

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

Addressing Perinatal Depression in the Outpatient Obstetric Setting


Nancy Byatt

University of Massachusetts Medical School

Tiffany A. Moore Simas

University of Massachusetts Medical School

Follow this and additional works at: http://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](#)



This work is licensed under a [Creative Commons Attribution-Noncommercial-Share Alike 3.0 License](#).

Byatt, Nancy and Moore Simas, Tiffany A., "Addressing Perinatal Depression in the Outpatient Obstetric Setting" (2012). *UMass Center for Clinical and Translational Science Research Retreat. 2.*

http://escholarship.umassmed.edu/cts_retreat/2012/presentations/2

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



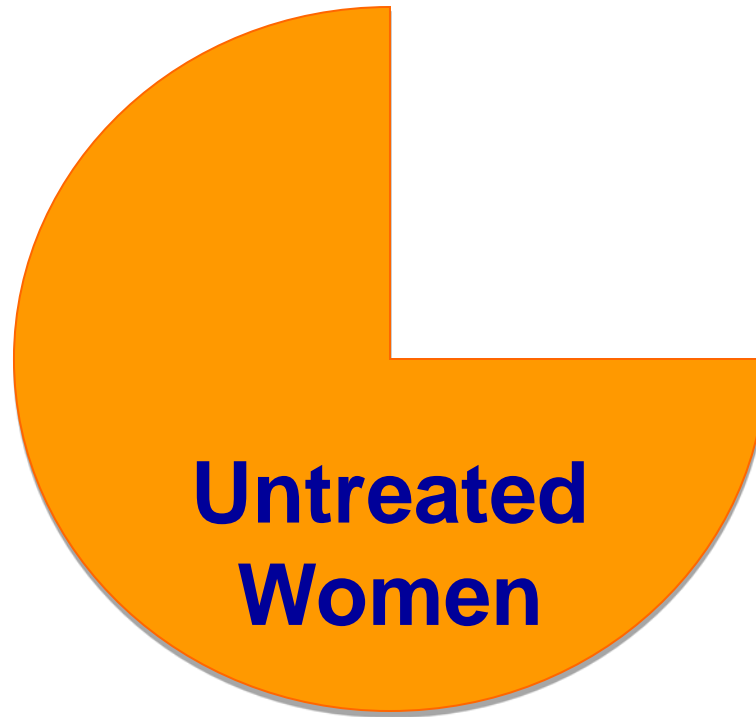
Perinatal time period is ideal for the detection and treatment of depression

Regular contact with health providers

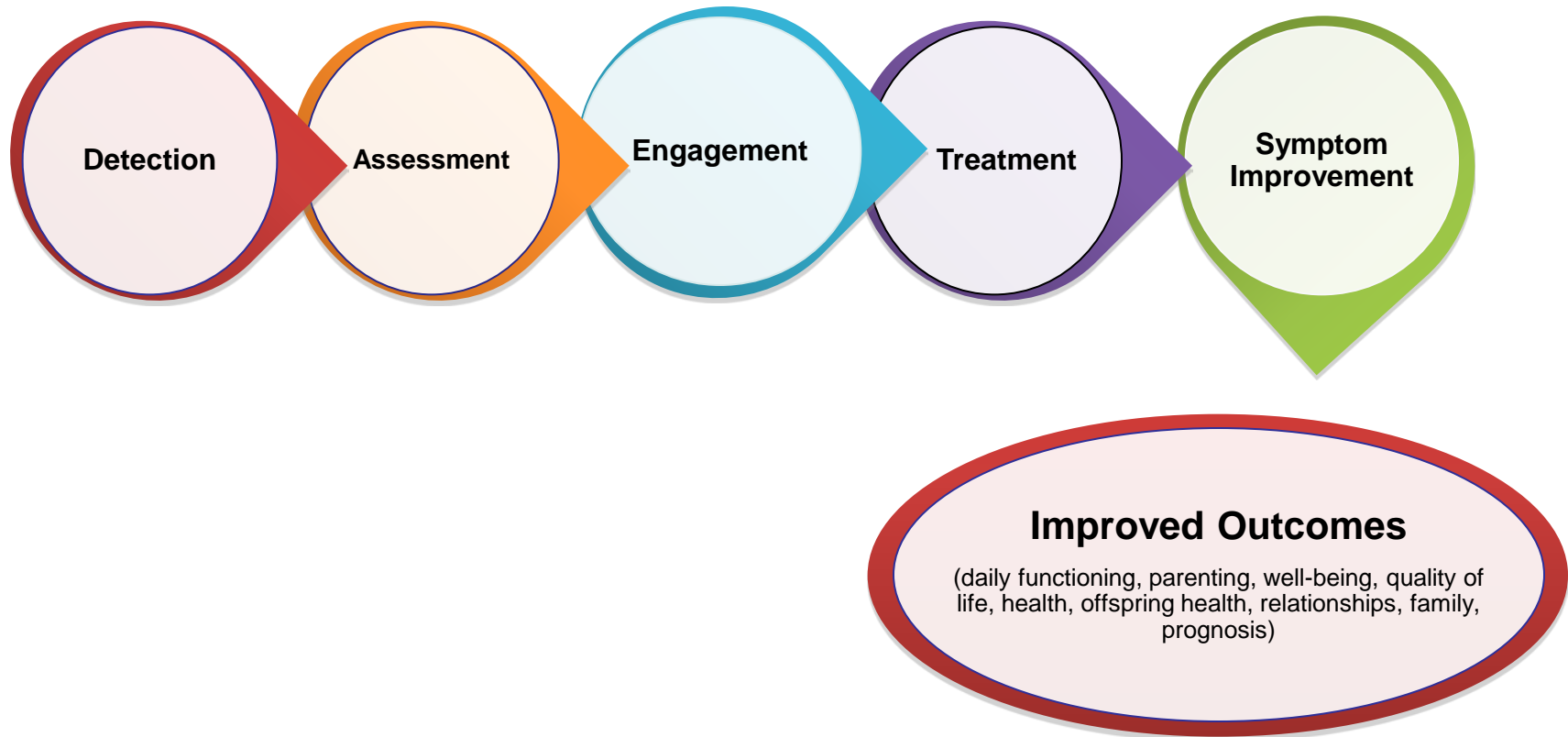
Regular opportunities to screen and engage women in treatment

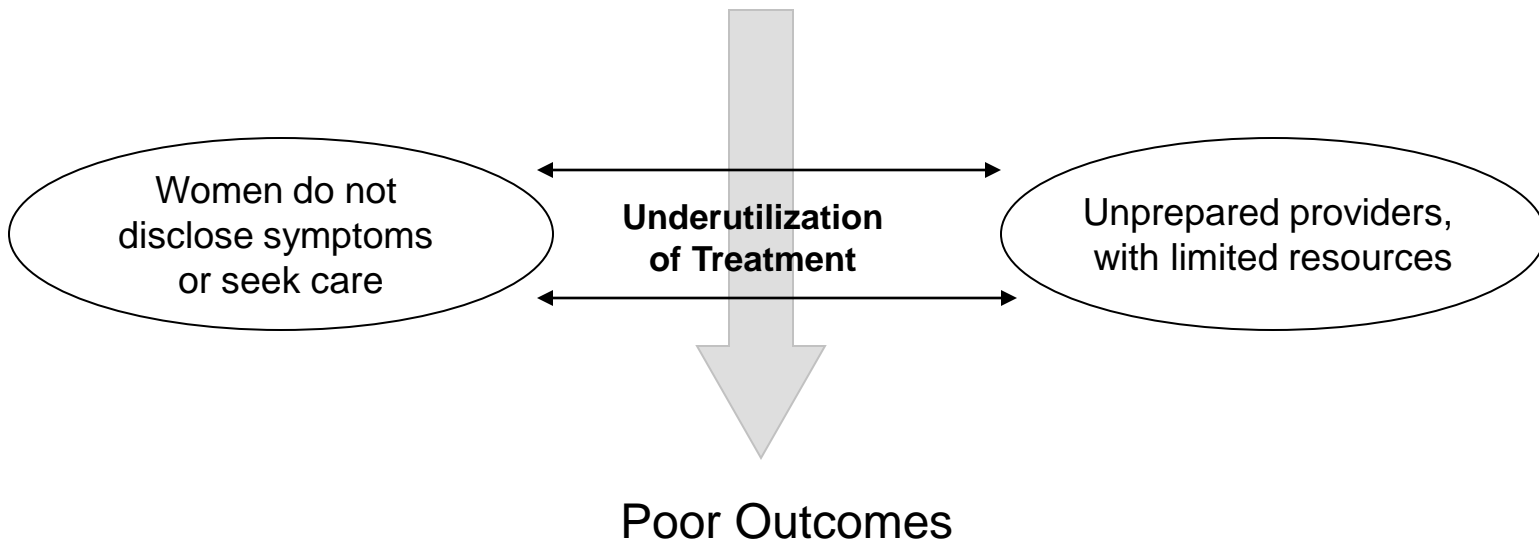
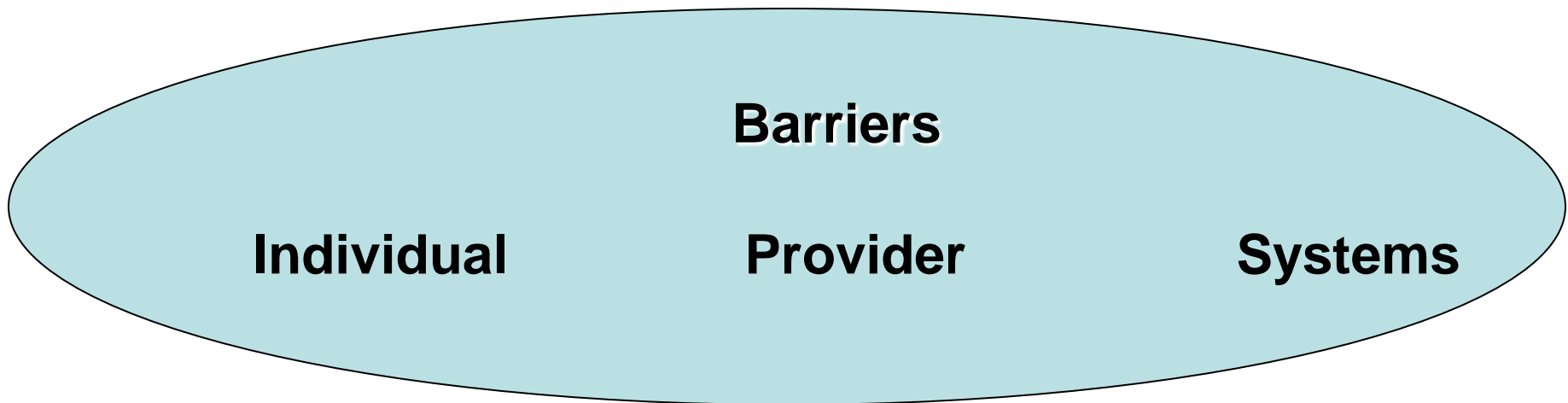


Perinatal depression is under-diagnosed and under-treated



Screening alone does not improve treatment





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

Fear, Stigma and Shame

“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

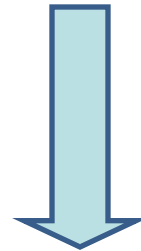
Positive feedback from provider

Destigmatize

Psychoeducation about resources and supports

Positive feedback from provider

“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

Methods – 4 two hour focus groups

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

*** Convenience sample of stakeholders**

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.”

Limited Resources (Time) & Discomfort

“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?”

Discomfort with Mental Health Treatment

“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.”

Providers

***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

Targeted provider training – Medication use

**“...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



Strategies for Improvement

A system change could improve engagement in mental health treatment

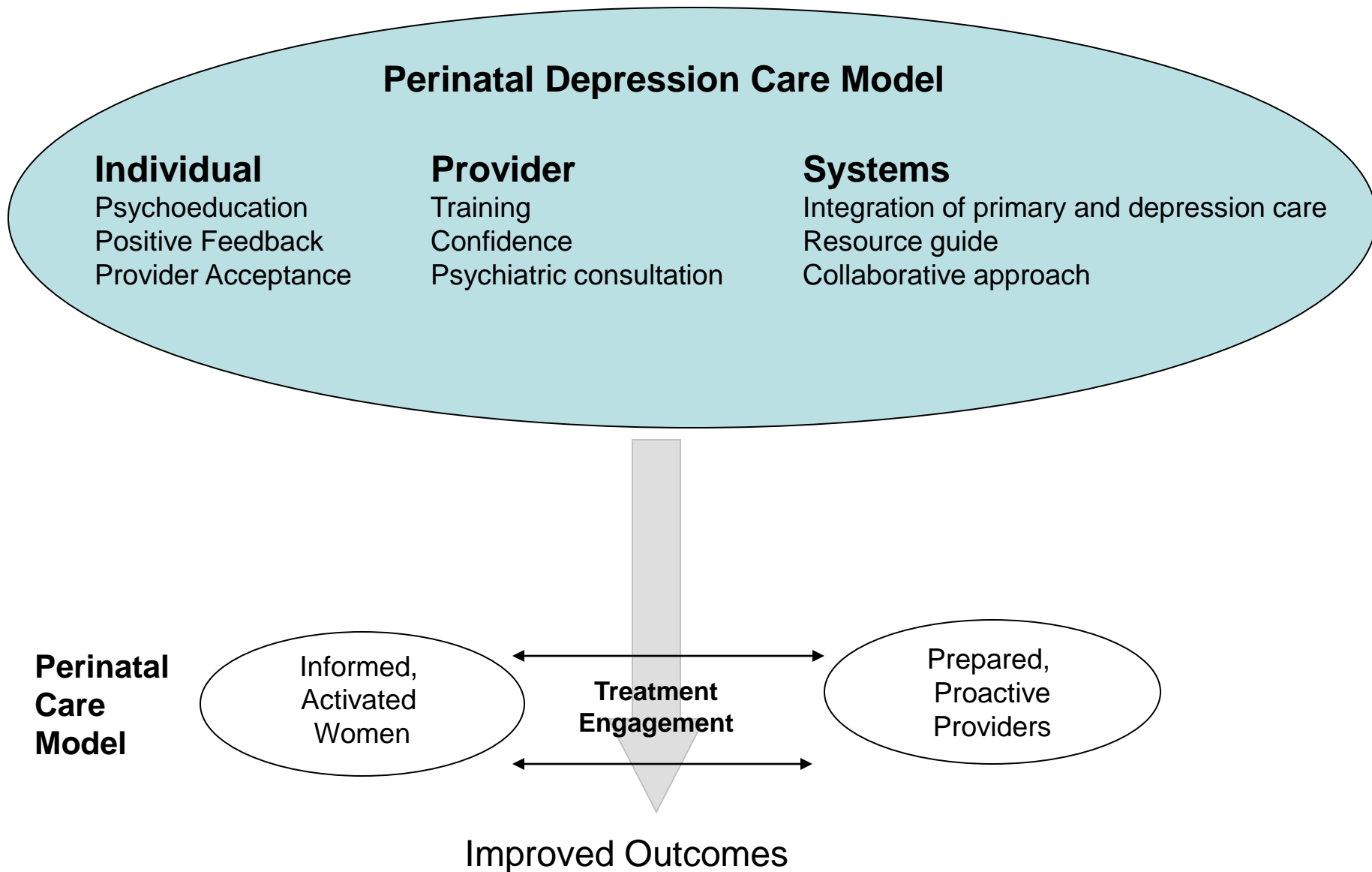
Integration of care



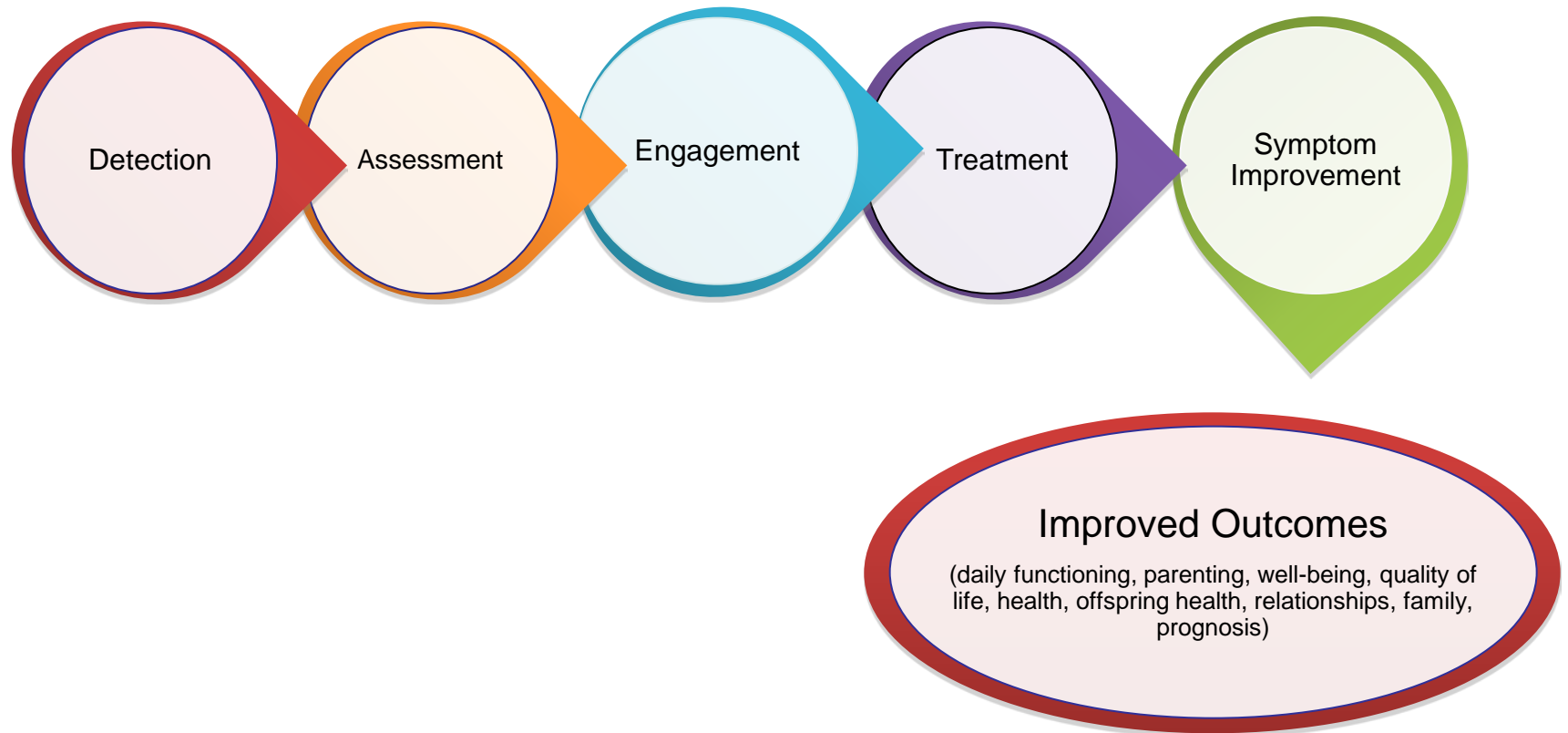
- Facilitate access to care
- Provide a comprehensive, integrated approach
- Engage women in mental health treatment



Perinatal Depression Care Model Adapted from Chronic Care Model



Why it is important to address perinatal depression in OB settings



In summary, future efforts should involve interventions 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