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

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1 in 8 women suffer from perinatal depression

Perinatal depression is twice as common as gestational diabetes

Depression
10-15 in 100

Diabetes
3-7 in 100

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

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

Adapted from slide created by Allain Gregoire, DRCOG, MRCPsych
Perinatal depression is under-diagnosed and under-treated

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.

Goals

1. Better understand how to engage perinatal women in depression treatment
2. Inform development of interventions to integrate depression treatment into 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?’ ”
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.”
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
- Lack of detection
- Fear/stigma
- Limited access

Provider
- Lack of training
- Discomfort
- Few resources

Systems
- Lack of integrated care
- Screening not routine
- Isolated providers

Women do not disclose symptoms or seek care

Underutilization of Treatment

Unprepared providers, with limited resources

Poor Outcomes

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

- Obstetric provider and staff training, toolkit
- Implementation assistance: clinic procedures, prompts, environment changes, feedback
- Immediate psychiatric guidance via telephone consultation

Improve access to and engagement in depression treatment

Improve depression outcomes
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

- Recruited working group members and clinic providers and staff to participate in Beta testing
- Two 1.5 hour trainings for OB/GYN residents, attendings and clinic staff
- Implemented RAPPID at 1 clinic site for 5 Mondays over 5 weeks
- Chart review and focus group
- Coded focus group data and identified themes
In 2010, Massachusetts passed a Postpartum Depression Act

PPD Commission

MCPAP for Moms Funding
Providers can call for patient consultations

- Family Medicine
- Psychiatric providers
- Primary care providers
- Obstetric providers/Midwives
- Pediatric providers

Telephone Consultation

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1-855-Mom-MCPAP

Telephone Consultation

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Telephone Consultation

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Edinburgh Postnatal Depression Scale (EPDS)

Validated in pregnancy and postpartum

10 items

Asks about self-harm

©MCPAP For Moms
Administer Edinburgh Postnatal Depression Scale

Administer EPDS for high-risk patients
Depression Screening Algorithm for Obstetric Providers

The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following glucose test
- If high-risk patient: *2 weeks postpartum
- 6 weeks postpartum visit

**EPDS Score**

- **Does not suggest depression**
  - Clinical support staff educates woman about the importance of emotional wellness
  - Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.
  - Contact clinical support staff to arrange follow-up care if needed. Give parent information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org).
  - If patient is already in treatment, ensure follow up appointment is scheduled.
- **Score <10**
  - Suggests patient is depressed
  - Assess to determine most appropriate treatment (refer to Assessment of Depression Severity and Treatment Options and Key Clinical Considerations documents)
  - Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).
  - If antidepressant medication is indicated:
    1. Screen for bipolar disorder (refer to Bipolar Depression Screen)
    2. Refer to Recommended Steps before Beginning Antidepressant Medication Algorithm and Antidepressant Treatment Algorithm
    3. Offer psychotherapy
- **Score ≥ 10**
  - Provider steps are in this purple box
  - Positive score on question 10
  - Suggests patient may be at risk of self-harm or suicide
  - Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.
  - Immediately assess further:
    1. In the past two weeks, how often have you thought of hurting yourself?
    2. Have you ever attempted to hurt yourself in the past?
    3. Have you thought about how you could harm yourself?
  - Document assessment and plan in medical record.
  - If there is a clinical question, call MCPAP for Moms 855-Mom-MCPAP (855-666-6272) or refer to emergency services.

**ALWAYS DISCUSS ALL SUPPORT/TREATMENT OPTIONS INCLUDING PSYCHOSOCIAL SUPPORTS**

* High-risk women with a history of depression or a positive EPDS Score, or those taking or who have taken psychiatric medications.

MCPAP for Moms: Promoting maternal mental health during and after pregnancy

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Recommended Steps before Beginning Antidepressant Medication Algorithm
(Discussion should include yet not be limited to the below)

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

- 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
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]

No

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

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
paroxetine (Paxil) 20-60 mg increase in 10 mg increments

Second line treatment

SSRIs

paroxetine (Paxil) 20-60 mg increase in 10 mg increments
venlafaxine (Effexor) 75-300 mg increase in 75 mg increments
fluoxetine (Prozac) 20-60 mg increase in 10 mg increments
duloxetine (Cymbalta) 30-60 mg increase in 10 mg increments

SNRIs

sertraline (Zoloft) 50-200 mg increase in 50 mg increments
venlafaxine (Effexor) 75-300 mg increase in 75 mg increments
fluoxetine (Prozac) 20-60 mg increase in 10 mg increments
duloxetine (Cymbalta) 30-60 mg increase in 10 mg increments

Other

paroxetine (Paxil) 20-60 mg increase in 10 mg increments
duloxetine (Cymbalta) 30-60 mg increase in 10 mg increments

If a first or second line medication is currently helping, continue it. Strongly consider using first or second line medicine that has worked in past

Considered a safer alternative medication because they have the lowest degree of teratologic 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.

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

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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

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Can refer moms to www.mcpapformoms.org
MCPAP for Moms has served many providers and parents in our first five months (July-Nov, 2014)

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
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<tbody>
<tr>
<td>OB Practices Enrolled</td>
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<tr>
<td>Trainings (including 7 community trainings)</td>
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<td>Women Served</td>
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<td>Doc-doc Telephone Encounters</td>
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<td>Face to Face Evaluations</td>
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<tr>
<td>Care Coordination Encounters</td>
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<td>Telephone Encounters with Ob/Gyns and Midwives</td>
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<td>Telephone Encounters with Psychiatric Providers</td>
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<td>Telephone Encounters with Other Providers</td>
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<td>PPD Coalition Started</td>
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<tr>
<td>Support Groups Available</td>
<td>139</td>
</tr>
</tbody>
</table>
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!