

HOUSE BILL 2666: MATERNAL MENTAL HEALTH WORK GROUP REPORT



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WORK GROUP REPORT
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Prepared by

The Maternal Mental Health Work Group
Appointed by Bruce Goldberg, M.D.
Director, Oregon Department of Human Services
Director-designee, Oregon Health Authority

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This report is available online at:

www.oregon.gov/dhs/ph/ch/maternal_mental_health.shtml

WORK GROUP MEMBERS

Wendy Davis, Ph.D., Work Group Chair

Postpartum Support International

Jillian Romm, R.N., L.C.S.W., Services Subcommittee Chair

Director, Mental Health Division, Center for Women's Health, OHSU

Viki Brown, R.N., M.S.N., Systems and Financing Subcommittee Chair

Director, Jackson County Public Health Services

Katherine Bradley, Ph.D., R.N.

Administrator, Office of Family Health, Oregon Health Authority

Joella Dethman

Director, Hood River County Commission on Children and Families

Donalda Dodson, R.N., M.P.H.

Executive Director, Oregon Child Development Coalition

RJ Gillespie, M.D., M.H.P.E.

Oregon Pediatric Society, Children's Clinic

Marcia Kahn, M.D.

Board President, Baby Blues Connection

Maria Loreda

Chief Operations Officer, Virginia Garcia Memorial Health Center

Pamela Mariea-Nason, R.N., M.B.A.

Director, Health Policy and Community Engagement, CareOregon

Shafia M. Monroe, C.M., C.C.E.

President and CEO, International Center for Traditional Childbearing

John Muench, M.D., M.P.H.

Director of Behavioral Medicine, Family Practice Department, OHSU

Brenda Story, C.A.D.C.

Executive Director, Unio Recovery Center

PRINCIPAL STAFF

Nurit Fischler, M.S.

Office of Family Health, Oregon Health Authority

CONTRIBUTING STAFF

Office of Family Health: Ed Herzog, M.A., M.P.S, Julie M. McFarlane, M.P.H, Sandra Potter-Marquardt, M.P.A, Kenneth D. Rosenberg, M.D, M.P.H, Sarah Tinker, Cate Wilcox, M.P.H.

Department of Medical Assistance Programs: Carol Camfield, R.N.

Addictions and Mental Health Division: Diane Lia, L.C.S.W., C.A.D.C. II, Kathy Seubert, M.C.S.W., L.C.S.W., Jane-Ellen Weidanz

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INTRODUCTION

The Maternal Mental Health Work Group was created by the 2009 Oregon State Legislature's passage of House Bill 2666. The purpose of the work group was to study maternal mental health disorders in Oregon and make recommendations to the Legislature. The work group was appointed by DHS Director Bruce Goldberg, M.D., in December 2009 and convened in January 2010.

As required by the legislation, the work group included representatives from the following groups: public health professionals; medical providers and researchers; hospitals, medical centers and childbirth professionals; medical and nursing schools; addictions and mental health treatment providers; community-based and social support organizations; private and public insurance and health plans; and vulnerable communities and diverse cultures.

The charge of the work group was to:

1. Identify vulnerable populations and risk factors in Oregon for maternal mental health disorders (prenatal through one year postpartum).
2. Identify and recommend effective, culturally competent and accessible prevention, screening/identification and treatment strategies (including public education and awareness, provider education and training, and social support services).
3. Identify successful maternal mental health initiatives in other states; recommend programs, tools, strategies and funding sources for similar programs in Oregon.
4. Recommend evidence-based practices for health care providers and public health systems.
5. Recommend private and public funding models.
6. Identify actions to be taken by 2015 to reduce the risk of harm to women and children.
7. Submit a report with findings and recommendations to the Legislative Assembly no later than September 15, 2010.

The HB 2666 Maternal Mental Health Work Group met 10 times between January and June 2010 to complete its work. Agendas and meeting proceedings are posted at www.oregon.gov/DHS/ph/ch/hb2666workgroup.shtml.

The findings and recommendations contained in this report represent the passion and dedication of each work group member to improving the mental health of all women, children and families in Oregon. It is our fervent hope that they provide a strong and compelling path to improving Oregon's systems and supports for pregnant and postpartum women and families.

Facts about maternal mental health

- Maternal mental health disorders include a range of mood and anxiety disorders affecting women during pregnancy and the first year postpartum (e.g., prenatal and postpartum depression, anxiety and panic disorders, and postpartum psychosis).
- Depression is the leading cause of disease-related disability in women¹ and the most common serious complication of childbirth.^{2, 3}
- In Oregon, nearly one in four new mothers (24 percent) report symptoms of depression either during or after pregnancy.⁴
- Effective screening and treatment exist, yet most cases of maternal depression are never diagnosed.⁵
- Only 35 percent of women diagnosed with maternal depression receive adequate treatment.⁶
- Maternal depression and anxiety affect a woman's ability to care for herself, relate to others and engage in healthy parenting behaviors.
- Children of depressed mothers are at risk for serious health, development, emotional, behavioral and cognitive problems that can persist for many years.
- At least 15.6 million children in the U.S. live with an adult who had major depression in the past year.⁷



Maternal mental health disorders are a major public health problem, impacting the lives of thousands of Oregon women, children and families each year. Maternal mental health disorders (e.g., prenatal and postpartum depression and anxiety) are clinically defined; treatable; and amenable to support, education and intervention. Risk factors are well-researched and provide a framework for early detection and intervention across the systems and providers that touch pregnant and postpartum women's lives.

The passage of HB 2666 and the development of the Maternal Mental Health Work Group are evidence of the growing commitment of Oregon's advocates, public agencies and legislative leadership to improve maternal mental health in Oregon. This report, developed for the 2010 Oregon Legislative Assembly, is both the result of that partnership and a demonstration of the commitment to continue this shared work.

This report frames a vision for maternal mental health in Oregon and makes eight overarching recommendations to move Oregon toward that vision. The recommendations recognize current economic constraints as well as opportunities associated with health care reform and the emerging science of maternal mental health. Each recommendation is accompanied by supporting scientific/policy rationale and specific activities. Some of the activities require legislative or state agency leadership, while others provide opportunities for local communities, private and non-profit partners to move the agenda forward in their own arenas.

The eight recommendations together reflect a holistic approach to improving maternal mental health in Oregon. The first three recommendations provide a priority starting point for increasing awareness, understanding and capacity to address maternal mental health in Oregon. Two legislative changes are included in these priority recommendations.

- First, require that pregnant and postpartum women be provided with education on maternal mental health disorders.
- Second, by 2015, require that pregnant and postpartum women be offered screening and assessment for maternal mental health disorders.

The long-term success of this work depends largely on Oregon's ability to respond broadly to the mental health needs of all women and families, while also tailoring services and systems to reach our diverse communities and vulnerable populations. This premise underlies all the findings and recommendations in this report.

Recommendations:

1. Provider training and support (page 17)

Develop and fund a coordinated statewide initiative to train and support health care, public health, addictions, mental health and early childhood providers to understand, identify and address the mental health needs of pregnant, postpartum and post-loss women and families.

2. Public awareness (page 19)

Increase public awareness and understanding of the importance, symptoms, risk factors and stigma associated with maternal mental health disorders.*

3. Screening and assessment (page 21)

Make screening and assessment for maternal mental health disorders available to all Oregon women during pregnancy, postpartum and post-loss.*

4. Treatment and support services (page 23)

Ensure that effective and culturally competent services are available and accessible statewide to treat women and prevent adverse consequences in children and families with maternal mental health disorders.

5. State and local systems integration (page 25)

Develop an integrated approach to maternal mental health across health, education, addictions and mental health, public health, and early childhood systems at both the community and state levels.

6. Medicaid coverage for maternal mental health (page 27)

Ensure that the Oregon Health Plan covers a full range of screening, assessment and treatment services; eliminate barriers to Medicaid providers billing for maternal mental health disorders (pregnancy through at least one year postpartum and post-loss).

7. Private health plan coverage (page 29)

Encourage Oregon's private health plans to promote screening, assessment and treatment for maternal mental health disorders for at least one year postpartum and post-loss under both mothers' and children's plans.

8. Monitoring and evaluation (page 31)

Conduct ongoing monitoring and evaluation of maternal mental health status, needs and outcomes in Oregon.

* Recommended activities include passing legislation.

Overview

The HB 2666 Maternal Mental Health Work Group studied the scope, impact and barriers to the identification and treatment of maternal mental health disorders. Historically, work in this area has focused almost exclusively on postpartum depression. However, the emerging scientific literature points to the importance of addressing the full range of mood and anxiety disorders that occur during the prenatal as well as postpartum period. Emerging prevention and intervention research also recognizes the impact of parental mental health on children, parenting, and families and the need to integrate a two-generation family focus into maternal mental health interventions. This broader understanding of maternal mental health formed the basis for all the work of the HB 2666 Maternal Mental Health Work Group.

Women with maternal mental health disorders experience physical, mental and emotional distress. They are overwhelmed by feelings of inadequacy, anxiety and despair. In some cases, their anxiety results in an obsessive disorder with repetitive, intrusive thoughts that include frightening, unwanted images of harm to their babies. If the woman and family do not have reliable information to help them understand what is happening, they live anxiously in fear, and women may even become suicidal. Informed and timely treatment can offer reassurance that these symptoms are familiar to an informed provider, and most importantly that they are temporary and treatable.



Prevalence of maternal mental health disorders

There is no more vulnerable time for mothers and children than during pregnancy and postpartum, when psychiatric admissions rise higher than any other time in a woman's life.⁸ Depression is the leading cause of disease-related disability among women, and pregnant and postpartum women are at increased risk for depression.⁹ An estimated 10 to 20 percent of all women experience depression during pregnancy or the first 12 months postpartum.¹⁰ One in eight (13 percent) experience postpartum depression.¹¹ Postpartum psychosis, a rare but serious disorder requiring immediate intervention, occurs in one to two of every 1,000 births.¹²

Although any woman can experience maternal mental health disorders, rates vary across age, socioeconomic status, race and ethnicity. Regardless of race, low-income women have higher rates of maternal depression, often in combination with stressful life circumstances and other risk factors. Studies have found that mothers living in poverty are two to three times more likely to have depression than other mothers. Self-reported depression rates among low-income mothers of young children are in the 40 to 60 percent range.^{13, 14}

"The co-occurrence of maternal depression with other adverse conditions appears to have a more pronounced negative effect on the social and emotional development of children than maternal depression alone. Whether depression occurs simultaneously with psychological conditions—such as eating disorders or substance abuse—or concurrent with environmental conditions—such as poverty and domestic violence—these combined conditions often result in poor attachment between infants and their mothers and less optimal mother-child interactions."¹⁵

— National Center for Infant and Early Childhood Health Policy

Impact of maternal mental health disorders

Research has shown that untreated or inadequately treated maternal mental health disorders can result in serious, long-term consequences for maternal health and pregnancy outcomes, parenting and family relationships, and infant and child health and development.

Impact on maternal health and pregnancy outcomes

The effects of maternal mental health disorders on women's health range from the negative long-term effects of damaged maternal self-esteem to the extreme of increased rates of maternal suicide.¹⁶ Suicide is one of the top three causes of maternal death worldwide.¹⁷

Depressed women have increased rates of substance abuse, inadequate prenatal care and poor prenatal nutrition. Pregnant women with depression are also at risk for increased rates of maternal hypertension, miscarriage and premature labor. They are 3.4 times more likely to deliver preterm, and four times as likely to deliver a baby with low birthweight.^{18, 19}

Impact on parenting and family relationships

Maternal mental health disorders threaten a woman's ability to care for herself, parent her newborn and other children, and maintain healthy family relationships. Maternal mental health disorders are associated with: less nurturing (reading, singing, playing, cuddling), increased familial conflicts, lower rates of breastfeeding, and mothers being less likely to follow safety or health guidelines for children.^{20, 21, 22}

Impact on infant and child health

A wide range of health and development problems in children are associated with untreated maternal mental health disorders.^{23, 24, 25} Studies have found that:

- Infants of mothers with maternal mental health disorders have higher stress hormone levels, show less self-soothing behaviors and are more likely to have impaired attachment. They are at increased risk for impaired cognitive, emotional and linguistic development and problems often persist as children develop.
- Toddlers show increased risk for behavioral/emotional problems and reduced language ability.
- Grade school children show increased rates of ADHD and mood disorders.
- Teenagers may experience increased rates of anxiety, impulsivity and lower scores on intelligence tests.



MATERNAL MENTAL HEALTH DISORDERS

Types²⁶

- ▶ Prenatal depression or anxiety
- ▶ Grief reactions to pregnancy or infant loss
- ▶ Post-traumatic stress disorder (PTSD)
- ▶ Major postpartum depression
- ▶ Postpartum anxiety or panic disorder
- ▶ Postpartum obsessive-compulsive disorder
- ▶ Postpartum bipolar II disorder
- ▶ Postpartum psychosis

Risk factors²⁷

- ▶ History of previous depression or other mood disorders
- ▶ Recent stressful life events
- ▶ Inadequate social supports
- ▶ Poor marital relationship
- ▶ Low self-esteem
- ▶ Child care stress
- ▶ Difficult infant temperament
- ▶ Single marital status
- ▶ Unplanned or unwanted pregnancy
- ▶ Lower socioeconomic status

Symptoms^{28, 29}

- ▶ Restlessness or irritability
- ▶ Anxiety or agitation
- ▶ Sadness, weepiness
- ▶ Withdrawing from loved ones and social isolation
- ▶ Feelings of hopelessness and powerlessness
- ▶ Loss of motivation and interest in normal activities
- ▶ Sleeping too much or too little
- ▶ Lack of interest in one's self or children
- ▶ Lack of interest in the newborn or hypervigilance about the newborn
- ▶ Feelings of worthlessness or guilt
- ▶ Impaired concentration or feeling overwhelmed

Barriers to identification and treatment

One of the biggest obstacles to identification and treatment of maternal mental health disorders is the embarrassment and fear women feel. The very symptoms of the illness—shame, insecurity, hopelessness and confusion—make it nearly impossible for a woman to reach out. Rather than realizing she needs support and care, she is likely to think she has failed, is not meant to be a mother and should not disclose how she is feeling. Women report they fear judgment, poor treatment and even that their baby will be removed from them. A woman may try to hide even the most severe symptoms in an attempt to prove she is a worthy mother.³⁰

Even when women and families want to reach out, they often encounter multiple barriers as they seek information and treatment. Common barriers include: inability to pay for mental health services, mistrust and fear of judgment, lack of trained providers, long waiting periods, transportation, language and cultural barriers, treatment settings that don't accommodate children, and a lack of coordination between primary health care and mental health services.³¹ The complex life circumstances in which women's depression is often embedded—including poverty, racism, lack of social supports, substance abuse, intimate partner violence, childhood abuse and stress linked to a life of hardship—can greatly compound the barriers to care.^{32, 33}

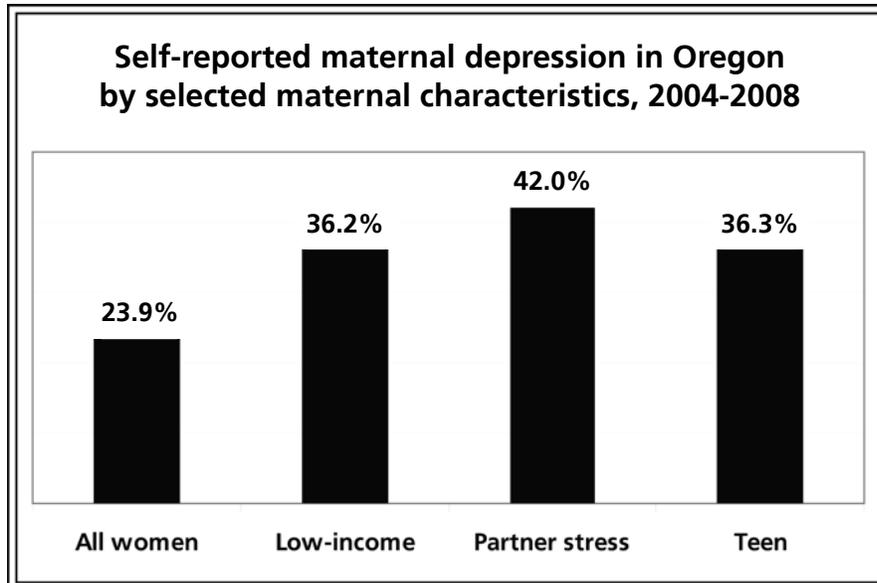
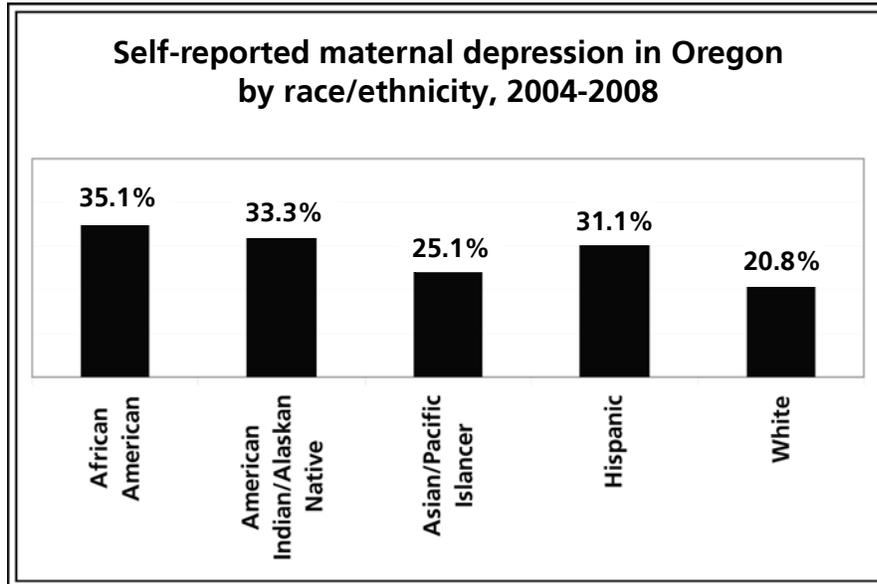
Providers also experience barriers to addressing maternal mental health concerns with their patients, including: lack of awareness, training, and time; managed care policies; insurance payment problems; competing priorities; and fear of legal repercussions.³⁴

Maternal mental health in Oregon

Maternal mental health disorders during and after pregnancy are a major public health problem— affecting thousands of women, children, and families in Oregon. Among Oregon women surveyed two to six months after giving birth:³⁵

- Twenty-four percent of new mothers report that they were depressed during and/or after pregnancy (12 percent during, 5 percent after, 7 percent both).
- Low-income women are more than twice as likely to report depressive symptoms than higher income women (36 percent compared to 17 percent).
- Women of minority race/ethnicity are more likely to report depressive symptoms than white women (35 percent African American, 33 percent American Indian, 25 percent Asian/Pacific Islander, 31 percent Hispanic compared to 21 percent white).

- Women who experience partner-related stress are more than twice as likely to report depressive symptoms than those without partner-related stress (42 percent compared to 16 percent).
- Teen mothers are more likely to report depressive symptoms than older mothers (36 percent compared to 22 percent).



Services and systems for maternal mental health in Oregon

Women and families with maternal mental health issues can be identified and receive treatment and support through a variety of health, mental health and social service providers and systems. These include: obstetric, primary care, and pediatric settings; public health; private practice and community mental health providers; early childhood and home visiting programs; childbirth support specialists; and peer or other social support programs for new mothers and families. However, availability and accessibility of these services varies widely around the state and is often limited by health insurance status.

Challenges to providing comprehensive maternal mental health services in Oregon include:

- Many women who receive Oregon Health Plan (OHP) Medicaid coverage during pregnancy lose eligibility two months after giving birth.
- The community mental health system is under-funded and only meets 46 percent of the identified need.³⁶
- System and funding barriers limit the ability of medical and mental health providers to screen for and deliver maternal mental health services to Medicaid clients.
- Many providers who work with pregnant and postpartum women do not recognize the importance of maternal mental health disorders or are not trained to identify, address and refer for these disorders.



Increasing early identification and treatment of women and families experiencing maternal mental health disorders in Oregon is critical.

- Approximately 50,000 infants are born each year in Oregon, and 40 percent of those births are to low-income women on Medicaid.³⁷
- More than a third (36 percent) of low-income new mothers surveyed in Oregon report that they were depressed during or after pregnancy.³⁸
- Among Medicaid clients with a 2007 delivery, 6 percent were screened for depression.³⁹

National policy documents and scientific findings

The HB 2666 Maternal Mental Health Work Group used scientific studies and national policy documents as the building blocks for their work. Key among these were:

- ▶ The National Research Council and Institute of Medicine's, "Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention" (June 2009).
- ▶ The National Center for Children in Poverty's, "Reducing Maternal Depression and its Impact on Young Children: Toward a Responsive Early Childhood Policy Framework" (2008).

Appendix C contains links to the findings from these and other key scientific studies and national policy documents.



Guiding criteria

After reviewing national scientific and policy findings as well as Oregon data, the Maternal Mental Health Work Group developed the following criteria to guide its policy recommendations:

The recommendations of the HB 2666 Maternal Mental Health Work Group will:

- *Address the breadth of maternal mental health disorders during pregnancy through at least one year postpartum and post-loss.*
- *Promote increased awareness of maternal mental health issues, risk factors, and their impact on women, children and families.*
- *Address barriers for individuals, providers and systems.*
- *Promote integration of physical and mental health services and their funding streams around the patient's care.*
- *Build upon and create opportunities for multiple partners and public involvement.*
- *Integrate and build upon existing Oregon programs, services and systems.*
- *Incorporate best practice models and evidence of effectiveness as appropriate.*
- *Promote innovative, culturally relevant and community-based approaches.*
- *Be sustainable and financially feasible.*
- *Recognize and value the complementary roles of a broad range of providers serving women and families (childbirth educators; doulas; public health nurses; peer counselors; early childhood, substance abuse, mental health, and medical providers; etc.).*
- *Provide an action-oriented framework that creates momentum and fosters change. The framework will:*
 - » *Identify opportunities for staging and scoping immediate and longer term strategies.*
 - » *Encourage and support providers, communities and policy makers to be innovative and implement change.*
 - » *Be practical and feasible to implement.*
 - » *Include criteria for measuring and evaluating outcomes.*

Opportunities and challenges

Development of the work group's recommendations was also guided by the current status of health care reform in Oregon and nationally. Both federal and state health systems are currently undergoing massive restructuring.

The federal Patient Protection and Affordable Care Act passed while this work group was in session, effectively setting in motion national health care reform. The law requires insurers to cover preventive care and screenings without any cost sharing (including postpartum depression) and also amends the Title V Maternal and Child Health Services Block Grant for new grants to states to provide postpartum depression services. At the present time, this new funding is not yet allocated. At the state level, Oregon is implementing a new structure for government-supported health services under the Oregon Health Authority, as directed by House Bill 2009. Fiscal constraints and uncertainties about the state budget and available funds for the coming biennium are also an important consideration.

In response to these dynamic realities, the work group framed a vision and recommendations which can engage multiple partners and provide critical direction for maternal mental health, while remaining flexible to take advantage of emerging opportunities in the shifting health systems landscape.



"Reflecting the continued widespread prevalence of maternal depression, the American Congress of Obstetricians and Gynecologists (ACOG) recently suggested an objective for Healthy People 2020⁴⁰ targeted at increasing the proportion of pregnant and postpartum women who receive screening for maternal depression and referral for evidence-based therapy."

— *National Institute of Healthcare Management*

VISION FOR MATERNAL MENTAL HEALTH IN OREGON

Individual and family level

Strong, nurturing relationships.

Accessible and culturally competent screening, assessment, treatment and support services.

Provider level

Adequate and available workforce.

Knowledgeable and engaged providers.

Community level

Public and provider awareness of the importance, impact and how to address maternal mental health disorders.

Community norms that reinforce positive maternal mental health practices.

Community-based social and parenting supports for pregnant and postpartum families.

Organizational/systems level

Broad network of public and private partners advocating for maternal mental health.

Strong state and local resource and referral mechanisms linking health, addictions and mental health, public health, education and early childhood services.

Statewide/policy level

Policy infrastructure support for maternal mental health as a priority within Oregon's systems and services for pregnant and postpartum women and families.

Linked health, addictions and mental health, social service, and early childhood policies.

Sustainable financing based in strong partnerships across public/private sectors and multiple disciplines.

Ongoing research, monitoring and evaluation.

VISION FOR MATERNAL MENTAL HEALTH IN OREGON

The HB 2666 Maternal Mental Health Work Group is committed to helping build and sustain maternal mental health systems and services in Oregon that are:

- ▶ Family and patient-centered;
- ▶ Two-generational (parent-child focus);
- ▶ Comprehensive, integrated and linked to community resources such as social support services and drug and alcohol treatment;
- ▶ Accessible statewide;
- ▶ Culturally and linguistically competent; and
- ▶ Tailored to the needs of Oregon's diverse communities and vulnerable populations, particularly low-income, culturally or ethnically diverse families and/or those experiencing other co-morbidities and family adversities.

"Over one-third of women of childbearing and child rearing years have depressive symptoms. These women face a disabling illness at a time when they are most needed by their families. They experience debilitating symptoms, such as chronically depressed mood, inadequate sleep, low energy and feelings of hopelessness, which make it more difficult to parent effectively. Most critically, parents are denied the full opportunity to promote their children's social, emotional and physical well-being, and the experience of a fulfilling parenthood."⁴¹

— *Mental Health American and SAMHSA*

Recommendation 1: Provider training and support

Develop and fund a coordinated statewide initiative to train and support health care, public health, addictions, mental health and early childhood providers to understand, identify and address the mental health needs of pregnant, postpartum and post-loss women and families.

Rationale

Health and social service providers for pregnant and postpartum women, children and families are in a unique position to identify and address maternal mental health disorders. However, lack of awareness, knowledge and training related to maternal mental health often keeps providers from screening and initiating intervention to address this critical issue. Organizational and system barriers including time, managed care policies, competing demands, insurance payment problems, and scope of practice also play a role.⁴²

A comprehensive provider training and support initiative in Oregon should:

- Include standardized components applicable to all provider types as well as individualized components targeted to specific providers and settings (medical, mental health, public health, early childhood, childbirth, lactation, doulas, child care, addictions, social service, etc.);
- Use a variety of delivery modes depending on provider needs (online, one-on-one, at conferences or grand rounds, in clinics or staff meetings, etc.);
- Include tools and guidelines to help clinics incorporate screening, assessment and referral into practice flow; link to resources for referral and treatment; and track outcomes; and
- Build upon successful training models and programs from Oregon and other states (e.g., Illinois and Iowa provider training models, Oregon START program, Postpartum Support International training, doula training, University of Washington online nurse training, online MedEd postpartum depression training tools).

Activities

- 1a. Develop a training program for all service providers who have contact with pregnant, postpartum and post-loss women to screen, identify, assess, address and/or make referrals for maternal mental health needs.
- 1b. Develop a provider consultation service staffed by experts in maternal mental health. Use the University of Illinois provider consultation line, Oregon Health & Science University (OHSU) expert consultation line and Oregon state alcohol and drug provider referral line system as models.
- 1c. Develop a maternal mental health provider education and support network in Oregon offering periodic seminars, networking and support opportunities for professionals working in the field. (Build on the Perinatal Mental Health Summit of March 2009.)
- 1d. Require the Oregon Health Authority (OHA), the Department of Human Services (DHS) and other public agencies to incorporate maternal mental health topics into training for staff working in programs that serve women, children and families during pregnancy, postpartum and post-loss.
- 1e. Promote adoption of maternal mental health training standards by professional societies and training programs in Oregon. The standards should cover training for new professionals as well as continuing education for medical, addictions and mental health, early childhood, and public health professionals.
- 1f. Develop incentives for health care providers to incorporate maternal mental health into their practices. Options may include continuing education unit (CEU) offerings and/or the development of standardized Healthcare Effectiveness Data and Information Set (HEDIS) quality measures and reporting/tracking mechanisms.



Recommendation 2: Public awareness

Increase public awareness and understanding of the importance, symptoms, risk factors and stigma associated with maternal mental health disorders. Implement the public awareness initiative in tandem with a provider education and support initiative to ensure that providers and health care settings are prepared to respond to increased demand for information and services.

Rationale

Increasing public (including provider) awareness of maternal mental health disorders, their symptoms, how commonly they occur, and their impact on women and children's health is critical. Successful public awareness efforts provide information as well as supportive messages targeted at decreasing stigma and isolation, and letting women and families know that the problem is both common and treatable. They also promote specific behaviors, such as reaching out for help. Information and public education are used as a vehicle to provide hope and a path to support and treatment. A successful public awareness initiative takes place in the context of a system of services and supports, including a well-developed resource and referral network and a knowledgeable and ready workforce spanning a wide variety of providers.

A comprehensive public awareness initiative for Oregon should:

- Include both community-based outreach and media/Web-based components using diverse methods, a wide range of settings and culturally-specific techniques to meet the needs of specific audiences in Oregon;
- Have behavioral outcomes related to increased understanding and awareness specific to each identified target audience;
- Integrate with existing community resources and programs; and
- Build upon successful existing initiatives such as the, "Speak up when you're down" campaign in New Jersey and Washington.

Activities

- 2a. Develop and implement an ongoing, statewide, sustainable public awareness/social marketing initiative for maternal mental health. Build on federal campaigns and/or funding linked to health care reform as well as other states' and partners' initiatives.
- 2b. Pass legislation requiring that education on maternal mental health disorders be provided to all pregnant, postpartum and post-loss women. Designate and support a state agency to coordinate development and dissemination of the educational materials. (Build on model legislation from Illinois and Michigan.)
- 2c. Convene partners to plan and implement activities for Oregon's Maternal Mental Health Awareness Month in May of each year, per HB 3625 (lead agency: Postpartum Support International of Oregon).



Recommendation 3: Screening and assessment

Make screening and assessment for maternal mental health disorders available to all Oregon women during pregnancy, postpartum and post-loss. Ensure that women who screen positive receive appropriate assessment, diagnosis and treatment by conducting screenings in a variety of settings and using validated tools as part of a coordinated approach to assessment and management.

Rationale

Providing universal and regular screening for maternal mental health disorders can both promote awareness of the issue and ensure that problems will be identified early. Depression is a highly treatable condition, especially when identified early during pregnancy or the postpartum period. Early identification of maternal mental health disorders enables health professionals to initiate services that can prevent later problems for both mother and baby.

However, maternal mental health problems are easy to miss in a clinical setting, and symptoms are often unrecognized or hidden. Validated screening tools for maternal depression exist, and using them increases the likelihood that maternal mental health issues will be identified. Unfortunately, screening for maternal depression is not standard, and although screening improves recognition of the disorder, improvement in outcomes requires adequate assessment, treatment and follow up.

While no national guidelines exist regarding recommended screening intervals for depression during pregnancy and the first year postpartum, the U.S. Preventive Services Task Force (USPSTF) recommends regular depression screening for all adults when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment and follow-up.⁴³ In addition, several professional organizations specifically recommend periodic screening during the prenatal and postpartum periods.

Despite the lack of comprehensive recommendations, there is evidence that brief standardized depression screening instruments can accurately identify maternal depression. OB/GYNs and pediatricians have several convenient opportunities to conduct screenings during prenatal office visits each trimester, at the standard six-week postpartum visit and during infant well-child visits.⁴⁴

The Edinburgh Postpartum Depression Scale is the most widely used tool, and numerous studies have found it has moderate to good reliability. As part of their recommendation to screen adults for depression in primary care settings, the USPSTF concluded that asking two simple questions, such as those included on the Patient Health Questionnaire-2, may be as effective as more formal instruments, and the American College of Obstetricians and Gynecologists (ACOG) has endorsed the use of this two-question screen. Other validated tools include the Beck Depression Inventory and Postpartum Depression Screening Scale.⁴⁵

Activities

- 3a. First, build support for screening and assessment by convening health plans, providers, professional societies and community service providers to explore and address issues related to inclusion of maternal mental health screening and assessment in their plans and services. Designate the Oregon Public Health Division to convene the partners.
- 3b. By 2015, pass legislation to require that all prenatal, postnatal and pediatric settings offer all women the opportunity to be screened to identify maternal mental health needs. Develop multiple entry points for women to receive screening, assessment and treatment. Settings for maternal mental health screening may include, but are not limited to: health care offices (primary care, OB and pediatric), public health, addictions, mental health, community social service, and early childhood agencies and programs.
- 3c. Support initiatives that create incentives for systematic maternal mental health screening in health care systems. Ensure access to further assessment and treatment (see recommendations 1, 4, 5 and 6 in this report). Ensure that outreach and screening opportunities are tailored to meet the needs of all women, with special emphasis on reaching vulnerable populations. Vulnerable populations include both those at increased risk for maternal depression and populations and groups that experience special barriers to accessing services (see Glossary).



Recommendation 4: Treatment and support services

Ensure that effective and culturally competent services are available and accessible statewide to treat women and prevent adverse consequences in children and families with maternal mental health disorders.

Rationale

A variety of effective treatments for maternal mental health disorders exist, including traditional cognitive and interpersonal therapies, medication, peer support and support groups.⁴⁶ Furthermore, given the complex nature of the issues, co-morbidities and long-term effects on children and families as well as mothers, an emerging body of research points to the need for comprehensive multi-dimensional prevention and treatment interventions to improve outcomes for families impacted by maternal mental health disorders. Critical features for engagement and delivery of care to diverse families with a depressed parent include:⁴⁷

- Promote nurturing parent-child relationships using a two-generation approach;
- Offer developmentally appropriate treatment and prevention interventions for children;
- Provide comprehensive resources and referrals for other co-morbidities associated with depression (e.g., substance abuse and trauma);
- Be available in multiple health care settings, including those that engage children and families; and
- Create a system of care that would use proactive approaches in the context of a two-generation model that is family-centered, culturally sensitive and accessible to vulnerable populations.



Activities

- 4a. Develop an inventory of community-based maternal mental health services; identify service gaps in Oregon.
- 4b. Engage existing health, social service and early childhood programs (e.g., Early Head Start, Early Intervention, child care, Healthy Start, WIC, public health home visiting, addictions and mental health, and domestic violence programs) to provide maternal mental health education and support services to their clients.

- 4c. Support targeted, community-level outreach to individuals and populations with increased risk for maternal mental health disorders and those with increased barriers to accessing services.
- Populations at increased risk for maternal mental health disorders include: low-income women; teens; racial/ethnic minorities; and women with stressful life events, a previous history of depression, or substance abuse.^{48, 49}
 - Groups and/or individuals with increased barriers to accessing services may include: adolescents; people with disabilities; the uninsured; non-English speakers; the homeless; immigrants; members of tribal communities and other communities of color; and those in domestic violence shelters, treatment facilities or the criminal justice system.
- 4d. Build on integrated clinic models, as well as existing infrastructure in Oregon communities, to expand the availability of innovative programs to treat women and children based on the effective practices recommended by the National Research Council and Institute of Medicine.⁵⁰ These include:
- Collaborative care (community-based care incorporating specialized training for providers, integration of mental health specialists with primary care for treatment or consultation, frequent client contact, stepped care, and care coordination);
 - Multiple settings for delivery of care, including home visiting;
 - Two-generation parent/child interventions;
 - Integrated primary care and mental health services;
 - Developmentally appropriate assessment and treatment of children; and
 - Comprehensive resources and referrals for other co-morbidities associated with depression (addictions, trauma, domestic violence, etc.).
- 4e. Develop a statewide network of peer social support services to address the maternal mental health needs of pregnant, postpartum and post-loss women, children and families. (Build on Postpartum Support International peer support model programs like Baby Blues Connection and Well-Mama, see Appendix B.)
- 4f. Expand/enhance a statewide information and referral phone and Web service to link providers and the public to available community resources for maternal mental health disorders and associated co-morbidities. (Build on SafeNet/211 information and referral warm line, as well as parent resource networks such as Postpartum Support International and Help me Grow.)

Recommendation 5: State and local systems integration

Develop an integrated approach to maternal mental health across health, education, addictions and mental health, public health, and early childhood systems at both the community and state levels.

Rationale

The impact of maternal mental health disorders is far-reaching, affecting women, children and families well beyond the prenatal and postpartum period. Consequently, awareness, identification and interventions for maternal mental health need to span all the services and systems that touch Oregon families. Coordination and integration of infrastructure as well as services is critical to create the network of supports depicted in the work group's vision for maternal mental health in Oregon (see page 15). This coordination and integration must span public, private, and non-profit systems; incorporate multiple disciplines; and ensure the needs of vulnerable populations are met.

The National Research Council and Institute of Medicine's study, "Depression in Parents, Parenting, and Children" identifies the following as four of the most important systems challenges to overcome:⁵¹

1. Creating a two-generation response to parental depression;
2. Responding to the needs of vulnerable populations, particularly low-income and culturally and ethnically diverse families;
3. Responding to families experiencing depression along with other co-morbidities and family adversities; and
4. Developing complex interventions that build on collaborative, integrated and comprehensive service models.

Activities

- 5a. Charge the Governor's Early Childhood Matters Advisory Council (ECMAC) with improving state level maternal mental health integration across education, health, public health, addictions and mental health, early childhood care and information systems, and other early childhood partners. To carry out this charge, the ECMAC will:
 - Identify state system needs, gaps and barriers;
 - Identify community system needs, gaps and barriers;
 - Develop a plan for expanding integrated services that reach vulnerable populations with comprehensive, two-generation, culturally competent and family-centered services;

- Develop measurable goals and shared outcomes; and
 - Report regularly to the Governor's office on progress and ongoing needs.
- 5b. Amend the OARs under ORS 417.777 section 3 to require local Early Childhood Councils (including members of communities of color) and the Oregon Commission on Children and Families to address maternal mental health through assessment and coordination of local services.
- Use the SAMHSA Maternal Depression Community Planning Guide⁵² in combination with Oregon-specific tools for assessing, planning and tracking maternal mental health efforts and ongoing needs. (Coordinate with the Oregon Public Health Division's maternal mental health initiative.)
 - Coordinate local and state systems integration efforts and report progress through the Governor's Early Childhood Matters Advisory Council.
- 5c. Include a section in the Title V Maternal and Child Health needs assessment to address maternal mental health status for the state and community, including communities of color.
- 5d. Require state agencies to prioritize maternal mental health by integrating education, screening, assessment, referral and/or treatment as appropriate into all programs that serve prenatal and postpartum women and families. Designate a lead state agency to convene and coordinate the work.
- 5e. Convene a team of public and private partners under the auspices of the Governor's Early Childhood Matters Advisory Council to identify and pursue funding and other resources for public education, prevention, infrastructure-building and community-based services for maternal mental health. Resources may include public and private grants, partnerships and opportunities created through national health care reform.
- 5f. Require the Oregon Department of Education (ODE) to identify ways to integrate maternal mental health into Oregon's Early Intervention services by providing and reimbursing for maternal mental health screening and assessment in Early Intervention services and designating maternal mental health as a qualifying condition for Early Intervention.

Recommendation 6: Medicaid coverage for maternal mental health

Ensure that the Oregon Health Plan covers a full range of screening, assessment and treatment; eliminate barriers to Medicaid providers billing for maternal mental health disorders (pregnancy through at least one year postpartum and post-loss).

Rationale

Forty percent of Oregon births are to low-income women on Medicaid, and low-income women are among those at highest risk for maternal mental health disorders.⁵³ In Oregon, more than a third (36 percent) of low-income women surveyed report that they were depressed during or after pregnancy.⁵⁴ Consequently, improvements in identification and treatment of maternal mental health disorders for Medicaid women in Oregon could make a critical difference in the lives of thousands of vulnerable women and families.

Barriers associated with identifying maternal mental health disorders and delivering services under Medicaid are well documented. In 2006, the National Academy for State Health Policy issued a brief identifying financing strategies for Medicaid reimbursement of maternal depression screening. Key strategies identified include:

- Eliminate barriers facing pediatric providers who bill Medicaid for maternal depression screening;
- Clarify screening tools eligible for Medicaid reimbursement;
- Distinguish reimbursement for screening from reimbursement for in-depth assessment;
- Identify billing codes and payment rates;
- Determine the best way to reimburse for screening;
- Encourage providers to conduct screenings as part of a risk-assessment for infants of at-risk mothers;
- Determine how women who exhaust their Medicaid coverage will be covered for services through one year postpartum; and
- Provide guidance and support to providers on resources for referral and follow up.⁵⁵



Activities

- 6a. Require the Oregon Health Authority (OHA) to address barriers that prevent or limit providers from delivering and billing for covered maternal mental health services for Oregon Health Plan (OHP) clients. Barriers and issues to be addressed include:
- Clarify maternal mental health service standards, coverage, billing codes and mechanisms, and screening tools (lead agencies: Addictions and Mental Health Division [AMH], Division of Medical Assistance Programs [DMAP], and the Health Policy Board).
 - Add screening codes for maternal depression to the prioritized health list and activate them for use (lead: Health Services Commission with DMAP and AMH).
 - Provide clear guidance for family physicians, pediatricians, nurse practitioners, OB/GYNs and other qualified health care professionals on how to bill for maternal depression screening, assessment and treatment.
 - Remove contract barriers that prevent pregnant, postpartum and post-loss women from accessing mental health providers with special expertise in maternal mental health treatment outside of the community mental health system when needed.
 - Develop and clarify reimbursement mechanisms for two-generation or dyadic treatment.
 - Develop a mechanism to allow qualified health care professionals to provide and bill for maternal depression screening and treatment of women under the child's OHP coverage.
- 6b. Extend Medicaid coverage, including mental health services, to at least one year postpartum and post-loss for women on the Oregon Health Plan.
- Seek a Medicaid plan amendment to extend OHP Plus Medicaid coverage to one year postpartum for all women who deliver on Medicaid.
 - Prioritize outreach to pregnant, postpartum and post-loss women to enroll and continue on OHP postpartum within OHP's Healthy Kids outreach efforts.
 - Implement automatic roll-over from OHP Plus to OHP Standard for women who qualify under Medicaid rules. (This can be done as a first phase while full postpartum Medicaid extension is in process.)
- 6c. Require OHA to develop options for maternal mental health coverage for undocumented women during pregnancy through one year postpartum, including exploring funding mechanisms used by Oregon's Prenatal Expansion Project.

Recommendation 7: Private health plan coverage

Encourage Oregon's private health plans to promote screening, assessment and treatment for maternal mental health disorders for at least one year postpartum and post-loss under both mothers' and children's plans.

Rationale

More than half (56 percent)⁵⁶ of Oregon births are to women with private health insurance. For these women (and their families), the availability and accessibility of prenatal and postpartum mental health services is largely governed by the coverage limitations, policies and delivery systems of their health plans. This will continue to be true even as national health reform shifts the parameters for health and mental health screening, services and coverage.

A new issue brief by the National Institute for Health Care Management further describes the role of health plans in identifying and treating maternal depression as follows:

"Health plans play an important role in ensuring early identification of maternal depression and coordinating management of care following a diagnosis. Health plans have an opportunity to pinpoint those at highest risk by encouraging obstetricians, pediatricians, primary care physicians and other health care professionals to screen for maternal depression, raising awareness of maternal depression through patient education in maternity programs and offering access to nurse case management during the pregnancy and postpartum period. Such simple interventions could have a substantial impact on the number of maternal depression diagnoses and would aid in the prevention of further complications and unnecessary costs."⁵⁷

Activities

- 7a. Encourage employers and insurance purchaser groups to require coverage for maternal mental health services (including care coordination) in plans they purchase (e.g., PEBB, OEBC, FHIAP) even if the coverage for the mother's benefit is through the child's plan.
- 7b. Convene a work group of the Insurance Commission to make recommendations related to prenatal, postpartum and post-loss maternal mental health disorders (including coverage of maternal mental health services under the child's plan, coverage of dyadic treatment, inclusion of care coordination, as well as opportunities to promote screening, assessment and education related to maternal mental health).
- 7c. Encourage all private health and mental health insurers in Oregon to develop quality standards that support screening and assessment at regular, established/standardized intervals during the prenatal, postpartum and post-loss periods and treatment for maternal mental health disorders as indicated.



Recommendation 8: Monitoring and evaluation

Conduct ongoing monitoring and evaluation of maternal mental health status, needs and outcomes in Oregon.

Rationale

Ongoing research and evaluation is critical to assessing new and existing needs, as well as monitoring progress and outcomes for maternal mental health interventions. Given the complex nature of maternal mental health issues, coordinated monitoring and evaluation across public and private systems is needed to ensure the availability of complete and accurate data for informed policy decisions.



Activities

- 8a. Develop an evaluation process and statewide system to track utilization, cost and outcomes for maternal mental health screening and services with a goal of demonstrating improvement. Use existing data warehouses such as the Health Care Quality Corporation, Division of Medical Assistance Programs (DMAP) data, claims and clinical data from all state payers and other community entities as feasible.
- 8b. Expand upon existing Oregon surveillance tools to improve the understanding of mental health disorders and associated co-morbidities among pregnant, postpartum and post-loss women and the impact on their children.
- 8c. Initiate research projects using existing data sources (e.g., Pregnancy Risk Assessment Monitoring System [PRAMS], DMAP, Oregon Community Health Information Network [OCHIN]) to determine factors associated with long-term maternal depression and to determine the prevalence of maternal mental health disorders other than depression.
- 8d. Ensure that monitoring and evaluation data are used for continual quality improvement and to inform maternal mental health funding decisions, program priorities and systems improvements.

CONCLUSION

Maternal mental health is a major public health issue, impacting the lives of thousands of Oregon women, children and families each year. The importance of identifying and treating maternal mental health disorders—and preventing associated long-term negative outcomes on women, children and families—is well recognized both in Oregon and across the nation. Health, addictions and mental health, early education, and social service systems are far from achieving the vision of integrated, supportive, family-centered and culturally competent maternal mental health care. However, the convergence of compelling data, political will and health care reform make this a time of great opportunity for this work.

The HB 2666 Maternal Mental Health Work Group is committed to helping build and sustain collaborative, integrated and comprehensive maternal mental health systems and services in Oregon. The success of this work will depend largely on Oregon's ability to develop maternal mental health systems and services that are:

- Responsive to a broad range of maternal mental health disorders and their manifestations in women, children and families;
- Culturally and linguistically competent;
- Accessible statewide;
- Two-generational and family-centered;
- Integrated and linked with existing community services and resources; and
- Tailored to the needs of Oregon's diverse communities and vulnerable populations, particularly low-income, culturally or ethnically diverse families and/or those experiencing other co-morbidities or family adversities.

The findings and recommendations contained in this report represent the passion and dedication of each work group member to improving the mental health of all women, children and families in Oregon. It is our fervent hope that they provide a strong and compelling path to improving Oregon's systems and supports for pregnant and postpartum women and families.

“Depression is increasingly recognized as a major world-wide public health issue. It has a negative impact on all aspects of an individual’s life—work and family—and can even lead to suicide. Typically, depression is discussed as an adult problem affecting women or men, and increasingly, it is recognized as a significant problem for children. But far too rarely is depression, particularly maternal depression, considered through a lens that focuses on how it affects parenting and child outcomes, particularly for young children; how often it occurs in combination with other parental risks, like post-traumatic stress disorder; and what kinds of strategies can prevent negative consequences for parents, for their parenting and for their young children.”⁵⁸

— *National Center for Children in Poverty*



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Glossary of terms and acronyms

Addictions and mental health providers in Oregon are covered by the Integrated Services and Support Rule, which prescribes minimum standards for the services and supports they provide. The two types of providers have distinct certification and licensing requirements. In some situations, addictions and mental health services are provided in coordination or by one provider with qualifications in both fields; in other cases the services and providers are distinct. For additional information, see www.oregon.gov/DHS/addiction/rule/lissr-rule.pdf.

Baby blues affect up to 80 percent of women shortly after birth. Women may feel sad, easily annoyed or confused, and may have headaches, poor sleep and appetite changes. Unlike postpartum depression, baby blues resolve without treatment, usually by 10 days after the baby is born.

Co-morbidities are conditions such as alcohol or drug addictions or other mental health conditions, such as post-traumatic stress disorder, that often occur together with maternal mental health disorders.

Doulas are birth companions who provide personal support to women and families throughout the pregnancy and childbirth experience.

Maternal mental health disorders include a range of mood and anxiety disorders occurring during pregnancy and the first year postpartum. These include: prenatal and postpartum depression, anxiety and panic disorders, and postpartum psychosis.

Medicaid is the federal health program for eligible individuals and families with low incomes and resources.

Oregon Health Plan (OHP) is Oregon's state Medicaid program.

OHP Standard is the Oregon Health Plan program that provides free or low-cost health care coverage to Oregon residents who have limited income, are age 19 through 64 and do not qualify for traditional Medicaid.

OHP Plus is the Oregon Health Plan program for people who are aged, blind, disabled, under age 19, pregnant or receiving Temporary Assistance for Needy Families benefits.

Post-loss refers to the period following an infant or fetal death or miscarriage.

Postpartum depression is a complex mix of physical, emotional and behavioral changes that affects up to 13 percent of women after giving birth. Symptoms range from mild to severe depression and may appear within days of giving birth through the first year of the baby's life.

Postpartum psychosis is a rare but serious disorder requiring immediate intervention due to risk of harm caused by delusional thought. The prevalence is 0.1 to 0.2 percent of women after birth. Symptoms may include losing touch with reality, visual or auditory hallucinations, confusion and memory loss, detachment, suspiciousness, or delusional need to harm oneself or others.

Prenatal refers to the period of time during pregnancy up to the birth of the child.

Prenatal depression is depression that occurs during pregnancy.

Prenatal or postpartum anxiety disorders include generalized anxiety, panic disorder and obsessive-compulsive disorder. Symptoms may include extreme and repetitive worries and fears, often over the health and safety of the baby. Some women have panic attacks and might feel shortness of breath, chest pain, dizziness, a feeling of losing control, and numbness and tingling.

Two-generation approach to depression treatment is an evidence-based approach which adds a parent-child dimension to depression treatment. Two-generation models of care focus on the context of parent-child relationships, helping parents improve their parenting skills while treating the depression, and also offering enhanced supports for children who may be at risk of mental, emotional and behavioral disorders because of a depressed parent.⁷

Vulnerable populations as used in this report refers both to populations and individuals at increased risk for maternal mental health disorders and those with increased barriers to accessing services.

- Populations at increased risk for maternal mental health disorders include: low-income women; teens; racial/ethnic minorities; and women with stressful life events, a previous history of depression, or substance abuse.^{48, 49}
- Groups and/or individuals with increased barriers to accessing services may include: adolescents; people with disabilities; the uninsured; non-English speakers; the homeless; immigrants; members of tribal communities and other communities of color; and those in domestic violence shelters, treatment facilities or the criminal justice system.

Maternal mental health initiatives in Oregon referenced in this report's recommendations

Please note: The following is not a comprehensive list of maternal mental health initiatives in Oregon, but one that contains contact information for initiatives that are specifically referenced in this report's recommendations. Many Oregon programs and services do excellent work in maternal mental health—either as their primary focus or incorporated into their work with mothers, children and families. Recommendation 4a of this report recommends developing a comprehensive inventory of maternal mental health services in Oregon.

Baby Blues Connection

Contact: Angie Fitzpatrick, 1-866-616-3752

Web site: www.babybluesconnection.org

Offers telephone and e-mail support, information and resource lists, and mom-to-mom support groups in Portland and Vancouver.

OHSU Perinatal Mental Health Program

Contact: Jillian Romm, rommj@ohsu.edu, 503-494-4042

Offers training for medical students and health care providers. Offers screening, assessment and treatment for OHSU OB/GYN patients; and preconception, pregnancy and postpartum consultations for women with mental health concerns.

Oregon Public Health Division Maternal Mental Health Initiative

Contact: Nurit Fischler, nurit.r.fischler@state.or.us

Web site: oregon.gov/DHS/ph/ch/maternal_mental_health.shtml

This initiative includes: state level policy support, surveillance and research, partnership development, provider training and education, as well as technical assistance to local public health departments to conduct needs and resource assessment and incorporate maternal mental health into local public health services.

Postpartum Support International

Contact: Wendy Davis, wdavis@postpartum.net, 503-246-0941
Web site: www.postpartum.net
Helpline: 1-800-944-4PPD

Offers support coordinators and groups across the state. Provides volunteer phone and e-mail support, links to local providers, and professional and volunteer trainings. Has a volunteer-staffed helpline for support and local resources.

Screening Tools and Referral Training (START) Program

Contact: Anne Stone, annestone2@oraap.org or Dawn Creach, dawn.creach@oraap.org

Offers training for primary care pediatric and family practice providers in screening for maternal depression, introduction to community resources for referral, and implementation of screening and referral within their practices.

Well Mama

Contact: 1-800-896-0410
Web site: www.wellmama.net

Offers telephone and e-mail support and professional trainings in the Willamette Valley and Southern Oregon. Support groups and counseling available in Corvallis and Eugene.

Web links and resources

Public awareness, support and education

Med Ed postpartum depression education Web site, supported by the National Institute of Mental Health (English and Spanish)

www.mededppd.org

National Women's Health Information Center

womenshealth.gov/faq/depression-pregnancy.cfm

Online Postpartum Depression Support Group

www.ppdsupportpage.com

Postpartum Progress Blog

www.postpartumprogress.com/weblog

Postpartum Dads, support and information for fathers and partners

www.postpartumDADS.org

Postpartum Support International

www.postpartum.net

U.S. Department of Health and Human Services educational materials (English and Spanish)

www.mchb.hrsa.gov/pregnancyandbeyond/depression

Provider tools and training

The Commonwealth Fund's, "Implementation Guide: Parental Depression Screening for Pediatric Clinicians"

www.commonwealthfund.org/Content/Publications/Fund-Manuals/2007/Apr/Parental-Depression-Screening-for-Pediatric-Clinicians--An-Implementation-Manual.aspx

Edinburgh Postpartum Depression Scale (EPDS), Postpartum Depression Screening Scale (PDSS), Patient Health Questionnaire (PHQ-9), and Center for Epidemiologic Studies Depression Scale (CES-D)

www.mededppd.org/screening_tools.asp

Massachusetts General Hospital's Center for Women's Mental Health

www.womensmentalhealth.org

Med Ed postpartum depression, online peer-reviewed postpartum depression education Web site supported by the National Institute of Mental Health

www.mededppd.org

Perinatal Foundation and Wisconsin Association for Perinatal Care

www.perinatalweb.org

Registered Nurses Association of Ontario, "Guideline for Postpartum Depression"

www.rnao.org/Page.asp?PageID=924&ContentID=806

University of Illinois, Chicago, Department of Psychiatry's Perinatal Mental Health Project

www.psych.uic.edu/clinical/HRSA

University of Washington, online postpartum depression training for nurses
steppingup.washington.edu/keys/default.htm

Community planning resources

The Commonwealth Fund's, "Implementation Guide for Parental Depression Screening: Prepare Your Community"

www.commonwealthfund.org/usr_doc/fig5Implementation_manual_12_19.pdf

SAMHSA and Mental Health America's, "Maternal Depression: Making a Difference through Community Action: A Planning Guide"

www.nmha.org/go/maternal-depression

State/county maternal mental health initiatives

Illinois Perinatal Depression Project

www.psych.uic.edu/clinical/HRSA

Indiana Perinatal Network

www.indianaperinatal.org/sections/about.php

Los Angeles County Perinatal Mental Health Task Force

lacountyperinatalmentalhealth.org

Massachusetts Perinatal Connections Project

www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Family+and+Community+Health&L4=Pregnancy+and+Newborn&sid=Eeohhs2&b=terminalcontent&f=dph_com_health_prego_newborn_c_maternal_depression&csid=Eeohhs2

Nebraska Department of Health & Human Services Pregnancy Depression Project

www.hhs.state.ne.us/MomsReachOut

Oregon Public Health Division's Maternal Mental Health Initiative

www.oregon.gov/DHS/ph/ch/maternal_mental_health.shtml

Perinatal Depression Information Network

pdinforonetwork.org

Washington state's, "Speak up when you're down" campaign
www.ccf.wa.gov/ppd/home.htm

The Wisconsin Association for Perinatal Care's, "Perinatal Depression: A Health Marketing Campaign to Improve Screening"
www.perinatalweb.org

Research and policy reports

Federal Maternal Child Health Bureau's online library knowledge path on maternal depression
mchlibrary.info/KnowledgePaths/kp_postpartum.html

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Oregon Public Health Division
Office of Family Health
Maternal and Child Health Section
800 N.E. Oregon Street, Suite 825
Portland, OR 97232
971-673-0352
www.oregon.gov/dhs/ph/ch

Oregon Health Authority



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