

MCH EPI Conference

EFFECTIVE PARTNERSHIPS AND TOOLS FOR PUBLIC HEALTH PROMOTION: WORKING TO INCREASE AWARENESS OF PRAMS AND IMPROVE PROGRAM SUSTAINABILITY

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MANDY McCULLOCH: Thanks for having us here to present about this. This is an exciting project, and we're really interested in seeing where it goes from here. I would like to recognize Ricky Tolliver as well. He's our PRAMS coordinator and typically we've done this presentation in about an hour and a half. So when we heard we had about 15 minutes, we shortened it a little bit and Ricky, luckily, gets to sit at the table back there while I stand up and tell you about our program.

So really my presentation will focus less on the PRAMS data and the PRAMS side of it, because I'm the program person and tell you about how we use PRAMS data to support a public health intervention that addresses perinatal depression. So just to give a little background on this, there's three main areas in perinatal depression that are kind of the top mood disorders that they speak of.

Baby blues is an initial first two weeks after pregnancy, women experience some changes in mood and may be sad or weepy, but after two weeks it usually resolves.

Perinatal depression is actually clinical depression that requires treatment. That can usually occur in the first year after birth. It's not immediate always. The prevalence is quite a bit higher. There's postpartum psychosis, which many of you have heard the stories, a lot of them become national news story, and that's a very rare occurrence and not what we are aiming our project about.

So it's really important that we address perinatal depression. It's the most common complication of child birth, and it can be treated. It's also debilitating to the mother and to the child. The research is early but the impact on a child and the family increasingly is more and more apparent.

Really, the time from zero to three years is a critical period for children in their social, emotional, cognitive development. So as you can imagine, if the mom is less engaged with the child during that time a lot of that is delayed.

So in Colorado, our PRAMS data showed us that about 14 percent of the women experienced that, that translates to about 10,000 women per year in Colorado, which is quite a few. But we also looked at those characteristics were of those women. And it is more likely, for women to have postpartum depressive symptoms if they're under the age of 25, if they are black or African-American ethnicity, if they have lower education, unmarried or in low income category.

Also women who experience or have a history of experience of abuse. Those with higher stress. And it also leads to the outcomes typically or we find that more women are prone to having a low birth weight baby, and tend to breast feed for a shorter time period.

This is important because I'm actually going to skip one side and I'll go back to that in a second. But the prenatal plus program is a program in Colorado that provides case management services to Medicaid-eligible pregnant women. And we see them throughout the pregnancy and up to two months postpartum. And what we found was that the risk factors for postpartum depressive symptoms that are the most prevalent according to the PRAMS data match very well with the demographics of the population that's served by prenatal plus.

As you can see, the majority of the moms in the program are single. Nearly -- a little more than 40 percent have less than 12 years of education. A third of them are teenagers. High prevalence of abuse and child abuse as well as domestic violence.

The highlight stress indicators, which you all are familiar with in the PRAMS data we use those same indicators in our prenatal plus program to indicate highlight stress. And 42 percent with a history or current psychiatric diagnosis, which includes depression.

So it seemed like a great match for the prenatal plus program to shift its efforts and/or add to its efforts, I should say, and address perinatal depression, screening and intervention.

And it was also not surprising that this topic consistently came up from our providers as a number one issue that they wanted to receive more training on.

So we took it a little further than just doing training, because we had done that for a number of years at our state conference, and we actually turned it into an intervention for the providers to follow. Which all of you I think in your handouts will have the protocol, the pathway that we use. So we'll get to that in a moment.

The main purpose of our intervention was to identify, educate and facilitate treatment for these women at highest risk for perinatal depression, with the ultimate goal to reduce the prevalence.

So to prepare for that, we made sure that the staff in the program had enough skills to offer the education to the clients and do the screening as well as give them grief counseling and refer them on to other resources. We did it through statewide training as well as putting together a manual for them.

We also felt it was really important to increase the community awareness of prenatal plus programs so those in the community knew these women were receiving services and of the high mental health needs of these women, but also not that they only knew about the program but they would be able to be effective community partners and treatment providers for the women so that women could be referred from our program to theirs and receive treatment.

The staff skills and increasing those skills were done on the state side of it, and then partnering with the local agencies we encouraged them to go out into their community and develop their own partnerships within their own communities.

So the goal of the program, the intervention, is to increase their knowledge of perinatal depression, the women's knowledge of it. Increase their awareness of resources.

The prenatal plus program is only through the first two months postpartum. As I mentioned earlier postpartum depression can occur at any time during the first year of the child's life. So we really wanted them to be aware of the resources so once they were out of our program they could also have that information in their hands or knew where to go or who they might be able to talk to once we weren't seeing them anymore.

Along with that, increasing their motivation and self-efficacy to actually seek help. We know a lot of women suffer with postpartum depression and don't actually seek health, otherwise because of stigma or because they aren't aware of the resources available to them. In turn hopefully decreasing their sense of helplessness and despair and knowing that it's treatable and there are people who can help them.

In the more long-term outcomes, we hope they identify the symptoms earlier. If they identify the symptoms earlier, they'll actually seek and receive care with the enhanced community collaboration that there are providers in the communities who can offer care; therefore decreasing the number of postpartum depressive symptoms and ideally decreasing postpartum depression.

So as you can see, I did not expect you all to be able to read the words on this slide. So I've given you a copy of the protocol, and I'm not going to go through this in detail but to give you an idea of what the program is actually doing. We're screening three different times during the pregnancy, and we do it with every woman.

There's an initial screening when they first come into the program. We do a two-question screen. Depending on the results of that, if it's positive they receive the Edinburgh Perinatal Depression Scale. If it's negative, then just offer them education and wait until the third trimester.

In the third trimester, everyone in the program, again, receives the EPDS and education and information, depending on the score that they have on their Edinburgh scale, then they're referred on for further treatment if needed or perhaps there's also a mental health

provider in the program. So they may be able to see within the program the mental health provider and address some issues early.

Then finally postpartum, two to six weeks postpartum, that's really the time frame we have to be able to see the mom and offer some intervention.

We felt multiple times throughout the pregnancy, offering the women education and information. In addition doing it for every woman, that we aren't just screening the woman who just appears sad that day in the office but every woman that comes in.

That's to decrease the stigma. It's a lot easier for the providers to say this is something we do with every woman and we really care about you. We want to make sure you're feeling okay, and they give them a survey.

And not make it, hey, we're pointing you out because we think you might look sad or the stigma of you might not be a good mom if that's the way you feel. Really trying to get rid of that and help the moms know this really happens to a lot of people and we really want to help you.

So for anybody that doesn't have experience with the Edinburgh post natal depression scale it's just a few brief points about it. It's simple ten item questionnaire. It's designed to screen women in child bearing years, because it doesn't look at some of the somatic symptoms of sleep difficulties and other things that could go along with regular depression, but in pregnancy can actually just go along with pregnancy.

So it is a screening tool. It's not a diagnostics tool, and it also is not a clinical, used for any sort of clinical judgment. There's other things that are going on that they do need to be seeking professional help.

What we are planning to collect with the intervention is some data, which is always exciting. Find out how many of the women did receive education. Ideally, we hope it's 100 percent. Percent of the women screened and then those that screened positive. So we'll know what the prevalence of perinatal depression symptoms is in our population.

In addition, we want to know how many are referred to treatment and then if they are referred to treatment, how many of them actually get into treatment, because that is an issue.

And if we know, hopefully we can find out if they get into treatment, and then what sort of treatment are they receiving? Is it counseling? Is it medication? Is it group therapy? That sort of thing.

And we're also conducting a client exit survey to test for knowledge and awareness on the part of the client.

So in conclusion, our program is based on identifying and training perinatal depression. We know it's a serious problem. We know that the risk factors for it exist in the population that we serve through prenatal plus, and in order to do that we're going to conduct regular universal screening. Give them education, resources and referrals that they need and facilitate them getting into treatment and offer follow-up. Not just for a few women, but for every woman throughout pregnancy and postpartum. We have a website at our state health women's website. You all have that. If you're interested in more information, we have a lot of resourced, educational materials for moms and providers up there. And that's all. Thank you.