

## **AMCHP 2007 ANNUAL CONFERENCE**

### **HEALTHY COMMUNITIES**

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#### **Maternal Depression and its Impact on Young Children: Strategies for Prevention and Methods for Establishing an Evidence-Base Influence Policy**

MARY ZOLLER: Good morning. I'm Mary Zoller with the Virginia Department of Health. And this project that I manage we call the three Ps of perinatal depression was a very exciting one. It's a pretty innovative project that we did under a HRSA grant and we were one of the first five states to get grants from HRSA to address perinatal depression. We had a project team, an internal project team that was involved with the three Ps. We also employed some contractors to assist us with evaluating the project and actually developing the web-based curriculum as well as conducting some focus groups, which I'll tell you about in a minute.

We had three goals and objectives. And our first one was to build the capacity of the health care system to screen for depression and help women who are suffering from depression who are either pregnant or postpartum. And we wanted to increase the ability of providers to recognize the signs and symptoms of depression and also give them incentive for completing it by providing continuing education credits.

Our second goal was to reduce the stigma of mental illness and barriers facing women with depression. And we really wanted to take a look at some of the issues of women who are minorities and who are members of racial and ethnic minorities. And take some of the themes from these focus groups and include them in the curriculum.

And our third goal was to look at ways that we could make systemic changes to assist women who were suffering from depression. And we wanted to come away from the project with an action plan for reducing barriers to care. And our first step was to conduct a baseline survey of providers so that we got an idea of, you know, where they were in terms of their knowledge, attitudes and practices in screening and identifying women with depression.

We decided to conduct focus groups of the five most predominant racial and cultural populations in Virginia. And also we decided to create an expert panel made up of--it was a 50 member expert panel made up of representatives of--from statewide associations, consumer groups, those groups that were most likely to come in contact with pregnant and postpartum women. And we wanted them to assist us in identifying the major issues relative to depression in Virginia to take account of what resources we had in--to address depression and advise us on ways to develop this online curriculum for providers.

So in summary, our approach to implementing the goals was to take the results of the provider survey, the results from the focus groups, the findings of our literature review, give those to our expert panel to synthesize that information and then develop the web based curriculum.

And I want to tell you a little bit about the provider survey. We did a random sample of the providers that we thought were most likely to come in contact with pregnant and postpartum women. And just to highlight a couple of the key findings, not surprisingly we found that they agreed with us, what we thought in that they thought that only--almost 78% said that they believe that post perinatal depression frequently goes undiagnosed. Only 40% were confident in diagnosing depression. And when we asked them how they typically treated depression we found some differences in providers in what they were--you know how they were handling women with depression once they encountered it. And I'm not going to read all of these since you have a handout there.

And one of the things that we learned from providers was that some of the barriers to treatment that they said they experienced were limited time, inadequate knowledge and skills, inadequate mental health care available and problems with reimbursement and insurance. And what they wanted was assessment tools, information on diagnosis and treatment and the kind of--and to learn about the resources that were available to them in assisting these women.

And then our second strategy involving the focus groups, this was truly a cutting edge proposition because our literature review found virtually nothing in the area of, you know, study with pregnant and postpartum suffering depression in these various cultural groups. So we had to think very carefully, we work with the Northern Virginia Health Education Center on how to approach these women, what type of setting, what kind of questions, how to word the questions because in some cultures there really is no equivalent for depression or mental health or whatever.

So we used women who were well known and respected in their communities and who would be trusted and they, you know, spoke to these groups in their own language. And we used words like feelings, experiences, do you feel you need help, you know things like that. And what we learned was that there were some things, many of them experienced a lack of support. And they also shared experiences in terms of loss, trauma, anxiety or depression, poor health. They definitely felt like there was a stigma against, you know, them if they expressed their feelings about being depressed. Insurance was a problem, lack of information about where to get help, lack of people who spoke the same language, stereotyping, racism, mistrust and poor quality health care.

And what they told us they wanted was they wanted community based support from others who know the system in groups where women can share feelings with one another. There was one group that wanted to continue to meet after the

focus groups because they felt it was so valuable to be able to get together and share common experiences and they had been really feeling isolated. They wanted to be aware of what services there were. And this recommendation I think is really important is they did not recommend--they didn't have any recommendations for help or support involving mental--mainstream mental health services.

So I think in terms of developing policy, you know this is an important one in that we don't impose what we think might, you know, be best for them but instead listen to the ways that they feel they might best, you know, receive help.

And also some of the avenues we came away with this for, you know, addressing these needs was to think about ways that we could restructure the postpartum period to address their feelings of vulnerability and isolation and be able to offer them assistance with the tasks of motherhood and to provide some recognition for their new status as a mother.

And also to education providers in terms of some of the cultural, historical and socioeconomic factors influencing their lives. And that all women really need to be assessed for physical, mental, spiritual and social well beings several times in the first year after delivery. And that when we think about allocating funds, developing interventions, we need to focus them on women where they are.

So in summary, we had the providers saying and the focus group members saying some similar--very similar things, that lack of insurance was a problem, there was difficulty in communicating. And providers said there was inadequate skill and knowledge. And the focus group said they--a member said they had in fact gotten, you know, poor quality health care. The provider said there was inadequate mental health services and yet the focus group said they didn't necessarily want mainstream health services. And they both lack knowledge about what was available in the community.

So we took this information from our focus groups and from our provider survey, our literature review and all of the research and reading that we had done on depression, funneled them into our expert panel to develop some learning objectives for the curriculum. And we also decided that we would partner with one of our--one of the other grantees and they agreed to let us use their phone service for providers. So if they had any questions about, you know is this woman depressed, you know what--are there other tools that I can use, you know those kinds of things that they could call this toll free number and take advantage of that.

And then we worked with regional perinatal councils, and expert panel to market the curriculum. We got national coverage and we made presentations and hospitals, meetings, conferences of professional groups. Our expert panel was very helpful in this regard.

And actually we have already gone ahead and done and we're hoping to be able to continue to do regional one-on-one training, grand rounds and things like that with providers on the website and on depression. We're going to continue to update our resource library. And if you go to our home page and you want to view the resource library you can do that without registering for the curriculum.

And we also are going to have CDs of the curriculum produced for those without web access or who, you know, want to take the curriculum in that forum. And hopefully identify some additional funding to keep it up a while longer after August of this year.

So you probably are interested--well, who's completed the curriculum in almost a year that we've had it up. Well 755 providers have completed it and got continuing education credit for it. In 2003, 37 have started and completed it. And we're not really sure, you know, how many people just logged on and were just curious to sort of peruse it and weren't really interested in taking it or maybe how many, you know we do have some statistics but, you know, how many people have taken a module and they're going to come back. And we're getting ready to send out electronic reminders to everybody who's started the curriculum and to remind them to go back and complete it.

And some of the data that we've collected on our people who are working on it, 35% have been in practice for 20 years or more, 25% have been in practice for 5 years or fewer and then the remainder have been somewhere in between. So this has been really interesting because over the last year I've been reviewing these statistics and there have been quite a lot of changes, you know, in terms of, you know, whose taking it. At first it was more the older, experienced providers and now we have a significant proportion of people who are new who are taking it. Most of the people who have completed it are nurses, 21% are other professionals, 15% are social workers, 3% are physicians, 96% are women.

And this has fluctuated dramatically since we've had it up. As of right now, 48% were from Virginia and California, Illinois and Maryland are our largest users as far as others states. And we've had three countries. I've just got a request from somebody from Sweden wanting to take it, you know, recently. And 44% are from urban environments. Most of the providers work in hospital based settings, but about a quarter work in local health departments.

And we have asked people who've completed the curriculum to give us some feedback so that we know, you know, what we might want to modify. But so far we've been pleased to find out that I think our research and approach in developing the curriculum paid off and was on target because 93% said the website was a good or perfect match for their continuing education needs. And I

thought this was really interesting, we thought that their being able to get continuing education credits was going to be like this huge draw, but actually 48% said that they could--they visited the website because they could complete it at times convenient to them. They said the level of difficulty was appropriate. They're likely to recommend it to their colleagues.

And I need to close here so I just wanted to share with you our policy recommendations based on Virginia's experience. And that is that web based training is an effective method for increasing the capacity of the health care system to identify and treat perinatal depression. However, there is a lot of research to support the fact that it should be used in combination with other approaches to educate providers and it should be available to providers in a lot of different formats.

And also that capacity building should precede public awareness campaigns. That public education campaigns are needed to continue to reduce the stigma of depression and as they say in New Jersey, to speak up when you're done. That a common language needs to be established for all those that are concerned with this issue so that we can communicate with each other clearly when we're addressing aspects of perinatal depression. And that providers really need to be encouraged to build referral systems in their own communities, to work collaboratively with other professionals who are seeing pregnant and postpartum

women. And that a screening tool should really be selected and promoted that includes identification of comorbid\* like substance abuse and domestic violence.

And then finally drawing on what our focus group said that support groups need to be created to meet the needs of populations who are not comfortable with traditional treatment. And I think this is a low cost effective approach that has been underutilized and could reap, you know, many rewards.

And finally that we need to continue to ensure that providers are rewarded for their efforts to assist women. So I hope you will visit our website and recommend it to providers in your states that are interested in helping women suffering from depression.