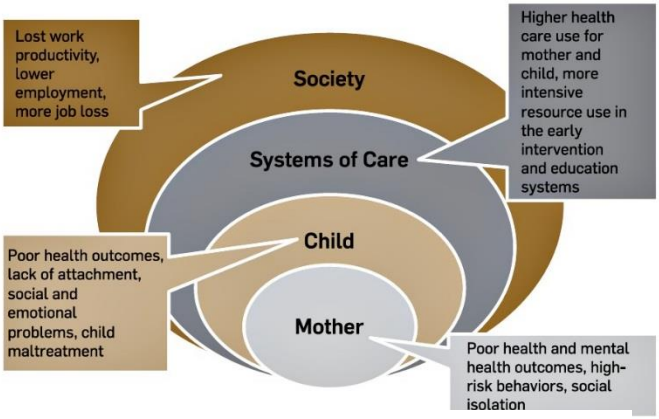
First 1000 Days Policy Brief: Parental Depression and Infant Mental Health

Purpose

There is a need to build capacity in Florida to identify and address parental depression, as well as provide mental health services to families with young children who have been impacted by trauma and other adverse experiences.



Sontag-Padilla. L. et al. (2014) Costs & benefits of treating maternal depression. *ZERO TO THREE, 34*(5).

Depression, particularly in mothers, has a direct and measureable impact on the health and well-being of women and their families, and, if untreated, contributes to long-term health, education and societal costs.

While depression affects all segments of the population, women of childbearing age are at disproportionate risk.[1] According to the Florida Pregnancy Risk Assessment Monitoring System (PRAMS), more than half of mothers in the state report experiencing postpartum depression after childbirth. The prevalence of depression is higher among mothers who are younger or older, black, low-income, single, with Medicaid or an unintended pregnancy. Less than 10 percent of mothers who experienced postpartum depression sought professional help.[2] Depression also affects 10-14 percent of fathers.[3]

Parental depression and family factors that contribute to it—intimate partner violence, trauma, stress, poor birth outcomes and infant mortality[4]—compromise the nurturing relationships that are key to healthy child development. The most rapid brain development occurs in the first 1000 days of life — a critical window for learning to see, talk, walk and think. The quality of relationships and experiences during this period set a foundation for all future health and development. Trauma and other adverse childhood experiences threaten outcomes and success over a lifetime.

---

[1] Agency for Healthcare Quality & Research (2005). Evidence Report/Technology Assessment No. 119, Perinatal depression: prevalence, screening accuracy, and screening outcomes.

[2] Florida Department of Health. Pregnancy Risk Assessment Monitoring System (PRAMS): Postpartum Depression, 2010.

[3] Paulson, J.F., et al. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. JAMA. 2010;303(19).

[4] Ammerman RT, Putnam FW, Bosse , NR, Teeters, AR, Van Ginkel JB. Maternal depression in home visitation: a systematic review. Aggress Violent Behav. 2010;15(3):191–200.

Building capacity in state programs that currently work with vulnerable expectant and new families, such as Healthy Start, offers a cost-effective strategy for addressing this critical issue. Professional development is needed to implement effective screening and evidence-base interventions within current program models. Targeted investment is required to increase the availability of infant mental health services for at-risk families in maternal and child health, child welfare and early childhood education.

Scientific Base

Research demonstrates that maternal depression can result in significant negative outcomes for the mother, her young children and the relationship between them.[5] In addition, depression in mothers experiencing social adversity, including poverty and other stressors, is a critical public health problem that contributes significantly to societal costs in terms of Medicaid and health care, welfare and lost productivity.[6]

Pregnant women who suffer from depression have a higher risk of smoking, drinking, using illicit drugs and being overweight - all factors that can increase the risk for poor perinatal outcomes. They may also be at risk for seeking less prenatal care, having a lower appetite and inadequate weight gain and poor self-care.[7] As a result, pregnant women with depression are 3.4 times more likely to deliver preterm and four times as likely to deliver a low birth-weight baby than non-depressed women.[8] These poor birth outcomes result from increased production of stress hormones in depressed women that contribute to reduced fetal growth and premature labor.[9] Undiagnosed and untreated maternal depression is also associated with increased rates of maternal suicide.[10] Depression during pregnancy is the primary risk factor for postpartum depression, the most common pregnancy complication.[11]

Surprisingly, as many as 10% of new fathers experience depression.[12] The most accurate predictor for male depression is if his partner is depressed. 24-50% of all fathers whose partners are depressed are depressed themselves.[13] Rates of paternal depression were highest 3-6 months after the birth. Symptoms of depression in men are similar to those in women but men typically present with more anger, irritability, anxiety, feelings of worthlessness and withdrawal, and also include being short tempered, drinking too much or being detached and emotionally withdrawn. Men are more likely than

"Children who experience maternal depression early in life may suffer lasting effects on their brain architecture and persistent disruptions of their stress response systems."

Center on the Developing Child
at Harvard University

[5] Beardslee, W. et al (2014). The impact of depression on mothers & children. Zero-to-Three, May 2014, Vol 34. No.5.

[6] Ammerman, RT et al (2015). Annual direct health care expenditures and employee absenteeism costs in high-risk, low-income mothers with major depression. Journal of Affective Disorders 190 (2016) 386–394.

[7] Gold, KG and Marcus SM (2008). Effect of maternal mental illness on pregnancy outcomes. Expert Rev of Obstet Gynecol.3(3):391-401.

[8] NIHCM Foundation (2010). Identifying and treating maternal depression: strategies & considerations for health plans.

[9] Diego, MA et al (2009). Prenatal depression restricts fetal growth. Early Human Dev 85, 65-70.

[10] NIHCM Op cit.

[11] Ibid.

[12] Paulson, J. F., Sharnail D., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *Journal of American Medical Association, 303*(19), 1961-1969.

[13] Goodman, J. H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. *Journal of Advanced Nursing, 45*(1), 26-35.

women to hide their depression and not seek help. The sleep deprivation that accompanies new parenthood can change the neurochemical balance in the brain, making some people with underlying risk factors more vulnerable to depression. A father's depression can significantly impact both mother and baby. When fathers are depressed, mothers may have the added stress of caring for the baby, herself and her partner. Obstetricians and primary health care providers are in a key role for detection by include depression screening for fathers when they accompany mothers to appointments or by asking mothers if their partners have any depression symptoms. All parents want the best for their baby and all health care providers can promote understanding that babies do better if they have emotionally healthy parents who are treated for depression.

In addition to the potential for major negative outcomes in the prenatal period, untreated depression in mothers continues to be a problem after the baby is born. Parents who are depressed are less likely to be responsive to the needs of their infants, compromising the development of a nurturing relationship that is key to healthy child development.[14]

Neuroscience and developmental research have identified two problematic effects of parental depression that "disrupt the 'serve and return' interaction essential for healthy brain development" during the first 1000 days of a child's life. Babies of mothers who are withdrawn or disengaged and fail to respond to the child can have similar signs of depression[15] such as lack of appetite, lack of enjoyment, flat affect, and overall "failure-to-thrive". Developmental problems in children are especially likely when a parent's depression occurs during the period of rapid brain development (prenatally to age three).[16] Maternal depression also threatens the health of young children with lower rates of vaccinations and pediatric check-ups.[17] Longitudinal studies have demonstrated that exposure to a depressed mother alters developmental trajectories in children, contributing to social, emotional, and behavioral problems through childhood and into adulthood.[18] The interaction of depression with other life stressors, such as poverty, isolation and family violence, can magnify its impact on long-term child health and well-being.[19]

In addition, high-risk children exposed to severe parental depression and other toxic stressors such as recurrent abuse or chronic neglect, domestic violence, or parental substance abuse, require more intensive, targeted treatment to mitigate against long-term mental, physical and behavioral problems.[20]

Parental depression effects not only individual family and child outcomes, but also requires significant resources on a societal level. A recent study using a large, nationally-representative database found substantial health care expenditures ($1.89 billion) and indirect labor productivity costs ($523 million) associated with depression in young, high-risk mothers. Direct and indirect aggregate costs of depression are almost five times greater in high-risk young mothers facing adversity such as poverty and other stressors compared to young mothers who are not high-risk. These costs are disproportionately borne by

---

[14] Center on the Developing Child at Harvard University (2009). Maternal depression can undermine the development of young children. Working Paper 8.

[15] Ibid.

[16] The National Center on Parent, Family, and Community Engagement at Boston Children's Hospital (2013).Family well-being: a focus on parental depression.

[17] McLennan, J. D., & Kotelchuck, M. (2000). Parental prevention practices for young children in the context of maternal depression. Pediatrics, 105, 1090–1095.

[18] Goodman, S.H. et al. (2011). Maternal depression and child psychopathology: a meta-analytic review. Clin. Child. Fam. Psychol. Rev. 14, 1–27.

[19] Beardslee et al (2014). Op cit.

[20] Center on the Developing Child at Harvard University. In brief: early childhood mental health. Accessed online at: *www.developingchild.harvard.edu/resources/.*

the public sector and taxpayers in the form of Medicaid, welfare, and special education expenses.[21] The prevalence of parental depression and its impact on the health and well-being of mothers, infants and families, as well as long-term societal costs, demand investment in a continuum of prevention, early intervention and mental health treatment services.

Guidance for Changing the Course

The greatest opportunity for turning this around is in the First 1000 Days of life. The American Academy of Pediatrics (AAP) and ACOG together have issued Guidelines for Perinatal Care that addresses perinatal depression.[22] Starting during pregnancy, all women should be screened for depression. All patients should be monitored for symptoms of postpartum depression and offered culturally appropriate treatment.[23] A woman experiencing negative feelings about her pregnancy should receive additional support from the healthcare team. After delivery, all patients should be monitored for symptoms of postpartum depression and offered culturally appropriate treatment. Women with postpartum blues should be monitored for the onset of continuing or worsening symptoms because these women are at high risk for the onset of a more serious condition. The postpartum visit at approximately 4-6 weeks after delivery should include a review of symptoms for clinically significant depression to determine if intervention is needed. Once identified, depression can be addressed with medications, therapeutic and psycho-educational strategies using evidence-based models.

While the outcomes of untreated depression are significant for both the mother and child, screening and early intervention and treatment can substantially lessen its effects. Treating depressive symptoms in the parent, however, is important but not sufficient for improving outcomes in their children. Rather, interventions that focus on both the parent and child achieve the best results, according to multiple studies.[24]

This emerging field of "infant mental health" is unique in that it focuses on both the child and the parents recognizing that babies develop in the context of families.[25] For the child, the focus is on promoting secure relationships. For the parents, the focus is on addressing their emotional capacity to be responsive to their child's emotional needs and well-being, which builds attachment. [26] Child-parent psychotherapy and early childhood mental health consultation, supported by home visiting and other psycho-educational services, can help mothers deal with past adverse experiences and coach them as they interact with their children. These approaches increase the mother's self-confidence and parenting skills as well as mother-

[21] Ammerman, RT et al. (2015) Op cit.

[22] American Academy of Pediatrics, American Congress of Obstetricians and Gynecologists. (2007). *Guidelines for perinatal care*, 6th ed. Elk Grove Village III: American Academy of Pediatrics and Washington, D. C.: American Congress of Obstetricians and Gynecologists.

[23] American Congress of Obstetrics and Gynecology. (2015). Committee Opinion No. 630: Screening for depression during and after pregnancy. *Obstetrics and Gynecology, 125*(5), 1268-1271.

[24] Nylen, KJ, et al (2006). Maternal depression: a review of relevant treatment approaches for mothers and infants. Infant Mental Health Journal, 27(4), 327-343.

[25] Winnicott, D. (1964). *The child, the family, and the outside world.* Harmondsworth, England: Penguin Books.

[26] Thomas, J. M., Benham, A.L., Gean, M., Luby, J., Minde, K., Turner, S., & Wright, H. H. (1997). Practice parameters for the psychiatric assessment of infants and toddlers (0-36 months). *American Academy of Child and Adolescent Psychiatry. 36*(10), 21-36.

child attachment and bonding.[27,28] These interventions increase the likelihood for ensuring good lifelong mental health so that children of depressed mothers will grow into "healthy, capable, fully contributing members of society."[29]

Home visiting and other support programs provide unique opportunities to identify depression in pregnant women and new mothers, as well as psycho-social education, counseling and linkage of high-risk women to needed mental health treatment in the community.[30] The success of these programs is dependent on staff training in the use of validated screening tools and evidence-based interventions.[31]

Depression screening is quick and easy and validated screening tools, such as the Edinburgh Postpartum Depression Scale (EPDS),[32] can be incorporated into prenatal care and community-based education and support programs like Healthy Start. Standardized screening during the prenatal and postpartum periods is key to identifying at-risk women early and connecting them to appropriate services. New evidence-based interventions, including Moving Beyond Depression™ and Mothers and Babies Course,[33,34] also offer treatment and prevention that can be delivered as part of ongoing services.

Currently, we have programs in Florida who are addressing these challenges in local areas. For example, Child First,[35] an intensive in-home therapeutic model for children who have experienced trauma and toxic stress, is being piloted in Palm Beach County. Promising strategies have been developed for infusing infant mental health into family support programs and child care.[36, 37]

Efforts to incorporate best practices for screening and treating parental depression in Medicaid Managed Care contracts are part of a Perinatal Initiative being implemented by the Agency for Health Care Administration. These strategies require partnerships across the continuum of maternal and child health, prevention and early intervention, mental health, Medicaid and school readiness programs and the investment of state funding in professional development and community-based services for vulnerable families.

Legal Foundation for Action

The significant shifts in how Florida meets the needs of these vulnerable famiies first require identifying the lead systems to guide these efforts. The Substance Abuse and Mental Health (SAMH) Program, administered by the Florida Department of Children and Families, is the legislatively appointed state

---

[27] Beardslee et al (2014). Op cit.

[28] Cohen, N. J., et al. (1999). Watch, wait, and wonder: Testing the effectiveness of a new approach to mother infant psychotherapy. Infant Mental health Journal, 20, 429–451.

[29] Center on the Developing Child at Harvard University (2009). Op cit.

[30] Golden, O. et al (2011).Home visiting and maternal depression: seizing the opportunities to help mothers and young children. The Urban Institute.

[31] Ibid.

[32] Cox J, Holden J, Sagovsky R. (1987) Detection of postnatal depression: development of the 10-item Edinburgh postnatal depression scale. Brit J Psychiatry 150: 782-86. Developed as the Edinburgh Postnatal Depression Scale and validated for use in both pregnancy and in the postnatal period to assess for possible depression and anxiety.

[33] Every Child Succeeds. Moving Beyond Depression. Accessed online at: http://www.movingbeyonddepression.org/.

[34] Northwestern University, Feinberg School of Medicine, Center for Community Health. Mothers and Babies Program. Accessed online at http://www.feinberg.northwestern.edu/sites/cch/research/mothers-babies-program/index.html.

[35] Lowell, D.I. et al (2011). A Randomized Controlled Trial of Child First: A Comprehensive, Home-Based Intervention Translating Research into Early Childhood Practice. Child Development, 82(1), 193-208.

[36] Brennan, E. M. et al. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. Early Education and Development, 19, 982-1022.

[37] Cohen, E. and Kauffmann, R (2000). Early childhood mental health consultation. Center for Child and Human Development, Georgetown University.

authority for substance abuse, mental health, and methadone designation. The program is governed by Chapters 394 and 397 of the Florida Statutes and is responsible for the oversight of a statewide system of care for the prevention, treatment, and recovery of children and adults with serious mental illnesses or substance abuse disorders.

Additionally, the Florida Medicaid program, administered by the Agency for Health Care Administration, funds prenatal care and behavioral health services for eligible families as authorized by section 409.906, Florida Statutes (F.S.), and in Rule 59G-4.050, Florida Administrative Code (F.A.C.).

Challenges

Florida's per capita investment in mental health services ranks 49 out of 52 states and territories.[38] State mental health service expenditures were $37.28 per capita compared to a national average of $124.99 per capita.[39] Florida delivers substance abuse and mental health services through a regional model managed by Behavioral Health Managing Entities (BHMEs). Not surprisingly, given limited funding, attention and efforts are focused primarily on deep-end treatment and crisis stabilization, with minimal support for prevention and community-based interventions.[40] Inadequate reimbursement, coupled with increased needs and lack of treatment services, have contributed to significant mental health systems issues.

Efforts to improve mental health services and develop effective systems of care at the community level failed during the last legislative session, although there is building momentum in the current session.[41] The challenge, even with this momentum, is garnering attention and resources for parental depression, infant mental health and related prevention and early intervention services for at-risk families.

Implementation of Medicaid Reform in Florida has also created challenges in accessing needed mental health services for the highest risk mothers and children impacted by depression. Behavioral health is provided as part of Medicaid Managed Care and includes both general and specialty plans. Limited provider networks and loss of fee-for-service reimbursement has affected timely access to counseling and treatment services in many communities.

Finally, parents themselves may be unable or unwilling to seek treatment. According to national studies, only half of depressed pregnant (50%) and non-pregnant (54%) women receive treatment. Cost is the most common barrier (55%), but opposition to treatment (42%), and stigma (26%) are also reported as factors.[42]

Recommendations for State Action

- **Allocate state mental health funds to build capacity to identify and address parental depression in programs currently serving vulnerable families.** More than 180,000 women are screened for Healthy Start and other services each year by prenatal care providers. In 2014-15, more than 24,000 pregnant women – about 13.5 percent of the total screened, indicated they felt "down, depressed or hopeless"

[38] The Henry J. Kaiser Family Foundation (2014). State Mental Health Agency (SMHA) Per Capita Mental Health Services Expenditures. Accessed online at http://kff.org/other/state-indicator/smha-expenditures-per-capita/.

[39] Ibid.

[40] Hansen, M. Mental Health in Florida: Presentation to NAMI Florida Annual Conference, December, 2014. Accessed online at: www.namiflorida.org/storage/MikeHansenNAMIPresentation.pptx.

[41] The News Service of Florida (November 13, 2015). "Backers hope 'this is the year' for mental health reform." Accessed online at: http://www.newsserviceflorida.com/assets/news3.aspx?Select=20151811.

[42] Ko JY, et al. (2012) Depression and treatment among U.S. pregnant and nonpregnant women of reproductive age, 2005-2009. Journal of women's health 21(8):830-836.

in the previous month.[43] Healthy Start provides services to 120,000 pregnant women each year, including 64,000 whose pregnancies are covered by Medicaid. This population is at highest-risk for experiencing parental depression. Program capacity to address this critical public health issue should be strengthened by:

1. Screening program participants for parental depression using the Edinburgh Postpartum Depression Scale (EPDS).
2. Incorporating evidence-based models, such as Moving Beyond Depression™ and the Mothers and Babies Course, into program interventions.

- Resources required: $150,000 in non-recurring funds for professional development and training for 800 staff statewide.
- Designate state mental health funding for treatment of parental depression.
- Leverage federal and state funding (Project LAUNCH, MIECHV) to develop a comprehensive, cross-sector strategy for infusing infant mental health services in home visiting, child care and other early childhood programs serving vulnerable families.
- Invest in education and training to ensure a qualified infant mental health work force is available to meet the state's needs.

Recommendations for Local Action

- Increase awareness of the community, health care providers and childbearing families about parental depression and its impact on mothers and young children through partnerships with advocacy groups such as Postpartum Support International.
- In Alachua County, advocates and MCH organizations, hospitals and other groups collaborated recently in community showings of the documentary, ***Dark Side of the Full Moon*** highlighting the prevalence of perinatal depression and challenges in its identification and treatment. As a result, a local Perinatal Depression Coalition was formed to coordinate efforts and services.

Conclusion

Parental depression is a significant risk factor that impacts maternal health, birth outcomes and child development during the critical first 1000 days when the quality of relationships and experiences shape life-long success. State investment is needed to strengthen and expand the capacity of existing programs to provide screening, education, counseling and support, as well as mental health treatment for vulnerable families.

[43] Florida Department of Health. Healthy Start Prenatal Executive Summary and Service Reports, CY 2014.