California Task Force on the Status of Maternal Mental Health Care – Meeting Minutes

DATE/TIME: Thursday, February 18, 2015 9-11:15 am (Webinar)

TASK FORCE MEMBERS PRESENT:
Stephanie Chandler, Genevieve Thomas Colvin, Emily C. Dossett, Erik Fernandez y Garcia, Tracy Flanagan, Justin Garrett, Neal D. Kohatsu, Sheree Kruckenberg, Janice LeRoux, Gretchen Mallios, Brynn Rubinstein, Beth Stephens-Hennessy, Stephanie Teleki, Laura Sirott

TASK FORCE MEMBERS ABSENT:
Angelica Alvarez, Carol Berkowitz, Athena Chapman, Elizabeth Fuller, Elliott Main, Sandra Naylor Goodwin, Connie Mitchell

PLANNING COMMITTEE MEMBERS PRESENT:
Joy Burkhard, Amanda Conley, Lauren Lessard, September Hill, Bruce Spurlock

PLANNING COMMITTEE MEMBERS ABSENT:
John Capitman

GUESTS:
Anna Sutton, Reggie Caldwell, Christine Morton, Diana Barnes, Jessica Walker,

SPEAKERS:
Dr. Jürgen Unützer, Cindy Lee Dennis (via recorded presentation)

AGENDA ITEMS	DISCUSSION	ACTION ITEMS
WELCOME, AGENDA	Joy Burkhard, Founder and Director of 2020 Mom and a key leader of the Task Force work, welcomes the California Task Force members and reviews the meeting's agenda. Agenda • Welcome & Where we are Headed	Meeting Materials available here: http://www.2020mom.org/feb_18_meeting

	• Presentation: Cindy-Lee Dennis, PhD (recorded presentation) • Presentation: Dr. Jürgen Unützer, • Presentation: Cindy-Lee Dennis (continued) • Discussion • Announcements	
WHERE WE ARE HEADED JOY BURKHARD BRUCE SPURLOCK	**Feedback from January meeting** Great, productive in-person meeting. Work stream groups are coalescing ideas and themes. **White Paper** Electronic copy of White Paper will be distributed to TF members TF members are invited to give feedback specific to the White Paper Planning Committee will meet in-person to synthesize ideas, information <u>Open Comments regarding January meeting:</u> Clearer instructions are desired for break-out work stream groups	Deliverable date for White Paper feedback will be sent out via email

CAN WE PREVENT POSTPARTUM DEPRESSION?
RESULTS FROM A SYSTEMIC REVIEW AND CLINICAL TRIAL
CINDY-LEE DAVIS, PHD
UNIVERSITY OF TORONTO
cindylee.dennis@utoronto.ca
 	
WEBSITE
http://www.cindyleedennis.ca/
	Joy Burkhard introduces Dr. Davis' credentials.
	Dr. Cindy-Lee Davis is a Professor at University of Toronto in Perinatal Community Health
	Research Chairs include:
	1. Canada Research Chair in Perinatal Community Health at the University of Toronto
	2. Shirley Brown Chair in Women's Mental Health Research
	Q. Can Postpartum Depression be prevented? Any evidence to suggest a possibility?
	Dr. Davis conducted a Cochrane Systematic Review to attempt to answer these research questions. See: "***Psychosocial and Psychological Interventions for the Prevention of Postpartum Depression: An Update***" (2013) Dennis, C-L, Dowswell, T.
	Objectives of Review
	• Assess effects of psychosocial and psychological interventions compared with usual partum care to reduce risk of PPD
	• Best applications, mechanisms for preventative effects, including:
	  ○ Psychosocial
	  ○ Psychological
		Slides are available here:
		https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/431/attachments/original/1455865671/Dennis.PPD-prevent-Michigan_2015.pdf?1455865671

	○ Intervention Provider, ○ Intervention Mode ○ Duration ○ Intervention Onset ○ Sample Selection Criteria Methods • Published, Unpublished studies meeting criteria: ○ RCT ○ PPD reduction risk was primary/secondary aim of trial • Quasi-Randomized trials excluded • Participants: Pregnant or less than 6 weeks postpartum Interventions • Educational interventions excluded, various non-pharmaceutical strategies included Outcome Measures • Primary: PPD • Secondary: Maternal, infant, family (not mentioned today) Study Characteristics • 28 RCTs • Approximately 17,000 women • 1995-2010 publication dates • Australia, UK (lead perinatal mental health research), other countries included as well Results • PPD at last assessment: beneficial effect related to prevention ○ 22% reduction in depressive symptomatology ○ 52% reduction in clinical depression ○ 17% reduction in psychosocial intervention • No preventative effects* found: ○ Antenatal, postnatal classes ○ Postpartum general home visits ○ Early postpartum follow-up ○ Continuity of care **When talking about preventing PPD, there is no evidence to suggest above interventions had a preventative effect* • Beneficial effects found: ○ Postpartum home visit by health professional ○ Postpartum telephone-based peer support	

	○ Psychological interventions ○ Interpersonal Psychotherapy • Group-Based, Multiple interaction interventions more beneficial • Intervention onset and duration affect beneficial effects Summary • Psychosocial and Psychological interventions may decrease PPD risk by approximately 22% • Evidence supports use of professional, telephone-based, interpersonal psychotherapy (IPT) is important, beneficial • Success more likely if interventions are: ○ Initiated postnatally ○ Individually-based ○ Include multiple contacts ○ Target 'at-risk' women • Successful interventions use of Edinburgh Postnatal Depression Scale (EPDS) administered within early postpartum period and tailored intervention to mother's needs • Additional research required in the early postpartum period **Canadian PPD Prevention Trial** See "*The effect of peer support on prevention of postnatal depression among high-risk women: a multi-site randomized controlled trial*" (2009) Dennis, C-L, Hodnett, E., et al. Postpartum Depression Peer Support Trial Objective • Evaluate effect of peer (mother-to-mother) support on the prevention of PPD among mothers identified as high-risk Why? Consistently see low levels of social support as risk factors. Mother's without a confidant/support network places them at high-risk for PPD • High Risk = EPDS score > 9 within first 2 weeks postpartum Design RCT Population sourced from Ontario-based program, *Healthy Baby Healthy Children* Mother's receive phone call from PH nurse 1 week postpartum >2,000 Screenings conducted Peer volunteers were PPD survivors; given 4-hour training	

	Intervention Peer volunteer initiate contact 24-48 hours after being matched 94% (328 / 349 mothers) intervention was initiated 25% (95 /349 mothers) continued interaction after 12 week monitoring period Dosage • Average of 9 contacts with peer volunteer • Half were phone conversations • Average discussion length = 14 minutes • Only 6.5% contacts initiated by the mother. Reason most often cited: Mother knew volunteer would call them –volunteer built trust, reliability, dependability Findings EPDS > 12 (at 12 weeks) • Intervention Group: = 14% • Control Group: =25% PPD risk reduction of 50% by offering peer support early in postpartum period • High maternal satisfaction (Likert-scale survey) • Peer volunteers satisfied and found training beneficial bi-directionally (Questionnaire) Summary • Telephone-based peer support effective among high-rsk mothers • Participating mothers reduced PPD risk by 50% • International uptake • Proactive and Preventive focus is key **Treatment of Postpartum Depression** Mothers prefer 'talk therapies' See *(2006) Dennis & Chung-Lee* Interpersonal Psychotherapy (IPT) focus on social context • Effective treatment for general depression • Not easily available for rural, remote areas Telepsychiatry Services available over the phone, acceptable alternative to face-to-face services. Opportunity for adjunct services. Trained nurses in IPT can increase utility of this service. Interpersonal Psychotherapy Trial Clinical trial to observe the effect of telephone-based IPT by trained nurses over	

	12 week period. Attention placed on PPD, symptomatology, anxiety, relationship quality, health service utilization at various time markers (12, 24, 36 weeks). Design Trial administered across Canada (36 health regions from 6 provinces) Mothers with EPDS > 12 referred by health professional Randomized • Control group: Usual PPD care • Intervention group: Usual care AND tele-IPT 241 Mothers enrolled Intervention Mothers received 12 weekly 1-hour IPT sessions 7 trained nurses logged activities Nurses with psychotherapy backgrounds not found to be easily trained in IPT, rather PH Nurses, Nurses with experience working with families, mothers were best suited for this intervention. Findings Mothers receiving IPT 4.5 times less likely to be clinically depressed (12, 24 week follow-up) Improvement in EPDS scores, anxiety, quality relationship with partner Summary Telephone IPT effective treatment for clinically depressed mothers. Viable treatment option for mothers living in rural, remote areas. Positive improvements made on maternal depression, relationship quality. Tele-IPT being tested in New York City, Norway.	
CENTER OF EXCELLENCE MATERNAL AND CHILD MENTAL HEALTH (MCMH) DR. JÜRGEN UNÜTZER, MD, MPH, MA UNIVERSITY OF WASHINGTON	Joy Burkhard introduces Dr. Unützer to the TF. Dr. Unützer is a well-recognized researcher and psychiatrist. Has over 225 publications. Chair in the Dept. of Psychiatry and Behavioral Sciences at Univ. Washington. Directs the AIMS Center (http://aims.uw.edu/), IMPACT Program (http://impact-uw.org/), serves as a Senior Scientific Advisor to the World Health Organization.	Slides available here: https://d3n8a8pro7vhmx.cloudfront.net/camaternalmentalhealth/pages/431/attachments/original/1455859206/Unutzer_UW_Maternal_and_Child_Mental_Health_for_2-18-2016.pdf?1455859206

WEBSITE https://depts.washington.edu/globalmh/members/jurgen-unutzer-md-mph-ma/	**Center of Excellence Maternal and Child Mental Health** Dr. Unützer opens presentation by quoting British Psychiatrist, John Bowlby. Bowlby suggests best way to improve mental health is to direct attention, resources to the child and mother. Mission of Center: clinical care, concentrate on mother/child dyad, research **Improving Care for Depression** "DAWN" Depression Attention for Women Now Project Modeled after IMPACT Program Goals: Improve care for depressive disorders, target barriers to care Screening: PHQ-9 Overview 205 Women, 2 sites (County hospital, University hospital) • Control Group: usual care • Intervention Group: collaborative care modeled after IMPACT 18 month observation period. Primary outcome to measure 50% or more depression score improvement (6, 12, 18 month) Intervention Women received care from same primary provider as control group. Addition of "Depression Care Manager" (DCM) to engage mother, supervise weekly, patients were offered 1 of 2 treatment options • Problem Solving Treatment-Primary Care • Antidepressant Medication OB/GYN clinics have PCP, trained DCM. DCM track patient PHQ-9, weekly consultations on every patient not improving. Recommendations made to social worker and PCP on how to change treatment. Problem Solving Treatment • Brief, structured psychotherapy • 6-8 sessions • Skill building • Can be delivered by range of health care professionals. Intervention chose to use Clinic-based Social Worker Antidepressant Treatment • Recommended 1 of 6 commonly prescribed medications • Dose guidelines. Patient not improving given higher dosage or	

prescription change

DCM Role
Reduce barriers to recovery, care participation
- Housing, Shelter, Legal Aid, Transportation, etc.

Findings at 12 months
96% patients had at least one in-person visit (mean = 10 visits)
53% used combination of PST and Prescription therapies
31% PST only
12% Prescription only
(1-2 patients refused treatment)

Intervention and Control group similar improvement at 6 months, intervention group continued to improve through 18 months.
Intervention group:
- Response to treatment had significant improvements
- Perceived greater improvement in symptoms

Application
Partnership with county health department
2,500 low-income mothers treated in 6 community health centers (2009-2014)
Care model adapted for pregnant and parenting women
Funded by King County Tax Levy
60% of women have significant improvement
Latina women have higher rates of improvement, current research efforts are attempting to understand why
Depression Improvement varies by clinic site (29-81%)
Collaborate Care Toolkit developed

University of Washington
Clinical services, perinatal psychiatry clinic collaborates with Obstetrics and Pediatrics, Mother-baby dyad focus.
Philanthropic work: Perinatal Psychiatry Consultation line available to any health care provider in the state of Washington
Perinatal Psychiatry Training Program available

Discussion
Q. Variability among clinics, any hypothesis on the variability of efficacy?
A. Qualitative surveys, analysis being conducted. More successful clinics designate a full-time DCM role; other clinics are merging DCM role with current

	social worker. Also, engagement of PCP in depression treatment. Differences may be attributable to patient population. **Q.** Is the Provider Training toolkit available on the website? **A.** No, expect availability in a few months **Q.** Who is the Perinatal Psychiatry Consultation line available to? How is it funded and staffed? **A.** Univ. Washington is the only academic medical center for 5-state region (7% of U.S. landmass) in the Pacific NW. Most counties do not have a single psychiatrist, psychologist or social worker. Consultation line is currently funded with philanthropic funds. Open 8-5 any provider in the state can call and discuss their case with a perinatal psychologist. **Q.** Have you done any analysis around any payment streams and how that impacts the implementation of your models? **A.** Collaborative Care program presented today is funded by the county Public Health Department through a tax levy. Clinics are paid a monthly-case rate, covers cost of DCM and psychiatric consultant. 25% of payment is tied to achieving good depression outcomes or achieving good quality of care; clinics not meeting either of 2 criteria paid 75% costs. This clause improved patient care and reduced time for women to see improvement in depression symptomatology. Additional questions may be directed to Dr. Unützer directly.	
CINDY-LEE DENNIS PRESENTATION (CONTINUED)	**Dr. Davis**: PPD informal surveillance does not work. However, screening alone is not effective. Access to appropriate treatment needs to be made available, follow-up to make sure treatment was initiated and adhered to. To improve child mental health trajectory through mothers, mothers need to be treated to remission. Currently involved in an IMPACT study. Recruiting 6,000 mothers and fathers across Canada. Participants are completing web-based questionnaires every 3 months. Observing families for 2 years.	
KEY CONCEPTS JOY BURKHARD	Joy Burkhard opens discussion to the TF to openly discuss both presentations today. **Discussion**	

	Washington **C.** Women respond to a lot of different things; don't have to be a psychiatric provider. Provider compensations, reimbursement needs to be in line with recommended care to make it easier to do the right thing. **C.** Tax for collaborative care model; performance outcomes tied to payment. When TF writes recommendations, need to be careful about what seem to be unfunded, unfundable mandates and to be cautious of lofty goals that remain goals. University of Washington is one-stop; sole provider of these particular services; not sure if similar success is possible in California. **C.** Payment, funding streams are more complex in California **C.** Possible to be effective in managing depression (80-90% efficacy rates). California needs to have a business model on the provider side, support needed to have resources and capacity to demonstrate effectiveness and incentive model. Size of California requires providers that are non-existent; need alternative resources for treatment for MD/PCP while also building up treatment resources **C.** Planning and research opportunity to gather data on ROI and learn from other countries, settings to inform how to move forward in California Canada **C.** Powerfully researched interventions, concerned if the PHN delivery model would require special licensing. Is this model something that can be billed? **C.** How to we weave prevention throughout the recommendations? **C.** Considering USPSTF recommendations to focus on postpartum women, can be doing a lot with preconception population. Can consider identifying those women before they are pregnant if they are seeking care; one presentation slide showed that 50% of women who have developed PPD had history of depression before conception. Opportunity to focus prevention at preconception and inter-conception. **C.** Recent focus-group and surveys completed at USC among Latinas; all were very aware of negative impacts of anxiety and depression during pregnancy and postpartum. When asked about traditional mental health treatments (therapy, medication) acceptability rates were very low. Crystal clear gap between what is medically offered and what patients want. A program similar to	

	the peer-support model presented today may be worthwhile in this particular LA population. Have to offer a lot of options to a lot of people. Emphasize this point in the paper; ability to offer bits of every option to some degree to cater to the disparate populations across the state of California. **C.** Need to consider cultural preferences related to treatment options. **C.** RN Depression Case Management, wondering if current home visiting programs (esp. MIECHV funded) are using nurses but not capturing data in what they are delivering in-home that addresses depression.	
NEXT STEPS	Monday, March 28, 2016 In-Person meeting Sacramento, CA (travel information coming soon)	
ADJOURNMENT	Joy Burkhard thanked everyone for their participation. The meeting ended at 11:15 AM.	