

Managing Postpartum Depression: Why is Pediatric Primary Care an Ideal Venue?

Serene Olin, Ph.D.
Assoc Professor, Department of Child Psychiatry

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Project Collaborators

Lead: Serene Olin, Ph.D.

Project Faculty

- Sarah Horwitz, Ph.D.
- Bonnie Kerker, Ph.D.
- Kimberly Hoagwood, Ph.D.

Project Support

- Dara Weiss, M.A.
- Emma Whitmyre, B.A.
- Lizzie Glaeser, B.A.

Project Collaborators

- Caron Zlotnick, Ph.D.
- The Institute for Family Health
- Pediatrics, Gouverneur Health Services

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Overview

- Maternal Depression
 - A Public Health Problem
- Why Primary Care?
- Overcoming Barriers
 - Provider Level
 - Mother/Patient Level
 - Structural/Organizational
- Introducing STRONG MOM program
 - Stepped Care Approach

Maternal Depression: Prevalence

- Depression is highly prevalent among new mothers
- Most likely to occur when they are pregnant or in the first year postpartum
- Termed the **most under-diagnosed obstetrical complication** in the US:
 - 1 in 5 (13-19%) prevalence rates
(Gaynes et al., 2005; Myers et al., 2013; O'hara & Swain, 1996; Petersen & Nazareth, 2010)
 - 7%-15% within the first three months postpartum (Gaynes et al., 2005)
 - Rates may vary:
 - Higher rates among those who are **poor** (Knitzer et al., 2008)
 - 40-60% in low income mothers of young children, pregnant and parenting teens
 - Higher rates in certain **cultural groups**
 - 23 - 26% in Latinas (Chaudron et al., 2005; Yonkers et al., 2001)
 - 23.2% in Native Americans (Baker et al., 2005)

How do these numbers fit with what you see in practice?

Postpartum Depression vs. Baby Blues

- Postpartum Depression is often confused with Baby Blues or Postpartum Psychosis (O'hara & Swain, 1996)
- **Baby Blues** are much more common and immediate
 - Incidence rates ~ 40-80%
 - Onset 3-5 days after childbirth; lasts for about 2 weeks
 - Symptoms more mild (crying, mood swings, exhaustion, tension, anxiety, restlessness)
- **Postpartum Psychosis** is much more rare and immediate
 - Incidence rates ~ 0.1-0.5%
 - Onset typically within 2 weeks after childbirth
 - Symptoms more acute, include psychotic episode (bizarre thoughts, hallucinations, thoughts of harming baby)
- **Postpartum Depression**, in contrast, is characterized by more chronic symptoms

Depression: DSM-V Diagnostic Criteria

A. Five or more symptoms must be present for 2 or more weeks, most of the time; At least one of them must be depressed mood or loss of interest/pleasure:

- Depressed mood
- Loss of interest or pleasure in usual activities
- Significant weight gain/loss
- General fatigue and loss of energy
- Sleep difficulties (Insomnia/hypersomnia)
- Psychomotor agitation or retardation
- Feelings of worthlessness/excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death (not just fear of dying)

B. Symptoms cause clinically significant distress or functional impairment

C. Symptoms are not due to physical effects of substance/medication use or general medical condition (e.g., hypothyroidism)

Postpartum Depression: A Public Health Problem

- Untreated PPD can have negative long-term consequences
- Depression in mothers of infants has been shown to:
 - Reduce maternal responsiveness and bonding
 - Reduce adherence to well-child visits and vaccine schedules
 - Reduce the length of breastfeeding
 - Reduce age-appropriate safety practices (e.g., sleep positions, use of car seats/socket covers)
- Very young children whose mothers are depressed have:
 - An increased use of emergency room care
 - A decreased use of preventive services
- Maternal depression has been linked to:
 - Poor language and cognitive outcomes in children
 - Behavioral problems in children and adolescents
 - Food insecurity among low income households

Why Manage Postpartum Depression in Primary Care?

- The frequency of pediatric visits during the first year of a child's life makes the PPC setting an ideal one for managing maternal depression
- Well-baby visits represent the most consistent contact mothers of young children have with the health care system (Chaudron et al., 2004; Perfetti et al., 2004)
- Screening and detection of maternal depressive symptoms can be integrated into routine well-child check-ups as part of anticipatory guidance (Earls, 2010)
- The Affordable Care Act (ACA), with its emphasis on care integration and quality, creates an opportunity to focus attention on new models to optimize care for managing maternal depression in pediatric primary care settings.

What are the legal and ethical considerations?

Chaudron et al., 2007

Challenges for Pediatric Providers

- **Perception of scope of responsibility**
 - Is it the responsibility of the pediatrician/pediatric primary care provider to address maternal depression?
- **Perception of lack of requisite skills** for identifying and managing maternal depression
- **Ethical challenges: risk/benefit ratio**
 - Burden of postpartum depression (and its effects on child health) is well established
 - Simple, accurate screens exist
 - Effective treatments are available: but will mother seek care?

Chaudron et al., 2007

Barriers To Care for Women

- **Psychological:**
 - Stigma: *I'm not crazy*
 - Attitudes/Beliefs (Cultural): *This will pass. I just have to be strong.*
 - Fear of judgment/Mistrust: *They will see I'm a bad mother. They will take my baby away.*
 - Myths/Shame: *This is supposed to be the happiest time in my life.*
- **Practical:**
 - Time, \$, childcare, transportation
- **Past Negative Experience with Helping Systems**
 - Bias/Cultural insensitivity among providers: *I felt disrespected/They were intrusive*
 - Lack of treatments that are acceptable (psychosocial vs meds)
- **Social Network/Community Barriers**
 - Support from important others/negative attitudes
 - Chronic stressors

Feinberg et al., 2006; Grote et al., 2014; Kerker et al., in press; Kingston et al., 2014; Wiedmann & Garfield, 2007

Barriers To Care at the Organization Level

- **Lack of reimbursements** for primary care providers, especially pediatricians (Heneghan et al., 2008; NIHCM Foundation Issue Brief, 2010; Olson et al., 2006; Wiedmann & Garfield, 2007)
- **Limited time** (Heneghan et al., 2008; Olson et al., 2006)
- **Limited treatment options** or access to mental health resources
- **Screening efforts are not systematic:**
 - What tool? How often/when to screen?
 - Standardized documentation needed: record screening outcome, education/counseling of mother, safety issues assessed/addressed, referrals, refusals and follow-ups.
- **Appropriate training for primary care providers lacking** (Heneghan et al., 2000; Horwitz et al., 2007)

What is the Evidence for Managing Postpartum Depression in Primary Care?

- A literature review of models/programs for managing postpartum depression *within* primary care (adult/child) found:
 - 18 unique programs/toolkits
 - Two-thirds in settings that provided routine care for infants
 - Strategies across pediatric and adult settings were highly similar
 - A **“screen and manage” approach was common**
 - Common strategies: psychosocial risk assessments, brief counseling, motivating help seeking, engaging social supports, assisted referrals to mental health
 - Treatments less common, and typically involved medication management
 - Devt of referral networks is the most common type of org/practice support
 - Incentives/reimbursement strategies rarely addressed

Summary of the Evidence for Managing Postpartum Depression in Primary Care?

- Studies have shown that **screening and management are possible and effective** in identifying maternal depression in pediatric practices
- Some with data suggests **positive health outcomes for women** (Leung et al., 2010; Milgrom et al., 2011; Rojas et al., 2007; Yawn et al., 2012)
 - Data are strongest for programs within family medicine practices
- Studies with positive outcomes were characterized by the following:
 - Specific **post-screening follow-up procedures** in place
 - **Treatment and management *within* primary care**
 - **Ongoing staff support and training**, including decision support tools

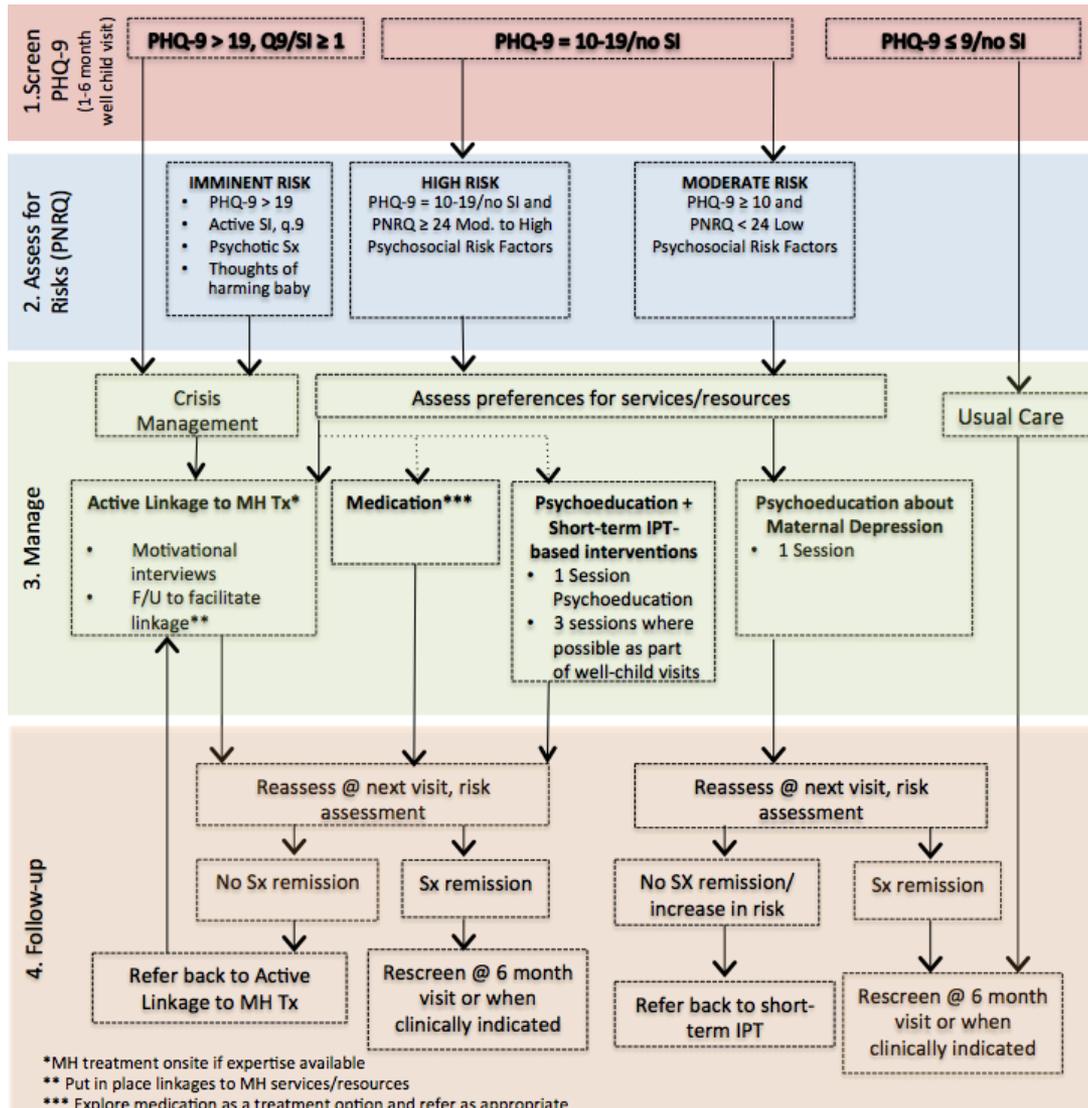
Conclusion of Review

- Making brief psychosocial intervention options available *within* primary care could increase access to timely, non-stigmatizing care for at-risk women, and reduce the potential negative consequences for their child and family.
- Efficacy trials support the benefits of integrating behavioral health care for depression within primary care (Gilbody et al., 2006); yet challenges and variability in implementing such collaborative care models persist (Collins et al., 2010; Solberg et al., 2013).
- Stepped care approaches, a variant of collaborative care, have been proposed but not well tested in pediatrics primary care

Why Stepped Care?

- Stepped care approaches increase the likelihood of care
- Different levels of care are administered based on case severity
 - Primary care providers could manage low-level mental health needs and refer those with complex needs
- Efficiency and costs effectiveness could be maximized
- Addresses two key barriers:
 - Limited availability of specialty mental health services and
 - Challenges with the logistics and attitudes about mental health care

Stepped Care Pathway



PNRQ- Postnatal Risk Questionnaire

Managing Postpartum Depression

Post Screening/Assessment:

Women at **Moderate Risk**: Meets Clinical Cut off but few risk factors

- Engagement: address barriers to care
- Education:
 - Dispel myths about postpartum depression
 - Change expectations
 - Warning Signs
- Linkages to resources:
 - Provide Targeted Resources: assist, link and follow-up
- Reassess and step up care if symptoms do not improve at follow-up

Managing Postpartum Depression (cont'd)

- Women at **High Risk** (Meets clinical cutoff and many risk factors)
- Augment with brief 3-session IPT-based preventive intervention (Adapted from Caron Zlotnick's ROSE Program, Zlotnick et al., 2001)
- Why IPT?
 - PPD linked to lack of perceived social support and social factors (e.g., unplanned pregnancy, financial stress, partner/family conflicts)
- Focuses on connection between interpersonal problem areas and depressed mood
 - Role transition: Reconceptualizes motherhood
 - Interpersonal disputes: Redefine expectations for self/others
 - Interpersonal Isolation: Use and Build Social Support
- Teaches skills:
 - How to manage stress (relaxation strategies)
 - How to lift mood (pleasant activities)
 - Asking for help (communication skills/build social supports)
 - Planning for future (increase hope)

Stepped Care: Feasible in Real World?

- Pilot study as part of QI efforts to improve care for mothers of babies
- Feasibility/Acceptability of Stepped Care:
 - Impact of training on Primary Care Providers
 - Does it change knowledge, attitudes, beliefs?
 - Can Care Management Protocol be integrated into existing workflow?
 - Can Primary Care providers deliver it with fidelity?
 - Training and consultation model
- Assess Impact:
 - Are women being identified?
 - Do those in need get linked more effectively?
 - Do women's symptoms decrease? Better social supports?
 - Does it influence parenting practices?
 - Does it change health care utilization patterns?

Introducing: The STRONG MOM Program

THE STRONG MOM PROGRAM

NEW MOM? FEEL SAD, WORRIED, AFRAID, OR TROUBLE MAKING DECISIONS?
Having a baby is hard. Many new moms have trouble finding energy to care for themselves, their infants, and their families. If this describes you, remember this: It is not your fault. You are not alone. And we are here to help.

Our STRONG program is for mothers of babies 6 months and younger; it does not have to be your first child to enroll in STRONG. Become a STRONG mom and raise healthy, happy kids.

S

Screening for depression to stay strong.

T

Get tips to manage stress & relationships.

R

Reach out for help when needed.

O

Overcome barriers to raising healthy, happy kids.

N

Navigate the challenges and isolation of early motherhood.

G

Grow into a self-confident mother!



WANT TO ENROLL?

CONTACT:

PHONE:

EMAIL:

WEBSITE:

The STRONG program was developed by The IDEAS Center at New York University, Department of Child and Adolescent Psychiatry, The Langone Medical Center.

For information: www.ideas4kidsmentalhealth.org.

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