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

Maternal Depression in Los Angeles County: Current Screening Practices and Recommendations

I. Introduction and Overview

This report examines the demographics and risk factors associated with maternal depression. It looks at the current state of screening practices for maternal depression and the issues affecting care in Los Angeles County. This report provides an in-depth look at the current landscape of services for maternal depression and highlights the need to catapult this issue to the forefront of public health policies in Los Angeles County.

Maternal depression is a condition characterized by intense feelings of sadness, anxiety, or despair after childbirth that interferes with a mother's ability to function.[1,2] Throughout this report, "maternal depression" will be used interchangeably with "perinatal depression." The perinatal period, defined as beginning three months prior to pregnancy and lasting up to one year postpartum, is a time of increased vulnerability to depression for women.[3]

Depression during the perinatal period is a major public health problem. Reports show that it affects 10% to 25% of all women, and up to 48% of women living in poverty.[4,5,6,7]

- Suicide is the leading cause of death for women during the first year after childbirth.[8]
- There is a seven-fold increase in the risk of psychiatric hospitalization for women following childbirth.[9,10,11]

Effects of Maternal Depression

Maternal depression is a widespread public health issue that impacts the well-being and livelihood of mothers, their infants, and their families. Yet 50% of women experiencing postpartum depression are never treated.[12,13] Postpartum depression is one of the most common complications after childbirth. Depression is also the second most common cause of hospitalization for women in the U.S., the first is childbirth.[14,15] Major and minor postpartum depression estimates range from 5% to 25% for new mothers.[16,17, 18,19, 20] New mothers are especially vulnerable to depression and most often face this disabling illness at a time when they are most needed by their families.[21] Depression impairs maternal safety and health management, such as preventive health measures, and management of chronic health conditions. It also strains the relationship with her partner, and increases the risk of self injury and suicide.[22, 23]

Furthermore, numerous studies have shown that the mental health of the mother affects the health of the baby long after infancy.[24,25] Maternal depression affects the different stages of a child's development: in utero, during the infant's bonding stage, and during the independent toddler years. For the fetus, maternal depression results in late or no prenatal care, a lack of compliance with health care services, and leads to unhealthy and risky behavior(s) during the pregnancy. Depression leads to adverse birth outcomes, such as low birth weight and premature delivery. In addition, new research suggests that certain stress hormones are elevated in the depressed or anxious pregnant mother. These hormones cross the placenta to affect the development of the fetus, leading to newborns who are more irritable and jittery for at least six months after delivery.[26]

A mother experiencing perinatal depression after delivery shows decreased responsiveness to infant cues, something that impairs her ability to breastfeed. If depression is left

untreated, symptoms remain for years and may lead to suicidal thoughts or behavior.[27] For the infant, perinatal depression results in poor weight gain, feeding problems, sleep problems, and poor maternal-infant emotional attachment.[28] Infants of clinically depressed mothers withdraw from daily activities and avoid interactions with caregivers, which compromises their linguistic, physical, intellectual and emotional development.[29]

The effects of maternal depression on the infant may extend well into later childhood and manifest as behavior difficulties, including hyperactivity, poor impulse control, conduct disorders, detachment, or social withdrawal.[30] In combination with other risks, maternal depression poses serious but typically unrecognized barriers to healthy early development and school readiness, particularly for low-income children. Perinatal depression often occurs alongside other factors such as poverty, substance abuse, domestic violence and intimate partner violence. These have all been shown to impact healthy parenting. Depression in other caregivers—fathers, grandparents, and child care providers—also impacts the early development of young children.[31]

Depression adversely affects parental response and interactions by creating negative perceptions of the child's behavior, leading in turn to the use of punitive and inconsistent discipline. As a result, the parent is also less likely to play with the child or use preventive safety measures such as car seats and safety latches. The parent is more likely to have an adversarial relationship with the child which may result in neglect or abuse.

Since the prevalence of depression in the United States has grown in the past decade, the social costs of depression are burdensome to the individuals, their families and society as a whole.[32]

Treatment of maternal depression can cause a major financial strain on the family, and results in even greater stress, depending on the level of care needed and insurance status. Maternal depression leads to a breakdown of communication and strained relationships between spouses and other family members. A depressed mother experiences avoidance, withdrawal and anger which can result in marital stress and even divorce.[33] The situation is magnified and worsened when depression occurs in a single-parent family. If the parent cannot work because she is ill, it can lead to job loss and reliance on public assistance.[34,35]

The price for ineffectively treating individuals with depression or not treating them at all is more costly to the United States economy than treating them. Untreated depression leads to lost productivity, decreased ability to earn wages, and diminished employment opportunities. Individuals with untreated depression are more likely to have repeated episodes of depression with increasing severity, resulting in more costly treatment such as hospitalizations. Moreover, maternal physical health is compromised when depression is unrecognized or untreated.[36, 37, 38]

The adverse outcomes that result from perinatal depression, affecting mothers, infants, families and society—both medically and socially—point to the need to address this widespread public health issue and elicit a strong community response.

II. What Do We Know About Maternal Depression in L.A. County?

L.A. County Perinatal Demographics

The prevalence of perinatal depression in Los Angeles County can be examined by means of perinatal risk factors such as ethnicity, income, education and access to health care. In 2007, there were over 151,000 live births in L.A. County.[39] Two surveys by the L.A. County Department of Public Health, were administered to mothers who recently delivered or experienced an infant or fetal loss respectively. These reports found that:[40, 41]

- Over a third of the women who had a recent delivery lacked health insurance or a usual place of care
- Forty percent of pregnancies were unintended

- Two thirds of women who recently gave birth were Hispanic
- Over half had 12 years or less of education

These results are of critical importance given the high risk groups disproportionately affected by perinatal depression are:

- Low-income (earning less than $20,000/year)
- Less educated (eighth grade education or less)
- Uninsured
- Immigrant
- Latinos and African Americans

Traditionally, these groups do not seek treatment for mental health problems and have less social support. [42,43,44,45]

Pregnant teenagers are also at high risk for perinatal depression, and account for 10% of all live births in L.A. County. In 2006, there were 9,336 live births to teenagers, ages 10 to 18 years in L.A. County. Nearly half, or 4,743, of these teen births were to students in the Los Angeles Unified School District.[46] More importantly, teen mothers were found to be seven times more likely to commit suicide than older mothers.[47]

With these perinatal demographics and risk factors in mind, one can begin to understand the magnitude and potential impact of perinatal depression in L.A. County. [48]

A Review of Maternal Depression Among Low-income Women

In 2005, the Women, Infants, and Children (WIC) program and the L.A. County Department of Public Health, Maternal, Child, and Adolescent Health Programs independently administered surveys to specific populations of women in L.A. County.

The 2005 L.A. County WIC survey used several questions to determine depressive symptoms among WIC mothers. Mothers were asked about feelings of depression, loneliness, and sadness, and crying spells within the past month. The same measures were adopted by the L.A. County Health Survey to assess the prevalence of depression.[49] Results showed 20% of the WIC participants self-reported depressive symptoms at the time of the survey. National surveys using diagnostic interview survey techniques find that 11% to 14% of low-income women on government assistance programs meet the criteria for depression.[50] Results suggest that the rate of perinatal depression among L.A. County WIC participants is similar to or exceeds national estimates.

Symptoms of depression in the Los Angeles WIC population were higher among certain groups of women. For instance, Spanish-speaking Latinas had higher rates of these symptoms than English-speaking Latinas. Of those women with depressive symptoms: [51]

- 24% had an eighth grade education or less
- 21% were obese
- 37% came from households with food insecurity

The WIC survey also suggests that there are a substantial number of low-income women suffering from perinatal depression who are undiagnosed because they have neither been screened nor treated for their depressive symptoms.[52]

The second survey to sample mothers in L.A. County was performed by the L.A. County Department of Public Health through the LA Mommy and Baby Project (LAMB). The LAMB survey collected health-related information from women who recently gave birth. The sample was based on race, Service Planning Area, and birth outcomes in L.A. County in 2005. Over 5,000 (n=5,211) mothers responded to the LAMB survey, a 50% response rate.[53] Depressive symptoms were determined by a Likert scale and yes/no items:

- Pregnancy was described as a hard time
- Self-reported depression
- Lost interest in hobbies/work during pregnancy
- Diagnosed with a mental health problem (self-reported)
- Perceived neighborhood as unsafe

- Reported any type of discrimination

LAMB survey results show a link between race and depression *(see Figure 1)*. African Americans and Latinas were more likely to self-report feeling depressed, while Whites and Asians were less likely to self-report feeling depressed.

Maternal age and income were two other significant factors in self-reported depression. Pregnant women under 20 years of age were more likely to experience more severe depression than older women. Pregnant women with incomes of $20,000 or less also experienced greater rates of depression than other income groups *(see Figure 2)*.

The results from the LAMB survey demonstrate:[54]

- 1 in 6 women reported pregnancy was a hard time
- 1 in 3 women reported depressive feelings
- 1 in 3 women lost interest in work during pregnancy
- 1 in 100 women reported having been diagnosed with a mental health problem

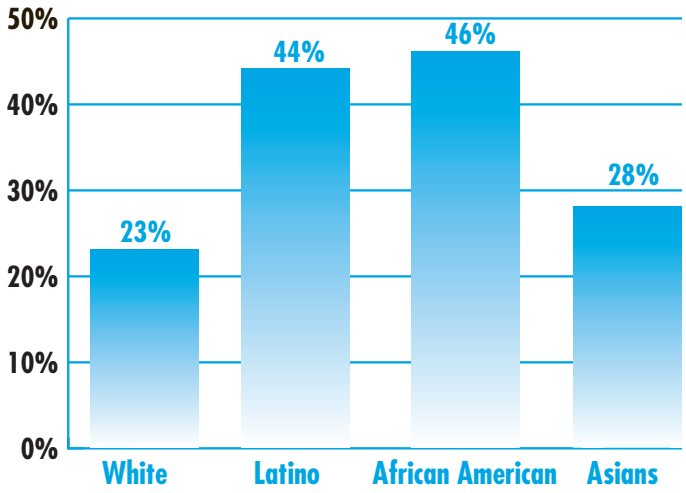
Responses to mental health symptoms during the postpartum period are shown in figure 3.[55] More than half (52%) of the women self-reported feeling:

- A little depressed – 35%
- Moderately depressed – 12%
- Very depressed – 5%

The LAMB survey findings emphasize the need to screen all women for depression during and after pregnancy. The report concludes that Latinas, African Americans, teens, and low-income women should receive early and frequent screenings, and increased patient education.

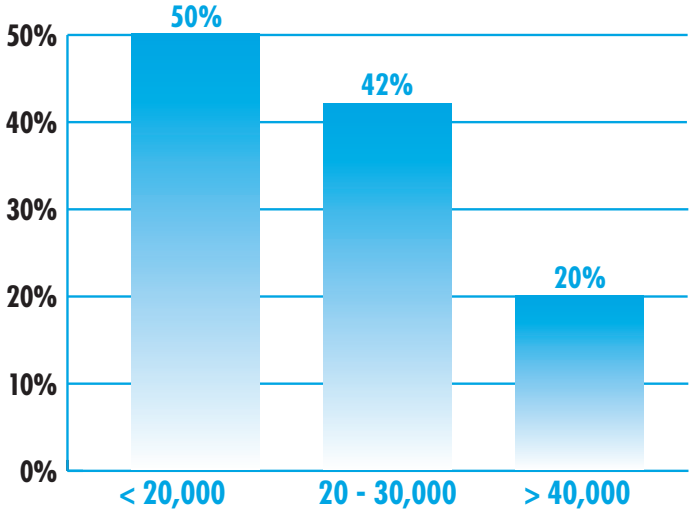
Chronic disease is a risk factor for maternal depression. For example, a recent study found that women with diabetes are nearly twice as likely to be diagnosed with depression or to be prescribed anti-depressant medication, during pregnancy or in the year following delivery, than those without diabetes.[56] This study found that the onset of depression in women with diabetes has a tendency to be higher during the perinatal period than in any other time period.[57] In Los Angeles, the rate of diabetes was 3%, according to the LAMB study. Among ethnic groups, Latinas had the highest rate of diabetes at 4%, and they account for 44% of total pregnancies, according to data from the state of California. [58, 59]

Figure 1 Self-Reported Race and Depression During Pregnancy



Source: 2005 L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs. Los Angeles Mommy and Baby Project

Figure 2 Self-Reported Depression During Pregnancy by Mother's Income



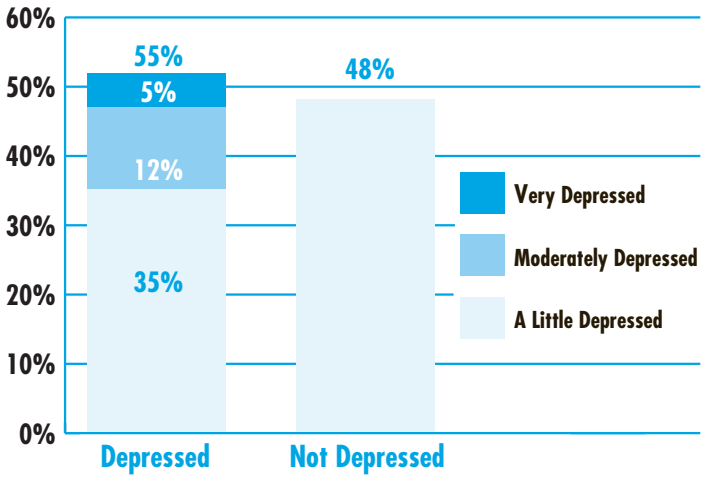
Source: 2005 L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs. Los Angeles Mommy and Baby Project

Additional risk factors for postpartum depression include: pre-pregnancy history of depression; interpersonal conflict and violence; stressful life events; lack of emotional, social or financial support; difficult pregnancy or delivery; and fetal or neonatal health problems.[60] Women whose expectations of motherhood are not met, and who are disappointed by the reality, are more vulnerable to developing depression.[61]

Provider Survey

LA Best Babies Network and the L.A. County Perinatal Mental Health Task Force administered a survey to participants attending the Confronting Maternal Depression conference, sponsored by Project ABC, (About Building Connections). Participants included clinical and community providers such as marriage family therapists (MFT), social workers, psychologists, home visitors and administrators. The survey identified providers challenges, trends occurring in perinatal depression, and the need for increased resources in L.A. County. Of the 84 participants surveyed, only four had received prior maternal depression training. This fact, coupled with the overwhelming interest in the maternal depression trainings, emphasizes the need and importance for more provider training in order to improve patient education, early and routine screening, and treatment of maternal depression.

Figure 3 Self-Reported Postpartum Depression



Source: 2005 L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs. Los Angeles Mommy and Baby Project

Participants identified the criteria used to determine who to screen, including visual observations of depressive signs or symptoms and asking relevant questions regarding maternal depression. Only five participants reported using a validated screening tool, such as Patient Health Questionnaire (PHQ-9) and Center for Epidemiologic Studies Depression Scale (CES-D). Providers noted an increase in the prevalence of perinatal depression but had few resources to which to refer women for appropriate treatment. They also reported patients' fear of the stigma of depression, which often results in the denial of signs and symptoms, or refusal of treatment. Another barrier to treatment is limited funding for services by Medicaid.

III. Screening and Treatment Services

Regardless of race, income, and other factors, the combination of screening and a relatively brief course of psychotherapy, medication, or both, has the potential to yield positive long-term results. Increased awareness has resulted in recommendations, guidelines, and standards of care from professional health care organizations. For example, the Centers for Disease Control and Prevention (CDC) has placed significant importance on screening for social and mental health concerns, and other such interventions, during the preconception period for women.[62] The U.S. Preventive Services Task Force (USPSTF) recommends that all adults receive depression screenings in general primary care practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.[63]

The American College of Obstetrics and Gynecology (ACOG) recommends psychosocial screening of pregnant women at least once each trimester, using a simple, two-question screen:

- Over the past two weeks, have you ever felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

Studies have found that a two-question verbal screen,

followed by a brief discussion with the mother by a health care provider, is both feasible and effective in identifying women who need follow-up or referrals.[64]

More extensive screening is recommended if the answer to either of these two questions is positive.

Validated screening tools to detect perinatal depression include:

- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire (PHQ-9)
- Postpartum Depression Screening Scale (PDSS)
- Beck Depression Inventory (BDI)*
- Center for Epidemiologic Studies-Depressive Scale (CES-D)

** BDI is valid but not as sensitive or specific for the perinatal population.*[16]

The MacArthur Foundation published a comprehensive, peer-reviewed depression management toolkit for primary care providers. The toolkit includes a Patient Health Questionnaire-9 (PHQ-9), in English and Spanish, and a set of recommendations for primary care providers to refer to for management of mild to severe depression. This type of toolkit tailored to primary care providers may encourage integration of maternal depression screening into routine practice.[65]

Complementing the recommendation by ACOG, the American Academy of Pediatrics has defined the scope of pediatricians' responsibilities as including the assessment and consideration of parental and family environmental factors that affect a child's health, including maternal depression.[66] Despite these recommendations, by national organizations, routine screening at the provider level is not a common practice.

Screening Programs in L.A. County

Screening for maternal depression in clinical sites in L.A. County is not a routine practice, nor is it widely integrated. Despite newer screening tools, Obstetricians-Gynecologists (Ob-Gyns) are not routinely conducting screenings, according to a study in the *Journal of Women's Health*. Among the reasons Ob-Gyns don't screen are: a lack of training and education, a failure to look for obvious signs and symptoms, a tendency to overlook mild depressive indicators, limited resources for psychosocial referrals, and financial liability for patients who screen positive.[67] Some Ob-Gyns also believe screening for maternal depression to be outside of their scope of work.[68]

Implementation of best practices screening models depends on the institution's level of expertise and commitment. The following programs are examples of integration of services to address maternal depression.

Several perinatal clinics in L.A. County are integrating mental health screening into perinatal health care. The LA Best Babies Network's Healthy Births Care Quality Collaborative is dedicated to incorporating best practices into ambulatory perinatal care. Ten clinical sites have initiated screening and treatment for maternal depression in the prenatal and postpartum periods. Each clinic screens for perinatal depression in expectant mothers using the PHQ-9 tool and provides referrals to services within the client's community. With the training and support of the Network, these clinics are learning to improve the health care system through the delivery of evidence-based care, and to engage women and families in the management of their own care. Clinics are also encouraged to work with each other to apply creative solutions in meeting the shifting demands of the health care they provide.

When the collaborative was launched, a survey was conducted of the ten clinics' current depression screening practices. The results showed that seven clinics screened an average of 40% of patients during their first prenatal visit, regardless of trimester. As a result of their participation in the collaborative, interim results show that by May 2009, the same seven clinics were screening 86% of patients during the first prenatal visit. During the second trimester, seven clinics were screening 11% of patients at the start of the collaborative. By May 2009, 51% of patients were

screened during the second trimester. In the third trimester, seven clinics were screening 3% of patients at the start of the collaborative, and by May 2009, 40% of patients were being screened.

The clinics also conducted postpartum depression screenings two weeks after delivery, either by phone call or office visit. At six weeks postpartum, depression screening was performed during an office visit. Upon entering the collaborative, three clinics screened only 3% of patients two weeks postpartum, by May 2009, 50% of patients were being screened. At the beginning of the project, only 20% of the patients were screened at six weeks postpartum, compared to 56% as of May 2009. As a result of participation in the collaborative there has been a significant improvement in screening rates for perinatal depression.

As part of the Care Quality Collaborative, and an increased demand by participating clincs, LA Best Babies Network partnered with L.A. County 211 to identify perinatal depression resources in L.A. County. Dialing 211 provides telephone access to over 28,000 health and human services programs throughout L.A. County, 24-hours-a-day, seven-days-a-week. A resource guide was developed for collaborative clinics seeking information on treatment services for perinatal depression. The 211 database has referrals to a wide variety of social services, including therapists trained to treat pregnant and postpartum women.

Another practice model is the DORA clinic (Diabetes, Obesity, and Reproductive Age Women), which offers women who are at high risk for developing diabetes medical services at Los Angeles County + USC Medical Center during the preconception and postpartum period. Every patient who comes in for an appointment at the DORA clinic is given a depression screening using the PHQ-9. The screening is self-administered and then reviewed by the physician. If further evaluation and treatment services are needed, the patient is referred to the psychiatrist on staff.

Another arena in which maternal depression screening is being integrated and proving to be effective is in home visitation programs, or coordinated case management service models. Examples of these programs in L.A. County include the Nurse Family Partnership, Best Babies Collaboratives, WIC Offers Wellness project, Comprehensive Perinatal Services Program, and Welcome Baby! pilot project.

The Nurse Family Partnership (NFP) program, through the L.A. County Department of Public Health, implemented a nurse home visitation program for first-time pregnant teens who are low-income and less than 16-weeks pregnant. The mothers are followed by a public health nurse from early pregnancy through the first two years of the child's life, for a total of two and half years of case management. The clients are screened for depression five times, from pregnancy to 18 months postpartum. The Mental Health Screening Tool consists of 16 questions that include both the PHQ-9 and supplemental questionnaires. Clients with positive screens are referred to local mental health practitioners.

The NFP preliminary results show that 60% of the participants (n=392) have been screened thus far and that 13% of the mothers are showing depressive symptoms *(shown in Figure 4)*.[69]

Figure 4 Nurse Family Partnership Screening Results

Mild depressive symptoms – 6%
Moderate depressive symptoms – 4%
Moderately severe symptoms – 2%
Severe depressive symptoms – 1%
Total with depressive symptoms – 13%

Mothers needing further mental health treatment are referred to Department of Mental Health (DMH) contractors who follow up within 30 days. Barriers experienced by the program staff are:

- Client's reluctance to seek clinical help due to stigma and transportation problems
- Clients who are mildly to moderately depressed do

not qualify for mental health services

- Client's lack of motivation due to stress of having to care for a baby
- Lack of mental health practitioners who are knowledgeable about perinatal mood disorders
- Lack of mental health practitioners who provide home visitation

As part of the LA Best Babies Network and the First 5 LA Healthy Births Initiative, Best Babies Collaboratives (BBCs) provide comprehensive, integrated, and continuous care to high-risk pregnant and interconception women. The BBCs consist of seven collaboratives made up of over 40 organizations that integrate maternal depression screenings and unique protocols for their case managed clients. Each BBC screens with the PHQ-9 and has different protocols regarding frequency and follow-up procedures for each client based on the results of the PHQ-9. Each BBC has specific objectives, strategies, activities and trainings for their case managers on maternal depression. The Network has provided various trainings on maternal depression, including two Maternal Depression Symposiums, to enhance provider education.

WIC Offers Wellness (WOW) is an interconception care and prematurity prevention project funded by the March of Dimes at the PHFE-WIC Program. WOW serves more than 100 mothers who complete a screening and assessment form. These forms include depression-related questions, a series of WOW surveys and the CES-D9. Participants are surveyed every six months. Responses are reviewed by a Care Coordinator who provides ongoing telephone support to these mothers. The Care Coordinator is not a mental health professional and does not formally assess, evaluate or treat the mothers. The information obtained through the survey is used for discussion and referral purposes with a WIC counselor. These counselors do not provide any formal mental health services. WIC moms are given a handout on postpartum depression, the Postpartum Support International warm line (telephone support) phone number, and are encouraged to attend the WOW support group. If mothers have access to health care coverage, they are encouraged to seek and use mental health services. Referral information to local mental health clinics is available as needed.

The L.A. County Department of Public Health Comprehensive Perinatal Services Program (CPSP) is conducting a survey of its 450 providers to gather information on perinatal depression screening practices, such as who conducts the screenings and their frequency. Through CPSP women receive comprehensive services, including prenatal care, health education, nutrition services, and psychosocial support, for up to 50 days after delivery. The current psychosocial assessment inquires about maternal stress factors but does not specifically ask about perinatal depression. It is estimated that only 2% to 3% of all CPSP providers currently use a depression screening tool. Provider training on use of the PHQ-9 will be offered to those who would like to implement depression screening at their clinic sites. Adopting the PHQ-9 screening tool would greatly improve screening for maternal depression.

The universal home visitation pilot, Welcome, Baby! is part of First 5 LA's Best Start LA Initiative. The program is designed to reach out to families at seven strategic points during pregnancy, birth, and postpartum. One of the major objectives of the home visits is to provide perinatal depression screening. Screening using PHQ-2, a two-question assessment, will be provided at each of the seven encounter points with the mother. If a positive screen is encountered, the PHQ-9 will be administered. If follow-up is needed, the mother will be referred for further evaluation and treatment.

LA Care Health Plan, a community-accountable health plan administers free or low cost insurance programs, including Medi-Cal, Healthy Families, and LA Care Healthy Kids. LA Care has made an effort to address maternal depression by offering training on maternal depression screening and care for their medical providers. Participants enrolled in Healthy Families or Healthy Kids who become pregnant are screened once during the pregnancy and once after

delivery, using the Edinburgh Postnatal Depression Scale (EPDS). If the screening results are positive for depressive symptoms, the case manager refers the client to Pacific Care Behavioral Health. Behavioral health services for Medi-Cal members are subcontracted to the Department of Mental Health.

Kaiser Permanente meets the mental health needs of each patient upon the confirmation of pregnancy or prenatal registration. The instrument used to screen for perinatal depression is the self-administered PHQ-9. A patient who scores between ten and 14, suggestive of moderate depression, is given patient education and information about perinatal depression. The social worker reviews all of the PHQ-9 surveys and contacts patients with a score of 15 or more, which suggests more severe depression. The social worker conducts a psychosocial evaluation and provides information and education about perinatal depression. If indicated, the patient is offered an appointment with the social worker for further counseling, evaluation, and referrals for support. If there is a positive response to the PHQ-9 question about suicide, the patient is seen immediately by the social worker. The social worker receives referrals from physicians, midwives, nurses or patients themselves. The treatment options available are counseling by a social worker or a referral to Kaiser's outpatient psychiatry department for counseling and medication evaluation. In addition, obstetricians can prescribe medications for depressive symptoms during the prenatal and postpartum periods. At the time of delivery, the PHQ-9 score is reviewed once again by the social worker who visits the patient in the hospital to assess her psychosocial status.[70]

Individual and group health plans, such as Health Net, Anthem Blue Cross, and Blue Shield of California, all include mental health benefits, with no restrictions during prenatal or postpartum periods. Mental health services are almost always offered by managed care plans, however, visits may be limited to a set number per year, and only with a referral from a primary care provider.

Coverage during Pregnancy

Medi-Cal is California's public health insurance program under the federal Medicaid program, which provides services for low-income individuals and families meeting eligibility requirements. Fifty-three percent of all births in L.A. County are covered by Medi-Cal.[71, 72]

In California, eligible CPSP providers can bill for and are reimbursed for psychosocial screenings by Medi-Cal. Reimbursements for pregnancy related mood and anxiety disorders include:

- *Presumptive Eligibility* (PE) for pregnant women allows immediate, temporary Medi-Cal coverage for prenatal care and prescription drugs for low-income, pregnant women, pending their formal Medi-Cal application. For continuous Medi-Cal coverage, the beneficiary must fill out a regular application before the end of the month she receives PE.
- *Full scope Medi-Cal eligibility* is available to low-income women, i.e. at or below 200% of the Federal Poverty Level (FPL). Full scope Medi-Cal covers a full range of medically necessary services, including mental health services, for as long as eligibility lasts.
- Restricted or limited scope Medi-Cal is available to low-income women without legal status in the U.S, but the women must be California residents. This coverage is limited to pregnancy-related conditions, including prenatal, delivery, and postpartum care services. Restricted Medi-Cal for pregnancy-only services terminates 60 days postpartum.

Access for Infants and Mothers Program (AIM), is a state sponsored, full coverage program for pregnant women with eligibility at 201-300% of Federal Poverty Level. AIM's mental health coverage includes outpatient and inpatient services, with a maximum of 30 days inpatient and 20 days outpatient care per benefit year. However, there are no visit limits for diagnosis and treatment of severe mental illness.

The Comprehensive Perinatal Services Program (CPSP) is a state program available to pregnant women with

restricted or full-scope Medi-Cal, including Presumptive Eligibility. CPSP integrates nutrition, psychosocial, and health education assessments and counseling with obstetrical care in order to decrease the incidence of low birth weight infants and improve pregnancy outcomes. The psychosocial assessment, repeated each trimester and postpartum, includes screening for anxiety and stress but not for perinatal depression.[73]

In California, eligible CPSP providers can bill and be reimbursed for psychosocial screenings and counseling by Medi-Cal. Reimbursements for pregnancy-related mood and anxiety disorders include: [74]

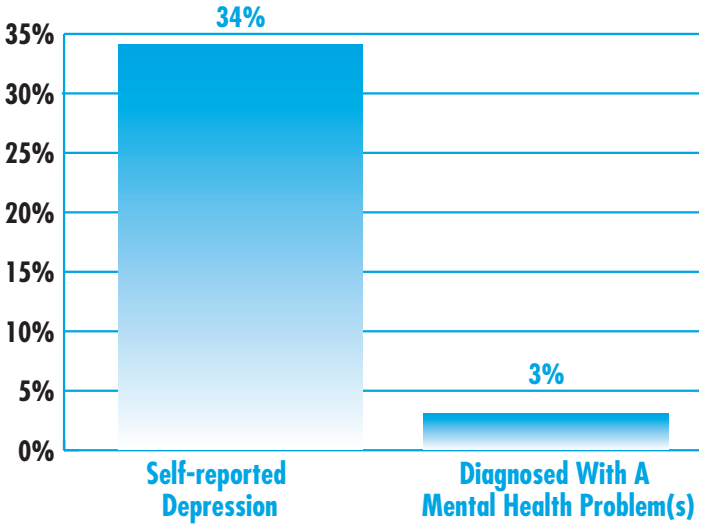
- An initial combined assessment includes 30 minutes of a psychosocial assessment reimbursed at $135.83
- If more time is needed to complete the initial psychosocial assessment, 15-minute intervals can be added, up to a maximum of 6 or 1.5 hours reimbursed at a rate of $8.41/15 min.
- Individual psychosocial counseling and/or reassessments can be provided in 15-minute intervals, up to a maximum of 12 or 3 hours reimbursed at a rate of $8.41/15 min.
- Up to 4 hours of group counseling can also be provided during pregnancy and reimbursed at a rate of $2.81/15 min.
- In the postpartum period, up to 1.5 hours of individual counseling can be provided and reimbursed at a rate of $8.41/15 min.

Once Medi-Cal-for-pregnancy-only coverage terminates, 60 days postpartum, service providers are no longer reimbursed for services.

Missed Opportunities in Screening and Treatment

Perinatal mood disorders are generally underdiagnosed and under treated. Some studies suggest that 50% of women suffering from perinatal depression remain undiagnosed and therefore untreated when routine screening is not practiced by their health care providers.[75, 76]

Figure 5 Incidence and Diagnosis



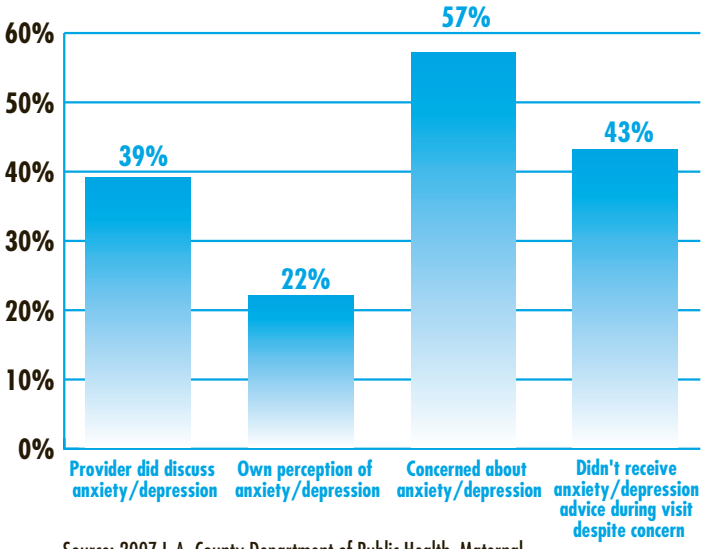
Source: 2005 L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs. Los Angeles Mommy and Baby Project

The 2005 LAMB study found that during pregnancy 34% of the survey respondents reported depressive symptoms, yet only 3% were diagnosed with a mental health problem *(see Figure 5)*. [77]

A second LAMB study in 2007 provides a closer look at how providers and patients discuss anxiety and depression during a medical visit in the preconception period. It also examines the patient's own perception of anxiety and depression (see Figure 6). Results show that a significant number of women were concerned about their symptoms of anxiety/depression (57%), but that most of them received no advice about their symptoms from their health care provider during an office visit.[78] Integrating a screening tool into a routine office visit provides an opportunity for patients to raise concerns with their medical provider about depression, and if necessary be referred for further evaluation and treatment.

Figure 6 shows that 57% of women expressed a concern about anxiety or depression during a visit with a provider, prior to becoming pregnant. These women are potentially at higher risk for developing postpartum depression. This emphasizes the critical importance of screening all pregnant women for perinatal depression "early and often," i.e. at least once a trimester and two to three times postpartum.

Figure 6 Preconception Discussions About Anxiety/Depression



Source: 2007 L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs. Los Angeles Mommy and Baby Project

Public Mental Health Services in L.A. County

The lead public mental health entity for L.A. County is the L.A. County Department of Mental Health (DMH). DMH serves mentally ill individuals who have Medi-Cal insurance. DMH has 50 program sites and contracts with 1,100 providers including non-governmental agencies and individual practitioners.[79] Mental health services are provided by a variety of clinicians, including social workers, marriage and family therapists, psychologists, and psychiatrists. Services include screening, assessment, and therapeutic services, such as individual or group counseling, and medication assessment and prescribing. In addition, DMH offers services to indigent or uninsured clients, on a limited basis. Given its limited resources, DMH is only able to serve chronically and persistently, severely mentally ill individuals. Women with perinatal mood disorders are served only if they meet criteria for "medical necessity," e.g., severe depression with suicidal ideation. Unfortunately, many women with perinatal mood disorders do not meet these criteria, and therefore do not qualify for services.

It is also difficult to access mental health care through community clinics. Figures provided by the Community Clinics Association of Los Angeles County (CCALAC) attest to the low numbers of mental health providers in L.A. County who treat low-income and uninsured populations. In 2006 there were 40 full-time mental health providers, serving 123 clinical sites of CCALAC members. In 2007, there were 74 full-time providers, an 87% increase. These 74 providers were responsible for 77,356 mental health encounters at the same 123 clinical sites.[80] Even with this increase in the number of mental health providers, there remains a large unmet need for mental health services in community clinics. The overwhelming number of people affected by mental illness is taxing an already overburdened safety net.

IV. Barriers to Meeting the Need

Barriers to providing and accessing the range of recommended screening and treatment services exist at the level of the individual patient, the provider, and the broader system. Patients face stigma, lack of awareness, and other challenges in recognizing and responding to their own emotional needs.

Medical providers in a number of specialties, obstetrics-gynecology, internal medicine, and pediatrics, face a multitude of obstacles to screening, treating, and referring patients. These include insufficient knowledge, low comfort level with mental health issues, low or no reimbursement, and lack of coordination with other treatment providers. Even psychiatrists and psychologists often lack specific knowledge about the treatment of pregnant and postpartum women. At the broader systems level, coverage limits in public and private insurance plans, along with lack of insurance, and fragmentation of services among providers during the prenatal and postpartum periods, continue to make it difficult to meet the mental health needs of pregnant and postpartum women in this county.

Individual Barriers

Patients with mental health illnesses often experience stigma, cultural biases, and fear of admitting to a mental health problem. They may harbor preconceived notions about seeking help, screening, or treatment, especially those in underserved, low-income and immigrant

communities. For many minority women, there are powerful negative stereotypes and connotations surrounding mental illness. The pregnancy and childbirth period is presumed to be a joyful time when a mother bonds with her infant, not a time for depressive symptoms to emerge. Women hide or ignore these feelings, and hope they will go away. When symptoms do occur, women may have difficulty identifying them as depression and may view them as a normal part of motherhood and everyday life. Low-income and immigrant women often distrust mental health agencies and community health centers.[81] They are often fearful of admitting that they are depressed, for fear that the Department of Child and Family services will take their children away from them.[82] An additional barrier is lack of understanding by family members of the older generations, who are often very influential and involved in the new mother's care and support system.[83]

Provider Barriers

Even with guidelines in place, it remains a challenge convincing health care providers to address women's mental health issues through frequent screening and referrals of high- risk women for further treatment.[84] One study found that 40% of primary care providers never, or rarely, assess patients for maternal depression.[85] Another study found that screening occurs primarily when clinicians suspect abuse or see red flags, such as severe depressive and psychosocial symptoms.[86] In general, health care providers tend to believe that mental health screenings are beyond their scope of practice, their guidelines and their comfort level.

Ob-Gyns in low-income communities face a number of barriers when they encounter a positive mental health screen, mainly due to limited resources for further evaluation and treatment. For example, several clinics participating in the LA Best Babies Network's Care Quality Collaborative cited the lack of mental health resources for pregnant women as the reason for not screening. If providers encounter a positive screen, they consider themselves responsible for treating the patient's depression. If referral resources are not available, many providers will avoid psychosocial screenings altogether.

Although some new mothers may neglect their own health care, they will take their child to the pediatrician several times in the first year of life.[87] Thus, pediatricians have a unique opportunity to screen for maternal depression during well-child visits. Recommendations are in place for pediatricians to screen for maternal depression, but currently most states do not reimburse pediatric providers for these screenings. One survey on the way pediatricians screen for maternal depression showed that 75% relied on observational cues, such as flat affect or withdrawal, to identify a mother with depressive symptoms.[88] The survey also asked about the pediatricians' barriers to screening. The majority cited a lack of time (91%) as the reason for not screening. Moreover, many did not feel adequately trained to recognize or discuss maternal psychosocial problems. They were also not familiar with local mental health resources, or did not believe the resources would meet the needs of perinatal patients.[89] Most pediatricians find that the pediatric visit is not an ideal setting in which to discuss maternal psychosocial issues, primarily because children are present and many disruptions occur. Providers also come up against cultural and linguistic barriers, making it extremely difficult to address sensitive psychosocial issues like perinatal depression.

Systemic Barriers

Low Medi-Cal reimbursement rates for perinatal depression present a significant barrier to care.[90] There are only a handful of state Medicaid agencies or programs that reimburse for depression screening.[91] Thus, Medi-Cal providers have little economic incentive to perform mental health screenings. This means that patients do not routinely receive screening for perinatal depression.[92]

Another systemic barrier is the limited number of providers accepting Medicaid. The fact that a service is covered by Medicaid does not guarantee its availability.[93] A low rate of reimbursement, along with a patient base with often complex medical and social needs, has made many health providers reluctant to participate in the Medicaid program.[94]

Workforce Challenges

Patients in L.A. County with Medi-Cal coverage have both the greatest need and the least access to mental health services. For mothers desperately struggling with depressive symptoms, clinics that provide mental health services and have appropriate providers are limited. They also face lengthy waiting times for appointments and linguistic and cultural barriers. If a woman is experiencing additional problems, such as substance abuse or domestic violence, along with perinatal depression, she is often required to initiate treatment that will address the other issue first, rather than receiving concurrent services. Another challenge for a postpartum woman exhibiting acute symptoms of depression is finding immediate counseling services in L.A. County that accept Medi-Cal, offer a sliding-scale fee, and/or provide treatment beyond 60 days postpartum once restricted Medi-Cal is no longer in effect.

Primary care providers and community clinics who serve the Medi-Cal population operate under tight budget constraints, and do not have funds for training and educating health care providers and mental health practitioners about perinatal depression. Without additional funding or grants, primary care providers simply cannot access the training they need in order to become knowledgeable about perinatal depression, treatment options, and referral resources.[95] Even women with private insurance have difficulty accessing treatment services, since few mental health professionals specialize in perinatal mood disorders and those that do are in high demand.

Crafting Solutions: What Is Needed

Bringing perinatal mood disorders to the forefront of maternal-child health issues in L.A. County demands a strong community response, involving organizations and people who share a common vision and dedication. Strengthening the health and resilience of all mothers and families in L.A. County should be a priority for all residents.[96]

The following is an outline of specific solutions to increasing access to perinatal mental health services for all women in L.A. County, particularly those who depend on the safety net system.

Promote Universal Depression Screening

Establishing a standard of care that includes screening in each trimester and in the postpartum period should be a key goal. Screenings identify women who are experiencing perinatal depression for further evaluation and treatment.[97, 98] Providers should develop a systematic approach to screening, including the choice of a screening tool, and screening during each trimester and at set points in the postpartum period.[99] Screening can take place in a variety of settings, including Ob-Gyns' offices, pediatric offices, WIC offices, or in women's health clinics. When screening is implemented in pediatric practices, it should be as a part of a child-focused effort to improve developmental outcomes.[100]

Prenatal programs, such as California's Comprehensive Perinatal Services Program (CPSP), should include a standard of care that addresses maternal depression. Currently, CPSP providers are not required to screen for perinatal depression, nor does the standardized comprehensive assessment contain validated questions regarding perinatal depression. By simply changing the assessment form and requiring screening for perinatal depression at set points, the safety net for low-income women can be greatly strengthened.

Raising awareness of maternal depression among health care providers, including family practitioners, pediatricians, Ob-Gyns, nurse-midwives, and nurse-practitioners, will increase the likelihood of depression being identified early and treated properly. Professional organizations such as the American Academy of Pediatrics (AAP) have demonstrated a commitment to these goals. The AAP's Mental Health Task Force is currently developing a statement that will include recommendations for screening for postpartum depression.[101] As awareness and interest grows, policymakers should focus on the

development of guidelines for practitioners and a clear set of recommendations regarding the pediatric provider's role with respect to perinatal depression.

Increase Women's Access to Mental Health Services

Improving access to mental health services is fundamental to addressing maternal depression and mental wellness for the entire family. One solution is to expand Medi-Cal services for pregnant women to include mental health services. This expansion would assure that high-risk, low-income women receive the optimal level of care during the perinatal period, resulting in the best possible outcomes for the entire family.[102] It is strongly recommended that Medi-Cal eligibility be extended so that women are able to access services beyond 60 days, up to two years postpartum. Maternal depression can occur up to one year postpartum, long after most Medi-Cal coverage expires.

While extending Medi-Cal eligibility addresses a coverage issue, Medi-Cal reimbursements must also be addressed in order to eliminate systemic barriers. Medi-Cal reimbursements for mental health services need to be in line with private insurers' rates.[103] Unfortunately, practitioners are unlikely to change their behavior without appropriate incentives, such as increased Medi-Cal reimbursements for screening and treating perinatal depression.

The state of Illinois provides one example of best practices for expanding access to care. The state is working to integrate perinatal mental health services with Medicaid and other programs to improve care. The Illinois Department of Public Aid has been using the Medicaid family planning waiver to implement the Illinois Healthy Women Initiative. This initiative provides pre- and interconception care to women who would otherwise lose maternity related coverage 60 days postpartum, including women ages 19 to 44 previously enrolled in Medicaid but who have lost their benefits. This initiative has improved access to a wide range of services, including preventive and reproductive care, genetic counseling, and perinatal depression screening programs.[104]

Not only has Illinois increased access to services, but it has also addressed reimbursement for these services. Illinois reimburses primary care providers who use a pre-approved standardized depression screening tool, such as the Edinburgh Postnatal Depression Scale. Partnerships between the state Medicaid agency and provider organizations have also been instrumental in promoting the new policy among the state's providers.

A promising partnership in Los Angeles that has the potential to improve access and quality care is the Public Private Partnerships, or P/PPs. The P/PPs are an organized system of primary health clinics that provide medical, specialty, and dental services to the medically indigent, in a way that is complementary to the L.A. County Department of Health Services' (DHS) current system of care. The program is triggered only if an indigent patient fails to qualify for health insurance or any other publically funded programs. The program thus provides access to primary care for a large number of uninsured people in L.A. County. The program has proven to be extraordinarily cost-effective, since community clinics are able to leverage other funds to cross-subsidize adult patient care for this program.[105]

Adding to the P/PPs' success, a study of mental health services in Los Angeles showed that that public/private partnerships (P/PPs) and the County's comprehensive health centers (CHCs) provided better care for depression than other County facilities.[106] Given how overburdened the public mental health system is in L.A. County, public/private partnerships may offer a better model for providing mental health services. The study also found that P/PPs address local communities' efforts to provide more accessible care for prioritized health needs and are a way to begin reforming local health care delivery systems.[107]

Another possible solution is California's family planning program, which provides contraception, STD screening and cervical cancer screening to Californians earning

less than 200% of the Federal Poverty Level. California has the largest family planning waiver in the country, known as Family PACT (Family Planning Access, Care, and Treatment). This program is funded by the state, and the federal governments, which pay 10% and 90% respectively.[108] One suggestion is for family planning waivers to be broadened in scope to offer women enrolled in the program an expanded range of benefits that include preventive services such as depression screening and treatment.[109]

Increase Education and Training for Prenatal and Mental Health Care Providers

Health practitioners who serve perinatal patients should be familiar with risk factors and identify any potential mental health problems through frequent screenings.[110]

However, most practitioners have limited knowledge about the prevalence or the signs and symptoms of maternal depression and its impact on the mother-infant dyad and the rest of the family. They also have limited understanding of the cultural traditions, values, and beliefs of diverse families and their influence on mental health. For instance, health practitioners often miss the diagnosis of depression among ethnic minority women because they tend to express their psychological distress through physical complaints. As a result, maternal depression and early childhood mental health disorders often go unrecognized and untreated.[111] One solution to this problem is to provide more training and education about perinatal depression for medical and mental health providers.[112]

All prenatal health care providers should receive training in the symptoms and effects of postpartum depression, and the use of postpartum screening tools. Continuing medical education can be offered in a variety of ways, including articles in popular medical journals, on-line webinars, grand round presentations, or conferences. Medical departments should work closely with psychiatry departments to develop workshops or grand rounds designed specifically for medical practitioners. Medical residency programs should include maternal mood disorders in their training curriculum.[113] Mental health professionals such as MFTs, LCSWs, psychologists, and psychiatrists should be trained to deal with depression through a family-oriented lens. Ideally they would work not only with the family, but also members of the team that play a prominent role in the lives of family members: Ob-Gyns, pediatricians, early childhood providers, and women's health agencies.[114]

Mental health practitioners should:

- Be knowledgeable about current guidelines for the treatment of perinatal mood disorders
- Be able to identify the consequences of untreated perinatal depression and anxiety on obstetric outcomes
- Be able to recognize and understand pregnancy and lactation risk categories for psychotropic medications
- Receive support and expanded training opportunities on perinatal mood disorders
- Be able to specialize in the diagnosis and treatment of perinatal mood disorders
- Use distance learning strategies and technology to increase access to training and educational programs.

Another priority is identifying strategies to attract students to mental health professions. Recruitment efforts should be modeled after that of other health professions. To increase the number of mental health professionals in the workforce, the following components are needed: [115]

- Raised awareness and interest in health careers among students in middle school and high school
- Expanded training opportunities on perinatal mood disorders for all mental health professionals
- The recognition of the treatment of perinatal mood disorders as a sub-specialty for mental health providers
- The promotion of mental health graduate programs
- The promotion of employer-community collaborations to recruit and retain mental health professionals
- The recruitment of non-traditional students, such as

mid-career and retired professionals from other fields, and facilitation of their re-training through weekend Masters degree programs or virtual or distance learning programs

- The initiation of partnerships between training programs and employers to create paid, on-the-job training for students, i.e., paid internships
- The encouragement of local businesses, community organizations, local government, and chambers of commerce to develop initiatives to "grow their own" through scholarships and other tuition assistance programs to help students and employees who wish to advance their skills

Increase Perinatal Mental Health Resources

There is a critical need to increase the mental health resources in L.A. County that address perinatal mood disorders. Mental health resources include services provided by psychologists, psychiatrists, social workers, marriage and family therapists, infant/toddler mental health specialists, and school counselors. In order to expand these resources, it is vital to educate and train more providers about perinatal depression.

Mental Health Prevention Should Be Integrated into Health Clinic Programs Throughout Los Angeles County

Increasing mental health resources and prevention in L.A. County can include the integration and expansion of programs funded through the Mental Health Services Act (MHSA). MHSA's goal is to improve the delivery of mental health treatment services in the State of California. The MHSA addresses a broad continuum of prevention, early intervention, and treatment needs that will effectively support County mental health programs. Prevention and Early Intervention (PEI) is one of the five components of the MHSA and is intended to prevent the development of serious emotional disorders and other mental illnesses by reaching out to critical populations. PEI funding for the perinatal population will help identify at-risk parents, who will be offered prevention and early intervention services beginning in the prenatal period. The funding also covers families stressed by maternal depression that have children under the age five. Integrating prevention and early intervention into the existing primary care network, such as community clinics, has the potential to transform the mental health care system and truly serve the underserved.[116]

The American Recovery and Reinvestment Act (ARRA) of 2009 may also benefit women with perinatal depression. The bill provides for a significant investment in early childhood programs and support for families. Potential opportunities for improving maternal mental health include leveraging efforts to increase developmental screening and referral to early intervention programs for young children by various social support agencies. While developmental screenings are focused on the child, incorporating a psychosocial screening of the parents would be more comprehensive in addressing family issues that may be impacting the child. [117]

Increase Public Awareness of Perinatal Depression

Increasing awareness of perinatal depression must be done on multiple levels and in a variety of ways. To increase the awareness of their pregnant patients, providers can offer written information, educational classes and support groups as well as routine screens for maternal depression. At the community level it is extremely helpful for providers from different disciplines serving the same population to meet and learn about each others services and about integrating community resources.[118] The Los Angeles Best Babies Network's Healthy Birth Learning Collaboratives (HBLCs) are examples of groups of perinatal stakeholders working together to improve pregnancy and birth outcomes in their service planning area. In these community-based meetings, medical providers learn who their local mental health providers are and vice versa. If service gaps exist, HBLC members can brainstorm on how to best fill them.

One example of efforts to increase perinatal depression awareness on the national level is the new initiative by the American College of Obstetricians and Gynecologists.

In recognition of the high priority of perinatal depression ACOG's new president, Gerald F. Joseph Jr., MD, has made perinatal depression the theme of his year-long presidential initiative. He is calling on ACOG to evaluate various screening tools and examine perinatal depression data, in order to provide Ob-Gyns with evidence-based guidelines to help their patients. He has also emphasized that care needs to start at the front end, with prevention, rather than with acute care at the back end, which is more expensive.

The U.S. Department of Health and Human Services' Maternal and Child Health Bureau (MCHB) also recognizes the importance of increasing awareness of perinatal depression. In 2004, MCHB awarded perinatal depression grants of $250,000 to five states. The funds were used by these states to increase awareness of perinatal depression and promote mental wellness for mothers and families. This initial investment in state public health departments is vital to improving essential services for women who are accessing treatment through the public health care system.[119]

Increase Psychosocial Support Services

Psychosocial support services are critical to addressing maternal depression. A study by Michael Rodriguez, MD, and colleagues, examined resilience, social support and depression among pregnant Latinas. They found that programs focusing on strengths, such as resilience, mastery, social support and active coping, all have positive mental health outcomes.[120] Programs that emphasize strength factors, rather than focusing on deficits, should be promoted.

Convincing women suffering from postpartum depression or perinatal mood or anxiety disorders to ask for help is a challenge, especially in low-income and ethnic minority communities. Reaching mothers at the grassroots level and providing them with social support and health education improves their help-seeking behavior. For social service agencies in Los Angeles, this means reaching out to mothers through organizations like Women, Infants, and Children, CalWorks, Cal Learn and other aid programs, in order to educate and provide mothers with resources. The family and the community are vital support systems for the mother and can also benefit from information about maternal depression. Equally important are faith-based organizations, valuable sources of psychosocial support. Agencies that provide mothers with basic needs such as food, clothing, and housing also help alleviate factors that contribute to maternal depression.[121]

The early-care and education agencies are crucial partners in improving maternal and infant mental health. Early childhood providers and Early Head Start/Head Start providers have frequent contact with parents and are a resource to the health care community. Educating these providers about perinatal depression and its impact on young children will increase public awareness, decrease stigmatization, and increase the referral of parents for evaluation and treatment.[122] Given the high number of teen pregnancies in L.A. County and the high risk of suicide associated with them, high schools for pregnant teens should screen for perinatal depression and provide treatment and support services in their school settings.

Other informal treatments, such as peer-to-peer support groups, have been shown in studies to have great potential. Research on evidence-based practices suggests that peer support accelerates improvement in mental health outcomes.[123] A study in Canada found that telephone-based peer support cut the risk of depression in half at 12 weeks postpartum and was effective in preventing perinatal depression among high-risk women.[124] Another study found that peer-to-peer support groups, frequently called "Sister Circles," reduce depression in black and Latina women.[125]

Treating maternal depression in isolation, with psychotropic medication and psychotherapy, leads to fragmented care. Instead, mental health services should be integrated into other health services. Treatment plans should be tailored to the needs of each individual. For instance, women struggling with maternal depression are often grappling

with other illnesses and issues, such as obesity, diabetes, domestic violence, or substance abuse. Treating the depressive symptoms alone is ineffective. For treatment to succeed, a variety of services and professionals must work together to address all of the issues impacting the woman's situation.

Future Directions: Where Do We Go from Here?

There is evidence of growing awareness of the unmet mental health needs of pregnant and postpartum women in L.A. County, and a strong impetus to take action, at multiple levels, to close the gaps in maternal and infant mental health services.

Multiple organizations and foundations are making the commitment to support perinatal mental health efforts in L.A. County, and funding initiatives have had success in raising awareness of perinatal depression. First 5 LA has provided funding to LA Best Babies Network, and its partner, the L.A. County Perinatal Mental Health Task Force for a perinatal mental health project focused on advocacy, promoting awareness, and educating policymakers on perinatal depression. The L.A. County Perinatal Mental Health Task Force, composed of over 35 individuals, agencies and organizations, is dedicated to promoting the well-being of pregnant and postpartum women through public education, provider training and promotion of policy reform. Support at the legislative level for maternal depression is evidenced by bills introduced in the both federal and state legislatures seeking support for perinatal mood disorders.

Maternal depression in L.A. County must be recognized as a condition that is very common, with serious consequences for mothers, infants, and families. With appropriate policy and systems changes, it is both preventable and treatable.

Success in reducing the fragmentation of services, overcoming cultural stigmas surrounding mental illness, and increasing resources for prevention and treatment requires a coordinated effort at the individual, provider and systems levels. Pregnant and postpartum women suffering from depression can be identified and treated effectively through policy changes aimed at providing universal depression screenings, integrated services, increased insurance coverage, reimbursements, and education and training of medical and mental health practitioners.

Through partnerships with communities, practitioners, and policymakers, it is possible to close the gap in unmet maternal mental health needs and to change the landscape of perinatal depression in L.A. County.

Notes

[1] (2006). Psychosocial risk factors: Perinatal screening and intervention. *Obstetrics & Gynecology*, 108, ACOG Committee Opinion No. 343, 469-77.

[2] Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA.

[3] Dossett, E. (2008). Perinatal Depression. *Obstetrics & Gynecology Clinics of North America, 35*, 419–434.

[4] Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA.

[5] Knitzer, J., Theberge, S., Johnson, K., (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood Policy Framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2*.

[6] *Position statement: Screening for prenatal and postpartum depression*. (n.d.) Perinatal Foundation and Wisconsin Association for Perinatal Care. Retrieved April 9, 2009 from http://www.perinatalweb.org.

[7] Isaacs, M. (2004). Community care networks for depression in low-income communities and communities of color: A review of the literature. Submitted to Annie E. Casey Foundation and the Howard University School of Social Work and the National Alliance of Multiethnic Behavioral Health Associations (NAMBHA).

[8] Oates, M. (2003). Suicide: The leading cause of maternal death. *The British Journal of Psychiatry, 183*, 279-281.

[9] Harlow, B.L., Vitonis, A.F., Sparen, P., Cnattingius, S., Joffe, H., Hultman, C.M. (2007). Incidence of hospitalization for postpartum psychotic and bipolar episodes in women with and without prior prepregnancy or prenatal psychiatric hospitalizations. *Archives of General Psychiatry, 64* (1), 42-48.

[10] Manisha, S. (2005). The role of state public health in perinatal depression: Fact sheet. Association of State and Territorial Health Officials.

[11] *Postpartum Mood Disorders*. The Jennifer Mudd Houghtaling Postpartum Depression Foundation Website. Retrieved May 1, 2009 from http://www.ppdchicago.org/.

[12] *Maternal Depression Making a Difference Through Community Action: A Planning Guide* (n.d.). Mental Health America, Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved March 4, 2009 from http://www.mentalhealthamerica.net/go/maternal-depression.

[13] Ramsay, R. (1993). Postnatal Depression. *Lancet*, 314, 1358.

[14] Gold, K., Marcus, S., (2008). Effect of maternal mental illness on pregnancy. Expert Review of Obstetrics & Gynecololgy, 3 (3), 391-401.

[15] Blenning, C., Paladine., H. (2005). An Approach to the Postpartum Office Visit. *American Family Physician*, 72 (12) 2491-2496.

[16] Gaynes, B., Gavin., N, Meltzer-Brody., S, Lohr, K., Swinson., T, Gartlehner., G, et al. (2005). Perinatal depression prevalence, screening accuracy, and screening outcomes: Summary, evidence report and technology assessment, No. 119. *AHRQ Publication No. 05-E006-1*.

[17] Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA.

[18] Knitzer, J., Theberge., S, Johnson., K. (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2*.

[19] Yonkers, K., Chantilis, S. (1995). Recognition of depression in obstetric and gynecology practices. *American Journal of Obstetrics and Gynecology*, 173 (2), 632-638.

[20] Gavin, N.I., Gaynes, B.N., Lohr, K.N., Meltzer-Brody, S., Garlehner, G., Swinson, T. (2005). Perinatal depression: A systematic review of prevalence and incidence. *American Journal of Obstetrics and Gynecology*, 106 (5 Pt 1), 1071-1083.

[21] *Maternal Depression Making a Difference Through Community Action: A Planning Guide*. (n.d.). Mental

Health America, Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved March 4, 2009 from http://www.mentalhealthamerica.net/go/maternal-depression.

[22] Ibid.

[23] (2006). *The State of Depression in America*. Depression and Bipolar Support Alliance. Retrieved May 18, 2009 from www.DBSAlliance.org.

[24] Knitzer, J., Theberge, S., Johnson, K. (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2*.

[25] McCue-Horwitz, S., Briggs-Gowan, M., Storfer-Isser, A., Carter, A., (2009). Persistence of maternal depressive symptoms throughout the early years of childhood. *Journal of Women's Health,* 18 (5) 637-645.

[26] Talge, N., Neal, C., Glover, V., (2007). Antenatal maternal stress and long term effects on child neurodevelopment: How and why? *Journal of Child Psychology and Psychiatry*, 48, 245-261.

[27] *Position Statement: Screening for prenatal and postpartum depression. (n.d.).* Perinatal Foundation/ Wisconsin Association for Perinatal Care. Retrieved April 9, 2009 from http://www.perinatalweb.org.

[28] Ibid.

[29] Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA.

[30] Ibid.

[31] Knitzer, J., Theberge, S., Johnson, K., (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2*.

[32] (2006). *The State of Depression in America*. Depression and Bipolar Support Alliance. Retrieved June 20, 2009 from www.DBSAlliance.org.

[33] Ibid.

[34] Ibid.

[35] Boath, E., Pryce, A., Cox, J., (1998). Postnatal depression: The impact on the family. *Journal of Reproductive and Infant Psychology, 16* (2/3) 199.

[36] (2006). *The State of Depression in America*. Depression and Bipolar Support Alliance. Retrieved June 20, 2009 from www.DBSAlliance.org.

[37] Greenburg, P., Leong, S., Birnbaum, H. (2001). Cost of Depression: Current assessment and future directions. *Expert Review of Pharmacoeconomics Outcomes Research*, 1 (1), 69-76.

[38] Greden, J. (2001). The Burden of Recurrent Depression: Causes, Consequences, and Future prospects. *Journal of Clinical Psychiatry*, 62 (Suppl 22), 5-9.

[39] (2007). Birth statistical master file. State of California Department of Health Services Center for Health Statistics.

[40] (2005). Los Angeles Mommy and Baby Project. L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs.

[41] (2007-08). Los Angeles Health Overview of a Pregnancy Event (LAHOPE) Project. L.A. County Department of Public Health/Maternal, Child and Adolescent Health Programs.

[42] (2005). Los Angeles Mommy and Baby Project. L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs.

[43] (2005). L.A. County Women Infant Children Survey.

[44] Le, H., Munoz, R., Soto, J., Delucchi, K., Ippen, C. (2004). Identifying risk for onset of major depressive episodes in low-income Latinas during pregnancy and postpartum. *Hispanic Journal of Behavioral Sciences*, 26 (4), 463-482.

[45] Abrams, L.S., Dornig, K. (2007). Bridging the gap: Barriers to service use among low-income women with postpartum depression. Funded by the Center for Vulnerable Populations Research at the UCLA School of Nursing and the UCLA Faculty Senate in cooperation with the Public Health Foundation Enterprises WIC Program.

[46] Ibid.

[47] (2008). Fact Sheet: Quick facts on teen pregnancy. LA Unified School District, Teen Parent Program.

[48] (2005). Los Angeles Mommy and Baby Project. L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs.

[49] (2005). L.A. County Women Infant Children Survey.

[50] Ibid.

[51] Ibid.

[52] Ibid.

[53] (2005). Los Angeles Mommy and Baby Project. L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs.

[54] Ibid.

[55] Ibid.

[56] Kozhimannil, K., Pereira, M., Harlow, B. (2009). Association between diabetes and perinatal depression among low-income mothers. *JAMA*, 301 (8), 842-847.

[57] Ibid.

[58] (2007) Birth statistical master file. State of California Department of Health Services Center for Health Statistics.

[59] (2005). Los Angeles Mommy and Baby Project. L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs.

[60] Ibid.

[61] Dossett, E. (2008). Perinatal Depression *Obstetrics and Gynecolology Clinics of North America*, 35, 419–434.

[62] Salganicoff, A., An, J. (2008). Making the most of Medicaid: Promoting the health of women and infants with preconception care. *Women's Health Issues*, 18S, S41-S46.

[63] Olson, A.L., Dietrich, A.J., Prazar, G., Hurley, J. (2006). Brief maternal depression screening at well-child visits. Pediatrics, 118, 207-216.

[64] Knitzer, J., Theberge, S., Johnson, K., (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2*.

[65] (2004). Depression Management Tool Kit. The MacArthur Initiative on Depression & Primary Care at Dartmouth & Duke. Retrieved January 6, 2009 from www.depression-primarycare.org.

[66] Chaudron, L., Szilagyi, P., Campbell, A., Mounts, K., McInerny, T. (2007). Legal and ethical considerations: Risks and benefits of postpartum depression screening at well-child visits. *Pediatrics*, 119, 123-128.

[67] Leiferman, J.A. (2008). Primary care physicians' beliefs and practices toward maternal depression. *Journal of Women's Health*,17 (7), 1143-1150.

[68] Ibid.

[69] C. Chow (personal communication, March 25, 2009)

[70] K.S. Bratman (personal communication, June 4, 2009)

[71] (2008). *Mental health coverage during pregnancy. Fact sheet.* Maternal and Child Health Access. Retrieved April 9, 2009 from http://www.mchaccess.org.

[72] California Department of Health Care Services. All Programs and Services. Retrieved May 6, 2009 from http://www.dhcs.ca.gov/services/Pages/AllServices.aspx.

[73] Comprehensive Perinatal Services Program website. California Department of Public Health. Retrieved April 9, 2009 from http://www.cdph.ca.gov/programs/CPSP.

[74] Medi-Cal rates as of 06/15/2009. Department of Health Care Services. Retrieved May 26, 2009 from http://files.medical.ca.gov/pubsdoco/rates/rateshome.asp.

[75] *Position statement: Screening for prenatal and postpartum depression.* (n.d.). Perinatal Foundation, Wisconsin Association for Perinatal Care. Retrieved April 9, 2009 from http://www.perinatalweb.org.

[76] Ramsay R. (1993). Postnatal Depression. *Lancet*, 314, 1358.

[77] (2005). Los Angeles Mommy and Baby Project. L.A. County Department of Public Health, Maternal, Child

and Adolescent Health Programs.

[78] (2007). Los Angeles Mommy and Baby Project. L.A. County Department of Public Health, Maternal, Child and Adolescent Health Programs.

[79] L.A. County Department of Mental Health website. Retrieved May 18, 2009 from http://dmh.lacounty.gov/services.asp.

[80] (2007) Patient Profile, Community Clinic Association of L.A. County. OSHPD Annual Utilization Report of Primary Care Clinics, Extract 1/20/09 (rev. 11/20/08).

[81] Knitzer. J., Theberge, S., Johnson, K. (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2.*

[82] Ibid.

[83] Abrams, L.S., Dornig, K. (2007). Bridging the gap: Barriers to service use among low-income women with postpartum depression. Funded by the Center for Vulnerable Populations Research at the UCLA School of Nursing and the UCLA Faculty Senate in cooperation with the Public Health Foundation Enterprises WIC Program.

[84] Wilen, J., Mounts, K. (2006). Women with depression—"You Can't Tell by Looking." *Maternal Child Health Journal*, 10 (S), 183-186.

[85] Leiferman, J.A. (2008). Primary care physicians' beliefs and practices toward maternal depression. *Journal of Women's Health*,17 (7), 1143-1150.

[86] Rodriguez, M., Heilemann, M., Fielder, E., Ang, A., Nevarez, F., Mangione, C. (2008). Intimate partner violence, depression and PTSD among pregnant Latina women. *Annals of Family Medicine*, 6 (1), 44-52.

[87] Heneghan, A., Morton, S., DeLeone, N. (2006). Pediatricians' attitude about discussing maternal depression during a pediatric primary care visit. *Child: Care, Health and Development*, 33 (3), 333-339.

[88] Ibid.

[89] Ibid.

[90] Ibid.

[91] *Depression Study. Medicaid Program Overview.* Retrieved on March 26, 2009 from http://www.hhsc.state.tx.us.

[92] Kautz, C., Mauch, D., Smith, S. (2008). Reimbursement of mental health services in primary care settings. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD.

[93] Salganicoff, A., An, J. (2008). Making the most of Medicaid: Promoting the health of women and infants with preconception care. *Women's Health Issues*, 18S, 41-46.

[94] Ibid.

[95] Kautz, C., Mauch, D., Smith, S. (2008). Reimbursement of mental health services in primary care settings. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD.

[96] Ibid.

[97] Knitzer, J., Theberge, S., Johnson, K. (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2.*

[98] Dietz, P.M., et al. (2007). Clinically identified maternal depression before, during and, after pregnancies ending in live births. *American Journal of Psychiatry*, 164 (10), 1515-1520.

[99] Knitzer, J., Theberge, S., Johnson, K., (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. National Center for Children in Poverty, Project Thrive Issue Brief 2.

[100] Ibid.

[101] *Goals and Activities.* American Academy of Pediatrics Task Force on Mental Health. Retrieved on June 2, 2009 from http://www.aap.org.

[102] Salganicoff, A., An, J. (2008). Making the most of Medicaid: Promoting the health of women and infants with preconception care. *Women's Health Issues*, 18S, S41-S46.

[103] Coppleson, Y., Gilani, S., Loh, L.M., Singh, I., Zablocki, A. (2008). Depression screening among primary care physicians, *The Mailman School of Public Health, University of Colombia.* Retrieved on January 29, 2009 from, http://www.mailman.hs.columbia.edu.

[104] Salganicoff, A., An, J. (2008). Making the most of Medicaid: Promoting the health of women and infants with preconception care. *Women's Health Issues,* 18S, S41-S46.

[105] (2009). Integrating prevention and early intervention into Los Angeles' Community Clinics: PEI proposal. Community Clinic Association of Los Angeles.

[106] Ibid.

[107] Mohanty, S., Diamant, A., Lagomasino, I., Asch, S. (2005). *Are Public/Private Partnerships Delivering Better Public Mental Health Services for the Safety Net Population?* AcademyHealth research meeting, 22, Abstract no. 3134. Retrieved on January 29, 2009 from http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=103622597.html.

[108] California Department of Public Health's Family Pact website, Retrieved on April 20, 2009 from http://www.familypact.org/en/home.aspx.

[109] Salganicoff, A., An, J. (2008). Making the most of Medicaid: Promoting the health of women and infants with preconception care. *Women's Health Issues*, 18S, S41-S46.

[110] Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA.

[111] Ibid.

[112] *Maternal Depression Making a Difference Through Community Action: A Planning Guide.* (n.d.). Mental Health America, Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved March 4, 2009 from http://www.mentalhealthamerica.net/go/maternal-depression.

[113] Chaudron, L., Szilagyi, P., Campbell, A., Mounts, K., McInerny, T. (2007). Legal and ethical considerations: Risks and benefits of postpartum depression screening at well-child visits. *Pediatrics*, 119, 123-128.

[114] Knitzer, J., Theberge, S., Johnson, K. (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2.*

[115] (2008). *Increasing the mental health workforce pipeline.* Retrieved on April 20, 2009 from http://www.hogg.utexas.edu.

[116] (2008). *Mental Health Services Act.* Los Angeles County Department of Mental Health website. Retrieved on June 2, 2009 from http://dmh.lacounty.gov/

[117] (2008). American Recovery and Reinvestment Act Resources. Zero to Three: Public Policy website. Retrieved on June 5, 2009 from http://www.zerotothree.org

[118] Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA.

[119] Singhal, M. (2005). The role of state public health in perinatal depression. Maternal and child health fact sheet. Association of State and Territorial Health Officials.

[120] Rodriguez, M., Heilemann, M., Fielder, E., Ang, A., Nevarez, F., Mangione, C. (2008). Intimate partner violence, depression and PTSD among pregnant Latina women. *Annals of Family Medicine*, 6 (1), 44-52.

[121] Onunaku, N. (2005). Improving maternal and infant mental health: Focus on maternal depression. National Center for Infant and Early Childhood Health Policy at UCLA.

[122] Ibid.

[123] Knitzer, J., Theberge, S., Johnson, K. (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2.*

[124] Dennis, C., Hodnett, E., Reisman, H., Kenton, L., Weston, J., Zupancic, J., et.al. (2009). Effect of peer support on prevention of postnatal depression among high risk women. Multisite randomized controlled trial. *BMJ, Vol.* 338, 3064.

[125] Knitzer, J., Theberge, S., Johnson, K. (2008). Reducing maternal depression and its impact on young children: Toward a responsive early childhood policy framework. *National Center for Children in Poverty, Project Thrive Issue Brief 2*.

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