSDT) screening or any other pediatric visit, and is considered a risk assessment for the child. Up to three maternal depression screenings are allowed for a child under the age of one. Providers are instructed to bill only when one of the standardized screening tools is used and to bill using the child's North Dakota Medicaid ID Number.[13]
- *Virginia:* Virginia covers the Behavioral Health Risks Screening Tool developed for pregnant and non-pregnant women of child-bearing age through the Maternal, Infant, and Early Childhood Home Visiting Program. The state provided information to practitioners on how to bill Medicaid for using the screening tool as well as what treatment services are available to women who screen positive. The Edinburgh Postnatal Depression Anxiety Subscale is used to address depressive symptoms and risk of co-occurring anxiety. Pregnant women are eligible for additional services, including case management

during pregnancy and up to the end of the month following their 60th day post-partum. Infants are eligible for case management services up to their second birthday.[14]

Diagnostic and Treatment Services

If a problem is identified as a result of an EPSDT screen, states have an obligation to arrange for medically necessary diagnostic and treatment services to address the child's needs.[15] Diagnostic and treatment services directed solely at the mother would be coverable under the Medicaid program only if the mother is Medicaid eligible. Mothers who are not Medicaid eligible may receive some benefit from diagnostic and treatment services directed at treating the health and well-being of the child (such as family therapy services) to reduce or treat the effects of the mother's condition on the child. Consistent with current policy regarding services provided for the "direct benefit of the child," such diagnostic and treatment services must actively involve the child, be directly related to the needs of the child and such treatment must be delivered to the child and mother together, but can be claimed as a direct service for the child. Such services also must be coverable under one or more section 1905(a) benefit categories such as rehabilitative services or other licensed practitioner services.

State Medicaid agencies should encourage the child's provider to refer mothers for other appropriate care, including diagnosis, therapy and/or medication. Mothers who are Medicaid eligible should be referred to their primary care providers or other appropriate providers. Mothers who are ineligible for Medicaid, or lose their eligibility 60 days postpartum, can be referred to community resources that offer appropriate mental health services, such as community mental health programs, federally qualified health centers or other programs that may exist in the community. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) offers a behavioral health treatment service locater at https://findtreatment.samhsa.gov/. Eligibility levels for parents in state Medicaid programs vary; in states that have taken up Medicaid's expansion of eligibility to low income adults, significantly greater number of low income mothers will be eligible and can receive comprehensive coverage than in states that have not.

The Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF), funds states, territories and tribal entities to create home visiting evidence-based programs that improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Medicaid coverage authorities offer states the flexibility to provide services in the home, which may improve care and service delivery for eligible pregnant women, parents, and young children. The majority of evidenced-based home visiting programs deliver services such as screening, case management, family support, counseling, and skills training for pregnant women and parents with young children and many of these services are also Medicaid-coverable. CMS issued an Information bulletin on March 2, 2016 describing the intersection between home visiting models and Medicaid[16].

Promoting Maternal Depression Screening Under Medicaid

Generally, experience in states has shown that there is broad agreement that communication to providers about screening tools, Medicaid billing codes, referral options and other information is

central for successful uptake and continued use.[17] States and managed care plans use a variety of approaches to promote maternal depression screening among providers, including:

- Posting information about maternal depression screening on provider websites and publishing information in provider newsletters.
- Delivering provider trainings to promote the use of maternal depression screening tools and proper billing codes.
- Conducting in-person visits to clinics to train providers on how to implement screenings, help practices modify clinic flow, and discuss referral strategies.
- Offering practitioners continuing medical education (CME) credits for participation.

States that elect to cover this service utilizing a managed care delivery system must ensure that the service is appropriately reflected in the managed care plans' contract, and can include performance standards to ensure that the service is widely performed. Activities designed to promote maternal depression screenings among Medicaid providers and to train them on how to incorporate maternal depression screening and treatment into the EPSDT well-child visit are generally eligible for Medicaid administrative matching funds.

Conclusion

Maternal depression can take a substantial toll on the health and well-being of both mothers and children, and can increase related health costs, impede the development of the child, and create negative social consequences. Maternal depression screening during the well-child visit is considered a pediatric best practice and is a simple way to identify mothers who may be suffering from depression and may lead to treatment for the child or referral for mothers to other appropriate treatment. In addition to covering this screening for Medicaid eligible mothers, states may cover maternal depression screening for non-Medicaid eligible mothers during the well-child visit. States may also cover treatment for the mother when both the child and the mother are present, treatment focuses on the effects of the mother's condition on the child, and services are for the direct benefit of the child.

States interested in learning more on this topic and to request technical assistance may contact Kirsten Jensen, Director, Division of Benefits and Coverage at Kirsten.jensen2@cms.hhs.gov.

Endnotes

[1] *Managing Maternal Depression Before and After Birth*, American Academy of Pediatrics, October 25, 2010 Managing Maternal Depression Before and After Birth, American Academy of Pediatrics, October 25, 2010 http://pediatrics.aappublications.org/cgi/reprint/peds.2010-2348v1

[2] Earls, Marian, MD. *Clinical Report – Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice*, American Academy of Pediatrics, 2010 http://pediatrics.aappublications.org/content/early/2010/10/25/peds.2010-2348

[3] Earls, 2010

[4] Veriker, Tracey, Jennifer Macomber, and Olivia Golden, *Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve*, The Urban Institute. August 2010

[5] Maternal Depression Can Undermine the Development of Young Children, Working Paper 8, Center on the Developing Child, Harvard University, December 2009. http://www.developingchild.harvard.edu.

[6] Earls, 2010
[7] Center on the Developing Child, Harvard University, December 2009
[8] http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1#discussion1
[9] Section 1905(r) of the Social Security Act.
[10] *Identifying and Treating Maternal Depression: Strategies and Considerations for Health Plans*, National Institute for Health Care Management Foundation, June 2010. See Table 4. http://www.nihcm.org/pdf/FINAL_MaternalDepression6-7.pdf Tools like the Edinburgh Postpartum Depression Scale and Postpartum Depression Screening Scale have been developed specifically to measure postpartum depression. As part of their recommendation to screen adults for depression in primary care settings, the USPSTF concluded that asking two simple questions, such as those included in the Patient Health Questionnaire-2, may be as effective as more formal instruments.
[11] Colorado Department of Health care Policy and Financing, Provider Bulletins: *Postpartum Depression Screenings and Payment in the Pediatric Primary Care Office* (March 2014) and *Supplement* (August 2014).
[12] *Handbook for Providers of Healthy Kids Services: Policies and Procedures for Healthcare for Children*, Illinois Department of Healthcare and Family Services, January 2015. http://hfs.illinois.gov/html/010915n.html
[13] North Dakota Department of Human Services, Medical Services Division, Medicaid Coding Guideline, effective July 1, 2011, revised June 11, 2013. https://www.nd.gov/dhs
[14] *Reimbursement Efforts to Address Depression Among Pregnant and Postpartum Women*, Colorado Department of Public Health and the Environment, November 2013. https://www.colorado.gov/pacific/sites/default/files/PF_Reimbursement-Efforts-to-Address-Depression-Among-Pregnant-and-Postpartum-Women.pdf
[15] EPSDT – *A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents*, Center for Medicaid and CHIP Services, CMS, June 2014 https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/epsdt_coverage_guide.pdf
[16] *Coverage of Maternal, Infant, and Early Childhood Home Visiting Services*. Center for Medicaid and CHIP Services, CMS, March 2016. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-02-16.pdf
[17] *Reimbursement Efforts to Address Depression Among Pregnant and Postpartum Women*, Colorado Department of Public Health and the Environment, November 2013. https://www.colorado.gov/pacific/sites/default/files/PF_Reimbursement-Efforts-to-Address-Depression-Among-Pregnant-and-Postpartum-Women.pdf

Edinburgh Postnatal Depression Scale (EPDS)

Date:_____ Clinic Name/Number:_____

Your Age:_____ Weeks of Pregnancy/Age of Baby:_____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK** (✔) on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—*not just how you feel today.* Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, *call your health care provider regardless of your score.*

Below is an example already completed.

I have felt happy:
Yes, all of the time ____ (0)
Yes, most of the time ✔ (1)
No, not very often ____ (2)
No, not at all ____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

1. I have been able to laugh and see the funny side of things:
   As much as I always could ____ (0)
   Not quite so much now ____ (1)
   Definitely not so much now ____ (2)
   Not at all ____ (3)

2. I have looked forward with enjoyment to things:
   As much as I ever did ____ (0)
   Rather less than I used to ____ (1)
   Definitely less than I used to ____ (2)
   Hardly at all ____ (3)

3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time ____ (3)
   Yes, some of the time ____ (2)
   Not very often ____ (1)
   No, never ____ (0)

4. I have been anxious or worried for no good reason:
   No, not at all ____ (0)
   Hardly ever ____ (1)
   Yes, sometimes ____ (2)
   Yes, very often ____ (3)

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot ____ (3)
   Yes, sometimes ____ (2)
   No, not much ____ (1)
   No, not at all ____ (0)

6. Things have been getting to me:
   Yes, most of the time I haven't been able to cope at all ____ (3)
   Yes, sometimes I haven't been coping as well as usual ____ (2)
   No, most of the time I have coped quite well ____ (1)
   No, I have been coping as well as ever ____ (0)

7. I have been so unhappy that I have had difficulty sleeping:
   Yes, most of the time ____ (3)
   Yes, sometimes ____ (2)
   No, not very often ____ (1)
   No, not at all ____ (0)

8. I have felt sad or miserable:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Not very often ____ (1)
   No, not at all ____ (0)

9. I have been so unhappy that I have been crying:
   Yes, most of the time ____ (3)
   Yes, quite often ____ (2)
   Only occasionally ____ (1)
   No, never ____ (0)

10. The thought of harming myself has occurred to me:*
    Yes, quite often ____ (3)
    Sometimes ____ (2)
    Hardly ever ____ (1)
    Never ____ (0)

TOTAL YOUR SCORE HERE ▶ ____

*** If you scored a 1, 2 or 3 on question 10, PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) OR GO TO THE EMERGENCY ROOM NOW** to ensure your own safety and that of your baby.

If your total score is 11 or more, you could be experiencing postpartum depression (PPD) or anxiety. **PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) now** to keep you and your baby safe.

If your total score is 9-10, we suggest you **repeat this test in one week or call your health care provider** (OB/Gyn, family doctor or nurse-midwife).

If your total score is 1-8, new mothers often have mood swings that make them cry or get angry easily. Your feelings may be normal. However, if they worsen or continue for more than a week or two, call your health care provider (OB/Gyn, family doctor or nurse-midwife). Being a mother can be a new and stressful experience. Take care of yourself by:

- ▶ Getting sleep—nap when the baby naps.
- ▶ Asking friends and family for help.
- ▶ Drinking plenty of fluids.
- ▶ Eating a good diet.
- ▶ Getting exercise, even if it's just walking outside.

Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.

Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

See more information on reverse. ▶

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the *British Journal of Psychiatry*, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky.

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Studies show that postpartum depression (PPD) affects at least 10 percent of women and that many depressed mothers do not get proper treatment. These mothers might cope with their baby and with household tasks, but their enjoyment of life is seriously affected, and it is possible that there are long term effects on the family.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist health professionals in detecting mothers suffering from PPD; a distressing disorder more prolonged than the "blues" (which can occur in the first week after delivery).

The scale consists of 10 short statements. A mother checks off one of four possible answers that is closest to how she has felt during the past week. Most mothers easily complete the scale in less than five minutes.

Responses are scored 0, 1, 2 and 3 based on the seriousness of the symptom. Items 3, 5 to 10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is found by adding together the scores for each of the 10 items.

Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan. The scale indicates how the mother felt during the previous week, and it may be useful to repeat the scale after two weeks.

INSTRUCTIONS FOR USERS

1. The mother checks off the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or reading difficulties.
5. The scale can be used at six to eight weeks after birth or during pregnancy.

Please note: Users may reproduce this scale without further permission providing they respect the copyright (which remains with the *British Journal of Psychiatry)*, quote the names of the authors and include the title and the source of the paper in all reproduced copies. 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.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry,* 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

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MCPAP For Moms

APPENDIX VI

Table of Contents

This is the MCPAP for Moms toolkit, created to assist front-line perinatal care providers in the prevention, identification and treatment of depression and other mental health concerns in pregnant and postpartum women. This toolkit contains the following:

Funding provided by the Massachusetts Department of Mental Health

MCPAP For Moms

Assessment of Depression Severity and Treatment Options[1]

EPDS SCORE or clinical assessment

EPDS 0-8	EPDS 9-13	EPDS 14-18	EPDS ≥19
SIGNS AND SYMPTOMS OF DEPRESSION * Signs and symptoms in each column may overlap			
LIMITED TO NO SYMPTOMS	MILD SYMPTOMS	MODERATE SYMPTOMS	SEVERE SYMPTOMS
☐ Reports occasional sadness	☐ Mild apparent sadness but brightens up easily	☐ Reports pervasive feelings of sadness or gloominess	☐ Reports continuous sadness and misery
☐ Placid - only reflecting inner tension	☐ Occasional feelings of edginess and inner tension	☐ Continuous feelings of inner tension/ intermittent panic	☐ Unrelenting dread or anguish, overwhelming panic
☐ Sleeps as usual	☐ Slight difficulty dropping off to sleep	☐ Sleep reduced or broken by at least two hours	☐ Less than two or three hours sleep
☐ Normal or increased appetite	☐ Slightly reduced appetite	☐ No appetite - food is tasteless	☐ Needs persuasion to eat
☐ No difficulties in concentrating	☐ Occasional difficulty in concentrating	☐ Difficulty concentrating and sustaining thoughts	☐ Unable to read or converse without great initiative
☐ No difficulty starting everyday activities	☐ Mild difficulties starting everyday activities	☐ Difficulty starting simple, everyday activities	☐ Unable to do anything without help
☐ Normal interest in surroundings & friends	☐ Reduced interest in surroundings & friends	☐ Loss of interest in surroundings and friends	☐ Emotionally paralyzed, inability to feel anger, grief or pleasure
☐ No thoughts of self-reproach, inferiority	☐ Mild thoughts of self-reproach, inferiority	☐ Persistent self-accusations, self-reproach	☐ Delusions of ruin, remorse or unredeemable sin
☐ No suicidal ideation	☐ Fleeting suicidal thoughts	☐ Suicidal thoughts are common	☐ History of severe depression and/ or active preparations for suicide
TREATMENT OPTIONS * Treatment options in each column may overlap			
LIMITED TO NO SYMPTOMS	MILD SYMPTOMS	MODERATE SYMPTOMS	SEVERE SYMPTOMS
		☐ Consider inpatient hospitalization when safety or ability to care for self is a concern	☐ Consider inpatient hospitalization when safety or ability to care for self is a concern
	☐ Consider medication	☐ Strongly consider medication	☐ Strongly consider medication
☐ Therapy for mother ☐ Dyadic therapy for mother/ baby	☐ Therapy for mother ☐ Dyadic therapy for mother/ baby	☐ Therapy for mother ☐ Dyadic therapy for mother/ baby	☐ Therapy for mother ☐ Dyadic therapy for mother/ baby
☐ Community/ social support (including support groups)	☐ Community/ social support (including support groups)	☐ Community/ social support (including support groups)	☐ Community/ social support (including support groups)
☐ Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	☐ Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	☐ Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	☐ Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)
☐ Support with dysregulated baby; crying, sleep, feeding problems ☐ Physical activity	☐ Support with dysregulated baby; crying, sleep, feeding problems ☐ Physical activity	☐ Support with dysregulated baby; crying, sleep, feeding problems ☐ Physical activity	Support with dysregulated baby; crying, sleep, feeding problems ☐ Physical activity
☐ Self-care (sleep, hygiene, healthy diet)	☐ Self-care (sleep, hygiene, healthy diet)	☐ Self-care (sleep, hygiene, healthy diet	☐ Self-care (sleep, hygiene, healthy diet)

[1]Information adapted from: Montgomery SA, Asberg M: A new depression scale designed to be sensitive to change. British Journal of Psychiatry 134:382-389, 1979

Limited or no symptoms of depression → Severe symptoms of depression

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Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women

Assessing Thoughts of Harming Baby

Thoughts of Harming Baby that Occur Secondary to Obsessions/ Anxiety	Thoughts of Harming Baby that Occur Secondary to Postpartum Psychosis / Suspected Postpartum Psychosis
☐ Good insight ☐ Thoughts are intrusive and scary ☐ No psychotic symptoms ☐ Thoughts cause anxiety ↓ Suggests not at risk of harming baby	☐ Poor insight ☐ Psychotic symptoms ☐ Delusional beliefs with distortion of reality present ↓ Suggests at risk of harming baby

Assessing Suicidal Ideation

Lower Risk	Higher Risk
☐ No prior attempts ☐ No plan ☐ No intent ☐ No substance use ☐ Protective factors (what prevents you from acting?)	☐ History of suicide attempt ☐ High lethality of prior attempts ☐ Current plan ☐ Current intent ☐ Substance use ☐ Lack of protective factors (including social support)

Suggests Medication May Not be Indicated	Suggests Medication Treatment Should be Considered
☐ Mild depression based on clinical assessment ☐ No suicidal ideation ☐ Engaged in psycho-therapy or other non-medication treatment ☐ Depression has improved with psychotherapy in the past ☐ Able to care for self/baby ☐ Strong preference and access to psychotherapy	☐ Moderate/severe depression based on clinical assessment ☐ Suicidal ideation ☐ Difficulty functioning caring for self/baby ☐ Psychotic symptoms present ☐ History of severe depression and/or suicide ideation/attempts ☐ Comorbid anxiety dx/sxs

Risk Factors for Postpartum Depression[1]

☐ Personal history of major or postpartum depression ☐ Family history of postpartum depression ☐ Gestational diabetes ☐ Difficulty breastfeeding ☐ Fetal/newborn loss ☐ Lack of personal or community resources ☐ Financial challenges	☐ Complication of pregnancy, labor, delivery or infant health ☐ Teen pregnancy ☐ Unplanned pregnancy ☐ Major life stressors ☐ Violent or abusive relationship ☐ Isolation from family or friends ☐ Substance use/addiction

How to Talk about Perinatal Depression with Moms[1]

- ☐ How are you feeling about being pregnant/a mother?
- ☐ What things are you most happy about?
- ☐ What things are you most concerned about?
- ☐ Do you have anyone you can talk to that you trust?
- ☐ How is your partner doing?
- ☐ Are you able to enjoy your baby?

[1] This guideline has been adapted from materials made available by HealthTeamWorks and the Colorado Department of Public Health and Environment (CDPHE) http://www.healthteamworks.org/guidelines/depression.html.

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Summary of Emotional Complications During Pregnancy and the Postpartum Period

	Baby Blues	Perinatal Depression	Perinatal Anxiety	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder	Postpartum Psychosis
What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.	Depressive episode that occurs during pregnancy or within a year of giving birth.	A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.	Distressing anxiety symptoms experienced after traumatic events(s).	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. May include rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.	Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.
When does it start?	First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.	Most often occurs in the first 3 months postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes.	Immediately after delivery to 6 weeks postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes.	May be present before pregnancy/birth. Can present as a result of traumatic birth. Underlying PTSD can also be worsened by traumatic birth.	1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.	Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hour.
Risk factors	Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeing, sleep problems.	Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss. Dysregulated baby-crying, feeding, sleep problems.	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss. Dysregulated baby – crying, feeding, sleep problems.
How long does it last?	A few hours to a few weeks.	2 weeks to a year or longer. Symptom onset may be gradual.	From weeks to months to longer.	From 1 month to longer.	From weeks to months to longer.	Until treated.
How often does it occur?	Occurs in up to 85% of women.	Occurs in up to 19% of women.	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.	Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.	May occur in up to 4% of women.	Occurs in 1-2 or 3 in 1,000 births.
What happens?	Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of baby blues, but baby blues is a risk factor for postpartum depression.	Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotics symptoms.	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.	Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women).	Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g,. tactile and olfactory) hallucinations. May have moments of lucidity. May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.
Resources and treatment	May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.	For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings. Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications. Additional complementary and alternative therapies options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate.				Requires immediate psychiatric help. Hospitalization usually necessary. Medication is usually indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g., consistent sleep/wake times, help with feedings at night).

[1] Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996)

[2] O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002. [Epub ahead of print]

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Funding provided by the Massachusetts Department of Mental Health

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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Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[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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Depression Screening Algorithm for Obstetric Providers

The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following Glucola test
- If high-risk patient,* 2 weeks postpartum
- 6 weeks postpartum visit

If first EPDS screen → Clinical support staff explains EPDS

If subsequent EPDS screen → Give EPDS to woman to complete

Woman completes the EPDS. Staff tallies score and enters into medical record. Staff informs OB provider of score prior to patient appointment.

EPDS Score

Provider steps are in this purple box

Score <10

Does not suggest depression

Clinical support staff educates woman about the importance of emotional wellness

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org), and we encourage women to engage in social supports. If woman is already in treatment, ensure follow up appointment is scheduled.

Score ≥ 10

Suggests patient is depressed

1. Assess to determine most appropriate treatment (refer to Assessment of Depression Severity and Treatment Options and Key Clinical Considerations documents)

Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).

If antidepressant medication is indicated

1. Screen for bipolar disorder (refer to Bipolar Depression Screen)
2. Refer to Recommended Steps before Beginning Antidepressant Medication Algorithm and Antidepressant Treatment Algorithm
3. Offer psychotherapy

Positive score on question 10

Suggests patient may be at risk of self-harm or suicide

Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.
Immediately assess further:

1. In the past two weeks, how often have you thought of hurting yourself?
2. Have you ever attempted to hurt yourself in the past?
3. Have you thought about how you could harm yourself?

Document assessment and plan in medical record.

If there is a clinical question, call MCPAP for Moms 855-Mom-MCPAP (855-666-6272) or refer to emergency services.

ALWAYS DISCUSS ALL SUPPORT/ TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS

* High-risk = women with a history of Depression or a positive EPDS Score, or those taking or who have taken psychiatric medications.

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Massachusetts Child Psychiatry Access Project
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Depression Screening Algorithm for Obstetric Providers

(with suggested talking points)

The EPDS should be administered during:
- ☐ Initial intake or first obstetrics visit
- ☐ Visit following Glucola test
- ☐ If high-risk patient,* 2 weeks postpartum
- ☐ 6 weeks postpartum visit

The clinical support staff/ provider speak the italicized text

If first EPDS screen

If subsequent EPDS screen

Clinical support staff explains EPDS

Emotional complications are very common during pregnancy and/or after birth. 1 in 7 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact you and your baby's health. ☐ e will be seeing you a lot over the next months and want to support you.

Woman completes the EPDS Staff tallies score and enters into medical record. Staff informs OB provider of score prior to patient appointment.

Give EPDS to woman to complete

EPDS Score

Provider steps are in this purple box

Score <10

Does not suggest depression

Clinical support staff educates woman about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every woman deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Score ≥ 10

Suggests patient is depressed

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

Assess to determine most appropriate treatment (refer to Assessment of Depression Severity and Treatment Options and Key Clinical Considerations documents)

Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).

If antidepressant medication is indicated

1. Screen for bipolar disorder (refer to Bipolar Depression Screen)
2. Refer to Recommended Steps before Beginning Antidepressant Medication Algorithm and Antidepressant Treatment Algorithm
3. Offer psychotherapy

Positive score on question 10

Suggests patient may be at risk of self-harm or suicide

It sounds like you are having a lot of strong feelings. It is really common for women to experience these kinds of feelings. Many effective support options are available. I would like to talk to you more about how you have been feeling recently.

Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.

Immediately assess further:

1. In the past two weeks, how often have you thought of hurting yourself?
2. Have you ever attempted to hurt yourself in the past?
3. Have you thought about how you could harm yourself?

If concerned about the safety of woman/baby: You and you baby deserve for you to feel well. Let's talk about ways we can support you.

Document assessment and plan in medical record. If there is a clinical question, call MCPAP for Moms 855-Mom-MCPAP (855-666-6272) or refer to emergency services.

Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org).

My office staff and I are available to help you and provide ongoing support.

If woman is already in treatment, ensure follow up appointment is scheduled.

ALWAYS DISCUSS ALL SUPPORT/ TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS

* High-risk = women with a history of Depression, a positive EPDS Score, or those taking or who have taken psychiatric medications.

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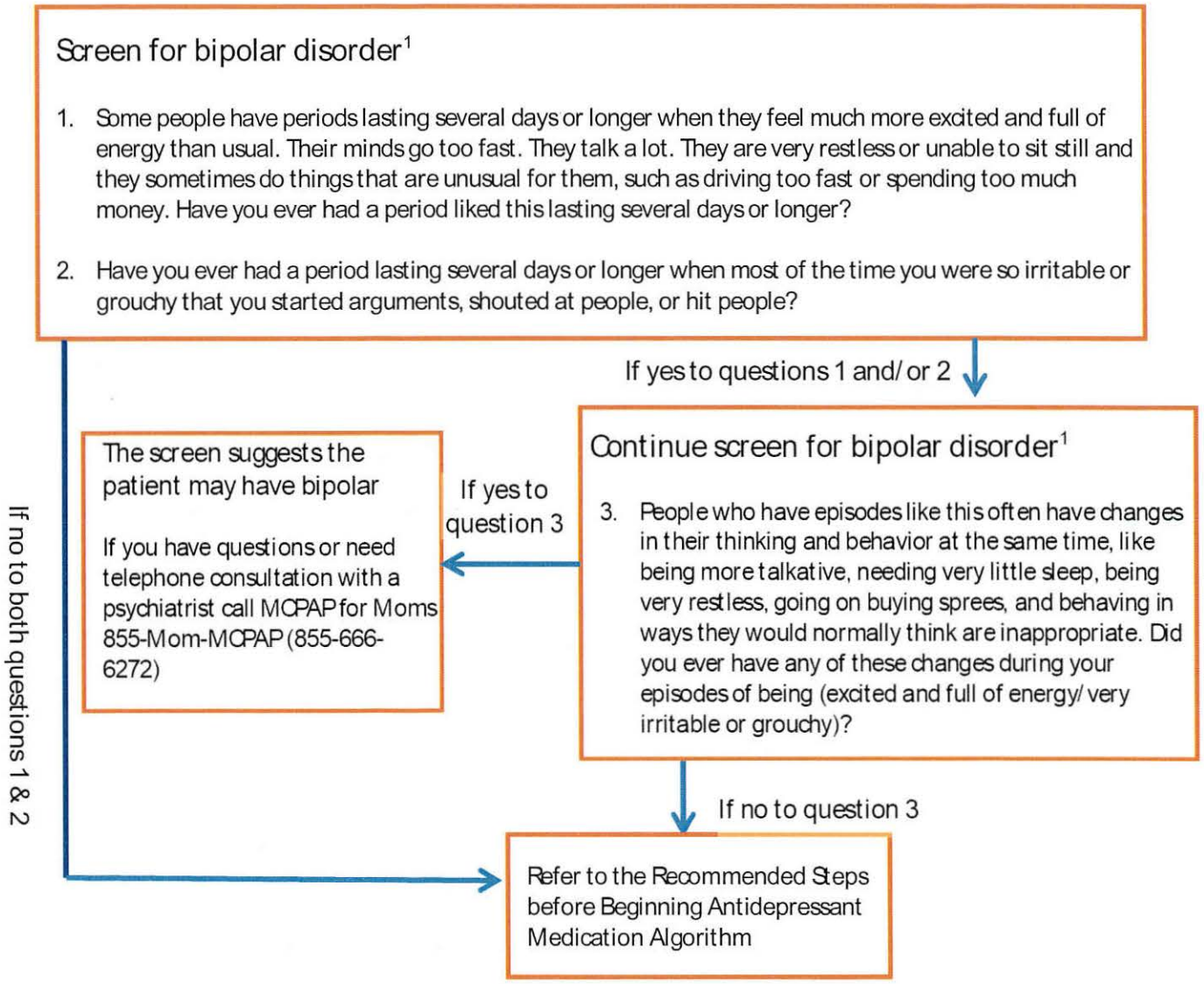
Bipolar Disorder Screen

This algorithm can be used when treatment with antidepressants is indicated, in conjunction with the Depression Screening Algorithm for Obstetric Providers.

In this algorithm, the provider speaks the italicized text and summarizes other text.



CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272

[1]Taken from the Composite International Diagnostic Interview-Based Bipolar Disorder Screening Scale (Kessler, Akiskal, Angst et al., 2006)

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Funding provided by the Massachusetts Department of Mental Health

Massachusetts Child Psychiatry Access Project
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Recommended Steps before Beginning Antidepressant Medication During Pregnancy and Lactation

(Discussion should include yet not be limited to the below)

Counsel patient about antidepressant use:

- ☐ No decision during pregnancy is risk free.
- ☐ Most studies on antidepressant use during pregnancy have examined SSRIs.
- ☐ SSRIs are among the best studied class of medications during pregnancy.
- ☐ Both medication and non-medication options should be considered.
- ☐ Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment and/or as an alternative when clinically appropriate.

Antidepressant use during pregnancy may increase risk of:	Risks of under treatment or no treatment of depression during pregnancy:
☐ Persistent pulmonary hypertension of the newborn (PPHN), but low absolute risk ☐ Pre-term labor ☐ Transient neonatal symptoms ☐ Long-term developmental effects, data are mostly reassuring	☐ Postpartum depression ☐ Pre-eclampsia ☐ Pre-term labor ☐ Substance abuse ☐ Suicide ☐ Poor self-care ☐ Impaired bonding with baby
☐ The preponderance of evidence does not suggest associations with birth defects (with possible exception of paroxetine).	☐ Postpartum depression is associated with negative outcomes for mother, baby, and family.

SEE ANTIDEPRESSANT TREATMENT ALGORITHM ON BACK FOR GUIDELINES RE: PRESCRIBING MEDICATIONS

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272

www.mcpapformoms.org
Tel: 855-Mom-MCPAP (855-666-6272)
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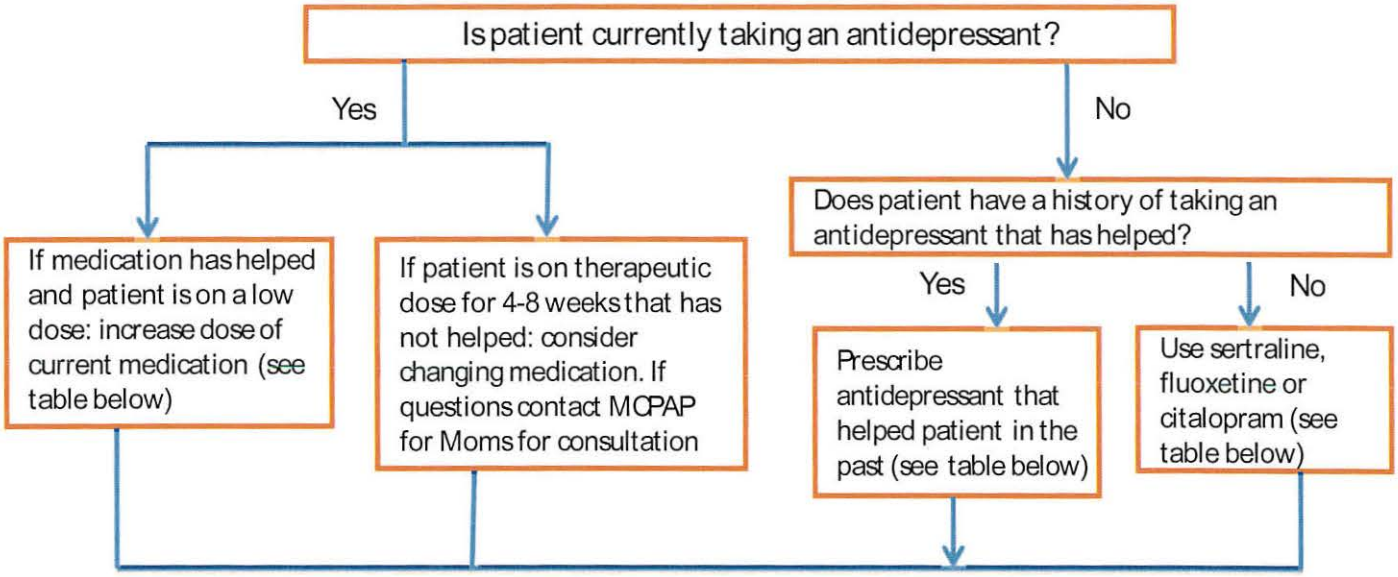
Antidepressant Treatment Algorithm

(use in conjunction with Depression Screening Algorithm for Obstetric Providers)



To minimize side effects, half the recommended dose is used initially for 2 days, then increase in small increments as tolerated.

First line treatment (SSRIs)			
* sertraline (Zoloft) 50-200 mg Increase in 50 mg increments	fluoxetine (Prozac) 20-60 mg Increase in 10 mg increments	citalopram (Celexa) 20-40 mg Increase in 10 mg increments	escitalopram (Lexapro) 10-20mg Increase in 10 mg increments

Second line treatment			
SSRIs	SNRIs	Other	If a first or second line medicine is currently helping, continue it Strongly consider using first or second line medicine that has worked in past
* paroxetine (Paxil) 20-60mg Increase in 10 mg increments	venlafaxine (Effexor) 75-300mg Increase in 75 mg increments	bupropion (Wellbutrin) 300-450mg Increase in 75 mg increments	
* fluvoxamine (Luvox) 50-200mg Increase in 50 mg increments	duloxetine (Cymbalta) 30-60mg Increase in 20 mg increments	mirtazapine (Remeron) 15-45mg Increase in 15 mg increments	

* Considered a safer alternative in lactation as it has the lowest degree of translactal passage and fewest reported adverse effects compared to other antidepressants. In general, if an antidepressant has helped it is best to continue it during lactation.

Reevaluate depression treatment in 2-4 weeks via EPDS & clinical assessment

If no/ minimal clinical improvements after 4-8 weeks

1. If patient has no or minimal side effects, increase dose
2. If patient has side effects, switch to a different med

If you have any questions or need consultation, contact MCPAP for Moms at 855-Mom-MCPAP (855-666-6272)

If clinical improvement and no/ minimal side effects

Reevaluate every month and at postpartum visit. Refer back to patient's provider and/or clinical support staff for psychiatric care once OB care is complete. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.

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MCPAP For Moms

MCPAP for Moms: Promoting Maternal Mental Health During and After Pregnancy

One out of every eight women experience depression during pregnancy or in the postpartum period. Many health care providers are on the front line serving these women and their families, often with limited access to the mental health resources and supports needed to address depression.

MCPAP for Moms is an exciting new statewide program designed to bridge this gap. It is an expansion of the successful Massachusetts Child Psychiatry Access Project (MCPAP), which has improved child mental health care in Massachusetts by offering pediatric primary care providers rapid access to child psychiatry consultation, education, and care coordination. MCPAP for Moms aims to promote maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage depression. Providers working with fathers and other caregivers experiencing postpartum depression can also access MCPAP for Moms.

MCPAP for Moms will have three core components:

- Trainings and toolkits for providers and their staff on evidence-based guidelines for: depression screening, triage and referral, risks and benefits of medications, and discussion of screening results and treatment options.
- Real-time psychiatric consultation and care coordination for providers serving pregnant and postpartum women and their babies including obstetricians, pediatricians, adult primary care physicians, and psychiatrists.
- Linkages with community-based resources including mental health care, support groups and other resources to support the wellness and mental health of pregnant and postpartum women. MCPAP for Moms is partnering with MotherWoman and MSPP Interface Referral Service to develop community resources and link women with depression to these supports across the state.

The MCPAP for Moms phone line 855-Mom-MCPAP (855-666-6272) will open July 1, 2014.

Improving access to and engagement of pregnant and post-partum women in depression treatment leads to improved outcomes for mothers, which leads to better outcomes for babies, children, and families.

For more information about MCPAP for Moms and/or to schedule a training or informational session at your practice, please contact:

MCPAP for Moms Medical Director Nancy Byatt, DO, MBA, FAPM
Nancy.Byatt@umassmemorial.org

MCPAP for Moms Program Director Kathleen Biebel, PhD
Kathleen.Biebel@umassmed.edu

Or visit our website at: www.mcpapformoms.org

MCPAP is funded by the Massachusetts Department of Mental Health

MSPP INTERFACE
Referral Service
at the Massachusetts School of Professional Psychology

Massachusetts Child Psychiatry Access Project
MCPAP
For Moms

How to Find a Primary Care Practitioner

A primary care practitioner (PCP) is typically your first resource when you have a medical concern, including mental health concerns. For the purpose of most health insurance plans, this is also the person to coordinate your care. Your PCP's role is to provide preventive care to you, such as conducting a physical exam. They can also identify and treat common medical concerns, like a cold. It is important that you build a relationship with a PCP. This happens by seeing them over an extended period of time, so they become familiar with your medical history and can help identify specialists that can treat any specific needs that come up. Your PCP can also help optimize your mental health by providing direct treatment and/or ensuring that you receive the mental health care you need and deserve.

How do I start my search for a Primary Care Practitioner?

- Contact your insurance company, either by phone or online, to obtain a list of available practitioners that qualify as PCPs in your area. PCP's can be internal medicine doctors, family practitioners, nurse practitioners or physician assistants. In some cases, a doctor who is an obstetrician/ gynecologist can also be a PCP.
- A personal referral is another good way to identify a PCP. You may want to ask for suggestions from friends or family members that you trust. You can also ask your child's pediatrician or your OB/midwife that helped you during your pregnancy whom they would recommend. When asking for suggestions, consider your own temperament and qualities of the individuals that you have found comforting. A family member or friend who likes someone who is more strict and to the point might not be a good fit for you if you are looking for someone that values spending time with their patients and is more available for questions or concerns.
- State level medical associations, nursing associations or physician assistant associations also maintain lists of who is practicing in your area and can make referrals to providers who are members of the association.

How do I choose a Primary Care Practitioner?

- Making the final decision is up to you. Below are some questions you may want to consider:
  - Do you prefer working with a male or female PCP?
  - Is the age of the PCP or the years of experience important to you?
  - If a PCP is recommended by someone, do you know why they would recommend them?
  - Does this practice or PCP accept your insurance?
  - Is the PCP's office staff or location important?
  - Do you need a PCP who is available to you online so you can access them when you have time rather than during the typical work day?
  - Do you want a PCP who has certain training or experience?
  - What are your current health needs? Are you generally in good health and do not anticipate needing to see your PCP often, or do you have an ongoing medical issue where you may need ongoing support and consultation?
  - Does the PCP offer urgent appointments and who covers when your PCP is away?

What should I do if I don't have health insurance?

- All Massachusetts residents are required to have health insurance. If you are concerned you cannot afford health insurance, you can apply for MassHealth coverage. To apply for MassHealth, call the MassHealth Enrollment Center at 888-665-9993 or go online to download an application at: http://www.mass.gov/eohhs/consumer/insurance/apply-for-masshealth.html
- If you qualify for insurance through your work but have not enrolled because you are concerned about the costs, you may qualify for help for paying your premiums. To learn more about this option visit the Massachusetts Health Connector at: https://www.mahealthconnector.org/
- Having a baby is considered a "qualifying event," which means you can revisit your benefits if you need to change your plan to ensure your baby is covered. If you had insurance available to you through your work but did not take it for yourself, you can now choose to enroll to cover yourself and your baby.
- You can also talk with the hospital at the time of delivery to ensure that your child has MassHealth if you do not have other insurance. At the time of delivery, you can also enroll in MassHealth as well.
- If you are just not sure where to turn or you need help in applying, contact Health Care for All, which has a free helpline available Monday through Friday from 9am to 5pm at 1-800-272-4232 or contact them at their website: https://www.hcfama.org/

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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 and/or baby.
- ☐ If you have experienced strong feelings that could include thoughts about hurting yourself or your baby, seeing or hearing things that aren't there or worrying that people may be out to get you or want to hurt you. If you are experiencing these kinds of feelings, it is important that you call your health care provider right away or go to the emergency room to seek help.

How do I prepare to talk with my health care provider?

- ☐ Start a list of specific things that are concerning you and how they affect your life. Include any questions and details about any previous mental health concerns. This will help ensure that you do not forget anything and that your questions are answered.
- ☐ Consider asking someone to attend your appointment with you like a family member or friend. You may hear a lot of new information and it can help to have someone with you so you do not miss anything.
- ☐ If you feel at any point that your provider is not hearing your concerns, let them know that you feel as if they are not hearing you. You also can also ask to speak with a different health care provider.

What will happen when I talk to my health care provider?

- ☐ They may talk with you to better understand the experiences you are having. This will allow him/her to offer you the most appropriate resources or treatment for your situation.
- ☐ They may suggest that you meet with a therapist to support you and help you learn how to cope with the intense emotional experiences that you may be experiencing.
- ☐ They may refer you to a support group to help you connect with other new mothers having similar experiences.
- ☐ They may discuss medication as a treatment option. If you took medication prior to becoming pregnant, talk with your provider about whether they would recommend that you stay on the medication during pregnancy.

Having a baby is always challenging and every woman deserves support.

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