



## Preventing Perinatal Depression



Perinatal depression is more common than people would like to admit. Pregnancy and childbirth are supposed to be happy times, so why is mom feeling sad? High profile cases in the media highlight an extreme form of the disease called *postpartum psychosis*. Most women, however, who suffer from perinatal depression have a mild to moderate form of the disease that while not life threatening can still be quite debilitating and negatively affect their quality of life. Fortunately, preventing or treating perinatal depression is relatively simple: talk to your health care professional; get support from family, friends, or support groups; and take care of yourself physically and spiritually. Depression that still persists after self-care measures, however, may require medical or psychotherapeutic intervention.

Perinatal depression encompasses prenatal and postpartum depression. According to an Agency for Healthcare Research and Quality report, approximately 1 in 20 women who are pregnant or have given birth in the last 12 months are suffering from major depression. As many as 13% of women experience major or minor depression during the perinatal period.<sup>1</sup>

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In this issue, JoAnne Solchany emphasizes that it is important for pregnant women to prevent the onset of depression as it not only negatively affects the ability of a mother to prepare for her new baby but also negatively affects the development of the fetus. J. Martin Maldonado-Durán looks beyond the characteristics of individual mothers to modern society as a whole, where he sees social isolation as one cause of perinatal depression.

Public health professionals in this region are finding ways to prevent and treat perinatal depression. Doulas now provide support for women in the postpartum period, in addition to providing support in delivery and labor rooms. In Idaho, hospitals have adopted common standards for postpartum depression screening, education, and follow-up. Statewide campaigns, such as Washington State's *Speak Up When You're Down*, are increasing awareness of perinatal depression. Oregon communities have developed local perinatal mental health support networks. And finally, state agencies are collecting data to document the extent of the problem and to use in developing and evaluating programs.

<sup>1</sup>*Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes. Evidence Report/Technology Assessment: Number 119. Agency for Healthcare Research and Quality. U.S. Department of Health and Human Services. [www.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridepr.pdf](http://www.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridepr.pdf)*

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**Northwest Bulletin:  
Family and Child Health**

## Cynthia Shurtleff retires from the Northwest Bulletin's editorial board

This year the Washington State Legislature passed and the Governor signed into law Senate Bill 5093, Health coverage for all children. Taking effect July 2007, this law provides comprehensive health care coverage to all children in the state. One of the many people who were active in the passage of this bill was Cynthia Shurtleff, founding board member of the *Northwest Bulletin*. Cynthia recently retired from the bulletin's editorial board and also from WithinReach of Washington (formerly Healthy Mothers, Healthy Babies), where she is also a founding member.

Cynthia is a tireless advocate for improving the health of mothers and children. As founding chair of the Immunization Action Coalition of Washington, she worked to protect communities from vaccine preventable diseases by helping to make sure resources and policies were in place to foster the best possible health outcomes. She credits her success as an advocate to the coalitions that she's helped build over the years. "You can't accomplish all of these things without being in a coalition," she says. Qualities she has found useful as an advocate are:

*Persistence.* Gathering information, developing coalitions, deciding on priorities, working with state legislatures—all take time. "You can't always talk about an issue, decide what your priorities are, try to legislate change, and get it all accomplished in one year," she says.

*Patience.* Many times the political environment may not be sympathetic towards what you are trying to accomplish. Those times, however, do not need to be unproductive for an advocate. "It's during those times," says Cynthia, "that you can form your coalitions and talk to other groups. Maybe they have better ideas than you have as to how to deal with the political environment."

*Perspective.* Cynthia recommends taking the long view when dealing with state legislators and policy makers, and maintaining your relationships with them even when you're in disagreement. "They may disagree with you now," she says, "but they may agree with you later on another issue."

*Passion.* When asked about preventing burn-out, her answer was simple: "Believe in what you are doing and in what you're trying to accomplish."

Cynthia will continue her work with the Immunization Action Coalition of Washington, and as a community liaison for the Washington Chapter of the American Academy of Pediatrics. ♦

# Editorial: Which Baby Would You Want to Be? The Impact of Prenatal Depression on Moms and Babies

JoAnne Solchany

**C**onsider Tina, 28 years old and pregnant with her first child. Tina and her husband proudly announce their pregnancy to everyone they know, enjoy the details of preparing a nursery, and read every book they can find on childbirth and parenting. Tina regularly goes to her prenatal visits after initially changing practitioners when the first one “never looked me in the eye.” At about 4-months gestation, Tina is diagnosed with placenta previa. Although shaken and fearful, she is able to talk about her anxieties, “I worry if I’ll be able to do this!” and her fears, “What if something goes wrong with the baby?” with her family and friends. With their support, she remains calm and positive for most of her pregnancy. When the baby arrives, she feels overwhelmed but happy. Tina cherishes every moment with her baby.



Now consider Rachel, 24 years old and pregnant with her first child. She, too, is excited to be pregnant as she and her husband really want a baby. Rachel shares the news of her pregnancy with family and friends, but begins to feel more anxious than excited. She goes to her prenatal visits but never feels comfortable with her practitioner. Although her husband wants to look at baby furniture, she is not interested. She begins to worry about her ability to be a mother—the more she thinks about it the more she worries. Her concentration fades. She

loses her focus at work and often calls in sick. Rachel and her husband argue, often because she does not feel like going out or spending time with friends and family. Her appetite drops off and she has no energy to shower most mornings. Rachel finds herself crying for no reason but tells herself it’s just her hormones. She feels as if she’s living in a fog. When the baby arrives, Rachel cannot get excited, although she desperately wants to. She grieves over not feeling connected to her baby. Her greatest fear has come true—she is failing as a mother. She feels she has made a mistake having a baby.

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**Prenatal depression robs women of the positive experiences and emotions they require to become mothers and to care for their babies.**

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The question is simple—which baby would you want to be?

## Effects on moms

Prenatal depression robs women of the positive experiences and emotions they require to become mothers and to care for their babies. It negatively affects all aspects of a woman’s life—work, health, nutrition, and connections with friends and family. Women may lose the energy necessary to invest in their intimate relationships, which negatively impacts the support and encouragement they need.

Prenatal depression does not act alone—anxiety and stress also have an impact. In fact, depression, anxiety, and stress act as a trilogy of risks

that can negatively affect both mother and child. Unchecked anxiety and stress progress to depression, depression and stress increase anxiety, and, anxiety and depression increase vulnerabilities to stressors. Prenatal depression increases the risk of preterm labor, preterm delivery, and low birthweight. Without intervention, prenatal depression can lead directly to postpartum depression, a condition that increases the vulnerability of the newborn and the mother-child relationship.

## Effects on babies

Beneath the surface of prenatal depression, physiologic changes are taking their toll on the fetus. Prenatal depression interferes with adequate blood flow to the placenta, which negatively impacts the supply of nutrients and oxygen to the unborn child. Maternal hormones, placental hormones, and fetal hormones can all be triggered and expose the fetus to toxic chemicals its developing systems cannot yet handle. Research has found that some babies have high levels of neurotransmitters and stress hormones at birth.

Babies born to depressed mothers often demonstrate depressive behaviors after birth (eg, lethargy, difficulty feeding, and irritability). They may also have difficulties with self-quieting, low tone, abnormal reflexes, and orientation. These early difficulties can undermine the developing mother-child relationship.

## Preventing prenatal depression

Prenatal depression is treatable and there are many things that can be done during pregnancy to limit its severity and even prevent its onset. Treatment and prevention often include many seemingly simple things: regular exercise, getting out of the house and into the fresh air, eating well, and, most significantly, getting the necessary support from family, friends, and health care professionals. Treatment often requires psychotherapy with someone who understands mental health issues during pregnancy.

For some women, antidepressant medication<sup>1,2</sup> becomes necessary when other interventions are just not enough. Depression that goes untreated takes its toll

<sup>1</sup>Psychotropic medication use in pregnancy should be prescribed and monitored by health care professionals who are knowledgeable in treating mental health issues in pregnancy.

<sup>2</sup>For a review of psychotropic medication use in pregnancy refer to Grover S, Avasthi A, Sharma Y. Psychotropics in pregnancy: weighing the risks. *Ind J Med Res.* 2006;123:497-512.

on both the pregnant woman and her unborn child. There is always a risk of taking these medications during pregnancy, but any risk needs to be weighed against the risks from chronic lack of sleep, poor nutrition, lack of exercise, isolation, inability to function day-to-day, and an emotional state that becomes a barrier to the anticipation and welcoming of a baby. While the unborn child may take in small amounts of the mother's medication, consider what he might be taking in if the depression continues unabated—excess amounts of maternal stress hormones and other neuro-chemicals, inadequate nutrients and oxygen brought on by altered blood flow to the placenta, and an emotionally dulled prenatal environment—only to be born into the arms of a mother incapacitated by this devastating disease. ♦

*JoAnne Solchany, PhD, ARNP, RN, BC, is a board certified infant, child, and adolescent psychiatric nurse practitioner and psychotherapist. She is in private practice and on the faculty at the University of Washington's School of Nursing.*

*Dr. Solchany is author of the award-winning book, Promoting Maternal Mental Health in Pregnancy.*

*She is also a frequent presenter on maternal mental health, attachment, adoption, trauma, and divorce.*



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## Cultural Issues in Perinatal Depression

J. Martin Maldonado-Durán

**M**any traditional societies value motherhood, and pregnant women and new moms occupy a special place in these societies. Often there are prescribed expectations as to what a pregnant or newly delivered woman should do, such as what she should eat and how often she should rest. There may be multiple prescribed roles for her relatives. A woman is usually guided during delivery by one or several experienced women, and after the birth they take care of her and her baby. They may also help with her house work, provide food, take care of her other children, give her massages, and provide traditional remedies for pain and to promote the let down of milk.

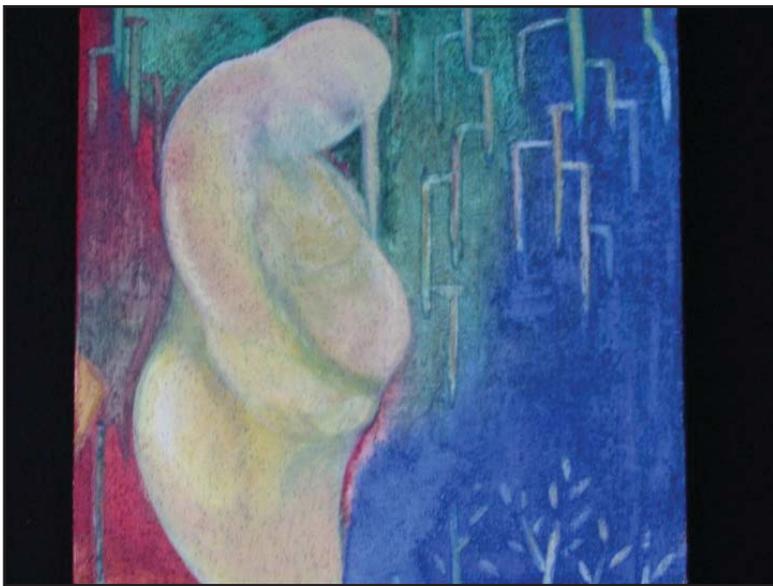


Illustration courtesy of Maria Raquel Morales.

As families become more nuclear in modern societies, these supports tend to diminish. Much of the care of the woman is expected to be provided by her partner or husband who often has not been socialized to provide for her needs. Many women, particularly if they have a less supportive partner, no partner at all, or no support from other family members, are at particularly high risk for perinatal depression.

### *The healthy immigrant effect*

Researchers have identified what is called the *healthy immigrant effect*. This effect is the opposite of what one would intuitively expect: *less* acculturated recent immigrants to the US have better mental and physical health than immigrants who have been in the country for a while.

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**Less acculturated recent immigrants to the US have better mental and physical health than immigrants who have been in the country for a while.**

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The epidemiological information available for Latina immigrants to the US suggests that the more a woman acculturates the worse her physical and mental health. Compared with Latinas who have recently immigrated to the US, more acculturated Latinas have higher rates of depression in general and in the perinatal period; tend to be overweight, eat less vegetables, and exercise less; and have higher rates of alcohol and street drug use. Less acculturated Latinas have lower rates of preeclampsia, less birth complications, and lower rates of premature birth and low birthweight babies.

This is paradoxical because immigrant women generally are poor or are fleeing from stressful circumstances in their home country, and come to the US precisely to find a better economic and political situation. Although the reasons for the declines in physical and mental health arising from acculturation are not really known, it is strongly suspected that in the US women may lose the psychosocial support from family networks that they had in their home country.

## Implications for women's health

Traditional ways of providing support in the perinatal period may not be antiquated but may ensure a more positive pregnancy outcome and improve the welfare of the new mother. Primary health care staff might think of respecting the traditional practices and their functions in the respective cultural group rather than recommending adoption of the mainstream US culture.

In all cases, it seems useful in dealing with this issue to consider a woman's world view, her situation, how she perceives her present circumstances, and her emotional needs and whether they are being met. ♦

*J. Martin Maldonado-Durán, MD, is a psychiatrist who works with children in the first three years of life, and with women during pregnancy and in the postpartum period. He has published numerous articles on child mental health in several languages. He edited the book, *Infant and Toddler Mental Health: Models of Clinical Intervention with Infants and Their Families* (American Psychiatric Publishing), and has coedited four books in Spanish on topics related to the perinatal period.*



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## Mothers at special risk for postpartum depression when caring for infants with special health care needs

*Jennifer Horner*

A mother caring for an infant with special health needs may be at increased risk for stress, worry, and possibly depression. She may find herself having to change employment due to the demands of care giving, increasingly isolated due to a lack of mobility, lacking spousal or family support, and chronically worrying about her infant's health. These stressors can impact her mental health. A recent study on the symptoms of depression in mothers whose children were born prematurely suggests that marital status, a child's need for rehospitalization, changes in parental roles, and worries regarding a child's health significantly predict maternal depression.

A mother's first step may be seeking help from her child's medical team. Partner support, support services, and employment also appear to act as buffers to depression. A mother's feeling of mastery can also positively impact her mental health. A 2001 study found that most mothers felt better about themselves by learning how to manage their children's chronic conditions. Providing interventions that promote empowerment and education may help decrease the stress and worry of caring for a child with chronic health care needs.

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# Supporting the New Baby's Mother: The Role of the Postpartum Doula

Heidi Koss-Nobel

**Supporting each other during birth and in the postpartum period is an ancient tradition of women that has been diminished in modern society.**

When Kimberly learned she was expecting her second child, her first reaction was terror. "I had a really hard time pulling out of postpartum anxiety and depression after the birth of my first child," Kimberly reported. "It was like I fell into a deep, dark hole I couldn't get out of." So when Kimberly gave birth to her second child, she took preventive measures. Acting on the advice of her therapist, she hired a postpartum doula. Her doula explained to her that the doula's job was not to solely assist with the new baby, but more importantly, to support the new baby's mother.

## Mood disorders: A combination of nature and nurture

The causes of perinatal mood disorders can be complex but they're generally related to a combination of nature and nurture. We know that fluctuations in estrogen during pregnancy and the postpartum period may affect a woman's mood. However, environmental stressors, such as lack of social support, can contribute to the onset of a perinatal mood disorder. Research has shown that particular aspects of social support in the home, such as supportive listening, can ameliorate the symptoms of postpartum depression (PPD). A study on the benefits of social support showed that mothers with PPD who received home visits interacted more responsively with other mothers and their babies than the control group. Also, their infants fared better in emotion regulation, response to stimuli, and language and mental development.

## A modern role for an ancient tradition



Doulas offer empathy, support, and reassurance for their clients. By caring for the new baby and older siblings, doulas enable their clients to catch up on serotonin-replenishing REM (rapid eye movement) sleep, which is critical for mental health stabilization. In addition to household support, such as meal preparation and light house-keeping, doulas also offer parent education as well as important referrals to health care providers who specialize in diagnosing and treating perinatal mood disorders.

The word doula (pronounced doo-la) is Greek in origin and roughly translates as "woman's servant." Supporting each other during birth and in the postpartum period is an ancient tradition of women that has been diminished in modern society. In response to this void, the profession of doula was born. Until recently, most doulas could be found soothing women in labor and delivery rooms. But with so many new mothers living far from their parents and other family members, an increasing number of doulas now specialize in easing women through the postpartum period.

## Doulas as key team members

A small but growing number of doctors and other health professionals now recommend postpartum doula care as part of a preventive treatment plan to women who are at high risk for perinatal mood disorders. Doula care can be "... as powerful as medication and talk therapy," said Margie Bone, a psychiatrist and a founder of the Community Birth & Family Center in Seattle, Washington. "If called in early, doulas can ease, or in some cases prevent, depression."

Over a decade ago, only a handful of providers in the Seattle area were willing to recommend postpartum doula services. Today, more than 100 providers—doctors, nurses, lactation consultants, and therapists—treat doulas as key team members. By helping families get off to a good start, doulas reduce the impact perinatal mood disorders may have on the exposed child and enable parents to forge healthier bonds with their children and become better parents. ♦

*Heidi B. Koss-Nobel is executive director and state co-coordinator of Postpartum Support International of Washington, and co-founder of the Northwest Association for Postpartum Support (NAPS). She also serves on the Washington State leadership advisory committee for the Speak Up When You're Down postpartum depression awareness campaign and is an instructor at the Seattle Midwifery School. Ms. Koss-Nobel is also a certified postpartum doula and certified lactation educator.*



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## Statewide Campaign Urges Women to Speak Up When They're Down

*Joan Sharp*

Postpartum depression (PPD) is the number one complication of childbirth, affecting 10% to 20% of new mothers. In Washington State, as many as 16,000 women suffer from some form of postpartum mood disorder each year—and a statewide campaign is underway to raise awareness about it.



The Washington State *Speak Up When You're Down* public awareness campaign centers around three key messages: PPD is real, help is available, and talking about how you feel is the first step toward recovery.

The campaign focuses on providing basic information about the signs and symptoms of postpartum mood disorders. It offers both a Web site, [www.speakup.wa.gov](http://www.speakup.wa.gov), full of helpful information for families and professionals; and a toll-free information number, 1-888-404-7763, which also functions as a "warm line" for those needing help. The phone line is operated by Postpartum Support International of Washington, one of the many partners supporting the statewide campaign.

*Speak Up When You're Down* posters and brochures in English and Spanish are available at no charge at [www.speakup.wa.gov](http://www.speakup.wa.gov). Contact information for those wanting to get involved is also available at the Web site. ♦

*Joan Sharp is executive director of the Children's Trust of Washington (formerly Washington Council for Prevention of Child Abuse and Neglect (WCP-CAN)), which leads the statewide campaign.*

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# We've Come a Long Way, Baby! St. Luke's Postpartum Depression Follow-up Program

Judy Cross

**S**uicide is a personal and family tragedy, but when the person who commits suicide is a new mother, grief is felt throughout the community. In Boise, Idaho, in 1990 and 1991, two young moms, each with a baby approximately two months old, committed suicide within a few months of each other. These suicides motivated the nursing staff of St. Luke's Regional Medical Center's Maternity Services to learn everything they could to address the problem of postpartum depression (PPD) in our community. A PPD program was established at St. Luke's in 1992 to detect and prevent depression and to improve the care of mothers with PPD.



Details of the evolution of the program were published in the *American Journal of Maternal/Child Nursing*. Although suicide related to postpartum psychosis is the leading or second leading cause of death during the postpartum period, the program has not documented a case of maternal suicide since its establishment.

Prescriptions for minimizing postpartum depression symptoms.

*Sleep* when the baby sleeps to avoid sleep deprivation syndrome.

*Eat a snack* with protein and a complex carbohydrate every 3 to 4 hours to maintain a steady blood sugar and stabilize serotonin levels.

Get out in the sunlight and get at least 20 minutes of *exercise daily* to stimulate endorphins.

*Talk* about your concerns with someone you trust at least weekly.

Make of list of activities (eg, music, meditation, bubble baths) that give you *energy* and do one activity daily.

Do something that you can *look forward to* (eg, a date with your partner) at least every week or two.

Over the last 15 years, St. Luke's has sustained a program for screening, education, and follow-up for mothers at risk of perinatal depression.

The key elements of the program include:

- ◆ Provide education about perinatal depression in childbirth and parenting classes.
- ◆ Consistently use a risk assessment tool<sup>1</sup> (ours available upon request).
- ◆ Provide written education materials for new mothers.
- ◆ Provide prescriptions for mothers to minimize PPD symptoms (table).
- ◆ Follow-up with a new mother 3 to 4 days after her discharge from the hospital.
- ◆ Offer a new moms' support group.
- ◆ Follow-up 3- to 5-weeks postpartum with mothers who scored at high risk for depression.
- ◆ Use a validated screening tool when any symptoms exist.<sup>2</sup>
- ◆ Provide an extensive community resource list to nurses making follow-up calls.

<sup>1</sup>St. Luke's uses a risk assessment tool based on research by Diane Boyer, RN, PhD, at Loyola University, Chicago, Ill. Boyer D. Prediction of postpartum depression. *NAACOG Clinici Issues in Perinatal & Women's Health Nursing*. 1990;1(3): 359-368.

<sup>2</sup>St. Luke's uses the PDSS (Postpartum Depression Screening Scale) developed by Cheryl Tetano Beck, RN, PhD, University of Connecticut, available through Western Psychological Services, Los Angeles, CA. This tool categorizes symptoms into an urgency scale and helps focus treatment options. It has been rated more valid than the Edinburgh Postnatal Depression Scale—the old gold standard ([www.dbpeds.org/media/edinburghscale.pdf](http://www.dbpeds.org/media/edinburghscale.pdf)).

We hear from other hospitals across the country that PPD is never addressed or discussed with patients, and that they have no plans of care for patients with PPD, much less education or prevention programs. This will not be the case at St. Luke's. ♦

*Judy Cross, RNC, MSN, FNC, is a clinical nurse specialist at St. Luke's Health System in Boise, Idaho. She coordinated the development of the hospital's postpartum depression program and led the team in winning the national Award of Highest Honor through the California Pacific Excellence in Patient Education Program. In 2003, she received the prestigious Joyce Stein Award for making a positive impact on the health of women in southern Idaho's Treasure Valley.*



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## UW Maternal and Child Health Education Opportunities for 2008

The University of Washington offers two pathways to obtain a Master of Public Health (MPH) degree in Maternal and Child Health (MCH).

The **Maternal and Child Public Health Leadership Training Program (MCH Program)** sponsored by the Maternal Child Health Bureau of the Health Resources and Services Administration, United States Department of Health and Human Services, offers a 2-year, in-residence program leading to an **MPH** degree in either the Departments of Health Services or Epidemiology. The program includes a practicum and thesis.

The MCH Program's core and affiliate faculty are drawn from diverse fields: obstetrics, pediatrics, social work, nutrition, child development, and physical therapy. Faculty research interests cover a wide range of health policy and epidemiological issues, including perinatal epidemiology; child and adolescent health; children with special health care needs; injury prevention; nutritional risk; behavioral, organizational, and social influences on health care utilization; and women's health. The program offers students practicum and thesis opportunities throughout the Northwest in local and state health departments, area hospitals, private and community health centers, and other regional programs.

More information about the program, including application forms and deadlines, is posted on the MCH Program Web site at <http://depts.washington.edu/mch-prog/>.

The **Extended MPH Degree Program (EXDP)** is available to employed mid-career public and community health professionals who cannot attend school full time. This program can be completed in 3 years or less and is delivered through a combination of independent study and required attendance on campus. The EXDP also offers a one-year **Certificate of Public Health in MCH**. Individual MCH courses may also be completed on-line.

More information about the program, including application forms and deadlines, can be found at the EXDP Web site at <http://depts.washington.edu/hsedp>.

# State Reports

## Alaska Report



### Continuing the Effort to Understand and Support Maternal Mental Health

*Yvonne Goldsmith, MS*

The Pregnancy Risk Assessment Monitoring System (PRAMS) is one source of data on postpartum depression (PPD) in Alaska. PRAMS is an ongoing state-level, population-based surveillance system that identifies and monitors selected maternal experiences and behaviors before, during, and after pregnancy. Each state uses the same standardized protocol that involves a mail questionnaire with telephone follow-up to survey mothers who recently gave birth. Responses are then weighted to be representative of all women who gave birth in the state during that year.

In 2000, seven states, including Alaska and Washington, collected information about self-reported PPD using PRAMS.<sup>1</sup>

In Alaska:

- ◆ 39.8% (95% CI, 36.9%-42.7%) reported no PPD
- ◆ 54.9% (95% CI, 51.9%-57.8%) reported low to moderate PPD
- ◆ 5.4% (95% CI, 4.1%-6.7%) reported severe depression

In Washington:

- ◆ 41.0% (95% CI, 37.6%-44.5%) reported no PPD
- ◆ 53.8% (95% CI, 50.3%-57.3%) reported low to moderate PPD
- ◆ 5.1% (95% CI, 3.8%-6.5%) reported severe depression

An analysis of PRAMS data from all seven states indicated that women who were mothers of newborns, who had fewer than 12 years of education, who were Med-

icaid recipients, and who delivered low birthweight infants were most likely to report severe depression. In addition, women who were physically abused during pregnancy and who reported stress (emotional, financial, or traumatic) were more likely than other women to report being severely depressed.<sup>1</sup>

For 2004 and 2005, Alaska PRAMS continued to include a question about PPD. The percentage of women who recently had a live-born infant and who reported that they always or often felt down, depressed, or hopeless since their new baby was born was 10.8% and 9.3% in 2004 and 2005, respectively.

### Alaska's PSI Chapter

Postpartum Support International (PSI) is a non-profit organization dedicated to increasing awareness of maternal mental health issues. Their mission is to provide current information, resources, and education; and to advocate for further research and legislation to support perinatal mental health. This organization recently established an Alaska chapter under a two-year grant and assistance from Alaska's Title V Maternal and Child Health Program. A task force, composed of family advocates and professional staff from a wide variety of health fields, identified four activities for the grant period:

- ◆ Develop camera-ready educational materials that can be easily distributed by providers to the public.
- ◆ Establish a support group based at Providence Hospital's Behavioral Health Services in Anchorage. Create a database of facilities and professional staff who can provide services.
- ◆ Conduct assessments of culturally sensitive, cost-effective intervention tools, and incorporate this information into the educational materials.
- ◆ Hold a state-wide conference at the end of the grant period to disseminate information to providers.

The initial grant period runs through December 2008. It is hoped that additional grants can be found to continue the effort to understand and support maternal mental health. ◆

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<sup>1</sup>Centers for Disease Control and Prevention, Pregnancy Risk Assessment Monitoring System (PRAMS) and Postpartum Depression. Available at: [www.cdc.gov/prams/PPD.htm](http://www.cdc.gov/prams/PPD.htm). Accessed April 24, 2007.

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## Idaho Report



### Open for Discussion: Postpartum Depression

Judy Cross

Idaho faces many challenges in providing mental health services: poor funding, lack of providers and services, isolated communities, rugged travel conditions, cultural barriers, poverty, and lack of insurance. In fact, 100% of Idaho is federally designated as a Health Professional Shortage Area in mental health. Also of great concern, the Idaho Department of Health and Welfare's Bureau Chief for the Division of Medicaid announced in April that coverage for mental health services will be decreased for all Idaho Medicaid recipients except for those receiving disability support.

Providing mental health services to new mothers and their infants creates additional challenges. The sense of stigma felt by many new mothers suffering from postpartum depression (PPD) makes it difficult for them to ask for help. In addition, some health care providers avoid assessing for PPD because there is a lack of referral resources for identified problems. The American Academy of Pediatrics is now strongly encouraging pediatricians to screen for PPD<sup>1</sup>, but many are not well equipped for this task and are equally frustrated with poor resources.

Considering the challenges that Idaho faces in delivering mental health services, adequate data are needed to effect change. The 2005 Idaho Pregnancy Risk Assessment Tracking System (PRATS) Survey<sup>2</sup>, administered by Idaho's Department of Health and Welfare to new mothers over the age of 18, approximately 6 months after they have delivered a baby, documented:

- ◆ 66% of Idaho mothers (67% of Hispanic mothers) acknowledge significant symptoms of depression
- ◆ 2.6% responded that they "agree" or "strongly agree" with the statement "I have thought

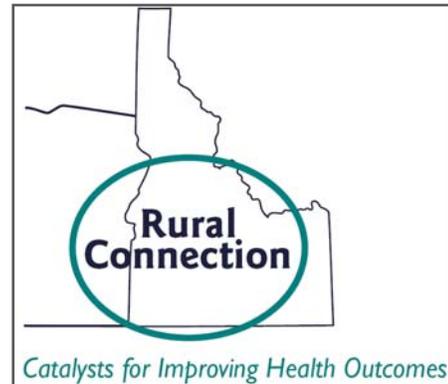
<sup>1</sup>Chaudron L, Szilagyi P, Campbell A, Mounts K, McInerney T. Legal and ethical considerations: Risks and benefits of postpartum depression screening at well-child visits. *Pediatrics*. 2007;119:123-128.

<sup>2</sup>Idaho PRATS Data supplied by Traci Berreth, MPH, MCH Special Projects Coordinator, Idaho Bureau of Clinical and Preventive Services. Telephone: 208-334-5774. Email: [berretht@idhw.state.id.us](mailto:berretht@idhw.state.id.us).

that death seemed like the only way out of this living nightmare."

### Idaho Rural Connection

Approximately 12 years ago, the Idaho Rural Connection was started, linking 13 rural hospitals, St. Luke's Regional Medical Center in Boise, and Boise State University, into a consortium charged with improving standards of care for patients.



Within the medical specialty of obstetrics, PPD was a focus of intense activity. Consortium hospitals adopted common standards for screening, patient education, and follow-up. A patient and family education booklet, *Adjusting After Delivery*, and a risk assessment questionnaire<sup>3</sup>, were made available to consortium hospitals.

Follow-up practices vary depending upon the resources available in the different communities, but the awareness and education of patients, families, staff, and physicians have increased exponentially. Affordable mental health care remains the greatest challenge.

Although there is still much to learn about PPD and many challenges ahead, it is exciting and fulfilling to see how attitudes have changed. When we first addressed this problem, nearly everyone thought PPD was simply a severe case of the "baby blues." Today, in childbirth classes, couples talk about PPD; say they have read articles or heard about it from family, friends, or health care providers; and are open to discussing their risks and what they are doing to prevent it. ◆

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<sup>3</sup>Boyer D. Prediction of postpartum depression. *NAACOG Clinical Issues in Perinatal & Women's Health Nursing*. 1990;1(3): 359-368.



## Strong Local Networks and Partnerships

Wendy Davis

The greatest strength of Oregon's perinatal mental health network is the collaboration between public health agencies, hospitals, educators, health care providers, and support groups. Several regions have effective coordination between hospitals, childbirth providers, support groups, and psychological services. The public health system has made perinatal mental health a priority. Healthy Start, WIC (Special Supplemental Nutrition for Women, Infants, and Children), Early Childhood, and other public health organizations have initiated staff training and developed procedures for screening and referral. In 2006, the Oregon Department of Health Services' Office of Family Health added information and resources for pregnancy and postpartum mood disorders to the prenatal/postpartum handbook given to all new mothers.

Oregon communities have developed focused local support networks rather than create one statewide service. Community task forces have worked closely with the Postpartum Support International (PSI) Oregon coordinators to create sustainable perinatal support networks that increase public awareness and provide education, screening, assessment, support, and treatment.

Services, however, are inconsistent throughout the state and depend to a large degree on programs initiated by individual leaders, and sustained by volunteers or staff supported by hospitals or county agencies. Partnerships between public and private sectors are our greatest strength, but we need to identify more funding partners to ensure improved services. Many rural areas lack social support networks and health care providers who are informed about perinatal mental health. A future goal is to provide statewide education for medical and support providers.

## Key Support and Educational Services

*Baby Blues Connection (BBC)*, founded in 1994, is a not-for-profit network run by volunteers who have been trained to provide support, information, and resource lists. The network also maintains mom-to-mom support groups in Portland, Oregon, and Vancouver, Washington. Most volunteers are survivors of perinatal mood disorders, and several health care professionals volunteer as facilitators and advisors. Based in Portland, BBC provides phone and email support, and speakers to professional and peer groups. The network, funded by small donations, grants, and volunteer spirit, is a well-respected resource in the community.

[www.babybluesconnection.org](http://www.babybluesconnection.org)  
503-797-2843 or 360-735-5571

*Mid-Valley Behavioral Care Network* began a four-county postpartum initiative in 1997. They created a model program providing community-wide screening and psychoeducational classes in Spanish and English. Classes are offered through Easter Seals Community College and a family services agency. Contact Kathy Savicki at [kathys@mvbcn.org](mailto:kathys@mvbcn.org).

*Coos County Perinatal Task Force* and *Lane County Perinatal Consortium* are community partnerships at their best, involving hospitals, public health, community agencies, health care providers, motivated volunteers, and social support networks. Both community partnerships identified the need to increase access to psychiatric care.

Lane County Contact: Csilla Andor at [csilla@fourth-trimester.com](mailto:csilla@fourth-trimester.com).

Coos County Contact: Anne Abdy at [AAbdy@bayareahospital.org](mailto:AAbdy@bayareahospital.org)

*Oregon Health and Sciences University* will launch a perinatal mood disorders initiative this year. Developed in collaboration with the Oregon's Postpartum Support International coordinator, the initiative will provide training for medical students and health care providers statewide.

Contact Wendy Davis at [wdavis@postpartum.net](mailto:wdavis@postpartum.net). ♦

*Wendy Davis, PhD, is a counselor and consultant specializing in perinatal mental health. She provides training to providers and organizations, is founding director and clinical advisor for Oregon's Baby Blues Connection, and serves as coordinator chairperson for Postpartum Support International.*

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## Washington Report



### Perinatal Depression: Developing Professional Awareness of the Need to Help Women Speak Up

*Kathryn Barnard*

**M**aternal depression is a widely recognized health problem that creates health risks both for the mother and her child. Researchers estimate that approximately 15% of all women have perinatal mood disorders. Among low-income women, 40% to 60% of the population have symptoms of depression during the perinatal period. Although there are successful models for treating perinatal depression, less than 50% of pregnant women are screened for depression.

#### First Steps

The State of Washington's First Steps program is taking steps to better prepare to screen, assess, and refer pregnant women who are at risk for depression. While many risk factors are associated with the occurrence of depression, staff will receive training to screen for four risk factors:

- ◆ A personal history of depression
- ◆ A family history of depression
- ◆ Family violence
- ◆ A score of 10 or greater on the Edinburgh Postpartum Depression Scale

Once the presence of depression is confirmed, the Patient Health Questionnaire PHQ-9 may be used to evaluate its severity.

In 2005, the number of births to mothers on Medicaid living in Washington State was 39,077. Of those birth mothers, 18,366 or 47% were estimated to have symptoms of perinatal depression. The prevalence of major depression was estimated to be 6%, or approximately 2,000 cases of major postpartum depression. The literature reveals that either drug treatment or psychotherapy is effective in treating major depression. Our community mental health system is charged with the responsibility of treating major mental health problems for Medicaid clients, so theoretically these women should have treatment resources. The larger

number of women with mild to moderate depression show improvement with family or peer support.

#### Providing Non-Judgmental Support

A major problem in reaching women with depression, however, is the reluctance many have to share their feelings. Pregnancy and the birth of a baby are regarded as positive events in family life. Women may not feel they can express sadness, apathy, and anger during these times, and so do not share these feelings, even with their partners. Studies have shown that large-scale screening programs for depression have very low return rates for further assessment and an almost zero return rate for treatment. A major goal for the First Steps program staff is to approach clients in a supportive way in which the woman is "joined with" rather than directed or told.

First Steps, in collaboration with the University of Washington's School of Nursing and under the direction of Dr. Kathryn Barnard, is developing a training program for health care providers in maternity support services. The training curriculum addresses cultural issues and the stigma associated with mental health problems. The three main themes are:

- ◆ Understanding perinatal mood disorders
- ◆ Developing a strategy for screening, assessment and referral
- ◆ Incorporating a non-judgmental way of interacting with a client

The Web-based training modules are being pilot tested and will be disseminated by the Washington State Department of Health in 2008.◆

*Kathryn Barnard, PhD, FAAN, is founder and first director of the University of Washington's Center on Infant Mental Health & Development. She has been honored by both the American Academy of Nursing and the Institute of Medicine; and is internationally recognized for her pioneering work to improve the physical and mental health outcomes of infants and children.*

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#### References:

- Stepping Up: Prevention Strategies for Pregnancy, Parenting and Infancy  
[www.son.washington.edu/centers/steppingup/](http://www.son.washington.edu/centers/steppingup/)  
Washington State Department of Social and Health Services First Steps  
<http://fortress.wa.gov/dshs/maa/firststeps/>

# Resources

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## American Academy of Family Physicians

Benefits and Risks of Psychiatric Medications  
During Pregnancy

[www.aafp.org/afp/20020815/629.html](http://www.aafp.org/afp/20020815/629.html)

Postpartum Major Depression: Detection and Treatment

[www.aafp.org/afp/990415ap/2247.html](http://www.aafp.org/afp/990415ap/2247.html)

## Babycenter

Postpartum Depression

[www.babycenter.com/refcap/227.html](http://www.babycenter.com/refcap/227.html)

Brown M, Robinson J. *When Your Body Gets the Blues*. Emmaus, PA: Rodale; 2002.

## Familydoctor.org

Postpartum Depression and the “Baby Blues”

<http://familydoctor.org/379.xml>

## Health Resources and Services Administration (HRSA)

Depression During and After Pregnancy: A Resource for Women, Their Families, and Friends

[www.mchb.hrsa.gov/pregnancyandbeyond/depression](http://www.mchb.hrsa.gov/pregnancyandbeyond/depression)

## HereToHelp.bc.ca

[www.heretohelp.bc.ca/index.shtml](http://www.heretohelp.bc.ca/index.shtml)

This Web site contains fact sheets written in many different languages, and toolkits that help families with the day-to-day management of a mental illness.

## Massachusetts General Hospital (MGH) Center for Women’s Mental Health

[www.womensmentalhealth.org/topics/postpartum.html](http://www.womensmentalhealth.org/topics/postpartum.html)

## Maternal and Child Health Library

Knowledge Path: Postpartum Depression

[www.mchlibrary.info/KnowledgePaths/kp\\_postpartum.html](http://www.mchlibrary.info/KnowledgePaths/kp_postpartum.html)

## mededppd.org

This peer-reviewed Web site, developed with the support of the National Institute of Mental Health, provides education about postpartum depression (PPD) to primary care providers. A second half of the Web site provides information for women with PPD, and their families and friends.

[www.mededppd.org/](http://www.mededppd.org/)

## Mental Health America

Postpartum Disorders

<http://www.mentalhealthamerica.net/go/postpartum>

## National Alliance on Mental Illness

Managing Pregnancy and Bipolar Disorder

[www.nami.org/Content/ContentGroups/Research/Managing\\_Pregnancy\\_and\\_Bipolar\\_Disorder.htm](http://www.nami.org/Content/ContentGroups/Research/Managing_Pregnancy_and_Bipolar_Disorder.htm)

## Perinatal Depression

[www.perinataldepression.org/](http://www.perinataldepression.org/)

Contains resources to help health care professionals identify, treat, and refer women suffering from perinatal depression. Information includes screening tools, phone resources, and printable materials.

## Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes

Evidence Report/Technology Assessment: Number 119

Agency for Healthcare Research and Quality

U.S. Department of Health and Human Services

[www.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridep.pdf](http://www.ahrq.gov/downloads/pub/evidence/pdf/peridepr/peridep.pdf)

## Postpartum Education for Parents

Postpartum Distress Support

[www.sbpep.org/index.php?content=ppd/pepppd.htm](http://www.sbpep.org/index.php?content=ppd/pepppd.htm)

## Postpartum Support International

Also check Web sites for each state.

[www.postpartum.net/](http://www.postpartum.net/)

Sichel D, Driscoll JW. *Women’s Moods, Women’s Minds*. New York, NY: HarperCollins; 1999.

Solchany J. *Promoting Maternal Mental Health During Pregnancy: Theory, Practice & Intervention*.

Seattle, WA: NCAST Publications; 2001.

## Speak Up When You’re Down

Washington Council for Prevention of Child Abuse & Neglect

[www.wcpcan.wa.gov/ppd/aboutus\\_campaign.htm](http://www.wcpcan.wa.gov/ppd/aboutus_campaign.htm)

## Stepping Up: Prevention Strategies for Pregnancy, Parenting and Infancy

<http://steppingup.washington.edu/default.asp>

## Washington Council for Prevention of Child Abuse and Neglect—WCPCAN.

[www.wcpcan.wa.gov/](http://www.wcpcan.wa.gov/)

## Womenshealth.gov

Depression During and After Pregnancy

[www.womenshealth.gov/faq/postpartum.htm](http://www.womenshealth.gov/faq/postpartum.htm)