Disproportionate rates of postpartum depression: Too many African American mothers are affected in Ramsey County

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Policy Proposal
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Problem

Postpartum depression (PPD) is a deeply damaging disease for a mother to experience. Research connects it to an array of negative effects not only on mothers themselves, but also on their children during early childhood and into adulthood [1]. It contributes to physical, behavioral, and cognitive problems resulting in major disadvantages both short and long-term [2].

Minnesota boasts a state ranking as one of the lowest PPD rates nationwide [3]. Yet, this high rank obscures severe inequity: African American women are more than twice as likely to experience postpartum depression as their white counterparts in Ramsey County (**Figure 1**) [4]. This brief focuses on Ramsey County, an area with relatively high concentrations of African American residents and notably poor outcomes for children of color [5, 6].

Main Issues Contributing to this Problem

1. Higher levels of unaddressed risk factors (i.e. exposure to trauma, poverty) linked to PPD [7, 8]
2. Specific cultural perceptions or stigma associated with PPD [9]
3. Inadequate access to mental health services and support [10]

Magnitude

While no current Ramsey County-specific data exists, state PRAMS data (**Figure 1**) reveals that approximately 22% of black mothers experience postpartum depression [4]. This means a minimum of nearly 400 African American women struggle with PPD in Ramsey County annually. As **Figure 2** depicts, PPD affects a much greater proportion of black mothers.

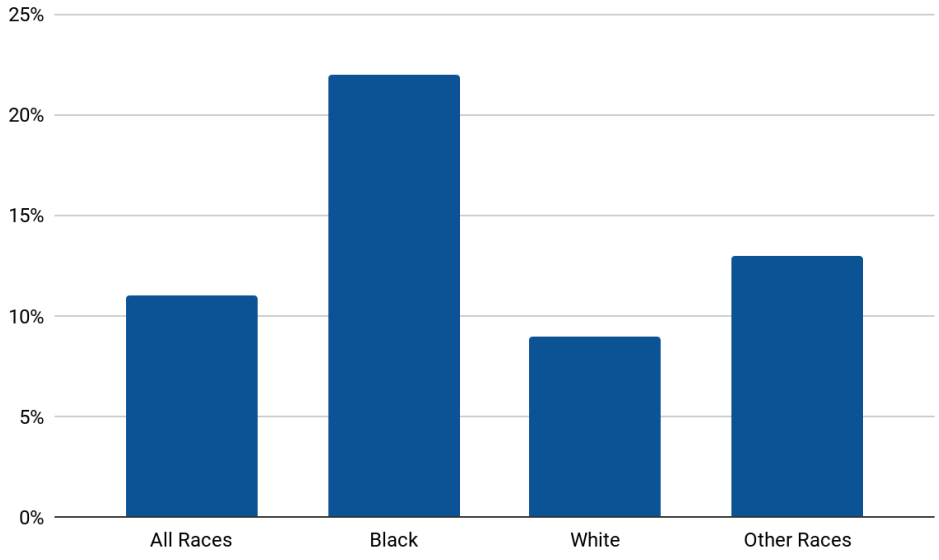

Figure 1: Author created using data from World's Best Workforce (2017) [4]. *Percent of Women in Minnesota Experiencing Postpartum Depression*

The exact burden of PPD is difficult to calculate, but should not be understated. A mother's postpartum mental health affects her abilities to think clearly, to bond with her child, to breastfeed, and more. It also affects her child's cognitive, behavioral, and physical health [1, 2, 12]. Additionally, society bears significant financial burden due to:

- Costs of increased early childhood health complications & long-term medical costs of chronic diseases associated with PPD [13, 14]
- Loss of productivity in the workforce for women with PPD and later for their children [15]

Wilder Research estimated the cost of each case of untreated PPD in Minnesota at $23,000 per year, including direct (e.g., treatment of infant health complications) and indirect (e.g., workforce productivity loss) costs [16]. No data was found for subsequent years, but if this 2010 estimate holds remotely true today, this means millions spent annually. Given this magnitude, one major issue to address today is the inadequate access African American women have to mental health care and support.

Policy Question

How can the Minnesota state legislature address access to mental health services and support for African American women in Ramsey County to reduce rates of postpartum depression and increase positive outcomes for the next generation?

Trajectory

The explanations for PPD and other racial health disparities point to social, economic, and political forces which disproportionately affect minority Minnesotans [10].

- *Residential segregation* systematically disadvantages communities of color, manifesting in dramatically higher poverty and incarceration levels (increasing risk of PPD) [11, 17, 18]
- *Interpersonal racial discrimination* itself is also linked to increased risk for adverse health out-comes [19]

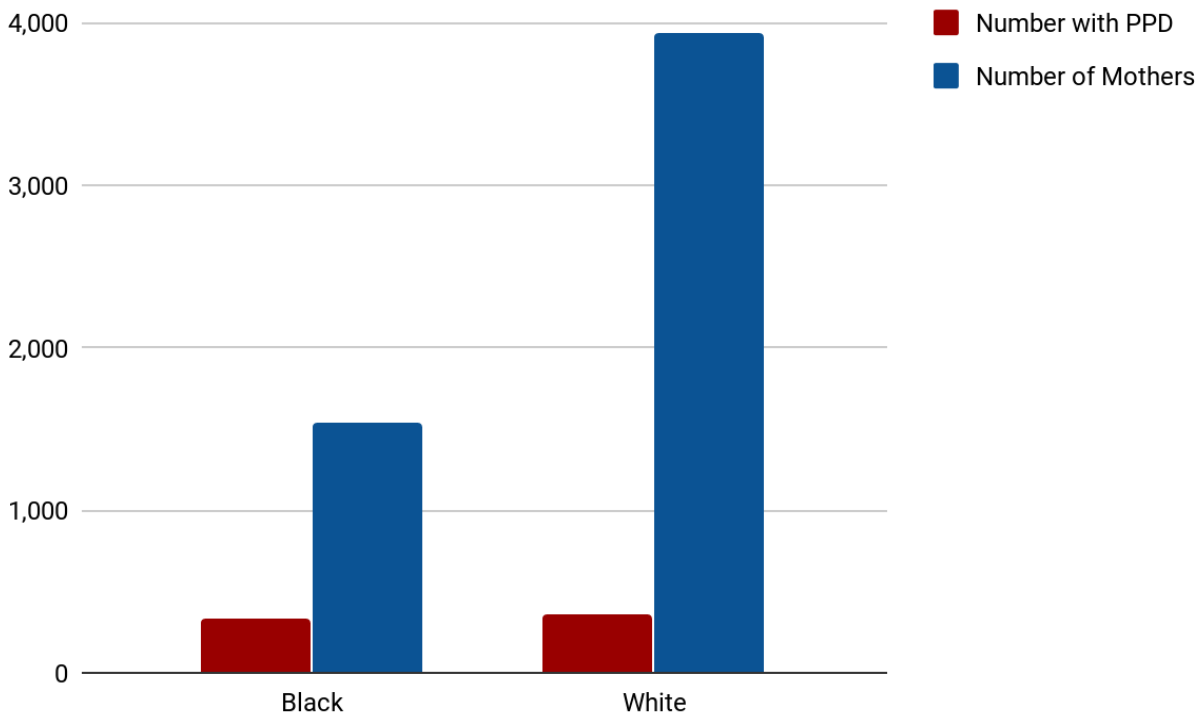

Figure 2: Author created using data from World's Best Workforce (2017) [4] and Minnesota Department of Health (2015) [7]. *Prevalence of Postpartum Depression (PDD) in Ramsey County by Race, 2015.*

- Drastically *lower median income and wealth* levels for people of color in Minnesota mean decreased opportunities to access care and higher stress levels, which majorly impact PPD [20]
- *Health insurance policies* add to the problem of inadequate healthcare coverage for low-income African Americans. Most can obtain coverage via Medicaid at some point during their pregnancies; many lose coverage 60 days after giving birth, the same time-frame at which PPD symptoms can worsen [12, 21]

Previous Policies

Several state-level policies related to maternal health are in effect, but targeted interventions are still needed to reduce racial disparities. The 2017 Minnesota Statute 145.906 & 145.908, "Postpartum Depression Education & Information," encourages development and dissemination of PPD-related materials at hospitals and other birthing facilities, and establishes a grant program to provide culturally appropriate screening and treatment [22, 23]. This legislation is encouraging, but no funds were appropriated to ensure or aid implementation [23].

On the federal level, the Affordable Care Act improved access for some women who previously lost coverage 60 days post-birth [24]. It also contained specific provisions with implications for PPD around screening and public awareness [24, 25]. It is unclear whether these provisions are funded or widely implemented by states today [26].

Pressure for Action

Investing in the mental health of African American mothers benefits society both short and long-term [10]. Changing population demographics and a steady growth of minority groups in Minnesota mean that addressing the health of women and children of color now is vital to the future of our workforce [10, 11].

Policy Options

Option 1: Appropriate funds for targeted increase of family home visiting programs

Family Home Visiting (FHV) programs are voluntary, home-based services delivered to pregnant mothers, continuing through the first few years of a child's life [27]. They provide families with clinical information and community resources and are a vital source of social support [27]. Minnesota Department of Health's (MDH) 2016 Report to the Legislature showed that along with improving infant health outcomes, Minnesota Family Home Visiting Programs positively impact maternal mental health [28]. Each program includes screening for postpartum depression and referral to appropriate community resources [27, 28]. Appropriating additional funds to increase the reach of home visiting programs for African American families is one possible way to address this disparity. This could be done in a sensitive way by targeting the state funds toward the 15 counties designated "high risk" for poor child outcomes (including maternal mental health) [6]. Of 87 Minnesota counties, Ramsey County is the only metro-area county in this high-risk category [6].

- **Effectiveness:** MDH named home visiting programs "a proven strategy to address the factors that create health inequity" [28]. All mothers need social support, but for those suffering PPD it is particularly important. Evidence shows that increased support is associated with decreased PPD [29]. Trained home visitors, particularly those who have developed a relationship with mothers during their pregnancies, could be especially effective in creating space for an accurate assessment of PPD, as well as offering support [28, 29].
- **Political Feasibility:** Home Visiting programs have received bipartisan support nationally and statewide [28, 30]. The Minnesota State Legislature has continued to appropriate some funding for them each year because of their popularity and demonstrated effectiveness [28]. However, an array of health-related priorities compete for limited state funding, which could cause tension.
- **Financial & Administrative Feasibility:** Minnesota currently utilizes several distinct evidence-based FHV programs [27, 31]. Cost estimates vary slightly depending on the program, but one example, the Nurse Family Partnership, costs approximately $4,100 per family [32]. Offering home visiting to each at-risk mother in Ramsey County alone could cost millions, not to mention for the other "high risk" counties [6, 7, 32]. In isolation, that makes this option unrealistic given strong annual budget constraints, but there are other important considerations: the cost per

case of untreated maternal depression is nearly 6 times the cost of family home visiting per family [16, 32]. By investing in these programs, the state ultimately experiences significant savings. To help even 100 more African American mothers in Ramsey County, and yield long-term savings of $2,300,000, the state could appropriate $410,000 [16]. The total cost of this appropriation would be $6,150,000 for all 15 counties [6, 32]. These programs already exist and could be administered by MDH or directly through counties, easing administrative expenses and hassle [6, 27, 31].

- **Ethical Feasibility:** This could be an ethical way to address specific needs of mothers of color, if home visitors are trained in culturally centered care, and are able to tailor support to diverse values, beliefs, and behaviors [28, 33]. Culturally appropriate care is vital, as experiences of racism from healthcare providers, even if inadvertent, can exacerbate depression [27, 33]. In reality, home visiting alone will not be enough for those struggling the most – mothers need additional support from mental health providers, which they may not have access to depending on their insurance [34]. However, for many, the diagnosis of PPD, social support of the FHV, and connection to existing help networks (e.g., Postpartum Support International) could be sufficient [35, 36].

Option 2: Appropriate funds for targeted aid in PPD screening & follow-up

Another way to address this disparity is to appropriate funds to assist in PPD screening and follow-up for healthcare providers likely to see the most African American mothers. Again, this is achievable by specifically providing funds to aid the 15 "high risk" counties in PPD screening and follow-up [6]. While screening for PPD has shown mixed success, it can improve diagnosis and even prevent stigma, by giving both providers and patients a space in which to talk comfortably about difficult experiences [26]. The recommendation is that counties use these funds to hire Community Health Workers (CHW) dedicated specifically to maternal mental health. The American Public Health Association defines a CHW as a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served" [37]. CHWs are uniquely equipped to provide culturally centered care, which could increase screening and follow-up effectiveness [33, 38].

- **Effectiveness:** Research from other states shows that merely mandating screening does not reduce levels of postpartum depression [39]. Combining the existing statewide screening recommendations with additional staff resources for high-risk counties is a unique way to maximize the potential of existing systems. For postpartum depression, time from birth to treatment initiation is of particular importance, as early detection and treatment minimizes the potential negative impacts of the illness [35]. Employing additional CHWs could be effective in ensuring treatment initiation rather than just detection [38]. Screening mothers for PPD during well-child visits (regular check-ups for their children) provides consistent intervals that often correspond to heightened times of PPD risk for mothers [40]. Minnesota law allows all public insurance plans to bill for this screening under the infant's insurance [40].
- **Political Feasibility:** This option could bode well politically because it builds on existing bipartisan legislation [23]. The 2017 update to the Post-partum Depression Information and Education Act speaks rhetorically to addressing racial health disparities—the next session could bolster such language by including funding for high-risk counties to address this. However, any type of targeted legislation presents the problem of systematically advantaging certain groups (counties, in this case) over others, which could create push-back. Additionally, as with all health policy, what is best for patients often creates extra work for providers—and this situation is no different. Time-strapped doctors typically do not appreciate extra recommendations. However, the additional CHW workforce could lessen this tension [41].
- **Financial & Administrative Feasibility:** Financially, this option is appealing due to evidence of the quality and cost-effectiveness of CHWs [41]. The average salary for a CHW in Minnesota is $39,562 [42]. Appropriating just $1,200,000 to address this disparity allows each high-risk county the opportunity to hire 2 additional CHWs dedicated to maternal mental health, with flexibility for each county to implement funds according to their specific needs. Administratively, even with additional aid, diagnosis could prove difficult due to increasingly short app-

ointment times and other logistical issues [43]. When identified, treatment could range from mental health provider visits to medication to support groups—costs could be minimal but would incur at state level for mothers on Medicaid [35, 36]. Ensuring that women with PPD are identified and followed up with in a way that helps them will require significant hand-holding [39, 43].

- **Ethical Feasibility:** Mothers diagnosed with PPD could be unable to afford or access appropriate treatment [36]. Detection is just the beginning of addressing the disproportionate rates of PPD [43]. Ensuring that treatment is not cost-prohibitive for mothers is vital. In addition, if providers are not equipped to administer the screening in a sensitive way, this identification and treatment process could be demeaning rather than empowering for women [39]. At worst, this could mean experiences of discrimination [43]. Ideally, the addition of CHWs to help facilitate this process could mitigate potential for harm by improving culturally centered follow-up and connecting women with appropriate resources [38].

Recommended Policy

Due primarily to budget constraints, I recommend proceeding with Option 2. Despite Option 1's ability to provide more sustained support for mothers at home, its high up-front cost to the state makes it less politically and financially feasible.

The major advantage of Option 2 is that it leverages the current system to the best capacity without dramatically increasing costs. It also could establish a baseline of the benefits of screening in high-risk counties, which future legislature could build on. Ideally, as awareness and understanding of PPD prevalence increases among providers and policymakers, there will be a better foundation for more broad-scale legislation in the future.

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