RESEARCH BRIEF
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Helping Mothers, Helping Babies:
Advocating for a Two Generation Approach to Treating Perinatal Mood and Anxiety Orders

INTRODUCTION

Georgia is currently experiencing a maternal health crisis, which has devastating effects not only for mothers, but for their children. The state is ranked last in the nation for maternal health outcomes by Amnesty International.[1] Maternal mental health is of specific concern. A study committee on Maternal Mortality conducted in Georgia in the Fall of 2019 listed mental health conditions as one of the causes of pregnancy related deaths.[2]

Studies show that not only are mothers impacted by mental health conditions, but their children are too. For example, when a mother experiences depression after giving birth, children can experience lasting effects, such as behavioral problems, depression symptoms, and stress-related health issues.[3] This is especially of concern in Georgia where responses to the 2017 Pregnancy Risk Assessment Monitoring System (PRAMS) showed more than 50% of new mothers reported feeling "down, depressed, or hopeless."

To assist more mothers and their children through these challenges, the state should implement strategies to support both mothers who experience pregnancy related mental health conditions such as Perinatal Mood and Anxiety Disorders (PMADs) and their children. While Georgia currently has evidence-based models such as home visiting and dyadic treatment available in a limited capacity, these services are not widely accessible enough to address the prevalence of PMADs. These practices are promising approaches to improving mothers and children's social-emotional well-being and should be adequately supported. Additionally, statewide policy change, such as extending pregnancy Medicaid to one-year postpartum, could provide additional access to care for Georgia's mothers.

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IMPORTANT TERMS:

- **Perinatal Mood and Anxiety Disorders (PMADs):** An umbrella term that encompasses maternal mental illness during pregnancy and up to one year postpartum. These disorders can affect all women - regardless of ethnicity, age, or socioeconomic status. Perinatal mood and anxiety disorders constitute a spectrum of mental illnesses. Often, the term "postpartum depression" is used to generalize these conditions, but mothers can experience more than just depression.[4]
- **Screening Tools**: Questionnaires completed by parents or healthcare providers to determine, for example, if a mother is experiencing depression or if a young child is experiencing social-emotional challenges.
- **Dyad**: Two individuals (like a mother and child) who have a significant relationship with one another.
- **Dyadic Treatment**: An approach in which a clinician treats a young child and parent/caregiver together.
- **Pregnancy Risk Assessment Monitoring System (PRAMS):** A surveillance system used to gather data on maternal attitudes and experiences during the perinatal stage of a mother's life.[5]

THE RELATION BETWEEN MATERNAL HEALTH AND CHILD OUTCOMES

PMADs can have long-term effects on the mother-child relationship; these disorders are correlated with delayed language and cognitive development and behavioral problems in children. The development and maintenance of the maternal-child bond through adequate treatment of PMADs is paramount for the continued growth and development of both the mother and the child.[6]

The relationship between mother and child is critical, especially during the first three years of life, when children's brains are growing most rapidly. Children learn through experiences with caregivers who engage and model behaviors vital to development. The serve and return interaction, when a caregiver appropriately replies to a child's gesture, speech, or eye contact, deepens neural pathways and promotes healthy attachment.[7] A sensitive, loving relationship between a caregiver and child full of serve and return interactions creates the foundation for long-term social-emotional health that is crucial for future success.[8]

Untreated PMADs cost the U.S. an approximate $14.2 billion for all births in 2017, with the average cost per mother-child pair at $32,000.[11]

PMADs can limit such serve and return interactions, affecting children's social-emotional development. Research indicates that children as young as three months can detect symptoms of depression in their mothers. Limited interaction between mother and child as a result of PMADs is associated with reduced cognitive, social, and emotional capabilities in children.[9] Infants of mothers who experience depression or anxiety may exhibit less smiling and vocalizing and exhibit more crying.[10] These effects are compounded by other symptoms of mood and anxiety disorders such as difficulty following up with a child's health care.

This brief will discuss the prevalence of PMADs in Georgia, outline the limited landscape of currently available services, and recommend ways the state can go further to support mothers and children.

PROMISING APPROACHES

Dyadic Treatment addresses the caregiver-child relationship and teaches positive interaction and emotional regulation for both mother and baby.

Child First is a dyadic treatment supported by the strongest form of evidence (randomized control trials) and has shown to be effective among diverse populations at reducing PMADs as well as negative child behavior.[12]

Two common dyadic treatment interventions are Parent Child Interaction Therapy (PCIT) and Child Parent Psychotherapy (CPP). PCIT is intended for children 2 to 7 years of age while CPP is intended for 0 to 5 years of age.

One study on the effectiveness of PCIT followed mothers and their children through the program, comparing the experience of mothers who exhibited maternal depression symptoms to those who did not. Initially, the children of mothers who experienced depression were reported to show more challenging behaviors when they initially joined. By the end of the program, not only had both groups experienced significant improvement in the children's behavior, but the mothers who were experiencing depression reported significant decreases in depressive feelings.[13]

Home Visiting is the practice of trained professionals meeting with families in a community setting. Home visitors work with families on improving health outcomes, understanding child development, and enhancing parenting techniques. Evidence-based home visiting programs have been shown to address PMADs.[14] In one study, regular checkups by home visitors to screen for PMADs led to a 65% increase in participating mothers accepting referrals to community-based support groups to manage their symptoms.[15] Home visiting removes transportation barriers to provide greater access to care.

PREVALENCE OF PERINATAL MOOD AND ANXIETY DISORDERS IN GEORGIA MOTHERS

Nationally, perinatal depression is estimated to affect 1 in 10 women.[16, 17] In Georgia, more than 50% of new mothers reported at one point feeling "down, depressed, or hopeless," and 49% reported that at one point they were "having little interest or pleasure in doing things." [18] These reports, however, may be the tip of the iceberg as the American Academy of Pediatrics (AAP) calls PMADs, "the most underdiagnosed obstetric complication in America".[19]

While all mothers are at risk for PMADs, certain are at a higher risk. Young mothers between 14 and 18, mothers who have a low socioeconomic status, and mothers who are African American, Hispanic, or uninsured are at a higher risk for PMADs than their older, whiter, wealthier counterparts.[20] Poverty especially exacerbates the risk for PMADs. Fifty five percent of mothers living at or below the federal poverty level (FPL) reported experiencing depressive symptoms.[21]

Women with co-occurring substance dependence prior to or during pregnancy are also at a higher risk.[22] Despite the prevalence of PMADs in mothers across Georgia, it is estimated that only one-fifth of women who experience symptoms during pregnancy or after childbirth seek treatment.[23]

LACK OF OPTIONS FOR GEORGIA'S MOTHERS

While some resources for new mothers exist in the state, expansion of services specifically targeted to support mothers

Georgia's current, limited landscape includes:

- Pregnancy Medicaid, which covers 50% of Georgia's births, ends just sixty days after a mother delivers.
- Limited numbers of families in only 20 of Georgia's 159 counties have access to Georgia Home Visiting programs despite studies showing that evidence-based home visiting programs mitigate the effects of PMADs.[24]
- Pediatricians can bill a child's Medicaid number when conducting PMAD screenings at periodic well-child check-ups. If screened positively, mothers without insurance are referred to a help line.

BARRIERS TO MOTHERS RECEIVING CARE

Mothers across the state have difficulty accessing services to help treat their PMAD symptoms. Barriers that exist for mothers include lack of access to health care, stigma surrounding mental health treatment, fear of child protective services, and difficulty finding culturally-sensitive care.

Health Care

Pregnancy Medicaid is critical for mothers in Georgia. Over 50% of births in the state are covered by pregnancy Medicaid, meaning many women rely on the public health insurance option for postpartum care. Currently, however, pregnancy Medicaid ends sixty days after birth, creating a significant barrier to a woman's ability to access services. Even when low-income mothers were screened "overcoming the next set of barriers was often too difficult."[25] Mothers are often not familiar with where to get treatment for postpartum depression, and financial barriers, often due to lack of adequate insurance coverage, means that many mothers do not have a primary care provider.[26] Low-income mothers are at an especially high risk for PMADs, yet they are less likely to have access to or knowledge of available healthcare services.

Postpartum Support International (PSI) has a help line, online support groups, and online chat with experts available to mothers for free. PSI coordinators in every state aid women and their families to triage needs and find location specific services. For prescribers, PSI offers webinar trainings and a psychiatric consultation line.

In Georgia, PSI has a website listing providers who are specifically trained in perinatal mental health. PSI Georgia also offers support groups across the state, educational materials, and live recordings with experts in the field of perinatal mental health. For providers, PSI Georgia conducts trainings for providers on best practice for screenings.

Due to the lack of primary care for mothers, pediatricians are tasked with screening for PMADS. Medicaid in Georgia currently reimburses pediatricians for PMAD screenings. In the case of a positive screen, the pediatrician is directed to refer a mother to receive care elsewhere – sending a mother back into the void of healthcare options. Pediatricians report feeling insufficiently trained in PMAD screening, which can lead to missed diagnoses.[27]

Furthermore, when a mother cannot or will not access outside services, pediatricians, who are not trained mental health providers, report feeling responsibility for managing mothers' symptoms themselves.[28]

Stigma and Fear

Beyond navigating a fragmented path through the health care system, mothers have difficulty seeking or maintaining treatment because of stigma and fear associated with PMADs.

Women across racial and ethnic groups reported fear of being reported to child protective services as a major barrier to reporting feelings of depression or anxiety.[29] Others reported feelings of judgement, specifically a fear they would be seen as bad mothers, as a reason for not reporting PMAD symptoms.[30] These phenomena are compounded when PMADs co-occur with substance dependence. Mothers who experience substance dependence may be more reluctant to seek services for themselves and their children due to stigma and fear.

This is especially troubling because children born with fetal alcohol spectrum disorders (FASD) and neonatal abstinence syndrome (NAS) require significantly more care than children who are born without FASD or NAS.[31] Without strong policies to support mothers experiencing PMADS co-occurring with substance dependence, children with FASD and NAS will be left further behind with few options to address their needs.

Culturally Appropriate Screening and Treatment

Racial and cultural barriers can be a major deterrent for mothers seeking treatment for PMADs. Mothers across racial and ethnic minorities reported that a lack of cultural sensitivity among providers and language barriers caused impediments in seeking and receiving care.

Despite evidence that Black and Latina women are more at risk for PMADs, White women are more likely to report seeking help when feeling depressed, receiving a PMAD diagnosis, and initiating treatment.[32, 33] Georgia should focus on providing culturally sensitive training to providers and developing culturally appropriate screeners for Georgia's diverse population.

Mothers also reported lack of child care and lack of transportation as major barriers to accessing treatment for perinatal mood and anxiety disorders.[34]

Strategies & Opportunities

States across the country have prioritized maternal mental health in order to support mothers and children. In order to support mothers in this state, Georgia policymakers should invest in maternal health care by extending pregnancy Medicaid, considering options where mother and baby can be treated together, developing culturally sensitive PMAD screeners, and expanding programs such as home visiting.

Extend Pregnancy Medicaid

Currently, pregnancy Medicaid lasts for 60 days after birth. PMAD symptoms often present later than 60 days after birth and require ongoing care for proper treatment. **Extending Medicaid to twelve months after birth** would cover mental health treatment for new mothers and later diagnoses. Medicaid is especially important to leverage as low-income mothers are more at risk for PMADs. This recommendation has support from two Georgia House Study Committees conducted in 2019: one on Maternal Mortality and another on Infant and Toddler Social and Emotional Health.[35]

Allow Reimbursements for Treating Mom and Baby Together

Pediatricians and other child-serving professionals should be encouraged to refer a mother and baby for treatment together when either member of the dyad faces emotional challenges. Such dyadic treatment allows mother and baby to be seen together and should be billable under the child's Medicaid number, allowing for the mother to receive treatment after her pregnancy Medicaid ends.

Develop Maternal Mental Health Screenings for Georgia's Diverse Population

Georgia has an incredibly diverse population and should work to develop PMAD screeners that can serve every resident of the state.

Expand Home Visiting

In 139 counties, Georgians do not have access to a home visiting program. Expanding home visiting to additional counties will allow more families to access these evidence-based services.

Conclusion

Georgia's children depend on adequate support for their caregivers. This report has shown the importance of positive early experiences for children and how their primary caregiver, often their mother, plays a critical role in shaping their brain architecture for lifelong success.

By investing in Georgia's mothers by extending pregnancy Medicaid, supporting dyadic treatment, providing culturally appropriate screening and care, and expanding home visiting, policymakers will support not only mothers but Georgia's next generation.

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