Policy Statement
January 2009

LA BEST BABIES NETWORK
Healthy Babies. Our Future.
Presented by First 5 LA

Access to Quality Care for Maternal Depression: Meeting the Challenge

Maternal depression (also known as perinatal depression) is a significant public health concern affecting countless women, infants and their families in Los Angeles County. Given L.A. County's vast size and large population, there is a high prevalence of perinatal depression. Unfortunately, resources are limited for providing treatment to women suffering from maternal depression.

L.A. County was the birthplace of 150,377 babies in 2005.[1] One in 4 babies born in California each year is born in L.A. County. When compared to national births, one out of every 27 babies born each year in the U.S. is born in L.A. County.

Each year in L.A. County, more than 50% of births are covered by public health insurance, (i.e., Medi-Cal), while the remaining births are covered by private health insurance.[2] Given the large number of births and families' dependence on public health insurance, there is a need to improve the delivery of services under the safety-net system, including perinatal mental health services.

The devastating effects of depression far too often underscore the need for increased screening and treatment services. As we increase the focus on screening and treating perinatal depression, we will likely move toward improved birth outcomes, as well as improved maternal and infant health.

Improving mental health before, during and after pregnancy is an important component in generating positive birth outcomes. While national studies indicate that perinatal depression affects roughly 10% of women during both pregnancy and in the postpartum period, it is likely that this percentage would be higher if universal screening were in place. Local surveys indicate that number may be significantly higher in L.A. County.[3, 4, 5]

Current systems are not equipped to provide necessary screening and treatment for women. For example, under the state's Comprehensive Perinatal Services Program, providers are reimbursed for screening women for maternal stress; however, the program does not require providers to use the evidence-based screening tools for prenatal depression. Health providers who are screening for prenatal and postpartum depression encounter a scarcity of mental health services available for referrals in L.A. County, particularly for women with Medi-Cal.

The screening and treatment of perinatal depression is critical to ensuring the healthy birth and development of the newborn. Perinatal depression can have some devastating effects on both mother and child. During pregnancy, depression can lead to increased risk of poor health status, lower quality of life and substance abuse.[6, 7, 8] Women with untreated depression have lower utilization of prenatal care services and have an increased risk of premature delivery and low-birthweight babies.[9, 10, 11, 12, 13] Mothers with untreated depression have a decreased duration of breastfeeding. Perinatal depression also can lead to a disruption in the bond between mother and child, resulting in impaired attachment.[14, 15, 16, 17]

The impact of perinatal depression on infants is

manifested in early development and leads to long-term cognitive and behavioral problems in childhood.[18, 19] The long-term effects on the child's well-being include difficulties with behavior, school performance and forming healthy relationships. Children of mothers with perinatal depression are also at increased risk of child abuse and neglect.[20] Many of these short-term and long-term effects on mother and child can be eliminated or minimized if perinatal depression is diagnosed and treated with a combination of psychotherapy and medication.[21]

I. Problem Statement/Rationale

Problem statement: All women need to be screened for perinatal depression every trimester and in the postpartum period. Women also need to be able to access culturally competent perinatal mental health services. Prenatal care providers need to be equipped with the knowledge and resources to appropriately screen patients and refer them to the appropriate level of care.

Rationale: All women in the preconception, pregnancy, or postpartum period should be screened for depression due to the higher rates of depression during each of these stages.[22] Because of the high rates of depression throughout the perinatal period, screening should occur at regular intervals, including at intake (i.e., the initial medical visit), as part of routine health history.[23, 24] Because the most significant risk factor for developing perinatal depression is a history of depression, women should be screened for past depression at intake, and at each trimester, to identify and treat women at risk for perinatal depression. Women should also be screened during the postpartum and interconception care period because many women still have symptoms of depression up to two years after delivery.[25]

Perinatal depression is highly treatable with both psychotherapy and medication. Prenatal care providers are uniquely poised to conduct depression screening due to an increased frequency and regularity of visits during the perinatal period.[26, 27] Unfortunately, screening is not performed as frequently or consistently as recommended for many reasons, which include: a lack of knowledge about standard of quality care; limited reimbursement for depression screening; and a lack of resources for referrals to providers who screen patients for perinatal depression.

II. Policy Recommendations

PROMOTING UNIVERSAL DEPRESSION SCREENING

We support policies that lead to universal depression screening, as well as increased access to perinatal depression screening and treatment through improved health insurance coverage. To achieve this we recommend:

- Establishing a standard of care to include screening in each trimester, as well as in the postpartum period, in programs such as the Comprehensive Perinatal Services Program (CPSP).
- Private insurance companies establish a standard of care to include screening in each trimester, as well as in the postpartum period.

INCREASING WOMEN'S ACCESS TO MENTAL HEALTH SERVICES

We believe women need increased access to mental health services including psychological and pharmacological treatment during pregnancy and the postpartum period. To accomplish this we recommend:

- Expanding pregnancy Medi-Cal services to include mental health services.
- An examination of the restrictions insurance companies place on mental health services. Although insurance companies are prohibited by law from setting caps on mental health benefits, most fee-for-service insurance plans have greater restrictions and higher co-payments for mental health services than for medical services.[28]
- Increasing Medi-Cal and Medicare reimbursement for mental health services because they are currently lower than private insurers' rates.[29]

INCREASING EDUCATION AND TRAINING FOR PRENATAL CARE PROVIDERS

Prenatal care providers including obstetric, family practice and pediatric health care providers need more education and training on depression screening and the importance of screening for perinatal depression. We recommend support of programs and policies that:

- Increase education for prenatal care providers on perinatal depression topics, such as defining the disease, understanding its impact, screening and diagnosis, as well as available resources to treat perinatal depression.
- Increase access to continuing medical education courses in the area of perinatal depression for medical providers.

INCREASING EDUCATION AND TRAINING OF MENTAL HEALTH PROVIDERS

Mental health providers need access to training in the most current treatments for perinatal depression. We support policies and programs that:

- Increase education and awareness among psychiatrists about the use of pharmacological treatment during and after pregnancy.
- Provide training for mental health providers in the area of evidence-based treatment of pregnant women and women in the postpartum period who are breastfeeding.
- Provide mental health professionals with cultural competency training.

INCREASING PERINATAL MENTAL HEALTH RESOURCES

There is a scarcity of mental health services available to women in L.A. County, particularly those under Medi-Cal. We support policies and programs aimed at workforce development and increasing the numbers of mental health providers.

We recommend:

- Training on screening and treatment of perinatal depression for medical professionals during residency training.
- Offering perinatal mood disorders as a specialty under psychiatry because there is a growing need to recruit and train more psychiatrists in this specialty.
- Training for all mental health professionals including psychologists; psychiatrists; social workers; marriage and family therapists; and marriage, family and child counselors on perinatal mood disorders, which should be offered as a specialty under these disciplines.

INCREASING PUBLIC AWARENESS OF PERINATAL DEPRESSION

We believe increasing education and public awareness about perinatal depression is needed in order to decrease the stigma associated with this disease. The stigma associated with depression can be a barrier for women using mental health services.

We recommend:

- Increasing funding for programs and organizations dedicated to educating women on the need for perinatal depression screening and making the screening process a part of the standard of care for prenatal care services.
- Developing messaging campaigns to educate women on perinatal depression and making them aware of its prevalence and the need to access services.

INCREASING PSYCHOSOCIAL SUPPORT SERVICES

As social isolation is a major risk factor in perinatal depression, we believe investments should be made to increase psychosocial support services such as support groups, online communities and classroom education. We recommend programs and policies that:

- Support community-based organizations and other community safe havens as centers for information on perinatal depression for women and their families.
- Increase investment in home visitation programs to improve postpartum screening and treatment.
- Improve access to wraparound services for women facing complicated social issues, such as substance abuse or domestic violence.

Recent Federal Legislation

Melanie Blocker-Stokes Postpartum Depression Research and Care Act
H.R. 20 Representative Bobby Rush (IL)

This bill would expand and intensify research at the National Institutes of Health with respect to postpartum depression and psychosis, including increased discovery of treatments, diagnostic tools and educational materials for providers. This bill would prioritize postpartum depression and psychosis by expanding research on mental illness; and establish grants for the operation and coordination of cost-effective delivery systems of essential services to afflicted individuals and their families.

Mom's Opportunity to Access Health, Education, Research, and Support for Postpartum Depression Act (MOTHERS Act)
S. 1375 Senator Robert Menendez (NJ)

This bill aims to ensure that new moms and their families are educated about postpartum depression, screened for symptoms and provided with essential services. In addition, it would increase research into the causes, diagnoses and treatments for postpartum depression. It includes two grants to help healthcare providers educate mothers and families, as well as identify and treat postpartum depression. Grants would provide for the delivery of essential services to individuals with postpartum depression and psychosis and their families, including enhanced outpatient and home-based health care, inpatient care and support services.

Recent California Legislation

AB 291 Postpartum mood and anxiety disorders: screening

(Assembly member Koretz in 2005-2006 Legislative Session)

This bill would have required the State Department of Health Services, in cooperation with other postpartum mood and anxiety disorders professional organizations, to prepare an information sheet for pregnant women containing specified information about the symptoms and treatments for postpartum mood and anxiety disorders, and related resources and assistance for parents, and to make that information sheet available to healthcare providers and members of the public. It would have required a physician or other healthcare practitioner that provides prenatal care to a pregnant woman during gestation or at delivery of an infant to provide the woman with a copy of that information sheet.

AB 2317 Postpartum mood and anxiety disorders

(Assembly member Koretz in 2005-2006 Legislative Session)

This bill would have required the State Department of Health Services to conduct the Perinatal Mood and Anxiety Disorders (PMAD) Community Awareness Campaign to increase awareness and provide education to pregnant women and new mothers on postpartum mood and anxiety disorders, including postpartum depression, panic disorder, obsessive-compulsive disorder, and postpartum psychosis.

Reference List

1 State of California Department of Health Services Center for Health Statistics. Birth Statistical Master File. 2005

2 Ibid

3 Agency for Healthcare Research and Quality (AHRQ). Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes.

4 Dietz PM et al. Clinically identified maternal depression before, during, and after pregnancies ending in live births. Am J Psychiatry. 2007 Oct; 164(10): 1515-1520.

5 AHRQ.

6 Orr ST, Blazer DG, James SA, Reiter JP. Depressive Symptoms and Indicators of Maternal Health Status During Pregnancy. Journal of Women's Health, vol. 16 no. 4 (June, 2007), pp. 535-542.

7 Nicholson WK et al. Depressive symptoms and health related quality of life in early pregnancy. Obstet Gynecol 2006 April; 107(4):798-806.

8 Flynn HA et al. Brief detection and co-occurrence of violence, depression, and alcohol risk in prenatal care settings. Arch Women's Mental Health 2007;(10)4:155-61.

9 Kim HG et al. Antenatal psychiatric illness and adequacy of prenatal care in an ethnically diverse inner-city obstetric population. Arch Women's Men Health 2006 9:103-107.

10 Dayan J et al. Prenatal depression, prenatal anxiety, and spontaneous preterm birth: a prospective cohort among women with early and regular antenatal care. Psychosom Med 2006 Nov-Dec; 68(6):938-46

11 Rahman A. Association between maternal depression and low birth weight in a developing country. Acta Psychiatr Scand 2007 June; 115(6):481-6.

12 Evans J et al. Depressive symptoms in pregnancy and low birth weight at term: longitudinal study. Br J Psychiatry. 2007 Jul; 191:84-5.

13 Steward RC. Maternal depression and infant growth: a review of recent evidence. Maternal Child Nutrition 2007 Apr; 3(2):94-107.

14 Henderson JJ et al. Impact of postnatal depression on breastfeeding duration. Birth. 2003 Sep;30(3):175-80

15 Huot RL. Negative affect of offspring of depressed mothers is predicted by infant cortisol levels at 6 months and maternal depression during pregnancy, but not postpartum. Ann N Y Acad Sci. 2004 Dec; 1032:234-6.

16 The World Health Organization. The importance of caregiver-child interactions for the survival and healthy development of young children: A Review. (2004). *http://www.who.int/child_adolescent_health/documents/924159134X/en/*

17 Feldman R et al. The national of the mother's tie to her infant: maternal bonding under conditions of proximity, separation, and potential loss. J. Child Psychol. Psychiat. 1999 Sep; 40(6):929-939.

18 Ciccheti D. Maternal depressive disorder and contextual risk: contributions to the development of attachment insecurity and behavior problems in toddlerhood. Dev Psychopathol. 1998 Spring; 10(2):283-300.

19 Grace, SL et al. The effect of postpartum depression on child cognitive development and behavior: a review and critical analysis of the literature. Arch Womens Ment Health. 2003 Nov; 6(4):263-74.

20 Buist, A. Childhood abuse, postpartum depression, and parenting difficulties: a literature review of associations. Aust N Z J Psychiatry. 1998 Jun; 32(3):3708.

21 Zlotnick, Caron et al. Postpartum Depression in Women Receiving Public Assistance: Pilot Study of an Interpersonal-Therapy-Oriented Group Intervention. Am J Psychiatry 201; 158:638-640.

22 Dietz PM

23 Ibid

24 National Collaborating Centre for Women's and Children's Health - National Government Agency. Antenatal care: routine care for the healthy pregnant woman. *http://www.nice.org.uk/nicemedia/pdf/CG62FullGuidelineCorrectedJune2008.pdf* 2003 Oct.

25 Maternity Center Association. Recommendations from Listening to Mothers: The First National U.S. Survey of Women's Childbearing Experiences. Birth 31:1 March 2004, p 61-5.

26 Zlotnick C.

27 American Academy of Family Physicians. Mental Health Care Services by Family Physicians (Position Paper); *http://www.aafp.org/online/en/home/policy/policies/m/mentalhealthcareservices.html*

28 Ibid

29 Glied S, Kofman S, Women and mental health: Issues for health care reform. The Commonwealth Fund. 1995.

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Presented by First 5 LA

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Funded by First 5 LA