Optimizing Maternal Mental Health

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Disclosure Statement
Nancy Byatt, D.O., M.B.A.
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With respect to the following presentation, there has been no relevant financial relationship between the party listed above (and/or spouse/partner) and any company within the past 24 months which could be considered a conflict of interest.

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Roadmap of presentation

1) What we know about parenting and mental health (Kate)

2) What we know about women and perinatal mental health (Nancy)

3) What we learned from recent studies of perinatal Depression (Kate)

4) How these studies inform the work and next steps (Nancy)

The parental role is critical to women living with mental illness

- Individuals with serious mental illness are living in the community and fulfilling traditional adult roles, including the role of parent (Bybee, Mowbray, Oyserman,& Lewandowski, 2003)

- Parents identify not being able to parent their children as compromising their well-being, and impeding recovery

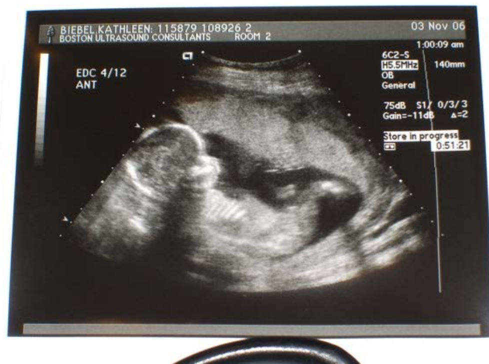
  (Mowbray, Schwartz, Bybee, et al., 2000)

- Mothers report receiving few or no services related to parenting (Mowbray, Oyserman, Bybee, et al., 2001)

Maternal mental health is a continuum

Traditional maternal mental health

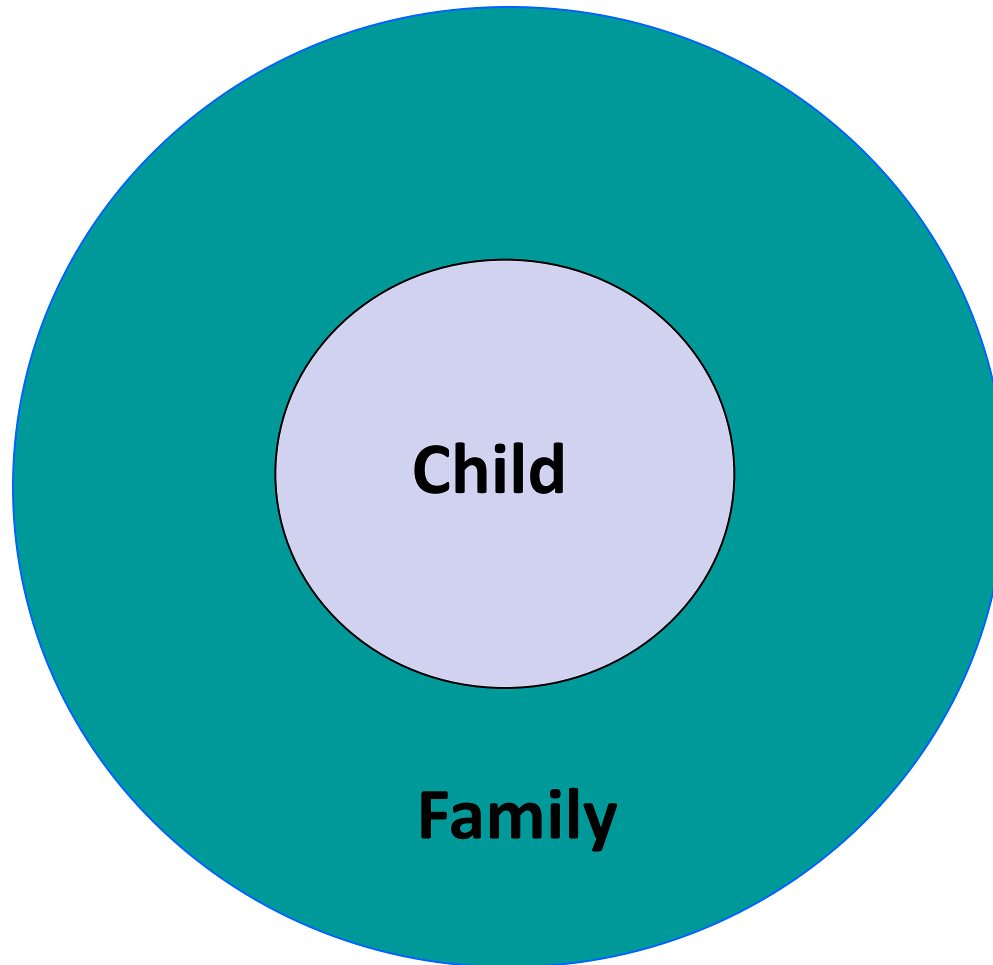
Focus on mid-pregnancy to 28 days after birth



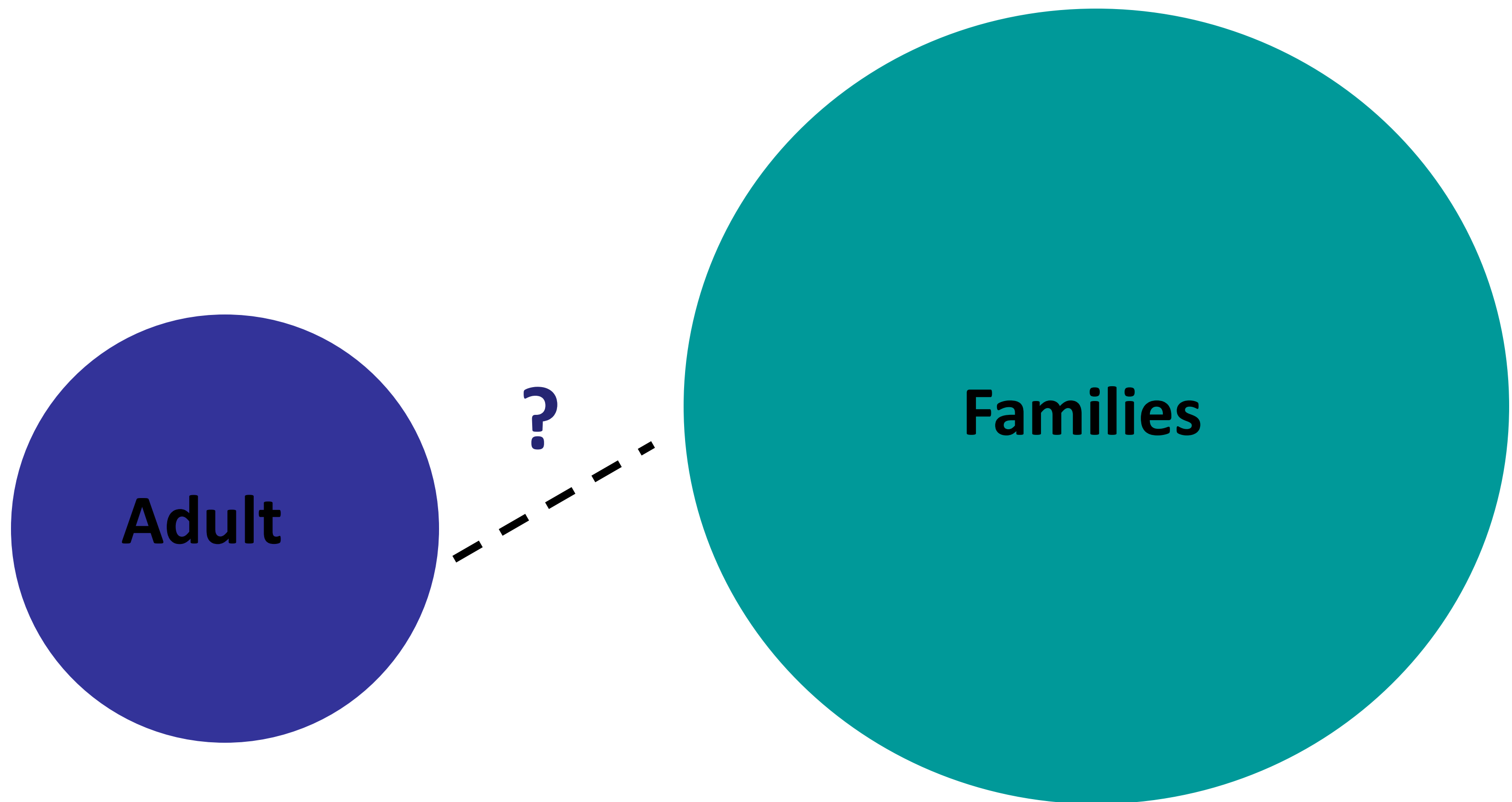
A new paradigm

A continuum of mental health. Include all of pregnancy and up to several years after birth and beyond

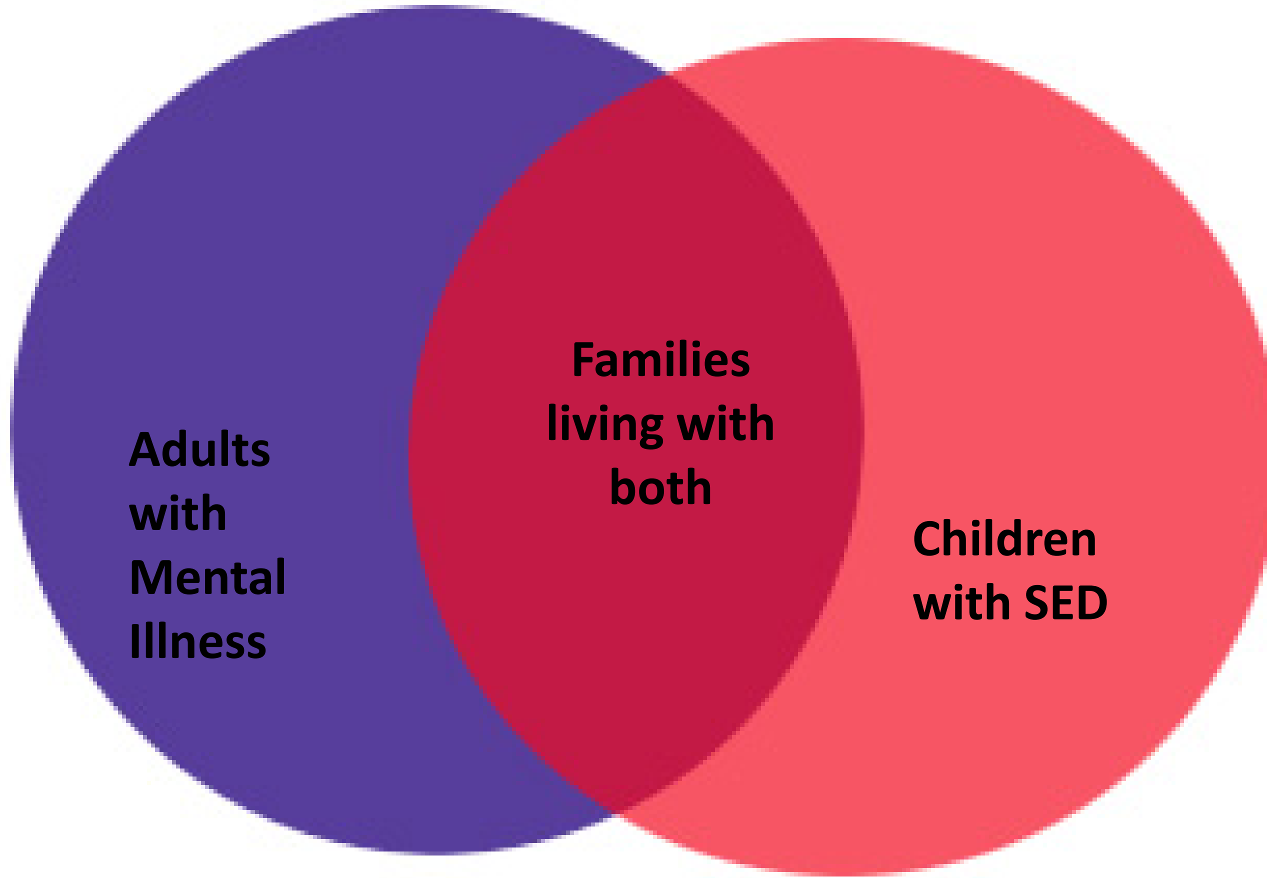
Child services/systems think more about families



Adult services/systems are disconnected from family issues



Families often have overlapping issues & needs



What we know about parenting and mental health

a) high prevalence

b) few policies and programs

How many parents with mental illness are there?

Majority of adults with mental illness are parents

Lifetime prevalence of disorder (Kessler et al, 1994)

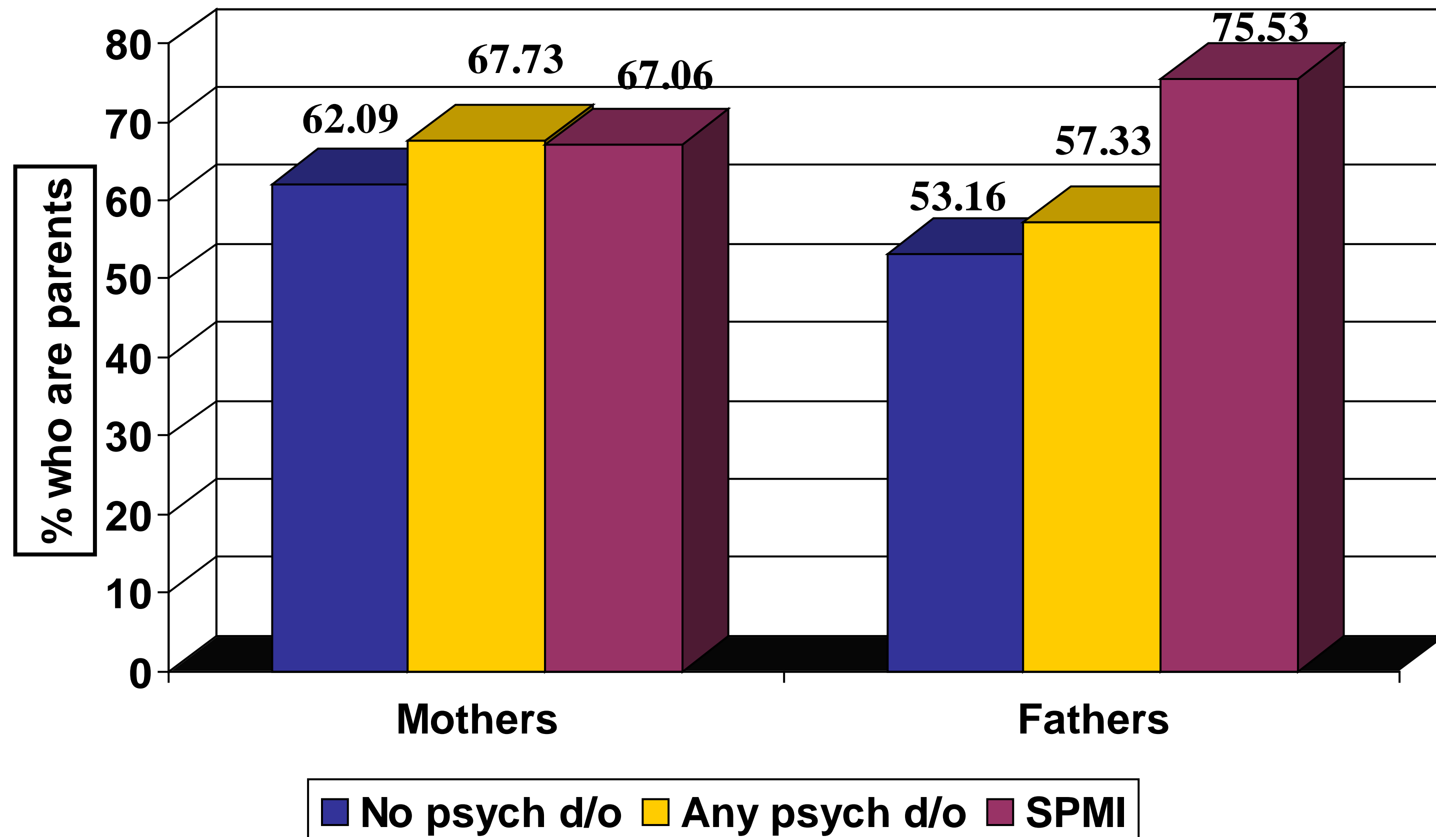
- 45% of American women
- 30% of American men

Prevalence of parenthood (Nicholson et al, 2000)

- 68% of women with disorders are mothers
- 57% of men with disorders are fathers

High prevalence of parenthood

no diagnosis v. any diagnosis v. serious persistent MI



Women and men with a lifetime prevalence of psychiatric disorder are at least as likely to be parents as are adults without psychiatric disorder.

High prevalence of parenthood across diagnostic categories

Disorders	% Women = Mothers	% Men = Fathers
Affective	67%	58%
Anxiety	68%	56%
PTSD	73%	68%
Psychosis	62%	55%

The majority of adults in all diagnostic categories are parents, including those meeting criteria for affective and anxiety disorders, PTSD, and non-affective psychosis.

How many children have a parent with a mental illness?

The average number of children is about 2.2.

49% of children have a mother with a lifetime prevalence of psychiatric disorder; 34% with a 12-month prevalence.

34% of children have a father with a lifetime prevalence of psychiatric disorder; 17% with a 12-month prevalence.

Limited State Mental Health Authority (SMHA: e.g., DMH) responses to mothers and parents

<25% (n=12) formally identify adults as parents (MA)

<25% (n=12) assess parental functioning (no MA)

<30% (n=14) have programs/services for adult clients who are parents (MA)

<10% (n=4) have policies/practice guidelines for adult clients who are parents (MA)

- Inpatient, residential, rehabilitation & Clubhouse settings

Few programs focus on maternal and family mental health

< 30 programs in US addressing parental mental illness

Multiple program models: case management, rehabilitation

Key ingredients: family-centered, strengths-based, non-judgmental

Perinatal mental health

Perinatal depression is common

Up to 20% of women during pregnancy

10-15% of women the postpartum period

Gavin et al. Obstet Gynecol 2005, Vesga-Lopez et al. AGP 2006.

1 in 8 perinatal women suffer from depression

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

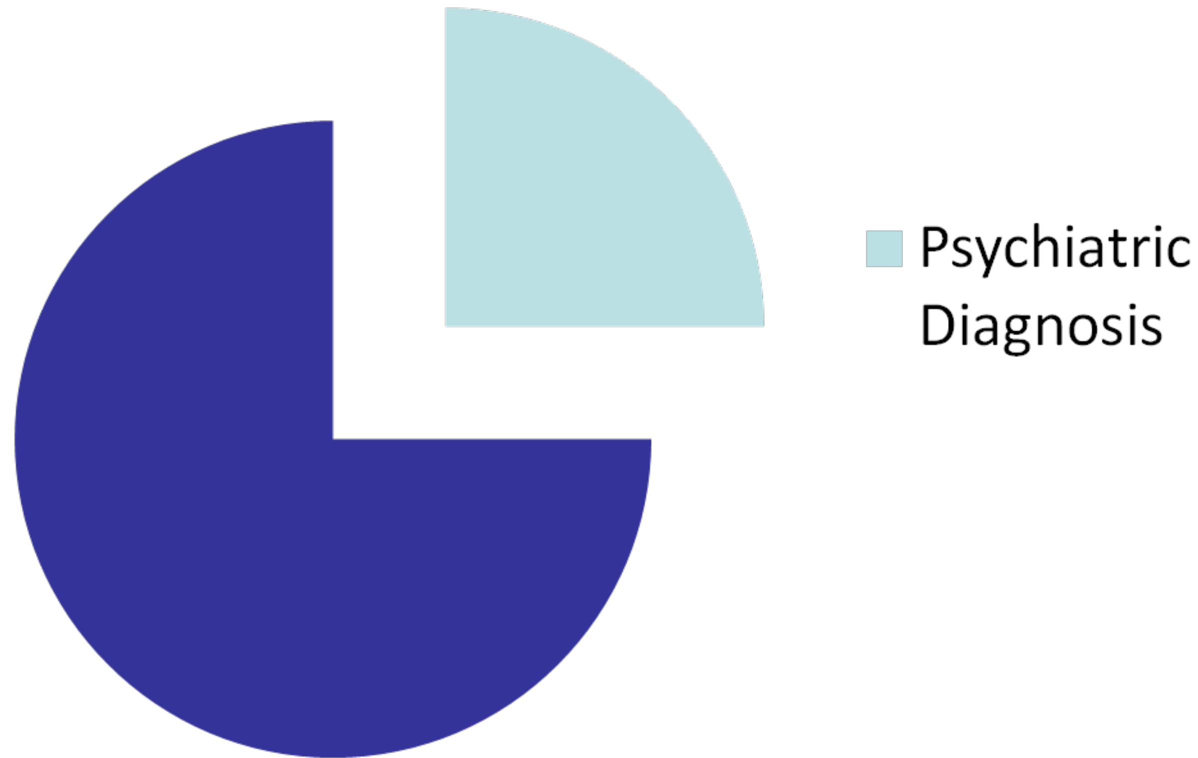
Perinatal depression is twice as common as gestational diabetes

Depression
10-15 in 100

Diabetes
3- 7 in 100

Gavin et al. Ob Gyn 2005, Vesga-Lopez et al. Arch Gen Psychiatry 2006. Andersson et al. *J Int Med* 2006. Baptiste-Roberts et al. *Am J Med* 2008.

25% of pregnant women meet criteria for a psychiatric diagnosis



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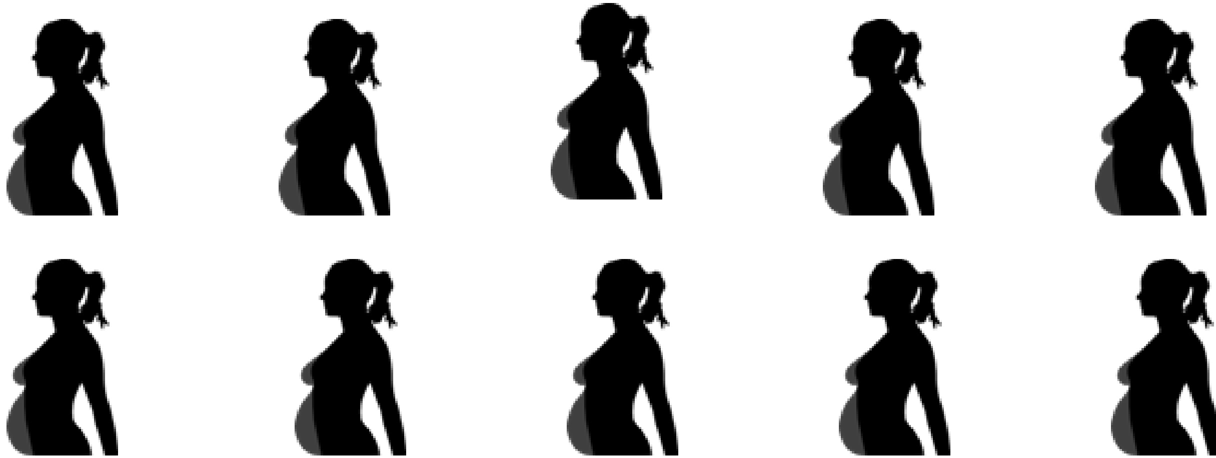

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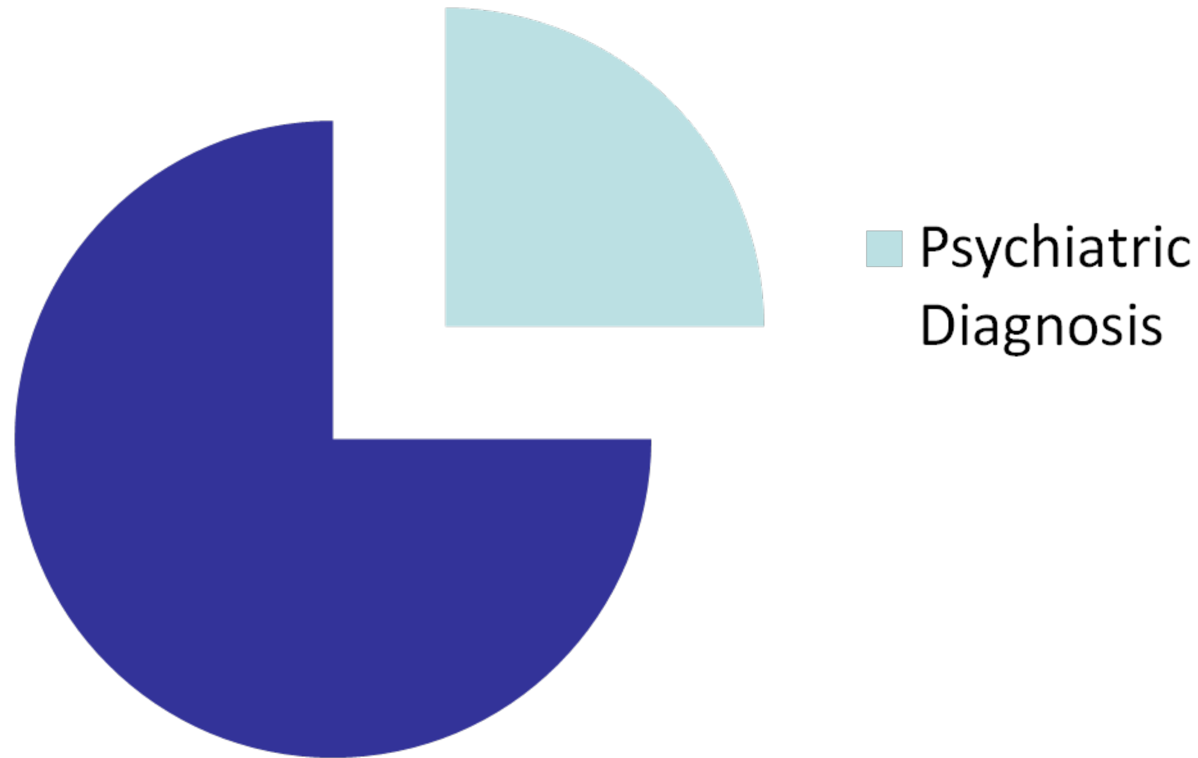
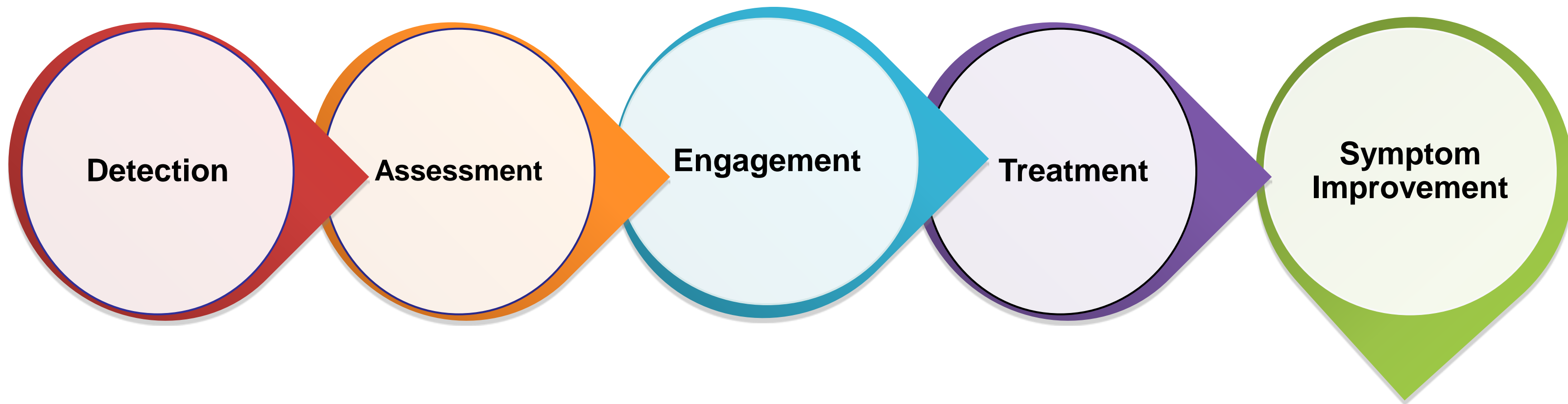
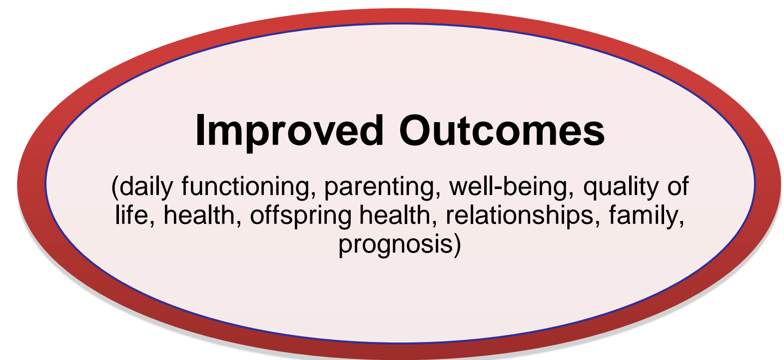


Gavin et al. Ob Gyn 2005, Vesga-Lopez et al. AGP 2006.

Front line providers are pivotal role in helping address perinatal mental health disorders





Gilbody et al. CMAJ 2008, Yonkers et al. Psych Serv 2009.

Perinatal depression causes suffering for mother/family

Maternal depression

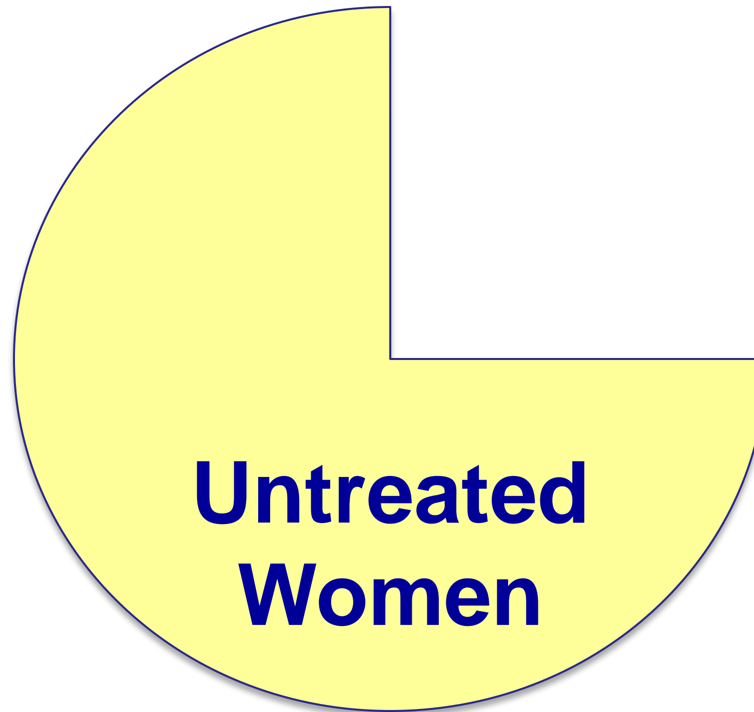
Poor maternal health behaviors
Maternal substance abuse
Low birth weight
Preterm delivery
Cognitive delays
Behavioral problems
Maternal suicide

Wisner et al. AJP 2009;. Cripe et al. Paediatr Perinat Epidemiol 2001;25 (2):116-123, Grote et al. Arch Gen Psychiatry 2010;67 (10):1012-1024, Sohr-Preston et al. Clin Child Fam Psychol Rev 2006;9 (1):65-83, Forman et al, Dev Psychopathol 2007;19 (2):585-602 Bodnar et al. J Clin Psychiatry 2009;70 (9):1290-1296, Flynn et al. J Stud Alcohol Drugs 2008; 69 (4):500-509,

Consider the risks of untreated illness

Wisner et al. AJP 2009. Cripe et al. Ped Per Epid 2001, Grote et al. AGP 2010, Sohr-Preston et al. Clin Child Fam Psych Rev 2006, Forman et al. Dev Psych 2007, Bodnar et al. JCP 2009, Flynn et al. J Stud Al Drugs 2008, Lindahl et al. AWMH 2005.

Perinatal depression is under-diagnosed and under-treated



Carter et al. Aust New Zeal J of Psych 2009. Smith et al. Gen Hosp Psych 2009. Marcus J Women Health 2003.

Perinatal time period is ideal for the detection and treatment of depression

Regular contact with health providers

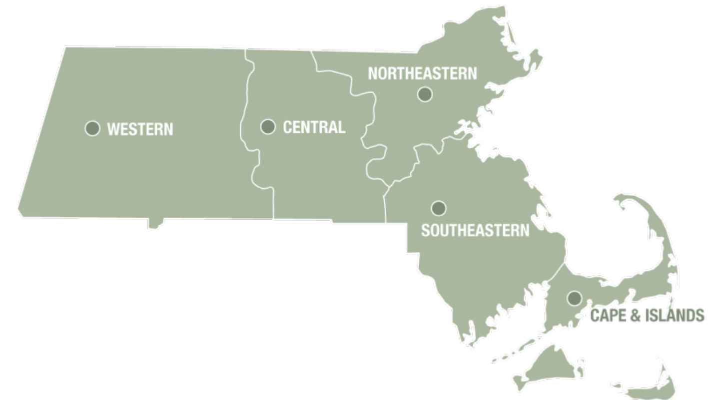
Regular opportunities to screen and engage women in treatment

ACOG 2010 Screening for Depression During and After Pregnancy (Reaffirmed in 2012)

"Depression is very common during pregnancy and the postpartum period…. screening for depression has the potential to benefit a woman and her family and should be strongly considered."

In 2010, Massachusetts passed an Act Relative to PPD

Established a commission made up of legislators, state officials, healthcare providers, advocates and consumers



Goal: strengthen PPD support programs in the state, including treatment, screening and public-awareness efforts

16,388 Massachusetts births likely to have been affected by maternal depression in 2010

72,835 births in the commonwealth

An estimated 16,388 births affected by maternal depression

Births

Maternal Depression

No Depression

As many as 292 of 730 CWC births could have been affected by depression in 2010

Births

Maternal Depression No Depression

Massachusetts DPH is creating a PPD regulation

Billing code F3005

If you screen you have to report it

(0-6 months post partum)

Screening alone does not improve treatment

Detection → Assessment → Engagement → Treatment → Symptom Improvement

Improved Outcomes

(daily functioning, parenting, well-being, quality of life, health, offspring health, relationships, family, prognosis)

Gilbody et al. CMAJ 2008; 178 (8): 997-1003. Yonkers et al. Psych Serv 2009; 60(3): 322-8. Miller et al.

Multi-level barriers to treatment exist

Barriers

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

Women do not disclose symptoms or seek care

Underutilization of Treatment

Unprepared providers, With limited resources

Poor Outcomes

Two studies of maternal mental health

Study 1: Perspectives of women

Study 2: Perspectives of OB/GYN providers

Use findings to develop preliminary guidelines to engage women in depression treatment

Inform development of interventions to integrate depression treatment into primary care settings

What we learned from recent studies of perinatal Depression

a) Mothers experience shame and stigma about their mental health while pregnant/parenting and have negative interactions with providers

b) Mothers have clear ideas about how providers can better address their mental health needs

c) OB/GYN providers are uncomfortable with mental health issues and have limited training

d) OB/GYN providers are interested in targeted trainings to inform their work

Study 1: Perspectives of women

Study of women with lived experience of depression during and after pregnancy

- Interested in experiences with providers
  - What is helpful?
  - What are barriers?
  - What can we do to affect change?

Byatt et al. 2013 General Hospital Psychiatry, In Press.

Study 1: Methods

Four focus groups with mothers (n=27) in Western Mass

Self -identified as having experienced perinatal depression or emotional crisis

Byatt et al. General Hospital Psychiatry 2013.

Study 1: Characteristics of mothers

Mean age: 32

80% had 1 or 2 children

Income variability

- 22% - less than 20K/year
- 11% - more than 100K/year

All parenting with a partner

Mental health treatment

- Pre-pregnancy – 70%
- During pregnancy – 22%
- After pregnancy – 67%

Byatt et al. General Hospital Psychiatry 2013.

Study 1 Barrier: Fear, stigma and shame

"You're scared to say to somebody, 'I need help and I need it now' cause you're scared someone's gonna take your kid."

Byatt et al. General Hospital Psychiatry 2013.

Study 1 Barrier: Lack of resources & supports

“Nobody took the time to really find out what was going on. Basically they wrote me a prescription and put me back on what I was on before and said, ‘Go find a therapist.’ ”

Byatt et al. General Hospital Psychiatry 2013.

Study 1 Barrier: Negative interactions w/ providers

"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. General Hospital Psychiatry 2013.

Study 1 Barrier: Providers lack of knowledge re: mental health care

"I think part of the reason why OBs and even midwives aren't asking is, they're not really prepared to deal with the answers."

Byatt et al. General Hospital Psychiatry 2013.

Study 1 Facilitator: Authentic & validating communication

"Not, you know, joking and saying 'Oh-no, all babies do that.' 'No, actually can we just talk about what my baby's doing right now and the fact that it's upsetting me'… people just take your stories as anecdotal…and just brush it off."

Byatt et al. General Hospital Psychiatry 2013.

Study 1 Facilitator: Holistic approach to mental health treatment and wellness

"Address everything that's not depression. You know, there's exercise…nutrition, sleep, friendships. Everything changes when you have a baby, and if there was some sort of way to encompass the whole self, that would be really cool."

Byatt et al. General Hospital Psychiatry 2013.

Study 1 Facilitator: Access to resources and supports

"When I delivered at UMass Memorial you have a nurse and you get these two booklets – one is on shaken baby and on one postpartum depression and psychosis. And the nurse goes through each with you… so you can kind of recognize…when you're angry and have to put the baby down…. That was really helpful, and I was surprised and happy they did that."

Byatt et al. General Hospital Psychiatry 2013.

Study 2: Perspectives of OB/GYN providers

Focus groups with OB/Gyn providers and staff

Discussion probes informed by literature review

- **What are barriers?**
- **What can we do to affect change?**

Byatt et al. Journal of Reproductive and Infant Psychology 2012.

Study 2: Characteristics of OB/GYN providers

Focus Group	Participants	N	Years of clinical experience
1*	OB/Gyn resident physicians (n=6)	6	PGY 1 to 4
2*	OB/Gyn attending physicians (n=8) advance practice nurses (n=4)	12	1 to 23 years
3*	Nursing staff (n=4) PCAs (n=2) Support staff (n=3) Licensed clinical social worker (n=1)	10	4 to 27 years
4	Resident physician (n=1) Attending physician (n=1) Advance practice nurses (n=2) Nursing staff (n=3) PCAs (n=2) Support staff (n=3)	*12	1 to 27 years

* Convenience sample of stakeholders

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Study 2 Barrier: Limited resources & time constraints

"We don't have enough time in our appointments… we can take the time, but then it backs our whole schedule up… I don't think we have the time to have a mental health style appointment … We don't have the luxury of doing that. We can't. We are just like, are you suicidal, homicidal? That's the only thing."

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Study 2 Barrier: Mental health is beyond the scope of services

"I tend to ask, Are you going to your appointments? Do you like who you're seeing? …and do you feel like it's helping? And I hope they say Yes to all of them. And as soon as they say No, I say, Now why did I open up that can of worms?"

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Study 2 Barrier: Discomfort with issues related to mental health

"There [are] patients that come in and say, 'I'm depressed. I have PTSD. I've been raped.' And you know, just like 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. Like, oh crap, that really sucks, I don't know."

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Study 2 Facilitator: Targeted provider training

"…to know what's good in what trimester and how to feel comfortable prescribing a mild antidepressant or something."

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Study 2 Facilitator: Learning engagement techniques

"It would be interesting to spend a week with the psychiatrists.... …likewise if we were to sit in with a mental health counselor and they were screening for depression and the depression screen was positive, they could say, okay, these are the steps that you can take to work with it… getting those basic steps, like sort a feeling comfortable having those conversations would be useful… that's how we are used to learning."

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Study 2 Facilitators: Other suggestions

Structured screening and referral

Integrated depression and OB care

Immediate back up from mental health providers

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

How these studies inform the work and next steps

System-level Barriers

Limited training among mental health providers

Limited mental health resources

OB and mental health care not integrated

Lack of collaboration with mental health providers

Byatt et al. 2012 Journal of Reproductive and Infant Psychology

Both groups valued depression care yet noted complex barriers

- Complex psychosocial factors
- Women feel invalidated, disrespected, and/or judged
- Shame and stigma inhibit help-seeking

Byatt et al. 2013 General Hospital Psychiatry, In Press

Both groups noted perinatal settings are not equipped to address depression

- Professionals lack mental health training and skills
- Lack of resources and knowledge to prepare women
- Lack of information on risk and benefits of medications
- Limited access to mental health resources

Byatt et al. 2013 General Hospital Psychiatry, In Press

Interventions can be designed to close the gaps in the perceptions of women and providers

Empowering women

Training for professionals

Screening, education and treatment and/or referral

Improved coordination and follow-up of perinatal depression care

Byatt et al. 2013 General Hospital Psychiatry, In Press

Next steps

A system change could improve engagement in mental health treatment

Integration of care

- Facilitate access to care
- Provide a comprehensive, integrated approach
- Engage women in mental health treatment

Perinatal Depression Care Model Adapted from Chronic Care Model

Perinatal Depression Care Model

Individual
Psychoeducation
Positive Feedback
Provider Acceptance

Provider
Training
Confidence
Psychiatric consultation

Systems
Integration of primary and depression care
Resource guide
Collaborative approach

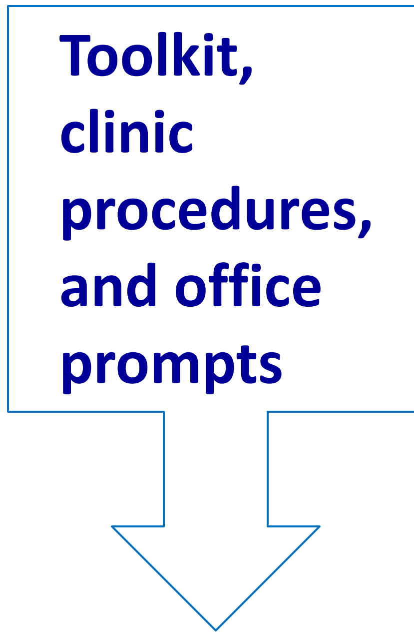
Perinatal Care Model

Informed, Activated Women

Treatment Engagement

Prepared, Proactive Providers

Improved Outcomes



Improved access to and engagement in depression treatment

Improved depression outcomes

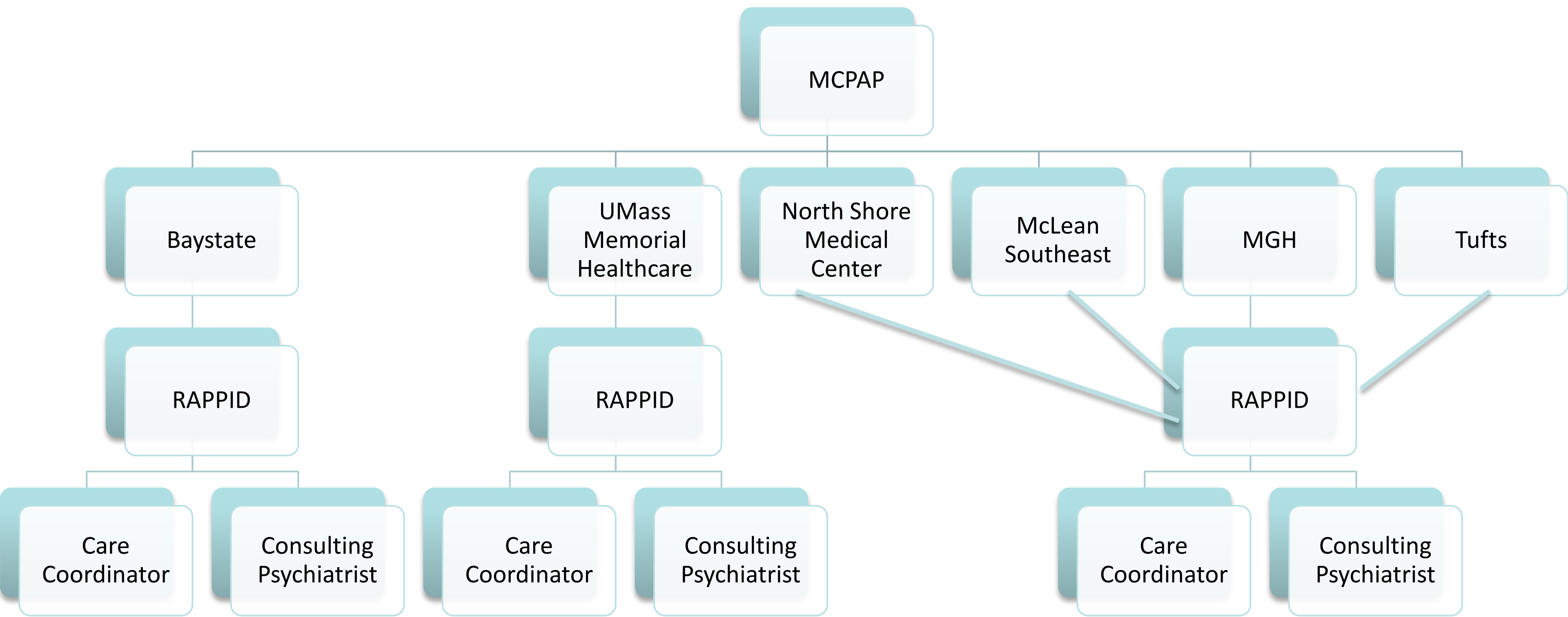
Improved outcomes for women's babies and children

Primary goal is to expand MCPAP to address perinatal depression

Designed to help PCPs meet the needs of children with psychiatric problems

Solved a statewide crisis in child psychiatry

Rolled out in 2004-2005, now being expanded to also address PPD


MCPAP
Baystate
UMass Memorial Healthcare
North Shore Medical Center
McLean Southeast
MGH
Tufts
RAPPID
RAPPID
RAPPID
Care Coordinator
Consulting Psychiatrist
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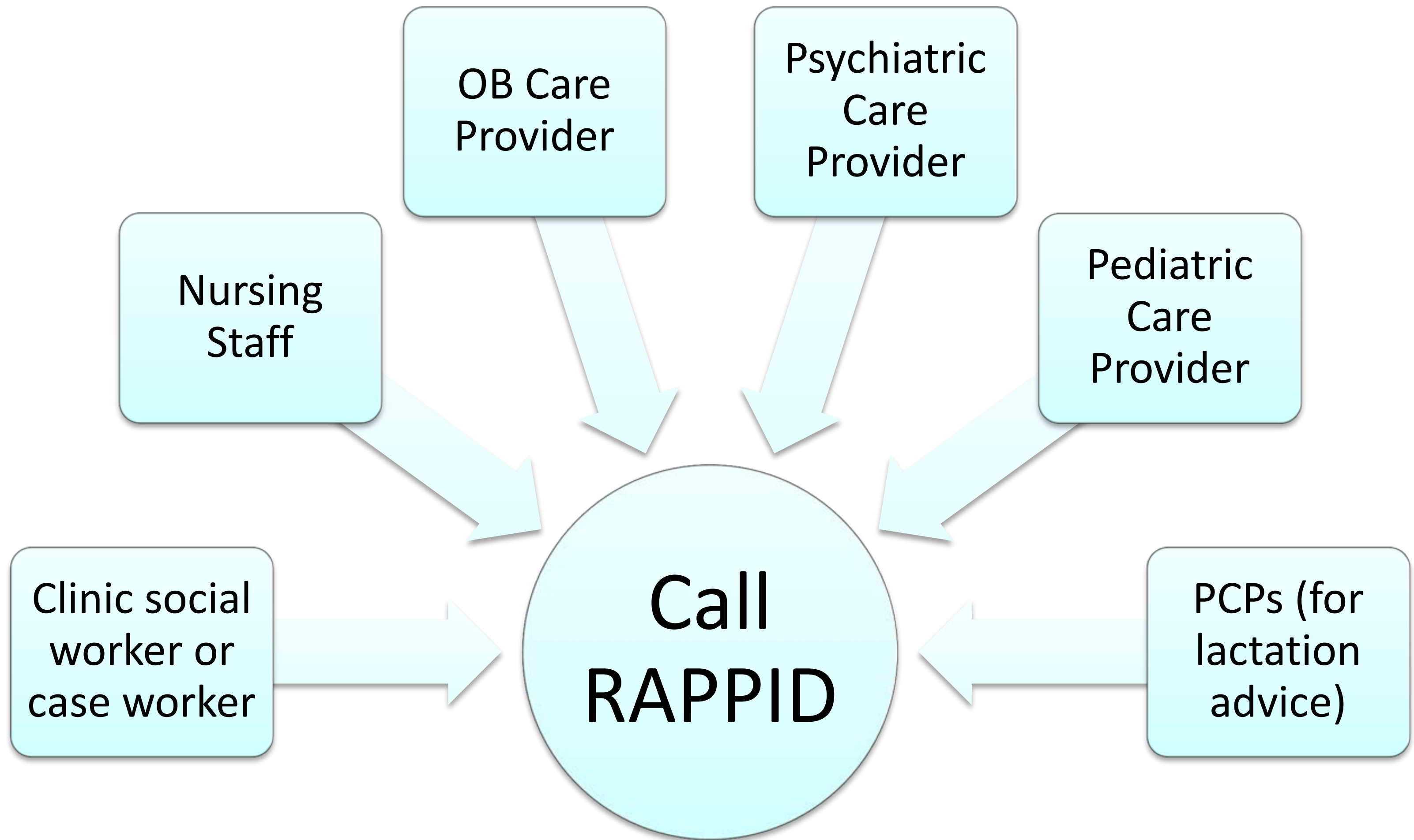
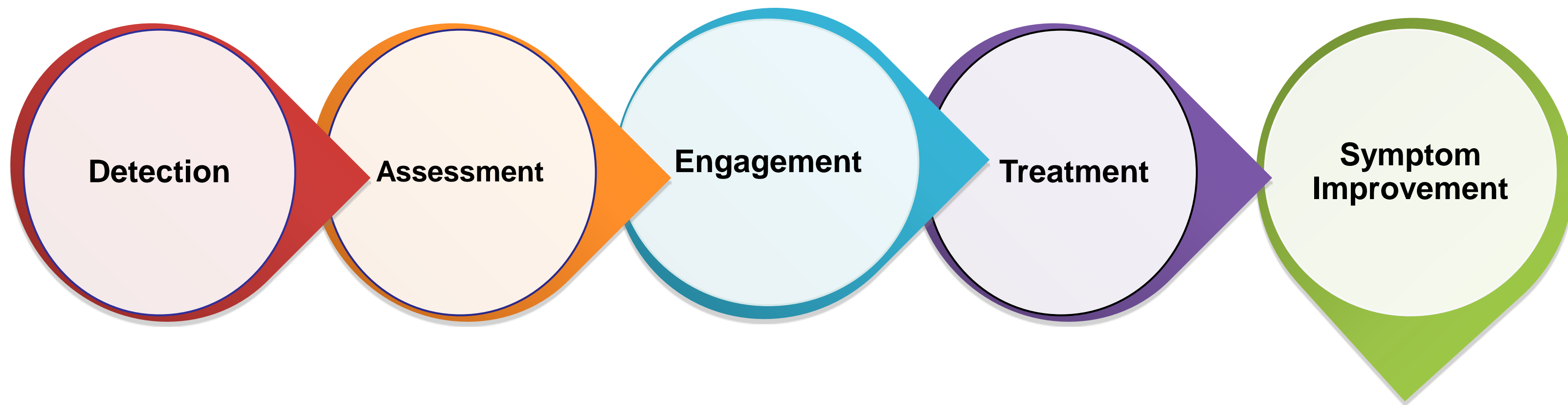
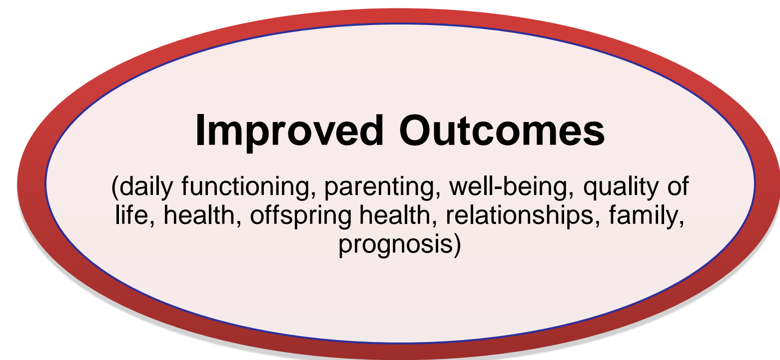

OB Care Provider
Psychiatric Care Provider
Nursing Staff
Pediatric Care Provider
Clinic social worker or case worker
Call RAPPID
PCPs (for lactation advice)





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In summary, addressing individual, provider and system-level barriers may improve outcomes

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Thank you!