Screening for Depression in Caregivers

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Overview

- Depression
  - Symptoms
  - Epidemiology – Prevalence, Risk factors
  - Consequences if untreated
- Issues in Access to Care for Depression
- Identification of Depression – Screening
  - Tools – PHQ-9 & EPDS
  - Responding to results, referral, and follow-up
- Resources
Who are caregivers?

- Mothers
- Fathers
- Grandparents
- Childcare providers
Symptoms of Depression

- depressed mood most of the day, nearly every day
- markedly diminished interest or pleasure in activities
- change in weight or appetite
- decreased or increased sleep
- restlessness or slowing
- fatigue or loss of energy
- feelings of worthlessness or guilt
- diminished ability to think or concentrate
- recurrent thoughts of death or suicide
Other symptoms that tag along postpartum...

- DSM criteria +
  - Anxiety
  - Obsessive thoughts (i.e., about the baby’s safety)
  - Ambivalent or negative feelings toward the baby, wanting to flee
  - Doubts or feelings of inadequacy about caring for the baby
  - Thoughts of harming the baby
In OB clinics – nearly 40% of women identified with a disorder

- **Depression** 21-23%
- Posttraumatic Stress Disorder 3%
- Panic Disorder 1-2%
- Eating disorders 5%
- Substance use disorder 19%
Pediatric Settings

- 20 – 30% of women identified with depression in first postpartum year
- Maternal depression -- up to 46% in some pediatric settings
- Parenting young children increases stress and depression risk
Depression in Pregnancy

- 10-20% of childbearing women
- Up to 30% of childbearing women may experience depressive symptoms which interfere with functioning
Depression in Pregnancy: Risk Factors

- previous episode of depression
- family history of depression
- Younger age, lower income, lower education
- poor social support, single
- life stress
- unintended pregnancy
- domestic violence
- history of adverse pregnancy outcomes
Depression in Pregnancy: Significance

- It affects the child’s health!
  - Risk of Prematurity
  - Risk of Low Birth Weight
  - Associated with increased use of alcohol, drugs, and cigarettes
  - Associated with decreased prenatal care
  - Risk of Postpartum Depression
Postpartum Depression (PPD)

- 10-15% of Childbearing Women
- Rates approach 30% among low-income and ethnic minority women
PPD Risk Factors

- **Family history**
  - 4 – 8 weeks postpartum

- **Hormonal factors**
  - Premenstrual mood symptoms
  - Premenstrual Dysphoric Disorder

- **Psychosocial Factors**
  - Social support
    - *Partner*
PPD Risk Factors

- Previous episode
  - Depression in pregnancy
  - Risk of recurrence:
    - 1 episode – 50%
    - 2 episodes – 75 – 80%

- Risk is not reduced with subsequent children
  - may be increased
PPD & Maternal Depression

- 4 weeks vs. 1 year
- What happens later?
  - Depression may actually be more common
Untreated PPD/Maternal depression: Consequences

- **Impact on Family**
  - Partner
  - Marital discord, divorce
  - Family violence

- Personal suffering of woman
  - Risk of suicide – 28% of maternal deaths
Untreated PPD/Maternal depression: Consequences

- Less likely to engage in healthy parenting practices
  - Seat belts
  - Outlet covers
  - Back-to-Sleep
  - Immunizations
  - Breastfeeding
  - Feeding
  - Sing, play, cuddle
Untreated PPD/Maternal depression: Consequences

- Less likely to attend well child visits
- Overutilization of health care/emergency services
- Difficulty managing children’s chronic health conditions
Untreated PPD/Maternal depression: Consequences

- Impairment of factors key for healthy early brain development, including before birth
  - Impaired bonding
  - Insecure attachment
  - Attachment disorder
  - Risk for neglect
Untreated PPD/Maternal depression: Consequences

- Developmental, behavioral, cognitive & emotional problems
  - Developmental and language acquisition delays
  - Conduct disorder and behavior problems
  - Anxiety, social wariness and withdrawal
  - Elevated risk for depression
    - Cycle of depression
Untreated PPD/Maternal depression: Consequences

- Combined with poverty, substance abuse, domestic violence, or trauma
  - Impact is even greater
Addressing maternal depression

- We must do something about this!

  - Prevention
    - Disrupt the cycle
  
  - Identification
  
  - Treatment
What helps with depression?

**Treatment**

- "the best gift a parent can give to their child"
  - Therapy
  - Medication

- Treatment does improve child outcomes
  - Example: STAR*D study – treatment of maternal depression
  - *Share this message:* *Children are resilient!*
Treatment preferences: What do women want?

- Depression advice from:
  - Informal sources (33%)
  - Ob Gyn provider (23%)
  - Mental health provider (25%)

- Prefer psychological intervention over medication
(Perinatal) Depression Treatment

- Non pharmacological interventions
  - **Psychotherapy – 1st line treatment**
    - *Parent-child*
    - Individual
      - **Interpersonal**, Partner assisted
      - Cognitive Behavioral
    - Group
    - Couples
  - Other Promising alternatives
    - Omega-3-Fatty Acids
    - Light therapy
    - Exercise
What to tell women about medication

- There are antidepressant medications that can be prescribed during pregnancy and breastfeeding.

- Monoamine Oxidase Inhibitors (MAOIs) are the only antidepressants that clearly should be avoided during pregnancy and breastfeeding.

- Other types of antidepressants (SSRIs, TCAs) should be discussed and used based on the risks and benefits.
What to tell referrals about medication

- They should see their treatment provider within 1-2 weeks after they first receive a prescription.
- They should let their provider know if they aren’t seeing any signs of improvement within 4 weeks of starting treatment.
Cost is a significant consideration for many women who require depression treatment.

- Some large pharmacy retail stores (Target, WalMart, Kmart) have low-cost ($4-5/month) prescription programs for select antidepressants available in generic formulations.
- www.needymeds.com is also another resource to find Patient Assistance Programs for low-income women.
- Your county relief office may also provide assistance.
To repeat the good news for moms…

- Treatment of maternal depression is associated with improved outcomes for their children!
  - Plus…dads/partners may help.
Father Zone
Postpartum Males

- Men face many of the same stresses
  - Lack of sleep
  - Role transitions
-Changes in social relationships and social functioning
### Prevalence of Partner Depression: An Iowa Sample

<table>
<thead>
<tr>
<th>Category</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive IDD (n=51)</td>
<td>6.3%</td>
</tr>
<tr>
<td>EPDS (10+) (n=86)</td>
<td>10.7%</td>
</tr>
<tr>
<td>EPDS (13+) (n=30)</td>
<td>3.4%</td>
</tr>
<tr>
<td>IDD or EPDS (n=104)</td>
<td>12.9%</td>
</tr>
</tbody>
</table>
Factors associated with Paternal Depression

- Lack of social support
- Marital discord
- Work and employment issues
- Parenting stress
- Personal history of depression
- Depression in their partner
Significance of Paternal Depression

- Non-depressed fathers may “buffer” effects of maternal depression
  - Social support
  - Increased infant-parent interaction
Significance of Untreated Paternal Depression

- **Impact on Children**
  - Parental behaviors – less positive
  - More externalizing/behavior problems
  - More internalizing problems
Really important message

- *Parental mental illness alone is not an indicator of fitness to parent and does not lead directly to abuse or neglect*

- Parental mental health *is an important issue in parenting*
  - 10 – 42% of child protection cases across Europe, UK, Australia, Canada, US – parental mental illness is a factor
Coexistent Depression in New Parents

- Postpartum period -- not a time of increased psychiatric morbidity for men

- Postpartum woman depressed -- increased onset of psychiatric illness in her male partner

- *When both parents depressed – child outcomes worse*
### Co-existent Depression in New Parents (Iowa Sample)

<table>
<thead>
<tr>
<th></th>
<th>Postpartum Woman Depressed</th>
<th>Postpartum Woman Not Depressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner Depressed</td>
<td>2.1% (14)</td>
<td>5.9% (25)</td>
</tr>
<tr>
<td>Partner Not Depressed</td>
<td>10.5% (69)</td>
<td>83.6% (552)</td>
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</table>
Parenting with mental illness

- Up to 1 in 5 young people live in families in which a parent has a mental illness

- Iowa ACES data support this –
  - Almost 20% of adult Iowans surveyed in the BRFSS reported having a parent with MI during their childhood
The good news for dads…

- Treatment -- the sky is the limit
  - No pregnancy!
  - No breastfeeding!
Partners in Treatment of PPD

- Involving partners in treatment of postpartum depression improves outcomes

- Going to treatment with the mom may be a good treatment gateway
Other Caregivers

- Depressed childcare providers
  - Leave the profession => increased turnover
  - Less sensitive, less interaction

- Other caregivers (grandparents, adoptive parents) get depressed too.
  - Data shows similar outcomes to moms and dads
Addressing caregiver depression

- We must do something about this!
  - Identification
  - Treatment
  - Prevention
Detection of Maternal Depression

- Detection rates for depression in Ob-Gyn settings 15-30%
- Pediatric settings – about 25%
Detection of Maternal Depression

- **Home visiting program for pregnant and parenting women**
  - Program participants with depressive symptoms or severe parenting stress
    - 41% had been referred for services
Caregiver Depression: Undertreated

- Treatment rates – nearly 75% of women screening positive for depression are untreated

- 18.3% of Iowa fathers with depressive symptoms are either taking medication or in counseling
Why?

Barriers to mental health detection and treatment exist on multiple levels:

- System/Organizational
- Patient
- Provider
Barriers to Detection and Treatment

- System
  - Availability of mental health providers, insurance limitations, training opportunities

- Women
  - Cost, time, stigma, provider relationship, medication concerns, logistical and treatment knowledge issues
  - Iowa Women: cost, insurance, not knowing where to go, long waits for care, negative experiences in past, trust in provider, concerns about taking medications while pregnant or breastfeeding

- Providers
  - Time, reimbursement, confidence in identifying & treating (training)
Challenges in Identifying Perinatal Depression

- “Normal” postpartum/pregnancy vs. Depression
  - Changes in appetite
  - Changes in weight
  - Sleep disruption/insomnia
  - Fatigue/low energy
  - Changes in libido
Assessing for Perinatal & Caregiver Depression

- Screening increases detection!
- ACOG strongly encourages screening
- AAP recommends screening
Maternal Depression Screening - Acceptability

- *beyondblue* screening program (Buist et al., 2006)
  - 85% no discomfort in screening

- UK: Highly-structured screening program (Shakespeare et al. 2003)
  - didn’t mind - just ask
  - ill-prepared - stigmatized
  - weren’t listened to - lack of feedback
  - intrusive - worried about consequences

- **Process of screening important**
What Iowa women tell us…

- **How** and **when** to screen:
  - Several time points
  - Mixed preferences on questionnaire vs. asking
  - Confidentiality
  - Red flag – history*
What Iowa women tell us…

- What?
  - Reassurance
    - Normalize symptoms
    - Assure symptoms will resolve
What Iowa women tell us…

What?
- Attribution of symptoms

Am I depressed or just pregnant/postpartum?
- Desire information about the difference
- Do use and appreciate the educational materials provided
What Iowa women tell us…

Who would I talk to?

- A familiar provider

- Professionals*

The nurses know what they’re talking about…and I’m comfortable telling them.

-- Erin, EPDS 12, on antidepressants since pregnancy

“It’s (MCH) the right place (to be asked about depression), but a mental health specialist should be on site.”

– Sarah, EPDS 9, in counseling
What staff tell us...

- System barriers
  - Time
  - *Reimbursement*
    - *Not anymore!!!*
  - Location and setting
- Availability of appropriate providers

*Psychiatrists know less about pregnancy and OBs know less about psych issues, so if those two coordinated better, there would be less fragmented care.*

*You have to deal with so many problems... If they don’t have food – who cares about depression?*
What staff tell us…

- **Screening**
  - Most used EPDS
  - EPDS use is “easy” and “straightforward”

  “I like the screening tool because it gives you a way to introduce the subject and talk to a person about depression without it seeming artificial or them suspecting that you think they’re depressed…It’s just a routine thing that you do with all clients.”

- If not – “Red flags”
What staff tell us…

- Screening barriers
  - Time
  - Setting (privacy!)
  - Referral – Follow-up & Follow-thru
  - Language/culture
  - Literacy
    - Screening tool questions not always understood or relevant
Making screening and referral routine

- Set the expectation to screen all women
- Establish a screening and assessment protocol
- Assign clear roles to staff
- Increase awareness
  - Posters
  - Flyers
  - Educational materials
  - Establish a referral network
Pt completes EPDS responses represent feelings in the last 7 days.

- **Score ≥12 postive score on #10**
  - Nurse reviews EPDS with pt and assesses current mood
  - Provide education about perinatal mood disorders and available local resources
  - Document EPDS score and assessment in EPIC flowsheet
  - Document in EPIC flowsheet
  - Provide education about perinatal mood disorders and available local resources
  - Notify LIP of findings
  - Consider follow up with local provider
  - Consider follow up with Women's Wellness Center
  - Consider Psych Nursing Team referral if current mood is low
  - Consider Psych consult if current suicide risk

- **Score <12 0 on #10**
  - Provide education about perinatal mood disorders and available local resources
  - Document in EPIC flowsheet
  - Consider follow up with Women's Wellness Center
  - Consider Psych consult if current suicide risk
Who should we screen?

- *Everyone* – not just women you consider at risk
When do we screen?

The onset or relapse of symptoms can occur at any point.

Women want to be screened at several time points.
When do we screen?

- **Obstetric Patients**
  - New Ob
  - 20 weeks
  - 26 – 28 weeks (GTT)
  - 36 weeks (GBS)
  - 6 weeks postpartum
  - As needed…

- **Other Caregivers**
  - New appointments
  - Annual exams
  - All well-child visits
  - As needed…
Introducing a screening tool

- Depression screening is part of *routine* health assessment
  - Weight
  - Urine
  - Blood pressure
  - Mood

- Private location
- Address confidentiality
Introducing a screening tool

We are interested in how she has been feeling/how things have been going

“Because you are a caregiver, we would like to know how you are feeling now. Our clinic/program asks all caregivers to complete this questionnaire.”
Introducing a screening tool

“Along with the self-history form [and any other forms], there is a questionnaire about how you’ve been feeling lately. We’re asking all women to fill it out.”

“Your provider will review the questions with you during your appointment.”

“Your answers are a confidential part of your medical care.”
Screening tools are for

- SCREENING ONLY – does not replace clinical assessment

“You have to look at it a whole lot more than just what the number comes out at the end…”
What should we use to screen?

- **Patient Health Questionnaire**
  - (PHQ- 9)
  - Validated for use in all caregiver populations
What should we use to screen?

**Patient Health Questionnaire (PHQ-9)**

- A 9-item scale designed to compare depressive symptoms against DSM-IV criteria items in a health care setting
- Sensitivity: 88%
- Specificity: 88%
This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability. You do not have to answer any questions you are not comfortable answering.

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

If you checked “several days” or more for some of the questions above, discuss your answers with a doctor. Also talk to your doctor if you have had thoughts of hurting yourself or thoughts that you would be better off dead. If you are thinking of harming yourself, ask for help immediately. Your doctor or nurse can provide help and are excellent people to tell about these kinds of thoughts.

Patient Signature ___________________________ Date ____________ Time ________

Physician Signature ___________________________ Date ____________ Time ________
Tips for Scoring Screening Tools

- Provide women a copy without scores
- Score on a duplicate for your records and notes
- During scoring, provide educational materials and resources
Scoring the PHQ-9

- Add the scores for each item to obtain a total score
- 10 or greater = significant risk of having or developing depression
- Score of 1 or more on #9 indicates likely suicidal ideation
Screening Guidelines - Example

*PHQ-9 Score 0-4*

- Provide education
- Recommend to call if symptoms develop or get worse
Screening Guidelines - Example

*PHQ-9 Score 5-9*

- Provide support and education
  - Explain that she is considered at risk for depression

- Recommend to call if symptoms get worse
- Screen again in 4 weeks
Screening Guidelines - Example

*PHQ-9 Score 10+

- Provide support and education
- Offer treatment and/or referral to [Women’s Wellness & Counseling Service – or local option]
- If decline treatment and/or referral, recommend to call if symptoms get worse and screen again in 4 weeks
Screening Guidelines - Example

*If PHQ Item #9 is present at all:*

- This item should be discussed further using the following questions
  - “Have you done anything to hurt yourself, or to try to kill yourself?”
  - “Do you feel like killing yourself now?”
  - “If you killed yourself, how would you go about it? Do you have a plan?”
Reimbursement -- not a barrier anymore!

- PHQ-9 screening (administered by RNs, social workers (BSW or licensed)) can be billed under the child’s Medicaid number (CPT Code 99420)
What else could I use to screen?

- **Edinburgh Postnatal Depression Scale**
  - EPDS (Cox et al., 1987)
  - Validated in a number of populations
    - *Medicaid approved its use up to 1 year after delivery*
  - 3rd grade reading level
  - Available in 20 languages
Using the EPDS

- Brief and easy to use
- Self-administered
- It can be read aloud or done over the phone
As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean: “I have felt happy most of the time” during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all

2. I have looked forward with enjoyment to things
   As much as I ever did
   Rather less than I used to
   Definitely less than I used to
   Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

4. I have been anxious or worried for no good reason
   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

*5. I have felt scared or panicky for no very good reason
   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all

*6. Things have been getting on top of me
   Yes, most of the time I haven’t been able to cope at all
   Yes, sometimes I haven’t been coping as well as usual
   No, most of the time I have coped quite well
   No, have been coping as well as ever

*7. I have been so unhappy that I have had difficulty sleeping
   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

*8. I have felt sad or miserable
   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all

*9. I have been so unhappy that I have been crying
   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never

*10. The thought of harming myself has occurred to me
   Yes, quite often
   Sometimes
   Hardly ever
   Never

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)
J. L. Cox, J. M. Holden, R. Sagovsky
Scoring the EPDS

- 10 Items
- Rate over the **last week**
- 0-3 scale per item, some reverse-scored(*)
Scoring the EPDS

- 0 = no depressive symptoms
- 30 = severe symptoms
- ≥12 = “positive screen” – but use clinical judgment, assess duration

Exceptions:
- Depression history – consider ≥9
- 0 or unexpectedly low
- #10
The thought of harming myself has occurred to me.

- Yes, quite often
- Sometimes
- Hardly ever.
- Never.

Follow up on response scores 1-3
Other screening approaches (NOT Medicaid approved)

- **Patient Health Questionnaire (PHQ-2):**
  1. Have you often been bothered by feeling down, depressed, or hopeless?
  2. Have you often been bothered by little interest or pleasure in doing things?

- **Olsen et al. 2005 and Iowa – 1st Five**
  1. In the past couple of weeks, have you been in a depressed mood most of the time?
  2. During the past couple weeks, have you often had little interest or pleasure in doing things?

- **Pregnancy Depression Screening Scale (PDSS)**
Other screening approaches

- Some women will prefer to simply be asked about their mood, rather than completing a form.
Screening Fathers for Depression

- Screening tool – EPDS (cut-off is >9)
- Be attentive to the “0s”
- Screening – getting men to “open up”
  - e.g. mental health prompt list
Reaching Fathers

Think outside the box:

- Mothers attend the majority of maternal and child health appointments
- Edinburgh Postnatal Depression Scale-Partner Version
  - Completed by mothers
Responding to Screening

- Provide education to all women and encourage them to contact you with change

  “[Client name], thank you for completing the questionnaire about how you’re feeling (since having a baby). I’ve reviewed it and would like to follow-up on a few of your answers.”

- Review of items is essential
- Opportunity to discuss responses and other feelings, problem solve
Responding to a positive screen

- Provide education
  “These symptoms are common [in pregnant/postpartum women/mothers/parents] and can have serious consequences [for you and your baby/child(ren)].”

- Conduct further assessment and/or offer treatment/referral
Responding to Screening

- Normalize, reassure and/or “share a story”
- Develop a list of clinical follow-up questions
Clinical follow-up questions

- What has your mood been like most of the time for the past couple weeks?
- Have you been able to enjoy things in the past couple weeks?
- What areas of your life bring you enjoyment? Have you been able to do these things recently?
- Do you feel you are getting enough support to manage things well?
- Are you able to rest or sleep while your baby is sleeping?
- Are you finding it difficult to get out of bed?
- Are you eating enough? Do you enjoy your food as much as usual?
- Are you finding yourself feeling guilty or bad about how well you are doing things (or how well you are caring for your baby/child(ren))?
- Are you having difficulties concentrating or staying focused on things? Are you having difficulty making decisions?
- Do you feel like it takes more energy than usual to do your usual activities?
Clinical follow-up questions*

- Many women/new mothers have thoughts they find frightening or unwelcome. Are you having any strange thoughts like that?

- Many people, when they are experiencing difficulties with their mood, have thoughts of wanting to die or ending their own life? Have you had any thoughts like that?

- Do you worry that you might hurt your baby (or other children)?

*Please note that questions about harm to the baby are not included in the EPDS (or PHQ-9) and should be included in a woman’s assessment.
The next step...

- Screening alone does not improve outcomes
  - This is why inadequate screening policies exist.

- Adequate treatment or referral for treatment and follow-up are essential
Experienced staff tips: Making referrals

- Act as an advocate
  - At times call for her
- Develop a list of referral resources
  - Agency-affiliated or co-located care
- Explore barriers
- Share what you know about untreated depression
- Follow-up is challenging, but essential
  - Call her to follow-up
  - Get consent to check with her provider
Making referrals

- Primary care provider

- Mental health care provider
  - Symptoms are severe
  - She is having thoughts of self-harm or harming others
  - Co-occurring psychiatric disorders are present (e.g. substance abuse, psychosis)

- Therapy is 1st line, Listening Visits (milder symptoms)

- Medication – Physician (FP, Ob-Gyn, Internist, Psychiatrist)
  - previous successful treatment with antidepressant medications
  - preference for medications
  - more severe symptoms
Improving referral uptake

- 1298 women screened with EPDS
- 16% scored $\geq 10$ EPDS – all physicians notified of screening results

- Women who reported their physician discussed depression with them after screening were significantly more likely to seek treatment (39% vs. 14%)
Improving referral uptake

- Provide on-site mental health referral options
  - "We offer treatment right here in the clinic, including counseling or medication. These treatments can be really helpful for what you are experiencing. Are you interested in learning more?"
Improving referral uptake

- Provide individualized feedback
- Monitor referral needs in an ongoing fashion
- Provide education about normative perinatal mood changes (or the stress of parenthood) vs. depression
Improving referral uptake

- Ask women about their perspective on symptoms, treatment preferences and barriers to/concerns about treatment
  - “Do you have concerns about going to talk to someone?”

- Is she already in treatment?
- What has worked for her in the past?
- Where does she live?
Crisis Intervention

- Serious thoughts of suicide or self-harm, infanticide or psychosis
- Do not leave her alone
  - Find a friend or family member
- Guidelines consistent with your resources
  - On-site consultant mental health professionals
  - Crisis teams
  - Local law enforcement for well-being check
  - Emergency Room
  - 911
When should I be concerned?

- Tell me more about the thoughts you have been having about hurting yourself (or your baby)(or others).
- When did you have these thoughts? Was it in the last 7 – 14 days?
- What ways have you thought about to harm yourself (or your baby)(or others)?
- Have you done anything towards that plan?
- Do you have what you would need available to you?
- How often are you having these thoughts? How long have you had them?
- How likely is it that you might actually act on those thoughts?
- What keeps you from acting on those thoughts?
- Have you ever tried to harm yourself (or your baby) (or anyone else) in the past? How?
- Have you given away any of your things?
Referral & Follow-up

- Document total score and steps taken
- Make follow-up phone calls if needed
Resources

- What’s available for Iowa women and providers in the perinatal mental health field?
- Education
- Consultation and Support
- Clinical and Treatment Resources
- Research Initiatives
Perinatal depression is more than the baby blues. It is a term used for depression during or after pregnancy. Having a baby can be one of the biggest and happiest events in a woman's life. While life with a new baby can be thrilling and rewarding, it can also be a difficult and stressful time.

Everyone has feelings of depression from time to time. When they occur during or after pregnancy and last for several days or weeks, this could be a sign of a more serious problem. The good news is... it is treatable and help is available.

If you, or someone you know, is experiencing perinatal depression or if you would like more information, contact the Healthy Families Line at 1-800-369-2229.
Consultation and Support Resource

- **Iowa Perinatal Mental Health Consultation Service**
  - [www.beyondtheblues.info](http://www.beyondtheblues.info)
  - Consultation about:
    - Assessment and treatment of perinatal mood and anxiety disorders
      - Medication administration
    - Screening and referral
Clinical and Treatment Resource Information

- Where can I send my patient?
  - Listing through beyondtheblues website
  - University of Iowa Women’s Wellness and Counseling Service (WWC)

- What if I am referring dad or another caregiver?
  - http://www.healthcare.uiowa.edu/icmh/iowa/

- Telehealth resources are in development
Who WWC serves

- Aimed at women age 18 and older suffering from mood and/or anxiety disorders
  - Pre-pregnancy planning
  - Pregnancy
  - Postpartum period (up to 12 months after delivery)
Referrals to the WWC

- Women may be self-referred or referred by a maternal or child health provider

- Non-UIHC providers & Perinatal Women
  - Call 1-319-335-2464

http://www.uihealthcare.org/womenswellness/
Suggested Website Resources

- **Prevention & Mitigation of Maternal Depression**

- **Screening Tools (EPDS/PHQ)**
  - health.utah.gov/rhp/pdf/EPDS.pdf
  - http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
Suggested Website Resources

- **Perinatal Websites**
  - www.beyondblues.info
  - http://www.uihealthcare.org/womenswellness/
  - www.postpartum.net
  - www.postpartumprogress.com
  - www.womensmentalhealth.org

- **Internet Resources for families with mental illness**
  - Family Talk  www.fampod.org
  - http://www.parentingwell.org/
  - For military families:
    - http://www.ouhsc.edu/safeprogram/
Addressing Caregiver Depression

- Caregiver depression is common (10% to 20%) and associated with negative consequences for the health of children
- Screen all mothers & fathers
  - Don’t forget about other caregivers
- Resources exist in Iowa
- We need to identify – treat – prevent
  - Improve accessibility of mental health services to caregivers