



Preparing for Conflict and Negotiation: A Case Study on Perinatal Depression

Women's and Children's Health Policy Center
Johns Hopkins Bloomberg School of Public Health



**THIS IS AN ABBREVIATED VERSION OF THE CASE STUDY, PREPARED FOR THE
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**THE FULL DOCUMENT IS AVAILABLE AT
<http://www.jhsph.edu/wchpc/MCHLDS/M4CaseStudy.pdf>**

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Preparing for Conflict and Negotiation: A Case Study on Perinatal Depression and the MCH
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Background

Perinatal depression (depression during pregnancy and postpartum depression) occurs in approximately 10 percent of pregnancies. It is characterized by persistent symptoms including strong feelings of anxiety and despair. Women experiencing perinatal depression may have trouble taking care of themselves, their infants, and other family members.¹ Recent research has pointed to the effectiveness of short, simple screening tools in identifying women with perinatal depression.² The best time to screen for postpartum depression is thought to be sometime between 4 and 8 weeks after birth. Ideally, the six-week postpartum check would represent an opportunity for intervention. However, the no-show rate for the six-week postpartum appointment is very high.³

The Problem

On May 9, on a busy suburban beltway east of the state Capital, Shannon Green is driving her three small children (all under age 4, including a 2 month-old infant) home from a shopping trip when she falls asleep at the wheel of her minivan and crashes her car into a guard rail. Paramedics who arrive on the scene find that the mother was not wearing her seatbelt, and while the car was equipped with child safety seats, none of the children was strapped in. The mother survives the crash but has no memory of the accident. Her sons, two-year-old Colby and four-year-old Kyle, survive despite multiple broken bones, but her infant daughter, Taylor, sustains major head injuries and eventually dies after three days on life support. The surviving children are currently in the custody of their grandparents, while Shannon Green awaits the findings of an investigation by Child Protective Services.

After the initial outrage from the public about the mother's negligence in not strapping in the children, family members come forward to provide more details. According to them, Shannon Green has had a particularly hard time since giving birth to her third child two months ago. Mrs. Green's husband has been working on construction jobs out-of-state and was able to visit only sporadically during Mrs. Green's pregnancy; he was unable to be present at the birth. Mrs. Green's family lives out-of-state, but her mother and sister have visited twice since Taylor was born. Both noted concern about Mrs. Green's general fatigue, lack of connection to her newborn, and overall stress. They described Ms. Green as "going through the motions as if she were in a fog."

Because Shannon Green's husband's job does not provide health insurance, the children have been covered under the State Child Health Insurance Program (CHIPKIDS). They were enrolled at the clinic in their hometown, Starmount Community Health Clinic, about one hour east of the state capitol. When Shannon took Taylor (and the other two children) to the pediatrician for Taylor's two-month well-child visit, the doctor noticed how tired and addled the mother seemed. The doctor gently referred Shannon to the local mental health center as well as a community support center staffed by volunteers, in addition to providing the number for the state child development hotline.

Mrs. Green's mother, who accompanied her daughter on this doctor's visit, said that she had called the local mental health center herself trying to get services for her daughter, but had been told that her daughter must call to make the appointment. Mrs. Green's mother returned home a week later and was still trying to get her daughter to make the call when the car accident occurred.

¹ American College of Obstetricians and Gynecologists Letter in Support of H.R. 20, the Melanie Blocker Stokes Postpartum Depression Research and Care Act, 10/15/2007

² Barson, R. 2006. Considering Interventions for Depression in Reproductive Age Women in Family Planning Programs. Baltimore, MD. Women's and Children's Health Policy Center. Johns Hopkins Bloomberg School of Public Health.

³ Staff Interview, American College of Obstetricians and Gynecologists, April 2008;

The Reaction

News coverage and editorials all over the state put pressure on state and local authorities to answer the basic question: “Who missed this?” Medical and mental health experts called to comment on the incident in the media said the accident was an unfortunate result of untreated postpartum depression.

State Representative Jane Dixon, Chair of the Committee on Children and Families, has been especially vocal in her outrage and has used the incident as an opportunity to reintroduce state legislation to provide more funds for perinatal depression and revamp the mental health referral and treatment system for mothers and children. The \$20 million legislation, which could mean as much as a 10% increase to the state mental health and public health budgets, had been previously introduced in the last two sessions of the legislature. Unfortunately, the bill never moved beyond the committee due to funding concerns and the absence of broad support from her colleagues. But with the Shannon Green tragedy, support seems to be moving her way, setting the stage for major reform. Senator Dixon has been given the green light by the House leadership to hold a hearing on the legislation in a little over a month. The hearing will feature testimony from the State Perinatal Task Force. At the other end of the political spectrum, some legislators who fault the mother are developing punitive measures to remove children from the home when a mother is diagnosed with postpartum depression.

State Health Care System

The Midwestern state where this scenario takes place is a reasonably affluent state with a State Child Health Insurance Program (SCHIP) whose benefits are rated in the moderate range. There are two major cities: the Capital City (the capital) and Brownville to the south. Families enroll in Medicaid and SCHIP through community health centers and public health centers. Pregnant women with children eligible for SCHIP can receive additional services, such as home visiting and parent support, through these centers. Mental health services are provided through community mental health centers located across the state. In areas outside Capital City, where it is hard to attract mental health professionals, local mental health clinics have long waiting lists and personnel openings. The recent downturn in the economy has stretched public health and mental health clinics to capacity.

The State Health Department has tried to have meaningful collaboration with the State Mental Health Department on a number of initiatives to forge stronger ties, but has found the state and local staff well-meaning but overworked, and, because of scarce resources, only able to address the most serious cases of mental illness. Until now, perinatal depression has not been at the top of their list of priorities.

The Role of Public Health

Pam Albright is the director of the Women’s and Maternal Health Section in the Family Health Division of the State Health Department. She has long been an advocate for addressing women’s health across the lifespan, but fragmented federal funding streams have made comprehensive approaches difficult. While distressed at the breakdown of a system that resulted in an infant’s death, she is grateful for the spotlight on perinatal depression and wants to make the most of this opportunity.

Pam Albright’s boss, the head of the Division of Family Health, is Dr. Steven Alvarez, trained as a pediatrician. He is supportive of addressing perinatal depression, although his primary focus has been on child health. Above Dr. Alvarez, as Commissioner of Public Health, is Dr. Anne Siders, a primary care doctor who has been with the department for 20 years. She is supportive of maternal and child health issues but is not an expert, and has been occupied in recent years with disaster planning (the state hosts a large nuclear facility) and with revamping the state laboratories.

Drs. Alvarez and Siders have tasked Ms. Albright with identifying what the Department (including local health departments) wants and needs from the new legislation and then negotiating these needs through the Perinatal Task Force, with funding for public health at the top of the list. Ms. Albright is confident in her knowledge and ideas but is extremely nervous about these negotiations, both because of the media coverage they will receive in this high profile situation and because she is not completely sure how much public health really wants to take on in terms of revamping the existing system of care.

The Legislation

Rep. Dixon's legislation must sort out appropriate roles for mental health versus public health. For many at-risk families eligible for Medicaid or the State Child Health Insurance Program, local health departments provide a key entry to the health care system even though eventual treatment for mental illnesses, especially in complex cases, requires the mental health system. In the context of revamping the system of care to better identify and treat perinatal depression, six key issues must be resolved. For each issue, the legislation will need to specify which agency (the State Mental Health Agency or Health Department) will have primary responsibility and funding for implementation. These issues will form the basis of Pam Albright's negotiating points.

- 1) **REFERRAL AND TREATMENT:** Developing more effective referral mechanisms (including identifying points of entry) and treatment options to ensure that women with or at-risk of perinatal depression receive the mental health services they need in a timely and effective manner.
- 2) **RESOURCES AND TRAINING:** Providing resources and training to assist pediatricians, obstetricians and gynecologists, nurse midwives, and other practitioners in diagnosing and treating perinatal depression, including information on evidence-based screening tools.
- 3) **STANDARDS AND GUIDELINES:** Developing guidelines and protocols for referrals and follow up for practitioners and lay health workers when perinatal depression is suspected.
- 4) **CONFIDENTIALITY:** Addressing privacy and reporting issues while ensuring the safety of the mother and children.
- 5) **FINANCING:** Securing coverage from state Medicaid and third party insurers for services performed by all providers for screening and intervention for perinatal depression.
- 6) **OUTREACH:** Developing a public awareness campaign for perinatal depression.

Intra-agency Negotiation—The Department of Health

Ms. Albright's first negotiation task will be internal, within the Department of Health. In the next five days, she needs to talk to key players individually within the Department to see what issues are most important to them, and also bring all the key players together for a consensus meeting. While Albright understands that the primary concern is ensuring adequate funding for referral and treatment for local health centers, she personally would like the legislation to include specific language encouraging the use of evidence-based screening tools during and after pregnancy by key health care professionals.

Ms. Albright recognizes that some of her departmental colleagues would like to take the lead in every aspect of the legislation—an unrealistic and potentially ineffective position. She must somehow convince her colleagues that it is in their best interest if the legislation results in more meaningful collaboration between the two agencies. She will be negotiating with the following colleagues:

- 1) **The Director of Child Health, Eric Benjamin,** is a pediatrician. He is a close colleague of Pam Albright's and is very supportive of any extra funding going to perinatal depression, having seen firsthand the negative effects of maternal depression on infants. He would like to see a stronger role for public health in assuring that mothers are treated for perinatal depression, beyond simply

referring them to mental health services. However, Dr. Benjamin is concerned about placing any further mandates, or even recommendations, on pediatricians since many already seem overburdened by existing pediatric care guidelines. While some pediatricians, particularly the younger ones, would welcome having a clearer role in addressing parents' mental health needs, even prescribing medications, others see these activities as significantly beyond their role. Nevertheless, Dr. Benjamin's primary concern is funding for public health.

- 2) **The Deputy Director of Medicaid/SCHIP, Judith Stevens**, has been in her position for four years. Before her current position was created, she was Director of the Women's and Maternal Health Section (Pam Albright's current job). She is regarded as extremely bright, but a far better manager of finances than people. Her tenure as Director of the Women's and Maternal Health Section was marked by rocky relations with local health departments, which Pam Albright has worked hard to repair. Judith Stevens continues to give Pam Albright unsolicited advice on a regular basis about how to run the women's health section. Judith's input into and support of the Medicaid reimbursement and financing piece of the legislation is particularly important to Pam.
- 3) **Jim Kennan is the Health Director for the Capital City Health Department**, which has a reputation as an incubator for promising practices and new approaches, including a well-regarded lay health visitor program. Dr. Kennan is known as an extremely bright but impatient man, who self-confidence and brash style can rub people the wrong way. Dr. Kennan would like to see a larger role for lay health visitors in screening for prenatal depression, as well as more funding to the local health department to ensure that mothers receive the mental health services they need. He has been particularly frustrated in his workings with the local mental health agency. He recognizes that the local mental health agency is under-funded and capable of handling only the most severe cases, but he feels that the agency has been less than collaborative when the health department has tried to reach out and develop more effective referral mechanisms, including the use of lay health visitors. He is pushing Pam Albright to be a tough negotiator with mental health, if not downright adversarial.
- 4) **Dawn Minton, the long-time Director of the Starmount Health Department**, is considered a leader in public health in more rural areas. She has taken the Shannon Green tragedy very hard and wonders if her hands-off management style played some role. She was aware of the lack of comprehensive mental health services and the "disconnect" between public health and mental health and wonders if she has done enough to bridge the gap. At the same time, she is conflicted about the role of the local health department in assuring that women receive these services. Ms. Minton has close colleagues at the local mental health agency that she is reluctant to criticize. In addition, she is frustrated at Jim Kennan's vocal criticism of the whole system—which she is taking personally.

What's Next?

The outcome of Pam Albright's negotiations within the Health Department will set the stage for subsequent negotiations on the State Task Force on Perinatal Health, which meets one week after the consensus meeting within the Department of Health and one week prior to Rep. Dixon's hearing. On the State Task Force level, Ms. Albright will have to work with representatives of other agencies and large political constituencies, and the negotiations will certainly garner attention and publicity.

All the negotiations are in preparation for the upcoming hearing chaired by **Rep. Jane Dixon**. Pam Albright must therefore keep Rep. Dixon's legislative perspective in mind as she prepares. Rep. Dixon has sponsored no major legislation so far, and she is considering running for Governor in the next election; she really wants a bill that will pass.