

Colorado Maternal and Child Health 2016-2020 Needs Assessment Prioritization Template

Pregnancy-related Depression

1. Issue under consideration

Pregnancy-related depression

2. If no MCH Issue Brief exists, provide data to support the need to address the issue (such as numbers of the MCH population affected, severity, urgency and national comparison data). Include health equity data, if available.

Please see MCH Issue Brief #6 on Mental Health of Women of Reproductive Age. Additionally, maternal death data from 2004 – 2012 shows the leading causes of death up to one year post delivery are accidental drug overdose (#1) and suicide (#3), both of which may indicate poor maternal mental health status.¹

3. Describe effective strategies or possible innovations to address the issue. Include citations and level of evidence.

Although not yet universal, postpartum depression screening rates in Colorado have improved in recent years and we know that providers are aware of and know how to use appropriate, evidence-based screening tools.² To continue to move the mark on pregnancy-related depression, we need to move beyond screening and begin to focus on the referral to evaluation component of the screening continuum, including addressing the obstacles that exist for women to access the services, and identifying opportunities to finance the system. This is a similar theme to the work of the developmental screening priority area, and similar strategies could be applied. This would include identifying in a community the essential roles of 1) screening for pregnancy-related depression, 2) referring when concerns exist, and 3) evaluating and connecting women to services when appropriate. Related to each of these roles, there is a need to identify the quality standards and key community partners, develop a screening to referral protocol and develop capacity to provide technical assistance. Working systematically through this process would help to address the concerns of providers who want to know what to do once a woman is identified with symptoms of pregnancy-related depression in their community. Beyond community level systems coordination, the following strategies could be pursued at the state level:

- 1) Continued efforts to expand the available network of specialized providers by exploring barriers in the insurance industry that limit the number of providers who can be considered “in network” and addressing challenges among specialized providers in accepting various types of insurance including Medicaid
- 2) Working with insurance companies to create a category of specialization for maternal mental health
- 3) Continued capacity building activities, including investments in certificate training, developing a maternal mental health endorsement and encouraging inclusion of PRD-related treatment in the curriculum for various health fields
- 4) Developing/supporting a professional consultation line using telehealth resources to enable providers in rural communities to access appropriate expertise

There also needs to a focus on awareness & community mobilization to begin addressing stigma and the social norms that prohibit women from asking for help postpartum.³

4. How do the potential strategies address and/or impact the social determinants of health or health inequities?

If all women have access to screening, referral and treatment regardless of income status or race/ethnicity we will begin to level the playing field, but we also begin to de-stigmatize the condition, in particular among families who might be less likely to ask for help. “Stigma can prevent families from acknowledging and talking about what they are experiencing. It also can prevent them from seeking help. Stigma can be a particularly significant barrier for low-income families and families of color. (Focus groups indicated they were) wary of the stigma involved in admitting they have a problem, fearful of what admitting to depression will mean for their children, fearful that if they are not seen as good parents, the child welfare department will take their children away and reluctant to take medications because they fear that the side effects will impair their parenting”⁴

¹ Maternal Mortality Database, CDPHE

² Beckwith, K. The State of Pregnancy-Related Depression Efforts in Colorado. Retrieved at: https://www.colorado.gov/pacific/sites/default/files/PF_The-State-of-PRD-Efforts-in-Colorado.pdf.

³ Oregon Health Authority. Maternal Mental Health - Community Strategies. Retrieved at: <https://public.health.oregon.gov/HealthyPeopleFamilies/Women/MaternalMentalHealth/Pages/CommunityStrategies.aspx>

⁴ Mental Health America & SAMHSA. Maternal Depression Making a Difference Through Community Action: A Planning Guide. Retrieved at: http://www.mentalhealthamerica.net/sites/default/files/maternal_depression_guide.pdf

5. Using your best estimation, what is the cost of implementing the strategies per year (staff and funding necessary)?

Estimated costs for implementation is \$250,000 to include: funding for internal CDPHE staff to coordinate activities (estimate 1.5 FTE at HPIII and .5 FTE at GPV), external contracts for project-related activities, travel, training, and operational support (computers, etc.).

6. Using your best estimation, what is the anticipated impact or change that the proposed strategies would have on the issue in two years, five years, and ten years (if sustained)?

Two years: Increase in % of women identified with pregnancy-related depression; increase in % of maternal mental health providers who are accessible to women; increase in the level of benefits available to women to address mental health issues through private pay or public insurance; increase in % of providers willing to address PRD in their community

Five years: Increase in % of women successfully referred to treatment; decreased stigma in the community around seeking help for pregnancy-related depressive symptoms

Ten years: Improved child outcomes related to having a mother who is emotionally well and able to provide a safe, stable relationship during critical development years; decreased incidence of child maltreatment; mitigation of toxic stress in early childhood

7. What population-based measures could be used to demonstrate the MCH impact on the issue? Please include relevant proposed national performance measures or potential state performance measures.

- Current SPM: Percent of mothers who reported that a health care worker talked to them about what to do if they were depressed during or after pregnancy.
- Percent of mothers who reported that they *were asked if they were depressed* before, during and after their most recent pregnancy.
- Percent of mothers who reported that they *were depressed* before, during and after delivery.
- Percent of mothers who reported that they were taking prescription medicine for depression during their most recent pregnancy.
- Percent of mothers who reported that they were taking prescription medicine for depression since their new baby was born.
- Percent of mothers who reported that they were receiving counseling for depression during their most recent pregnancy.
- Percent of mothers who reported that they were receiving counseling for depression since their new baby was born.

8. What is the state and local capacity to implement the proposed strategies? [Capacity may include staff time, funding (current, other sources, opportunities for leverage), staff technical expertise, partnerships/collaborations, data and technology resources, etc.]

Given the work on this priority over the past 4 years, there has been a tremendous increase in staff capacity at the state level to implement these efforts. There is also a lot of interest among other community partners statewide in working together to tackle these issues including from private funders, academia, medical professionals, Medicaid and health plans and early childhood partners – including the Early Childhood Colorado Partnership, Project LAUNCH and Essentials for Childhood. These external stakeholders are willing to come to the table to think about how we can address this issue from multiple facets and with a multi-stakeholder approach. We also have an engaged PRD Advisory Committee of roughly 50 members (30 of whom actively participate in quarterly meetings to inform our work.) Members include content experts, community champions, direct service providers, and organizational decision makers. We have also garnered the support of partners at the national level who have provided technical assistance and guidance, including staff with the 2020Mom Project and Postpartum Support International. Both of these organizations see Colorado at the forefront of making innovative and important changes to address pregnancy-related depression and often refer to us in their efforts with other states as a model. At the local level, there has also been an increase in capacity in a number of communities that have chosen to work on PRD over the past couple of years. Twenty-seven of 53 local communities have chosen to address mental health as a priority in their public health improvement plans, but without specificity as to areas of focus it is unknown what the capacity is in these communities.

9. What is the MCH public health role (lead, partner, convener, etc.) in implementing the potential strategies? Do other agencies serve as a lead or partner on this issue?

The MCH public health role is to serve as a lead in making the connections between the various levels of services, benefits and awareness and driving the conversations at the population health level. It also is an essential partner at the table with health plans to determine how best to improve access to maternal mental health services, and improve availability of maternal mental health expertise. Other agencies will likely serve as the lead on different aspects of the priority work (for example, health plans and HCPF will need to be the lead in the implementation of any expanded health benefits related to screening and treatment). In addition, there are other partners who are leading complementary efforts that need to be taken into consideration – ex: developmental screening, ECCS, Essentials for Childhood, Project LAUNCH, etc.

10. Discuss local public health agency interest, capacity, opportunity or progress on this issue.

There are currently 4 large public health agencies that have selected pregnancy-related depression as a priority area (Tri-County HD, Denver Health, Larimer County PH, Northeast County HD), in addition to some of the smaller public health agencies that are aligning this priority with other work on mental health.

11. Describe the state and federal will (interest, politics, investment) concerning this topic.

Mental health is currently part of the Governor’s health plan and a state Winnable Battle. Over the past 4 years we have seen an increasing interest in addressing pregnancy-related depression in particular. There are a number of key initiatives at the state level currently looking at the proposed priority, including but not limited to the SIM grant and the Behavioral Health Transformation Council. The State Innovation Model (SIM) grant has a significant focus on the integration of behavioral health integration in physical health settings. Colorado was the recipient of funding from Project LAUNCH – a 5-year grant focused on social-emotional development in young children, which includes a strategy focused on improving maternal mental health. Aspects of this grant will also focus on behavioral health integration related to early childhood mental health. There is also an early childhood mental health funders group that is forming, and they are interested in expanding the efforts initiated through Project LAUNCH to other communities in the state. Through the collective impact efforts of the Essentials for Childhood grant, housed here at CDPHE, the topic of improved social/emotional health for children and their caregivers has risen to the top as one of the common agenda areas. In addition to these grant specific efforts, Colorado also expanded Medicaid through the Affordable Care Act – and with that came an expansion of mental health screening and treatment. This has resulted in an increase in access to mental health services for many adults who previously did not qualify for Medicaid. Also during 2014, HCPF approved an expansion of their depression screening code to all adults, inclusive of pregnant and postpartum women. The benefit can be billed once per year per client, and is also billable by the child’s pediatrician using the child’s Medicaid number. Finally, in December 2014, Colorado launched a new 24/7 mental health crisis line with increased 24/7 access to crisis services in all counties in the state. All of the additional resources currently going into mental health in the state indicate that this is a prime time to continue to include pregnant and postpartum women in the conversation, as well as provide resources to ensure services are aligned across the various initiatives.

12. When facing competing MCH priorities, why do you consider addressing this issue to be a good use of MCH resources?

“Health in the earliest years—beginning with the future mother’s well-being before she becomes pregnant—strengthens developing biological systems that enable children to thrive and grow up to be healthy adults.”⁵ By addressing the mental health of the mother during and after pregnancy, we have the potential to improve not only the woman’s health outcomes, but also support the early relationship she will build with her child. The health of the next generation is dependent on the existence of safe, stable and nurturing relationships early in life. Focusing on this priority now has the potential to impact all of the MCH populations throughout the life course.

13. Additional comments

There is opportunity for integration of these efforts with other mental health and substance abuse efforts, as well as with child health priorities focused on developmental screening. The key to the next five years will be coordinating efforts at the community and policy level to improve access to mental health services.

⁵ Center on the Developing Child at Harvard. InBrief: Foundations of Lifelong Health. Retrieved at: http://developingchild.harvard.edu/index.php/resources/briefs/inbrief_series/inbrief_foundations_of_lifelong_health/