Federal/State Partnership Meeting

Depression in Parents, Parenting and Children:

Opportunities to Improve Identification, Treatment, and Prevention

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KAREN HENCH: Division of Healthy Start and Perinatal Services within the Maternal and Child Health Bureau, and I had the privilege of being the project officer for the MCHB portion of the report that you're about to hear.

I want to thank you for joining us in this session. I know when you were coming up the hall you were probably accosted by Michael Kogan trying to railroad people into his session. But make no mistake you've come to the best session here. (Laughter).

I want to introduce our three presenters today. You have their bios in your binder, so I won't go over that. But our handouts can be found under Tab 8. First we'll have a presentation by Dr. Elizabeth Howell. She's the Assistant Professor, Department of Health Policy and Obstetrics Gynecology and Reproductive Sciences at the Mount Sinai School of Medicine, and Dr. Robert Phillips, Dr. Sergio Aguilar-Gaxiola, as the Director of the Center for Reducing Health Disparities, Professor of Internal Medicines at the School of Medicine and Health Disparities and Clinical Internal Medicine at the University of California Davis.

And then, finally, Dr. Robert Phillips. He's the Director of the Robert Graham Center Policy Studies and Family Medicine and Primary Care at the American Academy of Family Medicine.

Dr. Howell.

ELIZABETH HOWELL: Thank you. Good afternoon. My colleagues and I would like to thank the Maternal Child Health Bureau and HRSA for the opportunity to present the findings on the IOM Committee Report entitled Depression in Parents, Parenting in Children, Opportunities to Improve Identification Treatment and Prevention. Depression affects millions of U.S. adults over their lifetime, many of whom are parents with children.

The burden of depression and the barriers to quality of care for depressed adults are increasingly well understood. But the ways in which depression affect parenting and children's health and children's psychological well-being and functioning are often ignored.

To address these issues, the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, the California Endowment, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration turned to the National Research Council and the IOM to conduct a study to review the relevant research literature on the identification, prevention

and treatment of parental depression and its interaction with parenting practices and its effects on children.

On behalf of the entire committee, my colleagues and I are pleased to present this report at the Maternal and Child Health Bureau State/Federal Partnership Conference.

The Committee on Depression Parenting Practices and the Healthy Development of Children was formed to specifically describe the following: What is known about the interactions among depression and its co-occurring conditions? Parenting practices and child health and development. What are the findings, strengths and limitations of the evidentiary base that support the assessment, treatment and prevention interventions for depressed parents and their families.

What are the disparities in the prevalence, prevention, treatment and outcomes of parental depression among different sociodemographic populations, and what strategies exist for widespread implementation of best practice and promising programs given the large number of depressed parents.

What strategies exist that can foster the use of effective interventions in different service settings for diverse populations of children and families.

The 17 committee members brought to the committee knowledge about mental health, public policy, child health, parenting, family services, substance abuse, community health and service delivery.

The committee was diverse in expertise, experienced and perspective. The committee met five times over the course of about ten months and held one public workshop and other public sessions.

We also visited two programs that provide multi-faceted approach to mental health services in substance abuse settings to underserved mothers and their families.

You'll hear a little bit more about these programs later in the presentation.

Committee members also spoke to parents, healthcare providers, community-based organization leaders and policymakers. And before I continue, I would like to also just note that the committee has dedicated this report to Jane Nitzer, an active member of the committee until her death in March of 2009. Her contributions to the committee's deliberations and findings can be seen throughout this report.

Depression is a common universal and debilitating public health problem. Both national and international data support the universal nature of depression. It's a

widespread problem that affects approximately 20 percent of adults in their lifetime.

It's the leading cause of disability worldwide. And for some an episode of depression will resolve in weeks or months. But for many approximately 30 to 50 percent depression is a recurrent, chronic condition that does not resolve completely.

Ironically, depression is one of the most effectively treated psychiatric disorders. There are disparities in prevalence rates in depression among adults. For example, women are twice as likely to be diagnosed with depression as men.

Depression is more common in younger and divorced adults than their older and married counterparts. Although existing data report lower rates in lifetime prevalence for adults in certain racial and ethnic groups, data does suggest that racial and ethnic minorities with depression are much less likely to be treated.

It is clear that there's a positive association between social disadvantage and depression prevalence except in the case of first generation immigrants.

Studies consistently have documented that lower socioeconomic status is associated with higher rates of depression. As mentioned, many adults in the U.S. are parents. One national survey, The National Co-Morbidity Survey, notes

that parents have similar rates of depression and disparities within populations compared with the general adult population.

It's estimated that 7.5 million parents are affected by depression each year in this country.

Depression rarely occurs alone. In fact, about three-quarters of individuals with lifetime or recent major depression also have at least one additional mental health or substance abuse diagnosis such as anxiety disorder, post traumatic stress. In addition to the knowledge that depression is a universal problem we also know that depression does not occur in a vacuum.

Multiple biological mechanisms, genetic factors, environmental risk factors, personal vulnerabilities and resilience factors for depression as well as co-occurring conditions have been identified. Many of these factors associated with depression including medical and psychiatric diagnoses, economic and social disadvantage, and conflicted or unsupportive relationships, place additional stress on depressed adults, making coping even more difficult.

It's very important to note that although depression is one of the most prevalent psychiatric conditions, it's also one that's highly amenable to treatment. Yet despite advances in research gaining better understanding of depression, many depressed individuals will never receive treatment of any kind. And community

samples, it's estimated that 70 percent of individuals with depression do not receive any type of treatment.

In national surveys, the estimates have been about 40 percent. So this is any type of treatment. Not just effective treatment. And the take-home point here is that despite the availability of effective therapies for depression, we're not doing a very good job at treating people.

And rates for effective treatment are even lower. Individual, provider and system level barriers exist that decrease access to and quality of care for depressed adults. These barriers may include transportation issues, physical disabilities, stigma, language barriers, a cult of customs and beliefs and health insurance coverage.

These barriers are responsible for causing and maintaining existing disparities in access to and participation in effective treatments for depression.

Although the prevalence in etiology of depression are increasingly well understood, the ways in which depression affects the individual adult, the family and society are often ignored. Here are a few findings on the impact of depression.

As we mentioned earlier, depression is recurring in nature. And it leads to sustained individual family and societal costs. While it's very difficult to estimate the true costs of depression, it's essential to consider not only the individual family members, but also the family as a whole.

Expressed in monetary terms, the economic burden of depression is a major health problem. In 2000, it was estimated that the costs related to depression in the U.S. was over 80 billion, with 26 billion in treatment costs, 52 billion in workplace costs, including absenteeism and reduced productivity, and five billion in suicide-related costs.

I bring up these statistics only so that you realize that these estimates never included the costs of depression on parenting practices and on the adverse outcomes in children and families who have depressed parents.

So many of these cost estimates are not accounting for the full effects of depression on family, on individuals and on family members.

A review of available literature identifies the depression in parents interferes with individual achievement, parenting quality, and is associated with poor health and development in their children at all ages.

Clinically significant depression has detrimental effects on the intellectual processes and attitudes about self, the world and the future, and it impedes adaptive behaviors in family and social interaction.

In terms of the impact on the individual, the NIMH collaborative health program found that over a five-year period depressed persons had lower educational achievement, lower income levels, fewer periods of employment and decreased occupational status as compared to non-depressed persons.

We know that depression has adverse impacts on parenting. Impaired parenting can impact a child from infancy through adolescence all the way up into young adulthood.

For example, infants with mothers with depressive symptoms are more than likely to have a difficult temperament less secure attachment and poor neural behavioral regulation. In studies of later child outcomes, parental depression has been associated with poor academic performance and an increased risk for delays in motor and performance skills and problematic parent/child interaction.

Children of depressed parents are more likely to have negative affect. And they're more likely to have behavioral problems in school. They're actually more likely to drop out of school. And on the last note, an important thing to realize is that rates of depression are higher in children with depressed parents. Likewise,

depression in children who have depressed parents has an earlier age of on set, longer duration, and is associated with greater functional impairment as compared with depression in children who do not have depressed parents.

The committee estimates that 15.6 million children are at risk of adverse outcome because they are living with an adult who had major depression in the past year.

Depression is a common condition that affects millions of parents and children in our society. The individual and family costs of depression are enormous. Multiple barriers to the identification, prevention and treatment of depression exist. There are many barriers to depression care for vulnerable populations that must be addressed to improve access and quality to depression care for all families in the U.S.

Depression may interfere with parenting quality and may put children at risk for a host of adverse outcomes.

The data suggests that there's a dire need for depression care to take a life course perspective. Given the impact of parental depression on families and children, our committee and the IOM committee on preventing mental emotional and behavioral disorders among young people feel that prevention and treatment interventions for depression need to take a life course perspective.

This is a developmentally oriented diagram. It shows how we might think about prevention and treatment.

In both reports the committees document evidence for different kinds of prevention, and our report prevention and treatment.

This slide focuses on prevention. And here you can see that there were numerous opportunities for intervention. Early in life, prenatal care. Home visitation, high quality day care. Where there's evidence that you can actually prevent certain things from happening in the future.

Into childhood we have general interventions like parent skill training that have a strong knowledge base and more specific interventions such as prevention of depression.

And by community interventions -- I forgot to do the nifty slides -- we want you to recognize that we mean not just ways to strengthen communities but also to address poverty, violence and social isolation.

There were multiple opportunities for interventions across a person's developmental course. And the committee feels strongly that a developmental perspective is very important. The life course perspective has implications on

improving strategies to identify, treat and prevent depression in parents, children and families.

SERGIO AGUILAR-GAXIOLA: Buenos Aires. I also want to thank HRSA for co-sponsoring the development of this report and also for hosting this. And it is a pleasure to be sharing with you the information coming from the report.

I know that before I talk about the slides, let me tell you that one of the things that we want to emphasize in this report is that when we think about depression, we think about it as an individual condition.

Rarely we think about it as a family condition. And, yet, as my colleague, Dr. Howell mentioned, the impact of depression rarely stays within the individual. You know, I have been involved with very large studies with the World Health Organization.

One of them is called the world mental health survey or initiative. This involves 40 countries. And one of the consistent findings that the data came from each of the countries is that the, when you compare different mental health conditions, also with current conditions, the depression keeps coming as the number one condition for disability, for impairment.

This is the impact that depression causes on the day-to-day functioning of those who suffer from it. And as Dr. Howell mentioned, many, many of those suffering from depression are parents. And this has definitely an impact on children.

The next few slides that I will discuss with you are going to be on three different types of interventions that are described in the report. One is on screening, or deidentification of depression. Usually symptoms of depression.

Although, it can be a symptom of depression or major depression by the most part.

Another one is treatment and another intervention is prevention. And this diagram here comes from the original 1974 report of the institutes of medicine on prevention. Some of you might be familiar with that.

And it still continues to be used in the sense that it gives us a vision of what are the different types of interventions. And also how this is related to this other concept of promotion.

And if you notice here in this diagram, promotion is not only a part of -- it's not only an intervention in itself, so it is a discrete dimension in this continuum, but also it cuts across all the different types of interventions.

And this is important, because one of the things that we want to emphasize is that mental health is not only the absence of disorders. It is also the other half of the continuum, which is to enhance the individual's ability to achieve developmentally appropriate tasks. And once again it is important to look at this developmentally across the life span. And also to enhance individual's sense of self-esteem, mastery, well-being and social inclusion.

The other aspect coming from promotion is to recognize that we are constantly living in challenging circumstances. It is inescapable that we are going to be tested constantly. And some people more than others, in their daily life stressors.

And so the idea about how can we strengthen also the ability to cope with adversity is part of the aspects that we want to emphasize. And in this you just think about the concepts like resilience and also recovery, which are part of the notions within the mental health that we want to emphasize as well.

So the other thing is -- and this comes from the sister report, the Institutes of Medicine Prevention, preventing emotional and behavioral disorders among young people report, these are key concepts that we want to also emphasize.

And that applies not only to prevention, even though it says prevention. And that is that thinking about these things requires a different way of thinking. One of them is not to think just depression once again in the context of individuals. It is

in the context of families, of marriages. Even in the context of communities, I would say.

Also, the notion that mental health is inseparable with health. This is something that has come to be recognized more widely and is being very much supported by emerging data.

Also that successful prevention is inherently interdisciplinary. We need to work together coming from different angles in order to deal with a condition that is so incredibly taxing and burdensome for individuals as well as families.

The notion, once again, that the developmental perspective, that is key, as was emphasized by Dr. Howell. And something that is of great importance, and that is included in the report for especially for vulnerable diverse populations, and that is that we need to coordinate care at the community level system, which is where the few who come and receive services from diverse communities usually do it at the community level.

So let me talk a little bit about identification first. In the report, it is documented that there is effective screening tools available to identify adults with depression.

And I emphasize "adults." Also, that this screening programs are more likely to improve depressive symptoms in adults, especially when the screening leads to further evaluation and it follows with treatment. Specifically for parents.

However, the current screening programs do not consider whether the adult is a parent, which is once again a part of the message that we very strongly want to emphasize. Also do not consider the impact of the parents' mental health status on the health and development and of their children and do not integrate with their evaluation and treatment or other existing screening efforts.

And usually the settings on which that parents that are at higher risk for depression do not, in a routine basis, screened for depression. I'm talking about primary care, specialty care, schools, et cetera.

So there are some missing opportunities even though parents are being seen in different settings and that are tools that are effective, easy to use, to identify depression. We are missing opportunities to bring attention of depression in the context of parents and families.

In terms of treatment. The current evidence tells us that there is a variety of safe and effective tools for treating adults, both with elevated symptoms of depression as well as with major depression.

And those tools are things like psychotherapy, medication, as well as other approaches. Also, there is a variety of strategies to deliver these treatments in a wide range of settings.

So settings like I mentioned already primary care, specialty care, as well as Web-based interventions. Interventions in the workplace.

But specifically for parents, the evidence is that do not -- both the tools as well as the settings don't target parents and do not measure its impact on parental functioning or its effects on outcomes.

Once again, missing opportunities. And I know that you are -- you're coming from different states and we would love for you to take these messages to your places of work and to help as we disseminate this information.

The other thing is that individuals should have informed choices in treatment and tools that are available to them. We considered that the treatment tools and strategies to deliver this treatment should be flexible, efficient, inexpensive and, above all, acceptable to the participants in a wide variety of communities and clinical settings.

And acceptable includes issues of culture and language for the increasingly diverse population that we have here in the U.S.

We're going to be talking about this a little bit later in the presentation. In terms of prevention, we know that there is immersion prevention intervention for families with depressed parents or adaptations of other existing evidence-based parenting and child development interventions.

And these demonstrate promise for improving outcomes in these families. There are some of these emerging prevention interventions documented in the report. And things, for example, that interventions that prevent or improve depression in the parent. Those that target vulnerabilities of children of depressed parents. Also, those that improve parent/child relationships, and interventions that use two generation approaches.

We also -- I think that is important to go beyond two generations, because there are families that are comprised of three generations. And sometimes grandparents especially in some groups play a very important role in raising children.

Also, the broader prevention intervention that supports families in the healthy development of children also hold promise for depressed parents. I'm happy to report that there are a variety of prevention programs that appear to be effective in low income families. And from very culturally and linguistically backgrounds. One of those examples is Dr. Bill Beardsley who is one member of the workgroup

that assembled this report. And he has developed and has been around for several years back since 1989, the preventive intervention program for depression, which is a family-centered program to prevent depression in children with a depressed parent.

He has done two adaptations at least and actually more than that, but here in the U.S. adaptations with African American low income families, as well as Latino, low income families.

And in the case of Latino families, the intervention is made up of a series of conversations with a focus on building on the existing strengths in each family. And also the families are asked to share their stories.

And this is strength-based looking at what are the strengths that family brings and usually these interventions culminate with a discussion, open discussion with the parents and their children about the issue of depression.

And something that in several families is, it keeps hiding. There's a culture of silence in many families, and the idea is to break through this culture and to start talking about these things in the open.

So in conclusion for these slides, there are screening and treatment interventions available that are safe and effective for depressed adults but regularly integrated or considers their parental status or its impact on their children, on their child.

Also, there is emerging preventive interventions that demonstrate promise for improving outcomes for families with depressed parents. But we need to be very mindful about institutional as well as social cultural barriers that cause and sustain disparities and care for the principals, especially in the vulnerable diverse groups that I was referring to.

In fact, one of our recommendations in the report is that efforts should be made to ensure that effective strategies are employed to increase the participation of underserved populations, diverse populations, and to engage them in critical research strategies and clinical trials.

They tend to be underrepresented in studies and then available evidence that comes from other groups tend to try to be applied to these families. And we don't know well how this works out.

The other thing is that new research methods and innovative morals that partner with vulnerable communities should be supported. And the particular focus here is that it should be directed at prevention and early intervention efforts that are

community-based and culturally appropriate. So that the hybrid of disability that depression causes can be reduced, especially in these populations.

You know, many of these populations are poor. And if you think about depression causing tremendous disability, one of the direct impacts is associated with lost productivity which feeds into a vicious cycle of poverty.

There are some gaps that we want to call your attention to. Not everyone benefits from the interventions associated with the strongest evidence base, so we need to look at different barriers or obstacles to accessing care at the individual, provider as well as the system level.

And also there are few opportunities to identify the vulnerable population of children. I already spoke about those children who live with their parents and sometimes with their grandparents.

So in this multi-generational context, it's important to offer prevention and treatment services with the idea of improving the care of the depressed parent.

There are opportunities and challenges. Actually, I already alluded to an opportunity to identify and assess the impact of interventions in adults who are parents of children at various ages. These effects could examine outcomes

associated with effects on parenting practices, parent/child relationships and child outcomes.

And the idea of adding and implementing an explicit focus on parenting and parent child relationships to different forms of screening, prevention models for adults who struggle with depression.

So these are challenges. And there are some, once again, opportunities to develop systems of care that use more proactive approaches for prevention and early intervention in parents in the context of two generation, sometimes three generation models, that is family focus, culturally and linguistically informed and accessible to vulnerable diverse populations.

And, finally, that these interventions, to do them where people are. Other points of entry, and we know that when it comes to depression, especially vulnerable populations use them in community-based settings.

So with this I'm going to pass it on to Dr. Phillips.

ROBERT PHILLIPS: Thanks for asking us to come in and speak to this. Because you all -- where you're coming from in terms of Title V and Maternal and Child Health Bureau programs in your states, probably understand this more than just

about any audience that we could speak to. You start with families. So that's very valuable.

I also want to say, I have to give a disclaimer. I don't understand your programs very well. So I really do hope that you don't just have questions, but that you'll educate us about what you're doing in your states related to parental depression and defects on children or where you see opportunities. So I want to start with -- I'm going to do a lot of reiterating, but very succinctly, I hope, and talk about some of the critical features for care for parents and what we need to develop and hope that stimulates for you some thinking about your programs and where these might fit or not fit.

So starting with integrative, as Sergio said several times, we need to integrate across families. We need to integrate across programs. We need to integrate across communities to really deal with parental depression and its effects on children. Several states have initiated system wide efforts to increase screening and treatment.

Most of these programs have never been evaluated. And if they have, they're not well disseminated. And if you look in the appendix of the report, you'll see several of these programs. And I'll talk about them briefly.

But think about what your programs, where do they fit in the context of integrating. If someone shows up in a WIC clinic and is screened, for example, is there a place to send them for care where you might find out if they've actually followed up?

Comprehensive. We're interested in -- and these overlap somewhat. But Liz mentioned the need to consider comprehensiveness in terms of family, co-morbid conditions, dealing with the social determinance of health, like poverty, violence and isolation.

How do you deal with these comprehensively to really effect if not the depression of the parent, its outcome in terms of the child's development?

So some states are doing this through looking at how can we train healthcare providers to increase access to screening and services in nontraditional settings. How can you get physicians talking to school nurses when there's an identified case of a child possibly being affected by depression in the family?

Multi-generational, as Sergio said several times, we need to think about not just children, not just parents, but children and parents, and perhaps even grandparents who are taking care of their grandchildren. Because that's happening increasingly. And we know that those grandparents in particular often didn't expect to be in that position. Often have issues about why they're having to

do this. Their children are incarcerated. They have substance use issues. Lots of factors that can feed into the grandparents being depressed.

And then the whole time line of development that Liz put up is that we need to think about developmentally appropriate ways of dealing with this across those early years of childhood development. Some of their critical relationship issues are being founded.

But then even when they're adolescents and how they're able to deal with adversity and how they're able to cope with the situations they're in. So really how do we develop developmentally appropriate responses across your programs even. But particularly your focus on early child health development.

Availability across settings. I mean, your programs touch on so many different aspects of early childhood developments. So how available are these screening tools or intervention tools across your programs? And how do you reach out and touch community health centers or rural health centers where a lot of these families are going to be getting their healthcare and working with mental health resources that they have there.

As Liz mentioned, accessibility is a huge problem for a number of these families. Accessibility to healthcare, whether it's because of insurance or poverty or the interrelationship of those things.

And as Sergio said, there are Web-based therapy programs that have proven to be quite effective, at least for parents and families who can access the Web.

Programs in schools. I know high schools in my area often have teaching of English as a foreign language or GED prep courses. So if families are coming into schools, are there programs in the schools for parents as well as adults?

In my community, in Missouri, where I worked in a community center, we had parents as teachers. And I'm sure you probably in your states have programs like parents as teachers, we have parents coming in. Are they prepared to do screenings. And when they identify parents with depression, are they prepared to refer those folks or help them get into intervention or Families to Families, which is your program.

As Sergio emphasized the need for cultural sensitivity. For low income groups, minority groups, whether it's by race or ethnicity, they often look to their community-based programs and settings they trust. So if you're not finding these folks in your programs, not getting responsiveness, are you reaching out to these community-based programs to see how they might be involved?

So some of the model state programs you'll find in the appendix or throughout the report, the Ohio Department of Health and Mental Health has Help Me Grow,

which is a county-based visitation program in which they do screenings and referrals for maternal depression. Working Towards Wellness Program. A Rhode Island based program where they have telephone care management programs for depression and really aiming at that temporary assistance for family members, group of patients.

Or the University of Illinois Chicago Perinatal Mental Health Project where they do comprehensive care for maternal depression, including consultation and step care for depression in perinatal clinics really identifying people at risk and putting them through the steps depending on where they are in the process of depression and urgency and helping them with self-care and provider training for people who they're going to hand off those patients to and really indebted to Liz for finding these programs.

And the one that Sergio wanted to highlight was Interfamilia in Boston where it's a program for patients, Latino women, with substance use issues and who are parents and dealing with their depression in the context of treating them for substance use.

Because as you know these are often co-morbid. But really tailoring their treatment for addiction and mental illness, co-occurring disorders. And also then focusing on trauma. Because trauma often leads to both substance use and mental health disorders.

And focusing then on not just the patient but the entire family. So I mean you all probably have a host of other programs like these that I'd love to hear about and how you all might have these discussions about community state, federal and even international level initiatives.

I'm going to get to some of the challenges that exist. And Sergio touched on a number of these. But we really have some systemic problems. And that has to do with the lack of evaluation, lack of dissemination of a lot of these functioning successful programs. But break down even into issues of treating more than one generation in a healthcare setting, where we tend to split sometimes not only on age, but on organ system.

So how do you reintegrate those from organ to person, to families in healthcare settings? And I put that here outside of family medicine, but I've got to own a little bit that even in family medicine we don't always have good continuity with our patients much less with our families. How do we deal with as co-morbid health conditions. And we often focus on those co-morbid health conditions whether it's diabetes or substance use or trauma without dealing with the underlying depression and how it's affecting the family.

As Sergio really highlighted the issue of vulnerable populations and having systemic ways of dealing with them. You all are probably dealing with this in your

communities right now, but we have shortages of mental health and primary care providers.

And in Massachusetts, it's been a great example of this. When you pull everyone into the insurance system, that becomes even more apparent. I live in Northern Virginia in one of the wealthiest counties in the country and I can't get patients into a mental health provider in a shorter time than three weeks. And those mental health providers often don't take insurance.

So we have real problems with availability. And then there's great discomfort in treating both mental health and physical health conditions. So where Sergio started with these are inseparable. They're currently separated in most settings and then even if they are capable and comfortable with dealing with mental health issues and physical health issues, they're going to have trouble dealing with multiple ages, multiple generations and whole families.

And then financial, which is kind of a bedrock to the previous two, is that if you don't have insurance, particularly for the highest risk patients, and we know many of them are uninsured, it's going to be awfully hard to get them into a system. And that we have long-standing mental health carve outs that are still affecting me in my daily practice.

In my residency training I wasn't even allowed to put out a mental health diagnosis because of the carve outs and we have problems with early interventions for kids that's where you come into play in particular.

And we have the problem of treating families. When our insurance systems are really focused on treating individuals.

So these recommendations are in your report. I hope you got a copy. There were copies in the back. If you didn't get one, let us know. But Sergio ran through these very well that we really need to improve awareness and understanding and probably reaching out to your programs first.

We need to support innovative strategies and make sure they're evaluated and disseminated. We need to improve collaboration and capacity building so that really we can integrate these systems even within your programs. We need to improve provider education and training.

We need to improve service coverage and reimbursement strategies and we need to promote and support research so we can continue to learn about how to improve them.

So we wanted to tailor these back to you. I said we're naive, at least I'm naive about your program. So looking at Title V and looking at MCHB we wanted to

add about parental screening treatment to formula Block Grants. Looking at the triangle from your website, I didn't see depression or mental health mentioned here. You may be doing it, but could that be added in? Not just screening for depression, but dealing with how it affects parenting and how it affects children, or would it fit under the community integrated services systems.

Where in Healthy Start in particular could you add the screening, add the effect on parenting skills, add the effect on children in development. Good. I'm hoping you'll tell us more about how it's there. And then Family to Families, particularly vulnerable populations where you're looking for relationships of trust. Can we add information about parental depression and its impact on children?

And can we put that into the information centers and can we put depression. We know that depression and abuse are higher among special needs children. So really incorporating into these trusting relationships that Family to Families develops.

Finally, I look at this group as a learning community opportunity where -- and I'm wondering if you can develop that within Family to Family within Healthy Start, within formula Block Grant programs, so that if one of you is doing this well, how can you learn from that? How can you teach that, and how can you continue this learning community develop these skills across the entire country.

Finally, to consider ways to work with Head Start, WIC and Medicaid so the screening that happens in your setting leads to interventions and ongoing assessment as the children age and families continue to try to cope with depression of one or more both parents.

Liz started here with thanking with our funders. I want to take this opportunity to do it again, particularly to HRSA, not only for funding, but for bringing us here today. So thank you.
(Applause)

KAREN HENCH: I'd now like to open up the whole panel up for questions and comments and discussion. And I want you to know that a large portion of what we are supporting is the dissemination of that information. So this meeting is just one point where we are looking to disseminate this information.

We'll be presenting at the American Public Health Association meeting. We hope to be presenting at the AMCHP meeting next spring and to keep the ball rolling with getting the word out. And so as the speakers have said that we integrate this important measure and concept and task within multiple programs in health and education and other arenas.

Anyone have any questions?

UNKNOWN SPEAKER: I have a question.

You made a comment early in reference to the depressed parents having depressed children. Obviously that might be from lack of coping skills, they might fall into that. So then the question is as we have studies around women who are depressed but got into treatment, how did the kids fare? Did you see a better outcome for those individuals?

ELIZABETH HOWELL: So the data is a little bit mixed on that. There's been more recent data looking at whether treatment actually changes outcomes. So treatment in parents change improved outcomes in children. And from a large trial with, medication trial in depressed parents, in mothers, they found better outcomes in the children whose mothers had successful treatment.

They've done a lot of smaller studies, observational studies in groups and the results have actually been mixed. So you'll find somewhere where outcomes for children are better and others they're not. This is an area we need to do a lot more research. The problem is people are not identified as parents in many of these studies. So we haven't been adequately capturing that and looking at whether treatment is, the effects of treatment not just on the individual but on their children. So this is part of what this report is trying to do is really to foster this and make sure that people realize we need to start collecting this data.

UNKNOWN SPEAKER: I know Healthy Start, you do have a piece where one of the things we do, any mom that's in there gets screened for depression. And recently we have an MOU with the department of mental health so that those individuals who screen positive you automatically refer them to mental health. And then there's a collaboration between the caseworker, the nurse caseworker and the mental health individual to make sure that they again -- but we go from zero to two. And then after that they usually just start the Healthy Start program.

The mental health will keep them in if they still continue the need. But we have no idea what happens after that. So it's just -- we start off but we sometimes don't see the latter end on what goes on with those parents.

SERGIO AGUILAR-GAXIOLA: Can I very quickly comment? One of the big issues about what you ask is that there are population groups that don't access care. And those who access care also, I would proportion, have no idea that they have depression, for example. Or those who screen them, you know, they don't screen for depression. So there are a lot of missed opportunities, as I said. Just to give you an idea, in national studies that have been done, epidemiological studies, one with Latinos and Asian and Pacific Islanders, done by Dr. Elegria and David Takauchi. Dr. Elegria reports that over 50 percent of those who met criteria for major depression had no idea that they had depression.

And this is in the general population. And in some cultures, for example, they don't speak English. They don't have even words for depression. So it is -- it really makes it very challenging that when they are experiencing such a disabling condition as depression, if they don't know what's happening to them, it is very difficult for people to put it together and to seek services.

And if they do, they don't have the nomenclature, they don't have the language to talk about these issues.

ISADORE O'HAIR: I'm Isadore O'Hair. And I work with Karen in the Maternal Child Health Bureau, and we are visiting a lot of resources and the whole issue of breast feeding, specifically breast feeding in the workplace.

And I have skimmed through this, and I'm interested to see that I don't believe that it's something that you looked at particularly, I may be wrong. I may have missed it, but I'm wondering if you could comment on that.

ELIZABETH HOWELL: I don't think we particularly focused on that in this report. I'm a little bit familiar with that data about depressed mothers, there's some studies that suggest they're less likely to initiate and there's others that suggest they have shorter duration even if they do initiate they're more likely to.

And breast feeding earlier. We didn't -- we might have had two sentences in the report about that. But I agree that's a very important issue. Because for all the benefits of breast feeding that we know occur for children, and for women, actually, as well.

SERGIO AGUILAR-GAXIOLA: I would love to hear from you if there's some recommendations that you have or something that you think that we ought to be considering.

UNKNOWN SPEAKER: I think that there is the issue of a lack of really good study on the subject. After they review of all the studies looking at the relationship of breast feeding to health in general, and under breast feeding, they were left of hard data. There was some indications but really we need to study the [indiscernible]. But I also found that a lot of the work that is done about that is kind of focused on the impact of medication, anti-depressant medication on what is safe and I would like you to comment on that, too.

But I am particularly interested in the issue of initiation and duration and the relationship between the mother and the baby, where the mother is suffering from depression.

And that was something else that I didn't really find in here is looking at the diet. In other words, if the mother is depressed but they are babies with different

degrees of temperament, different forms of temperament, how do those kind of interact with each other?

How does that, if a mother's fortunate to have a kind of easy baby, that impact the depression as opposed to the --

ELIZABETH HOWELL: Independently, again, this is not in the report, and I don't think it was the focus, but I think infant temperament and colic and all sorts of infant factors have been associated with depression in mothers.

So it wasn't the focus of that. But I agree that is true. I have not either seen a study that shows, well, we know independently infant factors are associated with maternal depression. But among depressed mothers how do these sort of interact, what the degree and what the relationships are. And I don't know that data either. I haven't seen that.

ROBERT PHILLIPS: Isadore, I'm glad you and Karen are here. In consulting with Roger Kestler in developing this report, one of the things that became clear to me was the impact of maternal depression on children's ability later in life to form relationships and tying that back and looking at how does that dyad build a relationship. Now, whether that's linked to breast feeding, I think the evidence is a little unclear, but that may be one of the expressions of that lack of developing relationship.

UNKNOWN SPEAKER: We were one of the recipients of the grantee, of the grant that was looking at maternal infant mental health. And it's interesting. And we don't have a whole lot of evidence. But what we found is before we were involved with the grant that we were screening women for depression, getting them into services and yet they still were having a hard time parenting.

And so what we did with the grant was recommend getting them into clinical services, which, for a lot of population we were asserting, wasn't something that resonated -- many of them were undocumented. A lot of them were from central and South America. And the thought of going to a therapist just didn't resonate.

So what we did, we had mother baby groups, and this was based on the needs assessment where they said they wanted to decrease the social isolation and they wanted to feel better about parenting.

We found it was interesting if we had them in therapy and really working on reconnecting with their baby, then that really was beneficial for the babies and for the moms too.

So just treating the mom for depression without reconnecting her to her child may have been okay for the mom's mental health but it may not have translated to

that didactic relationship. So that was one of the really exciting things that we found in this program that we did.

ROBERT PHILLIPS: Correct me if I'm wrong, but if I think we looked, it's been a while since we did this. But we looked at how therapeutic was teaching parenting skills as a way of coping with depression, independent of treating depression. I thought there was some evidence for supporting the teaching of parenting skills, even independently of treating depression.

UNKNOWN SPEAKER: That's what we did. It wasn't just teaching parenting skills, it was soothing, it was Mayan wraps, it was all kinds of things that really promoted the bonding.

UNKNOWN SPEAKER: I'm [indiscernible] and I'm one of the project officers for the early childhood assistance programs, and MCHB, the kids they have a program talking about [indiscernible] and I think my question may have been answered somewhere along the line here. But one of the things that I was concerned about and had a question about is one of the slides said something about preventing depression in children of depressed mothers.

And I was trying to figure out how does that -- what happens because children are part of families. They're not entities in and of themselves so if you hear

[indiscernible] does that mean you have a happy child of a depressed parent. What happens with the parent?

SERGIO AGUILAR-GAXIOLA: That's an excellent question. There is in the report there is some evidence that if you, for example, treat a parent who is depressed who have small children and the depression is mild or moderate, that the impact, long-term impact on the children is going to be better than if the mother was severely depressed to begin with.

So there is an interaction in terms of the level of severity of when you, you know, deal with mothers in, especially with children early on.

UNKNOWN SPEAKER: So you really didn't mean just preventing the -- by isolating the mother. In the context of the mildly depressed mother you're able to add strategies to prevent later depression of the child?

SERGIO AGUILAR-GAXIOLA: Absolutely. That's one of the values of the report. I think that's one of the messages as well. And the reason for bringing promotion into the mix here.

UNKNOWN SPEAKER: The other question I had was if -- I forgot. Come back to me and I'll remember.

UNKNOWN SPEAKER: Just a couple of comments. I'm a Title V director for Alabama. And our mental health system is almost nonexistent. And I enjoyed his comment when he talks where he lives and getting three weeks to get somebody in. Title V program directors, I don't want to speak for them, I guess I'll speak for myself, I wouldn't want to identify women in our WIC program who are struggling if I don't have anywhere to send them. That's tough. You don't want to have to do that, but that's the reality that many of the states don't have a very good mental health type system.

So I don't have a question, just a comment. And I would --

SERGIO AGUILAR-GAXIOLA: Well, that comment hits home very hard. I'm coming from California. And we are experiencing a severe budget crisis. And the budget cuts for counties, for services, I mean as part of the safety net, almost nonexistent now.

UNKNOWN SPEAKER: It would be interesting to see someone do a pilot to what you're describing, a WIC program, because they are parents or are assumed to be parents and they're going to be low income. So it would give you a good snapshot of what you would find in a population.

But you have to have services to provide them once you find them.

UNKNOWN SPEAKER: Comment. This is exactly what we got when we were doing our project. And we are trying to get a legislate -- a bill in the legislation. Of course that's not going to happen now. But that really would mandate screening and we've gotten a lot of pushback from physicians in particular. And we have a couple of comebacks, one is just because you don't screen doesn't mean they're not depressed.

In terms of the physician world, they can prescribe. And I think the other more relevant comments, and the program we had was really with women who were eligible for WIC, 95 percent low income, but what we found was alternative modes of treatment have these parent groups was really effective.

But the people running to the group to understand that this was part of addressing depression. It's not going to get at people who are psychotic. But what we were promoting or what we were suggesting is that there be sort of a tiered system where the people who are really psychotic got in first.

And the vast majority of the women that we were dealing with who are just isolated and depressed and maybe anxious, that there were ways to connect them to less clinic-based services.

So it's a point well taken, though. That's the resistance that we've gotten.

UNKNOWN SPEAKER: I also, I think you've probably experienced this, too, what you'll find, when you move into some of the states, to encourage them to put these into Title V program areas, hopefully there wouldn't be this way in Alabama, they have more than they can do in a WIC program already around nutrition.

Those are some realities that you'll run into. And from councilwoman, registering to vote. Everybody wants a piece of the WIC business. I'm not saying it as a negative, I'm just saying that's a reality. As you move forward you're going to face those kind of challenges.

UNKNOWN SPEAKER: In the corner.

UNKNOWN SPEAKER: I just had a comment. Students do have services to refer but I wonder if there's an opportunity there to do the screening and collect the data properly to show the needs, to create some momentum or -- I know it's not that easy showing need and services don't appear. I know it's a complicated system.

UNKNOWN SPEAKER: Build it, they will come.

UNKNOWN SPEAKER: I do wonder if maybe that's the other side of it. The data [indiscernible].

SERGIO AGUILAR-GAXIOLA: I think that the reality about this is pay now or pay later. There is different data about whether, especially -- well, in mental health, that if you sweep the dust under the rug, that things are going to disappear or if you just wait enough developmentally things are going to get better.

What have they done? And that's one of the reasons. We have, I think in California this is a significant problem, increased populations in the juvenile justice and the social services and many other services in which they tend to be much more expensive and are not the -- as well tailored to treat these issues.

UNKNOWN SPEAKER: Can't pay now or later.

UNKNOWN SPEAKER: I have a comment as well. When I was speaking about the rule that plays into what we're talking about, the reason I said that is several years, I don't remember when it was, I belonged to the HMO they had a questionnaire that had to do with depression. And how often in the week are you depressed? Are you after so and so happens. And according to me it was almost like a joke. Everybody's depressed. The reason I'm saying that is because some people evaluate their level of stress that's based on what they're used to in their culture, their family, whatever, that they could be what you might consider depressed.

But because they've learned a certain amount of resilience in their community, families or whatever, they may learn how to overcome those things that might be a great stressor for another group or person or whatever.

That might be the case why people either deny, avoid or have hard times classifying themselves as being depressed.

I'm talking about different groups expectations or experience with what we as professionals call depression. And the other thing about is thinking in light of resources, I think one of the things that we think about in terms of family that we should remember, family systems and community systems that may not have entailed use of government, state or health department services but were provided to the family and the community, that in a place where, for instance, what you're talking about in Alabama, maybe if the state could not afford it, if there were certain community systems or family systems to support the mother, the father and the family like God knows talking about old school, the way it used to be.

Faith-based organizations, community-based organizations that provided some kinds of support, then that's the kind of support that may be missing with mildly depressed families in this economic climate where a lot of people are depressed.

We're not talking about people that have psychotic tendencies but mildly depressed. I think there are a lot of resources that used to exist. I was thinking in particular the case of the lady where she was talking about the new or undocumented folks that might be here.

It may not be a clinical depression but there's certainly isolation from the previous where in your community you may have immigrated from, there were those kinds of systems to support you.

So I'm thinking that one of the things to remember, not only in terms of the community systems, but that people that require our help are not empty vessels waiting for us to bring all this technology or things they don't know.

We assume people don't know so we want to help them to really respect the culture, the family values, the strength of the family and the communities working together for children as we try to provide these kind of services, particularly when you talk about mental health. And respecting the sensitivity of folks.

ROBERT PHILLIPS: Just really quickly, I want to say Chapter 7 in here avoiding the effects of depression in families, talks a lot about helping parents with parenting skills and bonding with children. It can be worth taking a look at. Mentions several programs that help with that.

UNKNOWN SPEAKER: Hi, my name is [indiscernible]. I work with [indiscernible]. And I really appreciate the intention-based culture. I have a question looking at it from two aspects. One is enthusiastic education in the families and the other from the aspect of the clinicians who are involved. I know my question is a kind of complex question, is in the course of your deliberation, did you work on or address the whole issue of cultural mistrust from the perspective issues that this lady here addressed quite well, and how do you overcome that in terms of the fact that there are many cultures, first of all, it's forbidden to talk about issues that we're craving, quote/unquote. I shouldn't say that because I'm a physician.

And then you have experience, cultural misdiagnosis; i.e., culture such as my family happen to be [indiscernible] and part of my family is African-American. So it's not uncommon to talk about visions or hearing voices and certainly someone who is very educated like all of you up there and a psychotherapist, social worker, whatever, they will understand many times the difference. And many times they won't. And so I wonder isn't this dearth of clinicians who have the ability, the cultural and linguistic ability, combined with the fact that we need to address that with -- a lot of clinicians, particularly doctors, have a misdiagnosis and inappropriately treating.

Because they don't want to [indiscernible]. So can you talk about the workforce in terms what can we do with the existing workforce at all different levels to try to help us to, number one, recognize what we need to do in terms of assessment.

Have to do that. And almost have to recognize what we don't know, to know enough of what we don't know and utilize those resources. So kind of a question but I'm wondering in the course of the deliberation where those things are addressed.

SERGIO AGUILAR-GAXIOLA: Actually, we discussed those things, and we discussed the different stages through this process that culminated on that report that you have in your hands. We had several meetings, five meetings that Liz mentioned. One of the meetings was in California, for example, and there were some people who came from the area and they addressed some of these issues.

Also in the process of reviewing the whole report, there were some workgroup members who were looking specifically at the issues that you are referring to. And also their reviewers brought this up. So we had different opportunities to address some of these issues.

One of the issues, for example, that came up, along with what you are discussing, is that part of the mistrust in some ethnic communities or culturally diverse communities is that we tend to look at them with deficit lens, that they come with their hands, to get the hand outs, when in fact many of them don't. We need to pay attention to their strengths and their assets and their resources that they have. And it's very important that we emphasize that as well. And that that, that that would really get us I think to a different point in terms of the public trust

that exists right now between the communities and the health systems. And there is some of that in the book.

Did we include, do justice to the complexity of this issue? Maybe not, because this is such a complicated issue that is constantly also, is very dynamic. That is, is constantly kind of evolving.

But very glad that you brought it up. These are the realities that we are facing in the makeup of the population and the challenges to the health systems will all increase based on the demographic projections.

ROBERT PHILLIPS: I would second what Sergio was saying that if you look under the index under cultural and linguistic considerations, it starts at page 4 and ends at page 425. It's almost in every chapter. So Sergio and others really helped us to make sure this was part of our consideration almost every step of the process. But it still may not be enough.

ELIZABETH HOWELL: One last thing I'll also say is also in the treatment chapter we talked about patient centered treatment and what alternatives are acceptable to the patient. Many people are hesitant to take medications, particularly in pregnancy, as you guys are probably well aware of, and there are a number of effective therapies that don't include medication treatments and we're doing more and more studies on alternative medicines that might be effective in treating

depression. And this is a conversation between the provider and the patient in terms of figuring out what is best and what might work for them. That's something that the committee, I think, felt strongly about, the sort of patient-centered focus.

ROBERT PHILLIPS: And I'd say lastly the comment about not having enough time in a visit to deal with this, that's where the issue of continuity really comes into play, is that this is often a year-long -- year's long process of helping patients recognize a problem and deal with it.

It just makes the issue of continuity that much more important. And to the issue in DC where you don't see people -- I think Karen mentioned this, as children roll off of Healthy Start after age two, is finding where they are going then? What care system are they going into then and how do you hand off that continuity so that next provider who is going to take care of that child from two through 16, perhaps, starts off at least understanding this is a family that has an issue of depression and you need to be aware of this as you're building that relationship of trust with this family.

KAREN HENCH: Are there any other questions for the panel? I think as everyone's guessing now, the discussion we're having is really just the tip of the iceberg of something that we need to drill much deeper into and work with others around both understanding and addressing. I have a question for you all. Because we want to make sure that this information is disseminated in the right

organizations and programs, where would you recommend that we make sure we get at least a copy of the executive summary of this information, those that you've been thinking about as we've been discussing this?

Healthy Start will get it. Title V. I was writing down Zero to Three. Head Start.

UNKNOWN SPEAKER: Do you deal with early intervention? Those kids that identify with special needs we refer to early intervention. I'm not sure if they ever go outside the kids that either have hearing problems or metabolic --

UNKNOWN SPEAKER: If they're in the regimen, it's in the Title V agency. And so we definitely -- there's a whole initiative now in mental health in early screening for social and emotional development.

UNKNOWN SPEAKER: In public schools, they have the --

UNKNOWN SPEAKER: So I think it's going to differ from state to state where the function might be for different things.

UNKNOWN SPEAKER: [Indiscernible].

KAREN HENCH: Any others that you thought of?

I'd like to give one more round of applause to our panel.

(Applause)