

## **MCHB/DHSPS February, 2007 Webcast**

### **Train the Trainer:**

### **Maternal Depression Screening**

February 19, 2007

JOHANNIE ESCARNE: Good afternoon. I'm Johannie Escarne from the Maternal and Child Health Bureau. I would like to welcome you to this webcast, "Train the Trainer: Maternal Depression Screening". I would like to make some technical comments. Slides will appear in the central window and should advance automatically. They're synchronized with the speaker's presentation. You don't need to do anything to advance the slides. You may need to time the slide changes to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to ask the speakers questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, select question for speaker from the dropdown menu and hit send. Please include your state or organization in your message so that we know where you're participating from. If we don't have the opportunity to respond to your question during the broadcast, we'll email you afterwards. Again, we encourage you to submit questions at any time during the broadcast.

On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider, which you can access by clicking on the loudspeaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window.

At the end of the broadcast, the interface will close automatically and you'll have an opportunity to fill out an on-line evaluation. Please take a couple of minutes to do so. Your response will help us plan future broadcasts in this series and improve our technical support.

We have two presenters with us today. Our first presenter is Dr. Lisa Segre, a research associate at the University of Iowa. She will describe the train the trainer maternal depression screening program. The other presenter is Darby Taylor from Des Moines, a certified trainer in the train the trainer program. She'll describe her experiences becoming a trainer and having certified trainers at her Healthy Start site. In order to allow ample time for the presentation we'll defer questions and answers to follow the presentation. However, we encourage you to submit questions via email at any time during the presentation. Please identify which presenter the question is for so we can direct the question appropriately. We'd like to begin the presentation. Lisa.

LISA SEGRE: Thank you for inviting us, Johannie. Darby and I are very excited to be here to tell you about train the trainer program and Darby was going to be physically here in Iowa city at the University of Iowa but because of bad weather that many of you have heard about here in the Midwest, Darby was unable to travel interstate 80 is closed, parts of it are closed today. So we're keeping her safe in Des Moines and she is joining us by conference telephone call.

Today -- next slide. The overview, we are here to introduce you at the different Healthy Start sites to the train the trainer maternal depression screening program. We'd like to describe how the train the trainer program has increased the sustainability of maternal depression screening in a Healthy Start visiting nurse services in Des Moines and we

would also like to help you explore whether this is a program that would also be useful at your Healthy Start site. Before I get started describing the program, I would like to mention that train the trainer is a multi-person effort. I would like to acknowledge the other members of the train the trainer team, Doctor Michael O'Hara and Mr. Gorman.

Sponsoring agency, a special recognition to the Iowa Department of management for their financial support and specifically to Ms. WAGLER at this agency for her encouragement.

Next slide. Maternal depression is a relatively frequent disorder, as many of you know. And this disorder robs women of their early positive parenting experiences. The first meta-analysis of the prevalence of postpartum depression was done by O'Hara and his graduate student in 1996 where they estimated that approximately 13% of women experience this disorder. This figure was replicated worldwide, I believe with the exception of Japan. The most recent meta-analysis conducted in 2005 reveals even higher rate of postpartum depression, as you see in the slide. Now, two of our recent studies show that the prevalence of depressed mood is not uniform across all groups of women. It is not uniformly distributed. African-American ethnicity is a significant risk factor for postpartum depression, even after accounting for differences in social -- socio-economic class and also in terms of income. The prevalence of postpartum depression is also significantly higher in lower income women. So you can see in the slide titled maternal depression and income the distribution of prevalence across women with various income levels, annual income level. So the axis on the bottom has income level plotted from left to right, lower income to higher income levels, and on the Y axis the prevalence of clinically significant depression found in that group. And as you can see, 40% of women with annual incomes of less than \$20,000, the very left-hand bar, have clinically significant depression. That's quite different from the 13% reported in the meta-analysis. If you look at the very right-hand where women receive annual incomes of \$80,000 the prevalence of depression is

about 13%. So the prevalence of depression varies by income groups. Now, an important point to note on this slide is even though 40% of women in the lowest income groups are clinically depressed, 60% of low income women are not depressed. And that makes the important point that low income or having few resources does not cause postpartum depression. But depression and poverty represent double burdens. So as case managers in Healthy Start or family support workers are working with these women who are both depressed and have a low income, it will be particularly important to address the depression so that these women would then be able to carry out the case manager plan. While depression may seem like a relatively small difficulty in comparison to their other concerns, it is really important to address that depression.

Next slide. It's important to note that the negative effects of maternal depression are not limited to a woman's mood. These negative effects begin as early as pregnancy and include poor maternal health practices, maternal health complications like increased infections. Maternal high blood pressure and even higher levels of fetal stress hormones. They're more likely to neglect or physically abuse their infants or children. These sub optimal interactions in turn have a significant negative effect on the emotional, intellectual and social development of children.

Next slide. Maternal depression screening and Healthy Start. Recognizing these difficult effects, HRSA in 2001 mandated depression screening at all the Healthy Start sites and each program developed their own screening protocol. To implement depression screening in their program the Healthy Start site in Des Moines collaborated with us at the University of Iowa and we used what I call the intensive consultation model to help Healthy Start-Des Moines implement depression screening. We refer to it as the intensive consultation model because we provided a lot of direct consultation to Healthy Start in

order to get the program going. The intensive consultation model will contrast with the train the trainer program, which I'm going to describe in just a moment. Let me describe first the intensive consultation model on the slide with all of the -- depicting all of the circle. At the individual level, each circle tells you a little bit about what Dr. O'Hara and I did to get depression screening going in Healthy Start-Des Moines. We provided intensive monthly two-hour workshops on perinatal depression. We gave lectures on introducing perinatal mood disorders, depression, the negative effects of depression, depression screening and referral, how to do that and then treatment, successful treatment of perinatal depression. In addition, we helped Healthy Start to develop a screening protocol. We helped them to identify a screening tool, the Edinburgh Postnatal Depression Scale. We helped them to set a cutoff score and also to establish a schedule for their screening. Additionally, to help the Healthy Start case managers in terms of their work-up screening we prepared the Healthy Start clients by giving them presentations and educating them about perinatal depression. And Dr. O'Hara describes his very first presentation in this capacity was in the bottom of a church where he presented to a large group of women and that presentation was immediately translated into Spanish, Vietnamese, Arabic for the Sudanese women and then, of course, we have evaluated the outcome of screening and I'll describe those results in just a moment. But in addition to the individual and agency level, we also needed to prepare the system for the depression screening and referral that was going to go on in the community. To accomplish this preparation we provided educational workshops to the healthcare community. We spoke to nurses and physicians and psychiatrists and psychologists giving them educational workshops about perinatal depression and finally, with the help of Dr. Scott Stewart, we developed treatment resources by teaching them to implement interpersonal psychotherapy and that would be the mental health professional.

Next slide you will see a lovely billboard. As part of the work to prepare clients, Healthy Start conducted an awareness campaign and this billboard is part of that campaign. All right. So let's look at the evaluation slide. As you can see, and I would like to direct your attention to the red figures, as you can see screening was quickly incorporated. By the end of the second year, 95% of Healthy Start participants had completed at least one EPDS screen during their time as a participant. By the third year of the screening program, 99% of women had completed the EPDS at least once and that progress was sustained throughout the rest of the years at Healthy Start.

Next slide. Train the trainer model rational. At the end of the grant, I think you can say that we had successfully implemented depression screening and Healthy Start. Our consultation was complete. However, many new staff would come on board and need training. This may be something that you're facing in your individual program. Healthy Start Des Moines needed to find a way to sustain this training. Additionally, at this point, many other programs in the State of Iowa were approaching the Iowa Department of Health -- to implement screening. Healthy Start really set the example in the State of Iowa and other programs became more comfortable with the idea of doing screening. Because we at Iowa have a collaborative relationship with the Iowa Department of public health, particularly their Maternal and Child Health programs, they asked us to do the consultation with all of these other programs. Well, because the intensive model was not feasible on a wide scale basis, we developed the train the trainer model that I'm here to tell you about today.

Next slide. The rational for train the trainer. In June 2006 Dr. O'Hara and myself trained representatives from 25 programs across the State of Iowa. And they, in turn, provided the training to the staff in their programs. By reaching one person, Dr. O'Hara and I were

reaching many people and this became a way that we could feasibly disseminate depression screening throughout the state.

Next slide. Describing workshop one. Each train the trainer program -- we're in our third program now here in Iowa -- each program is accomplished in two workshops. In workshop one, we provide basic education about maternal depression screening, much like we provide it to the case managers at Healthy Start early on. And so we provide them with this information about maternal depression and they, in turn, will train their staff and provide that educational material to their staff. Because it is difficult to see material one and then present it to another group, a core component, which is indispensable to train the trainers is the trainers must develop their own set of slides using a template I provide. Now, I know the trainers are very busy in their agencies and don't have time to develop their own set of slide material. It would take them a very long time. So I provide them with a CD, and on that CD they have a template. That template tells them exactly what information they need to put in that slide. In developing their slides, they can either just copy my slides or they can use the extensive supplemental material I've given them summarizing the literature and read the brochures and develop their own ways of presenting the materials. Half the trainers develop their own material and half use my slides. Either way, by engaging in the material through developing their slides, they learn it and therefore are more comfortable when they go to present the material. Some of the trainers in train the trainer are nurses who are implementing depression screening in their hospital and they go on to train the physicians. They're very happy when they get to that training that they're more comfortable with the material because it's difficult for them to present to physicians. So I've had good feedback from the trainers about having to do this part of the task. We, the mentoring team, review their slides and provide feedback so that at the end of the day, they have an approved set of training materials. And finally, and this

part of the program may not pertain so much to you because many of the Healthy Start programs have already developed screening protocols, but finally they develop screening protocols that are tailored to the needs of their program.

Next slide. Description of workshop one continued. After the first workshop they go home and they have about three months to prepare their own slides. They send the slides to us little by little and we provide feedback and also they develop their screening protocols using a worksheet. Now, I can think of some Healthy Start sites may not be happy with their current screening protocols and so this would provide us with an opportunity to help you with that, if that were desired. Now, the description of workshop two on the next slide, in workshop two we get all of the training materials and screening protocols finalized and then for those who have not ever provided a training, we review the logistics of organizing a training. That's fairly basic information. And most importantly, we prepare these trainers for the barriers that they're going to encounter in implementing screening. Most of them are not implementing screening by mandate. They have presented themselves because they're enthusiastic about maternal depression screening and not 100% of their staff are going to initially be on board with that. So we want to inoculate them against that resistance and we give some lectures to prepare them to meet that resistance and help them to overcome that.

Next slide. And the final step is they train their program staff, they implement maternal depression screening in their program and very importantly, they act as educational resources for their individual communities. Next slide. How do train the trainer participants feel about the time they have spent in our program? This slide shows you some evaluations of workshop one. And the participants have positively evaluated both workshop one and workshop two but since workshop one is more relevant to you, I've

given you those results. All of the participants felt that the workshop was useful in preparing them to develop their own training material. They felt that the program was well planned and organized and the program goals were clear. And you can see that from the results that I present on the slide.

Next slide with the map. Were we successful in disseminating screening in the State of Iowa? Well, I think if you look at the map, you can see that yes, we were quite successful in implementing screening throughout the State of Iowa. Iowa is divided into 99 counties and you can see that we have 31 certified trainers across the state and the certified trainers are represented by red stars on that map. And if you look to the dead center of the state, you'll see one county that has lots of red stars, four red stars and a blue circle, and that's Des Moines, where Healthy Start is located and they have quite a few certified trainers and Darby will tell you about that. In train the trainer three that we're currently doing, we have 18 trainees. I know under the map it says 13 trainees but we've recently added a few. And they are indicated by the blue circles and the blue circles simply indicates there is a trainer in that county, not the number of trainees there. So I think it's safe to say that maternal depression screening is being disseminated across the state but yet there are still some areas we need to reach.

Next slide. You're probably most interested in the question how effective are these certified trainers in their presentation? I've had some anecdotal reports from staff of the Iowa Department of public health. They frequently circulate throughout the state and have attended the trainings of certified trainers and have come back to me unbeknownst to the certified trainer and have come back to me and given me very nice compliments about the quality of the training and we also have the evaluations of 92 people who attended the presentations of six certified trainers. Those results of the evaluations are on the slide.

The results indicate that the percentage of attendees who reported to be knowledgeable or very knowledgeable about each of the topics listed in the left-hand side of the slide increased significantly from pre to post workshop. Those who attended the trainings of certified trainers felt that they had learned a lot about perinatal depression.

Next slide. Because Healthy Start programs across the U.S. have already established depression screening, you may be wondering how is train the trainer going to be useful to me. And to speak about that topic, I am going to now introduce Darby Taylor, the Healthy Start project director, of visiting nurse services, Des Moines, Iowa. The Healthy Start director on the usefulness of train the trainer in Healthy Start and on becoming a certified trainer.

DARBY TAYLOR: Thank you very much, Lisa. I appreciate the opportunity to share with you all, as Lisa said, the usefulness of train the trainer and Healthy Start how it's impacted our Des Moines Healthy Start project as well as my experiences with becoming a certified trainer.

Next slide, please. Train the trainer certainly impacts the sustainability of our screening process. As Lisa indicated, it allows us to address turnover of staff as well as expansion of staff. We do have some turnover, as do all of our projects, among our staff and case managers and we also provide the same training to our interpreters and outreach workers that we do to our case managers so it allows us to address turnover among interpretive staff as well. Providing the training to interpreters on tools that they're interpreting for is beneficial to all participants and for the staff as well. It also provides us with some in-house ongoing support and it allows us to individualize to the specific training needs of staff. We may have a newer case manager who comes on board and says I got a lot out

of that initial training but I think I could use just a little more support and information and it is easy for us to do that. We have three Healthy Start project staff currently who are certified. That would be myself as the project director. We have the mental health counselor who is certified as well as one of our case managers. So if we do that individualized support we have a range of options. It could be pure support, someone in the mental health department as well as supervisory support. We plan on training two more project staff this year. Another case manager trained to expand that peer base and we're also going to train a team leader, another supervisor in that capacity. It has been wonderful to have the standardized materials and to be able to respond to the individual needs of staff.

Next slide, please. Benefits of train the trainer are many. I am a newer project director and have been in my position a little over a year. I was actually -- had completed workshop one prior to becoming the project director. It all happened in the beginning of my tenure and so that gave me a wonderful overview of perinatal depression and just how important screening was to give me a good understanding so I could communicate that information to staff. It also gave me very clear expectations on what staff were required to do in terms of the process and allowed me to quickly respond to their questions.

Next slide, please. I'm able to do lots of things with the train the trainer certification. I can provide training to other staff. We have other staff here at visiting nurse services, nurses and our Maternal and Child Health program who do depression screening so we can train them. I can utilize the information with case managers, with staff that I directly supervise. We also do some contracted agency work with case management services in seven different agencies in Polk County and so I'm able to provide information to those supervisors and case managers as well and really just on that ongoing basis has been

really beneficial to us. I would like to say that the process of train the trainer was a very enjoyable one. Lisa is a wonderful presenter. An excellent trainer, easy to listen to and work with. Gives good feedback and makes training very interesting and she really engages all of the participants, as do the other presenters, during the train the trainer process. I would also like to support what Lisa said in terms of creating the power points was just a wonderful experience. It gave buy in and ownership of the slides better than being handed a Power Point presentation and train with it. The template took away the hours of work that Lisa indicated would have happened that you would have had to catch up with so it was just a wonderful thing. I really felt like I knew the material after the completion of that and it was just a very rewarding experience and it has been a terrific benefit to the Des Moines Healthy Start project.

Next slide, please.

JOHANNIE ESCARNE: Thank you, Lisa and Darby for a great presentation. We do have a few questions that have come in. So I will go ahead and begin the question/answer portion of this presentation. The first question I believe is for Lisa. The question is, we already use the EPDS with our clients. Would this help us out?

>> Well, this program would certainly be compatible with the tool that you're using and I think in the way that Darby described, it would help you out to train new staff about the EPDS tool and also about perinatal depression. On the other hand, I don't think you have to be using the EPDS tool to utilize this program. But it certainly is a compatibility.

>> Thank you, Lisa. Our next question is from someone who is in Kentucky. I'm wondering if the train the trainer program is available in our area or if this is just focused for the State of Iowa and the Healthy Start program?

>> Well, I'm glad to hear interest in the program. I think the purpose of the webcast is to tell the Healthy Start sites, describe the program to Healthy Start sites to see if they might be interested in participating in the train the trainer program. So hopefully it will be available to you.

>> Thank you, Lisa. I believe this is to either of our presenters. Are there any plans to present the two actual workshops? And how do we get the EPDS?

>> I bet Darby is wanting me to answer that about the plan.

>> I am, Lisa.

>> The two workshops, that is something that we are exploring, as I said, in response to the last person. And if you're interested, let Johannie know that you're interested and we will continue to explore that possibility. The Edinburgh tool is on the Internet and it will pop up. Different versions pop up, however. If you email me I'll give you the version that I would like you to have.

>> Thank you, Lisa. We have a question here in the audience. Caller: This question is for Lisa. Could you tell us a little bit more about what you mean by develop their own protocols? I'm assuming that whatever version of the EPDS they choose, they don't modify that. So what is it that each site develops for itself?

>> Thank you for that clarifying question. When I refer to a screening protocol, I'm referring to the tool that they choose. Not modifying that tool, but selecting a tool to use. The cutoff score that they're going to use and then also the screening schedule and who is going to do the screening. Those are all elements of a screening protocol and these elements need to be individualized to the particular site because women aren't always seen at the same time and so they need to individualize that. Not -- but you're right, it is not about modifying the tool. The tool is used in its whole without change. Thank you.

>> Thank you, Lisa for that clarification. The next question is do the train the trainer participants receive CEUs?

>> We have not in the State of Iowa given CEUs for the participation in workshop but that doesn't mean that CEUs could not be given for participation in the workshops. The workshops are fairly, you know, stringent in terms of the educational level and I don't think we would have a problem getting CEUs. On the other hand, CEUs have been given to the people who attend the trainer's workshops. We've worked out a relationship with the Iowa Department of public health where they arrange to provide CEUs for the trainer's presentations and that's gone very nicely.

>> Thank you, Lisa. The next question, can you talk about using the EPDS itself with other populations that are non-English speaking?

>> Darby, do you want to address that one?

>> Sure. I can tell you we have lots of experience that here at the Des Moines Healthy Start project. 75% of our part is pants do not speak English or speak limited English. We have a fairly significant Sudanese population here as well as Vietnamese and Spanish-speaking participants in the Des Moines Healthy Start project and we have used this tool with all of those populations. And certainly found it to be successful. It is something that Lisa covers in the train the trainer and cultural awareness in terms of the delivery of this tool and the languages that the EPDS is available in and really it's an education for staff and for all staff who are involved on explaining the tool to the participant, you know, the word depression might mean something different to a different culture so we just have lots of training for staff and provide ongoing support and education about that.

>> Thank you, Darby. The next question. We're planning to use the DBI tool every six months for screening. Would this train the trainer program be useful for us?

>> As I mentioned before, using the EPDS is compatible with the program. This may be a point where we would need to individualize, take a look at your screening. But the program really supported indication about perinatal depression and does not require the use of a specific tool so I think it could be used with different tools.

>> We have another question here.

>> This is me again, you can identify me by my accent but I'm particularly interested in how you explain the concept of depression to different cultural groups who might not be familiar with this.

>> Darby, do you want to field that or would you like me to field that one?

>> Maybe we can both do that. I can just tell you that we have to be very thorough in our explanation, that we have to really allow the opportunity for questions. You know, you're absolutely right that sometimes words just don't translate exactly and the EPDS has been a good tool for us. It is a pretty straight forward tool. It talks about how you've been feeling and we really have had good success in the outcome of that tool and I think have gotten some honest responses from participants who are really able to pick up on some of those high scores. We turn to our outreach workers and our interpreters as our biggest resource to help us understand the cultures that they may be part of so we can then impart that information. I can tell you there is one question on the EPDS I feel things have been getting on top of me. I know that particular question has been something that requires a little bit of additional explanation because sometimes that's interpreted very literally as in things are getting on top of me rather than feeling overwhelmed. So it is really providing that extra support and explanation. Lisa, would you add anything to that?

>> Thank you, Darby, yes. And I think those points are all very good points. And I will just add from an academic perspective that the EPDS tool has been translated into a number of languages and has been widely used in a number of different cultures with success and acceptability among the women. So I just will add that part to it.

>> Thank you. The next question, at what level of depression are significant effects noted in the mother/infant interaction?

>> That's a very nice question. Actually, it takes very little depression to begin to notice negative effects. One of my opening sentences on some papers is even mild forms of depression are associated with significant negative effects for children. Thank you.

>> Our next question, would we have to go to Iowa to get trained?

>> Well, I hope you're not going to try to come in the winter. It's going to be very difficult. I hope not. I think the plan would be to hold the training in Washington, maybe in conjunction with an already-scheduled Healthy Start event.

>> Thanks.

>> Thank you, Lisa. This question pretty much gets to the same type of topic. We currently use a screening tool that works well for our site. We do wonder whether training will be available and how we do apply for training in states other than Iowa?

>> Okay. So this is great. I'm hearing an overwhelming response that you would like to have this training, so I'll just direct those to Johannie and see what she does with that.

>> I'll have to take them back to my director here, Maribeth and see what happens. I will make sure that I let her know there is quite an interest in the training in other areas other than Iowa and we can see if maybe we'll be able to arrange maybe some regional trainings based on a lot of things, actually, but we'll have to talk to Maribeth. The next question, is this an evidence-based program?

>> That's a good question. It is an evidence-based program, train the trainer is currently being evaluated. I have received approval from our institutional review board to evaluate the program and look at its success so yes, it is evidence-based.

>> Thank you. The next question is could we have Lisa's email address? I don't believe you have it on your slides here, so there is a question requesting your email address.

>> Sure. You may have my email address. And it is just my first and last name which is on the front of the slide, so Lisa-Segre and that would be @ uiowa.edu.

>> Thank you, Lisa. The next question, is the Edinburgh culturally sensitive and appropriate for Latino clients? Is it available in Spanish?

>> You bet it's available in Spanish. Dr. O'Hara, who is co-mentor with me, a member of the train the trainer team, had it translated into Spanish and unfortunately he can't be here today but he has quite a story to tell you about translating into Spanish. At first it was translated into Spanish from Spain and then he had a graduate student translate it into Mexican Spanish and went through quite a process to get it translated so that it was understood by some of the immigrants that we have here in Iowa.

>> Thank you, Lisa. There are several questions, actually, about the a built of workshops in areas other than Iowa. As I said before, we will take these suggestions back to Maribeth and see if we would be able to coordinate some kind of maybe regional trainings or something of that sort. Of course, I can't say right now if these trainings would be available in the foreseeable future. The next question. Is there a screening tool recommended for screening fathers for depression after a baby's birth?

>> Oh, that's a good question. Now you're getting outside of my area of expertise. But we do have a person here at the University of Iowa in our laboratory, Dr. Robin, who has done studies with fathers, looked at depression with fathers and do not quote me on this

but I believe she has used the Edinburgh with fathers but I'm outside of my area of expertise.

>> Thank you for at least trying to answer the question. The next question, is screening a service that is reimbursed by insurance companies?

>> Well, that's another good question and we've had some developments and Stephanie trusty at the Iowa Department of Health says the American Medical Association is starting to look at approving the units. There are units they need to approve in order to get screening reimbursed. And because I asked her, we have a newsletter and I asked her, how will that affect our trainers? Will that have an impact? Will they be able to get reimbursed for training? Her response was no, that won't have a direct effect on the trainers but often when the American Medical Association adopts a procedure, then that's not far before Medicaid will adopt that procedure. So I think that's coming down the line. Also, the State of New Jersey has mandated depression screening and I believe they have reimbursement for depression screening, as I think does the State of Illinois. But that's all in the political realm. I'm a psychologist. That's what I know about that information.

>> Thank you, Lisa. The next question. Is Healthy Start in Iowa comparable to Healthy Start families in Virginia?

>> Okay, Darby.

>> Well, that I would probably have to know more about the Healthy Start families in Virginia. I guess I could tell you a little bit about the Healthy Start families in Iowa. About

75% of our customers don't speak English. We serve a very diverse population, the vast majority of our families are in poverty. We see probably very typical things that all of you see. We see families of homelessness and housing issues who are having employment issues in need of childcare assistance, in need of social support. We may have participants with substance abuse or history of substance abuse. Obviously depression, domestic violence, legal issues. Those are really the risk factors and the things that we see in the families that we case manage. That's kind of a difficult question to answer but that might give you a better picture of what we serve in Iowa. I think sometimes the perception is that Iowa is a rural state, which certainly it is, but the Des Moines Healthy Start project serves lots of families with lots of needs. Des Moines is an urban area relative to some of your areas it's much smaller but we do see some of the same things that exist in larger cities as well.

>> Thank you, Darby, for trying to answer the question. Hopefully that did answer her question. The next question, can EPDS be used on pregnant mothers?

>> Yes. We use it with both pregnant and postpartum women. So certainly yes.

>> Okay. Thank you, Lisa. I think we are -- I don't see any more questions coming in right now. Is there any questions in the room? No? Oh, yes, there is another question in the room.

>> I have another question and I'm just wondering whether the EPDS picks up differences between women who are having their first child or a subsequent child, and also for women who are having twins or higher order multiples?

>> The EPDS is really designed to screen for depression so it's not designed to provide a diagnosis, an elevated score and Healthy Start in Des Moines we use 12 and above indicate there may be something wrong and that the woman needs further evaluation. In terms of differences between first-time moms and second-time moms or moms who are giving birth to multiple children, because it screens for depression, it is really looking to assess whether the woman is depressed, not anything else about her state.

>> Thank you, Lisa. The next question, how do you deal with a mom who is depressed and does not accept it, how do you treat her?

>> Darby, do you want to try that one?

>> We would continue to provide information and we would offer a variety of resources. We would attempt to get that mom engaged in therapy. We have other services we can offer to her. We have mental health staff employed with the project we could make referrals to. We have support and therapy groups that are conducted in several different languages that occur at different times throughout the month. We would attempt to make the linkages. The biggest thing would be to keep providing the information. We would keep following up and keep attempting to make the referral. It's like referrals we make to lots of services. Families may choose not to accept that but we would be that supportive, caring presence in mom's life and really attempt to get her engaged in services.

>> And that's an excellent response. I would just add to that that the education that we provide in train the trainer really helps the case managers or actually the education that the trainers then provide in train the trainer really helps the case managers to be able to explain depression to women in words other than just depression. And also tries to help

them to make useful referrals. We talk about the process of making a referral and how you sometimes have to go about it in indirect ways to help the woman.

>> Thank you, Lisa and Darby. Does breastfeeding have a positive effect on the depression scale? That's our next question.

>> I'm not sure that I understand the question. If breastfeeding has a positive effect. I think I'll make a stab at this question, though, and I'm not sure that breastfeeding has a protective effect against depression, if that's the question.

>> Thank you.

>> Thank you, Lisa. Do you have measures of the program's system impact for increasing capacity for treatment?

>> A good question. It is related to one that was asked before, is this an evidence-based practice. We're gathering that information about the system impact but anecdotally you've seen the map and you can see how many certified trainers we have. We have evidence that those trainings that they provide are effective and what we're gathering now is data about the screening. How many women are screened after they implement the depression screening program in their individual sites. Thank you.

>> Thank you, Lisa. What kind of program adaptations are used for moms that screen with depression in addition to referral?

>> Could you read that one again?

>> Sure. What kind of program adaptations are used for moms that screen with depression in addition to referral?

>> Darby, can you take that one?

>> I'll try it. I'm not entirely sure I understand the question but I'll try. We could adapt the frequent see of home visits. We would ask mom if she wanted to be seen more frequently. Depending on her wishes and needs we may attempt to do a visit in the office. We may attempt to go out and do something with her. We -- again, you're probably going to make sure you've made the other referrals for her that you would need to address anything else that would be going on in her life. Like I said, we would encourage her to participate in our support groups, in our therapy groups and really our case managers have lots and lots of trainings. In addition to depression training they're bachelors prepared with two years of experience in Human Services, so generally they're coming from a human service background. Really just trying to appropriately meet mom's needs and be sensitive to her. Anything you would add to that, Lisa?

>> I think that's a good answer. The only thing I can add to that is in Des Moines, this is really only in Des Moines thus far, we are exploring an intervention that we've imported from the U.K. called listening visits on an experimental basis. It is evidence-based practice in the U.K. We're implementing it. Case managers and nurses can do these in the home with the woman. But again, we're just gathering the evidence on this practice and that's also available to the women.

>> Thank you.

>> For Healthy Start sites in rural areas with few mental health resources what do you do if there isn't a mental health specialist that you can't refer to mom to, and what do you do for women who can't afford treatment?

>> It's a terrific question and I'm not sure that I know the answer to that. I would certainly encourage mom to talk to her medical provider, to talk to her physician. You know, I know that's a source of frustration for lots of us about ability to pay for services especially when you're in a more limited rural area like that. Parts of Iowa certainly are and I know they face some of those same struggles that we -- and we face them in Des Moines. I know they're more pronounced in the rural areas. I would encourage mom to talk to her physician and see if there are any linkages that could be made there.

>> Thank you, Darby. I think this question can also be directed to you. Have you found a specific modality of treatment to be especially effective with this population?

>> I would say that not probably one in particular. I would say that we've had some success in getting moms to go to therapists or to go to counselors. We've actually had a lot of success with our in-house mental health staff. That has been a wonderful benefit to us that we have counselors here that can go out on home visits with case managers. That really sometimes not as frightening, perhaps, as going into an office environment and they can meet them and a health counselor prior to her coming out and have the case manager there for an initial introduction. That's been successful. We've offered therapy groups. The grief associated with losing your home and your country and then some of the cultural adaptations as well as the potential loss of some family members they may have encountered. I would say it's difficult to say what works for one person might not work for

everybody but we've found having a variety of options that has best allowed us to meet the needs of the participants.

>> Very interesting, Darby, thank you. I think this is a clarification to the breastfeeding question. I believe she meant to say do those women who breast feed have a lower depression score?

>> So the question is, is there lower prevalence of depression in breastfeeding women?

>> Yes.

>> I'm not aware of any studies that have looked at the prevalence of depression in breastfeeding women specifically and compared them. When I looked at the prevalence of depression across income levels, that study hadn't been done, either. So this is relatively new work sort of looking at prevalence in different groups of women. I'm not aware of a study that looks at breastfeeding women.

>> It's not a question, it's a comment on the issue of depression and breastfeeding, which is of interest to us here in our division at MCHB and I've recently found out that the new state breastfeeding coalition has put out a publication on this very topic. I haven't read it yet but it might be a useful resource. I think there is a psychologist in New Hampshire whose name escapes me at the moment, who is very interested in exploring this further.

>> Thank you. The next question. How do you decide which questions on the screening tool are due to depression or due to normal behavior after having a baby, such as lack of sleep?

>> That's a great question and one that was addressed in the development of the Edinburgh postnatal depression scale. A scientist from the U.K. when he developed the EPDS purposely avoided those somatic symptoms that confound symptoms of pregnant women and postpartum women with depression. Thank you.

>> Thank you, Lisa. The next question. It is very interesting to me the incidence of maternal depression continues to go up with low income families and the incidence of moms being induced in the hospitals is at an all-time high. Is there a connection?

>> That's an interesting question and certainly would merit further exploration. I'm afraid I don't have any immediate information on the connection between induced labor and perinatal depression.

>> Thank you, Lisa. When is the best time to screen women, one week or one month after they give birth?

>> Well, that's a question that we -- with which we struggle a lot in developing screening protocols in train the trainer. And the one study that has looked at the prevalence of depression in pregnancy and in the postpartum period has really not shown that there is a peak period of depression during any specific time that you would say oh, we should screen at that time. So between -- really kind of programmatic concerns can take over. When are you likely to catch women? What is going to work in your agency can guide that? Sometimes if you screen too soon the woman hasn't had a chance to get home and adjust and really develop some of the issues that are going to pop up. We at Healthy Start

screen on a fairly rigorous and regular schedule. So I don't have a specific answer for you there but those are some things to consider.

>> Thank you, Lisa. The next question is directed towards Lisa. Please describe a little more about the evidence-based listening visits from the U.K.

>> Okay. This is very experimental. And listening visits from the U.K. Listening visits in the U.K. are delivered by public health nurses there who are called health visitors. And health visitors use -- we really adapted our screening programs based on practice -- evidence-based practice in the U.K. They used the Edinburg postnatal depression scale. When they find a woman is mildly to let's say moderately depressed they'll offer a series of listening visits. There have been three randomized control trials of the effectiveness of listening visits as delivered by both public health nurses in the U.K. and by Swedish primary care nurses and they found that the listening visits are associated with reduced depression scores. As one way of addressing treatment gap services, the former director of Healthy Start and now one of the C.E.O.s at Healthy Start in Des Moines, thought it would be a good idea to bring along with Dr. O'Hara and myself, to bring over the trainer of the British listening visits to the site here in Des Moines to train the case managers to implement this intervention. So that was a very exciting and successful event and now the case managers and nurses use the listening visits as one of the many options in working with depressed women and they're very careful to use it with mildly to moderately depressed women. And the women I should stress have a range of treatment options that they can choose from. And we're currently gathering evidence on the effectiveness of these listening visits. They aren't quite ready for expansion until we gather that evidence. Thanks for your interest. It is a project near and dear to my heart.

>> Thank you, Lisa. The next question. Do you provide mother/infant interventions?

>> That's a very sophisticated question. One of the successful treatments has been mother/infant therapy. No, I do not provide any training in mother/infant psychotherapy.

>> Thank you. What is the training of the mental health counselors and do they have young child mental health training?

>> I would take that. In terms of Des Moines Healthy Start project they're licensed social workers with masters degrees here. You know, I don't -- I'm sure they have part of that as part of their schooling. It's not typically their background but they're LASWs.

>> Thank you, Darby. What is the Healthy Start screening schedule? If you screen too early you won't likely identify moms who have baby blues and not depression.

>> I can tell you that our schedule here, we do an assessment at intake whenever we get mom into service. We do it in third trimester, one to two weeks after birth, three, 12 and 18 months postpartum and then at discharge. I want to add that the case manager could do another EPDS whenever that may be warranted.

>> Thank you, Darby. This question I think may be directed to Lisa. I'm not sure if you'll be able to answer it. Have you ever found any relationships between overweight and depression?

>> I believe that's a question that we have recently looked at in Healthy Start, obesity and depression. There is a link. I know the link exists in the literature. I don't have a firm grasp of that literature but I'm aware that is an association.

>> Thank you, Lisa. Do we have any more questions? Either here in the room or online? It usually takes a few moments for them to come in. I'll give them another minute or so to see if anything else comes in. While I'm waiting to see if anything else comes in, Darby or Lisa, do you have anything further that you would like to expand on?

>> No. Go ahead, Darby.

>> Just one other thing in terms of treatment options for our participants that I failed to mention. We also have contracted services with a psychiatrist and so we're fortunate in that way if we have a participant who would not be able to access those needed services of a psychiatrist in another way, we have a contract to be able to have that participant seen. I just wanted to add that as well.

>> And I don't have anything to add about train the trainer. I'm very excited about the interest in the train the trainer program and I look forward to maybe working with you soon.

>> Well, we do have a few more questions. This question is for Lisa. Why screen again at 18 months postpartum?

>> If you look at the official diagnosis of postpartum depression, really pertains just to the period in the first month after childbirth that is in terms of the diagnostic and statistical

manual criteria. The clinical experience is that women can experience depression any time in those first two to three years. And so -- and that depression, even in its mildest form as I mentioned earlier, can have a significant negative effect on the development of children. So the reason to screen -- continued screening is that depressive episodes can come and go. If you participate in train the trainer you'll see a very complex slide that shows that depressive episodes come and go and sometimes they begin very late in the postpartum period. And you don't, because of the negative effects, want to miss that depression.

>> Thank you, Lisa. This question I'm not sure if it would be for Lisa or for Darby. What is the length of involvement with the mom?

>> I can field that, Lisa. Our program probably runs a little bit differently than some of yours in that we have some funding that allows us to serve families a little bit longer and we have an empowerment funding which comes from the State of Iowa so we can actually retain participants. They finish their Healthy Start service when the child reaches the age of two but then they can retain with the same case manager and be in empowerment service through the child's fifth year until they reach six years of age. Not a typical course of service delivery. I don't know we've had families enrolled quite that long but we have the flexibility. In terms of Healthy Start, we certainly try to get families enrolled when mom is pregnant or as close to birth as we can and keep them until the child reaches the age of two.

>> Thank you, Darby. If women have a drug addiction or HIV can they be screened with the same tools?

>> I believe that they can be screened with the Edinburgh Postnatal Depression Scale, yes. We're accessing or assessing their level of depression. And as you know, substance abuse and depression are typically co-morbid so yes, I believe that that would be a useful tool.

>> Thank you, Lisa. Do the mental health counselors provide clinical services in the home? I think this is directed toward Darby.

>> They can certainly see participants in their home, absolutely. As I also said they can come to support and therapy groups held in a church that we rent some space out as well. We're a home-based home visiting program.

>> Thank you, Darby. This question I think Lisa you may have already answered. The EPDS will it pick up depression more than 12 months postpartum?

>> Yes, it can be used after 12 months postpartum, certainly.

>> Thank you, Lisa. Any other questions? I think we're nearing our end time. I don't see any other questions coming in and if any questions come in at the very last moment, we'll email you a response. So don't worry if this webcast ends before your question comes in. We'll get back to you as soon as we can. With that being said, on behalf of the Division of Healthy Start and Perinatal Services I would like to thank our presenters, Darby and Lisa, and the audience for participating in this webcast. I would also like to thank our contractor, the Center for the advancement of distance education at the University of Illinois at Chicago School of Public Health for making this technology work. Today's webcast will be archived and available in a few days on the website [mchcom.com](http://mchcom.com). We encourage you to

let your colleagues know about the website. Thank you and we look forward to your participation in future webcasts.