Whereas, At least one in seven women experience anxiety or depression during pregnancy or in the first year after birth, making mental health disorders the most common complication of pregnancy;¹ and

Whereas, Despite the prevalence of anxiety and depression during pregnancy, maternal depression remains highly underdiagnosed and undertreated, with only 15 percent of women seeking professional evaluation for depressive symptoms (compared with 26% in the general population);¹ and

Whereas, Growing evidence has demonstrated that maternal depression during the antenatal and postpartum periods increases the risk for many adverse outcomes among women and their children (including, poor cognitive outcomes in offspring and increased suicide rates among postpartum women);²,³ and

Whereas, There may be missed opportunities for screening women in an outpatient setting;⁴,⁵ and

Whereas, The American Congress of Obstetricians and Gynecologists recommends women be screened at least once for depression during pregnancy and once during the postnatal period;⁴,⁵ and

Whereas, The American Academy of Pediatrics (AAP) recommends pediatrics screen mothers for depression at well-baby visits during the first six months;⁴,⁵ and

Whereas, The AAP also recommends postpartum depression screening of mothers with low acuity complaints presenting to a pediatric emergency department with their child;⁴,⁵ and

Whereas, Many obstetricians or pediatricians, who are often at the frontline of diagnosis, lack training in responding to maternal mental-health concerns;⁴,⁵ and

Whereas, A statewide program called Massachusetts Child Psychiatry Access Program (MCPAP) for Moms provides a full-time consulting care coordinator available for pediatricians or other providers seeking advice on the appropriate treatment of a depressed pregnant or breastfeeding woman;⁶ and

Whereas, Treatments through MCPAP can include consultation with a perinatal psychiatrist, individual or group therapy geographically convenient for patients, medications, home visits by a nurse or social worker, or simply a follow-up phone call;⁶ therefore be it

RESOLVED, That our American Medical Association work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 09/28/17

RELEVANT AMA POLICY

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.
Citation: Res. 102, A-12; Modified: Res. 503, A-17

Access to Mental Health Services D-345.997
Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness, including barriers that disproportionately affect women and at-risk populations; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process.
Citation: CMS Rep. 9, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Modified: Res. 503, A-17

See also: Access to Mental Health Services H-345.981