

Healthy Start Depression Screening: Where Are We Today? **(Webcast date: June 24, 2003)**

>>JANICE BERGER: Hello.

On behalf of the federal Healthy Start office I would like to welcome you to our very first WebCast.

Our topic for today is Healthy Start Depression Screening: Where Are We Today? We have two speakers.

Dr. Michael O'Hara from the University of Iowa and Kimberly Yonkers from Yale University.

I've been given the task of reading instructions for the WebCast to you.

So here they go.

Slides will appear in the central window and should advance automatically.

The slide changes are synchronized with the speakers' presentations.

You don't need to do anything to advance the slides.

You may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window.

Number two is, we encourage you to ask the speakers questions at any time during this presentation.

Although we will be answering the questions at the end of both of their presentations.

Simply type the question in the white message window on the right of the interface.

Select question for speaker from the drop-down menu, and hit send.

Please include your state or organization in your message so that we know where you're participating from.

The questions will be relayed onto the speakers periodically throughout this broadcast.

If we don't have the opportunity to respond to your questions during the broadcast, we will email you afterwards.

Again, we encourage you to submit questions at any time during the broadcast and don't be shy.

Number three, 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.

Number four, for those of you who selected accessibility features when you registered, you'll see text captioning underneath the video window.

Number five, at the end of the broadcast, the interface will close automatically and you will have the opportunity to fill out an on-line evaluation.

Please take a couple of minutes to do so.

Your responses will help us to plan future broadcasts in this series and improve our technical support.

Okay.

Without any further adieu I would like to introduce Dr. Michael O'Hara.

>>MICHAEL O'HARA: Good afternoon to all of you.

It's a pleasure for me to be here with you.

I am a professor of psychology at the University of Iowa.

I'm also involved with the Des Moines, Iowa Healthy Start project.

I've been working in the area of perinatal depression for about 24 years now and I'm very excited about today's WebCast and hope to share, along with Dr. Yonkers to make your life easier in the various settings you're providing your services.

The title of my presentation is the why and the how of screening for perinatal depression.

The prevalence of depression in pregnant and postpartum women is high.

It's a time that they're particularly susceptible to depression.

You can see from the current slide that a number of studies, certainly not exhaustive, but representative studies have estimated depression during pregnancy and the postpartum period to be on the order of 10% to 15%.

One in ten to one in six or seven women who are pregnant or post partum are likely to have a clear depressive episode.

Depression has a number of negative effects on women and their children.

Women who are depressed during pregnancy are at higher risk for problems like preeclampsia, longer labors, to deliver children with lower birth weight.

After the child is born, there is often problems with unscheduled acute care visits and we even see that women who experience depression during pregnancy are likely to have children who have problems in their behavior.

When we look at post partum depression when women are depressed in the postpartum period we often see problems associated with maternal interaction with the -- the mother's interaction with her child.

We see that women are often more hostile, irritable, or less positively engaged with their infant and young child.

Further along in the child's development, there are problems that we see in both cognitive and social development, and particularly among boys we see increased risks of acting out and more generally as children get older, higher risk for depression itself.

So women suffer from depression, children experience some of that suffering and it has impacts on them both during fetal development as well as later on.

So these are significant consequences of depression and it's one of the main reasons that the Healthy Start program has focused on identification and referral and treatment for depression in the perinatal period.

There are many barriers in the community to identifying depression.

For example, many, many women do not recognize when they are depressed.

This can be for many reasons.

For example, pregnant and postpartum women sometimes mistake the period of pregnancy for normal changes rather than for the onset of depression. Also, there is a lack of education among primary healthcare professionals. In many cases, primary healthcare professionals, G.P.'s, obstetricians, pediatricians don't recognize the signs of depression in pregnant and postpartum women.

Another factor is the lack of education among mental healthcare professionals. They are not comfortable in working with pregnant and postpartum women and haven't been educated to distinguish between the normal changes associated with pregnancy and the postpartum and the changes associated with depression.

In fact, in Iowa City where we expect physicians to be well educated, we referred a woman a couple of months ago back to her obstetrician. She was very clearly depressed and when she talked to her obstetrician about it he said to her, you're not depressed, you're pregnant.

And this was after we had worked her up for a thorough and again reflecting sometimes the problems that we have in the community regarding physicians understanding of depression.

Finally, there is an -- pregnancy is sometimes thought of as a time of joyful expectation and the fact that women may be depressed during this period is inconsistent with that image and certainly in the postpartum period much of the focus is on the new baby.

Presents for the new baby.

How is the new baby doing.

Mother often gets ignored and sometimes women will feel embarrassed or ashamed to report they are depressed or something is wrong.

There are barriers to treatment in the community in addition to identification. All the barriers that are there for identification, of course would mitigate against effective treatment.

However, there are also problems with the fact that some healthcare professionals will minimize the problems that women experience in pregnancy in the postpartum so my example of the obstetrician who wrote off the depressive symptoms to the woman's pregnancy would be an example of that. Some unhelpful advice like go out and do shopping, get out with your friends. While something like that might be helpful in the very short-term it is not a very effective intervention.

So if mental health and healthcare professionals are not weighing the full seriousness of these depressions it will preclude effective treatment.

There is also relatively little consensus on appropriate treatment.

By and large, the treatments that have been validated for major depression in - among antidepressant medications and psycho therapies are probably going to work just fine but most of those need to be tailored to some degree that a woman is pregnant or recently delivered.

Healthcare professionals sometimes don't recognize they need to be tailored.

Related problems are access and affordability.

In some communities it's very difficult to get prompt treatment.

Waiting lists are very common in community Mental Health Mental Health Centers clinicians sometimes have long waiting lists for psychotherapy.

Affordability is always a problem for mental healthcare in the United States and no different for pregnant and postpartum women.

Many don't have the insurance or ability to pay.

Sometimes they have insurance but it is not appropriate for the clinicians who are able to provide the care.

The Des Moines Healthy Start project is finishing up its second year with its focus on depression, Ms. Lowe is the project director.

The Des Moines project covers a 20 square mile area.

Des Moines is in central Iowa.

You can see the ethnic breakdown of this project.

It's largely Caucasian, as is the case for the state.

In working with Ms. Lowe I tried to identify a number of tasks to accomplish over the course of the Healthy Start project focusing on perinatal depression and I've listed for you some of the tasks we defined as very, very critical.

So, for example, our first task was to identify a screening tool.

I know that most, if not all of you by now, have identified a tool and are working with it.

It was also necessary to identify a depression threshold using that tool to determine how frequently we would screen women during pregnancy and the postpartum period and then also to refine referral mechanisms.

The tool that we decided to use in our project was the Edinburgh post natal depression scale, it's the EPDS, in brief, was developed in the United Kingdom by John Cox and his colleagues.

He's a psychiatrist who for the past 30 years or so has been working in this area and he was interested in giving community workers a tool to identify women in the postpartum period who might be having problems with depression.

The tool is brief.

It's only ten items.

And it has been found starting in the United Kingdom to be acceptable to women and applicable to pregnancy and the postpartum period.

It was developed specifically for postpartum depression and does not have a lot of somatic items.

Items that would pick up things like sleep disturbance and appetite and things like that that might be commonly experienced in women who are not depressed.

It's a good tool for first stage screening and it's been used around the world in translation.

It has probably been translated into more languages than any other tool and it also is -- seems to work well with various cultural groups.

All of these factors recommended the EPDS to our group.

For those of you who are not familiar with the way the EPDS works, I presented the stems of all ten EPDS items and I won't go over those with you.

You can see those on the screen.

And if any of you are -- do not have access to a copy of the EPDS, I'm sure if you just write in we'll be happy to send you a version that you can use or inspect at your leisure.

One of the critical features in selecting a tool, whether it's the EPDS or anything else, is that the individuals who presented to clients, to the women who you serve, need to be trained with respect to the tool postpartum depression and depression during pregnancy and how to present the tool to women in a way that respects their particular situation, their culture.

Any of the things that might potentially impede a woman's acceptance of this screening tool.

We think the EPDS is very good in that respect but it must be accompanied -- its use must be accompanied by training.

If you've not implemented that yet with your workers, I would encourage you to do so.

We use a threshold for the EPDS of greater than 11.

This is an intermediate threshold on this instrument.

Some recommended using 10.

Others recommend using 13.

Our project director wanted an intermediate level and so we're working with that right now and so any woman who has a score of 12 or above on the EPDS should be referred either for a further assessment by our Healthy Start psychologist or to one of the community agencies with whom we work.

With respect to screening frequency I know there has been a lot of questions about how often you should screen women.

We have decided to do rather intensive screening and so when a woman begins service with Healthy Start and then depending on when she began, we do a screening in each of the trimesters of pregnancy.

And as you know, women are eligible for services from conception until the child is age two.

So we try to screen throughout that entire period in order to pick up depressions that may be occurring both early in the postpartum period as well as late in the postpartum period and certainly depression can occur at any of those times.

With respect to referral mechanisms, this I know is a challenge for many of you in your settings.

We had hoped to find a masters level bilingual clinician that is English and Spanish speaking that would do all the assessments for us but we found we were unable to do so and so we retain the services of a Ph.D. psychologist who we could refer our clients who needed further assessments and needed immediate services.

And so that's what we have begun to do.

She uses a structured clinical interviews.

If clients need services, she can provide them herself or she can make the referrals to various community agencies in Des Moines.

Those include the local community Mental Health Center, the public hospital, private practice clinicians who accept Medicaid and we've had to -- how shall we say scrounge around for money for our undocumented clients, many of whom are immigrants from Mexico who are undocumented and they're not eligible for any of the formal services that normally Medicaid would pay for. But we do try to find money in order to pay for services for them.

So there are even more tasks.

Those are just the beginning tasks.

In our project we've endeavored to educate the case managers, their supervisors in the agencies for whom they work, educate the professional community, the psychologists, physicians, social workers, nurses and finally to educate the consortiums that work for us as well as for you in your cases in trying to educate the consumers.

So starting first with the case managers, we have roughly 15 agencies that provide case managers to serve our Healthy Start clients.

The educational and professional backgrounds of these case managers are really quite diverse ranging from bachelors degree in psychology to nurses, social workers and so on.

So they cover, really, the gambit.

Their level of experience is diverse.

Some of these case managers are just out of school and others are very experienced and know more about some of these issues than we do.

However, most of these case managers have had little mental health training or experience.

And so one of our goals in working with case managers is to do training with them.

So we provide a number of education programs on a regular basis to our Des Moines site.

They usually last about two hours and happen once a month and the case managers get continuing education credit if it's relevant for them and we always have pop and sweets for them as well.

Examples of programs are doing overviews of pregnancy and postpartum.

We have a program on doing case management with women who are depressed.

We talk about -- we have a program on detection of depression in women and how to talk to women about their depression.

We have a separate program on the medical management of depression and anxiety where we bring in a psychiatrist who goes through all of the details of medication management during pregnancy in the postpartum.

We also do programs on case management with severely depressed and suicidal women.

We train case managers how to actually initiate commitment proceedings if we have a very serious problem.

More generally how to get help themselves when they're faced with a very seriously depressed woman.

In terms of educating the professional community.

By that I'm focusing primarily on mental health service providers.

We do workshops in Des Moines.

One and two-day workshops to train providers to do psychotherapy suited for postpartum depression.

One we modified called interpersonal psychotherapy.

We trained people to do this with postpartum women.

We do workshops, train clinicians and for those interested in doing research with us we'll provide follow-up supervision for them.

Recently we've done a survey of mental health professionals in central Iowa to ask them about their experience and training with perinatal depression and asked them about continuing education programs that they would be interested in.

We'll also be doing specific training programs for obstetricians and for pediatricians and G.P.'s in the community at times when they normally like to have their education programs.

And then there are more tasks to be done.

We have to implement and sustain a screening program.

It's one thing to start it.

It's got to continue.

We've got to be sure that women who reach the threshold on our tool, the EPDS, or who otherwise seem to be at risk, are getting the assessment and treatment that they need.

We need to continue to build capacity in the community and to undertake a public information campaign in central Iowa about perinatal depression.

In the calendar year 2002, I won't go through all of these, but these are some of the things that our Healthy Start program has achieved.

Where we've set intermediate goals which we're largely making going up to our ultimate goals for the end of our project.

It's been a great challenge and a very pleasant experience in working with the Healthy Start clients and the Healthy Start staff.

So our goals for our project are basically to have happy, healthy moms.

And happy, healthy children.

And you can see in this next slide some of those images that I hope you can appreciate that this is what we're working towards.

And then finally in the last two slides you can see billboards, or images of billboards which will be going up shortly in Des Moines.

These were developed by Ms. Lowe and some of her marketing consultants to hopefully stimulate the community to realize that depression occurs in African-

American and Caucasian women, among others, and encouraging women to get help for themselves and their babies.
Thank you very much.

>>JANICE BERGER: Thank you.
We really appreciate your words.
Now I would like to introduce Dr. Kimberly Yonkers.

>>KIMBERLY YONKERS: Thank you very much.
It's a pleasure to be here.
Wonderful presentation.
My name is Kim and I work at the Yale School of Medicine in Connecticut.
What I'll be talking about today is a very serious problem.
Depression in perinatal women.
What I hope to do is provide a little bit of background and then move on and talk a little bit about what we're doing in New Haven.
As we're talking about this WebCast we thought it would be a good idea to provide different approaches to screening and detection of depression in perinatal women.
And we've taken a little bit of a different tack and we're very happy to talk about that and what decisions or issues came into making the decisions that we made ultimately.
Again, we invite you to email us if you have questions about this presentation.
So why don't we get started.

I would like to go to the first slide and tell you the members of our team.
We have a very diverse team.
It's really a very nice partnership between the community, as well as the Department of public health in New Haven and the Yale School of Medicine.
It's directed by Amos Smith at the community foundation.
Our care coordination manager.
We have a consortium coordinator, a monitor and a senior program assistant.

Next slide, please.
For the depression component, I direct that.
But Megan Smith really directs that and then we have two clinicians on the project.
One of the questions that we hear a great deal is why should we be screening for depression in our perinatal women?
We're already concerned about hypertension, diabetes, smoking, etcetera, etcetera, what's so important about perinatal depression?
Let me just reinforce several.
Depression does adversely affect mom's functioning and her quality of life.
That should be sufficient.
But in addition to that, it has a negative impact on the child that is well-established.

It increases the risk of poor perinatal outcomes and it also affects the child's development.

There does appear to be an association between depression and other risk factors for poor perinatal outcome.

Cigarette smoking, drug use and concurrent medication use.

We don't totally understand the relationship but it may be that these things are leading to depression or depression is leading to these or they're just fellow travelers.

But it is important to note that relationship.

And then finally, the woman who is suffering from depression often has poor weight gain, delayed pre-natal care and can have various levels of self-neglect.

We need to attend to these issues.

Given these great concern we elected to confront the problem of depression in perinatal women.

I would like to tell you a little bit about our approach in New Haven and some of our thinking that went into our decision.

One of the issues is what type of instrument questionnaire or tools are you going to use the measure depression or to detect depression?

Are you going to use a specific tool that only detects depression?

Or something that is more general and may, for example, identify women who are in distress?

No answer is the correct answer.

But you should know your community needs.

I'll give you an example of what happened with us in New Haven.

When we were investigating various options in terms of screening, people from our consortium said that they felt that abuse and post traumatic stress was a major problem in our population.

So we elected to use a tool that includes questions about stress and post traumatic stress in addition to depressions especially since they're such common travelers.

Now, after you've selected a tool or some sort of approach, what about further assessments?

We're really talking about screening.

And screening really tells you people who may be at risk or currently at risk.

But in all likelihood there will need to be some sort of follow up to really see what is going on with these women.

What we felt we had to do is really look at our community resources.

For example, all the providers in the greater New Haven areas, we assembled a book which took us months.

It clues all the behavioral healthcare providers in the area.

It's also on the web.

We find this to be very helpful.

It may not be an approach that works well for everybody but I think the notion of knowing what resources are available or not available can really help in guiding whatever approach one decides to take.

We were very concerned about the comfort level that the workers in New Haven would have when they're screening for depression, since some people had little background in terms of behavioral healthcare and maybe frankly sometimes overwhelmed if the patient was very afflicted with depression and not know what to do.

The doctor really emphasized the importance of training.

I just have to reiterate that training is really key.

It's very essential.

We elected to have another step, a sort of safety net for the people doing our screening so that we would have expertise in behavioral healthcare available by phone for people who were conducting the screening.

Now you see on the next slide, which has screening measures, just a list of some of the very commonly used ones.

The center for epidemiological studies.

We mentioned the Edinburgh scale.

What these measures share is they share a capacity to identify a patient population or group of women that are at risk and in distress.

It does not necessarily mean that they have the illness of depression, but they certainly are at high risk.

There are also some specific measures that will make a diagnosis, or at least a provisional diagnosis.

One of them is the prime MD.

It screens for depression using the DSM IV criteria.

There is also one commonly used in research.

One is the diagnostic interview schedule as well as the composite interview diagnostic inventory and other specific depression measures such as the inventory of depressive symptom -- what about the assessment after the screening?

Again, canvassing one site.

We did this in New Haven.

Are behavioral healthcare professionals accessible on site?

We have some of our sites that have psychological and psychiatric expertise next to our perinatal clinics and some don't have that.

Are they accessible for telephone or arrangement made that they will be.

Are they available to assist in training in a sort of system like the doctor has where people come out and they offer seminars and ongoing training?

What is the expertise of the screeners?

How quickly can community resources be mobilized to conduct evaluations especially in emergency situations?

Now, let me turn more specifically to what we're doing in New Haven.

We took a phased approach and we decided that we would try and understand what our system was like before the Healthy Start initiative.

We call it our needs and resource assessment.

We really wanted to determine the needs in terms of the depression as well as the clinician identification rate.

We also determined whether women were being referred to and going to their referrals.

As I mentioned before this also entailed making a manual or whole book, if you will, of some of the resources that were available.

We needed to know and we needed to disseminate that information.

And the overall goal was to really understand the system so that we could establish linkages between our OB/GYN providers and our basic healthcare providers.

Phase two entailed establishing the screening procedures and the care coordinator training.

What we decided to do is to use a risk assessment tool that what we refer to as the universal screening tool which asks a host of questions including questions about housing, childcare, what needs women have.

And into that tool we imbedded questions about depression and anxiety.

We relied on the prime MD behavioral health questionnaire that asks about anxiety and depression.

Our approach actually included putting these questions in with all the other usual questions that we would ask women to identify those at high risk for poor perinatal outcomes.

We then worked with our colleagues and devised an algorithm.

We established a hotline and staffed that hotline with clinicians who could conduct assessments after the screen and can assist in referrals.

We train care coordinators on this procedure of screening and referral.

You see the next slide has the brief patient health questionnaire.

This is an example for you to take a look at.

We're happy to provide this.

It is actually -- I think it is not in the public domain but it can be available through Columbia University or Pfizer pharmaceuticals.

You can see under number one is a list of questions.

And these are the actual criteria for major depressive disorder.

Number two includes questions about anxiety.

We also included a module that asks about post traumatic stress disorder which isn't on this slide.

Number three is also very important.

What we wanted to know is whether women were having a difficult time.

So even though they may only be having two or three symptoms of depression or anxiety, were they having functional impairment?

This would be enough, for example, to trigger a referral to us.

Now, let me tell you about phase three, which is our ongoing screening and referral project.

Women come in at any point during pregnancy.

There isn't a specific time and they're administered the universal risk assessment which includes the brief health questionnaire in our depression screening.

The care coordinators call our hotline if someone screens positive for minor or major depression, suicidal ideation or functional impairment.

Our team does a full patient assessment and the result of that is sent back to the care coordinator and placed in the medical chart.

In conjunction with the care coordinators, we provide patients two to three referral resources and then the care coordinators follow up with patients to assist in the referral procedures to make sure they have the means to make it to appointments and then our workers follow up at one month, three months and six months.

And we really ask a lot of questions about how current symptoms are, whether they're less severe, more severe and what barriers or problems people had in attaining any sort of behavioral healthcare services.

I just wanted to include a few slides on some of our preliminary findings because I think they are so dramatic.

I think these directly address the question of why do we have to screen for perinatal depression.

These data are not longitudinal.

They're cross sectional data but we've clustered them by trimester.

That approximately 10% of women will have major depressive disorders.

Probably 7 1/2% of women -- I'm averaging across the three trimesters.

When we look at the likelihood that any provider would have identified depression in one of our patients.

This is -- these data are actually prior to the inception of "Health Beat."

We found that approximately one quarter of providers had any sort of mention of a symptom, syndrome or any treatment for our depressed patients.

The 74% had no documentation that they were suffering from depression.

In collection of this data we also asked patients whether one of their providers had asked them.

So these results reflect not just what was in the medical chart but also what patients reported to us in terms of either receiving services or a diagnosis.

My sense is we could do much better than that.

That's what this program is about.

Among the women that were referred to our hotline, about -- a little less than half had major or minor depression.

A quarter had post traumatic stress disorder.

And 10% had a chronic mild depression which can be very debilitating.

When we looked at treatment attendants.

This is now after the inception of the program with our Healthy Start care coordinators and mom's hotline workers assisting in the referral process we see that about 30% have attended one behavioral healthcare appointment.

Now, recall I said 26 had any degree of detection.

This is prior to the program.

It didn't mean they received or attended services.

It meant somebody noticed they were depressed or put on a medication.

The treatment rate was actually half of that.

So now we're up to about 30% at one month.

At three months 38%, and so far at six months 30%.

So we're doing better.

We hope that we can do better still.

So what about the future?

What can we do?

We can ensure that all pregnant and postpartum women are screened at least once during pregnancy.

We can expand healthcare coverages.

Some instances the insurance that our patients have is on paper but when you don't have, for example, physicians or healthcare providers that accept managed Medicaid we might as well not have insurance.

We can expand healthcare coverage and insure that there are providers for the coverage that our patients have.

We can also extend the pool of providers that can offer culturally sensitive care.

One of the issues that we confront is many of our patients speak Spanish only and there are just not enough Spanish-speaking behavioral healthcare providers.

What else can we do?

These touch on some of the things that the doctor has been working on.

Addressing the attitudes of clinicians, patients and the public.

Decreasing the stigma of illness.

Educating clinicians and patients and very importantly, address the assumption that because someone has difficult life circumstances that they should be depressed.

Because somebody is unstably housed or because she doesn't have a lot of money she should be depressed.

That just is not true.

She has an illness.

Finally, we need to investigate some more innovative ways of making treatment more meaningful, accessible and acceptable to our patients.

I thank you very much for your attention.

>>JANICE BERGER: Thank you very much for your remarks.

It looks like we've been getting in a lot of questions on the computer.

So we're very happy to see that.

If I can -- what I'll do now is read you the questions and either one of you, I don't see that they're directed to either of you.

So feel free to answer.

And hopefully if you have more questions, keep sending them in.

The first question is can the EPDS be used prenatally or only post naturally?

>>MICHAEL O'HARA: The EPDS can be used prenatally.

There have been subsequent studies with pregnant women it seems to work equally well with about the same cutoffs, so yes.

>>JANICE BERGER: Is that the same with other instruments as well?

Like the Prime MD or any of the other instruments?

>>MICHAEL O'HARA: I think a concern that people have is that some women who are pregnant, many women who are pregnant, have changes in appetite, energy and sleep.

And that overlaps with some of the symptoms of depression.

With depression, though, it's not sufficient to have changes in appetite, energy and sleep.

Someone has to have low mood or decreased interest, and really functional impairment.

So when you add the low mood and low interest and/or low interest, the other symptoms can be there or not be there.

But you need to have those Gateway symptoms and that really, I think, addresses the potential problem of is somebody just pregnant or is she depressed?

>>JANICE BERGER: Okay.

Thank you.

The next one is from Georgia.

Where can we get the EPDS in Spanish or other languages?

>>MICHAEL O'HARA: You can get the EPDS in Spanish from me.

At MIKE-OHARA@uiowa.edu

A good Spanish version.

Many of our Spanish speaking women are Mexican American or Mexican and that's who we've worked with.

If you have other Spanish-speaking women from other countries, it might not work as well but there are a number of versions.

We're also developing a Vietnamese version in Iowa City.

And that should be available soon.

If you email me I can probably help you find other versions in other languages.

But I can't tell you other places specifically now to get those.

>>KIMBERLY YONKERS: Actually there is a book that John Cox wrote called, the

used and misused of the Edinburgh depression scale and in the index they have the scale in 20 different languages.

It is pretty comprehensive.

"The use and misuse of the Edinburgh depression scale."

I also mention our screening tool is also available in Spanish, it may not be available in other languages.

>>JANICE BERGER: And the one is by John Cox, COX?

>>KIMBERLY YONKERS: Published by GASKELL.

>>JANICE BERGER: Okay.

This goes along with that question.

Several people have asked to get copies of instruments, surveys, questionnaires that you've been talking about today.

Are there any copyright issues that people need to be aware of?

>>KIMBERLY YONKERS: The BHQ is copyrighted.

I don't think that it was developed by folks at Columbia University using a grant from Pfizer.

I don't think that Pfizer would have a problem allowing people to use it but they may want to -- if people are interested I can certainly investigate that for them.

>>MICHAEL O'HARA: The EPDS is in the public domain.

The only thing that Cox had requested when he developed it was that the actual article which serves as the basis for that be acknowledged in using that instrument.

So again, any of the sites are free to use it at no cost.

>>JANICE BERGER: Okay.

In your opinion, are screening tools culturally sensitive or insensitive or are there other factors that impact their sensitivity?

>>KIMBERLY YONKERS: I think there is this notion that certain populations tend to report physical symptoms.

What we refer to as somatic symptoms more commonly than emotional symptoms and that, I think, somebody who is distressed and impaired, having some degree of functional impairment and is reporting a number of physical symptoms should be questioned very closely about depression.

Any of these questionnaires should work quite well, even the language limitations, with just about every culture.

We have used the EPDS in Spanish from Mexico and South America, Puerto Rico. We've use the Prime MD with those populations, the inventory of depressive -- we've used it in many populations and have found no difference and we're pretty convinced that they work quite well in those populations.

>>MICHAEL O'HARA: Let me add I would agree with her and what she's said and reiterate what I had said in my remarks earlier.

And that is the important -- it's probably more important that the case manager, the case coordinator or care coordinator or whoever it is that is working with women and asking them to complete the instrument be well-trained, understand what the instrument is, where there are cultural issues to be able to describe the instrument in a way that makes sense to the woman in her particular cultural setting and basically try to deal with problems of stigma which are still out there, probably for all populations and make it culturally acceptable.

I think most of the instruments in and of themselves are pretty neutral and so the staff probably have more to do with the acceptability of the instrument on the part of clients than anything about the instrument itself.

>>KIMBERLY YONKERS: I would say that one thing to be aware of is we actually administer some of our forms.

Even though they are supposed to be self-report forms.

In part because some people may be reluctant to admit that they are not able to read their primary language.

So that really needs to be considered.

And the issue really does need to be approached sensitively.

Whatever screening instrument you're using.

And that means, for example, not saying something like you aren't crazy, are you?

But starting perhaps with a more open-ended question of are you having a hard time and then going into the more specific questions.

>>JANICE BERGER: Okay.

The next question says, how are referrals for Latino or Hispanic women handled within your program?

>>KIMBERLY YONKERS: With our program, we do have clinicians who conduct assessments in Spanish and we have providers from the community in several clinics who provide services to Spanish predominant or Spanish only speaking patients.

So they're essentially treated in the same way that our English speaking patients are.

The resources are somewhat more limited, but essentially it's not very different.

And I don't think even that the likelihood that somebody will attend a session of treatment is very different for our Latinos compared to our other patient populations.

>>MICHAEL O'HARA: Again, the Des Moines Healthy Start project is the same. We have case managers who speak Spanish.

We have our central clinician who does evaluations is bilingual. She also does work with Spanish-speaking women. When we get beyond those resources, though, it is a little bit more challenging. There are some clinicians in the community that speak Spanish but it is a limitation for us as well.

>>JANICE BERGER: Okay.

The next question is, how, where and by whom is prenatal screening done in your program?

>>KIMBERLY YONKERS: In our program, prenatal screening is done by care coordinators who are on-site in the various clinics which include three community clinics and two hospital-based clinics and also done by workers who are part of the New Haven Department of Health and they have a mobile caravan.

They are designated individuals who will administer the tool to women receiving prenatal care at one of these centers.

After the tool is completed, then that may or may not, if it does, if they're beyond a certain threshold, then the care coordinator calls the mom's hotline and we call the patient either at the clinic or another setting and do a more in-depth assessment.

>>JANICE BERGER: What's the educational level of the case coordinators who do the screening?

>>KIMBERLY YONKERS: It's variable from bachelors to masters level.

>>MICHAEL O'HARA: In the Des Moines Healthy Start program, the prenatal screening is done by the case managers assigned to the women when they enter the Healthy Start program.

And it is no different whether the woman is pre-natal or immediately postpartum or interconceptional.

She has one case manager that follows her throughout.

Whoever the case manager is that is assigned to work with her.

>>JANICE BERGER: Do outreach workers do -- can outreach workers do the assessment?

Do the screening?

>>KIMBERLY YONKERS: Certainly can.

They certainly can.

And we have that in New Haven.

There are issues in terms of people feeling comfortable administering some of these questions.

We try to work with people so that they will be more comfortable.

We're not asking them to provide services.

But they are the foot in the door.

They are the important person who lays the ground work for whether anything can go forward after that.

If a care coordinator or someone administering a questionnaire gives the impression that this is something they shouldn't have or there is something wrong with the patient for having an illness like this it may go no further for the patient.

So having a concerned by accepting approach is very, very important because stigma is everywhere.

>>MICHAEL O'HARA: In the Des Moines Healthy Start site the case managers go into the home and although there is other outreach that occurs to bring women into the program, once they're in the program it is the case manager who is -- will do the home visits and that's where a lot of these screenings take place.

>>JANICE BERGER: But as long as there is training, it's my understanding that outreach workers, case care coordinators, case managers can and do screening.

>>MICHAEL O'HARA: Correct.

>>JANICE BERGER: Okay.

Why are women screened with such frequency after delivery?

>>MICHAEL O'HARA: Well, it was the -- it is the policy of the Des Moines Healthy Start program to cover really the entire period from delivery through two years.

We screen more intensively in the early postpartum in part because depressions can really develop at any time.

There is -- even though a high risk time is, let's say, the first three to six months, the fact is that depression can develop at six months.

It can develop at nine months.

Maternal depression has negative affects on the woman's ability to function at six months like it does at three months and a similarly negative impact on the child.

And so we have made the choice, and I think we probably screen more than any -- well, I don't know if we screen more than any other program, but we probably do.

We want to capture as much of the maternal depression that is out there as we possibly can.

I would say it's not absolutely necessary to screen that often but that's the choice that we've made in our particular program.

>>JANICE BERGER: I guess this is for both of you.

Not every Healthy Start site has a depression grant, although all have to provide depression screening.

What is your recommendation for these sites regarding depression care services other than referrals to mental healthcare providers?

>>KIMBERLY YONKERS: I think a referral is basically what we're doing. We may have a tracking method in addition to that, but my sense is that even if my particular sort of sub group were not doing what we're doing in New Haven, at this point New Haven Healthy Start would still be screening for depression and still have the capacity to refer people. It may be somewhat of a luxury. We have the additional benefit of having mental health specialists then do a second look and see to make sure somebody is not at risk for herself or infant or psychotic or whatever. It may be a luxury but I think at least the basic screening and referral can be done under the rubric of the Healthy Start grant.

>>MICHAEL O'HARA: In thinking about this, it seems to me that what is very important is to try to understand what the community wants. And when I think about Healthy Start programs I think of the consortium that to some degree is representing the community and also what the clients want. The clients obviously represent themselves and if I were in a Healthy Start site that did not have a depression grant, probably one of the things I would do would be to use several of the consortium meetings to explore what we should be doing as a community and what the consortium should be doing in terms of capacity building. I think we also need to be talking to our clients and asking them what they want in that context. I've been involved in development of focus groups both for our own purposes in Iowa City and in the eastern Iowa community about what postpartum women one with respect to mental health services and also internationally. We find that different communities and different women have very different things they think they need. And so what I might find in a very rural community might be quite different than in a very urban community and so on. So I think we go to our consortium and ask them what they can be doing. Do they understand the problem? And it may be that education is what's needed first. We go to our clients and educate them to a degree and ask them and ask others in the community. I think there is no one answer that would be appropriate for sites that are as diverse as I know the ones you represent.

>>JANICE BERGER: Could you speak a little bit to if a community doesn't have a referral source, doesn't have any mental health providers, is there anything that they can do?

>>KIMBERLY YONKERS: Well, I think the first, as Mike mentioned, is going to the

consortiums and perhaps doing a little bit of what we did, is investigating and seeing what is out there before we started this.

And generally people referred from our perinatal clinics, referred to our local mental health clinic, which didn't take managed Medicaid insurance so that was of little help.

We really did canvassing to find out what the community resources are.

And that was very illuminating to have that and even to have a manual with a list of the providers.

These are actually -- they sound sort of trite, but having a book where you can look up the names or services and have that at hand is really very, very nice to have.

Some system whereby a consultant can be contacted by phone, perhaps a nurse or a social worker can do an evaluation with physician backup remotely.

These are all options.

And they would just be paid on an as-needed basis.

Consultant basis.

These are all possibilities but, you know, I think as Mike mentioned, as he mentioned, a lot of decisions lie with the consortium and what they're willing to do to see this problem attended to.

>>MICHAEL O'HARA: I agree completely.

I might just add that we need to think of depression as a healthcare problem, not a mental -- it is a mental healthcare problem obviously.

But to me we need to think of it in terms of just generally healthcare.

We always have to look to our physicians as one of the major leaders.

If we don't have specialized mental healthcare in a community, then I would recommend that physicians be brought into this and challenged to expand the scope of the work that they're doing and help the consortium and help the Healthy Start program to develop and deliver services.

When you say there is nothing there, of course that's a serious problem.

My guess is there are very few places where there is literally nothing there.

There are probably a lot of places with a little there.

The question is how could build on what is there, capacity building.

It may be that people have to be brought in to do some training and consultation to begin to build capacity.

I think what we don't want to get discouraged about is if you can't deliver a state of the art program that would be available in New Haven or perhaps even in Des Moines, that doesn't mean you shouldn't start where you're at and try to build up your own capacity.

And I think that with a little bit of resource investment and the investment of time and energy on the part of the consortium and the Healthy Start staff, that you can make a lot of progress whether you already relatively well advanced or even if you're just beginning to develop perinatal mental health capacity in your community.

>>JANICE BERGER: For some of those communities who have very limited resources, is there a way to provide training to case managers, nurses, whomever, to work with the patients after they have a positive screen? For depression?

>>MICHAEL O'HARA: It's kind of a loaded question, actually. Obviously people like Dr. Yonkers and myself and our colleagues are perfectly able to provide that training. I don't know that we're perfectly able to go to 50 or 100 sites and do that. Certainly there are people, and not limited to the people in this room, who can provide training to Healthy Start sites. I think it's an exciting prospect to do that. But we haven't organized that in any fashion up to this point other than in our local sites.

>>KIMBERLY YONKERS: There are also some possibilities for national training. For example, at national nurses meetings, it's very likely that they'll have special sessions on depression. At their annual meeting, ACOG will typically have panels and training sessions for depression and anxiety. There are a host of events whereby people can go and obtain training. Even the American Psychiatric Association. It is possible to register and take courses. It may, depending on what the community needs and what people decide, it may take some work identifying one, maybe two individuals who will receive some degree of specialized training.

>>JANICE BERGER: That is a good point. This sort of goes along with that. What are the qualifications of those who conduct the assessment following a positive screen for depression?

>>MICHAEL O'HARA: Well, in our site we have masters level clinicians or myself. I'm a physician. Really somebody who has had experience, clinical experience with patients I think is best because you know that you have somebody who has already screened positive for some kind of problem and you already have the screen in front of you. So it may be straight forward or it may be less straightforward. The next issue is when you've gotten a sense of what is going on with a patient, it won't be complete because it's over the phone and not a comprehensive hour-long conversation, what does the patient really need now? Do they need Medicare, inpatient hospitalization or need to be evaluated in an emergency room? Can they wait a week or two weeks for an appointment?

Sometimes a month?

What resources are there?

What community support?

Is there a church involved?

What is the social network for the patient?

These are some of the things that I think can optimally be evaluated by somebody who has some clinical experience in psychology, social work or medicine.

>>KIMBERLY YONKERS: I don't think I can add anything to that.
I would agree.

>> JANICE BERGER: Texas/Mexico border health site has difficult with the EPDS.

The clients report that the questions don't make sense.

Any recommendations?

>>MICHAEL O'HARA: Well, I would want to talk to, let's say, an informant in the community.

Someone who is perhaps well-educated and understands a little bit about psychology and measurement and try to find out what the source of the confusion is.

We did have to make some changes when we worked through our translation into essentially Mexican/Spanish to make it work and it seems to be working well right now.

Other than trying to get some information about what are the items or what the problem is, it would be hard for me to address.

I would want to talk to someone in the community and try to find out what the source of the problems are.

It may be that the whole approach to screening doesn't make sense and so some of the items are just exacerbate that or it could be there are one or two items that don't make sense and sort of contaminate the rest of the instrument because the patient or client is put off by it.

>>JANICE BERGER: So do I understand from what you said that if a question doesn't make sense to a particular population, that people have the ability to revise the questions or do they need permission to do that?

>>KIMBERLY YONKERS: We actually use the EBDS in Dallas which is probably very similar patient population.

What we did was actually held focus group and we asked -- we had about three of them and we went over the questions, question by question with perinatal women in our maternal health clinic and we asked them about the translation, whether it made sense, and tweaked it as needed.

There are a couple of questions.

There is one question on sometimes things get on top of me which can be tricky if you translate it very literally.

I don't know that it would be very acceptable.

So if you're having some problem with confusion, I would really try and canvas the patients, get them in a room, sit down, figure out whether it is the translation.

It probably is the translation.

Or whether there are other issues with the questionnaire.

And my sense is as long as it performs in terms of identifying people with depression, then you can make it change the wording.

You don't have to use it perfectly like John Cox published it.

>>MICHAEL O'HARA: Let me emphasize something.

A good translation is not a word for word translation into any language.

What you want to do in a translation is capture the sense, the meaning of what is being translated.

So any good translation of the EPDS will capture that.

And in some respects it was what Dr. Yonkers was talking about.

Literal translations probably won't work in any language and it's not what we attempt to accomplish.

We attempt to accomplish giving the same meaning in each item so that the instrument itself has the same meaning overall as it does in English.

By the way, that would include tweaking items for American English versus British English or Scottish English, actually.

So I think we don't necessarily want to get trapped into thinking everything has to be the same.

We do have to evaluate how well the instruments works, though, over time.

To some degree you begin to create a new instrument.

But given that Healthy Start programs have years to run, in general, you should be able to develop your experience with the EPDS or any other measure you would choose to use and really focus on how well it works for your population, not how well it works in New Haven, Iowa City or Edinburgh, Scotland.

>>JANICE BERGER: Okay.

This is an interesting question I hadn't thought about.

When screening so many times for depression, do you use the same questions each time?

If so, doesn't the patient anticipate the question?

>>MICHAEL O'HARA: The answer is yes.

And yes.

And in fact we've found that actually if you screen women lots and lots of times it has a -- a therapeutic effect.

It actually will cause the -- we've actually done studies on this.

If you give the same depression instrument to a person multiple times relative to just a few times that actually the scores will tend to go down.

That is one of the drawbacks of multiple, frequent screenings.
Our screenings are every several months.
But to some degree if a woman understands why it's happening, you would hope that it would actually go a little more quickly and that she would be able to respond in a very knowledgeable way to it.
So there are some drawbacks.
And you do have to understand that some individuals will begin to depress their scores independent of how they're feeling.

>>JANICE BERGER: Okay.
This sort of goes along with that.
How many women have actually completed all the screenings and their acceptance of frequency of -- I guess what is their acceptance of the frequency of the screenings.

>>KIMBERLY YONKERS: Probably nobody.
Probably because nobody has gone through a full cycle.
Our problem seems to be more with the case managers complying with our request to do the frequent screening.
We don't have too many instances that I'm aware of, there may be others where I'm not, where the women don't want to do the screening.
It seems to be more either the case manager feeling like it's intrusive or not necessary, or thinking that the client really doesn't want to complete it.
So the -- to me it's still an open question whether this frequency of screening is optimal or perhaps is too much.
We just don't know yet.

>>JANICE BERGER: Okay.
Twin Cities Healthy Start in Minneapolis/St. Paul area is using the Beck during pregnancy and the Edinburgh post partum.
What is your view of this, using the two.

>>KIMBERLY YONKERS: I don't think there is any right or wrong.
The Beck is certainly an excellent questionnaire.
I would just be a little concerned about two questionnaires that are essentially doing the same thing and the capacity of the people who are administering the questionnaire to really always keep in mind that this is the threshold for the Beck, this is the threshold for the Edinburgh, and having to handle two questionnaires rather than one.
So it's just a little bit more complex.
And it could be potentially confusing.
I don't think there is any particular weakness in either of the questionnaires that are being used.
I think my sense of one thing that really needs to be appreciated, however, is that they are measures of distress and they will not make a diagnosis of depression.

That some degree of evaluation beyond that perhaps by somebody else needs to be done to really get a sense of what's going on with the particular patient.

>>MICHAEL O'HARA: We actually use the Beck in some of our research when we're screening women for depression during pregnancy. So it actually, despite some of the complaints about it having so many somatic items, still seems to work pretty well for screening for depression during pregnancy.

Aside from the complexity I wouldn't see a problem to that.

>>JANICE BERGER: What's the liability to staff for clients who do not follow through for appointments?

>>KIMBERLY YONKERS: Well, I think it's a good question.

It depends on probably what's happened.

And it's probably not terribly different than for a patient who, for example, was depressed and nobody bothered asking her the question about a bad outcome.

There are some triggers we have to appreciate.

So, for example, if a Healthy Start coordinator or staff member finds that -- or assesses a patients and find out there is child abuse, then she or he, at least Medicaid is mandated to report it.

So there are certain facets of that.

But if somebody has screened positive for depression, appropriate evaluation and referrals have been made and the patient doesn't go there is really only so much we can do.

That's pretty much the situation anywhere with patients who have depression or other problems.

>>MICHAEL O'HARA: If the question refers to legal liability, I would suggest that you talk to your agency or Healthy Start attorney.

I know we have one for our Des Moines Healthy Start site and we occasionally have legal issues that come up.

And it could be that some of these issues are different in different states so I would suggest that you seek legal council.

I don't think Dr. Yonkers nor can I give you any specific answer that would keep you out of trouble.

It's what we pay these people for.

>>JANICE BERGER: Okay.

Many women are in denial about depression and the need for services.

How has your program addressed or changed your outreach message to change this belief?

>>MICHAEL O'HARA: Well, in my last two slides I showed you some billboard images that we're going to be using.

We're going to also try to get other media to get the message out that depression is something that affects women and their children. We found in Iowa and also up from some of the work that I've done in Europe, that having one -- there are several ways to approach these stigmatizing depression.

To talk about it in terms of problems that women are having and try to shift the focus from mental illness.

The other is to focus really on the welfare of the child.

And focus on how women can become better mothers.

Shifting the focus somewhat from depression.

So these are ways that we're trying to use to make it more acceptable to get help and to also stimulate families to encourage women to get help.

Because sometimes a significant barrier to getting care, we've found, is the husband or partner or the man in the person's life.

The woman's life.

And so if we could enlist the support of husbands, partners, and mothers and mother-in-laws, I think we could go along way toward making -- increasing the ease with which women get help for their depression.

>>KIMBERLY YONKERS: I agree.

I think education is awfully critical.

We try to put conferences on, we try to do trainings.

And I think one of the real take-home messages is the stigma really starts at home.

If we're afraid of it, if we don't think it's our responsibility, if we think that we're going to get in trouble.

If we think that we can't handle it, then that message is transmitted to our patients and we really need to educate ourselves.

And as he said earlier, we handle diabetes, we handle hypertension, all these other important problems with few complaints as long as there is appropriate training and backup.

And I would encourage people to view depression along that same spectrum.

>>JANICE BERGER: Is fatherhood or the male partner incorporated into depression screening and/or services?

>>KIMBERLY YONKERS: At our center, no.

We don't include or we don't survey fathers for reports of their partner's depression.

In large part because we screen in the perinatal settings and oftentimes the father of the child is not there.

So that's not a component of it.

It -- certainly if you have something that you're concerned about in a patient, my view is try to canvas support and help from the family whether it's the father or mother or sister or other people.

That can be very, very helpful.

>>MICHAEL O'HARA: We don't normally screen or ask husbands or partners to participate.

I will add, though, that we have recently developed a partner version of the EPD, is that is designed for partners to complete as sort of an adjunct to the screening process.

If anybody is interested in that, you can email me at the address that I have given before.

And what we find is that it does add something to what the woman herself does.

That partners have a slightly different perspective and we're just now beginning to work with that tool.

In our Healthy Start program often case managers are in contact with partners but they don't participate in the screening generally speaking unless there is a specific problem that they bring to the attention of the case manager.

>>JANICE BERGER: Okay.

I think we have time for one last question.

Are the screening tools sensitive to a very young population or someone who was previously diagnosed with a chronic mental health problem?

>>KIMBERLY YONKERS: Again it depends on which screening tool.

Some of them are somewhat like specific so you'll pick up people who have stress and may have another mental health problem.

Whether you're talking about -- bipolar or something else it is entirely possible. They are sensitive to young populations.

There are some data to suggest that adolescents score higher on many of these scales than adult women.

>>MICHAEL O'HARA: I would agree.

I think you can use them, particularly the EPDS with adolescents as well as adults.

For women who have had histories of major depression or other kinds of chronic mental illness I think they're suitable as well.

You might find that these women, even though they screen positive, are really reporting other problems that would tend to elevate their scales but they need to be identified anyway.

>>JANICE BERGER: Okay.

We have a number of other questions that we got in that unfortunately I don't think we'll have time to deal with today.

There are several people who are interested in more information on the mom's hotline, the hours, staffed by whom and the qualifications.

Could they email you to get more information if they would like to implement something such as that in their own program?

I'm being reminded to ask if it is okay for you to give out your emails.

If people have more questions.
Would you -- if you want the give your email again?

>> Mike-OHARA@UIOWA.EDU.

>> Mine is Kimberly.YONKERS@Yale.EDU.

>>JANICE BERGER: I want to say thank you very much to both of you for being with us today.

I think it was very helpful, very informative.

And I know I learned something from each of you every time I hear you speak.

So I really appreciate it and on behalf of our federal Healthy Start office we thank you very much for being with us today.

And also to all of you who called in, thank you very much for joining us for our very first WebCast.

And I want to remind you about our second WebCast on data on July 29th.

We'll be sending out more information by email in the next couple of weeks.

Thank you again.