

## Maternal Mental Health Screening, Assessment and Treatment

### About the Title V Block Grant

The federal Title V Maternal and Child Health (MCH) Block Grant helps states ensure the health of all mother and children. As part of Minnesota's Title V Block Grant activity requirements, the MDH conducts a statewide needs assessment every five years. The needs assessment provides guidance to Title V activities for the next five years by identifying priority issues. This fact sheet describes one of Minnesota's priority issues.

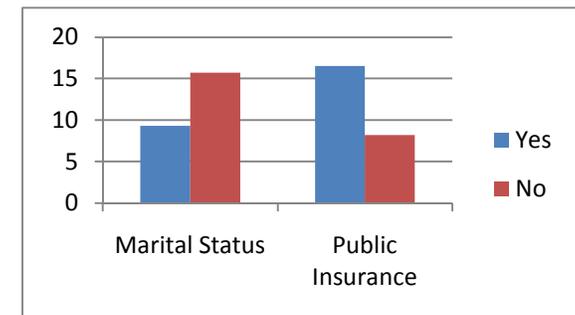
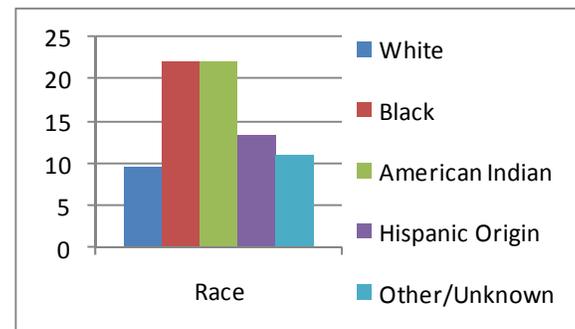
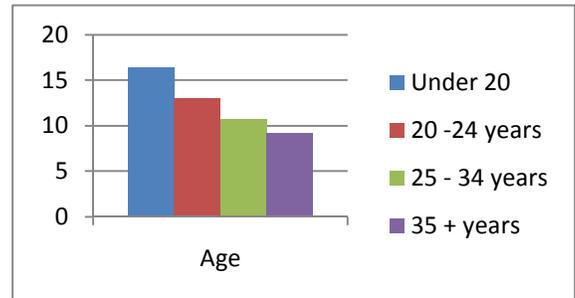
### Seriousness of the Issue

In 2007, there were 86,832 pregnancies in Minnesota with 73,675 live births, 12,770 abortions, and 387 fetal deaths of at least 20 weeks. These pregnancies occurred to the estimated 1,058,541 women of childbearing age (15-44 years old).<sup>1</sup>

Three mental health conditions are typically associated with the perinatal or postpartum period: the postpartum "blues", postpartum depression, and postpartum psychosis. Postpartum blues is considered normal and is experienced by approximately 50 percent of all mothers within the first 10 days after childbirth. One in 10 women becomes clinically depressed when pregnant and approximately 10 to 20 percent experience clinical depression in the postpartum period. Postpartum psychosis is a rare condition occurring in 1 or 2 in 1,000 women. Other mental health disorders which may appear or become exacerbated during the perinatal period include anxiety, eating and trauma-related disorders although these conditions have received little attention.<sup>2</sup>

Minnesota data from the 2007 Pregnancy Risk Assessment Monitoring System Survey (PRAMS) shows 11.4 percent of women indicating symptoms of postpartum depression. Women who were: younger, Black or American Indian, unmarried, or on public insurance were more likely to report symptoms of postpartum depression.<sup>3</sup>

### Characteristics of Minnesota Women Reporting Symptoms of Postpartum Depression – 2007



Maternal depression is a multifaceted illness with varying consequences for a woman's mental health, her functioning as a mother, the family's functioning, and her child's development.

- Factors that can place mothers at risk for maternal depression include prior history of depression, family history of depression, hormonal changes experienced during pregnancy, genetics, poor environment and lack of support.



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- Babies depend on the emotional nurturance, protection, and stimulation that depressed mothers may not consistently provide.
- Infants of clinically depressed mothers often withdraw from daily activities and avoid interaction with caregivers, which in turn jeopardizes infant language, physical, intellectual, and emotional development.
- Evidence of infants experiencing symptoms of depression has been found in children as young as four months of age.
- Older children of mothers depressed during infancy often exhibit poor self-control, aggression, poor peer relationships, and difficulty in school.<sup>4</sup>

### Evidence Based Practices

Treatment for depression has been shown to be effective. Medication and therapy are both recommended for moderate to severe depression. Some studies have also found medications alone to be an effective treatment. Despite the high prevalence of depression and the effectiveness of treatment, few mothers are treated for depression. Once prenatal care has been completed many mothers do not have regular contact with health or mental health care services for themselves.<sup>5</sup>

Pediatricians are often the health care professionals with the most frequent contact with depressed women of childbearing age. *Bright Futures in Practice: Mental Health* recommends that pediatricians ask parents about specific symptoms of depression. Only one-fourth of mothers with depressive symptoms are recognized by pediatricians.<sup>6</sup>

Identifying valid screening tools and developing systems which support screening in pediatric settings are both areas which have been researched. Early identification of women who are at higher risk of developing post partum depression was the focus of a recent study examining the predictive validity of the Postpartum Depression Predictors Inventory – Revised (PDPI –R). The study found, that the PDPI – R, administered at the 3<sup>rd</sup> and 8<sup>th</sup> months prenatally, was able to predict 82 percent of postpartum major and minor depressions.<sup>7</sup> Another study, conducted in Minnesota, focused on the validity of a 2-question screen and the 9-item Patient Health Questionnaire (PHQ-9). The study found the 2-question screen did not miss any cases of postpartum depression, while the PHQ-9 was found to have a false positive rate of only 8 to 10 percent. The results suggest the tools

would perform well together in a two-stage screening process.<sup>8</sup>

A study published in the June 2009 issue of *Pediatrics* found using cues embedded in the electronic medical records of infants 0-6 months to be an effective method of both detecting and referring mothers at risk of postpartum depression. Providers were unable to close the child's medical record without entering (and referring where indicated) the Edinburgh Postpartum Depression Scale (EPDS) score. As a result the EPDS was administered 98 percent of the time and mothers with positive scores were always referred.<sup>9</sup>

Since Medicaid covers over one-third of U.S. births to low-income pregnant women, it is an important source of support for maternal depression screening, assessment, and treatment. The National Academy for State Health Policy identifies the following key strategies to support Medicaid reimbursement for maternal depression screening by pediatric providers:

- Eliminate barriers (i.e. age limits on patients who can be served) facing pediatric providers who bill Medicaid for maternal depression screening.
- Clarify screening tools that are eligible for Medicaid reimbursement and distinguish reimbursement for screening from reimbursement for in-depth assessments.
- Identify billing codes and payment rates that pediatric providers can use for a maternal depression screening.
- Determine the best way to reimburse for maternal depression screening.
- Determine how women who exhaust their Medicaid coverage will be covered for services through one-year postpartum.
- Provide guidance and support to pediatric providers on resources for referral and follow-up.<sup>10</sup>

In a 2005 document, the National Center for Infant and Early Childhood and Zero to Three make the following recommendations of steps which can be taken to improve maternal mental health for all women:

- Increase maternal depression awareness in the health care, early care and education, and /family support communities.
- Perform outreach and education to expectant and new mothers to address stigma and patient barriers.
- Assure earlier identification of maternal depression in health care settings by addressing barriers to recognition, screening, assessment, and referral.

- Invest in evidence-based interventions that improve the mother-child relationship.
- Build a comprehensive network of community perinatal services and service providers to strengthen mental health in the pregnant and postpartum family.<sup>4</sup>

### Current Resources and Capacity

As part of the ABCD Screening Academy Project, the Minnesota Department of Human Services (DHS) is working to establish coverage for maternal depression screening performed during a pediatric visit for eligible enrollees in a Minnesota Health Care Program. DHS will issue an update to providers notifying them of billing guidelines as soon as coverage policy has been finalized.

Postpartum Support International's (PSI) mission is to promote awareness, prevention and treatment of mental health issues related to childbearing. They provide current information, resources, education, and advocate for further research and legislation to support perinatal mental health. PSI has two coordinators in Minnesota. The group has developed and maintains a list of providers who treat women with postpartum depression.

The National Alliance on Mental Illness (NAMI) Minnesota offers education, support and advocacy about all mental illnesses, including postpartum depression. NAMI sponsors an annual conference focused on maternal depression titled "Beyond the Baby Blues".

In 2005, the Minnesota legislature passed legislation requiring hospitals to provide new parents with written information about postpartum depression. It also requires providers of health care services to pregnant women to have information about postpartum depression available for pregnant women and their families. The Minnesota Department of Health (MDH) website makes both a fact sheet and tri-fold brochure available for download in English, Hmong, Russian, Somali and Spanish. The MDH is also able to provide training on maternal depression and the legislation to health care providers and others.

In Minnesota, all local health departments receive funding to provide home visits for at-risk pregnant women, infants and toddlers. Forty-two of 91 local health department programs report using a tool to screen for maternal depression. Programs also provide education, support and referrals around maternal mental health issues.

The MDH Child and Teen Check-ups (C&TC) provider trainings on screening for developmental and mental health issues and newborn assessment include information about signs, symptoms, risk factors and screening tools for postpartum depression.

<sup>1</sup> Minnesota Department of Health Center for Health Statistics. (2007). *Minnesota Health Statistics Annual Summary*, Retrieved August 25, 2009, from <http://www.health.state.mn.us>

<sup>2</sup> Ostler, T. (2009) Mental Illness in the Peripartum Period. Zero To Three. Retrieved August 31, 2009 from: [http://www.zerotothree.org/site/DocServer/29-5\\_Ostler.pdf?docID=9261](http://www.zerotothree.org/site/DocServer/29-5_Ostler.pdf?docID=9261)

<sup>3</sup> MDH. Minnesota Pregnancy Risk Assessment Monitoring System (2009). *2007 Data Tables*.

<sup>4</sup> Onunaku, N. *Improving Maternal and Infant Mental Health: Focus on Maternal Depression*. Los Angeles, CA: National Center for Infant and Early Childhood Health Policy at UCLA; 2005

<sup>5</sup> Dubowitz, H., Feigelman, S., Lane, W., Prescott, L., Blackman, K., Grube, L., Meyer W., & Tracy, J.K. (2007). Screening for Depression in an Urban Pediatric Primary Care Clinic, *Pediatrics*, 119, 435-443

<sup>6</sup> Heneghan, A.M., Chaudron, L.H., Storfer-Isser, A., Park, E.R., Kelleher, R.E., Hoagwood, K.E. et al. (2007). Factors Associated With Identification and Management of Maternal Depression by Pediatricians. *Pediatrics*, 119, 444-454.

<sup>7</sup> Oppo, A., Mauri, M., Ramaccotti, D., Camilleri, V., Banti, C., Rambelli, C., et al. (2009) Risk factors for postpartum depression: the role of the Postpartum Depression Predictors Inventory-Revised (PDPI-R). *Archives of Women's Mental Health*, 12, 239-249.

<sup>8</sup> Gjerdingen, D., Crow, S., McGovern, P., Miner, M., Center, B. (2009) Postpartum Depression Screening at Well-Child Visits: Validity of a 2-Question Screen and the PHQ-9. *Annals of Family Medicine*, 7 (1), 63-70.

<sup>9</sup> Cassels, C., (2009) Screening at 2 Months Identifies Most Women With Postpartum Depression. *Medscape Medical News*. Retrieved June 11, 2009 from, <http://www.medscape.com/viewarticle/704281>

<sup>10</sup> VanLandeghem, K., (2006). Financing Strategies for Medicaid Reimbursement of Maternal Depression Screening by Pediatric Providers, *National Academy for State Health Policy*, Retrieved August 28, 2009 from: [http://www.nashp.org/Files/Maternal\\_depression\\_screening\\_brief.pdf](http://www.nashp.org/Files/Maternal_depression_screening_brief.pdf)