When Everything is Not Fine

Addressing Parental Mental Health in Primary Care

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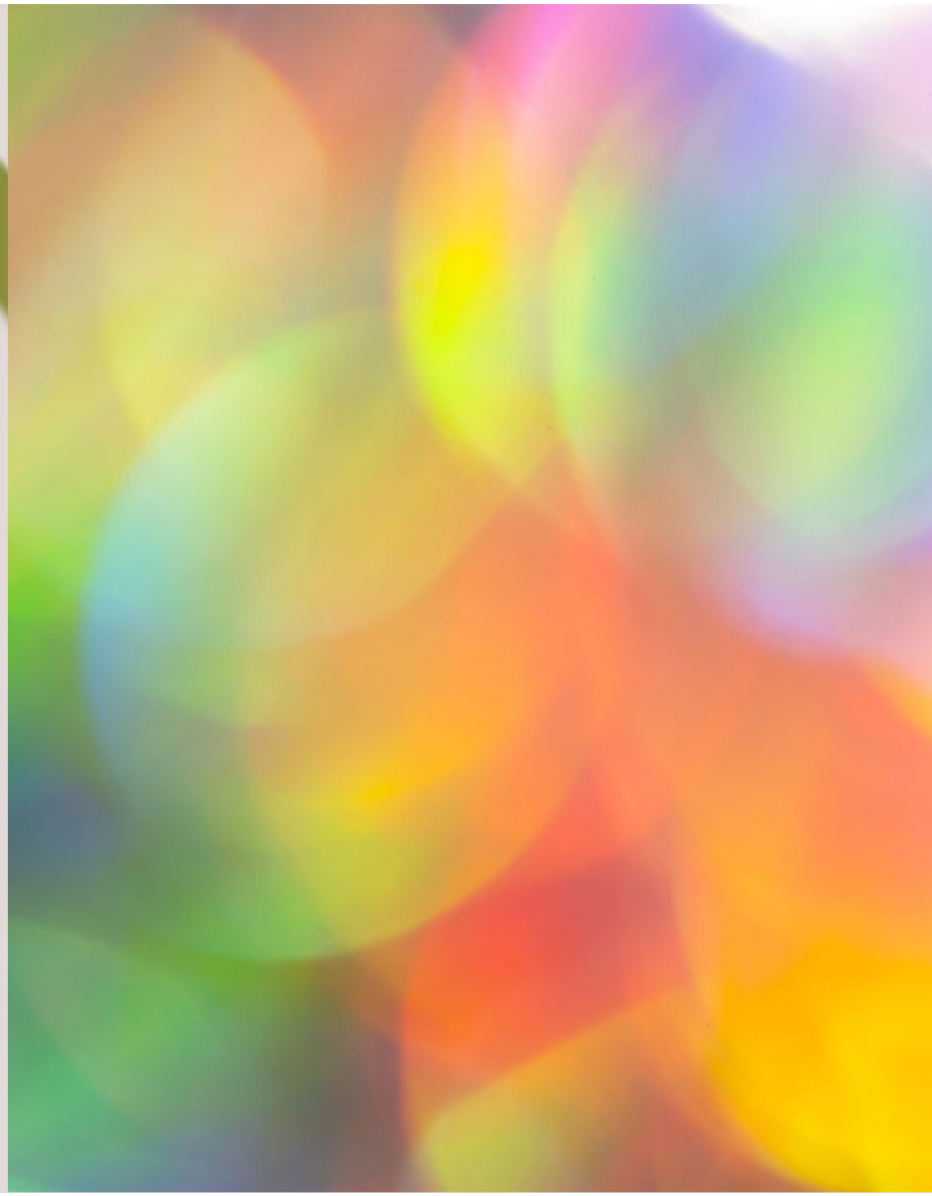


Objectives

Describe	Describe the prevalence and impact of mood and anxiety disorders presenting in the parents, focusing on the peripartum period
Understand	Understand risk factors, warning signs and the spectrum of mental health presentations in parents, with an emphasis on peripartum mood and anxiety
Increase	Increase confidence in screening for parental mood and anxiety disorders in the adult primary care and pediatric care settings
Provide	Provide resources for peripartum mood and anxiety treatment in primary care and linkage to resources

Disclosures

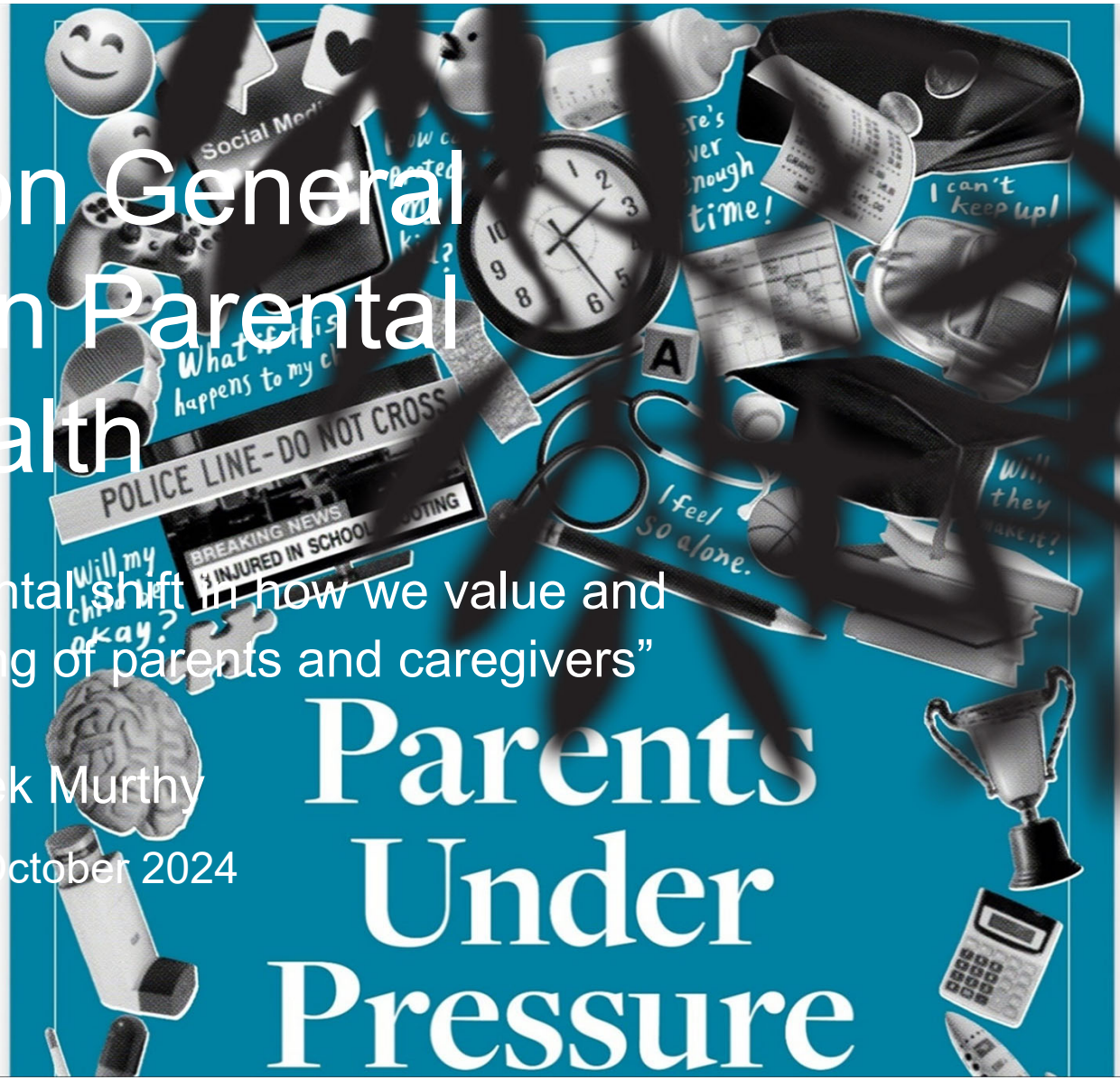
I have nothing to disclose

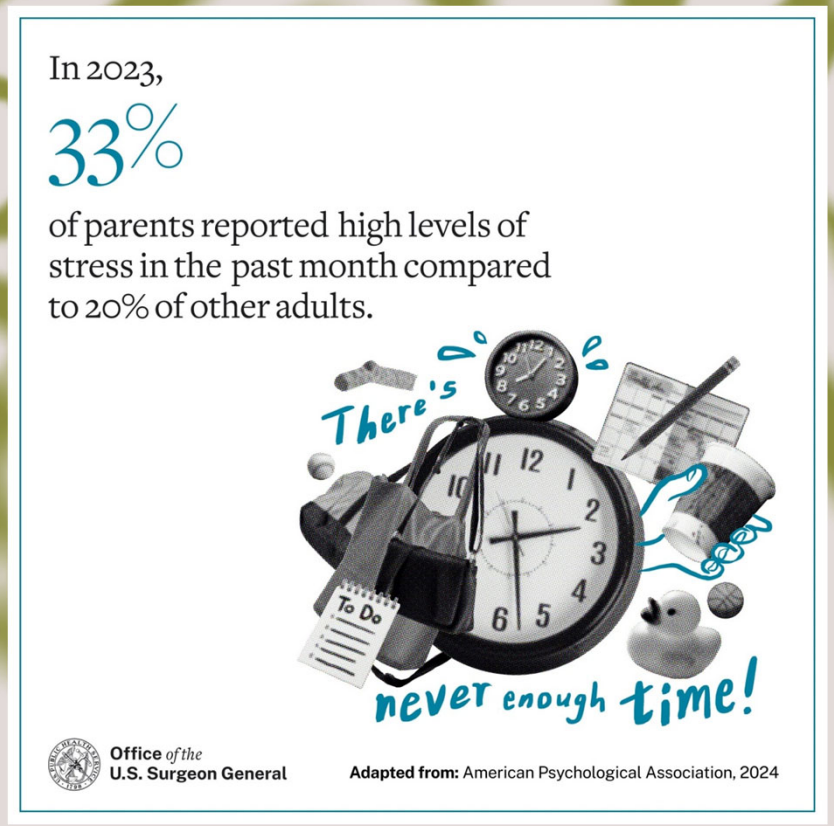
US S[illegible]on General Advis[illegible]n Parental Menta[illegible]alth

“We need a [illegible]ntal shift in how we value and prioritize th[illegible]g of parents and caregivers”

[illegible]k Murthy

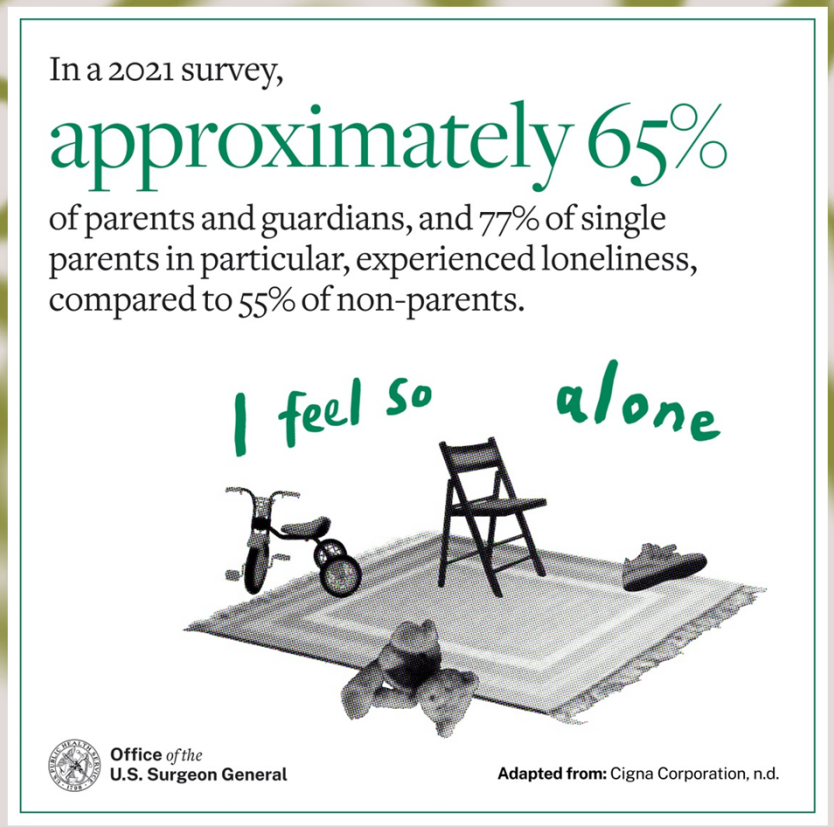
[illegible]ctober 2024





State of Parental Mental Health in the US

- 41% of parents say “most days” so stressed they cannot function,48% say “most days” stress is completely overwhelming
- Mental labor of parenting can limit working memory capacity, negatively impact attentional resources, cognitive functioning, and psychological well-being
- Prolonged stress can lead to harmful mental health outcomes including anxiety and depression
- 23.9% (20.3 million) had any mental illness, 5.7% (4.8 million) parents had a serious mental illness

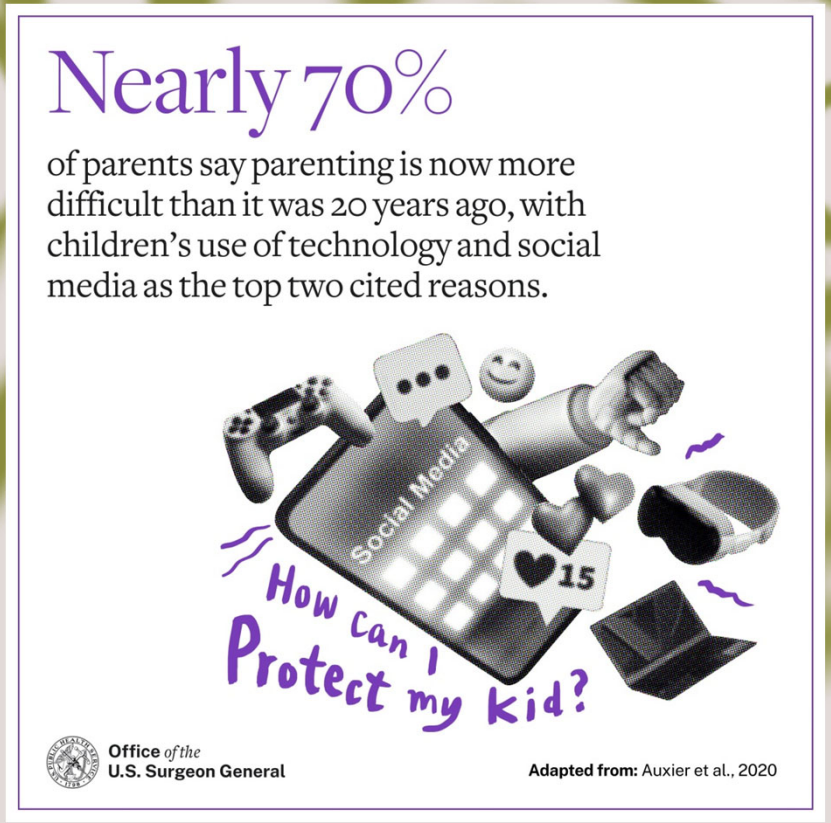


Why are we so stressed?

- Stressors associated with childrearing
  - Common demands of parenting
  - Time demands
  - Financial strain and economic instability
  - Concerns about children's health and safety
  - Difficulty managing technology and social media
  - Parental isolation and loneliness
- Additional risk factors for poor mental health outcomes in parents
  - Family or community violence
  - Poverty
  - Racism and discrimination

Why now?

- Time spent on primary child care increased 40% among mothers (8.4h in 1985 to 11.8h in 2022) and 154% among fathers (2.6h in 1985 to 6.6h in 2022)
- Increasing utilization of technology and social media; contribution to intensifying culture of comparison
- Degradation of social support network “where is the village”
- Historically underrecognized, understudied, underscreened, underdiagnosed, particularly among men



Can’t we just deal?

- Mental health conditions amongst children are rising
- Children experiencing mental health challenges are themselves at increased risk for depression and anxiety
- [illegible] a primary caregiver with poor mental health 4x more likely to have poor health and 2x more likely to have mental, behavioral, or developmental disorders
- 3-in-4 parents are extremely or somewhat worried that their child will struggle with anxiety or depression

Parental Mental Health & Perinatal Mental Health

Impact on childhood outcomes

Graphic courtesy of HMHB

Peripartum Mood & Anxiety Disorders

(PMADs)

- #1 postpartum complication
  - Affects 1:5 birthing parents and 1:10 partners
  - ~ 1 million American women
- Can present anywhere in pregnancy through the first year after birth
- Only 40% of cases detected, most underdiagnosed obstetric complication

Perinatal mental health impacts

It starts before birth and impacts can be lifelong

High cortisol levels in pregnancy may lead to	Low birth weight Premature birth Hypertensive disorder
Parental impacts in the perinatal period	Parental relationship issues *Increased risk of IPV* *Suicide*
Child health outcomes	Heightened neonatal startle reflex Impaired social interactions and delays in development Mood and behavioral issues in child *Infanticide*
Impacts to parenting dyad	Impaired parental-infant attachment and bonding Early breastfeeding cessation Impaired parenting skills Parental difficulty managing chronic conditions *Increased incidence of abuse/neglect*

Graphic courtesy of HMHB

How does PMADs differ from other parental mood disorders?

Hormonal changes in pregnancy	Increasing progesterone & estrogen after 36wk associated with increasing cortisol Rapid fall in progesterone postpartum coupled with *sleep deprivation* PP neurotransmitter changes
Predisposing personal factors	Perfectionism or need for control High worry or low self confidence Body image dissatisfaction
Social-emotional contributors	Good mom vs bad mom paradigm and contribution of social media Limited support systems “where is the village” Adjustment to new roles/responsibilities

What really is PMADs?

PMADs are distressing feelings during pregnancy or postpartum

- Historically emphasize depressive symptoms (PPD)
- Mental health changes in peripartum period more accurately include *depression AND anxiety*
  - Can also be a mixed presentation or exacerbation of underlying mental health diagnoses
- Anxiety symptoms may be more common, higher functioning and often harder to recognize
  - Anxiety presentations include: generalized anxiety, panic, PTSD, OCD or insomnia
- In extreme cases peripartum mood changes can manifest as suicidality or psychosis


Everyone else seems to be so much more put together
If they really knew how I am feeling they will think I am a bad mom
What if I drop the baby or the stop breathing
Am I going crazy, why is everything so hard?
Maybe my baby would be better off with a different mom
Sometimes I just want to scream or run away”
I thought this was supposed to be such a joyful time, I can’t connect with my baby I am so miserable
I don’t even want to leave my house, I don’t want people to see what a failure I am

What really is PMADs?

Depression symptoms

- Persistent sad, anxious, or “empty” mood
- Loss of interest or pleasure
- Feelings of hopelessness or pessimism

OR

- **Irritability**, frustration, or restlessness
- **Guilt**, worthlessness, or helplessness
- **Rage**
- *Persistent doubts about the ability to care for the baby*
- *Trouble bonding or forming an emotional attachment*
- *Inability to made decisions or concentrate*
- Difficulty sleeping (even when the baby is asleep)
- Excessive crying
- Fatigue
- Mood swings
- Appetite changes
- Physical aches or pains, headaches, cramps, or digestive problems
- Thoughts of death or harming oneself or the baby

What really is PMADs?

Anxiety symptoms

- Common anxiety symptoms
  - Intolerance of uncertainty
  - Hyperalert state and/or excessive behaviors to prevent undesired outcomes
  - Poor problem orientation or low self-esteem/efficacy
  - Avoidance
  - Panic
  - Excessive checking/tracking
- Perinatal PTSD:
  - Triggered by pregnancy or birth trauma
  - Re-living traumatic event: flashbacks, nightmares, sense of doom, hypervigilance, increased arousal
- Perinatal OCD:
  - Intrusive/repetitive thoughts that are usually upsetting
  - Compulsions/repetitive behaviors
- Breastfeeding can be an anxiety trigger/focus

PMADs in crisis

Suicide is the second leading cause of maternal death

- Birthing parents with a hx of depression have a 70% greater risk of suicide
- 14% of birthing parents report suicidal ideation

Psychosis is very rare but is an emergency

- Occurs in 0.1-0.2% of births
- Higher risk in patients with Bipolar d/o
- Can manifest with agitation, thought disorder, hallucinations, delusions, paranoia, dissociation
- Associated with increased risk of infanticide and suicide

Differentiating psychosis from other disorders

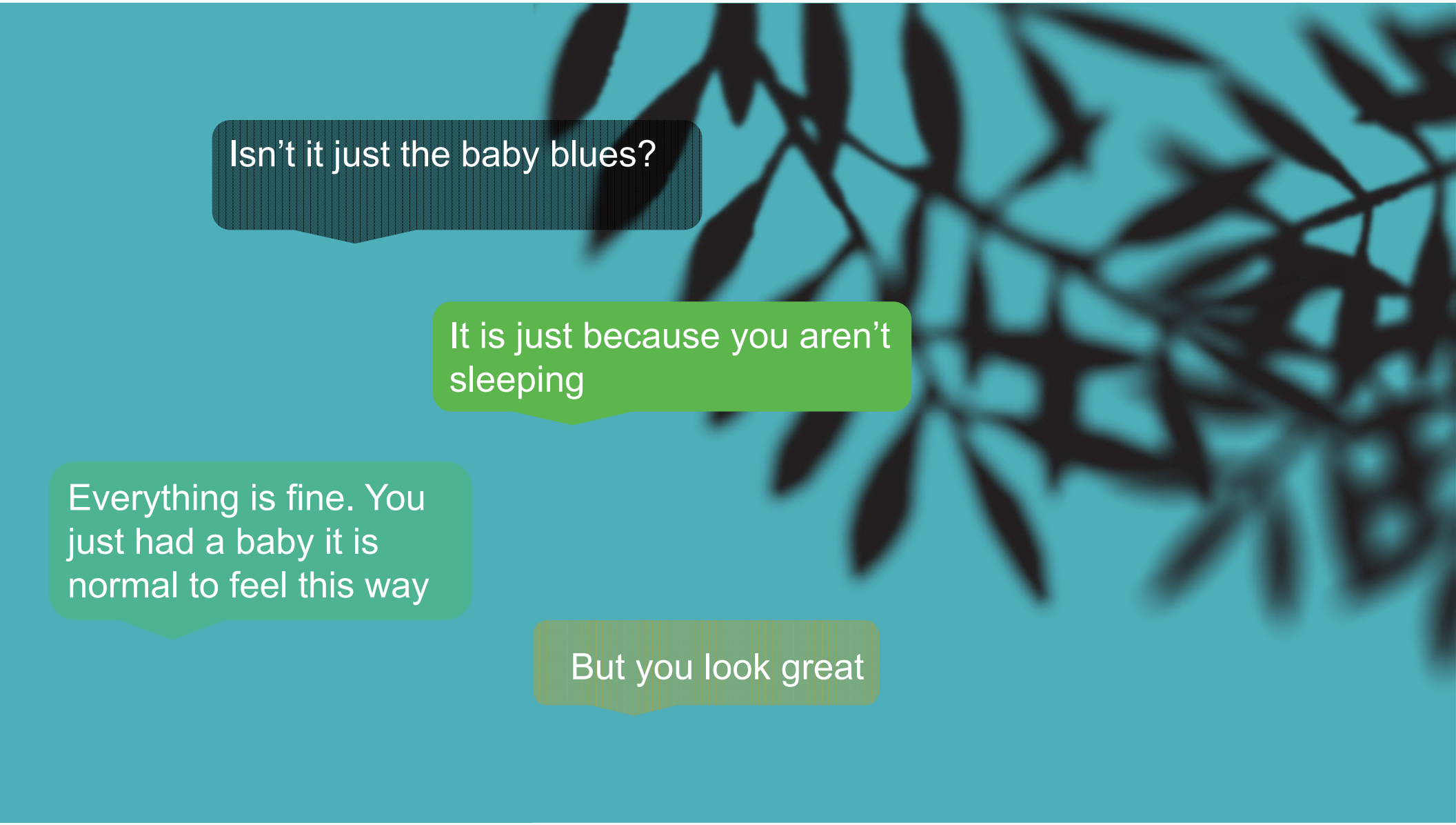
- True psychosis is *rare* and ***always an emergency***
  - Often auditory or visual hallucinations
  - Bizarre, non-distressing to the patient
  - Can happen as a stand-alone symptom or as depression or anxiety with severe features and psychosis
- OCD can present as intrusive or ruminating thoughts that appear similar to psychosis
  - Usually distressing to the patient, they are aware their thinking is abnormal
  - Intrusive thoughts alone can be present without a diagnosis of OCD in the peripartum period
- Lack of sleep can also result in visual or auditory hallucinations that are unrelated to a mood disorder

Who is at risk?

- Increased risk in parents with more **life stressors or limited support**
  - Lower SES, teen parents, history of trauma or adverse childhood events
  - Partnership strain and/or single parents, military families, LGBTQ+ parents, BIPOC and/or immigrant parents
  - **Up to 30% of AI/AN experience PMADs**
- **History of mood or anxiety disorder**
  - Personal or family history of mood d/o or SUD
  - Mixed feelings about parenthood, poor relationship with own parents
  - PMDD/PMS or mood changes related to contraception
- **Pregnancy complications**
  - Premature delivery, birth trauma, NICU stay, dyad separation in the first days of life, fertility issues, childhood illness

…any patient regardless of risk factors can develop PMADs…

Graphic courtesy of HMHB


Isn’t it just the baby blues?
It is just because you aren’t sleeping
Everything is fine. You just had a baby it is normal to feel this way
But you look great

What is normal?

What is PMADs?

- **Frequency**
- **Intensity**
- **Duration**
- **Distress**
- **Interference**

Warning signs

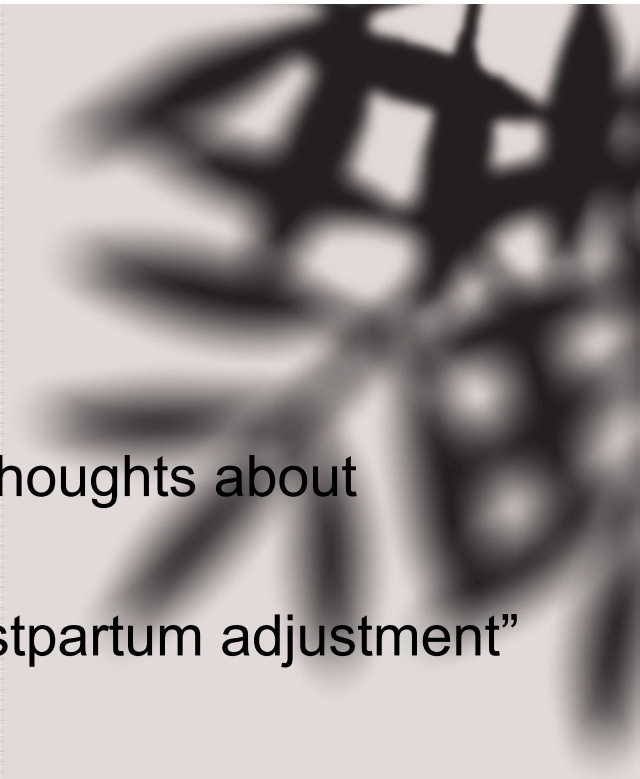
Parent

- Missed appointments
- Overutilization of the ER/sick visits
- Excessive worry about baby
- Reduced attunement
  - Blunted affect
  - Reduced eye contact
  - Lack of response to child needs
- Tearful, irritable appearance

Child

- Irritability/fussiness, difficult to sooth
- Poor eating or sleeping
- Poor eye contact/engagement
- Resistant behavior
- Restricted growth and development

Just the baby blues?



- Many parents feel overwhelmed, depleted
- 90% of birthing parents experience scary, intrusive thoughts about themselves and their babies
- Symptoms of PMADs often overlap with “normal postpartum adjustment”
- “Baby blues” self limited in the first few weeks.
  - 15-20% will develop into PMADs
  - If a parent is beyond 2-3 wks PP and feeling sad, tearful, anxious, nervous or *worried about the way they are feeling* – it is no longer the baby blues

WHY IS DIAGNOSIS AND TREATMENT SO IMPORTANT?

ONE STUDY FOUND 16% OF WOMEN WERE DEPRESSED 2-4 MONTHS POSTPARTUM AND 15% WERE STILL DEPRESSED AT 30-33 MONTHS

Help is available. If you, or someone you know is suffering with postpartum depression, reach out to your health care provider!

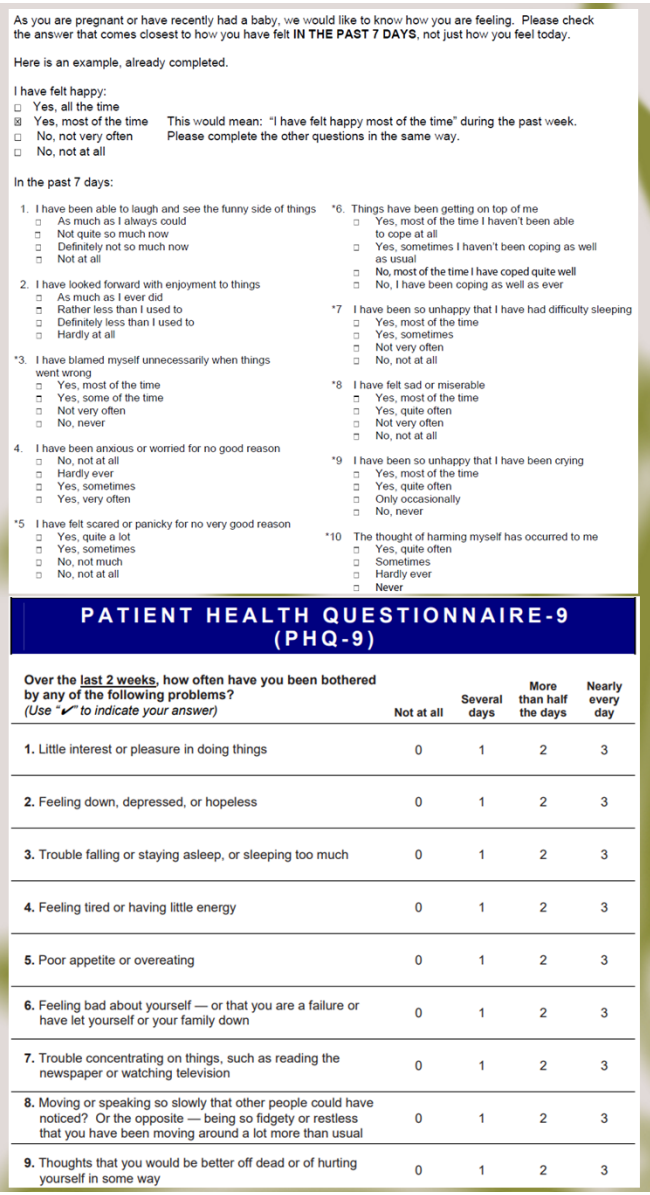
Healthy Mothers, Healthy Babies
The Montana Coalition

Screening & Detection

Screening tools

- While observation or verbal questions can elicit a response, sensitivity is lower than a formal screen
- Currently < 20% patients are screened
- Screening tool options
  - **Depression:** PHQ2, PHQ9, or Edinburgh
  - **Anxiety:** no best recommended tool: Edinburg has an anxiety subset, GAD-7

- *Screenings are billable (CPT 96161)*



As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all
2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Screening for parental mood disorders in pediatric visits

In primary care we are already accustomed to mood disorder screening for adult patients (and hopefully teens)

PMADs screening recommended by Bright Futures and AAP Mental Health Task Force

Many postpartum patients only have 1 PP follow up at 6 weeks	WCC often the first and most frequent visit a new parent is having	No perfect interval: Suggestion every WCC 0-12mos

All well-child visits can be an appropriate time to check-in on both pediatric mood and caregiver mood

Particularly attentive to caregivers of children with complex medical needs

Montana local grade card D+

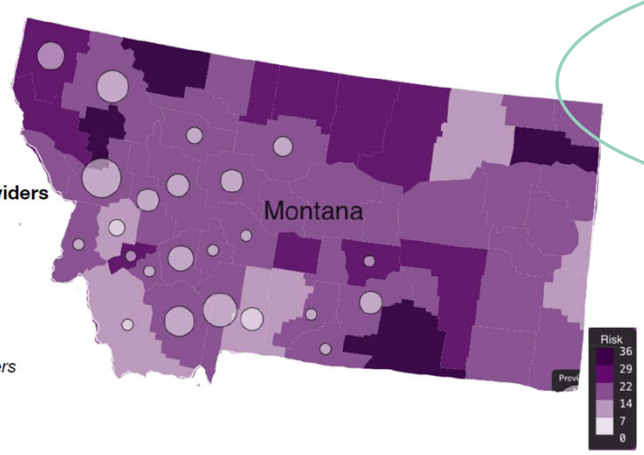
Counties with the Highest Risk

- Roosevelt - 32
- Lake County - 32
- Glacier County - 31
- Big Horn - 31

Counties with the Most Providers

- Missoula - 12
- Gallatin - 9
- Flathead - 8
- Madison - 7
- Lincoln - 6

Notice the lack of providers in the counties with the greatest need.



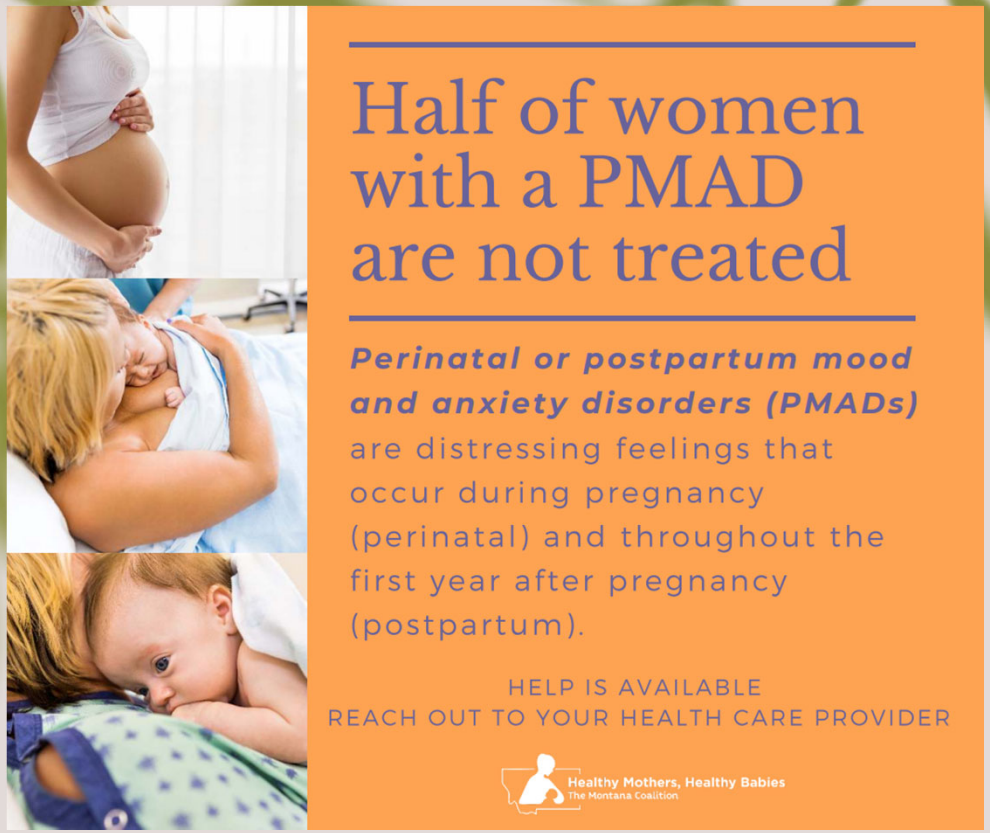
Providers and Programs	D
Meets Ratio of Non-Prescriber MMH Providers to Perinatal Population	✗
Meets Ratio of MMH Prescribers to Perinatal Population	✓
Has at Least One Inpatient MMH Treatment Program	✗
Has at Least One Outpatient Intensive or Partial Hospitalization MMH Program	✗
Has or Has Had a State-Sanctioned MMH Task Force or Commission	✗
Meets Ratio for CBOs Providing MMH Direct Services to Perinatal Population	✓
Has a Perinatal Quality Collaborative (PQC) that Has Prioritized MMH	✗

Screening & Screening Reimbursement	F
Top Performer on the "Prenatal Depression Screening" HEDIS Measure (Among Commercial Insurance or Medicaid)	✗
Top Performer with Commercial Insurance and/or Medicaid on the "Postpartum Depression Screening" HEDIS Measure (Among Commercial Insurance or Medicaid)	✗
Medicaid Requires MCOs to Collect the "Prenatal Depression Screening" HEDIS Measure	✗
Medicaid Requires MCOs to Collect the "Postpartum Depression Screening" HEDIS Measure	✗
Obstetric Providers Submit Claims to Private Insurers for Prenatal MMH Screening (Among at Least 1% of Prenatal Patients)	✗
Obstetric Providers Submit Claims to Private Insurers for Postpartum MMH Screening (Among at Least 1% of Postpartum Patients)	✓

Insurance Coverage & Treatment Payment	C
Expanded Medicaid	✓
Extended Medicaid Coverage to One Year Postpartum	✓
Requires Health Plans to Develop a MMH Quality Management Program	✗
Providers Submit Claims to Private Insurers for Prenatal MMH Treatment (Among at Least 10% of Prenatal Patients)	✓
Providers Submit Claims to Private Insurers for Postpartum MMH Treatment (Among at Least 10% of Postpartum Patients)	✓

Courtesy of Policy Center for Maternal Mental Health https://www.mmhmap.com/

Screening ≠ Detection ≠ Treatment

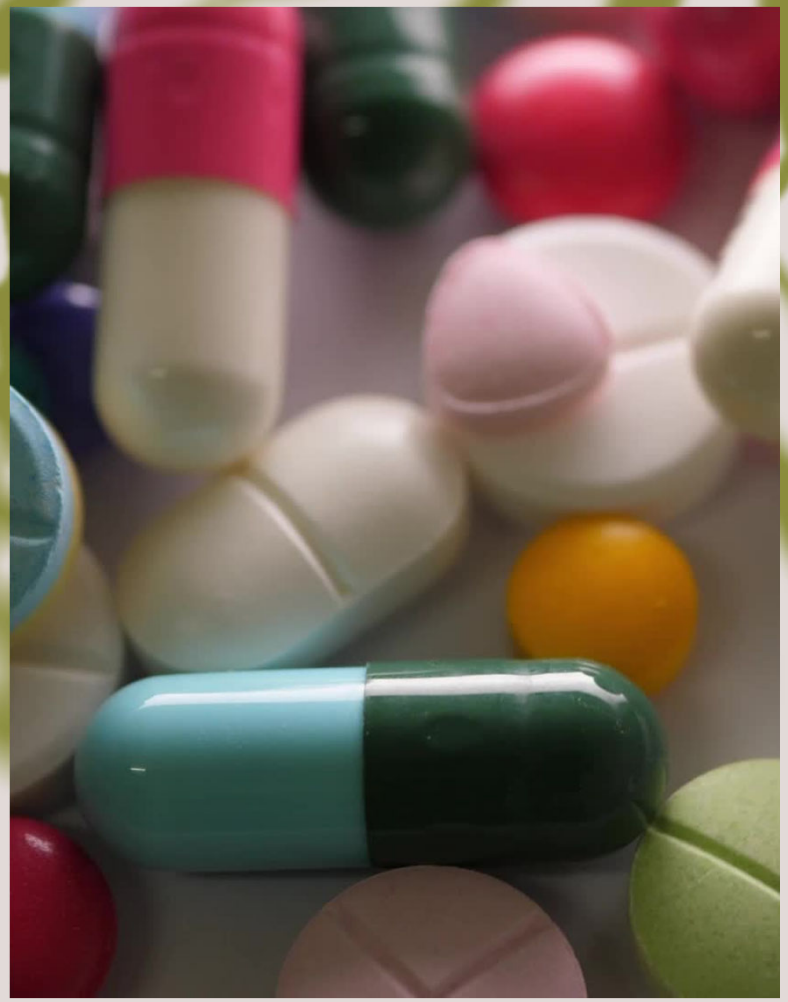


- A positive screen is not a diagnosis
  - A negative screen doesn't mean you can't have PMADs
- People with lived experience often report
  - Having ignored completion of a screener or completed untruthfully
  - Having completed a screener and not had it addressed
  - Having expressed concern or distress which was minimized
- Providers often express
  - Being unsure what to do with positive screens
  - Feeling they have limited resources to support patients
  - PMADs being outside their scope of practice

Addressing Parental Mental Health

- Close follow-up, normalization, reassurance, feeling heard
- Working with parents to promote emotional wellness: routine, self-care, exercise/movement, sleep, nutrition, reaching out to their support system.
  Isolation/loneliness prevention is key
- Ensure adequate support services: visiting nurse, postpartum doula, lactation support, WIC, childcare, parent groups
- Referral to a mental health provider with training in PMADs or parental mental health
- Assess for safety, provide crisis/support lines
- **Address barriers to engaging in care**

Identifying local resources



Addressing PMADs: Medication

- Medication is safe and effective
- Patients should be referred to their OB, PCP or a psychiatric provider for treatment
- Most SSRIs or other medications for depression or anxiety can be used to treat PMADs
- Caution with sedating medications and impact on overnight arousal
- **Zuranolone** a pill approved for severe PPD. Taken daily for a 14 day, with symptom resolution as soon as 3 days

Resources

- National Suicide Hotline: 988
- Suicide Prevention Lifeline: 1-800-273-8255
- Postpartum Support International: https://www.postpartum.net/ or PSI HelpLine: 1-800-944-4773 (call or text)
- National Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262)
- The Crisis Text Line can be reached by texting "MT" to 406-741-741
- Montana Warm Line: 1-877-688-3377
- Montana Crisis Recovery 1-877-503-0833
- LIFTS resource guide: https://hmhb-lifts.org/
- Self-led online support based in CBT: https://mycare.mmhnow.org/
- Cuddling Cubs Playgroup: https://www.cuddlingcubsplaygroup.org/
- Book Suggestions:
  - Good Mom's Have Scary Thoughts by Karen Kleinman
  - This Isn't What I expected: Overcoming Postpartum Depression by Karen Kleinman
  - Dropping the Baby and Other Scary Thoughts by Karen Kleinman
  - The Postpartum Depression Workbook by Abigail Burd
  - The Pregnancy and Postpartum Anxiety Workbook by Pamela Wiegartz, Kevin Gyoerkoe and Laura Miller

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There’s no way to be a perfect mother
and a million ways to be a good one
- Jill Churchill

Any questions?

Case 1

Nora is a 4mo female brought in by mom for routine well-child care. She is the 3rd child in her family. Mom (Kelly) is at home with her children while her partner works outside the home. She routinely brings in all her children to visits. You have never seen mom as a patient

Nora's birth was complicated by a difficult repeat c-section, a short NICU stay for respiratory distress at birth and significant newborn weight loss due to feeding difficulties which have now resolved. Nora is exclusively breastfed. While normally bright and calm, Kelly's demeanor seems tired and less engaged with her kids today

Case 1

Kelly reports she has been more irritable and easily sensory overloaded lately. Nora only wakes 1-2x at night, but her 2yo has been getting up frequently as well. Kelly does most overnight care as her partner is up early for work and operates heavy equipment which he has to be alert for

Additionally, Nora tends to be fussy in the early evenings. When thinking about her birth experience Kelly starts to have heart racing and feeling flushed. She notes also that recently she has been feeling like food is “getting stuck” when she swallows, and this causes heart racing and feeling flushed. She has started being nervous at mealtime, worrying she will choke with her children home. Sometimes she skips eating because of it

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Case 3

Mira is 27yo G3P3 9mo PP presenting with several months of headaches, weight loss and fatigue

Reports she has both trouble falling asleep and is often up at least 1x nightly with one of her children aged 9mo, 3yr and 5yrs. She has trouble falling back asleep. She averages 4-5hrs/night. Headaches worse on days she sleeps poorly and associated with neck tension. Reports that while she prepares multiple meals a day for her children, she often does not eat or prepare her own meals because she is “too busy”

She reports she doesn’t have a working car and lives far out of town and rarely has visitors or spends time outside the home. Her partner is often absent for work

On her PHQ9, she circled “several days” to thoughts of being better off dead or self harm