May 22nd, 1:15 PM - 2:45 PM

Addressing Perinatal Depression in the Outpatient Obstetric Setting

Nancy Byatt
University of Massachusetts Medical School

Let us know how access to this document benefits you.

Follow this and additional works at: https://escholarship.umassmed.edu/cts_retreat

Part of the Maternal and Child Health Commons, Obstetrics and Gynecology Commons, Psychiatry Commons, and the Psychiatry and Psychology Commons

Repository Citation

Creative Commons License

This work is licensed under a Creative Commons Attribution-Noncommercial-Share Alike 3.0 License. This material is brought to you by eScholarship@UMMS. It has been accepted for inclusion in UMass Center for Clinical and Translational Science Research Retreat by an authorized administrator of eScholarship@UMMS. For more information, please contact Lisa.Palmer@umassmed.edu.
Addressing Perinatal Depression in the Outpatient Obstetric Setting

Nancy Byatt, DO, MBA
Assistant Professor of Psychiatry

Tiffany A. Moore Simas, MD, MPH, MEd
Associate Professor of Ob/Gyn & Pediatrics

University of Massachusetts Medical School
Disclosures/Conflict of Interest

Dr. Byatt has received funding for this study from the Meyers Primary Care Institute/Rosalie Wolf Interdisciplinary Geriatric Healthcare Research Center Small Grants Initiative.

Dr. Moore Simas is on the MA Governor-appointed commission on PPD screening.
Prevalence - Perinatal depression is common

Perinatal depression affects:

• Up to 20% of women during pregnancy
• 10-15% of women the postpartum period
• 25% of women pregnant in the past year meet criteria for a psychiatric diagnosis

Perinatal depression has deleterious effects and causes suffering for mother, child and family.

Maternal depression

-> Poor maternal health behaviors
Maternal substance abuse
Maternal suicide
Low birth weight
Preterm delivery
Cognitive delays
Behavioral problems

Perinatal time period is ideal for the detection and treatment of depression

Regular contact with health providers

Regular opportunities to screen and engage women in treatment
Perinatal depression is under-diagnosed and under-treated

Screening alone does not improve treatment

Improved Outcomes
(daily functioning, parenting, well-being, quality of life, health, offspring health, relationships, family, prognosis)

Women do not disclose symptoms or seek care

Underutilization of Treatment

Unprepared providers, with limited resources

Poor Outcomes
Perspective of Women
Study and purpose

Study of women with lived experience of depression during and after pregnancy

- Interested in experiences with providers
  - What is helpful?
  - What are barriers?
  - What can we do to affect change?

Use findings to develop preliminary guidelines to engage women in depression treatment

Inform development of interventions to integrate depression treatment into primary care settings

Methods

Four focus groups with mothers (n=27) in Western Mass

Self-identified as having experienced perinatal depression or emotional crisis

Probes targeted to identify barriers and facilitators to accessing care, and potential strategies for change

Characteristics of mothers

Mean age: 32
80% had 1 or 2 children

Income variability
• 22% - less than 20K/year
• 11% - more than 100K/year

All parenting with a partner

Mental health treatment
• Pre-pregnancy – 70%
• During pregnancy – 22%
• After pregnancy – 67%

General findings

Barriers to care
- Fear, Stigma and Shame
- Lack of resources and supports
- Negative interactions with providers
- Providers lack of knowledge re: mental health care

What would facilitate care
- Flexible care options
- Recognition of importance of perinatal mental health
- Integrate prevention, detection, and management of depression into perinatal care

Barriers to Care
“You’re scared to say to somebody, ‘I need help and I need it now’ cause you’re scared someone’s gonna take your kid.”

Lack of resources and supports

“Nobody took the time to really find out what was going on. Basically they wrote me a prescription and put me back on what I was on before and said, ‘Go find a therapist.’ ”

Negative interactions with providers

“I’m telling you the god’s honest truth, the person who screened me said, ‘Well, you have a happy, healthy baby. What else do you want?’ ”

Lack of training among providers

“I think part of the reason why OBs and even midwives aren't asking is, they’re not really prepared to deal with the answers.”

Facilitators to Care
What mothers’ said about facilitators to care

Relationships critical to wellness for mother, child and family

How a “good” or “bad” relationships can influence if and how care is received by mothers

Positive feedback from provider

Destigmatize

Psychoeducation about resources and supports

“Not, you know, joking and saying ‘Oh-no, all babies do that.’ ‘No, actually can we just talk about what my baby’s doing right now and the fact that it’s upsetting me’... people just take your stories as anecdotal...and just brush it off.”
Destigmatize mental health treatment

“Address everything that’s not depression. You know, there’s exercise…nutrition, sleep, friendships. Everything changes when you have a baby, and if there was some sort of way to encompass the whole self, that would be really cool.”

Have a conversation about resources and supports

“When I delivered at UMass Memorial you have a nurse and you get these two booklets – one is on shaken baby and on one postpartum depression and psychosis. And the nurse goes through each with you... so you can kind of recognize...when you’re angry and have to put the baby down.... That was really helpful, and I was surprised and happy they did that.”

Summary of individual-level facilitators

- Focus on mothers and babies
- Recognize the transition to parenthood
- Acknowledge the whole person
- Learn through authentic communication
- Have a conversation about supports
- Validate experiences

Perspective of OB/Gyns
Study and purpose

Focus groups with OB/Gyn providers and staff

Discussion probes informed by literature review
  • What are barriers?
  • What can we do to affect change?

Groups electronically recorded. Immediate impressions and emerged themes identified.

Grounded theory approach utilized to analyze quantitative data.
  - data reviewed, segmented, and coded using iterative, constant-comparative process to identify emerging themes and recurrent patterns

Byatt et al. 2012 (under review).
### Methods – 4 two hour focus groups

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Participants</th>
<th>N</th>
<th>Years of clinical experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1*</td>
<td>OB/Gyn resident physicians (n=6)</td>
<td>6</td>
<td>PGY 1 to 4</td>
</tr>
<tr>
<td>2*</td>
<td>OB/Gyn attending physicians (n=8) advance practice nurses (n=4)</td>
<td>12</td>
<td>1 to 23 years</td>
</tr>
<tr>
<td>3*</td>
<td>Nursing staff (n=4) PCAs (n=2) Support staff (n=3) Licensed clinical social worker (n=1)</td>
<td>10</td>
<td>4 to 27 years</td>
</tr>
<tr>
<td>4</td>
<td>Resident physician (n=1) Attending physician (n=1) Advance practice nurses (n=2) Nursing staff (n=3) PCAs (n=2) Support staff (n=3)</td>
<td>*12</td>
<td>1 to 27 years</td>
</tr>
</tbody>
</table>

* Convenience sample of stakeholders

Byatt et al. 2012 (under review).
Providers

*Barriers to Addressing Perinatal Depression*
Provider Barriers

**Limited Resources**
- Time constraints
- Lack of training and skills

**Limited Motivation**
- Feeling beleaguered
- Feeling overwhelmed

**Discomfort with mental health treatment**
- Lack of comfort with depression dx & tx
- Depression is beyond the scope of practice
Limited Resources – Time constraints

“We don’t have enough time in our appointments... we can take the time, but then it backs our whole schedule up... I don’t think we have the time to have a mental health style appointment ... We don’t have the luxury of doing that. We can’t. We are just like, are you suicidal, homicidal? That’s the only thing.”
“I tend to ask, Are you going to your appointments? Do you like who you’re seeing? ...and do you feel like it’s helping? And I hope they say Yes to all of them. And as soon as they say No, I say, Now why did I open up that can of worms?“
“There [are] patients that come in and say, ‘I’m depressed. I have PTSD. I’ve been raped.’ And you know, just like basics of how to kind of approach that, how to respond…. I would like to talk about it more, but I do not know where to start. Like, oh crap, that really sucks, I don’t know.”
Facilitators to Addressing Perinatal Depression
Provider Facilitators

**Targeted provider training**

- Depression dx & tx, Medication use in the perinatal period, Triage & referral, Available resources

**Learning counseling techniques**

- Resident training, Motivational enhancement techniques, Screening

**Enhanced support and guidance from mental health providers**

- Easier access to mental health appointments, Easier referral process, Enhanced social work involvement, Urgent care appointments, Postpartum follow-up visit
“...to know what’s good in what trimester and how to feel comfortable prescribing a mild antidepressant or something.”
Learning counseling techniques

“It would be interesting to spend a week with the psychiatrists.... ...likewise if we were to sit in with a mental health counselor and they were screening for depression and the depression screen was positive, they could say, okay, these are the steps that you can take to work with it... getting those basic steps, like sort a feeling comfortable having those conversations would be useful... that’s how we are used to learning.”

Providers May Make a Difference with Increased Training and Support

Structured screening and referral

Training

Improved provider confidence

Integrated depression and ob care

Immediate back up from mental health providers

System-level Barriers

Limited training among mental health providers

Limited mental health resources

OB and mental health care not integrated

Lack of collaboration with mental health providers

Byatt et al. 2012 (under review).
Strategies for Improvement
A system change could improve engagement in mental health treatment

**Integration of care**

Facilitate access to care
Provide a comprehensive, integrated approach
Engage women in mental health treatment
Perinatal Depression Care Model Adapted from Chronic Care Model

Perinatal Depression Care Model

Individual
Psychoeducation
Positive Feedback
Provider Acceptance

Provider
Training
Confidence
Psychiatric consultation

Systems
Integration of primary and depression care
Resource guide
Collaborative approach

Perinatal Care Model

Informed, Activated Women

Treatment Engagement

Prepared, Proactive Providers

Improved Outcomes

www.chroniccare.org
Why it is important to address perinatal depression in OB settings

Improved Outcomes
(daily functioning, parenting, well-being, quality of life, health, offspring health, relationships, family, prognosis)
In summary, future efforts should involve interventions to address individual, provider and system-level barriers.
Acknowledgements

UMass Medical School Faculty Scholar Award

MotherWoman, Inc.

Liz Friedman, MFA
MotherWoman

Doug Ziedonis, MD, MPH
UMMS

Jeroan Allison, MD
UMMS

Kate Biebel, PhD
UMMS

Gifty Debourdes-Jackson, MA
UMMS

QUESTIONS?
Feel free to contact us

Nancy.Byatt@umassmemorial.org

TiffanyA.MooreSimas@umassmemorial.org