Lily*, a financial professional and mother in her 30s, came to Cambridge pediatrician Dr. Michael Yogman’s office for her baby’s two-month well-child visit. To the experienced office staff she seemed like any new mother. But the Edinburgh Postnatal Depression Scale (EPDS) revealed that she had symptoms of depression. In an in-depth interview with Dr. Yogman and the practice social worker, Lily confided that she had a history of depression and anxiety, had very specific suicide plans, and contemplated throwing the baby, who was very colicky, out the window.

She was immediately sent to a Boston hospital emergency department for treatment of postpartum depression (PPD). She received inpatient treatment and outpatient psychotherapy. At the baby’s four-month visit, he was smiling and happy, and Lily and her husband described the intervention as “life-saving.”

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“Postpartum depression is a hidden epidemic: it’s under-identified and vastly undertreated. If we treat maternal depression, a major source of toxic stress, we could decrease infant emergency room admissions and improve outcomes later in life,” says Dr. Yogman, who routinely screens mothers (and sometimes fathers and other caregivers) at one, two, four, and six months during the postpartum year.

PPD affects nearly 20 percent of mothers: in Massachusetts, with 72,835 births in 2010, that translates to 9-14,000 mothers with depression. In July, MCPAP is launching *MCPAP for Moms*, which will provide perinatal providers with the information and assistance they need to screen, identify and refer mothers for treatment. While the program’s focus is on depression occurring in pregnant and postpartum women, it will also address depression in fathers and adoptive parents.

“Postpartum depression is associated with attachment difficulties and an increased risk of anxiety and/or disruptive disorders among children of depressed mothers. It is associated with changes in the children’s social, cognitive, and psychological development. PPD also increases the risk of the father or partner becoming depressed,” says John Straus, MD, MCPAP Founding Director.

**A Focus on Prevention**

One major study screened 10,000 women for PPD and found that one-third of women with PPD developed depression during pregnancy. Overall, the greatest predictor for PPD is a prior history of depression.

*MCPAP for Moms*’ goal is to have providers conduct two prenatal and four postpartum depression screenings. “Two-thirds of women with postpartum depression could be identified before the birth of their child, and the condition could be addressed before it has negative consequences,” says Dr. Straus.

Providers should also monitor the mental health of fathers and other caregivers as well as adoptive parents.

MCPAP for Moms will address the barriers that have prevented effective PPD diagnosis and treatment: stigma, lack of provider training, lack of referral networks and resources, and limited access to mental health treatment. “Just as we have helped pediatric providers address children’s behavioral health, we will support them in addressing parents’ mental health in this very crucial period,” says John Straus, MD, MCPAP Founding Director.

**A Comprehensive Program**

Directed by UMass Memorial Medical Center, *MCPAP for Moms* features three core components:

- Training and toolkits for obstetric and pediatric providers featuring evidence-based guidelines for depression screening, triage and referrals, risks and benefits of psychotropic medications, and discussion of screening results and treatment options. The training materials, toolkit and additional resources will also be available on our website at [www.mcpapformoms.org](http://www.mcpapformoms.org).
- Real-time psychiatric consultation and care coordination for providers serving pregnant and postpartum women and their babies.
- Linkages with community-based resources including mental health care, support groups, and other resources to support the wellness and mental health of pregnant and postpartum women. A database of statewide PPD resources is being developed by the Massachusetts School of Professional Psychology Interface Referral Service. Information about community and psychosocial supports will be available at the *MCPAP for Moms* website: [www.mcpapformoms.org](http://www.mcpapformoms.org).

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MCPAP for Moms is partnering with MotherWoman, an organization for mothers based in Hadley, MA, to develop perinatal support coalitions in six communities that will ensure that pregnant and postpartum women with depression receive the care and treatment they need. Based on MotherWoman’s successful Community-Based Perinatal Support Model®, the coalitions will be guided by a leadership team and include a perinatal support group for mothers at risk for or experiencing PPD. MCPAP for Moms’ eventual goal is to have support groups available at every birthing hospital.

“We want to create an environment where women feel comfortable discussing depression with providers without fear of being stigmatized or losing custody of their child and providers are empowered to discuss the condition with mothers, screen, and make referrals to appropriate resources. Creating those resources is a key part of the program,” says Dr. Byatt.

“Having a program that trains providers and provides resources and referrals is critical; it will make providers more comfortable jumping into an area they aren’t experienced in,” says Dr. Yogman.

How the Program Will Work

MCPAP for Moms will serve the following providers:

- Obstetric providers – obstetricians/gynecologists, midwives, labor and delivery nurses, and family physicians
- Primary care providers (internists, family practitioners) of mothers who are post-partum
- Front-line psychiatric and mental health providers, such as psychiatrists, psychiatric nurses, psychologists and social workers

Because pediatric providers do not serve moms directly, their role is one of screening and referral. MCPAP for Moms will offer a pediatric screening algorithm that includes screening for PPD. Unless it is an emergency, pediatricians should refer moms with a positive screen back to their obstetric providers or primary care physicians, who can obtain assistance directly from MCPAP for Moms.

Pediatricians can also call their regular MCPAP Hubs for assistance or consultation with the screening tool, results of screening, or other concerns. If appropriate, the MCPAP Hub will facilitate the connection with MCPAP for Moms.

MCPAP for Moms services include:

- **Psychiatric consultation** – MCPAP for Moms’ perinatal psychiatrists will provide real-time phone consultation regarding diagnostic support, medication options (when indicated), psychotherapy and community support needs, treatment planning, and medication concerns during preconception, pregnancy, and lactation. MCPAP for Moms psychiatrists are also available for in-person patient assessment when needed.

- **Care coordination** – Care coordinators will work with providers to arrange services for patients.

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Effective Treatment, Improved Outcomes

It is essential to maximize non-medication treatment options. Evidence-based psychotherapy treatments for depression include and cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT). We will also encourage referrals to support groups. Depending on the severity of the depression, medication may also be indicated. MCPAP for Moms psychiatrists will assist providers in assessing whether medication is indicated and which medication may be best when a woman is pregnant or lactating.

Engaging fathers in treatment is also beneficial. “The best outcome for babies is treating the dyad and the triad. Treatment makes all the difference in the world,” says Dr. Yogman.

*Name changed to protect patient confidentiality.

Are you struggling to help parents of your pre-school age patients with difficult behaviors?

MCPAP is recruiting providers for our next Primary Care Triple P Positive Parenting Program training. The two-day training will take place in early October, followed by a one-day pre-accreditation workshop and a half-day accreditation date in November.

MCPAP is prioritizing behavioral health clinicians or medical providers working within pediatric practices for participation in this free initiative that provides parents with increased confidence and parenting skills. Funded by a Race to the Top grant through the Department of Early Education and Childcare and the Department of Mental Health, our goal is to increase access to services for young children with behavior challenges and their parents.

For more information or to enroll please contact Marcy Ravech at MCPAP 617-350-1978 or marcy.ravech@valueoptions.com.

For more information on MCPAP for Moms

visit www.mcpapformoms.org

Pediatricians enrolled in MCPAP should expect to receive a toolkit of information over the summer.

You can also contact your Regional Hub. Obstetric providers, family practitioners, adult primary care providers, and psychiatrists can contact MCPAP for Moms at 855-Mom-MCPAP as of July 1, 2014.
Recent Black Box Warning for ADHD Medications

By Hisla Bates, MD

The US Food and Drug Administration (FDA) posted a new black box warning on December 2013 that suggests stimulant medication methylphenidate (Ritalin) and its derivatives, used to treat ADHD, may cause prolonged and painful erections lasting several hours, a condition known as priapism. Priapism is a condition where blood accumulates in the penis, and urgent medical intervention is needed to relieve the blockage. Although priapism is rare, it has serious consequences if it goes untreated, causing permanent damage to the penis. The list of medications that are implicated are Concerta, Daytrana, Focalin/Focalin XR, Metadate CD/Metadate ER, Methylin/Methylin ER, Quillivant XR, Ritalin/Ritalin LA/Ritalin SR. The drug labels and patient Medication Guides have been updated with this information. Other non-stimulant medications such as Strattera (atomoxetine) have been implicated as well. Strattera (atomoxetine), has been associated with priapism in children, teens, and adults. According to the FDA, priapism appears to be more common in patients taking atomoxetine than in those taking methylphenidate products; however, because of limitations in available information, the FDA does not know how often priapism occurs in patients taking either type of product. There were four cases noted; the median age was 12.5 years, and the ages ranged from 8 to 33. Of the four cases identified, two needed surgical intervention, one required needle aspiration and another required a penile shunt. There seemed to be little correlation with dosage. Events occurred when drugs were being increased, decreased and even discontinued (including drug holidays).

When prescribing stimulants (methylphenaldate) including some non-stimulant (atomoxetine) medications for ADHD, it is important to warn caregivers and patients of priapism, a rare but serious side effect. Parents and children should know that any frequent or persistent penile erections should be reported immediately to a medical professional.

References

www.fda.gov/Drugs/DrugSafety/ucm375796.htm
www.fda.gov/drugs/drugsafety/drugsafetypodcasts/ucm379162.htm
www.fda.gov/safety/medwatch/safetyinformation/ucm381078.htm

Advice from the American Academy of Pediatrics (AAP)

ADHD: Clinical Practice Guidelines

The American Academy of Pediatrics (AAP) clinical practice guidelines offer some key action statements that help primary care clinicians evaluate, diagnose, treat, and monitor children and adolescents with ADHD. One such action statement is:

• Conduct a face-to-face follow-up visit on a monthly basis during initial stage, and then follow up with subsequent visits every three months in the first year of treatment. Subsequent visits occur at least twice a year.

Following AAP guidelines will give a practice a 100 percent score on the HEDIS® ADHD measure that many health plans use!
New Policy Statement on Care Coordination and Free Access to an Online Curriculum

Care coordination is an essential element of a transformed American health care delivery system that emphasizes optimal quality and cost outcomes, addresses family-centered care, and calls for partnership across various settings and communities.

The policy statement, Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems, appeared in the May issue of Pediatrics. This policy, co-authored by the Council on Children with Disabilities (COCWD) and the Medical Home Implementation Project Advisory Committee, specifically outlines the essential partnerships that are critical to this framework. Implementation of this framework aims for lower health care costs, less fragmented care, and an improved experience for children and families.

The policy provides practical application of care coordination integration in practices and communities and is intended to be broadly focused, realizing that every community has different needs, assets, and service gaps based on location, population, and cultural factors. An accompanying article in AAP News, “Beyond the Medical Home: Coordinating Care for Children,” also highlights the importance of this policy.

To further augment and facilitate the application of the recommendations within this policy statement, the online Pediatric Care Coordination Curriculum provides content which can be adapted to the needs of any entity (e.g., a single practice, a network of practices, parent and family organizations, or a state-wide organization such as Title V MCH programs). By design, the majority of the content is universally relevant, but optimal use of the curriculum results when it is adapted and customized to reflect local needs, assets, and cultures. Access to this online resource is free and available through the Boston Children’s Hospital website. (www.childrenshospital.org/care-coordination-curriculum).


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