Healthy Mothers, Healthy Babies Coalition of MA
P.O. Box 620453, Newton Lower Falls, MA 02462

January 26, 2010

Committee on Financial Services
Massachusetts State House
Boston, MA 02133

Dear Members of the Committee on Financial Services,

"Help me; I can't continue to feel like this. Please, what can I do, where can I go?" These are the words of a 17 year old mother of a 10 month old little girl. Mandated screening may have identified this condition before this new mother felt so desperate.

The estimated prevalence of postpartum depression (PPD) is about 10-15% for the adult population of new mothers and can be as high as 40-50% for adolescent mothers. When untreated, PPD can lead to impaired mother-infant relationship; impacting the cognitive development and emotional behavior of the child. The children born to mothers who suffer from postpartum depression are more likely to exhibit failure to thrive, have difficulty adjusting socially, and, as they hit school age, they do less well academically. The ramifications are far beyond 'baby blues.'

This is a public health issue that can no longer be ignored. A concerted effort by health care providers to screen, refer and treat new mothers throughout the perinatal period will prevent the long-term effects that can occur for families.

We are writing on behalf of The Partners in Perinatal Health (PIPH) and Healthy Mothers, Healthy Babies Coalition of Massachusetts (HMHB of MA). As organizations comprised of health care professionals who provide services to women and their families across the perinatal period, we see the impact of postpartum depression frequently. We are committed to the issue of improving maternal mental health in the Commonwealth and we fully support this bill.

Please help us to help women and their families receive the services they deserve. We ask for your support for **House Bill 3897, *An Act Relative to Postpartum Depression.***

Thank you for your time and consideration of this testimony.

Sincerely,

Cheryl Aglio-Girelli, RN, BSN, FACCE
Co-chair, HMHB of MA

Kathy Beans, RN, BSN, LCCE
Co-chair, PIPH

THE BOSTON ASSOCIATION FOR CHILDBIRTH EDUCATION, INC

P.O. BOX 29, NEWTONVILLE, MA 02460

January 26, 2010

Dear Members of the Committee on Financial Services:

Imagine you are a postpartum home visitor and you are paying a visit to a mom and her two week old newborn. You have been concerned because she is not answering the phone. You have tried calling many times, to no avail.

When you arrive, it takes a long time for the mother to open the door. When you are sluggishly welcomed into the home, you see the lights throughout the house are out, the curtains drawn, mom was still in bed, the baby is crying in the crib. As you engage her further, you learn she has been feeling awful, overwhelmed, scared, and listless. She thought being a mother would be such a joy. Now, she is feeling so down, she can't even get out of bed. She is having a hard time relating to her baby. She feels anyone else will do a better job at taking care of her newborn's needs. She says to you: "The baby just cries when I pick her up. I am exhausted!

Postpartum depression is real. It is scary. It hurts. And it costs. PPD is much more prevalent than we would like to admit. As a maternal and child public health professional with over 15 years experience working with mothers and infants in different capacities, I have seen postpartum depression face to face. It is not a pretty sight! I am here as a representative of maternal and child community health workers, including childbirth educators, lactation counselors and community doulas, but also as a board member of MACHW – Massachusetts Association of Community Health Workers and board member of the Healthy Mothers, Healthy Babies Coalition of Massachusetts.

What makes postpartum depression even more difficult, is that there are few services where women and their families can get help. OB providers too often don't know how to ask. And if they do identify depression, they don't have where to refer. Women often say they tried telling their providers how they were feeling, but felt unheard. For the few that are able to get an appointment with a mental health provider, it might take weeks before they are seen. Women need to know early on that if they should need help, they will be able to find it.

As you have already heard today, prevalence rates are very high. Untreated PPD hurts all in the family, especially the baby. This is a public health issue that must be addressed. We need to do better at helping providers screen for depression. But we also need to do better at having services available for mothers and families struggling with depression.

Please support House Bill 3897, An Act Relative to Postpartum Depression.

Thank you for your time and consideration of this testimony.

Sincerely yours,

Lorenza Holt

Lorenza Holt, MPH

Executive Director

Joint Committee on Financial Services
House Bill 3897, An Act Relative to Postpartum Depression
Marylou Sudders, President & CEO
Massachusetts Society for the Prevention of Cruelty to Children
January 27, 2010

Good Afternoon Chairman Buoniconti, Chairman Koutoujian and members of the Committee: My name is Marylou Sudders. I am here to testify on House Bill 3897, An Act Relative to Postpartum Depression. It is a bill that could be a life saver for a woman.

Some of you know me from my professional life as the President of the Massachusetts Society for the Prevention of Cruelty to Children and/or as a former Commissioner of Mental Health. My entire professional life has been devoted to the "world" of mental illness because of the profound impact that the illness has had on my family, and in particular my mother.

My mother, Lillian Bates Beaumont – affectionately known as Lilly – suffered from a significant post partum depression after my birth that subsequently manifested as a clinical depression from which she would never recover.

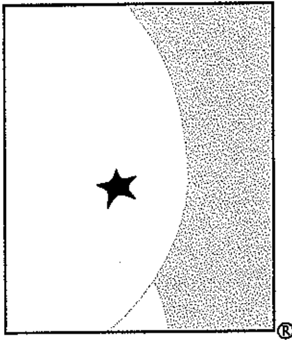
She was never accurately screened or diagnosed; obviously not treated; and, suffered the stigma that she was responsible for her lack of energy. Eventually, she took matters in her own hands and self medicated her depression with alcohol, dying not long after her 40th birthday from cirrhosis. I was 15; and during the last 9 months of her life, served as her case manager – actually her everything by that point.

Depression clearly runs in our family....and there were signs according to family elders that my lovely mother as a young woman was "remote", "quiet" and "sensitive". But, for everyone, she dramatically changed after giving birth to me....the words "blue", "seems sad" and "not interested in mothering" were whispered. One of my aunts came to stay with us for an extended period to help my mother during this "transition"....but it was not a "transition"....it was post partum depression. This now elderly aunt recalls that she never saw my mother smile again....

My mother knew on some level that things weren't right....her somatic complaint was that she was always tired. During one physician visit, she was actually told to get busy and she would feel better. Of course, she was busy....the favorite neighborhood baker, substitute church organist, volunteer at school and church for a long time and then finally back to work as a legal secretary.....so exhausted that the living room became her bedroom and finally her world.

It hurts reliving so personal a story every once in a while....because I know that she could have lived.....that if she had been diagnosed rather than dismissed, that had she been listened to rather than shamed, and if she had been treated rather than ignored....that she might have witnessed her daughters transition into adulthood and might have had a sense of joy in her life.

The tragedy of course is that we know that post partum depression is real, diagnosable and treatable...so I urge that you do everything possible to pass this bill. Thank you.



BirthReady.com

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January 24, 2010
To the Legislators,

I hope you will join me in supporting the House Bill 3897 An Act Relative to Postpartum Depression. I feel this bill is necessary because the two major obstacles to essential support that families need are lack of insurance coverage and sensitive, accurate information.

In my work as an educator and lactation consultant, I visit new families at their homes. I work to connect them with community resources and feel it is too often a matter of luck and geography as to what is available to them.

When insurance companies do not cover the basic cost of screening or treatment, much less recognize postpartum depression as a concern, this only adds to anew parent's confusion and despair.

Whenever a family meets with a health care professional, it's an opportunity to connect and guide a family to resources, information, and sensitive help. But health care professionals (as well as the community at large) need to be educated in order to be effective. We miss important, time-sensitive opportunities.

House Bill 3897 would compel insurance companies to cover the cost of postpartum depression screening and for referrals. It would require more education of health care professionals. This would be a step in the right direction in establishing the kind of support that all families with an infant need and deserve.

I recommend supporting House Bill 3897. Thank you for your consideration.

Sincerely,
Robin Snyder-Drummond
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Ed Tronick, Ph.D.
University Distinguished Professor
University of Massachusetts, Boston

Director,
Child Development Unit
Children's Hospital Boston

Lecturer
Harvard Medical School
Boston, Massachusetts

Ed Tronick, Ph.D.

Biography

Ed Tronick is a developmental and clinical psychologist and is recognized internationally as a researcher on infants, children and parenting. Dr. Tronick is a University Distinguished Professor of Psychology at the University of Massachusetts, Boston, is Director of the Child Development Unit at Children's Hospital, a Lecturer in Pediatrics, Harvard Medical School, an Associate Professor at both the Graduate School of Education and the School of Public Health at Harvard and a faculty member at the Fielding Graduate University. He is a member of the Boston Psychoanalytic Society and Institute, a past member of the Boston Process of Change Group and a faculty member of the Touchpoints program. With Dorothy Richardson and Marilyn Davillier he has created an Infant-Parent Mental Health Post Graduate Certificate Program at the University of Massachusetts Boston as a sister to program he developed with Dr. Kristie Brandt in Napa. He consults for Dalmatian Press's educational books and other entities. He has worked with Dr. TB Brazelton on mother-infant face to face interaction, Newborn Assessment Scale and the Touchpoints Project. Dr. Tronick developed the Still-face paradigm and with Barry Lester the NICU Network Neurobehavioral Assessment Scale. He continues to do research on the effects of maternal depression and other affective disorders on infant and child social emotional development. His current research focuses on infant memory for stress and epigenetic processes affecting behavior. He has published more than 200 scientific articles and 4 books, several hundred photographs and has appeared on national radio and television programs. His research has been funded by NIDA, NICHD, NIMH, NSF and the McArthur Foundation. He has also served as permanent member of an NIMH review panel, and reviews for the National Science Foundations of Canada, the US and Switzerland. Dr. Tronick has presented his work to analytic societies including Berlin, Milan, Buenos Aires, Sao Paulo, Rome, Pittsburg, NYC, St. Louis, Kansas City and to societies and congresses including the N.Y. Academy of Science, the Society for Research in Child Development, the Marce' Society, the American Psychoanalytic Meetings, and numerous universities in the US and abroad.

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Kathy L. Abbott, IBCLC, RLC
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H 3897

My name is Kathy Abbott and I'm a member of the North Shore Post Partum Depression Task Force. Even though my work (I'm a Lactation Consultant in private practice and also a La Leche League Leader) involves post partum mothers, I have to admit I didn't really know much about Post Partum Depression, but being on this Task Force has taught me a lot.

To begin with, I learned that instead of thinking about PPD as a category to be checked off, we should instead be thinking about Post Partum Depression as a spectrum, and more importantly we should think of it as a very wide spectrum. And we should understand that every mother from the one who has just a touch of Baby Blues, to the mother who compulsively checks to see if her baby is still breathing, to the tragic mother who ends her baby's life, every mother needs and deserves our help. At one point or another every mother struggles with the adjustment of a new baby. It doesn't matter if she is a first time mother or the mother of five, at some point she will struggle in her ability to cope.

Now, does that mean that all new mothers are crazy? No of course not. What's crazy is that we live a country that constantly puts mothers between a rock and a hard place. The United States is one of only three countries in the world (that's developed/undeveloped countries) that does not have a law guaranteeing maternity leave, paid or unpaid. What's crazy is that in a country with health care as highly developed as ours, we don't allow our health care providers to spend the time they need to give their patients the attention they deserve. I know that our health care providers are caught in a time crunch and that spending the extra time it takes to care for the needs of a mother with post partum depression is going to cause a burden for some. But this is an issue needs our attention. As legislators you may know someone close to you who has struggled in some way. Maybe you've had friends or neighbors that you've worried about and didn't know how to help. Or maybe you were surprised to learn that a mother you know, who you thought was fine, was seriously struggling with depression, and that you had missed the signs entirely.

It happened to me. Fourteen years ago, before I became a mother myself, a friend of mine, her name is Darla, called me from the hospital the day after the birth of her baby. She was crying. After 19 hours of labor the doctors had gone ahead and performed a c-section. That was not the birth she had wanted and she felt traumatized. She had no mother herself, and no close friends with babies of their own, so she called me. I listened on the phone and soothed her as best I could. When I put down the phone I thought, "Wow. That was weird. Isn't childbirth supposed to be a happy time? Why is she being so dramatic?" Rather than going to visit her after the birth I left a card and a few rolls of film in her mailbox. She probably needs some time alone with her baby I thought. And as I knew nothing about babies there was really no point in having me there.

Four years later I had my own baby. And two weeks after the birth it hit me. My life was never going to be the same again. I felt totally overwhelmed. I cried for hours. I was grieving for

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my old life. My husband looked at me like I was nuts. "Didn't you know a baby was going to change everything?" his eyes seemed to say. Of course I knew. But still I grieved.

Last June our Task Force decided to ask a local reporter to do a story about Post Partum Depression. Because my old friend Darla is a hair dresser and hears a lot of women's stories I asked her if she knew anyone who might talk to a reporter. To my surprise she said, "You can tell him my story!" "What do you mean?" I asked. I was looking for a story with more than just a few tears after a birth. "I'll tell him about the hammers." She said. "What hammers?" I asked her. "When my son was a baby I was so worried that I might do something to him, that one day I got all the hammers I could find in the house and I took them out to the back yard. I threw them all into the woods so that I could be sure that I wouldn't hurt my baby." Wow! All these years and I had never heard that story before. I never knew.

Darla was never diagnosed with PPD. Her health care providers had missed it. I missed it. The reporter that I told her story to said he couldn't use her story. Why? Because there was no official diagnosis of Post Partum Depression. Two other women that I contacted who did have an official diagnosis, told me that we could use their story, but only if we promised not to reveal their names. Again our reporter declined. The story would not be told unless we could find a "poster child" willing to be in the spot light.

We now estimate that 10% of mothers experience some form of the spectrum that we call Post Partum Depression. And that the poorer a mother is, the better the chance that she will struggle with it. Ladies and Gentlemen this is a hidden epidemic. And worst of all we know that there is shame in being labeled as a mother with PPD. We need your help. We need a better safety net for mothers. We need to let them know that mothering a new baby is hard work. That it is normal to struggle. And that it is okay to ask us for our help. And when they do ask for our help our health care providers need to be prepared to give it to them. Passing this bill is the first step in identifying mothers at risk. It is the first step towards putting PPD on our health care provider's agenda. It is a small but needed step towards making it okay to talk about these issues without fear, and without shame. It's time to create the safety net that our mothers and their babies so badly need. This bill is a way to begin.

H 3897

Thank you,

Kathy Abbott

Kathy Abbott, IBCLC

Nurses United for Responsible Services
Representing Advanced Practice Psychiatric Nurses since 1974
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Testimony to the Joint Committee on Financial Services
Supporting House Bill 3897, *An Act Relative to Post-Partum Depression*
Presented by Jeanne Watson Driscoll, PhD, RN, PMHCNS-BC
Nurses United for Responsible Services
(January 27, 2010)

Co-Chairs Buoniconti and Koutoujian and Honorable Committee Members, my name is Dr. Jeanne Watson Driscoll. On behalf of Nurses United for Responsible Services (NURS), I appreciate this opportunity to testify before the Joint Committee on Financial Services in support of House Bill 3897, *An Act Relative to Post-Partum Depression*. NURS is an organization that represents Advanced Practice Psychiatric Nurses - Psychiatric Clinical Nurse Specialists and Psychiatric Nurse Practitioners - in Massachusetts. Most Advanced Practice Psychiatric Nurses have active behavioral health practices in which they provide psychotherapy and/or medication management. I am an Advanced Practice Psychiatric Nurse, in private practice with thirty years of experience specializing in women's behavioral health issues. I have co-authored two books related to mood and anxiety disorders that occur during the childbearing years (Women's Moods (1999) Sichel, D. & Driscoll, J.W. published by HarperCollins, New York and Postpartum Mood and Anxiety Disorder: A clinician's guide (2006) Beck, C.T. & Driscoll, J. W., published by Jones & Bartlett, Sudbury, MA) as well as published articles and video productions pertaining to this topic for both professional and lay audiences. I have all too often witnessed depression during pregnancy and in the post-partum period; I have seen firsthand the dramatic impact of proper treatment, which unfortunately, many women could be receiving - but are not receiving.

Perinatal depression is a significant problem in the Commonwealth, affecting approximately 15% of women who are pregnant or in the post-partum period. Untreated depression can have serious consequences not only for mothers but also for their children and families. It is now recognized that pregnancy, once thought to be protective against depression, is not. Women who are depressed when pregnant may not care for themselves optimally and are at increased risk for delivering infants prematurely with lower birth weights and smaller head circumferences as well as various other problems.

Maternal depression in the post-partum period can have a long term negative impact on children's intelligence, behaviors, and mental health. Interestingly, certain interventions, such as teaching mothers to wait for their infants' quiet-alert times and then making eye contact, can protect against long-term poor outcomes in children of depressed mothers even if the mothers remain depressed. In any case, increasing detection of perinatal and postpartum depression is a relatively simple step that can enable treatment and targeted teaching with enormous benefit for mothers, their children and society.

Perinatal depression is generally under recognized and undertreated. H. 3897, if passed, would help correct this situation by mandating screening and insurance reimbursement for that screening. Additionally, the bill would increase access to continuing education on perinatal depression for OB/GYN, family practice, and pediatric healthcare providers, establish a DPH-led multidisciplinary task force to promote collaboration among state and non-government agencies and individuals working on this issue and develop a culturally-sensitive, multilingual public awareness and education campaign. Equally important, this bill would expand the Early Intervention Partnership Program (a pregnancy and post-partum home visiting program for at-risk women) from nine to thirteen sites, thus allowing even more women and their children to benefit from added observation and support during the post-partum period.

Please vote favorably on H. 3897. It is a modest, yet prudent, investment in our state and its citizens.

Respectfully submitted,

Jeanne Watson Driscoll, PhD, RN, PMHCNS-BC
On behalf of Nurses United for Responsible Services

By Deirdre Wilson

When an Infant-Parent Bond is Broken

As parents, most of us know instinctively how to interact with our babies – the adoring gazes, gentle touches and affectionate coos come naturally. We delight in the way our infants make eye contact with us, follow our movements, smile or happily gurgle.

But some parents, especially those dealing with serious life events, are not as tuned in to their infants' emotional needs. A life-threatening illness, job loss, divorce or postpartum depression can distract a parent during what should be a joyful time of bonding.

Researchers say this kind of distraction can harm an infant's ability to learn at a crucial time of life and lead to serious mental health problems down the road, including depression, anxiety and acute separation fears.

The problem is fixable – a distracted parent taught to recognize and respond to an infant's emotional needs can repair the relationship and put everything back on track. But identifying the problem and helping the parent mend the broken bonds, is not easy, and many health providers feel inadequately trained in this area.

This fall, the University of Massachusetts in Boston will offer a new 10-week postgraduate certificate program in infant-parent mental health (learn more online at http://ccde.umb.edu/certificates/infant-parent-mental-health/). The goal is to teach social workers, psychologists, pediatricians, nurses and others to spot and help treat troubled infant-parent relationships, as well as early signs of other mental health disorders such as autism. The program will be directed by Dorothy Richardson, Ph.D., head of the Brookline-based Rice Center, which offers mental health services and support to parents and children in early life. It's based on an award-winning program developed in Napa, Calif., by Ed Tronick, Ph.D., who heads the Child Development Unit at Children's Hospital in Boston, and Kristie Brandt of Napa's Parent-Infant & Child Institute.

Damage and Repair

A renowned researcher, Tronick has long studied the infant-parent relationship and how it affects a baby's overall wellbeing. He's best known for his "still face" studies: In experimental settings, he instructed a parent to keep a

straight face and not engage with his or her infant no matter what the baby did to get the parent's attention. Tronick discovered that, after a short time, the infant would give up trying to engage the parent and even display a sense of shame, turning his or her head down and away.

Under normal circumstances, Tronick believes there's a mismatch in the parent-infant relationship about 60 percent of the time (a parent on a phone call, for instance, may not notice an infant's efforts to interact). But most parents eventually respond to their baby's needs. And each time this happens, the infant and the relationship itself experiences crucial growth.

When it doesn't happen on a consistent basis, however, real damage is done. "You see depression in infants where this happens over repeated periods of time," Richardson says. "The infant becomes preoccupied with the task of self-soothing and parts of their brain are not available to explore their environment and learn."

These infants may also have serious problems with colic, feeding, sleep or simply regulating themselves, Tronick says. Infant-parent relationship problems are not new, he adds, pointing to the stress families felt during the Great Depression, World War II, and now in the current economic downturn. "These high levels of stress compromise parenting," he says. And the hope is to better equip health providers to help parents repair broken bonds and prevent more serious issues later in their child's life. ✦

Deirdre Wilson is senior editor of the *Boston Parents Paper*.

Children's Hospital Boston

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Joint Committee on Financial Services
January 27, 2010
HB3897-An Act Relative to Post-Partum Depression
Sponsor-Representative Ellen Story

Good afternoon Chairman Koutoujian, Chairman Buoniconti and members of this Committee. Thank you very much for allowing me the opportunity to testify before you today on behalf of Children's Hospital Boston.

My name is Shari Nethersole. I have been a practicing Primary Care Pediatrician at Children's Hospital Boston for the past 25 years and have been the hospital's Medical Director of Community Health for the last 5 years. I am also an Assistant Professor of Pediatrics at Harvard Medical School.

I'm here today to testify in support of *House Bill 3897- An Act Relative to Post-Partum Depression* and its' attempt to improve the early detection of maternal or peri-natal depression in mothers by screening in pediatric practices. My goal today is to address for you the perceptions, adjustments and progress in pediatric primary care subsequent to the incorporation of formal screening tools in practice.

I would like to begin with a brief overview of the make up of the primary care practice at Children's. Children's Hospital Primary Care Clinic (CHPCC) is the single largest provider of primary care to children in the City of Boston. We provide care to approximately 12,000 children and youth per year. As you know, children are seen on average 2-3 times per year-the total number of visits resulting for the patients we see annually is over 36,000. CHPCC is open 6 days a week and 5 evenings. We see children ages birth through young adulthood. Our children and families come from largely underserved communities with over 60% on Medicaid and the majority being minority.

Since my training in pediatrics in the early 80s, medicine has made great strides: there have been significant advances in both the science and practice of medicine. Our challenge now is to make certain we apply that knowledge consistently and correctly. As part of my pediatric clinical training, we were taught to ask a few questions about child development. My colleagues and I would choose questions randomly from the Denver Developmental screen to ask parents and to assess for delays or abnormalities—there was no consistency.

In general, there was no *formal* assessment of children's development, mental and behavioral health, substance abuse experiences, used in pediatric primary care practices in Massachusetts until 2006- although many of these have been available for a number of

years. I would like to also add that there have been for many years' behavioral developmental pediatricians who have been committed to assessing for delays and are largely responsible for the development of the tools being used.

In the absence of these formal screening tools, for the past 15 years Children's has used specific age-based visit forms to direct questions to get at these delays. These were quite useful for younger children but, in my opinion, of little value for the older children with behavioral delays. For many practices not using specific forms, developmental and behavioral assessment queries were inconsistent and physicians used observation as the basis of their judgment.

The screening tools have improved our practice—our visits are now more patient/parent centered, delays or abnormalities are identified earlier and proper referrals made. Prior to the implementation of the screenings, it was up to the provider to observe abnormal development and behavior; now the parents help direct the provider to hone in on specific concerns for further evaluation. It also gives parents much greater opportunity to address their concerns—such as how the child speaks, behaves, family worries, etc.

To illustrate my point I would like you to refer to the PEDS Response Form and Pediatric Symptom Checklist that we have distributed. As you can see, parents complete these forms for the younger children; the older children complete a related questionnaire themselves. Tools such as these have significantly improved our care and the early identification of developmental, cognitive, emotional and behavioral health problems in children and youth so that appropriate interventions can be started as soon as possible.

In addition, the use of these tools open up the conversation for parents to raise issues and concerns they may never have considered important during the pediatric visit. They can also be used as an educational tool and help parents better understand age- appropriate behavior. The parents' responses to the questions immediately allow me to hone in on their concern and provide the necessary supports-making the visit more productive.

Screenings have also allowed me to be more efficient—while I have always been good at picking up developmental delays—the screenings confirm the findings (positive or negative) and allows parents to talk about other family issues that may have an impact on the child-not directly pertinent to developmental delays. For the older youth, it has definitely helped me pick up things that otherwise would have been missed. Screenings have improved my practice in ways both expected and unexpected.

It did take a while, about a month, to incorporate the screenings into our practices and make things doable—we now are much more efficient with our time and issues of importance for families and identifying developmental and behavioral issues early and getting children and families the necessary care to prevent more severe problems.

Just as we have improved the early identification and referral of children with developmental and behavioral disorders by asking about these in a formal, validated way, asking the mother about maternal mental health improves our understanding of the

child's risks and helps direct us to the necessary referral options. Very effective screening tools that identify maternal depression are available for use in pediatric practices and can readily be incorporated at least during the 0-4 month well child visit. We have demonstrated that the use of screening tools improve our practice, it helps us apply what we know works into our practice.

In conclusion, I strongly recommend building the peri-natal depression screen into pediatric practice and would like to make two points:

- The use of formal, validated screenings have significantly changed and improved our practice in pediatrics particularly in the early years
- Pediatric practices are well situated to incorporate maternal depression screenings

Again, thank you for allowing me to testify before you today. I welcome the opportunity to address any questions or concerns that you may have.

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Joint Committee on Financial Services
January 27, 2010
HB3897-An Act Relative to Post-Partum Depression
Sponsor-Representative Ellen Story

Good afternoon Chairman Koutoujian Chairman Buoniconti and members of this Committee. Thank you very much for allowing me the opportunity to testify before you today on behalf of Children's Hospital Boston.

My name is Dr. Alison Schonwald and I am a Developmental Behavioral Pediatrician at Children's. I'm also an Assistant Professor of Pediatrics at Harvard Medical School. I have been at Children's since 1995. My special interest and expertise is in the early identification of children with developmental and behavioral disorders, autism spectrum disorders, etc.

I'm here today to testify in support of House Bill 3897- An Act Relative to Post-Partum Depression and its' attempt to improve the early detection of maternal or peri-natal depression in mothers by screening in pediatric practices. There is an intrinsic link between maternal depression and the developmental progress of the infant. Therefore, the early identification of developmental disorders is critical to the well-being of children and their families.

The MA experience with peds screening tools: I will begin by framing for you the experience in Massachusetts with developmental, mental health and substance abuse screenings and the implementation of these in pediatric practices across the state. The use of validated screening tools in peds practices is the gold standard of evidence based and evidence informed care-it has proven to be a more effective way to identify (early) those children with developmental and behavioral disorders than previous unstandardized and more variable methods.

Over the past several years, Massachusetts has succeeded in convincing pediatricians to change their practices and implement validated screening tools. This was not an easy transition (My colleague, Dr Shari Nethersole, will speak to the perceptions, adjustments and progress in this area). This important and significant change came about from two directions: first, in 2006 the American Academy of Pediatricians released a policy paper on the identification of infants and young children with developmental disorders; and secondly, also in early 2006, all MA Health insured children were required to be offered voluntary validated behavioral health screenings as part of their well child visits (landmark decision that the Commonwealth is violating the federal Medicaid Act by

failing to provide periodic screening, diagnosis, and home-based treatment services to an estimated 15,000 children with serious emotional disturbance). In Massachusetts both public and private payors reimburse pediatric providers for these screenings.

Children's experience counters the arguments: Clinicians at Children's were using screening tools prior to the Rosie D mandate and the release of the AAP policy paper. In 2006, Children's Primary Care Practice providers implemented routine developmental and social emotional screenings at each well child visit, ages 6 months to 5 years old. We wanted to improve practice and to address the perceived obstacles and concerns: that screenings would be impossible to add to existing visit requirements, that the use of screening tools would be burdensome in practice- increase visit time, not be effective, place further demands on referral systems, etc. Our data at Children's and the Martha Eliot Health Center show that the implementation of screening tools is both feasible and effective in large urban practices and they, in fact, do increase the rate of early identification of developmental and behavioral concerns and do not put extra demands on the visits. Equally important, parents were happy with the opportunity to speak with their pediatricians about these issues. Our findings have been published in Pediatrics, the most significant peer reviewed journal for pediatric practices; this further supports the validity of our data. Our experience is recognized statewide and nationally: Mass Health cites Children's on their website as a model for successful implementation of screenings. Our website www.developmentalscreening.org describes our experience for others to use when starting to screen in their offices, and has over 2000 visits per month. I have included for your reference our published research findings and examples of the screening tools

How this relates to the proposed peri-natal depression screening proposed in HB3897: I see a parallel situation here to the maternal mental health screening tool being proposed in HB3897. Many of the same questions and concerns addressed above will emerge- time, resources for referral, how to manage the questions, how to document in the chart, how to bill and the answer to thee question, "why screen in pediatric visits?" Many providers feel they are doing a good job already and wonder if they really need to include a validated screening. In my opinion, as a Developmental Pediatric specialist, screening for maternal depression in pediatrics is critical because of the link between the child's development and the mother's mental health (as well as the potential risk). With the necessary billing codes in place and pediatric practices already implementing screening tools, this is quite possible.

I want to conclude with 3 points and a recommendation.

- Maternal depression screenings should be an integral part of pediatric practice in the first year of life because of the link to child development and the associated risk.
- Pediatric practices are well situated to incorporate these screenings
- Pediatricians already ask many questions about risks to development a child might be exposed to in his or her environment. We already document these in the child's record—housing situation, physical and mental health of family members, parental job situation, etc---these are all critical to the well being of the infant/child—asking about maternal mental health in a validated way improves our existing practice, it

improves our understanding of the child's risks and helps direct us to recommend the necessary referral and treatment options.

I strongly recommend building the peri-natal depression screen into pediatric practices and suggest replacing the current 0-3 month social/emotional screening with a maternal depression screening. This is a much better use of time and critical for the child, mother and family.

Again, thank you for allowing me to testify before you today. I welcome the opportunity to address any questions or concerns that you may have.

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Joint Committee on Financial Services
January 27, 2010
HB3897-An Act Relative to Post-Partum Depression
Sponsor-Representative Ellen Story

Good afternoon Chairman Koutoujian, Chairman Buoniconti and members of this Committee. Thank you very much for allowing me the opportunity to testify before you today on behalf of Children's Hospital Boston and on behalf of both the professional mental health community of which I am a part and the parents and children we serve.

My name is Dr. William R. Beardslee and I have been a child psychiatrist at Children's for 30 years. I am also the Director of the Baer Prevention Initiatives and a professor at Harvard Medical School.

You will hear testimony today from a number of survivors of maternal depression, clinical practitioners, researchers, advocates, program administrators and leaders who will share their experiences and support of this bill with you. These will be powerful words that I have every confidence will move you deeply. This is a significant bill with substantive community and professional support that will have far reaching benefits for mothers with depression and their families.

The time for action is now. The scientific knowledge base is such that we know not treating parental depression is very costly to parents and to children and we know how to treat it and even to screen for it. I have been a researcher in this area for more than 30 years. I have followed the research closely and that is the inescapable conclusion. I applaud you for considering this legislation.

We must attend to this issue first and foremost because of the suffering it causes and because it puts mothers and children at risk.

- One in eleven infants will experience their mothers' major depression in the first year of life. you will hear from many eloquent people today but in my own work, others' words stand out. One said, "Depression attacks the soul." And the other said, "It is circles within circles ... a sadness out of control." We must attend to the suffering.

- Second, this bill is very timely. The Institute of Medicine, the most prestigious scientific body in the United States, recently concluded in two publications the promise and potential lifetime benefits of preventing and treating mental, emotional and behavioral disorders in children and families. I was privileged to be one of the authors of both of those reports. We, in those reports, recommended actions such as this legislation. We are now able to demonstrate that clear, practical public health interventions can have a powerful impact on reversing the pain of depression and the devastating impact on children and families;
- Third, the research of myself and my team at Children's Hospital Boston and the Judge Baker Children's Center over the last 30 years has shown that we can intervene effectively with parents with depression such that they can be effective parents and their children can develop resilience. We have followed a group of families for more than five years with public health preventive interventions and demonstrated their value. These strategies have been used in a number of countrywide programs in Europe, one in Central America, and we have applied the principles to help mothers struggling with depression in Head Start and related early childhood centers. We know what is needed and this bill embodies those principles.
- So because of the progress of science and the awareness of the suffering, the time to act is now. We know what needs to be done: screenings to identify woman at risk, referrals for vital treatment and support services and public education. These are the salient points in this legislation.

Why is this important and necessary?

Maternal depression is particularly worrisome because of its prevalence. An estimated 15% or 11,500 expecting and new mothers in Massachusetts suffered from maternal depression in 2007. The rates of depression are even higher for those we should be most concerned about, that is, mothers with previous histories of depression or those experiencing other stressors, such as financial hardship or social isolation. Financial hardship and social isolation are particularly prevalent now given the profound recession in our economy. Despite the frequency of depression among new mothers, large numbers of affected individuals may not be identified as having a treatable condition, and only 15% obtain the necessary professional care-that is 1-2 in 10 get the care they need! But just as tellingly, studies demonstrate that we have treatments that work and that can work with a wide array of parents.

Mothers with maternal depression suffer silently from feelings of despair, guilt, anxiety and the fear of hurting themselves or their babies. Unfortunately, in most cases, the depression goes undetected because mothers mask their feelings in response to the stigma that is associated with reaching out for help.

Scientific data shows that maternal depression is treatable when identified early. By intervening early, the likelihood that children of depressed mothers will grow into health, capable, fully contributing members of society is increased. The continuing failure to address the consequences of depression for large numbers of vulnerable infants and children, represents a huge missed opportunity. Let us address that now and pass legislation that will provide the vital help that parents and their children need.

Again, thank you for allowing me to testify before you today. I welcome the opportunity to address any questions or concerns that you may have.

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