Improving health care systems to promote maternal mental health: A Massachusetts statewide initiative

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Nancy Byatt, D.O., M.B.A. & Kathleen Biebel, Ph.D.

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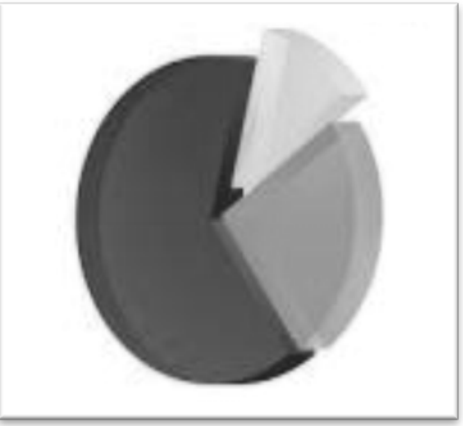
Massachusetts Child Psychiatry Access Project

MCPAP

For Moms



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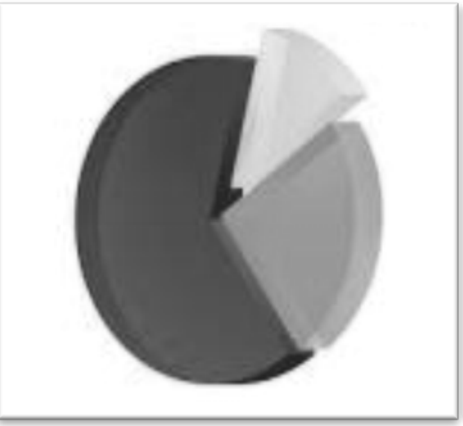

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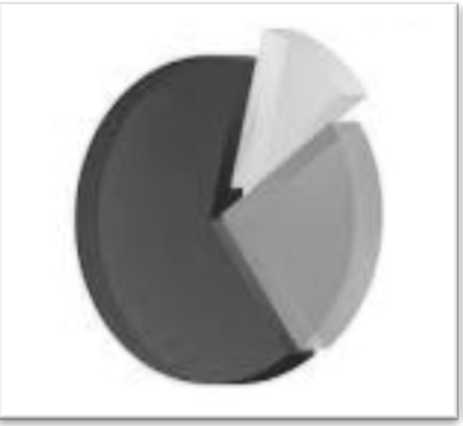

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1 in 8 women suffer from perinatal depression

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

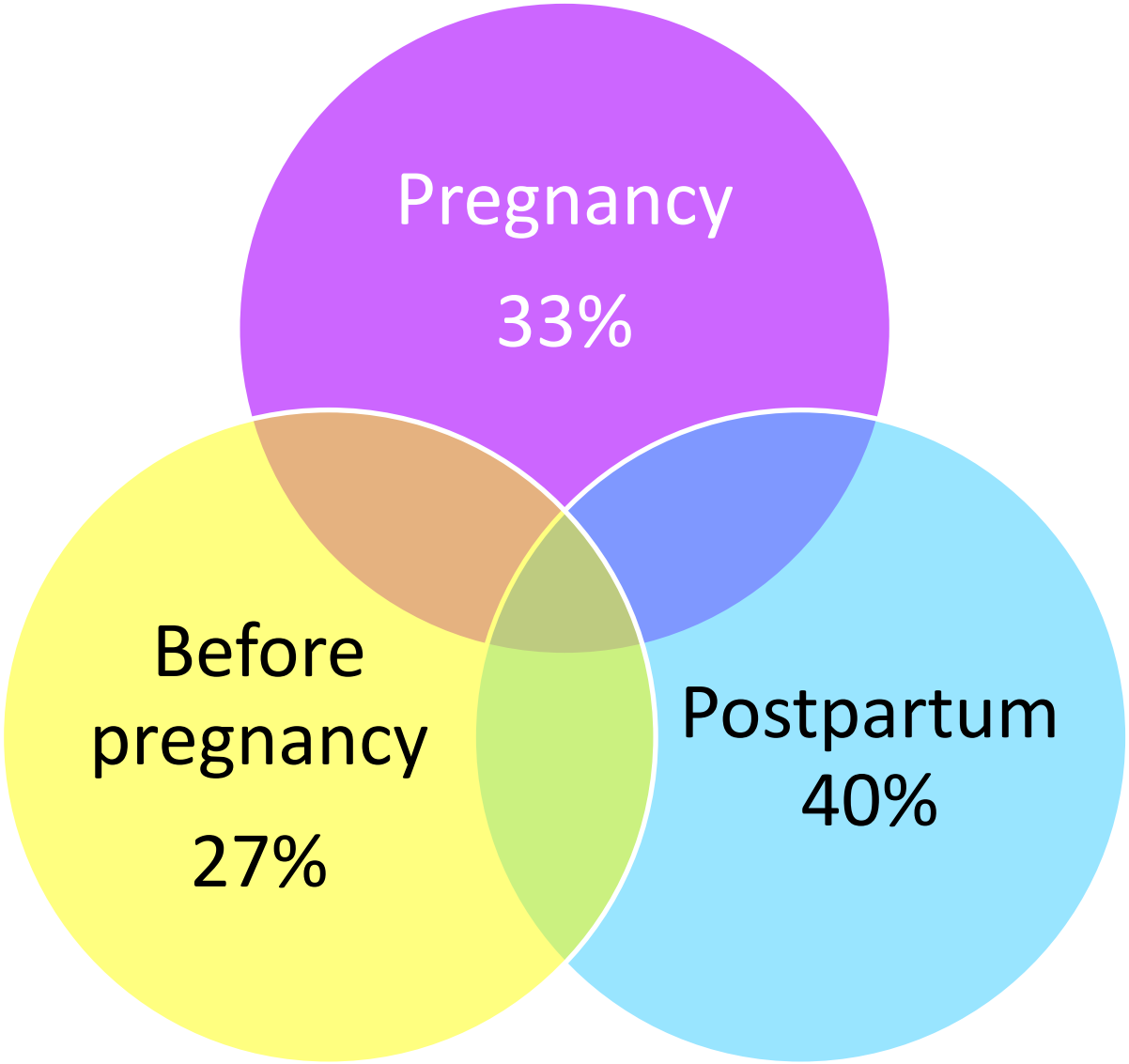
Perinatal depression is twice as common as gestational diabetes

Depression
10-15 in 100

Diabetes
3-7 in 100

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

Two-thirds of perinatal depression begins before birth



Wisner et al. JAMA Psychiatry 2013

Perinatal depression effects mom, child & family

Poor health care
Substance abuse
Preeclampsia
Maternal suicide

Low birth weight
Preterm delivery
Cognitive delays
Behavioral problems

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

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

Generation 0
Childhood impact

Maternal depression

Generation 1
Childhood impact

Maternal depression

Generation 2
Childhood impact

Maternal depression

Generation 3
Childhood impact

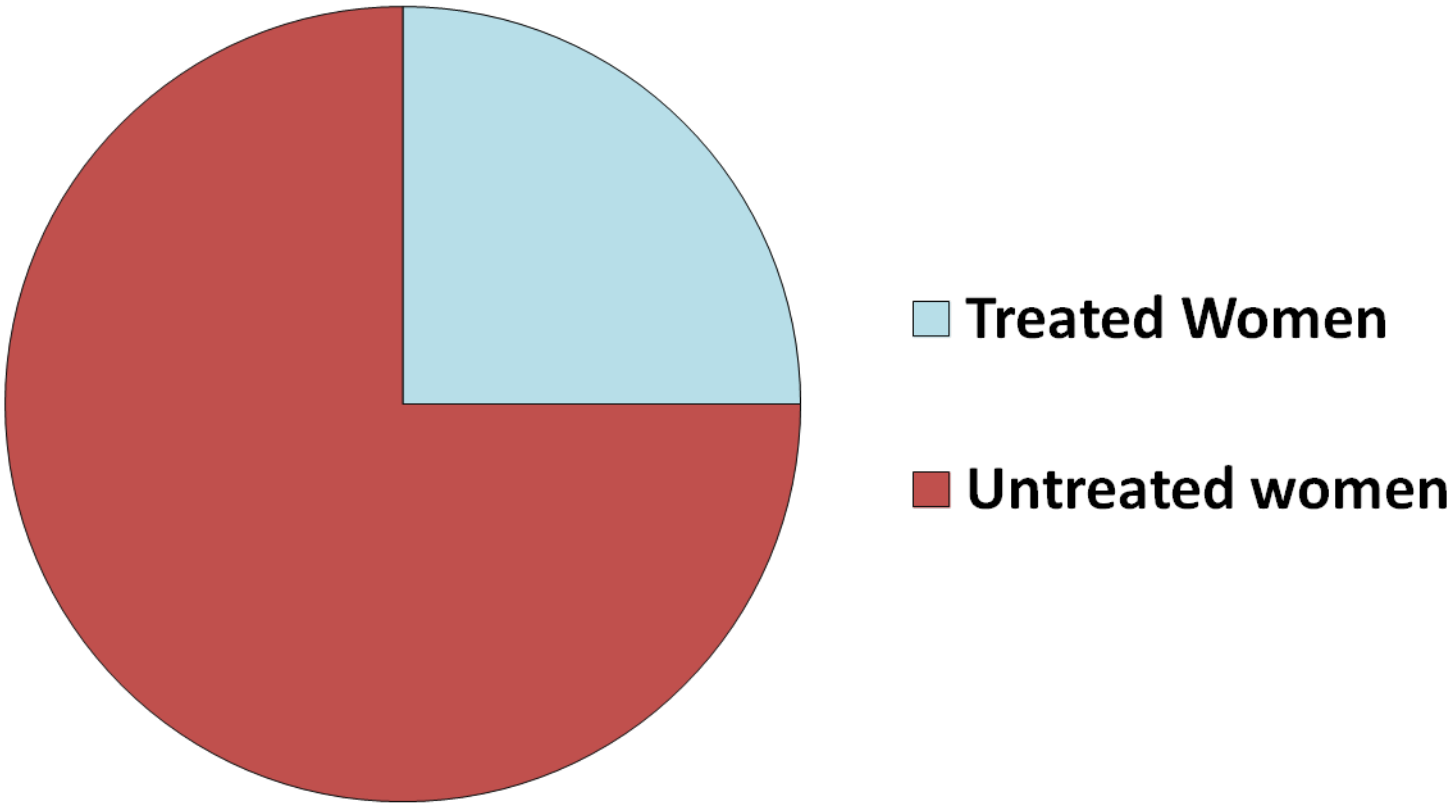
Maternal depression

Generation 4
Childhood impact

Maternal depression

Adapted from slide created by Allain Gregoire, DRCOG, MRCPsych

Perinatal depression is under-diagnosed and under-treated



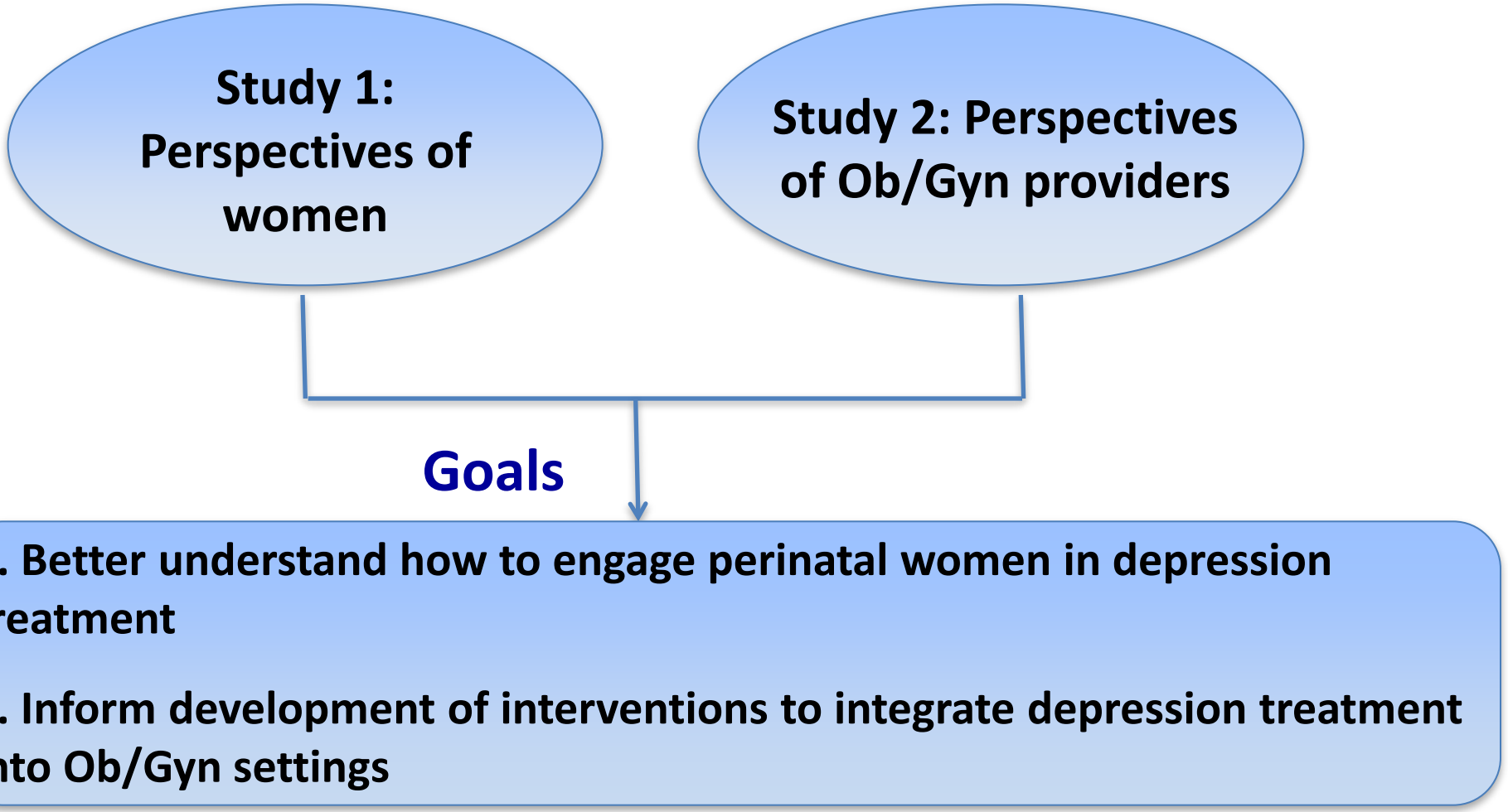
Carter et al. (2005). *Australian and New Zealand Journal of Psychiatry*, *39*(4), 255–261; Marcus et al. (2003). *Journal of womens health 2002*, *13*(1), 373–380. Smith et al. (2009). *General hospital psychiatry*, *31*(2), 155–62.

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

- Regular opportunities to screen and engage women in treatment
- 80% of depression is treated by primary care providers
- Front line providers have a pivotal role

Transforming obstetrical practice to include depression care could provide a solution

We conducted qualitative studies to understand how depression could be addressed in Ob/Gyn settings



Women with perinatal depression experience multiple barriers to receiving mental health care

Fear, stigma and shame

Lack of resources and supports

Negative interactions with providers

Providers lack of knowledge about mental health care

Byatt et al. 2014 General Hospital Psychiatry.

“I’m telling you the god’s honest truth, the person who screened me said, ‘Well, you have a happy, healthy baby. What else do you want?’ ”

Byatt et al. 2014. General Hospital Psychiatry.

Women with perinatal depression are clear on what would be helpful

Ob/Gyn providers to integrate depression into obstetric care

Authentic and validating conversation

Access to resources and supports in Ob/Gyn settings

Byatt et al. 2014 General Hospital Psychiatry.

Obstetric providers have numerous challenges when considering maternal mental health

Limited resources and time constraints

Mental health beyond scope of services

Discomfort with mental health issues

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

“There [are] patients that come in and say, ‘I’m depressed. I have PTSD. I’ve been raped.’ … the basics of how to kind of approach that, how to respond…. I would like to talk about it more, but I do not know where to start. Oh crap, that really sucks, I don’t know.”

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Training, integrated systems, and access to mental health providers can support obstetric providers

Targeted provider training

Learning engagement techniques

Structured screening and referral

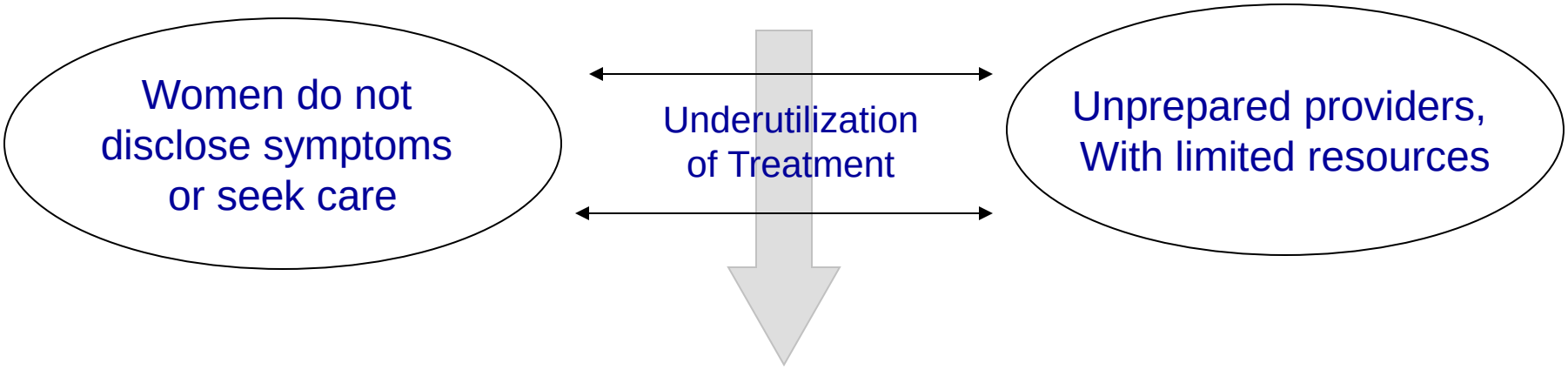
Integrated OB and depression care

Immediate back up from mental health providers

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

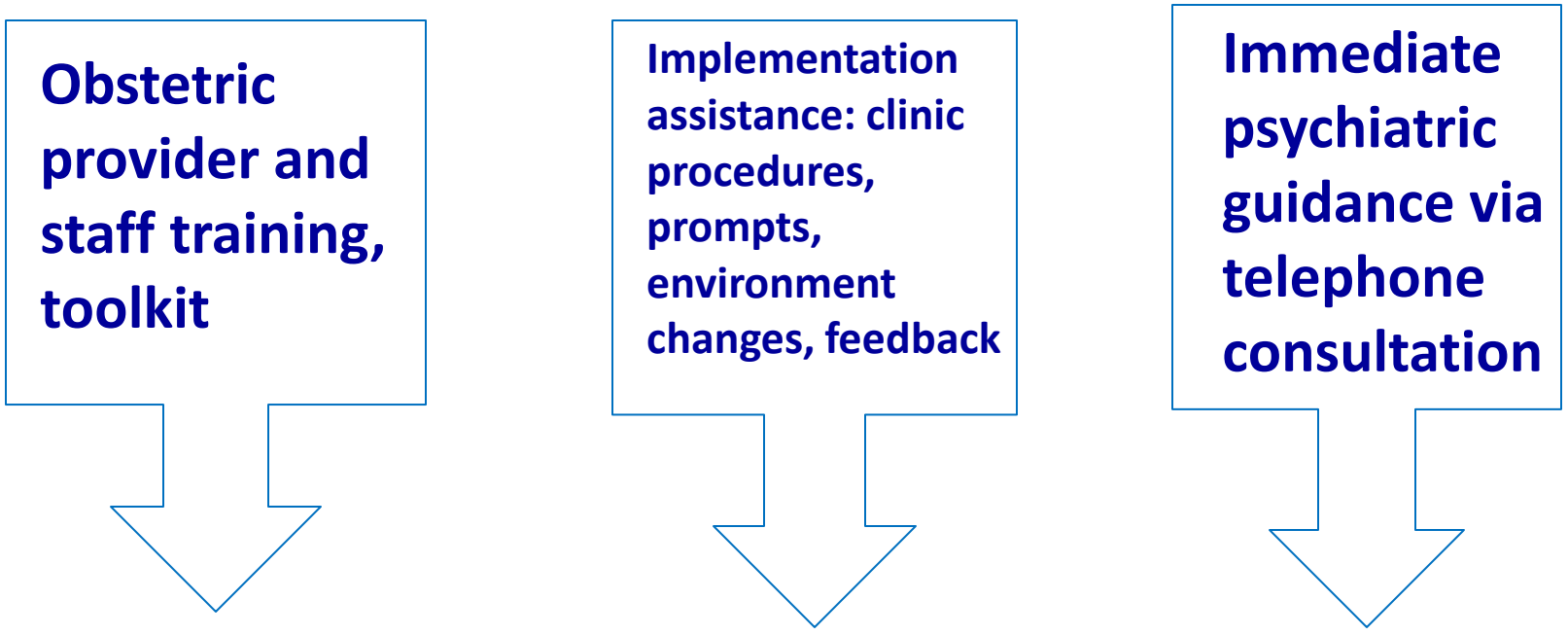
Barriers to Treatment

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



Poor Outcomes

In response, we developed the Rapid Access to Perinatal Psychiatric Care in Depression Program (RAPPID)



RAPPID Intervention Development

Established multidisciplinary working group and developed timeline

Developed RAPPID program components via iterative process

Prepared for beta implementation

Beta-tested RAPPID in one clinic site

Elicited feedback on beta version

Finalized RAPPID components and products for pilot implementation study

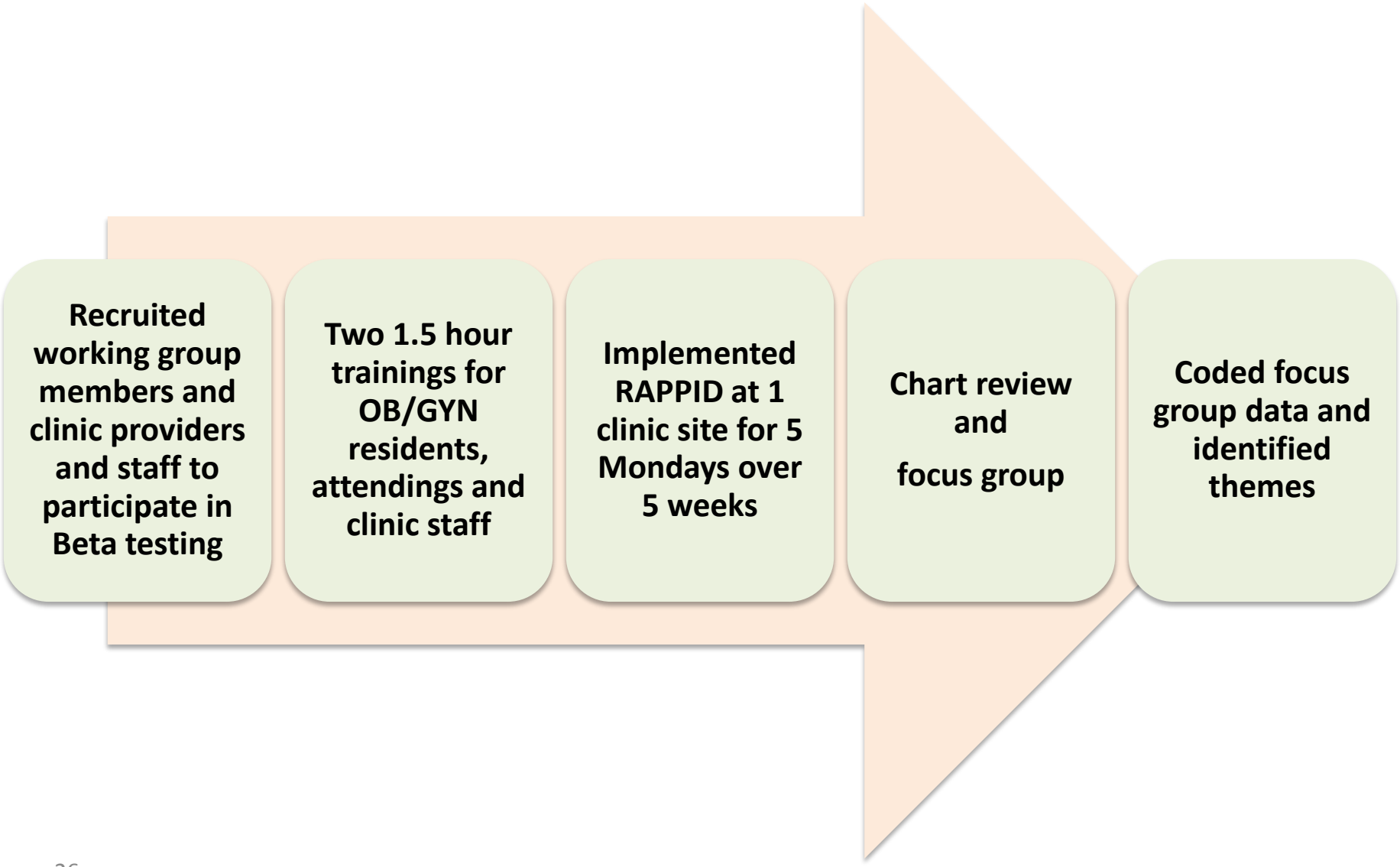
We established and obtained iterative feedback from a multidisciplinary working group

We recruited psychiatric and perinatal health care professionals from one Ob/Gyn clinic site

Obtained iterative feedback on the core program components and uncovered barriers and facilitators to implementation of RAPPID over a period of 8 months

Iterative feedback from advisory group and MCPAP leadership

We trained Ob/Gyn providers and staff and Beta tested RAPPID



In 2010, Massachusetts passed a Postpartum Depression Act

PPD Commission

MCPAP for Moms Funding

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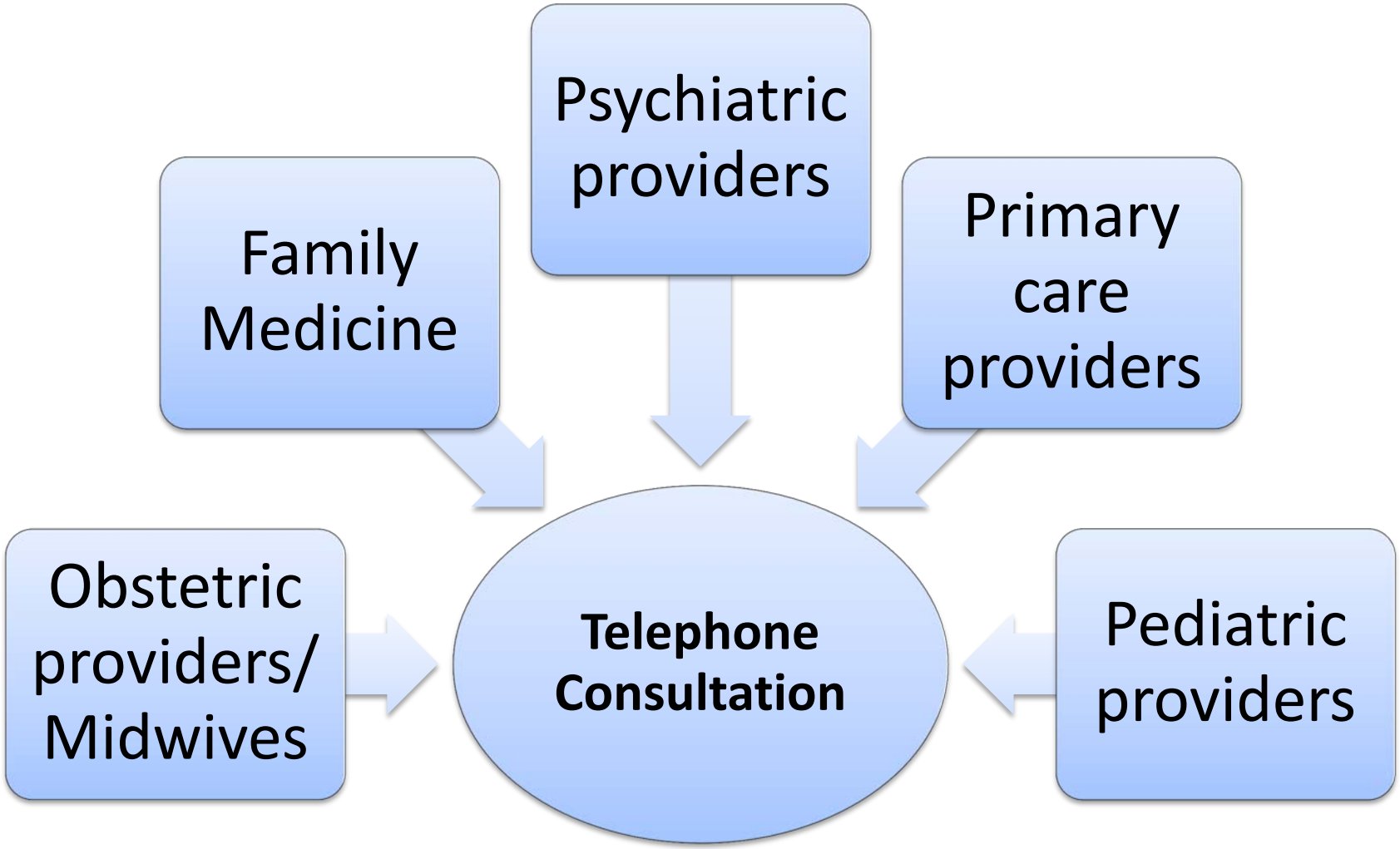
Education

855-Mom-MCPAP

Care Coordination

Providers can call for patient consultations



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Telephone Consultation

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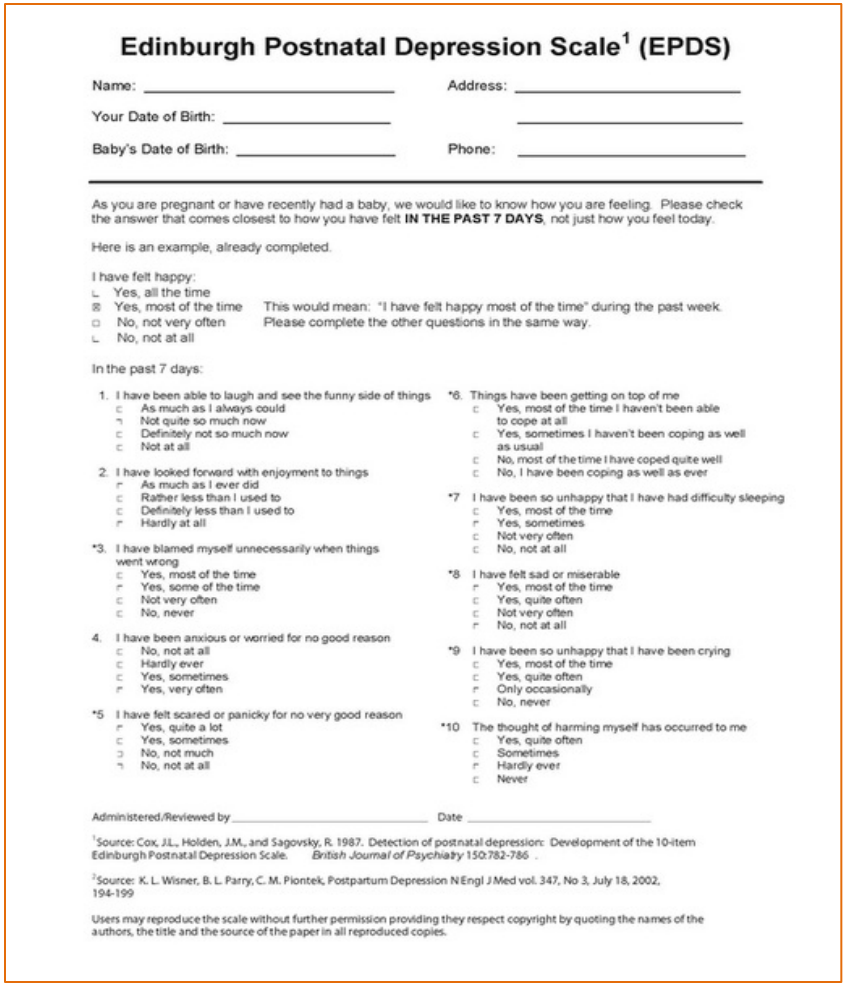
Telephone Consultation

Edinburgh Postnatal Depression Scale (EPDS)

Validated in pregnancy and postpartum

10 items

Asks about self-harm



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

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

Here is an example, already completed.

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

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

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

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

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

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

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

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

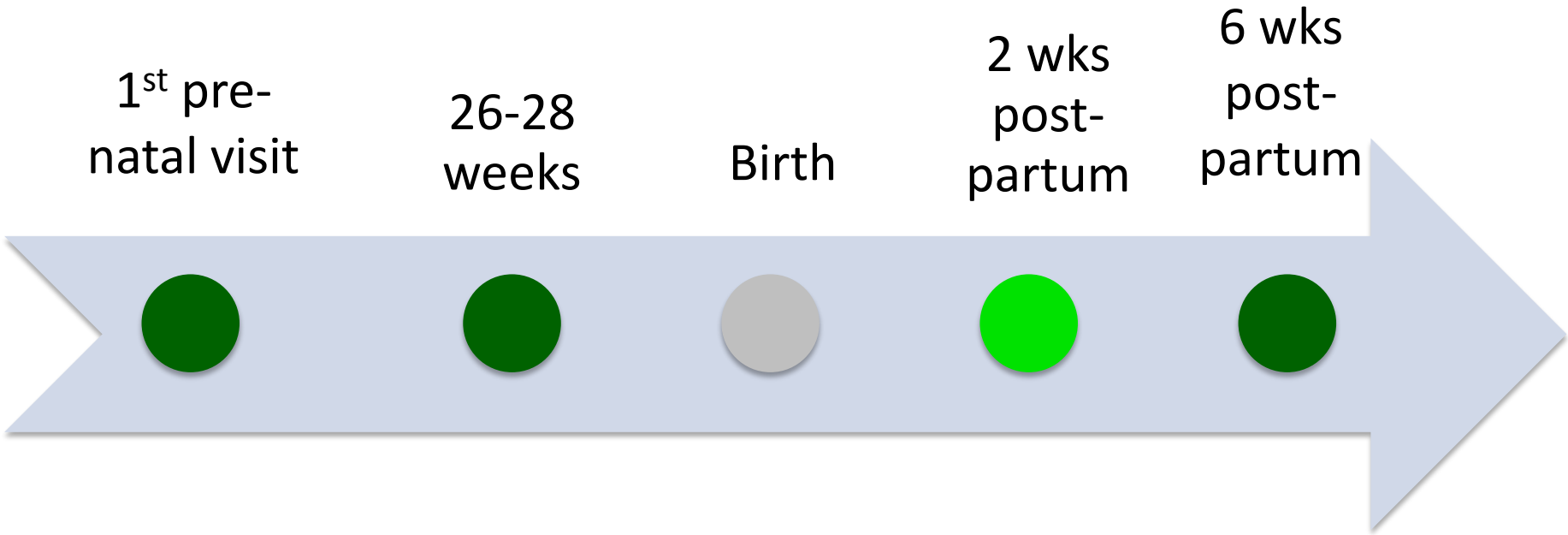
*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

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

Administered/Reviewed by _____ Date _____

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

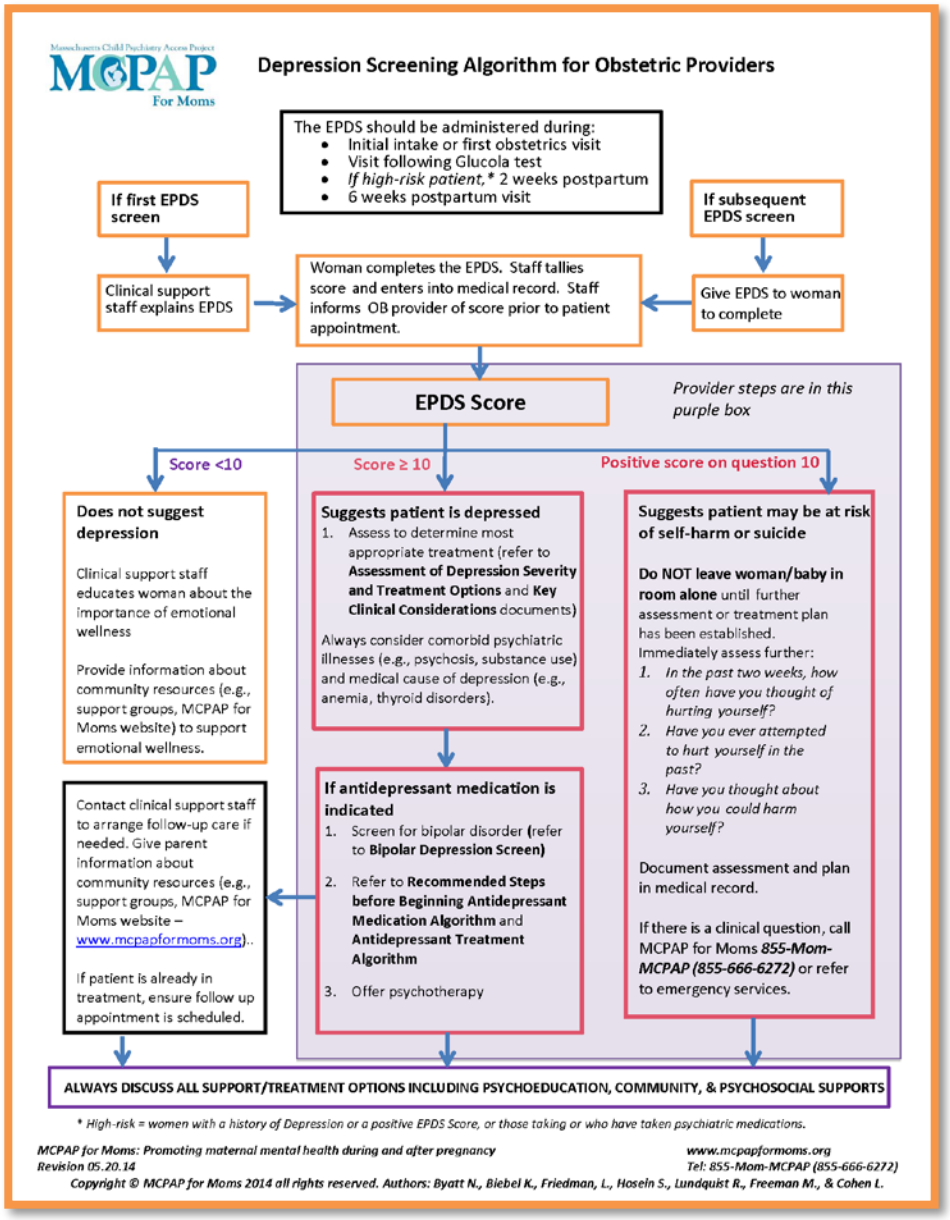
[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199



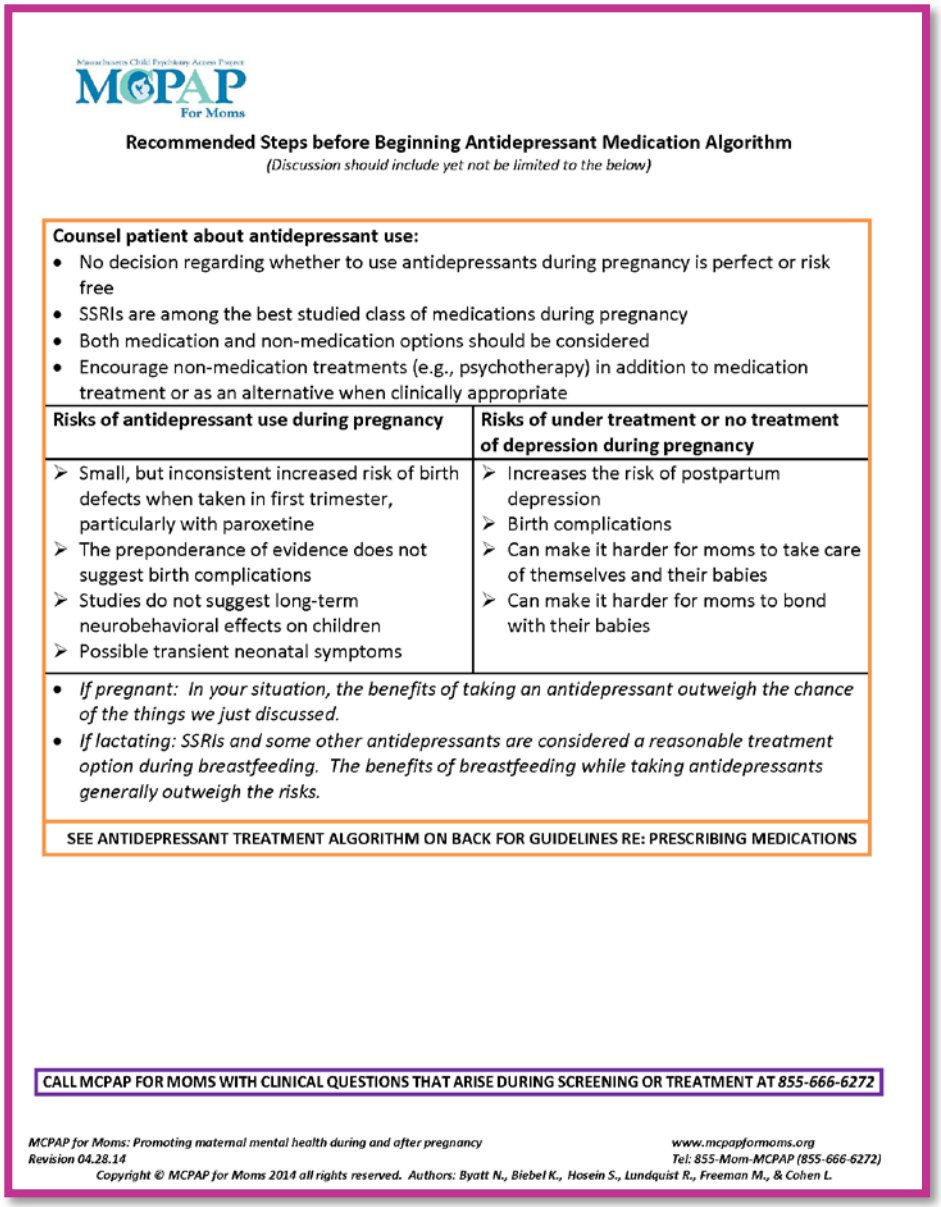
Administer Edinburgh Postnatal Depression Scale

Administer EPDS for high-risk patients

Screening - Algorithm for Obstetric Providers



Treatment - Recommended Steps Before Beginning Antidepressant Treatment



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Recommended Steps before Beginning Antidepressant Medication Algorithm

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

Counsel patient about antidepressant use:

- No decision regarding whether to use antidepressants during pregnancy is perfect or risk free
- 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 or as an alternative when clinically appropriate

Risks of antidepressant use during pregnancy	Risks of under treatment or no treatment of depression during pregnancy
➢ Small, but inconsistent increased risk of birth defects when taken in first trimester, particularly with paroxetine ➢ The preponderance of evidence does not suggest birth complications ➢ Studies do not suggest long-term neurobehavioral effects on children ➢ Possible transient neonatal symptoms	➢ Increases the risk of postpartum depression ➢ Birth complications ➢ Can make it harder for moms to take care of themselves and their babies ➢ Can make it harder for moms to bond with their babies

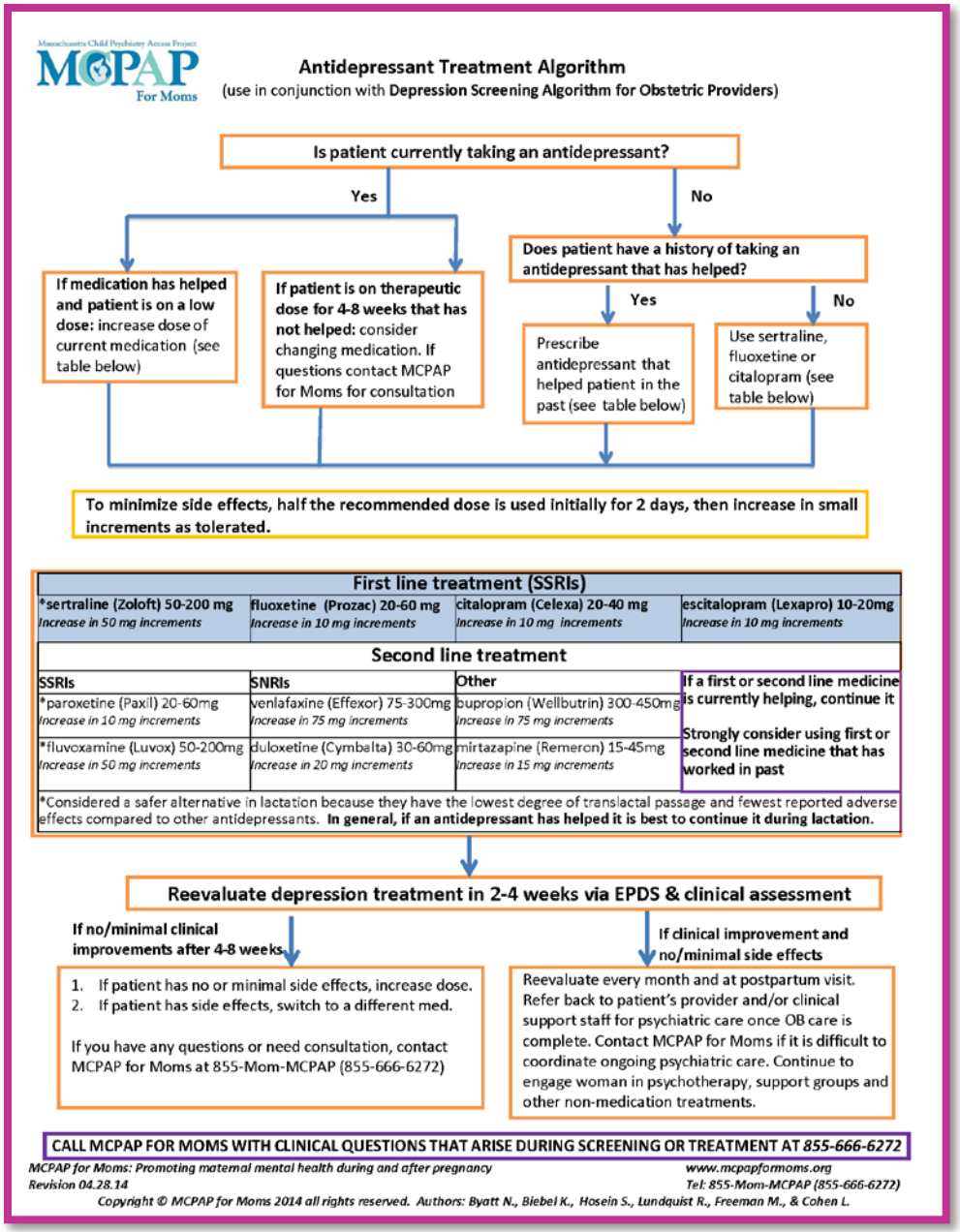
- *If pregnant: In your situation, the benefits of taking an antidepressant outweigh the chance of the things we just discussed.*
- *If lactating: SSRIs and some other antidepressants are considered a reasonable treatment option during breastfeeding. The benefits of breastfeeding while taking antidepressants generally outweigh the risks.*

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*

MCPAP for Moms: Promoting maternal mental health during and after pregnancy
Revision 04.28.14
www.mcpapformoms.org
Tel: 855-Mom-MCPAP (855-666-6272)

Treatment - Antidepressant Treatment Algorithm



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

Is patient currently taking an antidepressant?

Yes

If medication has helped and patient is on a low dose: increase dose of current medication (see table below)

If patient is on therapeutic dose for 4-8 weeks that has not helped: consider changing medication. If questions contact MCPAP for Moms for consultation

No

Does patient have a history of taking an antidepressant that has helped?

Yes

Prescribe antidepressant that helped patient in the past (see table below)

No

Use sertraline, fluoxetine or citalopram (see table below)

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**
*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*	**Strongly consider using first or second line medicine that has worked in past**
*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 because they have 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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Revision 04.28.14 *Tel: 855-Mom-MCPAP (855-666-6272)*

Education about various treatment and support options is imperative

Ask women what type of treatment they prefer

There are effective options for treatment during pregnancy and breastfeeding.

Depression is very common during pregnancy and the postpartum period.

There is no risk free decision.

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

Linkages with support groups and community resources

Support the wellness and mental health of perinatal women

Can refer moms to www.mcpapformoms.org

MCPAP for Moms has served many providers and parents in our first five months (July-Nov, 2014)

OB Practices Enrolled	26
Trainings (including 7 community trainings)	57
Women Served	194
Doc-doc Telephone Encounters	172
Face to Face Evaluations	21
Care Coordination Encounters	142
Telephone Encounters with Ob/Gyns and Midwives	122
Telephone Encounters with Psychiatric Providers	26
Telephone Encounters with Other Providers	25
PPD Coalition Started	6
Support Groups Available	139

Provider and parent feedback has been overwhelmingly positive

"Your program is awesome."–Perinatal woman

"I love this service! I am going to call every day."
–Obstetric provider

"It's kind of amazing that I can just call you guys and you're there."–Obstetric provider

"It was perfect! I plan to have them come here and train us so we can all use it."–Family Medicine provider

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

Please contact us for more information

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Thank you!