Maternal Mental Health Coalition

Meeting #4: Education and Screening

Postpartum Support Virginia
Hope and help for new mothers

Local hospital logo
Today’s Agenda

Education
What to say about PMADs
When to say it

Screening
Why…What…Where…When…How
MESSAGE

We care as much about a mother’s MENTAL HEALTH as we do about her PHYSICAL HEALTH

EDUCATION + SCREENING
Why Should We Talk About PMADs?

- **20%**
  - Percentage of childbearing women who will experience PMADs

- **30%**
  - Percentage of NICU mothers with PTSD

Pregnancy-Related Illnesses
- Birth Anomalies
- Gestational Diabetes
- Preeclampsia

PMADs: **30**
- The number of times a woman will see a healthcare provider in the perinatal timeframe

- **$22,000**
  - Annual cost per mother/infant dyad of **NOT** treating PMADs
Why Should We Talk About PMADs?

Women who receive educational information about PMADs are more likely to SEEK HELP SOONER

Cindy Lee Dennis, PhD
SUICIDE

is the **leading** cause of death in the first year postpartum

20% of postpartum deaths

Women use more lethal means in the postpartum period

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**Psychiatric Hospitalizations**

Admissions to a psychiatric hospital:
2 years pre- and post-delivery

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You Can’t Tell By Looking

- Women may hide how they are feeling
  - Judgement “BAD MOM”
  - Having baby taken away

- Women might not KNOW they are suffering
  - This is just how new moms must feel
Talking About PMADs

- Women are at increased risk in perinatal timeframe
- #1 complication of pregnancy and childbirth
- Combination of physical changes, lack of sleep, life situations, expectations
- Transition to motherhood can be a challenge
- I’m going to ask every time I see you: *How are you doing?*
- I expect that you will answer honestly

*Emotional health is as important as physical health*
The Verbal Hug

VALIDATE  I’m sorry you are having a tough time
NORMALIZE  Lots of women have these feelings
PROVIDE    You will feel better with help
HOPE       Let’s connect you with resources
## Screening Recommendations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Recommendation(s)</th>
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| **United States Preventive Services Task Force**  | • Screening for depression in the general adult population, *including pregnant and postpartum women*.  
• Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, appropriate follow-up.                                                                                                                      |
| **American College of Obstetricians and Gynecologists** | • **Clinicians should screen patients** at least once during the perinatal period for depression/anxiety using a standardized, validated tool.  
• Screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up / treatment when indicated.  
• **Clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy,** refer patients to appropriate behavioral health resources when indicated, or both.                                                                 |
| **American Academy of Pediatrics**                | • **All women should be screened for depression during pregnancy and postpartum.**  
• Women may be screened for peripartum depression using a single tool, such as the Edinburgh Postnatal Depression Scale, or using a two-step process, such as the Patient Health Questionnaire-2 followed by a more comprehensive screening test if the initial screen is positive. |
| **American Academy of Family Physicians**         | • If a woman who has depression or anxiety disorder could become pregnant or is planning a pregnancy, her **family physician should inform her about potential risk of untreated illness during pregnancy** along with the risks and benefits of treatment options for depression and anxiety disorders during pregnancy.  
• Treatment for depression/anxiety during pregnancy should be individualized. |
Screening Protocols

Edinburgh Postnatal Depression Scale

- Since 1987, FREE, validated
- 10 questions (or 3-question version)
- Depression and anxiety
- Question #10 (suicidality)

EPDS-3

1. I have blamed myself unnecessarily when things went wrong
2. I have been anxious or worried for no good reason
3. I have felt scared or panicky for no very good reason

We Screen Everyone!
Thoughts About Screening

Providers Care….
- Majority recognize PMADs and the harmful effects
- Screening childbearing women is within scope of practice
- Bright Futures
- Surgeon General
- 90% of MDs assume responsibility….BUT only 40% rarely/never screen or assess
- Non-validated/Non-uniform screen is NOT useful

But face barriers…
- Time
- Lack of education
- Lack of confidence/self-efficacy
- Reimbursement issues
- Lack of knowledge of available resources/referrals
- Staff training
- Fear of liability
- Mother is ‘not my patient!’

Pandora’s Box
Barriers to Care

Cost and Access
- Insurance
- Time off from work
- Transportation
- Childcare

Other Factors
- Depressed mother
- Shame and stigma
- Cultural issues
- Fear of being a “bad mom”
- Fear of losing baby
- First time many women experience mental health issues
The Goal

COMPREHENSIVE MATERNAL MENTAL HEALTH PROGRAM

EDUCATION / SCREENING
Childbearing women would receive information about PMADs and be screened for them during pregnancy, at delivery, and throughout first year postpartum

TREATMENT
PCPs will initiate care when possible
Women will receive FREE social support
Therapy is easily accessible
Medication management from many providers
Old Way
- Expect that transition to motherhood is **EASY**
- Expect women to
  - recognize they need help
  - be able to find it

New Way
- Expect that transition to motherhood is **HARD**
- **PUSH** information
  - to women and families
  - early and often

**GOAL**
Women will have information and resources Where and when they need it
Obstetric Screening – Why?

- OBs are de facto primary care providers during childbearing years
- Women WANT
  - Relationship with provider
  - Someone to help with transition to motherhood
- Healthy mother = healthy baby
Tidewater Physicians for Women

Screening schedule
- New OB appointment to establish baseline score
- Glucola appointment (between 26–28 weeks)
- Mother Baby unit post delivery (by hospital staff)
- 6 week postpartum checkup

Cut-off score of 10 (and anything on #10)
- Have a conversation about patient’s emotional experience
- Offer counseling and/or medication
- Provide resources: support groups, mothers’ groups, PSVa, doulas, etc
Hospital Screening – Why?

- Captive audience
- Capture antenatal depression/anxiety
Pediatric Screening – Why?

- Poor prenatal follow-up
  - only 1-2 post-partum follow-up visits with OB
  - minority women have poor postpartum follow-up

- Babies see pediatrician 6-7 times in the first year

- Usually MOM brings in baby

- Nature of relationship
  - Trust & respect
  - Longevity

- Fear
  - Being labeled a “bad mom”
  - CPS
Pediatric Screening – EXAMPLE

- CHKD Clinic in Norfolk
- Screening schedule:
  - Well-child checks starting at 2 weeks
  - 1 month, 2 months, 4 months
- EPDS online; cut-off score of 12 (and Q10)
  - Refer to in-house social workers
  - Provide PSVa info, PMAD pamphlet, referrals
- Have protocols in place for emergency situations
  - Suicidality
  - CPS
The Screening Gold Standard

PERINATAL
Conception to baby’s 1st birthday

PREGNANCY
1st trimester
Baseline

3rd trimester
50% of PPD cases start in 3rd trimester

DELIVERY
In hospital

6-wk obstetric postpartum visit

POSTPARTUM
Well-baby visits
2 months
4 months
6 months
9 months
12 months
Special Situations

GRIEF & LOSS
- Miscarriage
- Stillbirth
- Fetal demise

NICU MOMS
- Traumatic birth
- NICU is traumatic
- Fear of losing baby

LOW-INCOME IMMIGRANT
- Daily life challenges
- Language barriers
- “Perfect” immigrant
- Physical symptoms

Heartbroken
The end and the beginning of our miscarriage story
www.ReadySetSarah.com
Example 1: Alice

**SITUATION**
- No history of anxiety / depression
- Very traumatic birth
- Breastfeeding issues

**SYMPTOMS**
- Sense of failure
- Physical symptoms
- Nightmares, flashbacks

**THINGS TO SAY**
- How are you feeling after the labor and delivery?
  - I understand that it might have been very frightening for you.
- How is feeding baby going?
  - The most important thing is that baby is fed.
Example 2: Becky

**SITUATION**
- Twins
- History of fertility treatments
- Family history of depression
- Recent cross-country move
- Lack of social support
- Recent parental illness

**SYMPTOMS**
- “I used to be able to do anything”
- Overwhelmed / anxious
- Focus on baby’s eczema

**THINGS TO SAY**
- You have two of the most important risk factors: fertility issues, family history.
- Plus you have lots of other things going on:
  - Twins
  - Recent move
  - Lack of social support
  - Parental illness
- You are doing a great job despite all the challenges.
Example 3: Carla

**SITUATION**
- From El Salvador
- Children at home
- History of sexual assault
- No insurance

**SYMPTOMS**
- Shutting down
- Extreme guilt
- Ignoring pregnancy

**THINGS TO SAY**
- Sometimes anxiety shows up as physical issues – stomach ache, headache, “attachment of the nerves”
- You need to take care of yourself so you can be a good mom for your baby
- We’re going to get you help that doesn’t cost anything