



# Issue Brief

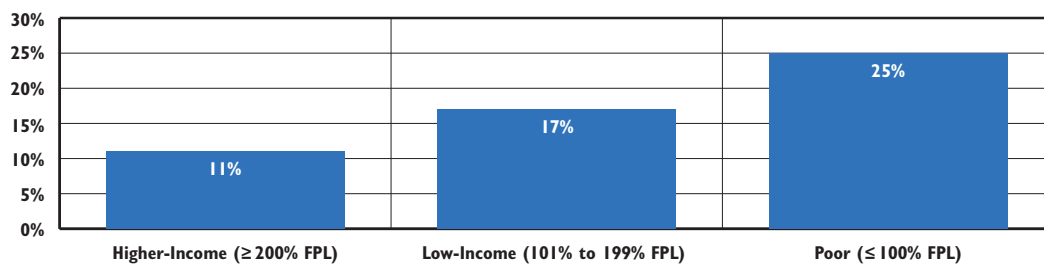
## Maternal Depression in Rhode Island: Two Generations at Risk

Maternal depression occurs in many families in the U.S. and Rhode Island, and, when untreated, negatively impacts the development of children and the overall well-being of the mother and the family. (Harvard) Healthy brain development in young children requires consistent, nurturing relationships and frequent, positive interactions with parents and other important caregivers. Maternal depression interferes with a parent's capacity to support healthy child development and can have long-lasting and negative effects on children's health and learning. (Alliance, CLASP)

In 2017, the World Health Organization identified depression as the leading cause of poor health and disability among people worldwide, citing an overall 18% increase in prevalence between 2005 and 2015. In the U.S., approximately 5.9% of people suffer from depression for an estimated 8.5% of total years lived. Worldwide, depression affects people of all ages and social groups, but is more common among women and is associated with poverty, unemployment, occurrence of major life events, physical illness, and drug and alcohol abuse. (WHO)

In the U.S., researchers estimate that between 10% to 20% of all pregnant or postpartum women experience depression. Rates are significantly higher for mothers with previous histories of depression and those experiencing economic hardship and/or social isolation. (Harvard, AAP)

### Maternal Depression by Family Income



Source: Center on the Developing Child at Harvard University. (2009). *Maternal depression can undermine the development of young children: Working paper number 8*. Cambridge, MA: Harvard University.

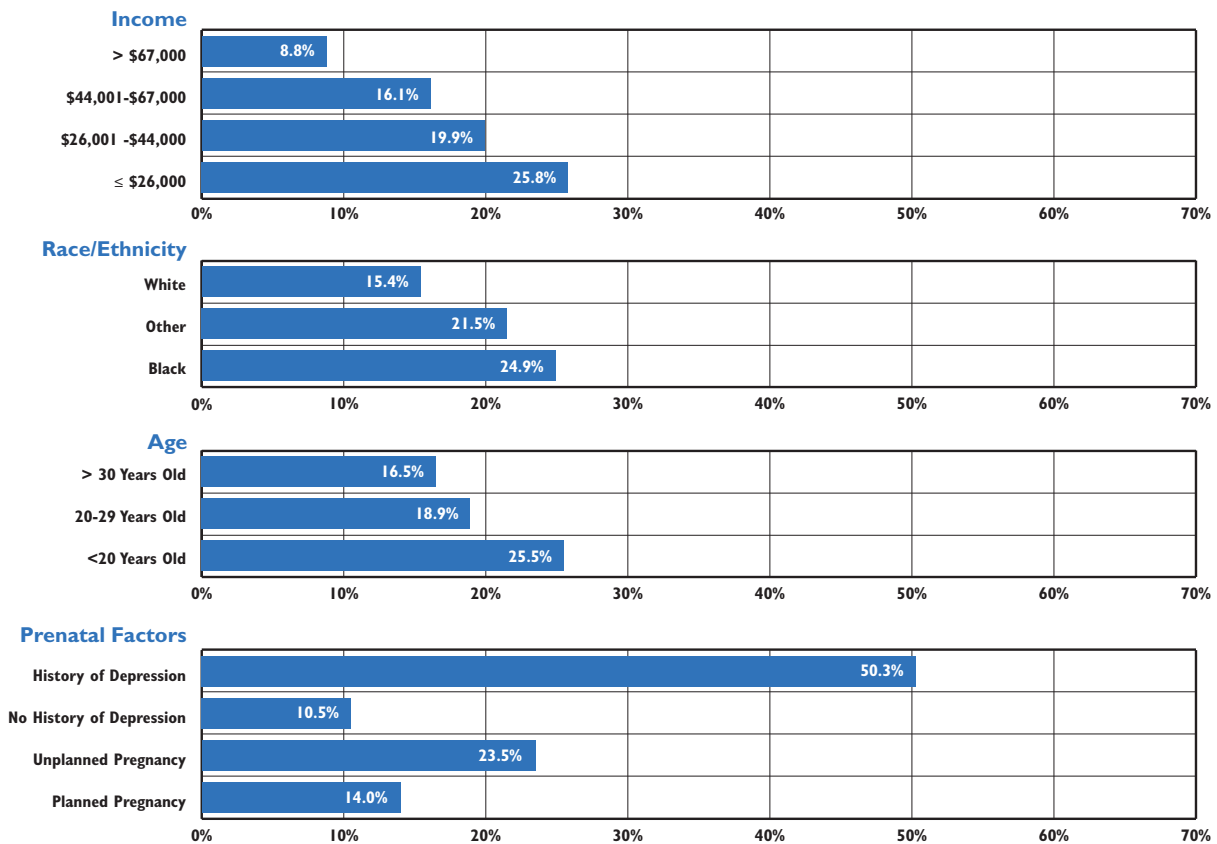
### Maternal Depression in Rhode Island

In Rhode Island in 2012-2015, 18.1% of mothers with infants report that they were diagnosed with depression during and/or after pregnancy with higher prevalence among lower-income families, racial and ethnic minorities, mothers under age 30, and mothers without a high school diploma. (PRAMS, 2012-2015)

## Depression vs. “The Baby Blues”

- ◆ A brief period of sadness and anxiety after the birth of a new child is very common. Up to 80% of mothers experience “the baby blues” during the first week after delivery, peaking at three to five days postpartum. Symptoms usually resolve within two weeks postpartum with support from family and social networks. “The baby blues” is not considered a form of maternal depression, but if symptoms continue for more than two weeks, then depression may be present.
- ◆ Maternal depression is an overarching term for longer-lasting depression that occurs during pregnancy and/or the first 12 months after the birth of a new child. Approximately 10% to 20% of women experience depression during pregnancy or in the first 12 months postpartum. A history of depression is a significant risk factor for depression both during pregnancy and after the baby is born. Symptoms include: persistent sadness, frequent crying, feelings of worthlessness, fatigue, inability to perform everyday tasks, and recurrent thoughts of death or suicide. Symptoms may interfere with a mother’s ability to care for herself or her child. X

### Risk Factors for Maternal Depression, Rhode Island, 2012-2015



Source: Rhode Island Department of Health, PRAMS 2012-2015. Note: data available on maternal depression among Hispanic mothers (19.0%) show no statistical difference from non-Hispanic mothers (17.7%).

### Depression in Fathers and Adoptive Mothers

- ◆ Expecting and new fathers can also experience depression. Studies show that approximately 6% to 10% of men experience depression either in the prenatal or postnatal periods, and that depression in fathers is associated with maternal depression.X Adoptive mothers experience depression at levels similar to mothers who give birth. Sleep deprivation, history of infertility, history of depression or other mental health disorders, and lower marital satisfaction all contribute to depression among adoptive mothers.X

## Consequences of Maternal Depression

### Impact on Children

- ◆ Depression interferes with a person's ability to develop and sustain healthy relationships and to have positive interactions with others. Healthy brain development in infancy requires a "serve and return" pattern of interactions with parents and other caregivers noticing and responding to the baby's needs and signals. Babies who do not experience positive, consistent interactions with their parents and other caregivers experience "toxic stress" that interferes with brain development. (RAND)
- ◆ Maternal depression is associated with delayed cognitive, linguistic, and behavioral development, and social emotional problems in children. Chronic childhood health problems such as obesity and asthma are also associated with maternal depression. Untreated maternal depression can also place a child at risk for maltreatment and involvement with state child welfare officials as children may not receive adequate attention, food, and medical care, and they may experience unsafe and unsanitary living conditions. Maternal (RAND, Field)
- ◆ Depression is not just limited to pregnant women and new mothers. Maternal depression often continues or recurs throughout the child's youth and results in less consistent and positive parenting practices. A negative cycle can develop where parenting practices associated with maternal depression cause child behavior problems which then lead to increased maternal anxiety and depression. (Scientific A)

### Impact on Mother

- ◆ In most cases, depression is a chronic, recurring disease. On average, adults with depression experience at least five episodes across their lifetime. Risk for depression peaks during the reproductive years. Depression severely impacts a person's quality of life, creating economic and social disadvantages, interfering with relationships, and leading to social isolation. Depression is associated with chronic disease risk factors such as obesity, smoking, and substance abuse, and contributes to several medical and psychiatric disorders. (NIHCM, RAND)

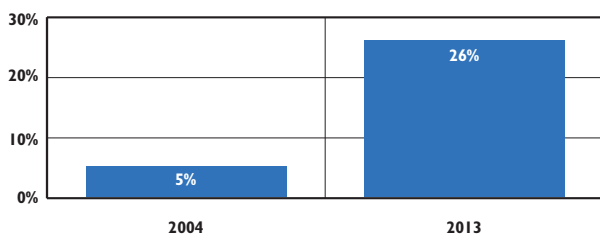
### Public Sector Systems Affected by Maternal Depression

- ◆ **Public Assistance:** Depression is associated with unemployment and underemployment and is likely bidirectional: unemployment leads to depression and depression leads to unemployment. Depressed mothers have difficulty getting and keeping jobs, leading to lower income and a greater need for public assistance. (RAND, CLASP)
- ◆ **Public Health:** Children of depressed mothers are more likely to be born premature, at low birth weight, stay in the NICU, have asthma, and experience infant hospitalization. Women who are depressed are more likely to have cardio-vascular disease, stroke, and type-2 diabetes.
- ◆ **Early Learning & Public Education:** Infants and young children of depressed mothers are more likely to have early childhood developmental delays and need IDEA Part C services. Children of depressed mothers are less likely to enter school with the necessary skills and knowledge to be successful, leading to poor school performance and need for special education services.
- ◆ **Child Welfare:** Almost one in four custodial caregivers being investigated for child maltreatment is experiencing depression. Depressed mothers are two- to three-times more likely to physically abuse, emotionally abuse, or neglect the medical needs of their children than mothers who are not depressed. Maternal depression and intimate partner violence frequently co-occur and both increase the risk for child maltreatment.

## Screening for Maternal Depression

- ◆ Maternal depression often goes undetected, undiagnosed, and untreated. Screening is the first step in identifying women who may be suffering from maternal depression. Brief, accurate, and evidence-based questionnaires are available and can be used in a variety of settings with pregnant and parenting women. Positive screens should be followed up with further evaluation by professionals to determine if depression is present. (van der Ze NIHCM)
- ◆ The U.S. Prevention Services Task Force has endorsed the 10-question Edinburgh Postnatal Depression Scale as a valid and reliable tool to identify maternal depression as well as two simple questions to screen for depression in the general population. The two-question screen for depression is: Over the past two weeks: 1) Have you ever felt down, depressed, or hopeless? 2) Have you felt little interest or pleasure in doing things? X
- ◆ Because of the frequency of prenatal care visits and the fact that almost all pregnant women receive some prenatal care, obstetric practices are important settings to screen for maternal depression, refer for evaluation and treatment, and follow-up with patients who are depressed. The American College of Obstetricians and Gynecologists recommends routine, universal screening for depression at least once during pregnancy or in the postpartum period using a standardized and validated tool coupled with follow-up evaluation and treatment for patients who screen positive. (Lancaster, ACOG)
- ◆ Pediatric health care providers are an even more important setting for maternal depression screening since they have frequent contact with almost all new mothers during the first year postpartum. Although pediatricians are not trained to diagnose and treat maternal depression, the majority of providers agree that screening and referral is within the scope of pediatric care. The American Academy of Pediatrics recommends routine, universal screening for maternal depression during well-baby visits in infancy at one, two, four, and six months of age. X

### Screening for Maternal Depression at Well-Baby Visits, U.S., 2004 and 2013



Source: Kerker, B. D., et al. (2016). Identifying maternal depression in pediatric primary care: Changes over a decade. *Journal of Developmental and Behavioral Pediatrics*, 37(2), 113-120.

- ◆ A national study of pediatricians found that screening rates have increased over the last decade, but overall, only about one-quarter of pediatricians reported routinely screening for maternal depression. Studies have shown that screening for maternal depression during well-baby visits leads to significantly higher detection of the condition. When screening is combined with enhanced care, depression symptoms improve. (Kerker, van de)

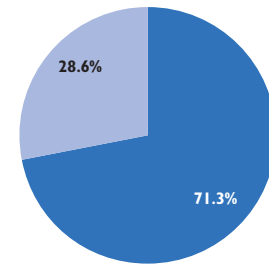
### Family Home Visiting Programs & Maternal Depression Screening

- ◆ In Rhode Island, the First Connections program provides voluntary, short-term home visits and developmental screenings to families with children under age three. Families with risk factors for poor outcomes are routinely referred to First Connections. In 2014, 90% of the 3,267 families who received a First Connections home visit were screened for maternal depression. (RFP, Senate)
- ◆ Longer-term, comprehensive, evidence-based home visiting programs in Rhode Island (Healthy Families America, Nurse-Family Partnership, and Parents as Teachers) also screen women for depression. In 2014-2015, 67% of participants were screened for maternal depression, and 24% of those screened had positive screens. (Senate Report)

## Treating Maternal Depression

- ◆ Detecting possible maternal depression is only the beginning. Women who screen positive for maternal depression should receive follow-up evaluation, diagnosis, and treatment. National data indicate that nearly 60% of all women with depressive symptoms do not receive a clinical diagnosis, and 50% of all women with a depression diagnosis do not receive any treatment. (MMWR) A study of low-income mothers with major depressive symptoms found that more than one-third received no treatment at all. (CLASP)
- ◆ In Rhode Island in 2012-2015, 71.3% of women diagnosed with depression during pregnancy report receiving treatment (counseling and/or prescription medication). Women with education levels beyond high school were more likely to receive treatment than those with a high school diploma or less. X

### Treatment for Maternal Depression During Pregnancy, Rhode Island, 2012-2015



71.3% ■ Treated for Depression  
28.6% ■ No Treatment

Source: Rhode Island Department of Health, PRAMS 2012-2015

## Treatment Options

- ◆ **Psychotherapy:** Both Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT) have been shown to reduce depressive symptoms during the postpartum period. Both treatment strategies involve talking one-on-one with a licensed mental health professional (e.g., therapist, psychologist, psychiatrist, or social worker). Psychotherapy can be used in combination with antidepressant medication. (Zero to Three SAMHSA- Mat Depression).
- ◆ **Medication:** Prescribed antidepressant medications are highly effective at reducing depression. Although no definitive study has been conducted, antidepressants are generally considered to be safe during both the prenatal and postpartum periods, but may be a second choice option during pregnancy. Antidepressant medication is often combined with psychotherapy. (Zero to Three).
- ◆ **Mother-Infant Psychotherapy (Two-Generation):** Mother-infant therapy, also known as dyadic treatment, is designed to improve the mother-infant relationship by improving mother-infant interactions. Research indicates that focusing only on reducing the mothers' depression alone does not lead automatically to improvements in parenting and children's development. In order to improve child well-being, experts recommend treating maternal depression while also providing interventions to improve parenting and mother-child interactions. (Harvard)
- ◆ **Peer Support:** Led by a peer support specialist, parent support groups for new mothers and/or mothers who have experienced depression help them navigate the health care system, access mental health services, and reduce depression. (SAMSHA)

## The Day Hospital at Women & Infants

- ◆ Launched in 2000, the Day Hospital at Women & Infants was the nation's first partial hospital program treating pregnant women and new mothers with depression alongside their babies in a warm, nurturing setting. The concept of keeping mothers and babies together during treatment in a hospital-based program has received national recognition. Treatment includes group, individual, and family therapy, support to promote bonding and attachment between mother and baby, lactation consultation, and medication assessment.

## RItE Care and Maternal Depression Screening & Treatment

- ◆ In Rhode Island in XXXX, X% of births and X% of infants under age one had health insurance coverage through RItE Care, the state's Medicaid managed care program for eligible uninsured children, their families, and pregnant women.
- ◆ Uninsured parents report high rates of unmet medical needs, including going without medical care, prescriptions, and mental health treatment for themselves. Uninsured parents also report additional family stress associated with being low-income, including running out of food, being unable to pay the rent, and having trouble with unexpected bills.(Chester)
- ◆ In 2016, the federal Centers for Medicare and Medicaid Services issued an informational bulletin on maternal depression, screening, and treatment. The bulletin clarified that state Medicaid agencies are authorized to cover maternal depression screening as part of a well-child visit under the Early Periodic Screening Diagnosis and Treatment (EPSDT) provision.X
- ◆ States must affirmatively act to implement the coverage and instruct pediatric health care providers on how to bill for maternal depression screening. As of March 2017, there were 11 state Medicaid programs that provide coverage through the child's Medicaid insurance for maternal depression screening during well-child visits. Most of the states that cover maternal depression screening at well-child visits also cover screening in nonmedical settings, including at home visits, in community-based settings like WIC offices, or through Early Intervention (Part C of IDEA).X
- ◆ Under EPSDT, Medicaid covers medically necessary treatment for the child, including treatment resulting from the impacts of maternal depression. Specifically, treatment that includes both the child and the parent (e.g., parent-child psychotherapy or mother-infant interaction therapy) can be billed through the child's Medicaid insurance. Diagnostic and individual treatment services (e.g. medication and individual psychotherapy treatments) are covered under Medicaid only if the mother is Medicaid eligible.X
- ◆ As of December 2017, Rhode Island has not yet issued guidance or billing instructions for maternal depression screening or treating children exposed to maternal depression through RItE Care.X

## Early Intervention & Maternal Depression

- ◆ Early Intervention is a program authorized under the federal *Individuals with Disabilities Education Act (IDEA)*, Part C and overseen by the U.S. Department of Education. States are required to identify and provide appropriate Early Intervention services to children under age three who are developmentally delayed or have a diagnosed condition associated with a developmental delay (e.g. Down Syndrome). States may also choose to provide Early Intervention services to children who are at risk for developmental delays even if they don't currently have a delay.X In Rhode Island, the program Center for Child and Family Health at the Executive Office of Health and Human Services implements Early Intervention and serves over 4,000 infants and toddlers per year.X
- ◆ National research has shown that maternal depression is common among families receiving Early Intervention services, with 23% of mothers whose children became eligible as infants and 58% of mothers whose children became eligible as toddlers having symptoms of depression. Despite the prevalence of maternal depression, maternal mental health is not directly addressed by Early Intervention. Because of links between maternal depression and child developmental delays, experts call for increased integration of maternal mental health and well-being services within Early Intervention.X

## Recommendations

- ◆ **Rlte Care Coverage:** Continue to provide Rlte Care coverage to pregnant women, children, and parents in low-income families. Extend Rlte Care eligibility for pregnant women from six weeks to 12 months postpartum to ensure access to proven treatment for maternal depression.
- ◆ **Private Health Insurance:** Continue to ensure that mental health parity provisions are strongly enforced among health plans and that private insurance providers have adequate systems in place to support screening, diagnosis, and treatment of maternal depression.
- ◆ **Universal, Routine Screening for Maternal Depression:** Universal, routine maternal depression screening using a valid and reliable tool should be delivered by prenatal and pediatric health care providers at nationally recommended intervals.
  - ◆ Adopt Medicaid policies and develop guidance to promote maternal depression screening at pediatric well-child visits billable through the child's health insurance so that more new mothers with depression can be identified.
  - ◆ Maternal depression screenings should also be continued through Rhode Island home visiting programs, including First Connections, Early Head Start, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers.
  - ◆ Consider implementing strategies to screen for maternal depression in other large programs serving vulnerable families with new babies and young children, including WIC and Early Intervention.
- ◆ **Prompt Referral and Treatment:** Pregnant and parenting mothers who screen positive for depression should be referred for further evaluation, diagnosis, and treatment. Adopt Medicaid policies and develop guidance allowing or dyadic mother-child psychotherapy to be billed under the child's health insurance.
- ◆ **Early Intervention:** Rhode Island should formally adopt the "at risk" provision to determine eligibility for Early Intervention and include maternal depression as an indicator for eligibility. Rhode Island should also consider implementing regular maternal depression screening for participating families through age three and developing services to address maternal depression and provide relationship-based interventions.
- ◆ **Family Home Visiting:** Rhode Island should build on the existing infrastructure of home visiting services by providing supplemental screening for maternal depression to vulnerable families (recognizing that the primary screening should be delivered by prenatal and pediatric health care providers) and integrate strategies to address maternal depression within comprehensive, evidence-based models.
- ◆ **Professional Development:** Provide high-quality professional development on maternal depression to health care providers and other professionals who work with pregnant and parenting mothers. Promote Infant and Early Childhood Mental Health competency endorsement.
- ◆ **Public Awareness Campaign:** Develop and implement a statewide campaign to build awareness of maternal depression and the availability of effective treatments and services for both the mother and child. The campaign should be culturally sensitive and aim to reduce stigma.
- ◆ **Reduction of Risk Factors Contributing to Depression:** Strong efforts should be made to reduce risk factors that contribute to maternal depression, including untreated mental health problems across the lifespan, poverty and economic insecurity, domestic violence, and unintended pregnancy.

**First 1,000 Days of Rlte Care:** Consider implementing a *First 1,000 Days of Rlte Care Initiative* modeled on the effort in New York State to improve health and developmental outcomes for infants and toddlers in low-income families. The initiative could include strategies to promote and track routine screening for maternal depression, developmental delays in young children, and elevated blood lead levels as well as follow-up and treatment.

## References

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Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action.

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## Acknowledgements

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