Screening for Maternal Depression: A Community-Wide Approach

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First 5 Alameda County

OVERVIEW

- Maternal depression defined
- Introduction to First 5
- Components of a system for maternal depression screening
- Measuring impact
- Results
- Barriers and Challenges

Perinatal Depression

- Related to childbearing
- Includes prenatal depression, postpartum blues, postpartum depression, and postpartum psychosis
  - Postpartum blues: occurs within 10 days of giving birth by 50-80% of all mothers
  - Postpartum psychosis:
    - rare form of maternal depression (estimated incidence 1.1 to 4.0 cases per 1,000 deliveries)
    - seems to be correlated with a personal or family history of bipolar or schizoaffective disorder
- Is the 2nd major reason (after childbirth) for hospitalization of women in the U.S.

FACTORS IN DEPRESSION

- Hereditary disorder for many
- Social risks and conditions contribute
  - Low-income women: response to multiple adversities - four or more risk factors correlate with the greatest level of risk
  - Low-income/women of color: often co-morbid with trauma, post-traumatic stress disorder (PTSD), anxiety, or substance abuse
- Biologic and hormonal factors

EPIDEMIOLOGY OF DEPRESSION AMONG WOMEN

- In U.S. twice as many women (12.3%) as men (6.7%) are affected each year (12.4 million women and 6.4 million men)
- Low-income women have double the estimated prevalence (25%)
- Most prevalent among women of child-bearing/rearing age (16 to 53 years)

Epidemiology of Depression Among Mothers

- Estimated rates of depression among pregnant and postpartum women range from 8 to 20%
- Low-income women with young children, estimated prevalence rates are approximately 40%
  - Early Head Start mothers: rates as high as 48% at enrollment
  - Teen moms at community pediatric health centers: 40%
  - Women participating in state welfare-to-work programs: 35-58%

Children of depressed parents have high rates of anxiety, disruptive and depressive disorders that begin early and often continue into adulthood

(Weissman, et al JAMA 2006)

HOW DEPRESSION AFFECTS PARENTING

- Lack of attunement and inability to read infant cues
- Less nurturance and interaction with children
- Less likely to engage in positive parenting practices and preventive child health practices
- May lead to non-effective coping strategies
- Other factors that frequently co-occur with depression can affect children, e.g. poverty, violence, history of trauma

Impact on Child's Social-Emotional Development

- A child's earliest experiences & relationships have life-long consequences (Neurons to Neighborhoods)
- Increased risk of social and emotional problems in young children of depressed mothers
- Parental depression linked to lack of school readiness and early school success
  - Poorer cognitive development
  - More limited language skills
  - Fewer social interactions skills
  - Difficulty in appropriately engaging adults
- Strengthening protective factors can mitigate the impact on young children, even if it does not reduce the depression

(Early Head Start)

First 5

- Created in November 1998 by Prop. 10, a tobacco tax
- Supports health, well-being and school-readiness of children prenatal to age 5, their families and providers who serve them
- Each CA county developed a strategic plan: Alameda County plan is known as Every Child Counts (ECC)

ALAMEDA COUNTY, CA

- Total population – 1.5 million (2000 census)
- Approx. 20,000 births per year (1,000 in NICUs)
- 125,000 children birth to 5 years
- One of most diverse counties in the US
  - 64% of households speak English in the home
  - over 50 languages spoken by entering kindergarteners

Parenting & Depression

- Every Child Counts (ECC)
  - Developed a system-wide strategy to promote identification/early intervention of maternal depression
  - Linked to ECC programs serving families with young children and our overall strategy of early identification of children with developmental concerns – “child find”

Family Support Services

A balance between prevention & targeted services . . .and direct services & systems change

- Hospital-based enrollment of new mothers for postpartum home visits
- Intensive Family Support Services
  - Babies/families discharged from NICU
  - Pregnant & parenting teens
  - Children/families referred to the Child Abuse Hotline (CPS) who do not meet the threshold for services
  - Developmental screening in pediatric offices
  - Specialty Provider Team

First 5 Components

1. Identifying partners
2. Increasing awareness & knowledge about importance of maternal (and caregiver) depression in the context of the developing child
3. Increasing screening in a number of settings
4. Increasing capacity for referrals and identifying funding for treatment
5. Addressing cultural issues related to screening, referral and treatment
6. Measuring impact: building an automated tracking and referral system that generates outcome data

ADDITIONAL COMPONENTS OF A COUNTY-WIDE SYSTEM FOR MATERNAL DEPRESSION SCREENING?

1. Indentifying Partners

Engaging partners: Ideas and Experiences in your community?

First 5 Components

1. **Indentifying Partners**
   - Public Health Nursing
   - Teen Services
   - Special Start (NICU)
   - Children's Hospital
   - County Behavioral Health Department
   - County Social Services Agency
   - Community-based grantees

2. Building capacity, increasing awareness & knowledge

- Multi-disciplinary/multi-cultural training and promotion
  - Maternal depression is a designated monthly seminar topic attended by over 100 providers from a wide range of disciplines
  - Includes multi-cultural panels
- Harris training on early childhood mental health to expand county capacity for treatment & referral
- Technical assistance and SPT applied training

3. Increasing screening in various settings

- Postpartum chart review for history of depression and observation prior to discharge
- Home visits for newborn and teen parent and families at risk for abuse – required to use standardized tool and tied to contract
- Moms with infants in the NICU – Special Start
- Community-based organizations with grants to provide family services, e.g. centering parenting
- Exploration of screening at child care sites

Postpartum Screening

- Referrals made to Specialty Provider Team for direct service, consultation or outside referral
- SPT received 305 mental health referrals from HOCs or PHNs – 131 for depression or past history of suicide attempt (2007-08)

4. Increasing capacity for referrals and identifying funding for treatment

- Training for mental health and child development specialists (over 200 providers have completed the 2 year Harris Training Seminar)
- Leveraging EPSDT reimbursement for mental health treatment services
- SPT joint visitation and modeling
- CBO grants for delivering family services with required training
- Advocating for state policy

5. Addressing cultural issues related to screening, referral and treatment

- Using Edinburgh in appropriate language and using providers familiar and comfortable with cultural issues
- Incorporating cultural issues into training
- Exploring innovative treatment methods

5. Measuring Impact

Outcome Measures

- Number of caregivers screened for depression by year, race/ethnicity
- Percent of caregivers who screen positive by program, race/ethnicity
- Percent of positive screens by risk factors: past history of mental illness/suicide attempt, health insurance (poverty proxy), mother's educational level, geographic area, etc.

5. Measuring Impact

Outcome Measures

- Percent of families referred to Specialty Provider Team by reason for referral
- Percent of caretaker positive screens whose children are screen positive for child development concerns
- Stories of families screened and treated reported by contracting agencies

5. Measuring impact: building an automated tracking & referral system

ECChange

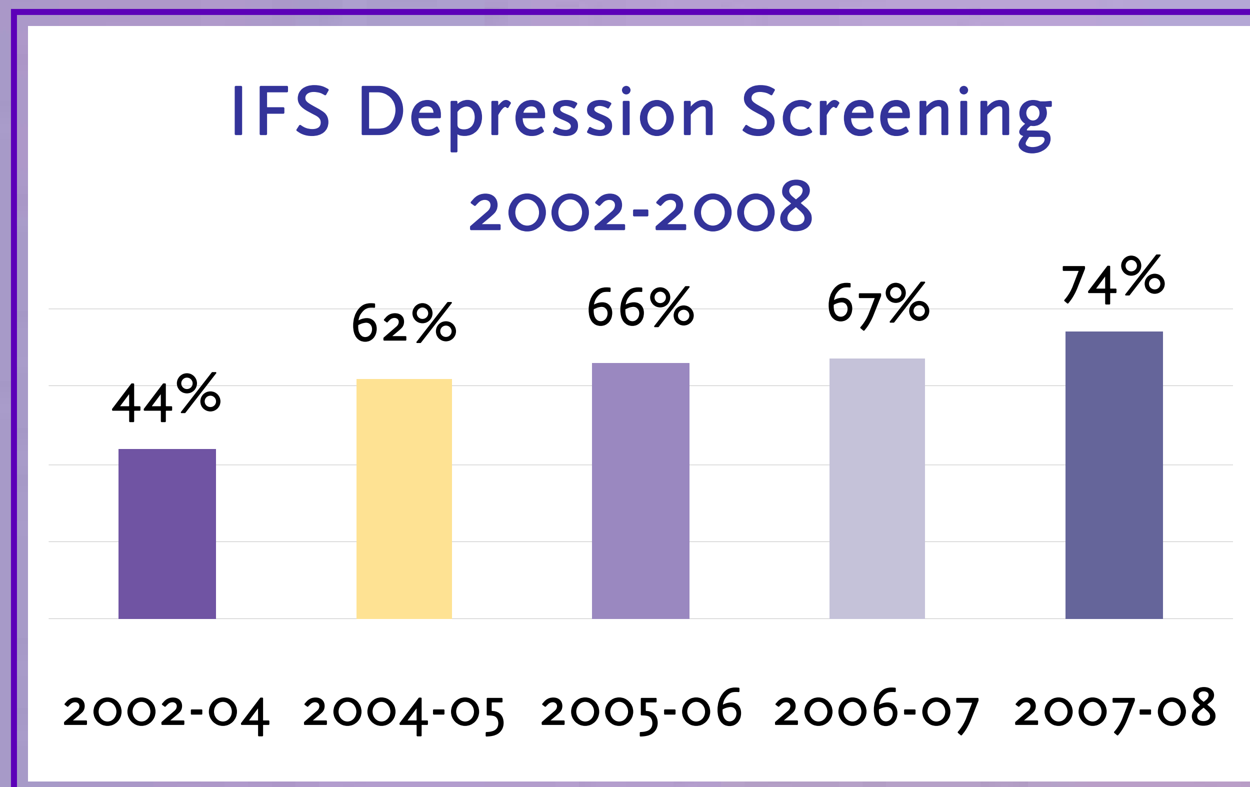
every child counts

web-based cross-agency information system for case management and accountability

- use technology as a systems change tool
- link outcomes reporting to client services
- support cross-program & agency data sharing where appropriate - minimize duplication
- management tool to monitor case loads, quality, productivity

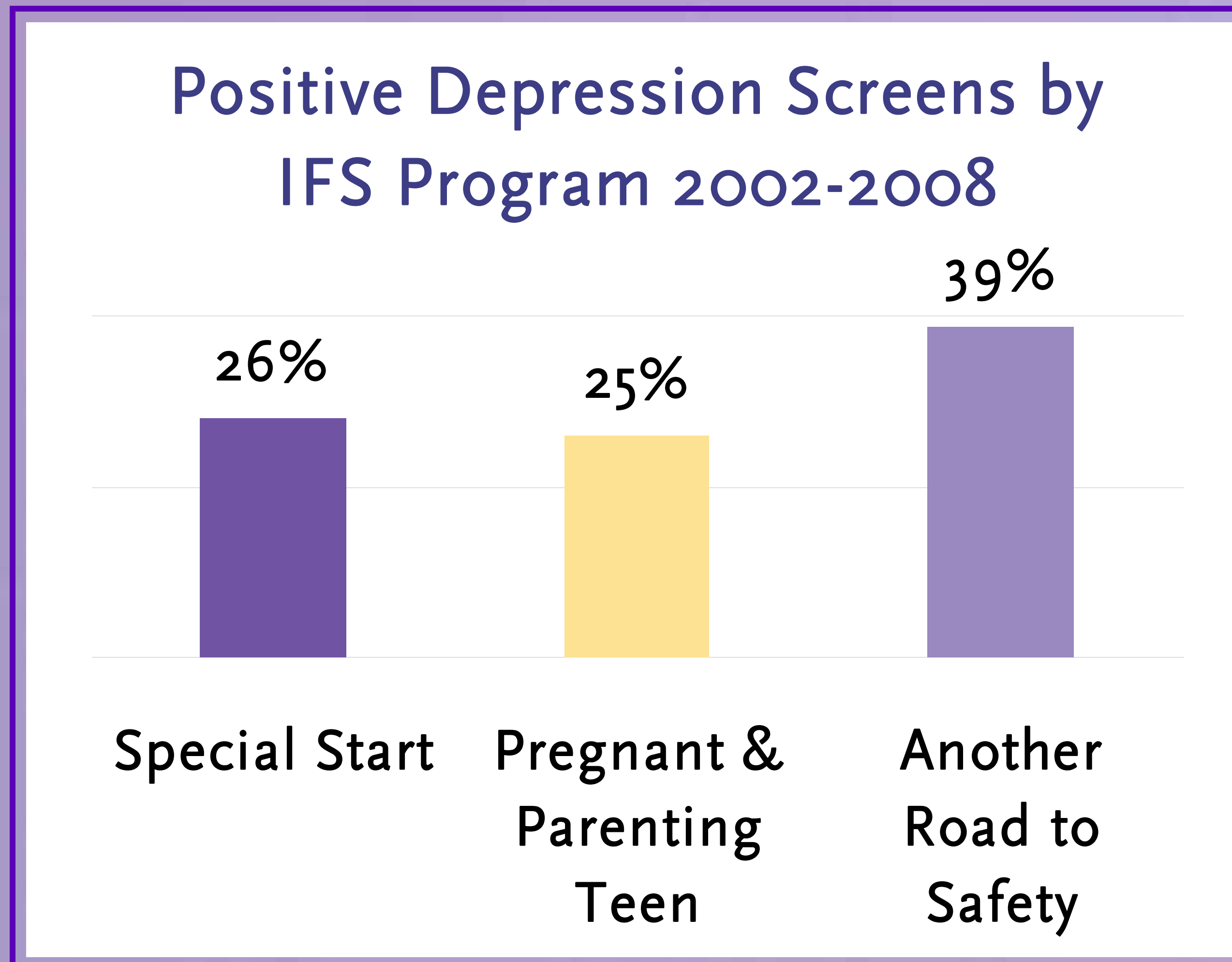
Intensive Family Support screening

- 2,787 caretakers screened
- Percent of caretakers screened increased over time

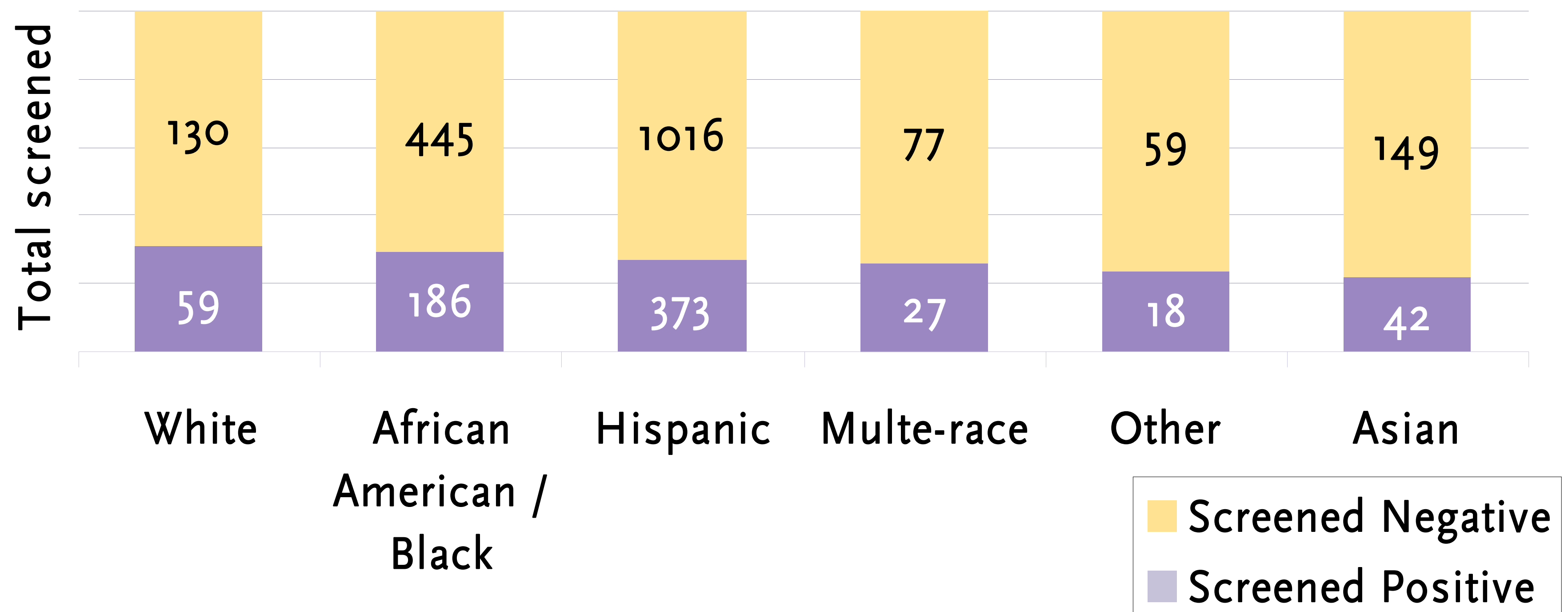


RESULTS

- 27% of those screened were positive
- Positive Screens varied slightly across programs



RESULTS



- Rates of depression vary little across R/E
- No significant difference between English and non-English-speaking mothers

Associated Risk Factors for Screening positive

More families who live in neighborhoods with low performing elementary schools (API < 4) screen positive for depression than those who do not

- ♦ Poverty
- ♦ Violence
- ♦ Health disparities
- ♦ Substance use
- ♦ Limited access to community services

Positive Depression and Child Development

- 73% of mothers screened for depression also had developmental screens conducted on their child
- Mothers who screened positive for depression were more likely to have a child who scored ‘of concern’ in at least one developmental domain compared to those who did NOT screen positive for depression - 61% versus 57% ($p=0.058$)

Barriers & Challenges

- Identifying additional validated & culturally appropriate screening tools for use in the field by non-clinicians
- Identifying culturally appropriate – best practice treatment options
- Lack of trained and skilled Early Childhood Mental Health providers to meet the need
- Lack of integrated services for parents in relationship to children

Barriers & Challenges

- Identifying reimbursement strategies for screening and treatment
- Identifying depressed moms prenatally
- Integrating screening with pediatric visits – coordination with pediatric developmental services
- Measuring follow-through & effectiveness of referrals

every child counts

www.first5ecc.org

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