

Janice Goodman
Testimony regarding House Bill 3897
An Act Relative to Postpartum Depression

My name is Janice Goodman. I'm an advanced practice psychiatric/mental health nurse, an associate professor at the [MGH Institute of Health Professions School of Nursing](#), and a [Robert Wood Johnson Foundation scholar](#) with a program of research focused on postpartum depression. Most importantly, however, I'm a clinician who specializes in providing mental health treatment for pregnant and postpartum women.

I thank you for this opportunity to testify. I want to make a few brief points.

My first point, and perhaps the strongest argument for routine depression screening of all pregnant and postpartum women, is that fact that *you can't tell who's depressed just by looking.*

Research consistently shows that the majority of women suffering from postpartum depression are never diagnosed. Massachusetts has an exemplary standard of care, with some of the best doctors, nurses, and hospitals in the world, but often, the best we offer is a quick 'how are you feeling'. With postpartum depression, I have found time and again that this isn't enough.

In a recent study which I conducted here in Boston and which will be published next month in the Journal of Women's Health, fewer than half of the pregnant women who screened as depressed on a short 10-item questionnaire during pregnancy, and only 25% who screened as depressed at 6 weeks postpartum, were identified by their provider as having symptoms of depression. This is not because these women didn't have great doctors and nurses. It is because, without a structured screening program which uses a reliable standardized questionnaire, depression is missed and women fall through the cracks. Even the best provider will miss most of the patients who suffer from postpartum depression.

The good news is, however, that a simple 10-item questionnaire that women can fill out in the waiting room before a visit, can substantially improve depression detection rates. It is quick, easy to administer, easy to score, and the health care provider need only follow up with women who score above a certain point.

My second point is that: If postpartum depression isn't detected, women aren't going to get help.

In our research, only 25% of the women who were depressed were referred for help by their health care provider. Mainly this is because providers hadn't detected depression and therefore no referral was made. There is a silver lining here, however. When providers did identify women who were struggling with symptoms, they did a really good job of referring them for help. It's identifying women who need help that is key.

What are some of the reasons why it's so hard to for providers to identify women who are depressed? I conducted interviews with a subsample of women in our study which gave some insight into this. Women told me that the pace of their medical visits makes it hard for them to trust and open up to their care provider about emotional or mental health concerns. And then, of course, there's *stigma*. It doesn't feel okay to talk about depression, especially when you're pregnant or you've just had a baby. These are supposed to be happy times. Women fear that they are bad mothers because of the way they feel. Also, many women *don't recognize it themselves when they're depressed*. They assume that feeling bad, or tired, or overwhelmed, or whatever, is par for the course. They don't realize that it's not normal and that they don't have to feel this way. Routine screening of all pregnant and postpartum women would overcome all of these particular barriers. It would be a standard part of a visit, the permission to talk about it would be explicit, stigma would be reduced because no woman would be singled out, and women who assumed this was normal, would find out differently.

My third point is that postpartum depression can occur at any time – it can start in pregnancy, in the first few weeks or months postpartum, or even several months after a baby is born. My own research as well as that of others shows that depression rates are equally high during pregnancy as they are at 6 weeks postpartum and as they are even at 6 months postpartum. Therefore, screening can't be a one-time deal. It needs to begin in pregnancy and then be repeated at various times throughout the postpartum period.

My fourth point is that women desperately want help

I served as the Massachusetts coordinator for [Postpartum Support International](#) from 2002-2006. During that time I established a state-wide, toll-free “Warmline” where women and families could call and receive information about postpartum depression and a list of resources in their area where they could get help. Answering those phone calls, I heard many stories of families trying for days, weeks, sometimes months, to find appropriate help. Many times their requests for help had been ignored, or minimized, or they had been sent to places that were not appropriate. I have heard the same kinds of stories from patients who I see in my private practice – sometimes it takes a long time before they get to me, or to someone else who can provide them with the help they need. We need to do better than this.

My final point is that postpartum depression is very treatable.

There really is good news here. We can do a lot to prevent and treat this problem. Once depression is identified, there are a number of effective treatments. Sometimes a support group with other women coping with postpartum depression is all a woman needs to get back on track. Sometimes, therapy, medication, or a specialized home visiting program is needed.

Of course, prevention and early intervention is best. The earlier a woman receives help, the greater the chance for a speedy positive outcome. Without treatment, postpartum depression can severely impair a woman's/a mother's well-being and functioning. Untreated depression can persist and become chronic. Worst case scenario, it can lead to suicide and/or infanticide. Intervening early is also critical for the baby because of the

negative effects that postpartum depression has on mother-infant relationships and on infant development. Time really is of the essence, because the longer a mother is depressed, the more negative the effects for the child.

So what do we need?

- We need to increase public awareness and education about perinatal depression, and we need to reduce the stigma around it
- We need mental health screening to be a *routine* part of care for pregnant and postpartum women and we need to *use standardized tools* to screen
- We need health care professionals who have contact with pregnant women and mothers of young children to be well educated about perinatal depression and competent to screen, refer, and, in some cases, treat it
- We need to increase the cadre of mental health providers who can provide specialized care to these women and families – including treatment for mothers and babies together, which is so important.
- We need to improve the availability and access to mental health care for perinatal women. If a woman screens positive, she needs further assessment and timely treatment. It is not a problem that can wait. As a woman in one of my studies so pointedly stated (and I quote):

“For some people it’s really hard to get to that point where they’re like, ‘I need help.’ And then they call and they’re like, ‘Well, we can’t see you for 3 months.’ You know well like, what the hell am I supposed to do for 3 months?? It’s like calling the suicide hotline and getting put on hold.”

Thank you for your consideration of this very important bill.