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Report of the LD 792 Workgroup: Efforts Concerning Postpartum Mental Health Education

To the

Joint Standing Committee on Health and Human Services
Senator Joseph C. Brannigan, D-Cumberland, Chair
Representative Anne C. Perry, D-Calais, Chair

From the

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Executive Summary

Background

The Department of Health and Human Services and the Maine Primary Care Association have completed a report on the activities of a workgroup convened at the direction of the Joint Standing Committee on Health and Human Services to review existing efforts in Maine concerning education and screening for postpartum depression (PPD). DHHS and the Maine Primary Care Association conducted the workgroup in accordance with Resolve, Chapter 58, 123rd Maine Legislature. Stakeholders included the Maine Medical Association, the Maine Association of Psychiatric Physicians, the Perinatal Mental Health Alliance of Southern Maine, Mid Coast Hospital, the Postpartum Support Center of Maine, and Postpartum Support International, Maine Chapter, as well as related advocacy groups and representatives of medical and mental health professionals and groups as well as hospitals with expertise in primary or family care, obstetrics, gynecology, pediatrics, and postpartum depression.

The purpose of this report is to summarize workgroup findings on the prevalence of PPD, screening tools and treatment for PPD, resources available to women suffering from PPD, and activities occurring in other states around this issue, as well as to make recommendations on the direction of future efforts to address PPD in Maine.

The Resolve directed the workgroup to review the following efforts for screening and education related to PPD:

- Projects initiated by health care providers aimed at the early screening and treatment of depression;
- The Maine Health Access Foundation's study on barriers to integration of mental health care into health care settings;
- Ongoing efforts for screening within DHHS, Maine Center for Disease Control and Prevention;
- Projects implemented in New York, Illinois, New Jersey, New Hampshire and other states.

This report contains an overview of material on each of these categories and includes recommendations for policy change, both short and long term.

Summary of Report

Prevalence

In 2004-2005, almost 1 in every 8 new mothers in Maine (13.3 percent) reported that a health care provider diagnosed them with depression since the birth of their child.

In 2004-2005, 8.4 percent of new mothers in Maine report always or often feeling down, depressed or hopeless since the birth of their child and 7.3 reported having little interest or pleasure in doing things.

Scope and Impact

PPD ranges in severity from mild and transient "baby blues" experienced by 50-80 percent of women to postpartum psychosis, which affects less than 1 percent of women. Postpartum major depression falls within the spectrum of postnatal mood disorders and affects up to 25 percent of women in the year after delivery. Poor maternal mental health can adversely affect family functioning and the well-being and emotional development of children.

Screening

Women are not systematically screened for PPD and are often without knowledge of PPD, treatment options, or available resources. While there is anecdotal evidence that some providers screen for PPD, there is no evidence that all postpartum women are screened or screened consistently. Clearly, there is a need for more uniform screening given the prevalence of postpartum depression and its impact on the family.

There are several programs within the Maine Center for Disease Control and Prevention (MCDC) that have contact with women during the postpartum period and have the opportunity to ask about PPD. It should be noted that these programs do not serve all women and have eligibility criterion.

Validated screening tools include the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS). Screening is recommended at the first trimester for a history of depression as well as at the second and third trimester, 4-6 weeks postpartum, and at well-child visits.

PPD Screening Pilot at Three Health Centers in Maine

In response to workgroup discussions about the use of various screening instruments and the amount of time it would take to administer a screening during a typical patient encounter, three health centers participating in the workgroup conducted a month-long pilot screening in October 2007. While not definitive, the results provide a snapshot of how PPD screening would work "on the ground."

DFD Russell Medical Center in Leeds, Fish River Rural Health in Eagle Lake, and Penobscot Bay Medical Center in Rockport all participated in the six-week pilot and screened using the PHQ-9 as well as a team approach to care. Fish River administered the screen through its Perinatal Program. DFD and Pen Bay administered the screen using nurses or physicians. In total, 72 women were screened for PPD and 11.1 percent or about 1 in 8 tested positive.

At the end of the pilot period, the three practices reported that the screening experience had been a positive one. They noted that it was less labor intensive once staff got into the rhythm of giving the survey out and that none of the women objected to taking it and were in fact very willing to do so and quite honest in their reporting. Practices also found it useful and helpful in identifying patients who might not have presented their concerns at a regular check up.

Other States

A majority of states have not pursued the legislative route for postpartum efforts and programs; however, five states nationally have legislation passed for PPD efforts or programs (Minnesota, New Jersey, Texas, Washington, and West Virginia). Legislation is pending in Illinois and New York regarding mandated screening by doctors and nurse practitioners. Approximately three of the five states with enacted legislation have state dollars for PPD education and screening programs.

Barriers

Regulatory and reimbursement issues have been barriers to integration of depression screening and treatment into health care settings. Both federal (Medicare and Medicaid) and commercial payers of services have different criteria for credentialing of mental health providers and for reimbursement, making it difficult for any one health center to develop on-site mental health resources. Additional barriers occur when the person who is positive is not the patient of the health care setting, for example, when a pediatrician screens a mother positive for depression. With one exception, no payer reimburses providers for administration of the PHQ-9 or other depression screening tools. Other barriers have been a lack of knowledge about the signs, symptoms, and treatability of depression, as well as the stigma associated with a diagnosis of mental illness and the lack of knowledge about best practices. Further examination of these issues will be addressed when the Maine Health Access Foundation issues the Maine Barriers to Integration Study in June 2009. John Gale of the Muskie School of Public Service is the project director and the Study Advisory Group is co-chaired by Bill Foster, Dean at the Muskie School, and Wes Davidson, Executive Director of the Aroostook Mental Health Center.

Recommendations

In implementing the following recommendations, all populations should be considered. This includes, for instance, rural and urban women, ethnic and minority women, and newly arriving immigrant populations. These recommendations provide an Action Template to address postpartum depression in the state of Maine. Providing education and awareness, improving screening and treatment, and filling gaps in services around PPD does not just belong to women or to health care providers, but to all of us as we work toward an integration of physical and mental

health issues in our state. In this way, we can improve the lives of Maine women, children, and families.

Addressing PPD on a statewide level should be an ongoing effort by public and private stakeholders, with the goal of reducing the impact of PPD on women through appropriate screening, interventions, and connections to treatment. Local resources and volunteer efforts should be maximized wherever and whenever possible. If human and financial resources permit, a statewide campaign should be developed with annual reports to the Health and Human Services Committee and the Advisory Council on Health Systems Development. These reports could include updates on the progress and resources necessary to make a measurable improvement in the lives and health outcomes of women and their children.

In addition, DHHS, specifically the Maine CDC and Office of Adult Mental Health Services, will continue to seek federal and other national funding, as it becomes available, to implement the recommendations in this report as well as create a focus for PPD efforts in the state. Private stakeholders are encouraged to also seek federal or other national funding as appropriate.

Screening and Treatment Recommendations

- Health care professionals should be encouraged to screen women at the first trimester for a history of depression as well as administer the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS) at this time and also at the 2nd and 3rd trimester.
- Postpartum depression screening should occur 4-6 weeks postpartum at the follow-up appointment with the OB provider and also in the year following birth during any primary care visit or at all well-child visits in the primary care or pediatrician's office.
- Assessment and supportive discharge plans should be developed in hospitals/birth centers for new mothers and families who sustain traumatic or life-threatening birth conditions, premature birth, infant's serious and/or life-threatening illness, or pregnancy loss, as well as for women who have screened positive for depression in the prenatal period.
- Use of either the PHQ-9 or the EPDS as appropriate and validated screening instruments for PPD in the health care setting. (Algorithms for treatment based on scoring by the EPDS and the PHQ-9 can be found in the Appendix of this report).
- Work with the sponsoring senator of LD 792 to coordinate a meeting of all insurers to discuss education about and screening for prenatal and postnatal depression being added to their standards of care for prenatal, postnatal and the first year of pediatric well childcare. Encourage insurers to develop standards for reimbursement or other incentives specific to screening for depression in the pre and postpartum periods.

- A statewide campaign to educate health care providers and Maine residents about postpartum depression should be developed.
- Continuing Medical Education Credits (CMEs) on PPD prevention, screening, and treatment should be offered to health care professionals through their professional conferences and associations. PSI, Maine Chapter, and other stakeholders should work with the health care associations (Maine Medical Association, Maine Hospital Association, Maine Nurse Practitioner's Association, Maine State Nurses Association, etc) to connect their membership with online PPD training opportunities that provide CMEs and Continuing Education Units (CEUs)

Integration Recommendations

- Leverage existing resources in both the public and the private sector in a strategic and coherent manner to support integration of behavioral health with health and public health programs and the State Health Plan.
- Participate in the Maine Health Access Foundation's examination of regulatory, fiscal, and policy barriers to co-location of primary care and mental health/behavioral health services.
- Encourage better integration, cooperation, and referral systems of mental health and primary care providers, such as co-location.
- Federal, state, or grant dollars should be sought to support education, technical support, pilot projects, and practices changes necessary for screening, tracking, support, and treatment for PPD.
- Encourage linkage at the local level between the behavioral health providers in the Community Service Networks and the major health providers and community coalitions in the Public Health Districts.
- Enhance Electronic Medical Records Systems to know who is in care, monitor progress, provide reminders for care, and provide decision support for best practices.
- On-going support for and expansion of the Home Visiting Program.
- Work with the DHHS Office of Integrated Access and Support to develop educational and awareness materials regarding depression for their workforce and for the population that they serve, which has a high proportion of individuals at high risk for depression, including women and families with dependent children.

Data and Resources Recommendations

- Continue to analyze Pregnancy Risk Assessment Monitoring System (PRAMS) data on postpartum depression on an ongoing basis.
- Continue to fund mental health questions on the Behavioral Risk Factor Surveillance System, with analysis of data for women of childbearing age and families with children in the household.

- Starting with postpartum women, expand and coordinate the administration, scoring, and reporting of depression screening across the various DHHS programs serving women of childbearing age, selecting the tools from the PHQ series that are the most appropriate to a particular site.
- DHHS and partners will convene a workgroup to identify existing systems that can be used for technical support for individuals as well as identify programs for the education, treatment, and referral of postpartum depression. Partners include the Maine Association of Psychiatric Physicians, the Maine Hospital Association, the Maine Medical Association, the Maine Primary Care Association, the Perinatal Mental Health Alliance of Southern Maine, Postpartum Support International, Maine Chapter, the Postpartum Support Center of Maine, various professional associations and educational institutions such as the University of Maine system, University of New England, the Area Health Education Centers (AHECs), the Maine Center for Public Health, and the Maine Public Health Association.
- Support for maintenance and continuation of the DHHS Women's Behavioral Health Web Site as a single portal for obtaining information and linking to various other web resources. The federal grant that supported the construction of this web site came to an end in October 2007. This web site could be a source of up-to-date resources by county and public health districts, linking to 211, or to the statewide crisis system as appropriate.

Introduction

Depression is one of the most prevalent, and disabling, mental health conditions in the country.[1] Women are twice as likely as men to suffer from depression.[2] Women of childbearing age are particularly at risk as rates of depression peak during childbearing years.[3] Research has shown that poor maternal mental health can adversely affect the development and emotional wellbeing of children.[4-6] Despite their high risk for development of depression and anxiety disorders, there is evidence that postpartum women are not systematically assessed for these conditions.[7] The U.S. Preventive Services Taskforce (USPSTF) recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.[8] Despite this recommendation, multiple contacts with health care providers, and the availability of valid screening tools, women are not systematically screened for postpartum depression (PPD) and are often without knowledge of PPD, treatment options, or available resources.

Postpartum depression ranges in severity from mild and transient "baby blues" experienced by 50-80 percent of women to postpartum psychosis, which affects less than 1 percent of women.[9] Postpartum major depression falls within this spectrum of postnatal mood disorders.[9] Studies of the prevalence of postpartum depression have yielded widely varying estimates, ranging from three percent to more than 25 percent of women in the year after delivery.[9] These rates vary according to the methods used to diagnose depression, to identify patients, and whether the studies were retrospective or prospective.[9]

The debilitating effects of PPD can involve the entire family, and women who have PPD are at high risk for recurrent depression.[9] The majority of women exhibit symptoms by six weeks postpartum, and if untreated, many women are still depressed at the end of the first postpartum year.[9] PPD can occur at any time in the postpartum year.

In Maine, estimates of the burden of perinatal depression also vary, depending on what screening instrument is used, how the instrument is scored, on what population, and in what time frame. In 2004-2005, almost 1 in every 8 new mothers in Maine (13.3 percent) reported that a health care provider diagnosed them with depression since the birth of their child.[10]

While there is anecdotal evidence that some providers screen for PPD, there is no evidence that all postpartum women are screened or screened consistently. Clearly there is a need for more consistent screening given the prevalence of postpartum depression and the impact on the family. A recent informational survey by University of Southern Maine students on behalf of the Maine Primary Care Association investigated current PPD screening practices, use of specific screening tools, barriers

to screening, implementation of the tool, and the referral process for at-risk women. All health centers surveyed were affiliated with the Maine Primary Care Association.

Of the 33 health centers that responded to the survey, 67 percent indicated that they perform some form of PPD screening. However, only 19 percent of the health centers report "always" screening for PPD and only 31 percent of providers screened for PPD at the 6-week postpartum visit. The screening tool most used was the PHQ-9; however, informal questioning such as "How's it going?" was also considered by providers as a screening tool (3 out of 17).

In response to these emergent issues, Senator Nancy Sullivan sponsored LD 792, *An Act Concerning Postpartum Mental Health Education*, in February 2007. The bill called for health care practitioners who provide perinatal care to women or to their newborn babies to provide education to pregnant women about prenatal and postpartum mental health and to screen each woman to identify current mental health issues or risk factors for possible prenatal and postpartum mental health issues. The bill called for screening of the postpartum mom at every well-baby appointment for the first year. The bill also included education and information to the partner, spouse, father, or other family members as appropriate to increase their understanding of the illness and improve the course of treatment for the mother.

The Maine Primary Care Association and its members strongly supported the legislation, as did an array of advocate groups, including the Maine Psychological Association. However, during the public hearings, concerns were raised about legislatively mandating the practice of medicine, and it was suggested that various stakeholders work together to develop strategies to build upon and expand on existing efforts regarding screening and education for perinatal mood disorders. Following a work session involving advocates for LD 792, members of Health and Human Service Committee, the Department of Health and Human Services, the Maine Medical Association and the Maine Primary Care Association, LD 792 was amended to a Resolve that charged the Maine Department of Health and Human Services (DHHS) and the Maine Primary Care Association with convening a workgroup to review existing efforts in Maine concerning education and screening for postpartum depression. Since that time, the workgroup met four times and formed four Subcommittees: *Data and Resources; Integration; Other States,* and *Screening and Treatment.* The workgroup's findings and recommendations are detailed in this report; further information can also be found in the Appendix of this report.

This report is organized into categories that reflect the information requested by the Legislature in the Resolve.

Overview of Postpartum Depression Efforts in the State

Maine Prevalence Data Collected by DHHS CDC

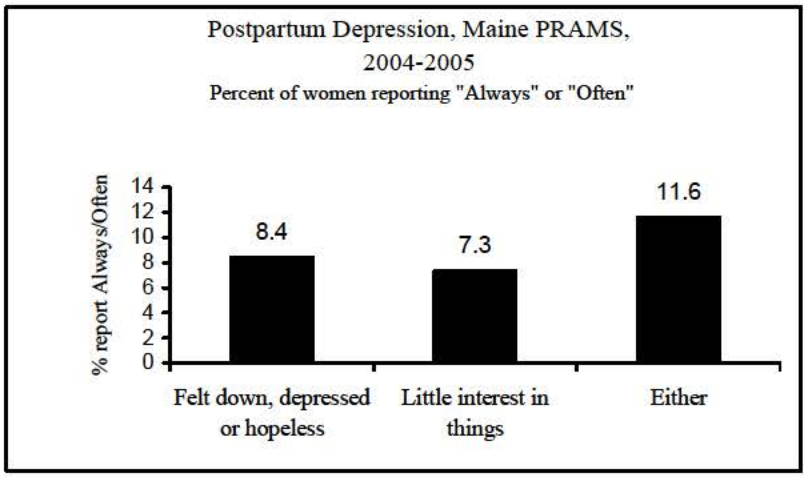
In Maine, two major public health surveys – the BRFSS and PRAMS – ask questions on the prevalence of depression among women and the prevalence of postpartum depression in the population. However, there is currently no comprehensive survey information on the percentage of women who are actually being screened for postpartum depression from either public health entities or from physician groups. Both PRAMS and BRFSS data are epidemiologically sound, comprehensive mechanisms that use random sampling techniques. The response rates generated by these studies are sufficient to generalize to the population as a whole: PRAMS for new mothers and BRFSS for adults over the age of 18.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The best source of data specifically related to postpartum depression comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a representative survey of new mothers in Maine that is mailed two to eight months after giving birth and has a high response rate (>75 percent). Since 2004, the survey has included three questions on postpartum depression, two of which ask for a reply on a five-point scale: always, often, sometimes, rarely, or never. The three questions are:

1. Since your baby was born, how often have you felt down, depressed, or hopeless?
2. Since your baby was born, how often have you had little interest or little pleasure in doing things?
3. Since your baby was born, has a doctor, nurse, or other health care worker told you that you had depression?

The results of the 2004-2005 PRAMS data indicate that 8.4 percent of new mothers in Maine reported "always" or "often" feeling down, depressed or hopeless since the birth of their child and 7.3 percent reported having little interest or little pleasure in doing things; 11.6% reported "always" or "often" to at least one of the two questions.



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Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is a statewide telephone survey of adults in Maine. There are no questions specifically addressing postpartum depression, but it is possible to estimate the prevalence of depression among women of childbearing age using this survey. In 2006, a depression and anxiety module was added to BRFSS. This module includes the PHQ-8, a variant of the PHQ-9, which is a widely used validated tool for diagnosis of depression. Survey respondents were also asked about whether a health care provider had ever given them a diagnosis of depression.

Data from the 2006 BRFSS reveal that 32.7 percent of all women of child-bearing ages (ages 18-44) in Maine reported a past history or current symptoms of clinically significant depression. Of these women, 11.9 percent reported current symptoms of moderate to severe depression, defined as a score of >10 on the PHQ-8. Of those women age 18-44 with at least one child under age 18 in the household, 30.2 percent reported either a history of past or current depression. It should also be noted that 17.9 percent of men in Maine with at least one child in the household also report either past or current depression, suggesting that strategies to address the impact of parental depression on children should address fathers as well.

These analyses are consistent with the literature that shows that depression varies by gender, and that women age 18-44 have the highest prevalence of current symptoms or a past diagnosis.

DHHS Screening and Education Efforts

There are several programs within the Maine Center for Disease Control and Prevention (MCDC) that have contact with women during the postpartum period and have the opportunity to ask women about symptoms of postpartum depression. These programs are not necessarily the best sources for overall prevalence data, but they can provide information on who is being screened for PPD among different populations. It should be noted that these programs do not serve all women and have eligibility criterion. While many screening gaps exist, these programs provide a foundation on which to build future efforts that can be expanded to capture all postpartum women.

Women, Infants, and Children (WIC)

WIC does not have an ongoing surveillance system for measuring depression in its population, but women are asked about depressive symptoms using the following

screening tool, which is a variant of the PRAMS question and the PHQ-2, a short version of the PHQ-9 series:

- Over the past two weeks, have you ever felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

When a woman responds yes to one or both of the questions, she is directed to support resources within her community as well as encouraged to talk with her primary care provider.

Unfortunately, though these questions may be routinely asked of all women, the responses and the documentation of screening is not currently available in WIC's electronic database. Therefore, there is no way to estimate the percent of WIC clients who are actually screened and who report postpartum depression. The WIC program has an antiquated electronic information system that is scheduled to be replaced in the next two to three years. The WIC Director has agreed to look at adding the PHQ-2 questions to the WIC assessment tool when the new electronic information system is developed.

Healthy Families (Home Visiting)

Maine's Home Visiting program, which is universally available to all first-time families and adolescent parents in Maine, does not currently screen for postpartum depression, although home visitors do indicate in their paperwork whether a family has received substance abuse or mental health counseling. There have been discussions about Healthy Families adopting the PHQ-9, but this has not occurred yet.

Public Health Nursing and Maternal and Child Health (MCH) Grantees

The Maine CDC has 52 Public Health Nurses (PHNs) who provide direct services to Maine residents. A large proportion of their work is with the maternal and child health (MCH) population. In addition, Public Health Nursing (PHN) contracts with three organizations to provide MCH nursing services in areas where there are not sufficient PHNs to meet consumer need. These nurses are referred to as "MCH Grantees." Currently, Public Health Nursing does not use the PHQ-2 assessment tool; however, the program is wiling to add this assessment tool as well and track the results over time. Modifying the electronic documentation system (CareFacts) to include the PHQ-2 as well as writing the program to generate a report on this data will take awhile due to the costs of making these changes as well as where it falls on the current priority list.

Screening and reporting on postpartum depression is not currently a requirement of the MCH grantees, but postpartum depression assessment has been identified as an

area of interest to add as a standard to the Grantee Demographics and Measures list. The revision is ongoing at this time and will be implemented July 1, 2008. The inclusion of the PHQ-2, a validated brief version of the PHQ-9, is being evaluated as a tool for inclusion in the Measures list.

During PHN and MCH grantee postpartum assessment, general questions are asked of all clients addressing coping skills and how they are feeling. The answers to these questions lead to the development of a postpartum care plan where expected emotional changes are addressed with the client, as well as monitoring for signs and symptoms of postpartum depression. In addition, postpartum clients receive a number of educational materials on the identification and treatment of postpartum depression.

DHHS Crisis Services

An Office of Adult Mental Health funded Crisis Call Line **1-888-568-1112** is available 24/7 to any citizen in Maine. The crisis line addresses all mental health and behavioral health issues and was not created to address PPD specifically. A brief assessment is made to determine what level of response is required, ranging from help with referral to specialty mental health to mobile outreach or emergency room evaluation.

Education Materials

Maine CDC programs provide new mothers with a variety of education materials on postpartum depression, including pamphlets and brochures and resource information. One frequently used resource is "Depression During and After Pregnancy" from the federal Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

Education and Outreach Efforts Across Maine

The ***Maine Association of Psychiatric Physicians*** (MAPPS) has received a grant from the American Psychiatric Association to provide education on postpartum depression and screening methods for primary care physicians and obstetricians. The project will create durable educational materials in order to come up with reproducible templates, provide a session at the organization's annual conference, include the issue on the organization's web site (http://www.mainepsych.org), and educate mental health providers. The project will also work with MAPP's Consultation Project, which links volunteer psychiatrists with rural primary care practices to provide an ongoing consultative relationship.

PPD Support Groups are offered throughout the state. A more detailed description of these programs and their location can be found in the Appendix of this report.

The ***Perinatal Mental Health Alliance of Southern Maine*** (PMHA) is a network of health professionals and parents who are dedicated to providing education and support for women who are experiencing or at risk for prenatal or postpartum mood and/or anxiety disorders. The group's goals are to increase education, screening, and awareness, implement peer support groups, provide trainings for health care providers and consumers, and build community collaboration. The group's web site is http://www.pmhamine.org.

Postpartum Support International (PSI) is a non-profit whose mission is to educate people about pregnancy-related mood disorders and to advocate, educate, and provide support for maternal mental health in communities and globally**.** ***PSI in Maine*** has three volunteer coordinators who offer women and families social support, information, and resources to help them through recovery from prenatal and postpartum depression and anxiety. The coordinators are also available to support the health care professionals who treat pregnant women and new mothers, including providing in-service training on perinatal mood disorders.

The ***Postpartum Support Center of Maine*** is in the process of creating a web site to provide information about postpartum mood and anxiety disorders and resources in Maine. The information will be organized by county. The completion date for the web site is March 1, 2008. (www.mainepostpartum.org).

Maine's Integrated Care Initiatives

Some 30 large health care provider groups in Maine have initiated programs aimed at early screening and treatment of depression in non-mental health settings. These projects have involved Maine Medical Center Outpatient Clinics, MaineHealth, St. Mary's, Maine General, a number of ob-gyn practices as well as the Maine Primary Care Association and the Federally Qualified Health Centers. Support for screening for depression in primary care has come from the practices themselves, acting voluntarily, and from federal funding partners, Maine Health Access Foundation, and from DHHS. All have had a focus on screening for maternal depression in postpartum and well-baby visits and some have also begun screening for alcohol use (with its impact on fetal alcohol syndrome) as part of regular prenatal care. These programs have engaged in learning collaboratives, professional education, workforce development, and dissemination of screening tools. What has worked in advancing the early identification and treatment of depression in these health care settings has been the adoption of a number of practice changes: use of electronic information systems to track the care of persons who have depression or to flag those who should be screened; co-location of mental health counselors within the primary care setting; availability of counselors on short-term notice to engage newly diagnosed persons; care management personnel to provide support for staying in treatment and linkage to specialty mental health and community resources.

Barriers

Regulatory and reimbursement issues have been barriers to integration of depression screening and treatment into health care settings. Both federal (Medicare and Medicaid) and commercial payers of services have different criteria for credentialing of mental health providers and for reimbursement, making it difficult for any one health center to develop on-site mental health resources. Additional barriers occur when the person who is positive is not the patient of the health care setting, for example, when a pediatrician screens a mother positive for depression. With one exception, no payer reimburses providers for administration of the PHQ-9 or other depression screening tools. Other barriers have been a lack of knowledge about the signs, symptoms, and treatability of depression, as well as the stigma associated with a diagnosis of mental illness and the lack of knowledge about best practices. Further examination of these issues will be addressed when the Maine Health Access Foundation issues the Maine Barriers to Integration Study in June 2009. John Gale of the Muskie School of Public Service is the project director and the Study Advisory Group is co-chaired by Bill Foster, Dean at the Muskie School, and Wes Davidson, Executive Director of the Aroostook Mental Health Center.

Report of Pilot by LD 792 Workgroup Participants

In response to workgroup discussions about the use of various screening instruments and the amount of time it would take to administer a screening during a typical patient encounter, three LD 792 workgroup participants agreed to conduct a month-long pilot screening in October 2007. While not definitive, the results provide a snapshot of how postpartum depression screening would work "on the ground."

DFD Russell Medical Center in Leeds, Fish River Rural Health in Eagle Lake, and Penobscot Bay Medical Center in Rockport all participated in the six-week pilot and screened using the PHQ-9 as well as a team approach to care. Fish River administered the screen through its Perinatal Program. DFD and Pen Bay administered the screen using nurses or physicians. In total, 72 women were screened for PPD and 11.1 percent or about 1 in 8 tested positive.

	Number Screened	Positive for depression	% Positive
DFD Russell	16	2	
Fish River	9	0	
Pen Bay	47	6	
Total	72	8	11.1

At the end of the pilot period, the three practices reported that the screening experience had been a positive one. They noted that it was less labor intensive once

staff got into the rhythm of giving the survey out and that none of the women objected to taking it and in fact were willing to do so and quite honest in their reporting.

The practices also found it quite useful and helpful in identifying patients who might not have presented their concerns at a regular check up. Follow-up discussion also included thoughts about the rigidity of the screening schedule (how to factor in patient visits at weeks other than exactly 20 or 32), feasibility of screening all women seen in the practice, and billing potential for staff time involved in the screening process.

Overview of Efforts in Other States

A vast majority of states have not pursued the legislative route for postpartum efforts and programs; however, the Other States Subcommittee, after submitting a request for information on postpartum depression efforts to the National States Women's Health list serve convened by the Office of Women's Health, U.S. Department of Health and Human Services, identified five states nationally that have legislation passed for PPD efforts or programs (Minnesota, New Jersey, Texas, Washington, and West Virginia). Legislation is pending in Illinois and New York regarding mandated PPD screening by doctors and nurse practitioners. Approximately three of the five states with enacted legislation have state dollars for PPD education and screening programs.

A majority of states with PPD programs have created them using one-time (one to two years) federal funding from the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (DHHS). The program in West Virginia, for example, is funded with federal Title XIX Medicaid funds as well as Title V Maternal and Child Health. A majority of these PPD programs are located in State Title V Maternal and Child Health Programs with State Public Health Departments.

Efforts in states funded by one-time federal dollars typically have a local, time-limited focus and have a pilot structure. They are not comprehensive in nature, nor do they develop sustainable activities/programs that continue beyond the pilot period. Educational and public information efforts across the country range from a $7,000, privately funded PPD awareness effort (posters on buses) in Indiana to the comprehensive statewide mandated training and screening program in New Jersey that was legislatively created and funded with a $4.5 million fiscal note. The New Jersey PPD program was funded through its Public Health Priority Funding (PHPF) program whose revenues are generated through a supplemental real estate transfer tax allocated by counties for priority public health services.

Additional information on PPD programs in other states can be found in the matrix in the Appendix of this report.

Pilot programs aimed at increasing screening and treatment for depression in health care settings and public health exist in a number of other states. These programs are targeted at depression across the life span, but specifically mention women in the perinatal period as a high-risk group in need of special attention. The New York City Department of Public Health and Mental Hygiene, for example, has a public education campaign with subway and TV ads, a distribution to more than 1,500 primary care sites of a Depression Action Packet with screening tools and best practice guidelines, a system of telephonic care management available to patients in these primary care practices, Continuing Medical Education Credits, tools for physician education, and a web site. In New Hampshire, with Commonwealth Fund support, pediatric practices in the Concord area have done depression screening of both parents at every well child visit and provided on site and telephonic care management to link these parents to resources in the community. The Robert Wood Johnson Foundation has also supported a variety of its grantees in integrating depression screening into primary care sites. In general, these various efforts have used the framework of the Chronic Care Model and the PHQ series for screening. The greatest success, as with the Maine Integration Collaboratives, has been when practices incorporate electronic tracking systems, integration of regular screening into the work flow of the practice, adoption of best-practice guidelines by the primary care provider, co-location of mental health in the primary care system and at least telephonic care management for patients.

Recommendations

In implementing the following recommendations, all populations should be considered. This includes, for instance, rural and urban women, ethnic and minority women, and newly arriving immigrant populations. These recommendations provide an Action Template to address postpartum depression in the state of Maine. Providing education and awareness, improving screening and treatment, and filling gaps in services around PPD does not just belong to women or to health care providers but to all of us as we work toward an integration of physical and mental health issues in our state. In this way, we can improve the lives of Maine women, children, and families.

Addressing PPD on a statewide level should be an ongoing effort by public and private stakeholders with the goal of reducing the impact of PPD on women through appropriate screening, interventions, and connections to treatment. Local resources and volunteer efforts should be maximized wherever and whenever possible. If

human and financial resources permit, a statewide campaign should be developed with annual reports to the Health and Human Services Committee and the Advisory Council on Health Systems Development. These reports could include updates on the progress and resources necessary to make a measurable improvement in the lives and health outcomes of women and their children.

In addition, DHHS, specifically the Maine CDC and Office of Adult Mental Health Services, will continue to seek federal and other national funding, as it becomes available, to implement the recommendations in this report as well as create a focus for PPD efforts in the state. Private stakeholders are encouraged to also seek federal or other national funding as appropriate.

Screening and Treatment Recommendations

- Health care professionals should be encouraged to screen women at the first trimester for a history of depression as well as administer the PHQ-9 or the Edinburgh Postnatal Depression Scale (EPDS) at this time and also at the 2nd and 3rd trimester.
- Postpartum depression screening should occur 4-6 weeks postpartum at the follow-up appointment with the OB provider and also in the year following birth during any primary care visit or at all well-child visits in the primary care or pediatrician's office.
- Assessment and supportive discharge plans should be developed in hospitals/birth centers for new mothers and families who sustain traumatic or life-threatening birth conditions, premature birth, infant's serious and/or life-threatening illness, or pregnancy loss, as well as for women who have screened positive for depression in the prenatal period.
- Use of either the PHQ-9 or the EPDS as appropriate and validated screening instruments for PPD in the health care setting. (Algorithms for treatment based on scoring by the EPDS and the PHQ-9 can be found in the Appendix of this report).
- Work with the sponsoring senator of LD 792 to coordinate a meeting of all insurers to discuss education about and screening for prenatal and postnatal depression being added to their standards of care for prenatal, postnatal and the first year of pediatric well childcare. Encourage insurers to develop standards for reimbursement or other incentives specific to screening for depression in the pre and postpartum periods.
- A statewide campaign to educate health care providers and Maine residents about postpartum depression should be developed.
- Continuing Medical Education Credits (CMEs) on PPD prevention, screening, and treatment should be offered to health care professionals through their professional conferences and associations. PSI, Maine Chapter, and other stakeholders should work with their health care associations (Maine Medical Association, Maine Hospital Association, Maine Nurse Practitioner's

Association, Maine State Nurses Association, etc) to connect their membership with online PPD training opportunities that provide CMEs and Continuing Education Units (CEUs).

Integration Recommendations

- Leverage existing resources in both the public and the private sector in a strategic and coherent manner to support integration of behavioral health with health and public health programs and the State Health Plan.
- Participate in the Maine Health Access Foundation's examination of regulatory, fiscal, and policy barriers to co-location of primary care and mental health/behavioral health services.
- Encourage better integration, cooperation, and referral systems of mental health and primary care providers, such as co-location.
- Federal, state or grant dollars should be sought to support education, technical support, pilot projects and practices changes necessary for screening, tracking, support and treatment for PPD.
- Encourage linkage at the local level between the behavioral health providers in the Community Service Networks and the major health providers and community coalitions in the Public Health Districts.
- Enhance Electronic Medical Records Systems to know who is in care, monitor progress, provide reminders for care, and provide decision support for best practices.
- On-going support for and expansion of the Home Visiting Program.
- Work with the DHHS Office of Integrated Access and Support to develop educational and awareness materials regarding depression for their workforce and for the population that they serve, which has a high proportion of individuals at high risk for depression, including women and families with dependent children.

Data and Resources Recommendations

- Continue to analyze Pregnancy Risk Assessment Monitoring System (PRAMS) data on postpartum depression on an ongoing basis.
- Continue to fund mental health questions on the Behavioral Risk Factor Surveillance System (BRFSS), with analysis of data for women of childbearing age and families with children in the household.
- Starting with postpartum women, expand and coordinate the administration, scoring, and reporting of depression screening across the various DHHS programs serving women of childbearing age, selecting the tools from the PHQ series that are the most appropriate to a particular site.
- DHHS and partners will convene a workgroup to identify existing systems that can be used for technical support for individuals as well as identify programs for the education, treatment, and referral of postpartum depression.

Partners include the Maine Association of Psychiatric Physicians, the Maine Hospital Association, the Maine Medical Association, the Maine Primary Care Association, the Perinatal Mental Health Alliance of Southern Maine, Postpartum Support International, Maine Chapter, the Postpartum Support Center of Maine, various professional associations and educational institutions such as the University of Maine system, University of New England, the Area Health Education Centers (AHECs), the Maine Center for Public Health, and the Maine Public Health Association.

- Support for maintenance and continuation of the DHHS Women's Behavioral Health Web Site as a single portal for obtaining information and linking to various other web resources. The federal grant that supported the construction of this web site came to an end in October 2007. This web site could be a source of up-to-date resources by county and public health districts, linking to 211, or to the statewide crisis system as appropriate.

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APPENDIX

LD 792 Workgroup Membership

Co-Chairs
Kevin Lewis, Executive Director, Maine Primary Care Association
Valerie Ricker, Director, Family Health Division, Maine Center for Disease Control and Prevention, DHHS

Members
Wendelanne Augunas, Penobscot Bay Medical Center
Dr. Richard Aronson, Maine CDC
Dr. Jeffrey S. Barkin
Dr. Martha Barry, Postpartum Support International, Maine Coordinator, and the Maine Psychological Association
Sue Bouchard, R.N., Fish River Rural Health
Dr. Stephanie Calkins, Maine Dartmouth Family Practice Residency
Anne Conners, USM/Muskie
Dr. Andy Cook, DHHS/CBHS
Kim Day, Maine Coalition to End Domestic Violence
Dr. Elsie Freeman, DHHS/Office of Quality Improvement
Molly Gallant, Maine Medical Association
Valli Geiger, Maine Primary Care Association
Michelle Houser, Perinatal Mental Health Alliance of Southern Maine
Laurie Kane Lewis, DFD Russell Medial Center
Dr. Neil Korsen, Maine Health/MMC
Sharon Leahy-Lind, Maine CDC
Dr. Lynn Ouellette, Maine Association of Psychiatric Physicians/Mid Coast Hospital
Dr. Douglas Robbins, Maine Medical Center
Charyl Smith, Maine Medical Association
Lisa Sockabasin, Maine CDC/Office of Minority Health
Sarah Stewart, Maine Coalition Against Sexual Assault
Senator Nancy Sullivan
Cheryl Taylor, Perinatal Mental Health Alliance of Southern Maine
Martha Tole, CD (DONA) Postpartum Support International, Maine Chapter/Postpartum Support Center of Maine

Data and Resources Subcommittee Members
Molly Diekmann, Maine CDC, DHHS
Dr. Elsie Freeman, DHHS/Office of Quality Improvement
Kim Haggen, PRAMS/ Maine CDC, DHHS
Janet Leiter, WIC/ Maine CDC, DHHS
Erika Lichter, MCH Epidemiology/Maine CDC, DHHS
Kip Neale, BRFRSS/Maine CDC, DHHS
Valerie Ricker, Director, Division of Family Health, Maine CDC, DHHS

Integration Subcommittee Members
Wendelanne Augunas, Penobscot Bay Medical Center
Sue Bouchard, Fish River Rural Health Center
Anne Conners, USM/Muskie
Dr.Elsie Freeman, DHHS, Office of Quality Improvement
Dr. Neil Korsen, Maine Medical Center

Other States Subcommittee Members
Dr. Elise Freeman, DHHS/Office of Quality Improvement
Sharon Leahy-Lind, Division of Family Health, Maine CDC, DHHS
Erika Lichter, MCH Epidemiologist, Maine CDC, DHHS

Screening and Treatment Subcommittee Members
Dr. Martha Barry, Postpartum Support International, Maine Coordinator, and the Maine Psychological Association
Michelle Houser, Perinatal Mental Health Alliance of Southern Maine
Dr. Lynn Ouellette, Maine Association of Psychiatric Physicians/Mid Coast Hospital
Valli Geiger, Maine Primary Care Association

Meeting Minutes for the LD792

"Resolve, To Direct the Department of Health and Human Services to Review and Report on Efforts Concerning Postpartum Mental Health Education"

Workgroup Meeting
Friday, June 22nd, 2007
Maine Primary Care Association
Winthrop Street, Augusta

Present: Martha Barry, Postpartum Support International (PSI) and Maine Psychological Association (MePA); Maine Chapter; Anne Conners, USM/Muskie; Dr. Elsie Freeman, DHHS; Valli Geiger, Maine Primary Care Association; Michelle Houser, Perinatal Mental Health Alliance of Southern Maine; Kevin Lewis, Maine Primary Care Association; Lynn Ouellette, Maine Association of Psychiatric Physicians/Mid Coast Hospital; Valerie Ricker, Maine CDC; Charyl Smith, Maine Medical Association; Sarah Stewart, Maine Coalition Against Sexual Assault; Cheryl Taylor, Perinatal Mental Health Alliance of Southern Maine; Martha Tole, Postpartum Support International, Maine Chapter/Postpartum Support Center of Maine.

Welcome and Introductions
Kevin Lewis welcomed participants to the meeting; introductions followed.

Review of the Resolve
Participants reviewed the resolve, which charges the work group with reviewing "*existing efforts in Maine concerning education and screening for postpartum depression."* The work group is charged with reviewing the following efforts for screening and education related to postpartum depression (PPD):

- Projects initiated by health care providers aimed at the early screening and treatment of depression.
- The Maine Health Access Foundation's (MeHAF) study on barriers to the integration of mental health care into health care settings, including regulatory, licensing and reimbursement, barriers to the provision of screening and treatment of postpartum depression and other mental health disorders.
- Ongoing efforts for screening within DHHS, Maine Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System and Pregnancy Risk Assessment Monitoring System, the federal Supplementation Nutrition Program for Women, Infants and Children, and the Department's Home Visiting Program as well as the Department's Public Health and Mental Health Work Group's assessment of screening tools for mental health and recommendations for tracking, education and treatment.
- Projects implemented in New York, Illinois, New Jersey, New Hampshire, and other states.

Agenda
Valerie Ricker thanked participants for attending and informed the group that Anne Conners of the Muskie School of Public Service would be working with the group to provide administrative and logistical support and documentation including drafting the report to the Legislature.

The group set the following agenda for the meeting:

- **Report on meeting participant programs and projects**
- **Report on *Postpartum Depression Screening Used by the Maine Health Center Professionals* by USM students in association with MPCA.**
- **Efforts in other states**
- **Process Used for Report Development**
- **Report deadlines**
- **Subcommittee Formation**
- **Future Meeting Dates**

Report on meeting participant programs and projects
Lynn Ouellette reported that the Maine Association of Psychiatric Physicians (MAPPs) has submitted a grant to the American Psychiatric Association to provide education on postpartum depression and screening methods for primary care physicians and obstetricians. The project seeks to create durable educational materials in order to come up with reproducible templates, provide a session at the organization's annual conference, include the issue on the organization's web site (http://www.mainepsych.org/), and educate mental health providers.

If funded, the project will also work with MAPP's Consultation Project, which links volunteer psychiatrists with rural primary care practices to provide an ongoing consultative relationship. Dr. Ouellette said the organization expects to learn in the fall whether the project will be funded and that MAPP's is feeling optimistic regarding its chances.

Dr. Ouellette said that she has worked closely with obstetricians, pediatricians, and family medical doctors at Mid Coast Hospital on postpartum depression issues as well as running a support group for postpartum depression.

Martha Tole asked about the role of the Maine Primary Care Association (MPCA).

Mr. Lewis said that the MPCA works to promote best practices among its members, acts as a vehicle for decision support for clinicians, produces durable educational materials, does outreach on Quality Improvement, and promotes the Care Model. The MPCA advocates universal access to health care and the elimination of health disparities in Maine. Its members include Maine's grant-funded Federally Qualified Health Centers (FQHCs), an island-based community health center, and the Maine Migrant Health Program.

Valli Geiger added that the MPCA promotes planned care rather than the reactive care and focuses on chronic disease including diabetes, cardiovascular disease, and depression. Through the Women's Behavioral Health Initiative, it has worked on integrating mental health and substance abuse screening into primary care in four FQHCs. The organization's web site is http://www.mepca.org/.

Cheryl Taylor reported on efforts surrounding postpartum depression at Southern Maine Medical Center (SMMC). SMMC started a Postpartum Support Group after its two lactation nurses, who are deployed to assist women after they leave the hospital, reported finding not only breast feeding problems, but that many women were depressed and needed help. If a woman is experiencing postpartum depression, she can't wait to be treated for two or three weeks. SMMC has a psychiatric nurse practitioner who will see women immediately. One difficulty the group has identified is accessing the mental health system; frequently patients are told that there is a two-or-three month waiting list.

Working with Michelle Houser, Ms. Taylor founded the Perinatal Mental Health Alliance of Southern Maine (PMHA) – a network of health professionals and parents who are dedicated to providing education and support for women who are experiencing or at risk for prenatal or postpartum mood and/or anxiety disorders. The group's goals are to increase education, screening and awareness, implement peer support groups, provide trainings for health care providers and consumers and build community collaboration. The group's web site is http://www.pmhamine.org.

PMHA encourages the use of the Edinburgh Postnatal Depression Scale (EPDS), a screening tool to help a woman and her doctor determine how she is feeling and educates physicians on flagging patients who have a history of postpartum depression or who have had problems in their pregnancy.

PMHA is working to establish its 501C3 non-profit status.

Martha Tole and Martha Barry reported on Postpartum Support International (PSI). They are two of the three Maine State volunteer coordinators for PSI. PSI runs in-service workshops to train providers in PPD and the "right question to ask." For example, PSI is conducting a workshop at Ingraham for its staff answering the crisis line.

Through a grant from Bread for the Journey, the Postpartum Support Center of Maine (PSCM), co-founded by Ms. Tole, applied for and received its nonprofit status and implemented a web site, www.mainepostpartum.org. The web site is currently under construction and will list resources in Maine organized by county.

Ms. Tole encouraged non-profits to register with the 211 information line so that if women call seeking resources on postpartum depression, then the referrals to the proper organizations will be available.

Educating providers is crucial, Dr. Barry said, noting that she has worked with both the Maine Psychological Association (MePA) and the American Psychological Association's

(APA) Committee on Women. In discussing outreach to women who may be suffering from postpartum depression, Dr. Barry said the group should consider also linguistic competency.

Ms. Ricker agreed adding that the group needs to consider both the language and the culture piece, i.e., what are the expectations of new immigrants like the Somalis about what is normal. Other cultural considerations include urban versus rural.

Mr. Lewis suggested that Dr. Barry may want to connect with the Maine Migrant Health Program around these issues.

Charyl Smith attended the meeting as a representative of the Maine Medical Association (MMA). Fifty percent of the physicians in Maine are members of the MMA. Ms. Smith said the MMA is willing to serve as a conduit of information to ob/gyns, pediatricians, and family care providers. Ms. Smith can be a liaison to Andy Maclean, J.D., Deputy Executive Vice President and Gordon Smith, Esq., Executive Vice President, as well as Jacky Ginty, Executive Director of the MOA.

Sarah Stewart reported that the Maine Coalition Against Sexual Assault (MeCASA) is working on a campaign to educate health care providers on screening for sexual violence. She noted the connection of sexual violence and the perinatal population and said there is a natural overlap with postpartum depression. She also said that survivors of sexual violence often do not routinely access the health care system so the only possible time for an intervention is when they are pregnant.

Valerie Ricker said the issue of postpartum depression is near to her heart as she started her career as a postpartum obstetric nurse before going to graduate school to become a nurse practitioner with a background in public health. As director of the Family Health Division at the Maine CDC, Ms. Ricker has worked with Sharon Leahy-Lind, the state Women's Health Coordinator, on the Women's Behavioral Health Initiative. Ms. Ricker is also working with the National Academy of State Health Policy (NASHP) on its ABCD (Assuring Better Child Health and Development) Screening Policy. Maine is one of 20 states to get technical assistance in moving to incorporate screening for postpartum depression into well child visits.

The ABCD program is funded by the Commonwealth Fund, administered by NASHP, and designed to assist states in improving the delivery of early child development services for low-income children and their families by strengthening primary health care services and systems that support the healthy development of young children, ages 0-3.

The CDC Division of Family Health receives it largest federal funding from the federal Maternal and Child Health Bureau and is required to complete a comprehensive assessment of the state of women and children in the state every five years. The last assessment was completed in 2005 and has 10 priorities: one of them is improving the mental health system of services and support for the maternal/child health population.

Other family health programs:

Public Health Nurses: 50 nurses who provide services across the state, including home visits for pregnant or postpartum women when there is an identified health need. In York and Cumberland counties, the program works with Home Health and Visiting Nurses of Southern Maine to provide those services in those counties.

Office of Child and Family Services Division of Early Childhood, Early Visiting program, contracts with 14 agencies to provide parent education and support to first-time families. The division contracts with agencies for services in all 16 counties.

Women and Infant Child Special Supplemental Program: WIC, contracts with nine agencies to provide services across the state.

Immunizations Programs: works with pediatric practices throughout the state.

Other CDC staff who will be participating in the workgroup but could not attend today include Dick Aaronson, medical director, for the MCH program; and Sharon Leahy-Lind, State Women's Health Coordinator.

Elsie Freeman said that she is a pediatrician by training, then became a psychiatrist, then obtained a master's in public health degree. She has been in Maine for three years. Prior to this, she was involved in child psychiatry in the Boston/Harvard system and worked in the Massachusetts Department of Mental Health. Since coming to Maine, Dr. Freeman has worked on the integration of mental and physical health. She is currently the medical director for the DHHS Office of Adult Mental Health Services as well as the Office of Quality Improvement within the new Division of Health Management.

Maine is the only state that has mental health and substance abuse included in its state health plan and is also out front and center regarding depression, screening and education, and the link to chronic disease. Dr. Freeman is currently applying for a MeHAF Integration Planning grant to develop Action Kits on depression and problem drinking. The kits will be aimed at both providers and consumers. In addition to the packet, the grant will outline an entire dissemination strategy and sustainability plan.

In the depression packet, the PHQ2 is provided on one side of the packet for consumers; the PHQ9 on the other for providers. The alcohol packet works under the premise of "how much is too much" and will help address the fetal alcohol problem in the state. The kits will be modeled on ones used by the New York City Department of Public Health, Division of Mental Hygiene. If the planning grant is awarded, the project will use the planning year to develop the prototype of the kits and an implementation plan and apply for a three-year grant for the statewide roll out.

Ms. Geiger asked if the kits could be modified to include postpartum depression; Dr. Freeman said that they could be.

Ms. Tole said that she would like to see a public education campaign around postpartum depression with the headline being: "Postpartum Depression is the Most Common Complication of Pregnancy." Not as a scare tactic, but as the truth. One participant said that provider education needed to be in place before a public education campaign could start. Dr. Freeman agreed and said that the provider education piece would be part of the packets.

Report on Postpartum Depression Screening Used by Maine Health Center Professionals by University of Southern Maine students in association with the Maine Primary Care Association.

Mr. Lewis and Ms. Geiger distributed a report and data analyzed by four graduate nursing students from the University of Southern Maine. The students worked in conjunction with MPCA in support of LD 792. Working with Ms. Geiger, the students designed a questionnaire to investigate current PPD screening practices, use of specific screening tools, barriers to screening, implementation of the tool, and the referral process for at-risk-women.

According to the report, a total of 75 health centers were contacted to complete the questionnaire, from which 33 responses were received from 26 health centers. Of the 33 responses, 67 percent perform some form of PPD screening. However, only 19 percent of the health centers report "always" screening for PPD. Four out of 13 providers screened for PPD at the 6-week postpartum visit.

The PPD screening tool most utilized by respondents was the PHQ9; however, eight out of 17 providers did not use a PPD screening tool, or were unaware of which tool is used in the practice. Other screening tools used included the Edinburgh Postnatal Depression Scale (2 out of 17); information questioning such as "How's it going?" (3 out of 17); PHQ10 (1 out of 17).

Of the respondents, 80 percent denied any barriers to PPD screening. Of the practices reporting barriers, the top barrier identified by health providers was the amount of time required to perform screening (4 out of 11). Respondents identified a positive patient-provider relationship as the major contribution to successful PPD screening. When women are identified, as at risk for PPD, 34 percent of the health centers will treat the patient, while 27 percent of facilities will refer the patient for treatment outside of the practice.

The report concludes that while the sample represents only a fraction of health care centers in Maine, there are clear trends in the data demonstrating an obvious need for more consistent PPD screening.

Ms. Geiger said that most respondents to the survey were those in primary care settings. Legislation to promote postpartum depression screening and education was first passed in 1989 in California. In 2001, New York and New Jersey were the only states that required hospitals to issue PPD information in hospitals.

In April 2006, New Jersey became the first state to pass legislation mandating all health care providers screen for postpartum depression and provide education for women who have recently given birth. New Jersey also developed a public education campaign, "Speak Up When You're Down" and established a mental health network for postpartum women.

Stakeholder identification
Participants suggested that the following people be invited to join the workgroup:

- Lisa Sockabasin from the Maine CDC Office of Minority Health or a representative from Multi-Cultural Affairs
- Dr. Buell Miller
- Dr. Hector Tarraza, MHA, President of ACOG
- Dr. Jim Foster, Mercy/Intermed
- Aubrie Gridley-Entwood, Coodinator, Maine Academy of Pediatrics
- Penny DeRaps, NP, Dexter
- Representative from Fish River Rural Health Center
- Dr. Leslie Costello
- Kelly Bowden, MMC
- Student interns for literature search, bibliography, inventory
- Dr. Neal Korsun

Efforts in other states
Dr. Freeman suggested getting road maps from other states outlining: how they implemented postpartum screening; how it was funded; how sustained.

Illinois has a Perinatal Mental Health Project.

Process Used for Report Development

- Identify screening tools
- Identify screening practices
- Develop training materials
- Dissemination (training materials)
- Identify other state efforts
- Develop supports for what to do when people screen positive
- Develop integration plan for how to engage practices
- Develop coverage chart: how to bill if person has MaineCare/Anthem, etc.
- Inventory what exists in Maine or report on same

Report deadlines:
Draft to group mid-November
Final draft to circulate December 1

Subcommittees

Screening and Treatment

Includes Tools and Practices
Support tools/structure

Integration

Includes referrals to mental health and options on a positive screen, service availability

Resources and Gaps

Identify pieces of existing system, overlaps
Education/Training

Other States

Participants agreed that each Subcommittee would develop findings and recommendations that would be included in the Final Report to the Legislature.

Meeting Schedule
Monday July 9th 2 to 5 p.m. Maine Primary Care Association
Monday September 17 2 to 5 p.m. Maine Primary Care Association
Monday November 5th 2 to 5 p.m. Maine Primary Care Association
Monday December 3 2 to 5 p.m. Maine Primary Care Association (if necessary)

Meeting Minutes for the LD792

"*Resolve, To Direct the Department of Health and Human Services to Review and Report on Efforts Concerning Postpartum Mental Health Education*"

Workgroup Meeting
Monday, July 9, 2007
Maine Primary Care Association
Winthrop Street, Augusta

Present: Richard Aronson, Maine CDC; Martha Barry, Postpartum Support International (PSI) and Maine Psychological Association (MePA); Anne Conners, USM/Muskie; Elsie Freeman, DHHS; Valli D. Geiger, Maine Primary Care Association; Sharon Leahy-Lind, Maine CDC; Kevin Lewis, Maine Primary Care Association; Lynn Ouellette, MAPP, Mid-Coast Hospital; Valerie Ricker, Maine CDC; Lisa Sockabasin, Maine CDC/Office of Minority Health.

Welcome and Introductions
Valerie Ricker welcomed participants to the meeting; introductions followed.

Review of Minutes
The minutes were accepted with the following changes:

- Correct spelling of Dr. Martha Barry's name.
- Replacing Ms. with Dr. for Dr. Barry and Dr. Ouellette.
- On page three, last paragraph, change Maine Psychiatric Association to Maine Psychological Association (MePA) and change National Committee on Rural Psychiatry to American Psychological Association (APA) Committee on Women with the APA's Women's Program Office.
- Aubrie Gridley-Gortwood is the Executive Director of the Maine Academy of Pediatrics.

Report Process
Sharon Leahy-Lind suggested establishing a Writing Committee to produce the final draft of the report to the Legislature. She agreed to serve on the committee, as did Valli Geiger and Elsie Freeman. Anne Conners of the Muskie School will author the report.

Further Stakeholder Identification
The group agreed to further refine the stakeholder list created at the last meeting, adding the LD workgroup member responsible for inviting the additional stakeholders.

Stakeholder	Work Group Member Responsible	Status
Lisa Sockabasin, Maine CDC Office of Minority Health	Sharon Leahy-Lind	Done
Dr. Buell Miller	Dr. Lynn Ouellette	Will email Charyl Smith of the MMA
Dr. Hector Tarazza, MHA, ACOG	Dr. Lynn Ouellette	Will email Charyl Smith of the MMA
Dr. Jim Foster, Mercy/Intermed	Dr. Martha Barry	Pending
Aubrie Gridley-Gortwood, E.D. Maine Academy of Pediatrics	Dr. Richard Aronson	Pending
Penny DeRaps, NP, Dexter	Kevin Lewis	Pending
Rep from Fish River Rural Health	Kevin Lewis	Pending
Dr. Leslie Costello	Dr. Martha Barry	Pending
Kelly Bowden, MMC	Dr. Aronson/Valerie Ricker	Pending
Student interns	Anne Conners, Valli Geiger, Lisa Sockabasin	Pending
Dr. Neil Korsen	Kevin Lewis and Dr. Elsie Freeman	Pending
Stephanie Calkins, Maine Dartmouth	Sharon Leahy-Lind	Pending
Gina Wilson	?	Pending
Rep from MCEDV	Anne Conners	Pending
Cathy Morrow	?	Pending

Charge to Workgroups
Participants agreed to spend the rest of the meeting defining the charge to the Subcommittees; establishing Subcommittee co-chairs; identifying additional Subcommittee members; and if possible setting meeting dates.

Screening and Treatment Subcommittee
Co-Chairs: Dr. Lynn Ouellette and Valli Geiger

The purpose of this Subcommittee is to identify appropriate screening and treatment tools for postpartum depression using an integration approach with an emphasis on sustainability and spread. This will include:

- Obtaining supportive testimony from the LD 792 public hearing for review.
- Giving guidance on what can be reasonably integrated into clinical practice.

- Educating providers; empowering consumers and families.

Members
Martha Barry
Sue Bouchard*
Stephanie Calkins*
Penny DeRaps*
Cathy Morrow*
Representative from Wabanaki Mental Health*
Gina Wilson*
Laurie Kane-Lewis*
Cheryl Taylor*
(*Indicates members need to be invited to become Subcommittee members).

Future Meeting Dates
Monday, July 23rd: 3-5 p.m.
Dr. Ouellette's Office, Brunswick

Monday, August 6: 3-5 p.m
Dr. Ouellette's Office, Brunswick

Integration Subcommittee
Co-Chairs: Dr. Elsie Freeman and Dr. Neil Korsen

The purpose of this Subcommittee is to examine the barriers to the integration of perinatal mental health care into health care settings, including regulatory, licensing, and reimbursement as well as barriers to the provision of screening and treatment of postpartum depression. The Subcommittee will also develop strategies for empowerment for providers, i.e., what can be done if a patient screens positive. This includes:

- Reviewing MeHAF Report on *Integrating Maine's Mental, Behavioral & Physical Health Systems.*
- Reviewing what is working.
- Identifying gaps.
- Conducting focus group of women who have experienced PPD.
- Educating consumers, providers, and families.
- Obtaining information regarding crisis programs.
- Developing referral process to mental health from primary care.
- Developing recommendations on systems of care.

Members
Sue Bouchard
Andy Cook
Penny DeRaps
Michelle Houser
Melody Martin
MMA and Maine MAP
Dr. Lynn Ouellette
Gail Sirois
Cheryl Taylor
Martha Tole
(All members need to be invited to join Subcommittee).

Future Meeting Dates
Not yet established.

Data and Resources Subcommittee
Co-Chaired by Valerie Ricker and Marty Henson

The purpose of this Subcommittee is to examine on-going data collection within the state, to examine national data and Maine's ranking related to same, and to review existing resources and identify gaps. This includes:

- Conducting inventory of existing resources for consumers and providers, including minority cultures and languages.
- Examining data obtained through the following existing data collection systems: DHHS, Maine Centers for Disease Control, including the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS), the federal Supplemental Nutrition Program for Women, Infants and Children (WIC), and the CDC's home visiting program.
- Getting feedback on the inventory from the screening workgroup.
- Conducting an inventory of materials given to postpartum women and their families when discharged from the hospital.
- Examining prevalence data and comparing/contrasting Maine to the rest of the nation.

Members
Lisa Sockabasin
Erika Lichter*
Dr. Aronson
Dr. Freeman
Sharon Leahy-Lind
Mary Henson and or Kip Neale*
Nora Browne or Janet Leiter*
Sheryl Peavey*
Representative from 211 system*
Jiancheng Huang*
Melody Martin*

(*Indicates members who need to be invited to become Subcommittee members).

Future Meeting Dates
Not yet established.

Other States Subcommittee
Co-Chairs: Dr. Freeman and Sharon Leahy Lind

The purpose of this Subcommittee is to examine efforts on postpartum depression screening, treatment, and resource allocation in other states. This includes:

- Reviewing efforts, including legislation, in*:*

Maryland
Minnesota
Michigan
Rhode Island.
Texas
Washington
Wisconsin

- Conducting a literature search.

Members
Dr. Aronson
Erika Lichter*
Kevin Lewis
Lisa Sockabasin
Martha Tole*
(*Indicates members who need to be invited to become Subcommittee members).

Future Meetings
Thursday, August 23rd
1-3 p.m.
8th Floor Conference Room
Key Bank Plaza

Additional Outreach
Kevin Lewis agreed to contact the Maine Medical Association regarding participating in workgroups and providing in-kind resources such as conference call support for subgroups.

Agenda for September 17, 2007 meeting
Members agreed to the following agenda

- Subcommittee Reports
- Revisit Timeline and adjust as needed
- Confirm Writing Committee
- Set dates for review of first draft
- Identify review process

Meeting Minutes for
The Workgroup for
Resolve, Chapter 58 (LD 792) Resolve, to Direct the Department of Health and Human Services to Review and Report on Efforts Concerning Postpartum
Mental Health Education
Monday, September 17, 2007
2-5 p.m.
Maine Primary Care Association
Winthrop Street
Augusta, Maine

Present: Wendelanne Augunas, Penobscot Bay Medical Center; Dr. Richard Aronson, Maine CDC; Dr. Jeffrey S. Barkin*; Dr. Martha J. Barry, PSI/MEPA; Sue Bouchard, Fish River Rural Health,*Dr. Stephanie Calkins, Maine Dartmouth Family Practice Residency; Anne Conners, USM/Muskie; Dr. Andy Cook, DHHS/CBHS; Kim Day, MCEDV; Valli D. Geiger, MPCA; Laurie Kane-Lewis, DFD Medical Center; Dr. Neil Korsen, Maine Health/MMC; Sharon Leahy-Lind, Maine CDC; Kevin Lewis, MPCA; Dr. Lynn Ouellette, MAPP/MidCoast Hospital; Valerie Ricker, Maine CDC; Charyl Smith, MMA; Lisa Sockabasin, Maine CDC; Martha Tole, PSI. *(*Indicates present by conference call).*

Welcome and Introductions
LD 792 Co-Chairs Valerie Ricker and Kevin Lewis welcomed participants to the meeting, particularly new members. Introductions followed.

Review of Resolve and Legislative History
Ms. Ricker reviewed the legislative history of the resolve. Sponsored by Senator Nancy Sullivan, the original Act called for health care practitioners to educate pregnant women about prenatal and postpartum mental health and to screen each woman to identify current mental health issues or risk factors. The bill also included education and information to the partner, spouse, father or other family members as appropriate as well as required screening by health care providers prior to discharge and at well baby visits. The mandate for screening was the deal breaker for support.

After a Health and Human Services Committee work session and a meeting of a workgroup, members suggested a stepped approach to postpartum depression education and screening in the state, which would emphasize education, outreach, and a review of existing efforts. The outcome of this workgroup meeting was a proposal for an amendment to LD 792.

The amended bill changed the Act to a Resolve that required DHHS in coordination with the Maine Primary Care Association to convene a Workgroup to review existing efforts in Maine concerning education and screening for postpartum depression. The Resolve charged the Workgroup with reviewing screening and education related to postpartum depression, including but not limited to:

- Projects initiated by health care providers aimed at early screening and treatment of depression;
- MeHAF's study on barriers to integration;
- Ongoing efforts for screening within DHHS/Maine CDC;
- Review of projects implemented in other states

Subcommittee Reports
Screening and Treatment
Dr. Martha Barry, Dr. Lynn Ouellette, and Valli Geiger presented an overview of the Subcommitte's work and recommendations.

Dr. Barry presented **statistics** to support screening and treatment planning. She noted that depression is more common in women than men and that 50-90 percent of new mothers in Maine are likely to have the Baby Blues immediately after birth up to 14 days postpartum with mild to moderate symptoms that will remit on their own while 10 to 20 percent of girls and women in Maine are likely to develop postpartum depression each year. The percentage is higher for adolescent girls at 26 percent.

Dr. Ouellette presented a summary on **treatment protocols** for perinatal mood disorders, noting that treatment providers including, but not exclusively, pediatricians, obstetricians, and family practitioners are in a vital position to provide treatment and screening of women for depression during pregnancy and in the postpartum period. In order to do this, providers need an understanding of the illness along with familiarity with the appropriate screening tools and guidelines for their use. Dr. Ouellette provided Workgroup members with treatment algorithms for the PHQ9 and the EPDS. She also distributed a chart regarding prescribing prescription products to treat perinatal depression produced by the University of Illinois, UIC Perinatal Mental Health Project.

Ms. Geiger presented the Subcommittee's **screening recommendations** which included:

Antenatal Depression Screening: first trimester: take a history of depression and bipolar disorder; screen using PHQ9 or Edinburgh Postnatal Depression Scale (EPDS). Repeat screening in second and third trimester.

Postpartum Depression Screening: Screen with PHQ9 or the EPDS 4-6 weeks postpartum and then in year following birth or during well-child visits.

Screening Scoring:
- PHQ9 less than 5 = no intervention necessary
- PHQ9 score of 5-9: indicates need for support
- PHQ9 score of 10 plus: if suicidal, immediate referral to crisis team; if not suicidal, follow up with screening questions.
- If all questions regarding suicidality are negative, but PHQ9 score is greater than 10, follow protocol and offer the patient combinations of anti-depressants, support groups, and self-care resources.

Discussion
Workgroup members discussed how the recommendations would fare in the political process. Subcommittee members stated that the recommendations reflect the ideal, realizing the likelihood that the recommendations may be watered down in the political process. Mr. Lewis said members should consider how to best come up with a final report that will: advance the discussion, increase awareness, and obtain bi-partisan support. Members agreed to share the recommendations with the following groups: the Maine Medical Association, ACOG, AAP, and the Association of Family Practice Physicians. Members agreed to consider what is feasible within existing resources and what the barriers are from a practice perspective.

Integration Subcommittee
Dr. Neil Korsen gave an overview of the Integration Subcommittee's work, which included reviewing existing integration efforts in the state and identifying what works as well as barriers to integration.

Barriers to PPD screening on the physician side include:

- **Training**. The Maine Health system trained 80 percent of its adult care physician on the PHQ9 for people with diabetes and CVD; a year later, roughly 40 percent of those populations have been screened once. This illustrates the challenges in putting screening into practice.
- **Time:** probably the biggest barrier in a 15-10 minute patient encounter.
- **Competing Demands**: patients have an agenda; physicians have an agenda; negotiating what's important to them and to you.
- **Reimbursement structure**: only pays the work done by the clinician.

Discussion
Members discussed the status of recommendations regarding screening versus guidelines with the latter representing a more formalized process. For many physicians to incorporate screening in their practices, they require formal guidelines issued by professional associations. The evidence for such recommendations is being developed but has not worked its way through the process as of yet.

Data and Resources
Valerie Ricker reported that the Subcommittee looked at Pregnancy Risk Assessment Monitoring System (PRAMS) and Behavioral Risk Factor Surveillance System (BRFSS) data in relation to depression screening and PPD. Members also decided to collect data on programs within the Maine CDC or other state government agencies already doing some surveillance, such as the WIC program.

Members considered whether the PHQ2 could be used as a shorter PPD screening tool as WIC is already using a modified version of this; although WIC is not generalizable to all programs. Ms. Ricker noted that depression is generally higher among people with low income and high stress.

BRFSS data is limited in terms of the number of women of reproductive age who respond to the survey. Cost (about $13,000 a year) is a barrier to adding depression and anxiety questions to the BRFSS survey.

Subcommittee members wondered if there were a cost associated with using the PHQ2 patented by Pfizer. Dr. Korsen said he thought there would not be a cost if the tool were being used for clinical purposes and if the Maine CDC and Pfizer exchanged documents stating such. Dr. Korsen offered to assist the Subcommittee co-chairs in identifying who at Pfizer should be contacted regarding the same.

Other States
Sharon Leahy-Lind said that the Other States Subcommittee is scheduled to meet on Monday, September 24, from 10 a.m. to noon on the first floor of Key Bank Plaza.

The Resolve directed the Workgroup to examine PPD screening and education efforts in New Jersey, New York, Illinois, and New Hampshire and other states as appropriate.

Ms. Leahy-Lind gave the following overview and said more detail would be forthcoming following the September 24th meeting.

New York: Pending legislation that mandates postpartum screening for all new mothers and calls for educational/informational programs about PPD for new moms, dads, and other family members as they leave the hospital.

New Jersey: A bill (S 213) signed into law in April 2006 that requires health care providers to screen women who have recently given birth for PPD and at well child visits. Also requires education for women and families.

Illinois: Bill pending: asks that doctors and nurse practitioners screen women for PPD because they see the early stages of the illness. If diagnosed, women referred to a psychiatrist so proper care can be sought earlier in pregnancy or early in postnatal period.

Ms. Leahy-Lind noted that she has sought information from other State Women's Health Coordinators regarding efforts in their states and that she is also looking for some outcome measures, although it may be too early for those to have been collected.

Discussion
Ms. Geiger noted that data is frequently not collected in a way that makes it easier to make a case for postpartum depression; i.e., a suicide may not be reported as caused by PPD. Dr. Richard Aronson said that there is a new process for maternal/mortality review in Maine. Dr. Andy Cook noted that suicide is fortunately an infrequent complication of PPD. He also noted that PPD has a profound influence on children and families.

Feedback from Maine Medical Center (MMC) and Dr. Doug Robbins
While a representative from MMC could not attend the meeting, Ms. Conners distributed an email from Dr. Robbins regarding a cross-disciplinary meeting held at MMC to discuss the resolve. Obstetricians, pediatricians, family practitioners, psychiatrists, nurses, and social workers attended the meeting.

Discussion at that meeting included:

- Concerns about which screening instruments are most effective and efficient - e.g. PHQ9 vs. the Edinburgh Postnatal Depression Scale vs. the 2-Question Patient Health Questionnaire.
- Most effective timing and frequency for screening.
- Major concern about finding resources (esp. psychiatrists) to treat women after they were identified. All agreed that this has been a major problem, and that screening without being able to offer treatment poses a serious dilemma.
- Barriers to treatment - Medicaid and lack of insurance; language in refugee populations stigma; and reluctance to go to a psych clinic - implication of utility of integrated mental health treatment in the primary care or OB clinic/office.
- Effectiveness of routine post-natal follow-up home visits.
- Need for funding for integrated care and care managers - not fully reimbursable through Medicaid and other insurance.
- Creation of a guide to resources - local and regional.
- Cognitive and affective consequences in the children of mothers with postpartum depression. Effects on attachment.

Those who attended wanted to meet again to share more information from each other's experience and to consider what can realistically be done at MMC. The group will meet again in two weeks.

Pilot Project
After discussing the challenges that PPD screening may pose to physicians in the state as well as how to engage key stakeholder groups such as the MMA and ACOG in constructive engagement around PPD, workgroup members decided to pilot PPD screening at two health centers: Fish River Rural Health in Eagle Lake and DFD Russell in Leeds. Wendelanne Augunus also agreed to see whether the ob gyn practice she works with at Penobscot Bay Medical Center would be interested in participating in such a pilot.

Laurie Kane-Lewis of DFD Medical Center proposed the following protocol for data to be collected for one month: October 2007.

- Prenatal patients screened using PHQ9 at first prenatal appointment; second trimester and third trimester.
- Postpartum patients screened at second and sixth week post partum visit. Mothers of children (0-12 months) screened at well-child visits.

Sue Bouchard of Fish River agreed to use this protocol. Workgroup members agreed to include results in the report submitted to the Legislature.

Next Steps

Workgroup members also agreed that it would be helpful to:

- Have a list of practices already screening for PPD.
- Follow up with Michelle Houser of the Perinatal Mental Health Alliance of Southern Maine regarding her lunch and learns and the reception she received from providers.
- Circulate screening recommendations with key professional stakeholder groups.
- Test cultural competency of screening tools by going to various communities in Maine and testing the tools for relevancy.
- Anne Conners of the Muskie School will work with Charyl Smith of the MMA regarding soliciting input on PPD screening from member physicians.

Report Writing Process

Writing Committee

Anne Conners, Muskie School
Dr. Elsie Freeman, DHHS
Sharon Leahy-Lind, Maine CDC
Valli Geiger, MPCA
Dr. Barry and Dr. Jeffrey Brakin: Reviewiers

Deadlines

Last Subcommittee meeting**: November 1st**
Data from pilots by **November 2nd**
Draft by **November 5th Workgroup meeting**
Second Draft **November 21**
Final Draft: **December 15th**

Scope of report

Focused on parameters of Resolve and PPD.

Meeting Minutes for
The Workgroup for
Resolve, Chapter 58 (LD 792) *"Resolve, to Direct the Department of Health and Human Services to Review and Report on Efforts Concerning Postpartum Mental Health Education"*
Monday, November 5, 2007
2-5 p.m.
Maine Primary Care Association
Winthrop Street
Augusta, Maine

Present: Valerie Ricker, MCDC; Sharon Leahy-Lind, MCDC; Molly Gallant, Maine Medical Association; Wendelanne Augunas, Penobscot Bay Medical Center; Kim Day, MCEDV; Dr. Lynn Ouellette, MAPP/MidCoast Hospital; Valli D. Geiger, MPCA; Dr. Elsie Freeman, OAMH/DHHS; Senator Nancy Sullivan; Sue Bouchard, Fish River Rural Health (by phone).

Welcome and Introductions
LD 792 Co Chair Valerie Ricker welcomed participants to the meeting. Introductions followed. Ms. Ricker reviewed the agenda for the day.

Subcommittee Report Outs
Integration
Dr. Freeman updated participants on what is working in Maine with regard to integration of screening and treatment of depression into health care for women of childbearing age.

- The FQHCs are engaged in a federally funded health disparities collaborative aimed at implementation of the Care Model for chronic disease care, including an increase in screening and treatment for depression. Funding through a MCDC Women's and Children grant has supported a focus on women of childbearing age. Four FQHCs have started programs to increase PHQ9 screening and treatment of depression and two have a special focus on screening all pregnant women in the first trimester and four-to-eight weeks postpartum.
- The Maine Health Depression Collaborative using MacArthur Foundation, Maine Health and Maine Health Access Foundation funds educated 80 percent of MaineHealth clinicians in use of PHQ9. Integration of screening and treatment of depression at 16 primary care sites; and formed a workgroup to examine ways to enhance screening and treatment of depression for women of childbearing age.
- Penobscot Bay Hospital has a full-time mental health professional on staff who runs a weekly drop-in group for support for mothers postpartum, takes calls from concerned professionals, links parents to mental health supports in the community, and works with Pediatrics and ObGyns to raise awareness.

Other States
Sharon Leahy-Lind shared that she placed a request on the National States Women's Health Listserv for information on postpartum programs. Specifically she asked whether or not there was a postpartum (PPD) program in the state, what state department the program was located, how the program was funded and if it was legislatively created and funded, what tools were generated by the program or project, and to provide an outline of implementation strategies and state contact information. 23 states responded. Committee members reviewed the information submitted and the following themes emerged.

- Nationally three states have passed legislation for PPD efforts or programs.
- A majority of states have not pursued the legislative route for PPD efforts.
- Five states nationally have state dollars for their programs and of those, 3 have legislative initiatives.
- A majority of states with PPD efforts are located in State Health Departments, usually the MCH division and are primarily funded by HRSA.
- Programs or efforts in other states funded by one-time federal funds tend to have a more local focus and are more pilot in nature as there is concern about sustainability.
- Efforts across the country ranged from $7,000 that funded an awareness effort (posters on buses) to a comprehensive statewide mandated training and screening program in New Jersey that was legislatively created and funded with a $4.5 million fiscal note.

In New Hampshire, no efforts were reported at the state level; however, Dr. Ardis Olson at Dartmouth is doing work on PPD.

Data and Resources
Valerie reported that the committee is looking at PRAMS and BRFSS data in relation to depression screening and PPD. They are also inquiring among perinatal nurse managers and home visiting programs about resources provided to women in the prenatal and immediate postpartum period, including which written, video, and DVD materials on mental health that are being given to women during the perinatal period. The committee has completed its work on data resources and made draft recommendations for ongoing data collection. Recommendations on educational materials and opportunities will be made once the group learns what is already provided in the prenatal and postnatal periods.

Screening and Treatment
DFD Russell Medical, Penobscot Bay Medical Center, and Fish River Rural Health conducted pilots during the month of October. The DFD Russell representative was not able to attend the meeting, but sent an email outlining pilot results that was shared by Valli Geiger.

DFD Russell Pilot
The DFD pilot tested with two clinicians, both female midlevels, one Family Nurse Practitioner (FNP) seeing general population and one Certified Nurse Midwife (CNMW) seeing only OB patients. The FNP had one well-child in the month and did a screening

PHQ on the mom, which was negative. The CNMW works three one half days a week and was screening as follows:

- At first prenatal appointment
- Second Trimester (20 weeks)
- Third Trimester (32 weeks)
- 2 week postpartum visit
- 6 week postpartum visit

The CNMW had 15 patients over the four-week time period that fit the criteria and had two positive screens requiring intervention.

Fish River Rural Health Center

Susan Bouchard reported that Fish River conducted its pilot through its Perinatal Program. All nine completed screens were negative. There were no problems at 1st, 2nd, 3rd trimester. Fish River has been running the screens in the program for some time at 1st, 2nd, and 3rd trimester and then again at two and six-weeks postpartum to compare.

Penobscot Bay Medical center

Ms. Augunas reported that Pen Bay conducted the pilot at the PBMC/Women's Health Center from October 2 – 26th. Three providers (1-OBGYN and 2-Certified Nurse Midwives, CNMs) agreed to participate and were interested in patient response to being surveyed as well as the time factor involved in scoring, follow-up, etc. In total, 47 patients fit the criteria, completed the survey, and voiced no concerns about taking the inventory.

Results were as follows:

1st Trimester (new maternity):14 screens completed (5 by an ObGyn, 9 by a CNW) resulting in 2 double positives
2nd Trimester (20 weeks): 14 screens completed, (5 by an ObGyn, 9 by a CNW) resulting in 3 double positives
3rd Trimester (32 weeks): 12 screens completed (2 by ObGyn, 10 by a CNW). No double positives reported.
6-week Postpartum: 7 screens completed (6 by OBGYN, 1 by CNM) resulting in one double positive

Ms. Augunas shared that a team approach (nurse, physician, midwife, LCPC) is in place and includes follow-up conversations with patient, medication as appropriate, connection to the PCP/Psychiatry/counseling, referrals to the New Mom's group, Home Visiting/Parent Education program, Public Health Nursing, and other community resources as needed.

At the end of the pilot period, Ms. Augunas met with the midwife, physicians, and their nurses for feedback. At the onset of the pilot, providers had voiced concerns that the survey would be time intensive and that women might find it intrusive. At the wrap up, the providers and nurses reported that the experience was a positive one. They noted that it was less labor intensive once they got into the rhythm of giving it out and that none of

the women objected to taking it and in fact were willing and quite honest in their reporting.

The group also found it quite useful and helpful in identifying patients that might not have presented their concerns at a regular check up. Follow-up discussion also included thoughts about the rigidity of the screening schedule (how to factor in patient visits at weeks other than exactly 20 or 32), feasibility of screening all women seen in the practice, and billing potential for staff time involved in the screening process.

Senator Sullivan asked if the PHQ9 tool was required by the legislature. Ms. Ricker said that no specific tool was required but that the committee looked at both the Edinburgh Postnatal Depression Scale and the PHQ9 and chose the PHQ9. Senator Sullivan then asked how physicians would handle this screening stating that in the hearing it came up as being considered to be an invasion of privacy. Ms. Augunas said that pilot testing indicated that most physicians did not see this as an issue. She also shared that the nurses hand out the PHQ9 to the patient, not the physician, then patients would self-report and return to the nurse. Ms. Bouchard stated that Fish River is looking at having patients complete the screening tool, have the physician review and then incorporate in the electronic medical record (EMR). Fish River has counselors onsite and will attempt to get the patient under care as soon as possible.

Members were reminded that the three pilots are not typical as these sites have mental health treatment incorporated thus are able to take action more quickly than sites that don't have access to mental health services. Ms. Leahy-Lind added that in recent project work she was involved with co-location was important. If there was no provider onsite and a patient had to be referred, once they go out the door they can't be followed. Without an EMR, there is no way to know if they received treatment and outcome of it.

Senator Sullivan asked if it was an expectation that PCPs offer something – that is if there is a protocol is it expected? Dr. Freeman replied that diagnosing and treating depression in the primary care setting is not new but there are no national guidelines for best practice. Sen. Sullivan: If doctors were in an insurance network, would they have to complete the screen in the 1st trimester? Dr. Freeman: FQHCs are mandated to offer mental health treatment. MaineCare provides for mental health treatment. Various health insurance companies such as Cigna and Aetna carve out mental health. Cigna wants to have a very small group of mental health providers. Credentialing and who is on their panel creates linking function issues thus it is very complex. Patients need someone who will follow through to see that they receive services, to navigate and find a provider. Ms. Ricker added that insurance companies pay a rate for pre-natal, delivery and post-natal, there is no incentive to add screening. The pilots demonstrated that screening is not costly or time-consuming. The issue is getting paid for the treatment. We need to get the providers, i.e. ObGyn's involved.

Dr. Ouellette reported that the Maine Association for Psychiatric Physicians submitted a successful application for a $22,000 grant. The focus of the grant will be to work with physicians in other specialties to screen for mental health.

Ms. Augunas stated that pediatricians would be important with PHQ screening since moms leave ObGyn and Pediatricians will be seeing them. We suggest thinking about ways to engage these providers. Ms. Ricker said that Dr. Aronson approached the AAP and they were receptive. She also shared that Maine has been selected as one of 20 state for the ABCD Screening Academy for developmental assessment and physicians are resisting this; however, the PHQ9 and PHQ2 are much easier to self-administer. Ms. Augunas said that Obs are more confident in prescribing but frequently they are the only doctor the family sees – how do we triage? We also need to be mindful that most physician practices are connected to hospitals. Should we look to hospitals for support on the linking process? Should we think about completing a resource list of what we can leverage?

Writing Subcommittee

Ms. Ricker distributed a draft outline for the Committee Report. She shared that report writer, Anne Connors, recommended that the body of the report be no more than 10 pages. Supporting documentation should be included in an appendix. Ms. Ricker then asked for input on the format, asking for additions and deletions. The following suggestions were made:

- Consolidate Introduction and Resolve History and keep this section brief.
- List Committees at the end (can make a brief statement to the effect that X # of committees came together to do…and briefly describe – then refer to appendix for committee listing).
- Pilot information is important as it sets the basis for recommendations based on data collected. Statements need to be very factual and positive. Ms. Bouchard asked about other types of data sharing that Fish River was collecting. She was asked to write up what they were doing and send it to Anne Conners with a request to include it in the "**What's Going on in Maine"** section. Ms. Bouchard also asked about the ACOG form if they were including PHQ2 info on the ACOG. Ms. Ricker asked that she print off a copy of the form and email Anne with a suggestion to include the PHQ2 questions on the ACOG form.
- Add a section called "Other Resource List" just before Conclusions to add existing systems that could be utilized to focus on this population.

Committee Recommendations

Screening and Treatment

- PHQ9 or Edinburgh be done once in 1st, 2nd, 3rd trimester, 4-6 weeks postpartum, 1st year following birth during primary care visit or during well-child visits in primary care or pediatrician office.

Question was asked if it was a recommendation or mandate. Discussion ensued that don't usually mandate for medical practice and, if we do mandate then how do we monitor? Senator Sullivan asked about New Jersey's experience since that state mandates. Ms. Leahy Lind said that actual language is "requires"; however, New Jersey allocated $4.5 million and as the screening program is just getting started, there is no data available. Senator Sullivan reminded members that if they mandate then the bill will be referred to committee and a study will be required thus a more time-consuming process.

***** Note: The treatment recommendations were not included in the package so Dr. Ouellette will forward them to Anne for inclusion**

Integration

- Leverage existing resources in strategic and coherent manner
- Support for looking at regulatory, fiscal, and policy barriers to co-location
- Encourage better integration, cooperation and referral systems of mental health and primary care providers – co-location
- On-going support for and expansion of Home Visiting Program
-

Elsie had to leave but said she would work on refining the subcommittee's recommendations and will submit therefore writer needs to connect with her (Elsie) for final language.

Dr. Freeman reported that there are policy and reimbursement issues around the state, it is not just a MaineCare issue. Perhaps engage MaineCare in a discussion with other insurers that would support screening and depression. Senator Sullivan suggested a meeting with health insurance lobbyists to see that this is best practice.

Ms. Geiger expressed concern that education without a mandate may not be successful. Ms. Ricker responded that if we mandate we need to think about how to monitor and fund. Ms. Geiger suggested including a strong recommendation that screening be a part of pre-natal care.

Data and Resources

- Continue to collect and analyze data from PRAMS and BRFSS to keep having PHQ questions included.
- Work with WIC Program to include PHQ questions and encourage their partners to include PHQ questions as well.

Other States

Same as Integration

Timeline

Ms. Ricker reminded members that the original date for the 1st draft report was November 15th and requested to move it to just after Thanksgiving. It will be sent to members via email and asked that they review and use the 'Track Changes' function in Word to edit and once completed to return to Anne Conners. Draft # 2 will be completed by December 10th with the final version completed just prior to Christmas.

Next Meeting Date: December 3. Ms. Ricker asked that members continue to hold this date and Anne Conners will confirm the need to have the meeting – we should know by Thanksgiving whether or not we need to meet again as a full group.

Ms. Ricker thanked Senator Sullivan for taking the time out of her busy schedule to meet with the group adding that her input on information to include in the report was most valuable.

Data and Resources Subcommittee

MINUTES

Date: 8/21/07

Location: 286 Water St., Room 16

Present: Valerie Ricker (Division of Family Health, MeCDC), Erika Lichter (MCH Epidemiology, MeCDC), Molly Diekmann (intern, MeCDC), Elsie Freeman (Adult Mental Health), Kip Neale (BRFRSS, MeCDC), Kim Haggen (PRAMS, MeCDC), Janet Leiter (WIC, MeCDC)

Absent:

Note Taker: Erika Lichter

Item	Discussion	Decision/ Action	Who's Responsible	Date Due
Inventory of existing resources	Materials on PPD may be available through Maine's Perinatal Outreach program.	Contact Kelly Bowden about getting materials	Valerie Ricker	
Prevalence of PPD vs. prevalence of screening for PPD	The group discussed the difference between having data on the actual prevalence of PPD in the population and the prevalence of screening for the PPD. We currently have several representative surveys of adults that can estimate the prevalence of the problem (e.g., BRFSS and PRAMS), but it would be interesting to obtain data from WIC, Home Visiting, and PHN to get at not only the prevalence of PPD among their population, but the percent of women who are actually being asked about it. We don't have any screening information from physicians as well. The group discussed the possibility of adding a question to PRAMS to get at depression screening, but this could not occur until 2009.			
PRAMS postpartum depression questions	The Pregnancy Risk Assessment Monitoring System (PRAMS) is a representative survey of new mothers in Maine. It is mailed to mothers 2-8 months after giving birth and has a high response rate. There have been 3 questions on postpartum depression on the survey since 2004. Two of the questions are similar to the PHQ-2, though not identical, leading to some difficulties in scoring and analysis. Kim thinks that questions about anxiety will be added to the survey the next time it is revised, which will be in 2009. The group reviewed results from the three questions and the question of how they should be analyzed was posed. Kim mentioned seeing a presentation on the analysis of the PPD questions and will pass the presentation along to Erika.	Send PRAMS presentation of analysis of survey questions to Erika	Kim Haggen	
BRFSS depression questions	The Behavioral Risk Factor Surveillance System is a statewide survey of adults in Maine. There are no questions that specifically address PPD on the BRFSS, but it is possible to examine the prevalence of depression among women of childbearing age. In 2006, a depression and anxiety module was added to BRFSS. This module includes the PHQ-8, as well as physician diagnosis of depression and anxiety. Prior to 2006, frequent mental distress was measured using the number of unhealthy mental health days in the past month as a proxy of current depressive symptoms. This question was asked between 2000-2006 (except for 2002). Elsie presented some analyses that she and Kip have worked on. These analyses reveal that consistent with the literature, depression	Send copies of slides to Erika	Elsie Freeman	

Item	Discussion	Decision/ Action	Who's Responsible	Date Due
	varies by gender and women age 18-44 have the highest prevalence of current symptoms or a past diagnosis. Elsie emphasized that we should be concerned about depression among all women of reproductive age, not just those in the postpartum period. She also noted that depression is one of the only chronic diseases that is more prevalent among younger vs. older individuals. She asked the question whether we want to include information on depression in general and who it is affecting in the report. She noted that men with children at home also report high rates of depression so screening efforts may want to include fathers at well-child visits.			
WIC and depression screening	Janet noted that WIC does not have an ongoing surveillance system for depression in its population. She thinks they may ask depression questions as part of the intake and these questions may be similar to the PHQ-2, but she does not believe that documentation of screening or symptoms is consistently documented. Janet also discussed wanting WIC to start participating in PNSS, the national Pregnancy Nutrition Surveillance System and this may be a risk factor recorded as part of this system.	Need to check on documentation of depression in WIC data and data elements of PNSS	Janet Leiter	
Other Programs	Does PHN and Home Visiting screen for depression? There has been discussion with Home Visiting about screening for depression, using the PHQ-9. At what stage is Home Visiting in determining a screening tool?	Talk with Jan Morissette and Sheryl Peavey	Valerie Ricker	
Inventory of existing resources	The group discussed that other individuals should be included in the discussion of existing resources, since that piece seemed separate from the data piece. Others who would be helpful for this piece include: Sharon Leahy-Lind, MeCDC, Sheryl Peavey, OCFS, Dick Aronson, MeCDC and a 211 representative. In the Integration subgroup, one member mentioned the good work being done in the Mid Coast region linking mothers in need with public health nursing, parenting educators and local HMP resources. Sheryl Peavey should be a major source of information about these resources that are already collaborating at the local level. Perhaps contact the coordinators of several HMPs as well?	Pull group together to discuss existing resources	Valerie Ricker	
Other data options	The group mentioned some other possible source for data on PPD: • Hospital discharge • Claims data The group was not sure whether there was a code for PPD in the ICD-9, but Elsie suggested looking at prescriptions for anti-depressant as a proxy for a diagnosis in claims data, since many insurers don't reimburse for depression screening so it does not get billed.	Is there a specific ICD-9 code for post-partum depression?	Erika Lichter	
Adopting the PHQ-2	Is there a cost associated with using the PHQ-2 since it is copyrighted by Pfizer? Communication from Neil Korsen who corresponded with Dr. Kroenke who developed the PHQ series with Pfizer funding. As long as the screen is used for clinical purposes and any printed form acknowledges Pfizer as holding the copyright, there is no fee associated with the use of the PHQ.	Check on cost associated with widespread adoption of PHQ-2	Elsie Freeman	

Item	Discussion	Decision/ Action	Who's Responsible	Date Due
Funding for BRFSS	Concern for ongoing funding of mental health questions in BRFSS except for the frequent mental distress question, since that is part of the core. In 2007, Maine included the severe mental illness module. This will be available next spring. This includes information on more general mood disorder. The depression and anxiety module will be run again in 2008, but thereafter funding is uncertain. The cost of the full depression and anxiety module in BRFSS is $13,000. ($1250 per question).			
Adding questions to PRAMS	PRAMS has a core with questions asked by all states. State can add questions from a standard list provided by CDC or states can make up their own questions. The survey can only be 80-85 questions, but there is no cost for additional questions. Revisions of the survey are currently underway.	Keeping group up to date with PRAMS revisions to 2009 survey	Kim Haggen	
Appropriate referrals	Are appropriate referral mechanisms in place for those who screen positive for depression? The Care Model and efforts to implement the Care Model within Primary Care Settings have focused on Diabetes, CVD, and Depression. Given the prevalence of depression and where yong mothers are apt to go for care (their child's doctor or their obstetrician) and given the stigma associated with gong to mental health specialists, primary care providers are the primary resource for diagnosis, medication management and referral to specialty care. The crisis system in Maine, funded through Child and Adult Mental Health in DHHS, is available 24/7 to any Maine resident regardless of insurance status.	The Integration Subgroup will be discussing what has worked in Maine and will look at a variety of strategies, including primary care, specialty referral, public health nursing. Elsie will obtain a complete description of the OAMHS crisis system.		
National Comparison	Possibility of a literature search on national data on PPD and depression more generally. Elsie suggested looking at the National Comorbidity Survey.	Lit Search	Molly? Erika will check with Ann about available resources for students.	
The report	It was suggested that we consider the DHHS commissioner as an important audience for the report. We should emphasize implementation of PPD screening as part of the care model for chronic disease since depression is a chronic illness. This fits well within the DHHS vision of integration. Cost estimates that would include maintaining surveillance systems and analysis should be put into report.			
Next steps	The group determined that the rest of the work could be done via email and Erika will help to pull it together.		Erika Lichter/Valerie Ricker	

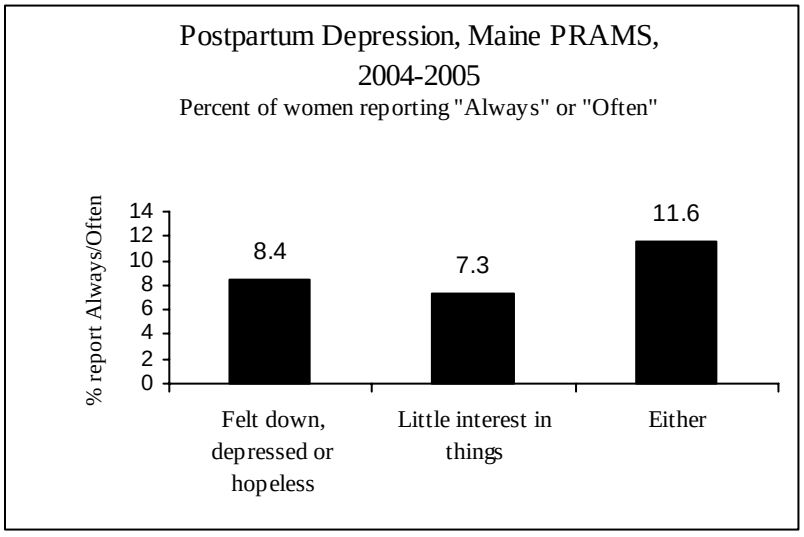
Data and Resources Subcommittee: Summary of data collection and public health screening efforts for postpartum depression

Data Collection on the prevalence of postpartum depression in Maine
Maine currently has two representative surveys of adults that can estimate the prevalence of the problem of postpartum depression.

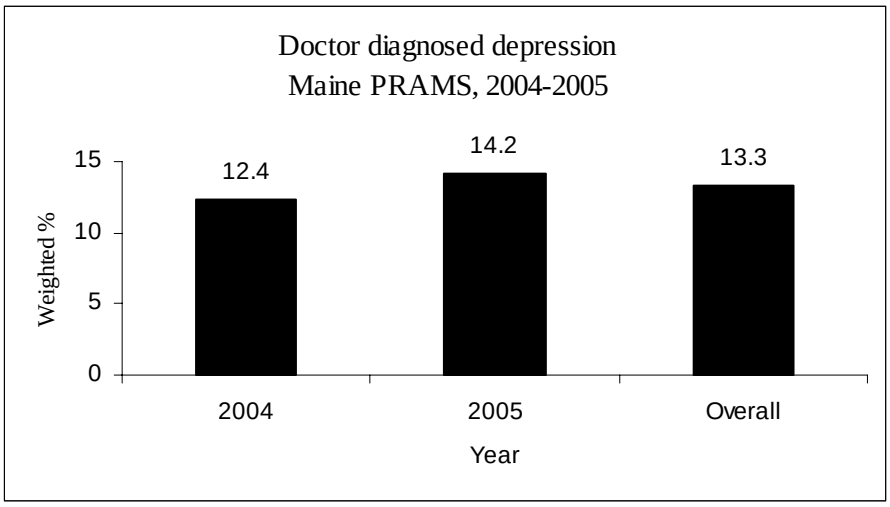
PRAMS
The best source of data on the prevalence of postpartum depression comes from the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a representative survey of new mothers in Maine that is mailed 2-8 months after giving birth and has a high response rate (>75%). Since 2004, there have been 3 questions on postpartum depression on the survey.

These questions are:
1. Since your new baby was born, how often have you felt down, depressed or hopeless?
2. Since your new baby was born, how often have you had little interest or little pleasure in doing things?
   (Participants are asked to reply to these questions on a 5 point scale: Always, often, sometimes, rarely or never.)
3. Since your baby was born, has a doctor, nurse, or other health care worker told you that you had depression?

The results of the 2004-2005 PRAMS data indicate that 8.4% of new mothers in Maine reported "always" or "often" feeling down, depressed or hopeless since the birth of their child and 7.3% reported having little interest or little pleasure in doing things; 11.6% reported "always" or "often" to at least one of the two questions.



In 2004-2005, almost 1 in every 8 new mothers in Maine (13.3%) reported that a health care provider diagnosed them with depression since the birth of their child.



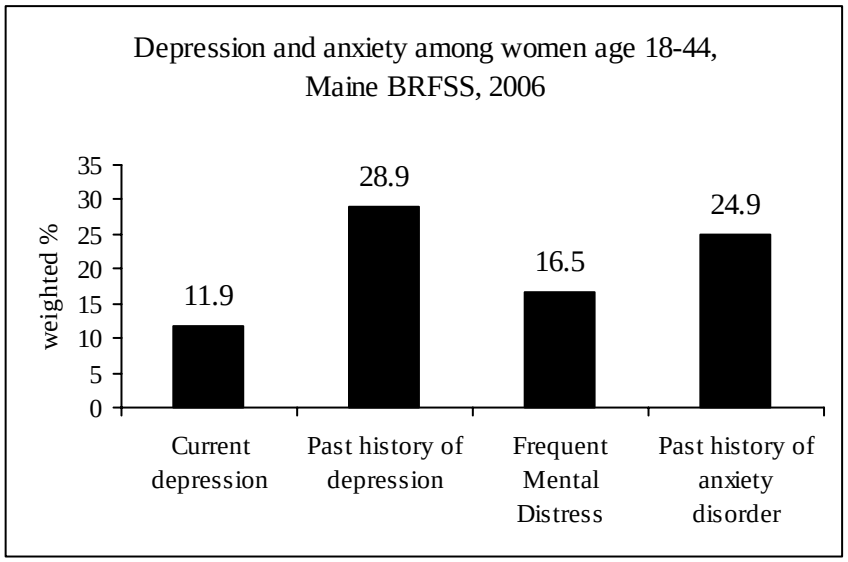
The PRAMS survey is revised every 5 years. Starting in 2009, 4 depression questions will be part of the PRAMS core—all states will be required to ask these questions. They are:

Since your new baby was born, how often have you felt down, depressed or sad?
Since your new baby was born, how often have you felt hopeless?
Since your new baby was born, how often have you felt slowed down?

There is the option to add additional questions to the 2009 PRAMS survey, including those on anxiety or screening for depression among health care providers. There is no cost to adding additional questions to PRAMS, but the survey is limited to 80-85 questions.

Behavioral Risk Factor Surveillance System
The Behavioral Risk Factor Surveillance System (BRFSS) is a statewide telephone survey of adults in Maine. There are no questions specifically addressing postpartum depression, but it is possible to estimate the prevalence of depression among women of childbearing age using this survey. In 2006, a depression and anxiety module was added to BRFSS. This module includes the PHQ-8, a widely used, validated tool for diagnosis of depression. Survey respondent were also asked about physician-diagnosed depression and anxiety. Prior to 2006, frequent mental distress was measured using the number of unhealthy mental health days in the past month as a proxy of current depressive symptoms. This question was asked between 2000-2006 (except for 2002).

Data from the 2006 BRFSS reveal that 26.7% of women in Maine reported a past history or current symptoms of depression. Of women of childbearing age (age 18-44 years), 11.9% reported current symptoms of moderate or severe depression, defined as a score of >14 on the PHQ-8, and 16.5% reported frequent mental distress. More than 1 in 4 (28.9%) reported have a past history of depression and 24.9% had a past history of anxiety disorder. Of those women age 18-44 with at least one child under age 18 in the household, 9.6% reported current depression and 21.5% were ever been told by a health professional that they had depression.



These analyses are consistent with the literature that shows that depression varies by gender, and women age 18-44 have the highest prevalence of current symptoms or a past diagnosis.

Although the BRFSS is a valuable resource for collecting information on depression among adults in Maine, there is concern for ongoing funding of mental health questions in BRFSS -- except for the frequent mental distress question, since that is part of the core. In 2007, Maine included the severe mental illness module. This will be available next spring. This includes information on more general mood disorder. The depression and anxiety module will be run again in 2008, but thereafter funding is uncertain. The cost of the full depression and anxiety module in BRFSS is $13,000. ($1250 per question). In addition to the cost, there are no specific questions on postpartum depression, although these could be added for a fee.

Depression Screening

There are several programs within the Maine CDC that have contact with women during the postpartum period and have the opportunity to ask women about symptoms of postpartum depression. These programs are not necessarily the best sources for overall prevalence data, but they can provide information on who is being screened for PPD among different populations.

Women, Infants and Children (WIC)
WIC does not have an ongoing surveillance system for measuring depression in their population, but women are asked about depressive symptoms using the following screening tool:

Over the past 2 weeks, have you ever felt down, depressed, or hopeless?
Over the past 2 weeks, have you felt little interest or pleasure in doing things?

Unfortunately, although these questions may be routinely asked of all women, the responses and the documentation of screening is not available in WIC's electronic database. Therefore, there is no way to estimate the percent of WIC clients who are actually screened and who report postpartum depression.

Healthy Families (Home Visiting)
Maine's home visiting program, which is available to all new families and adolescent parents in Maine, does not currently screen for postpartum depression, although home visitors do indicate in their paperwork whether a family has received substance abuse or mental health counseling. There have been discussions about Healthy Families about adopting the PHQ-9, but this has not occurred yet.

Public Health Nursing
Still waiting to hear about this….

Recommendations:

- **Continue to analyze PRAMS data on postpartum depression on an ongoing basis**
- **Continue to fund mental health questions on BRFSS, including a specific question on postpartum depression**
- **Revise WIC database to ensure inclusion of depression screening results**
- **Incorporate mental health screening into home visiting protocol**
-

Minutes from the Integration Subcommittee Meeting of The LD792 Workgroup Tuesday, August 28, 2007 Dana Center, MMC Portland, Maine

Present: Wendelanne Augunas, Penobscot Bay Medical Center; Sue Bouchard*, Fish River Rural Health Center; Anne Conners, USM/Muskie; Elsie Freeman, DHHS; Neil Korsen, Maine Medical Center. (*Indicates present by teleconference).

Welcome and Introductions
Elsie Freeman welcomed participants to the meeting; introductions followed.

Review of the Resolve and Charge to the Workgroup
Participants reviewed Resolve *Chapter 58, To direct the Department of Health and Human Services to Review and Report on Efforts Concerning Postpartum Mental Health Education.*

Elsie Freeman suggested that the Subcommittee focus on what's already happening in Maine in depression treatment and screening, with a particular focus on postpartum depression, identifying opportunities and barriers. Given the current budget climate, recommendations coming out of the workgroup and the Subcommittee will have to exist within current resources.

Existing Integration Efforts in Maine: Review of Documents
Integrated Health Care In Maine: Vision, Principles and Values, and Goals and Objectives, Integration Initiative Steering Committee & Advisory Group, March 2007. While this document does not specifically address postpartum depression, it promotes integration of mental and physical health through high-level leadership, timely access, integrated team-based care, information technology, educated workforce, evidence-based models of care, and reimbursement realignment.

Department of Health and Human Services Office of the Commissioner, Policy And Procedure Statement, Integrated Services Framework for High Risk Families/Individuals, May 22, 2007
This DHHS policy document recognizes that individuals with multiple, complex needs require not only integrated screening and care, but also appropriate environmental supports as necessary. The policy applies to all direct and contracted providers of DHHS, including its managed care vendor, its providers who address homelessness, poverty and behavioral health, and its welfare and healthcare workers. All providers are expected to develop comprehensive, integrated, collaborative, and continuous strategies of service delivery with the scope of each program's mission, design, licensure, and resources.

Road Map to Better Health: Maine State Health Plan 2006/2007
The state health plan calls for improving the care of all Mainers by recognizing that mental health is a vital aspect of overall health status and for the effective integration of

mental health into primary care. Regarding postpartum depression, the plan calls for the Mental Health/Public Health workgroup, working with MaineHealth, the Maine CDC Women's Health Program and the Maine Primary Care Association, to collect data on the number of women screened for depression in the postpartum period and support expansion of such screening beginning June 2006 and ongoing.

The group agreed to review the state health plan and identify further areas relevant to integration/postpartum depression.

Maine Health Access Foundation's Inventory of mental health/primary care integration projects in the state. 2006.
Members agreed to review the document and abstract the ones that seem the most relevant to postpartum depression.

Status of Maine Health Access Foundation's (MeHAF) Barrier Study
Neil Korsen informed the group that in June MeHAF accepted a proposal from Muskie and MMC to complete this study. However, some modifications needed to be made to the proposal, and the final contract went out within the last two weeks. Work on the study will begin within the next two weeks. The study will focus on changes needed in the current regulatory/reimbursement climate to promote integration. A committee has met monthly for almost a year to catalog the current rules. Barriers have been identified and preliminary results outlined in this report. The report will also include an environmental scan and reports from other states on integration efforts. John Gale and David Lambert are the leads from Muskie on the project.

Dr. Freeman asked if the report would be available by December, which is when the LD 792 Workgroup report is due. Dr. Korsen said he thought a preliminary draft, or some data, might be available by then.

What's Working: a report from group participants
Wendelanne Augunas, Women and Family Health Coordinator, Penobscot Bay Medical Center/Ob/GYN Associates
Ms. Augunas runs a weekly support group for mothers with new babies. All mothers discharged from Pen Bay go home with a flier on the group. Women enter the program sometimes right after the birth of a child or it could be one-10 months down the road. The program was originally funded through a grant and is now funded by the hospital. Parent education is provided through the Healthy Maine Partnerships. Ms. Augunas said that she tries to work with pediatricians on PPD issues as many depressed mothers won't stay in touch with other professionals, but will faithfully bring their children in for well-child visits.

What Works:

- Hospital system support for mental health professionals to run a group for mothers with no fee required, also for mental health professional role as ombudsman, linking moms to service.

- Ability of the mental health ombudsperson to link to community programs that are at least partially funded through DHHS Public Health: public health nursing, first-time visiting moms program, parent educators.

- Access to screening and referral via the obstetrician and/or child's doctors as this age woman may not seek regular general medical care for herself.

Barriers:

- Ms. Augunas said that she also sees internalized stigma as a barrier for the treatment of PPD.

Sue Bouchard, Fish River Rural Health, Eagle Lake, Maine

Ms. Bouchard gave an overview of integration efforts at Fish River. Fish River, as an FQHC, participates in Health Disparities Collaboratives around diabetes, cardiovascular disease, and depression. Of the three, the Depression Collaborative has the largest team. All of the Collaboratives are organized around framework of the Care Model.

Fish River also has a Perinatal Program open to moms-to-be and parents of children up to 2 years of age and offers its Healthy Families Aroostook program to children five years of age or younger. Fish River also has counselors from Aroostook Mental Health Center on site, participates in the Women's Behavioral Health project and has community members on its board of directors. In addition, a survivor of postpartum depression participates on Fish River's Health Disparities Collaborative team. Fish River has also developed a "Baby, Body and Me" program for mothers that focuses on support to mothers and offers information on child rearing, nutrition and exercise for moms, and stress reduction. The group meets quarterly.

The Perinatal Program uses the PHQ9 to screen all members in the first trimester and then again 4-8 weeks postpartum. If a woman scores 10 or greater, the perinatal caseworker immediately notifies the provider. If the score is less then 10, the caseworker waits for the case conference to provide the information. Fish River's perinatal program population is about 70 to 80 clients.

Providers also screen with the PHQ9 (targeted screening). If the initial score is 10 or greater, the patient is screened every 4-6 weeks, then in 6 months, then in one year, and then every six months thereafter or sooner if necessary. Male and female patients are both screened. Through its participation in the Women's Behavioral Health Collaborative, Fish River also screens women of reproductive age, 14-44, for substance abuse and depression. Fish River plans to start screening its chronic care patients for depression, starting with cardiovascular disease and diabetes.

Dr. Korsen asked if through its participation in the national Health Disparities Collaborative, Fish River had received any pushback from not using the Edinburgh Screen. Ms. Bouchard said that she was not familiar with this screen and that the national registry is PHQ9 driven.

Dr. Korsen also asked how the perinatal caseworkers were funded. Ms. Bouchard said that they were funded in part by Healthy Families/Aroostook and in part from HRSA funding. The Perinatal Program uses a home-based, parent-education model. Home educators visit families; provide encouragement and expertise, answer questions and link to resources.

What Works

Regarding opportunities, Ms. Bouchard identified strengths as:

- Co-location of mental health and health care
- Counselors with short-term availability
- Opportunity for step model of care, offering short-term treatment within primary care and referring out to specialty care only for select cases
- Community participation: collaboration with local Healthy Maine Partnerships, funding of perinatal workers through the HMP
- Engagement of the FQHC in the implementation of the Care Planning Model for depression, e.g. registry of persons with depression allowing FQHC to keep track of those struggling with depression
- Technical support from the Health Disparities Collaborative Training Program for staff on the Care Planning model in general, and the use of the PHQ-9 for screening, and treatment options for depression within primary care
- Federal grant support
- Reimbursement strategies that support integration of mental health into primary care.

Barriers

One barrier is having patients return to the health center to be screened again for depression. Fish River has recently revamped its reminder letter so that the word "depression" does not appear in it.

Dr. Elsie Freeman, Medical Director, DHHS

Dr. Freeman said that DHHS, the Maine CDC, and other programs are discussing using a universal screening instrument in various service settings.

Dr. Freeman said that a review of the most recent BRFSS data indicates that poorly educated, low income, younger women have the highest prevalence rates for depression showing that depression is not just an issue in the postpartum period but is an issue for younger women in general.

BRFSS data also showed that women of reproductive age with children have lower rates of depression (9.6 %) than women of reproductive age without children (11.9%). Given the small numbers involved in this initial BRFSS survey, the difference between women with and without children may not be significant, but a multi-year analysis of the BRFSS data should provide sufficient numbers to show whether women with children do better than women without.

BRFSS data also shows that fathers in the same age group (18-44) have a prevalence of depression (8.2 percent) that is lower than that for mothers, but is still highly significant.

These data suggest the importance of screening parents, mothers and fathers, for depression (and presumably other common behavioral health issues), not only during the postpartum period, but also at regular intervals in a child's formative years.

Dr. Korsen said that many young people, unless they have a chronic condition, aren't visiting doctors regularly for their own care, although they are bringing their children in for regular visits. Ms. Augunas said that her program also looks to engage fathers.

Dr. Neil Korsen, Associate Director, Center for Outcomes Research & Evaluation, Maine Medical Center

Dr. Korsen said that he has 20 years of experience as a family physician. Five years ago, he was the lead investigator for MaineHealth on a MacArthur-funded project on the Chronic Care Model and depression diagnoses. The project involved 10 practices in Maine in a randomized trial that compared a collaborative care approach to depression to usual care.

Dr. Korsen also led a program piloted at 20 practices over three years, which used the Learning Collaborative Model to implement new approaches in practices. This was funded by a Robert Wood Johnson grant.

Through the Maine Health System, Dr. Korsen worked with primary care practices affiliated with Maine Medical Center, Miles Hospital, St. Andrews Hospital, and Stephens Memorial Hospital on a broad-based dissemination of the PHQ9 and other components of the depression care model.

Dr. Korsen is also working on a MeHAF grant at two pediatric practices and four family medicine practices in Maine to pilot test a model of mental health integration. The project focuses on a set of assessments for common mental health conditions such as substance abuse, bipolar and depression; on who needs medication for these conditions, on the appropriate level of care to meet the family's needs, on co-location and integration of mental health specialists into the primary care practice, brief interventions and periodic re-assessments. Dr. Korsen is hoping for additional funding so that the project could expand to an additional 12-16 practices.

Within the Maine Medical Center Physician Hospital Organization (MMC PHO), Dr. Korsen has trained 80 percent of the 150 adult primary care practices on the PHQ9.

Dr. Freeman asked what resources the MMC PHO has devoted to this training; Dr. Korsen said that while the mental health integration work is grant funded, two family practice doctors help with outreach at 4 hours per week; Dr. Korsen contributes 8 hours per week; a project manager is at 16 hours per week; and an administrative assistant at 8 hours per week.

What Works

- Care Planning Model
- External funding support for start up, implementation

- Learning Collaborative model for workforce development and practice change
- Hospital support for development of staff and infrastructure to support integration of depression into health care as a quality improvement project
- Technical support that is uniform across various funders and that uses nationally validated tools, e.g., RWJ, MacArthur and MeHAF all supporting use of PHQ-9.

Other
Dr. Korsen said that the **National Committee on Quality Assurance (NCQA**) recently met to discuss quality measures for depression care. The group is recommending use of the PHQ9 with others accepted; however, the over all push is to eventually mandate the PHQ9. The NCQA develops measures of quality for health plans and has also recently started to develop them for providers. The NCQA's mission is to transform health care quality through measurement, transparency, and accountability. Entities are then certified for diabetes or cardiovascular care regarding their outcome measures.

Dr. Freeman asked if there were **barriers to the use of other screening instruments**, like the Beck, Hamilton, Edinburgh, in terms of cost/licensing. Re the PHQ9 and PHQ2, the Pfizer copyright is on it and authorizes free use for clinical purposes. The question would be what restrictions may apply if used outside of clinical settings, e.g. in Maine DHHS programs that serve women of child-bearing age.

Dr. Freeman asked if The **AAFP** has developed recommendations re depression screening; Dr. Korsen said he hasn't heard of any. The Preventive Services Taskforce has recommended that adults be screened for depression, but only if the recommended care is in place so that the system can appropriately respond.

Diabetes Association: recommended screening all diabetics for common emotional disorders.

Patient and Family Advisory Council to the MaineHealth depression and mental health integration programs meets quarterly.

Next Steps
Dr. Freeman and Anne Conners of the Muskie School will work on an outline of integration/depression/postpartum efforts, screens, and recommendations for review by Subcommittee members.

Adjourn
The meeting adjourned at 4:15 p.m.

LD 792
Postpartum Depression Workgroup
Other States Meeting
September 24, 2007
10:00 Am-Noon
Maine CDC Offices
Room 6B, 1st Floor, Key Bank Plaza

MEETING MINUTES

Present: Elise Freeman, Adult Mental Health Services, DHHS; Sharon Leahy-Lind, Div. of Family Health, ME CDC, DHHS; Erika Lichter, MCH Epidemiologist, ME CDC, DHHS

I. Revisit Purpose & Responsibility of the Other States Subgroup

Participants revisited the legislative language of LD 792 and purpose for the Other States Subgroup.

II. Review Information Compiled on Postpartum Efforts in Other States

Sharon Leahy-Lind provided participants with a copy of a matrix containing information on the four states identified in the legislation as well as information compiled on a total of 21 states nationally (*matrix attached*).

Sharon placed a request on the National States Women's Health listserv for information on postpartum program information from every state. She asked contacts in other states to provide information on whether or not there were PPD program in their states, where or in which state department the program was located, how the effort was funded and if it was legislatively created and funded, what tools were generated by the program or project, and asked for an outline of implementation strategies and state contact information. Several states responded to this request.

Participants reviewed the information organized and compiled on the 21 states that responded. The following key points were observed during the review of this information:

- **There are approximately 3 states nationally identified to date that have legislation passed for PPD efforts or programs.**

- **A vast majority of states have not pursued the legislative route for PPD efforts and programs.**

- **Approximately 3-5 states nationally have state dollars for their programs. Of those, 3 are the states with legislative initiatives as well.**

- **A majority of states with PPD programs are located in State Health Departments and have created PPD programs using one time (1-2 years) of federal funding from MCHB and HRSA/DHHS.**

- **These efforts or programs in other states that are using largely limited one-time federal dollars typically have a local focus and are more pilot by structure instead of creation of established practices with sustainable activities.**

- **Efforts across the country ranged from a $7,000 privately funded awareness effort (posters on buses) in Indiana to the comprehensive statewide mandated training and screening program in New Jersey that was legislatively created and funded with a $4.5 million fiscal note.**

- **There a several shoestring type efforts where the project is usually local and limited and the approach is mostly ad campaigns and brochures.**

Additional Research Required on Four Select States

Participants agreed that additional research should focus on the four states identified by the legislation plus an additional state with legislation that is also using state general fund dollars. The governing question for this research should be *What has been done and what does it cost to do it right*? As the LD792 workgroup moves forward it is important to know the amount of resources that are needed to do this work. To accomplish this task, participants also discerned additional categories that the subgroup needed information on that were either related to the infrastructure, capacity, or number of full-time or part-time dedicated staff need for this work. *The categories were defined as:*

- *Funding Source & Amount: federal, state, local, private*
- *Products Developed: awareness campaign, web site, brochures, hotline, provider training, videos, CMEs awarded*
- *Additional Resources: # of dedicated staff, qualifications of dedicated staff.*
- *Other Elements: surveillance plan or evaluation component*

ACTION: Sharon Leahy-Lind will design a checklist table that can be used for gathering this additional information while interviewing contacts in the four select states.

ACTION: Participants volunteered to share in the responsibility for calling the other states and collecting this information.

Elise Freeman will contact New York City
Erika Lichter will contact New Jersey and Illinois

Sharon Leahy-Lind will contact West Virginia and Washington state.

III. Next Steps

Once the additional information is organized and compiled, a draft of key points and information on what states are attempting to do and what it costs to pursue those efforts will be prepared for the larger workgroup.

Attending members will continue to work toward this end via email communication.

Screening & Treatment Subcommittee

MINUTES

Date: __7/23/07_____

Location: Dr. Lynn Ouellette's office – 153 Park Row, Brunswick, Maine

Present: Lynn Ouellette, Martha Barry, Valli Geiger, Wendleann Agunas
Absent:
Note Taker: Valli Geiger

Item	Discussion	Decision/Action	Who's Responsible	Date Due
Screening Tools – Which Tool	Discussed PHQ-9 versus Edinburgh PPD Scale – differences/similarities. Advantage of PHQ-9 in general practices is that it is already being used for general patients, with an office process in place. Each is available for free, each takes 3-5 minutes.	Recommend to larger group use of either tool.	Subcommittee will report back to larger group in Sept.	9/17
Screen Tool – When	Discussion about when the screening tool should be used. Evidence that 50 of women with PPD are depressed during pregnancy – need for assessment during each trimester, 1st trimester rather than a tool, a good patient history including history of past or family depression	20 weeks antepartum, 36 weeks antepartum, 4-6 weeks postpartum, High risk patient – 2 & 6 weeks, 3 mos, 6 mos, 9 mos – Well baby checks	Subcommittee will report back to larger group in Sept.	9/17
Screening Tool - By Who	PHQ-9 –evidence out there that results are more accurate if mom fills out in waiting room or treatment room. Can be scored by MA and given to PCP before PCP visit time begins	Up to practices to decide how to incorporate in to practice with suggestions	Recommendations be added to final report & Screening & Treatment Protocol	9/17
Assessment Questions if Screening Tool is +	Discussion on protocol development, if + screen what then? Must further assess for level of depression (mild, moderate, severe), assess for suicidality, assess for psychosis	Develop 4-8 additional screening questions	Lynn Ouellette	8/6
Treatment	To be discussed at the 8/6/07 meeting	Develop treatment protocol with decision tree	Subcommittee building on work of mededppd.org	8/6
Other –	Discussed strategy around recommendations to legislature, Martha Barry discussed Ill. Approach to legislative change.	Obtain statistics on number of births/year and number of MCD births/year in Maine	Martha Barry	8/6
Other -	Discussed need for information about language/cultural sensitivity of PHQ-9	What languages is PHQ-9 available in	Valli Geiger	8/6

Draft

P.
Lynn Ouellette M.D.

September 30, 2007

LD792 Screening and Treatment Subcommittee

TREATMENT OF PERINATAL MOOD DISORDERS

Treatment providers including, but not exclusively, pediatricians, obstetricians, and family practitioners are in a vital position to provide treatment and screening of women for depression during pregnancy and in the postpartum period. In order to do this, they need to have an understanding of the illness, familiarity with the appropriate screening tools and guidelines for their use. In fact, publications in the journals of the AAP, ACOG and AAFP have recommended that depression screening be part of routine perinatal care of mothers and their infants.

Inclusion of the woman's spouse or partner is a vital part of care. Both should be provided with prenatal education about perinatal mood disorders. This both diminishes stigma and increases the likelihood of acceptable treatment intervention. Screening for domestic partner violence prior to inclusion is recommended.

Approximately 15% of women experience significant depression during pregnancy. Untreated depression during pregnancy presents serious health risks for mothers and infants. Depression during pregnancy is the strongest predictor of postpartum depression.

Postpartum depression and anxiety disorders occur immediately up to a year after birth in approximately 15% of women. Children of mothers with postpartum depression are at risk for poor growth as well as attachment, cognitive and behavioral disturbances. The suicide rate is increased 70 fold with postpartum depression necessitating assessment of suicidality as part of every screening for postpartum depression. Delay in diagnosis is the biggest contributing factor to the length of postpartum depression

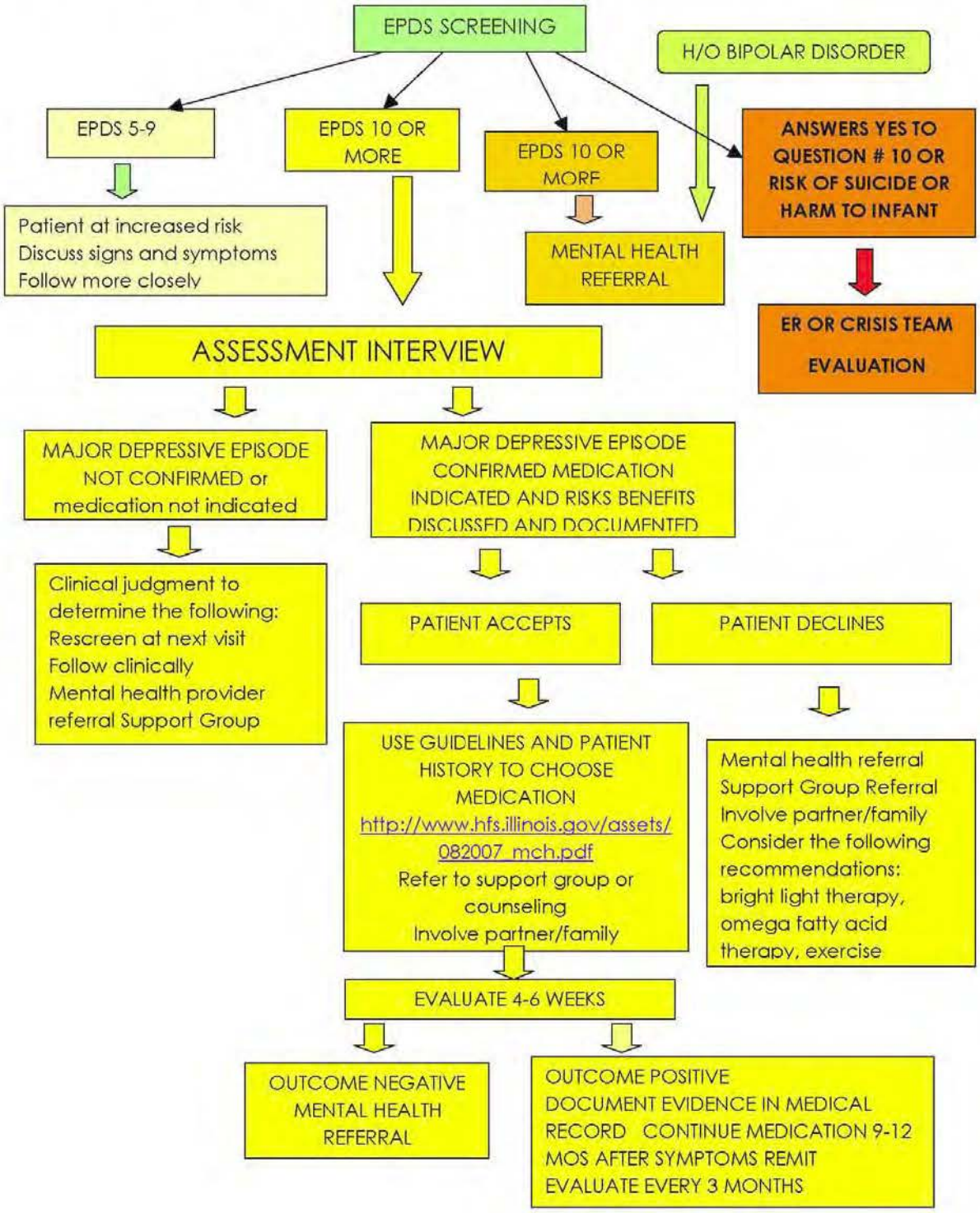
Practitioners also will need to have guidelines to interpret the results of the screening tools and to provide treatment for women who are assessed as suffering from perinatal mood disorders.

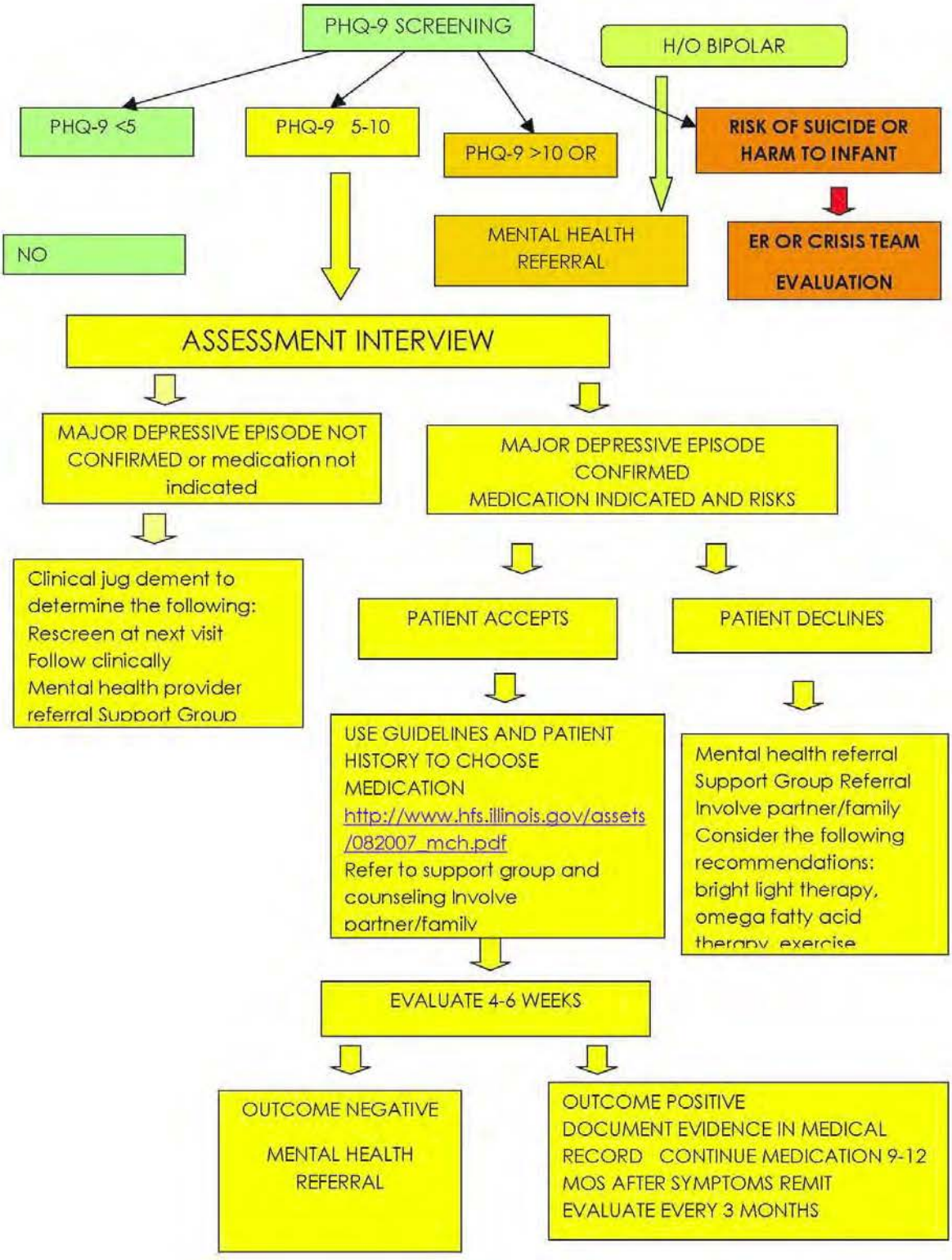
Recommendations for Treating Perinatal Mood Disorders

Algorithms for treatment based on scoring by the EPDS and PHQ-9 follow in the subsequent pages.

MDD is Major Depressive Episode according to standard DSM-IV criteria.

See enclosed attachment from http://www.hfs.illinois.gov/assets/082007_mch.pdf for medication safety data




PHQ-9 SCREENING
H/O BIPOLAR
PHQ-9 <5
PHQ-9 5-10
PHQ-9 >10 OR
RISK OF SUICIDE OR HARM TO INFANT
NO
MENTAL HEALTH REFERRAL
ER OR CRISIS TEAM EVALUATION
ASSESSMENT INTERVIEW
MAJOR DEPRESSIVE EPISODE NOT CONFIRMED or medication not indicated
MAJOR DEPRESSIVE EPISODE CONFIRMED MEDICATION INDICATED AND RISKS
Clinical jug dement to determine the following: Rescreen at next visit Follow clinically Mental health provider referral Support Group
PATIENT ACCEPTS
PATIENT DECLINES
USE GUIDELINES AND PATIENT HISTORY TO CHOOSE MEDICATION http://www.hfs.illinois.gov/assets/082007_mch.pdf Refer to support group and counseling Involve partner/family
Mental health referral Support Group Referral Involve partner/family Consider the following recommendations: bright light therapy, omega fatty acid therapy, exercise
EVALUATE 4-6 WEEKS
OUTCOME NEGATIVE MENTAL HEALTH REFERRAL
OUTCOME POSITIVE DOCUMENT EVIDENCE IN MEDICAL RECORD CONTINUE MEDICATION 9-12 MOS AFTER SYMPTOMS REMIT EVALUATE EVERY 3 MONTHS

SUMMARY OF TREATMENT RECCOMENDATIONS

PRENATAL DEPRESSION:

Mild to moderate depression may respond to non pharmacologic intervention such as cognitive behavioral therapy, interpersonal therapy.

Women with a history of bipolar disorder are at very high risk of recurrent illness and should be followed by a mental health professional. Some women who have a history of depression or develop depression during the perinatal period may have an underlying and previously undiagnosed bipolar disorder. In these women, treatment with antidepressants can precipitate mania and the clinician should be alert to this possibility. Prenatal screening for the possibility of past manic or hypomanic episodes or a family history of bipolar disorder is recommended

Pharmacologic treatments for depression during pregnancy carry overall small risks and need to be considered for moderate to severe depression taking into account the individual psychiatric history, the risks and benefits of untreated depression during pregnancy and the risk of fetal exposure to antidepressants. Antidepressant treatment should be guided by established safety data for use in pregnancy (www.hfsillinois.com/mch/medchart.html . The antidepressant that should be considered first is the one to which the woman has had a therapeutic response in the past unless that is contraindicated in pregnancy. SSRIs are the most commonly prescribed antidepressants for depression during pregnancy. There is the most relative safety data for fluoxetine (Prozac) first, followed by sertraline (Zoloft) and citalopram/escitalopram (Celexa/Lexapro). Tricyclic antidepressants also have established safety data with nortriptyline and desiprimine having the most favorable side effect profiles. When considering pharmacologic treatment of depression during pregnancy discussion of both the risks of untreated depression during pregnancy and fetal antidepressant exposure should be part of the informed consent process

POSTPARTUM DEPRESSION:

Mild to moderate postpartum depression may respond to non pharmacologic intervention such as psychosocial, interpersonal, cognitive-behavioral therapy and group therapy. These women should be followed closely for worsening of symptoms.

Postpartum psychosis is considered a psychiatric emergency and is associated with a significant risk of infanticide.

Women with bipolar disorder are at highest risk for recurrent illness and for postpartum psychosis and should be followed by a mental health professional. Some women who have a history of depression or develop depression during the perinatal period may have an underlying and previously undiagnosed bipolar disorder. In these women, treatment with antidepressants can precipitate mania and the clinician should be alert to this possibility. Prenatal screening for the possibility of past manic or hypomanic episodes or a family history of bipolar disorder is recommended.

The use of antidepressant in lactating mothers is associated with overall minimal risks to the breastfed infant and needs to be considered in the case of moderate to severe postpartum depression taking into account the individual history and the risks and benefits of medication treatment. In light of the available data, the benefits of breastfeeding are powerful in the face of the risks, but these need to be discussed with mothers. The first antidepressant that should be considered is the one to which a woman has had a favorable response in the past. The choice of an antidepressant should be guided by established safety data (www.hfsillinois.com/mch/medchart.html). SSRIs are the most commonly prescribed antidepressants for postpartum depression. All are secreted into breast milk but reports of adverse effects are rare.Exposure for the infant is lowest for sertraline (Zoloft), somewhat higher for paroxetine (Paxil), highest with citalopram (Celexa) and fluoxetine (Prozac). Given the current knowledge, none of the SSRIs are contraindicated during breastfeeding, but there may be some risk of accumulating fluoxetine because of its long half life and celexa has higher levels of secretion into breast milk so these medications need to be used with more caution. Premature infants, because of their immature hepatic metabolism require more caution when considering possible exposure to antidepressants through breast milk. Given the current state of knowledge, there is no rationale for switching from one antidepressant effectively used during pregnancy to another during the postpartum period to promote safety during breastfeeding, particularly since exposure in utero is higher than that during breastfeeding. Such a strategy unnecessarily exposes the mother to the risk of worsening postpartum depression by changing to an antidepressant which may not be effective.

Helpful Resources for Screening and Treatment of Perinatal Mood Disorders:

www.mededppd.org

9 CME modules on postpartum depression

http://www.mededppd.org/care_pathways.asp detailed explanation of screening and treatment decision tree

Up to date guidelines on the use of antidepressants during pregnancy and lactation

www.womensmentalhealth.org MGH Perinatal Psychiatry Program website- a resource for professionals and patients

Helpful resources for women and families:

www.pospartum.net Postpartum Support International

http://mchb.hrsa.gov/pregnancyandbeyond/depression/morethanblues.htm U.S. Department of Health and Human Resources, Health Resources and Services Administration, information on perinatal mood disorders

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The Use of Electroconvulsive Therapy in Postpartum Affective Disorders. Forray A, Ostroff RB.
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Information for Physicians on Prescription Products to Treat Perinatal Depression - August 2007
Treatment decisions should be based on patient characteristics and clinical judgment.
For questions, call the UIC Perinatal Mental Health Project at **1-800-573-6121**

Anti-depressants	Advantages During Pregnancy	Disadvantages During Pregnancy	Estimated % of Maternal Dose to Breastfeeding Baby**	Reported Side Effects to Breastfeeding Babies***	Teratogenicity
Bupropion (**Wellbutrin**®)	• No sexual side effects • No excess weight gain • Helps with smoking cessation	• Limited data available • No behavioral studies in human pregnancy • Lowers seizure threshold • Can cause insomnia • May increase risk of miscarriage	2%	Seizures	Morphologic - none found Behavioral - unknown
Citalopram (**Celexa**®)	• Few interactions with other medications	• Limited data available • No behavioral studies in human pregnancy	0.7% -9.0%	Uneasy sleep, drowsiness, irritability, weight loss	Morphologic - none found Behavioral - unknown
Desipramine (**Norpramin**®)	• More studies in human pregnancy, including neurodevelopmental follow-up	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthostatic hypotension, risking decreased placental perfusion • Fetal and neonatal side effects: tachycardia, urinary retention	1.0%	None	None found
Duloxetine (**Cymbalta**®)	• Also treats diabetic peripheral neuropathic pain • Balanced antidepressant; may be effective when selective agents are not	• No systematic studies in human pregnancy	Unknown	Unknown	Unknown
Escitalopram (**Lexapro**®)	• Few interactions with other medications	• No systematic studies in human pregnancy	3.9% - 7.9%	Enterocolitis	Unknown
Fluoxetine (**Prozac**®)	• More studies in human pregnancy, including meta-analysis and neurodevelopmental follow-up	• More reports of neonatal side effects than some other antidepressants	1.2% - 12.0%	Excessive crying, irritability, vomiting, watery stools, difficulty sleeping, tremor, somnolence, hypotonia, decreased weight gain, hyperglycemia	None found
Mirtazapine (**Remeron**®)	• No sexual side effects • Helps restore appetite in women who are not gaining weight • Less likely to exacerbate nausea and vomiting	• Limited data available • No behavioral studies in human pregnancy • Can cause excessive weight gain • Tends to be sedating • May increase risk of preterm birth	0.6% - 2.8%	None	Morphologic - none found Behavioral - unknown
Nortriptyline (**Pamelor**®)	• More studies in human pregnancy, including neurodevelopmental follow-up • Balanced antidepressant; may be effective when selective agents are not	• Maternal side effects additive to pregnancy effects (sedation, constipation, tachycardia) • Orthostatic hypotension, risking decreased placental perfusion • Fetal and neonatal side effects: tachycardia, urinary retention	1.3%	None	None found
Paroxetine (**Paxil**®)	• None	• No behavioral studies in human pregnancy • Specific association with cardiovascular malformations • More reports of neonatal side effects than most other antidepressants	0.1% -4.3%	Irritability, sleepiness, constipation, SIADH	Morphologic - Possible increased risk of cardio vascular malformations Behavioral - unknown
Sertraline (**Zoloft**®)	• Relatively well-studied in human pregnancy • Fewer reports of neonatal side effects than other antidepressants	• Possible specific association with omphalocele and septal defects*	0.4% -2.3%	Benign sleep myoclonus, agitation	Morphologic - possible increased risk of omphalocele and septal defects Behavioral - none found
Venlafaxine (**Effexor**®)	• Balanced antidepressant; may be effective when selective agents are not	• Limited data available • No behavioral studies in human pregnancy	5.2% -7.6%	Decreased weight gain	Morphologic - none found Behavioral - unknown

* Absolute risk is small ** These are weight-adjusted estimates that include the agent and its active metabolites. *** Reported side effects in breast feeding infants are based on case reports and case series.

Physicians may consider initiating treatment with these agents at half of the lowest recommended therapeutic dose. Treatment decisions should be based on patient characteristics and clinical judgment. Recommended dosages can be found in the Physician's Desk Reference, 60th ed. Table based on Wisner et al Postpartum Depression Article in N Eng J Med, Vol. 347, No. 3, July 18, 2002, pg. 196 and related articles. For other references, call the UIC Perinatal Mental Health Project at 1-800-573-6121.

General notes:

- Risks of antidepressants during pregnancy and lactation must be weighed against risks of untreated symptoms and treatment needs to be individualized.
- All antidepressants, if abruptly discontinued during pregnancy or at the time of birth, can lead to discontinuation side effects in the fetus or neonate. These signs can include respiratory distress, excessive crying, changes in sleep and behavioral state, difficulty feeding, increased or decreased tone, hyperreflexia, seizures or cardiac arrhythmias. Discontinuation side effects can be minimized by a partial dose taper during the last month of pregnancy, if the patient is asymptomatic, with a return to full dose after delivery to prevent postpartum recurrence.

All SSRI antidepressants (citalopram, escitalopram, fluoxetine, paroxetine, sertraline) may be associated with the following risks: possible increased risk of miscarriage, gestational age decreased by an average of 1 week, possible increased risk of persistent pulmonary hypertension in the newborn with exposure after 20 weeks gestation, although no teratogenicity has been found in prospective, controlled studies or meta-analyses, one case-control study found a possible increased risk of anencephaly, craniosynostosis and omphalocele, and a retrospective prescription events monitoring study found an increased risk of anomalies in general; absolute risks were small.

- Medications vary in the amount and quality of data available about effects in human pregnancy. A better-studied medication may have more reported side effects than a less-studied medication because more is known about it, not necessarily because it is riskier.
- Data presented here are based on studies during human pregnancy. The Food and Drug Administration's Pregnancy Risk Categories, as found in the Physician's Desk Reference, are based on a combination of animal and human studies.

INFORMATION ON PERINATAL SUPPORT SERVICES IN MAINE

The Screening and Treatment Subcommittee of the LD 792 Workgroup collected the following information about hospital protocols and support services around PPD. The survey is intended to be informational in nature and may not reflect every program and service in the state.

Acadia Hospital, 268 Stillwater Avenue, Bangor

Prenatal Therapy Support Group available for all pregnant mothers and for those who have recently delivered. Facilitated peer support group offered for new mothers. Infant massage instruction offered at the Well Child Clinic to assist with attachment without use of medication.

Blue Hill Memorial Hospital, 57 Water Street, Blue Hill

No formal PPD materials have been developed or are available. Requested a copy of the Perinatal Mental Health Alliance's brochure to use as a handout. Conduct telephone follow up calls with new mothers and ask how she is feeling and doing emotionally.

Bridgton Hospital, 10 Hospital Drive, Bridgton

Hospital meets with all mothers at 28 weeks for prenatal screening. Review history of depression. Discharge instructions cover PPD and baby blues.

Down East Community Hospital, Court Street, Machias

A "New Mother Handbook" is distributed, which discusses the difference between blues and depression. PPD is also discussed with patients and a PPD handout is given out at discharge.

Maine Medical Center, 22 Bramhall Street, Portland

Thirty-minute discharge class includes information of PPD; including postpartum blues, signs and symptoms of PPD, effect on family functioning and child development. Distribute HRSA booklet, "Depression During and After Pregnancy." After patient is discharged hospital conducts follow up phone calls to determine how families and mothers are doing. Women with signs of PPD are encouraged to notify their physician and call an RN. Continued follow up calls are made to women with positive symptoms of PPD.

Mayo Regional Hospital, 897 West Main Street, Dover-Foxcroft

Mothers are assessed and classified as low, moderate, or high risk for PPD and then treatment is per risk factor. Patients with high risk factors are referred to the hospital's mental health department for assessment while in-patient. The prenatal/delivering provider is notified of the risk in order to discharge the mother with appropriate medications if indicated. All mothers receive written PPD information as well as the HRSA handbook, "Depression During and After Delivery." All mothers receive a follow-up phone call from a nurse in OB within the

first two weeks of delivery. Mothers who qualify for the services of PATT or a Public Health home nurse then also have those referrals made.

Mid Coast Hospital, 123 Medical Center Drive, Brunswick

Postpartum Depression Support Program educates the local health care community about PPD, encourages screening for PPD by health care providers, develops educational materials for women in the perinatal period, maintains a referral network of mental health providers educated about PPD. A psychiatrist is available to support obstetricians in treating women with depression both during their pregnancies and postpartum.

Miles Memorial Hospital, 35 Miles Street, Damariscotta

PPD signs and symptoms are reviewed during prenatal education and the postpartum discharge. During each trimester, each OB patient has three private, one-hour educational sessions with an OB nurse. PPD is discussed during the third trimester visit. All patients are seen two to three days after discharge and depression and emotional issues are reviewed. PPD is discussed by the midwife and physician at 2 and 6 weeks postpartum.

Parkview Adventist Medical Center, 329 Maine Street, Brunswick

Discharge instructions list symptoms of PPD and direct patients to contact their obstetrician if they experience any symptoms. Verbal discussion of the signs and symptoms of PPD before discharge.

Southern Maine Medical Center, One Medical Center Drive, Biddeford

"Feeling Better After Birth" pamphlet distributed at discharge as well as information on the postpartum Depression Support Group offered at the hospital's Birthing Suite. Home visits the first two weeks after delivery are offered to all mothers. Hospital is currently working on a prototype for a Perinatal Mood Disorder packet for distribution upon discharge.

LD792 Postpartum Depression
Programs in Other States

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
New York	Pending legislation that mandates postpartum screening for all new mothers and calls for educational/informational programs about PPD for new moms, dads and other family members as they leave the hospital.			
Illinois	Bill pending- asks that they (doctors and nurse practitioners) do the screening because they see the early stages of the illness . And if diagnosed, women should be referred to a psychiatrist so they can seek the proper care much earlier in their pregnancy or early in the post-natal period		Creates the Postpartum Mood Disorders Prevention Act. The Director of Public Health, in conjunction with the Department of Financial and Professional Regulation and the Board of Nursing, shall work with physicians, healthcare facilities, nurses, and licensed health care workers in the State to develop policies and procedures related to the prevention, treatment, and diagnosis of postpartum mood disorders in women.	
New Jersey	A bill (S 213) signed into law in April 2006 requires health care providers to screen women who recently have given birth for postpartum depression and teach women and their families about the condition.	http://www.state.nj.us/health/fhs/ppd/ There is an educational webinar for providers, screening tool, patient brochures and posters.	The law, which provides $4.5 million in funding for education and screening, also requires providers to ask pregnant women about their history of depression or postpartum depression before they give birth. In addition, the state Department of Health and Senior Services has created a hotline and produced a brochure, called "Speak Up When You're Down," and a five-minute video for all interactive televisions in patient rooms. Offers Free mental health screenings and treatment to uninsured and underinsured new mothers. Uninsured and underinsured new mothers would be referred to existing community behavioral health agencies for assessment and each would be eligible to receive mental health treatment. Provide funding to DHSS for a medical education campaign for physicians, mid-level practitioners and nurses designed to recognize the signs and symptoms of PPD. The educational campaign would enable the DHSS to work with nurses, mid-level practitioners and physician organizations to develop a program to enhance the education of medical providers regarding PPD.	Legislation passed. The law, provides $4.5 million in funding for education and screening
New Hampshire				

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
Alaska	Northwest Bulletin issue on postpartum depression and includes reports from several states, including Yvonne's report on Alaska. Link address below depts.washington.edu/nwbfch/PDFs/NWBv21n2.pdf		The Children's Hospital at Providence is integrally involved in Postpartum Support Alaska. Part of the funds to support the project come from Children's Miracle Network through Providence and the coordinator is employed by and housed at Providence.	Partial Children's Miracle Network Contact: Debbie Golden, RN, BC, MS Perinatal Nurse Consultant *My new email address is debra.golden@alaska.gov* State of Alaska Division of Public Health Section of Women's, Children's and Family Health 4701 Business Park Blvd. Building J, Suite 20 Anchorage, AK 99503 phone: (907) 334-4494 fax: (907) 269-3432 email: Debbie_Golden@health.state.ak.us
Arizona	No PPD program at the state level Consumer requesting information and resources are referred to Postpartum Support International's Arizona chapter			No legislation No funding Contact: Jessica Yanow, M.P.H. Women's Health Coordinator Arizona Department of Health Services 150 N. 18th Avenue, Suite 300 Phoenix, AZ 85007 602.364.1486 yanowj@azdhs.gov
Colorado	Maternal and Child Health (MCH) at the Colorado Department of Public Health and Environment coordinates a coalition that addresses postpartum depression. This group consists of representatives from state and local health departments, Postpartum Support International (PSI), Mental Health America of Colorado, University researchers, community health center staff, social services organizations, other programs that serve women during the postpartum period.	A brochure is currently in development for use in a wide variety of settings that will include local, state and national resources.	MCH is also launching a pilot intervention within three sites of the Medicaid perinatal case management program, Prenatal Plus, starting in October. The intervention consists of the following: 1) mental health professionals within the program identify all available resources for specialized support and/or treatment for postpartum depression, 2) all clients receive increased education regarding postpartum depression throughout pregnancy and immediately postpartum, 3) all clients are screened twice during pregnancy and once postpartum with the Edinburgh Postnatal Depression Scale, and 4) all clients scoring positive are referred to treatment and provided additional program support.. The state program works very closely with The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, which runs a Postpartum Depression Intervention in their center and also works on building systems of care for women with PPD.	No legislation Funded by MCHB Title V Block grant Contact: Virginia Holland, MPH MCH Consultant Women's Health Unit Colorado Dept. of Public Health & Env. PSD-WH-A4 4300 Cherry Creek Drive South Denver, CO 80246-1530 Voice (303) 692-2538 FAX (303) 691-7957 virginia.m.holland@state.co.us

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
Indiana	"Something's Not right" is ... the theme of a statewide postpartum depression awareness campaign.		The phrase "Something's Not Right" will be seen in Fort Wayne bus huts, on signs inside city buses, and on billboards, public service announcements, posters and printed literature, in English and Spanish. A local coalition that includes Neighborhood Health, St. Joe Behavioral Health, the Postpartum Depression Support Group of Lutheran Hospital and Healthier Moms & Babies received a $7,000 grant to develop an awareness and education campaign from the Indiana Perinatal Network, a consortium working to improve the health of pregnant women. A 24/7 hotline will be available for moms and mothers-to-be – and concerned fathers – who want more information on postpartum depression or who recognize help is needed (425-3113).	$7,000 grant Indiana Perinatal Network
Iowa	The Iowa Department of Public Health applied for and received a federal grant from the Heath Resources Services Administration in 2007. The funding period is for two years. Known as the Iowa Perinatal Depression Project (IPDP), the IPDP is a statewide initiative that will benefit all women in Iowa and their families. It's goals include: Increase screening, early identification, and referral or women at risk for perinatal depression (PND); Enhance the network of qualified professional health care providers trained to conduct diagnostic screening and appropriate treatment interventions for PND; and Cultivate an environment of support for women with PND and their families. In addition, the IPDP also acknowledges the effect of PND on the infant during and after pregnancy. Subsequently, Iowa's endeavors to include components that acknowledge the mother and child dyad in relation to PND.	Since the initiation of the grant the IPDP has worked in collaboration with the IDPH on the following initiatives: Including: Train-the-trainer workshops on PND and Maternal Depression Screening Statewide PND speakers bureau Web-based training and evaluation on PND information for doctors and advanced practice nurses. Media campaigns to promote PND awareness Best-practice guidelines for clinicians on screening instruments and treatment protocols for women diagnosed with PN recommendations for Title V providers on best practices for screening	The IPDP is located within the Iowa Department of Public Health(IDPH), and collaborates with the Iowa Depression and Clinical Research Center (IDCRC) of the University of Iowa. Curriculum review of nursing and medical schools to determine the extent that PND and infant mental health is covered in Iowa nursing and medical schools Focus groups to better understand the unique cultural experiences of African American and American Indian women in Iowa Many of these activities were possible because of the collaborative relationship with the University of Iowa. Working with these experts got the IPDP not only off to a good start but far advanced of starting activities alone. U of I has been working in the areas of perinatal depression since 1980, and as partners, the IPDP was able to build on to their existing activities such as the evaluation pieces for the web-based training.	No legislation or state funding. 1 Year Funding from HRSA Contact: JMontgom@idph.state.ia.us

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
Kentucky	Perinatal Depression Initiative aimed at screening all families involved with the HANDS (1st time parent voluntary home visiting program located at the Department for Public Health, Early Childhood Development Branch		Policies and procedures around screening utilizing the Edinburgh Depression Screen and referrals to regional mental health centers	No legislation Funded by HRSA's Perinatal Depression Grant Contact: Joy Hoskins, RN, BA Assistant Division Director Division of Women's Physical and Mental Health Kentucky Department for Public Health Joy.Hoskins@ky.gov
Maryland	1) Maternal Depression Workgroup – multidisciplinary committee(physicians, nurses, social workers, public health providers, Medicaid, etc). This committee grew out of maternal mortality review of suicides in the state. Located at Maryland Medical Society (where maternal mortality review takes place). Survey was completed of ob/gyns and FPs about PPD screening; a packet was sent out to all obs with screening tool and articles; Funded very minimally by maternal mortality review program. 2). Healthy New Moms Campaign 3) Awareness grant from Aetna Insurance, ?$30,000, run by Maryland Medical Society, to help women and physicians find resources for PPD; referral list of providers; presentations at hospitals.	http://www.healthynewmoms.org/ DMH booklet, "About Postpartum Depression" which is made available to all hospitals in Maryland and is translated into Spanish, Korean, Chinese, Vietnamese, French, and Russian.	Maryland's Campaign to End Depression During & After Pregnancy. It's a public information and provider education campaign that promotes mental and physical wellness in new mothers and their families. The campaign features what looks like a very comprehensive and easy-to-use website that is split into four main categories: What Causes Perinatal Depression?, How is Perinatal Depression Treated?, You Will Get Better and Provider Resources. It provides information on support groups in Maryland, and includes some helpful contacts for sufferers with low incomes or no insurance. Mentor lots of students who want to explore the topic of depression among women. One did a policy brief last year at Hopkins.	None of the programs was legislatively created. House Bill 844 in Maryland Legislative Assembly in 2004 was created to educate all mothers about postpartum depression before they left the hospital. The bill didn't pass but it did lead to a strong recommendation from the General Assembly to provide educational materials to mothers before they left the hospital. $250,00-1 year funding from HRSA/MCHB to MD Dept of Health and mental Hygiene as well as $30,000 grant form Aetna Ins. To Maryland Medical Society Contact: Diana Cheng, M.D.Medical Director, Women's Health Maryland Department of Health and Mental Hygiene 201 W. Preston Street, Room 313 Baltimore, MD 21201 Phone: 410-767-6719 Fax: 410-333-5233
Mass	Two-year federal grant to address maternal and infant mental health – this is building on a previous grant from HRSA/MCHB.			No legislation Federal funding Contact:Karin Downs, RN, MPH Bureau of Family and Community Health Massachusetts Department of Public Health 250 Washington Street, 5th Floor Boston, MA 02108 karin.downs@state.ma.us

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
				phone: (617) 624-5967 cell: (617) 833-2911 fax: (617) 624-5990
Minnesota	Postpartum Depression Education legislation was passed during the 2005 Legislative Session. This legislation requires hospitals to provide new parents and other family members, as appropriate, written information about postpartum depression. It also requires providers of health care services to pregnant women to have available information on postpartum depression for pregnant women and their families.	http://www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/index.html PPD Fact Sheets in several languages PPD Brochures PPD Policy & Procedures	The 2005 legislation also required MDH to establish policies and procedures regarding implementation of the legislation.	
Nebraska	The Nebraska Perinatal Depression Project is the only statewide initiative and is located in the NDHHS, Division of Public Health, Lifespan Health Services Unit. The Nebraska DHHS has launched a postpartum depression awareness campaign called Moms Reach Out. The campaign features a website, a toll-free "Healthy Mothers, Healthy Babies" helpline, and downloadable posters and brochures in English and in Spanish.	http://www.hhss.ne.gov/MomsReachOut/index.htm Provider resources include: Website www.dhhs.ne.gov/PerinatalDepression interactive curriculum for continuing education for mental health practitioners, nurses and physicians Toolkit Traveling exhibit Brochures and posters	A steering committee made recommendations to NDHHS for provider education and public awareness. Based on these recommendations, contract deliverables were identified, and two contractors were competitively selected to reach program goals and objectives. Strategies also included statewide focus groups, family interviews, and three community-based programs received subgrants to address project goals.	No legislation. No state funding Nebraska received one time funding from the US Health & Resources Administration, Maternal & Child Health Bureau. The federal funds ended on May 31, 2007, but Nebraska will continue to provide the resources to providers and women with existing MCH/Title V funds.
Ohio	Ohio Department of Health is currently partnering with the Ohio Department of Mental Health in a Maternal Depression Pilot. Request for more information forwarded to Frank Putnam, MD, the coordinator of the Maternal Depression Pilot Project.			
Oregon	PRAMS Analysis Course is going to focus on perinatal depression and the goal is to have a report with recommendations to OFH for a program on the topic. Also have a New Parents Handbook which cover many topics - one page is dedicated to Post-partum depression.			No legislation Contact information Julie McFarlane, MPH Women's Health Program Manager Office of Family Health 800 NE Oregon St Suite 825 Portland, OR 97232 Julie.M.McFarlane@state.or.us phone direct 971-673-0365 fax 971-673-0240

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
Pennsylvania	Program at the DPH, Bureau of Family Health. Perinatal Depression Summit held in June 2007, currently prioritizing projects identified at the Summit. Focus groups with male partners and adult family members to determine the impact of perinatal depression on families and determine appropriate interventions to support fathers and family members. Audio conference training of mental health providers to increase provider knowledge regarding the signs and symptoms of perinatal depression.	Local Service Integration toolkit which identifies resources at the local level. Adopted/Modified Indiana's perinatal depression brochure with Pennsylvania-specific contact information.	Currently under development based on feedback and outcomes from Perinatal Depression Summit. Training sessions in three regions of the Commonwealth aimed at enhancing provider education collaboration at the local level. Development of public awareness campaign aimed at increasing awareness and decreasing stigma.	MCHBG/Title V funds. Contact information: Leslie A. Best, Director Bureau of Health Promotion & Risk Reduction Pennsylvania Department of Health Room 1008, Health & Welfare Building Harrisburg, PA 17120 Phone: (717) 787-6214 Fax: (717) 783-5498 lbest@state.pa.us
Tennessee	Tennessee does not have any specific programs for postpartum depression			Contact Information Margaret.Major@state.tn.us
Texas	Senate Bill (S.B.) 826, 79th Legislature, Regular Session, 2005, directs the Health and Human Services Commission (HHSC) to conduct a study to determine the feasibility and effects of providing 12 months of Medicaid health services to women who are diagnosed with postpartum depression and who are eligible for Medicaid at the time of diagnosis.	http://www.hhsc.state.tx.us/pubs/PostpartumDepressionStudy.html		
Utah	The Reproductive Health Program of State Health Department, in conjunction with Utah's Perinatal Taskforce, a collaborative group of perinatal health stakeholders have been addressing the issue of Postpartum Depression among Utah women for the past several years. Following analysis of Utah PRAMS data coupled with qualitative data captured through focus groups with women who indicated they suffered postpartum depression, the program (under the guidance of the taskforce) has undertaken both provider and public education to raise awareness of the problem in Utah. Educational interventions have focused on the importance of screening pregnant women for depression, validated tools available for screening, the impact of postpartum	Perinatal provider fact sheets, PowerPoint presentation, web-based downloadable Edinburgh screening tool, educational posters targeting pregnant/postpartum women and their families for provider exam rooms and public display. Please see www.health.utah.gov/rhp for examples of materials.	There have been numerous presentations to healthcare providers about this important issue. The posters developed with focus group feedback have been disseminated to prenatal care providers throughout the state for display in exam rooms.	Funding state general funds Contact information: Lois Bloebaum BSN, MPA Manager, Reproductive Health Program Community & Family Health Services Division Utah Department of Health P.O. Box 142001 Salt Lake City, UT 84114-2001 801-538-6792 (office) 801-557-0035 (mobile) 801-538-9409 (fax) lbloebaum@utah.gov

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
	depression of infant/toddler mental health, and the importance of family members support of women with postpartum depression.			
Virginia	Virginia was one of the first states to receive a 1 yr. federal grant to create a web-based curriculum on perinatal depression in 2004. It took about 18 months to design, write and pretest and it was up about that same period of time. We just shut it down when our funding ended due to the launch of NIH's comprehensive new web site on this topic. A 50-person expert panel in creation of this web site, which also helped market it to its members. We had CD's produced of the curriculum for organizations that want to offer it to their members and are in the process of distributing it. We also shared the curriculum with Nebraska, who still has their web site up. A copy of my power point presentation on the project is attached. We don't have a state program on depression per se, but we are working to incorporate screening for depression into maternity guidelines for local health departments, as well as working with our Medicaid dept. to have the managed care organizations they contract with include it as well. Our Healthy Start/Loving Steps and Resource Mothers program screen for depression and we maintain program data on the number of women screened.	Wed-based curriculum A brochure was developed for pregnant and postpartum women for use in the New Parent Toolkit, which is provided to all new parents in the state, but was not part of the grant project. This assists hospitals in meeting a Code requirement to provide postpartum women with information on this condition.		1 Year Federal grant in 2004. Currently no funding or legislation Contact information: Mary Zoller Policy Analyst Mary.Zoller@vdh.virginia.gov
Washington	Postpartum Depression Awareness Campaign Statewide Awareness Campaign. Funds allocated by the legislature were allocated to the Washington Council for the Prevention of Child Abuse and Neglect (WCPCAN) Children's Trust Fund of Washington who had led several other successful public awareness campaigns related to SIDS prevention. A workgroup was formed with membership representing a diverse community	http://www.wcpcan.wa.gov/ppd/home.htm	Washington has launched a new "Speak Up When You're Down" PPD public awareness campaign. It focuses on providing basic information about the signs and symptoms of postpartum mood disorders, offering a toll-free phone number (1-888-404-7763) and a website (www.speakup.wa.gov) for more information. Postpartum Support International of Washington handles the phone line.	2005-$45,000 Fully Funded by Legislature 2007- approx. $90,000 Funded by legislature Contact: **Polly Taylor, CNM, MPH, ARNP** Public Health Nurse Consultant Maternal and Infant Health Washington State Department of Health PO Box 47880

State	Description Programs	Tools	Implementation Strategies & Results	Legislation/ Funding Source
	perspective. Due to the limited funds, permission was received from the New Jersey Department of Health and Senior Services and the Division of Family Health Services to modify materials they had developed for use in Washington State. The name of the campaign is "Speak Up When You're Down" www.speakup.wa.gov The materials have been distributed widely and in the last legislative session the funding was more than doubled to continue the public awareness campaign and expand the partnership with the Washington Chapter of Postpartum Support International(PSI). PSI offers a warm line, referrals for counseling, training for individuals to lead peer support groups and stipends to assist women with costs related to medication, therapy or other support services. This project was well supported by two female legislatures after hearing the tragic story of a man whose wife committed suicide shortly after giving birth. Continued challenges include education of health care providers, adequate screening and additional treatment resources.			Olympia, WA 98504-7880 **Physical Address:** 111 Israel Rd SE Tumwater, WA 98501 '360-236-3563 *polly.taylor@doh.wa.gov **7** 360-586-7868
West Virginia	West Virginia screens pregnant and postpartum women enrolled in the Right From The Start Project (RFTS) at least once during the prenatal period, once within 2 months postpartum and any other time the Edinburgh Postpartum Depression Screening Tool indicates a need. The RFTS Project provides home case management of low-income pregnant women up to sixty days postpartum and Medicaid eligible infants up to age one year. The WVDHHR contracts with agencies statewide who employ registered nurses and licensed social workers to provide in-home care coordination services which includes depression screening and referral to appropriate community resources.	www.wvdhhr.org/rfts		Statewide, legislatively mandated program supported by Title XIX and MCHBG Title V funding Contact information: Jeannie Clark, RN, ASN, BA, BSN Director of Perinatal Programs WVDepartment of Health and Human Resources Bureau For Public Health Office of Maternal, Child & Family Health 350 Capitol Street, Room 427 Charleston, WV 25301-3714 Phone: (304) 558-5388 FAX: (304) 558-7164 email: jeannieclark@wvdhhr.org

Putting Prevention into Practice: Closing the Gap Between What We Know and What We Don't in Women's Healthcare

Essay by Jane Honikman
Founding Director, PSI

Mental illness related to childbearing is one of the most prevalent complications for childbearing women today. The impact it has on a woman and her family can be profound. If left undiagnosed and untreated, it can lead to such tragedies as chronic affective disorders, poor infant-mother bonding, marital discord, divorce, suicide, infanticide, child neglect, and substance abuse. We have learned a great deal about postpartum depression (PPD) and similar disorders since Hippocrates studied it in ancient times, but it remains a challenge to put this knowledge to active use. One way to do this effectively would be to institute regular mental health screening of pregnant and postpartum mothers using a specific tool designed for that purpose.

There are many psychiatric and psychological terms to describe the wide range of emotional reactions that women can have to pregnancy and childbirth. These include "maternity blues," "adjustment," "stress," "depression," "anxiety," "panic," "obsessive/compulsive disorder," "distress," and "psychosis." The distinguishing features of the continuum and spectrum view of postpartum mood and anxiety disorders can range from very mild ("baby blues") to very severe (psychosis), although the distinction between them can become blurred (Pitt 1968; O'Hara 1987; Gruen 1993). Words and phrases such as "euphoria," "sadness," "overwhelmed," "crazy," "losing it," or "concerned" are part of the common language women use to express their emotional states after childbirth. Such a plethora of terminology indicates the complexity of this syndrome, and, in part, explains the confusion surrounding the issue.

The history related to the problem of naming postpartum PPD according to its symptoms or syndrome dates to the American Psychiatric Association's removal of the term "postpartum" in 1952 from the first edition of the Diagnostic and Statistical Manual of Mental Disorders (Hamilton and Parry 1990). It is a sign of practitioners' growing awareness of this problem, however, that the term "postpartum depression" was included in the 1994 DSM IV under "Mood Disorders with a Postpartum Onset Specifier."

The importance of parent self-help support groups received little attention until the 1970s and 1980s, with the beginning of the postpartum consumer movement. This included prevention and treatment issues within the cultural component of social support systems. The fact that scholars from several disciplines now recognize the role of social support suggests that it promotes mental and physical well-being, especially in the face of stressful experiences (Kruckman 1992).

Inspired by the founders of the Marcé Society, the author organized and has been facilitating a community-based, weekly postpartum distress support group since 1987. The support group believes strongly that, "Voluntary organizations can play a very important part in the support of the depressed mother. One of the main contributions voluntary organizations can make is to provide social support for the isolated mother" (Brockington 1992). This weekly group is sponsored by Postpartum Education for Parents (PEP), which began in 1977. It offers general parent support through its "Warm Line." Local public awareness about postpartum mental illness has increased since PEP's inception, but the average attendance at the distress

group meetings has remained low. Women find the group by themselves or are referred to the group by enlightened professionals, family, friends, or the PEP Warm Line.

In 1992, the live-birth rate was 4,084,000 in the United States. About 40% of these mothers experienced mild mood disturbances (the "blues"), 10% had a major depression after delivery, and 0.2% became psychotic (O'Hara 1995). Referrals from the health-care community to the PEP Postpartum Distress Support Group are not uniform or consistent with the expected statistical distress levels, as reflected in the attendance at the support group in Santa Barbara, California. However, as early as the mid-1980s, there was evidence that practitioners' recalcitrance in this area could be on the wane. For instance, one source contained the lukewarm exhortation: "There is a possibility that current American obstetrical practices need reconsideration with regards to preparation for postpartum adaptation" (Affonso and Arizmendi 1986).

Nevertheless, herein lies the source of the problem: the vast majority of these women's physicians are not screening them for birth-related depression and other mental distress. Such screening, especially using a specific tool, may be the most effective way to close the gap between what we know and what we do in this area of women's health care to prevent the potentially devastating effects of postpartum mental illness.

PEP attendees' comments indicate that new parents are not adequately warned during pregnancy about possible mood disturbances prior to and following the birth of their babies. The author's research has addressed the screening practices of health-care practitioners, who are the primary caregivers for a woman during pregnancy and through the first six weeks postpartum (Honikman 1995).

While the intention and current routine practice of maternal health-care providers is apparently to discuss mental-health concerns during pregnancy and postpartum, most professionals do not use a specific screening tool to monitor their patients' well-being. The overall findings of the author's study reveal that the majority of health-care providers are actively concerned to some degree with the mental health of their pregnant and postpartum patients. They do not, however, routinely discuss the major maternal mental-health disorders, either during pregnancy or after the delivery. This lack of involvement with potentially severe emotional reactions may stem from insufficient knowledge, discomfort with the subject matter, or merely being rushed.

Modern health-care practitioners normally screen their patients for a history of premenstrual syndrome, previous personal psychiatric history, and family psychiatric history. They also subjectively evaluate and discuss prenatal and PPD, anxiety, and stressful life events. However, they do not use a standardized questionnaire to identify these factors. This lack of a formal, systematic process increases the potential for poor intervention, treatment, and follow-up care by appropriate mental-health experts. They do refer to psychiatrists, psychologists, counselors, and support groups, which suggests that there is an interdisciplinary, professional team approach in operation.

Any woman who has been identified as high risk requires the support of her partner, according to the research literature. There appears to be a general willingness among physicians to include the partner in developing a treatment plan, judging by the number of physician respondents to my research survey. These respondents said

they regularly ask about their patients' level of support from their partners and social support systems.

Surveyed professionals tended not to have literature about the major and most devastating disorders available to their patients. This is a significant response that requires a change in order to promote prevention, early intervention, and appropriate treatment for suffering women and their families. There are excellent materials, including videos, now available for general use. There needs to be continued educational seminars in order to improve mental health-care assessment by the maternal health-care community.

Tremendous attention is focused on a woman from her child's conception through the postpartum period, which altogether comprises the process of childbearing. Keeping mentally healthy during this time is of vital importance to the future of the entire family and the community at large. If the mother is not well, then everyone is at risk. A woman's personal history of previous psychiatric illness and her family's mental health history are clues for future mental wellness. According to the results of the author's study, professionals now routinely inquire about these two variables. It makes sense, therefore, for them to consistently use a recognized screening instrument to test for depression and anxiety during pregnancy, and to follow their patients closely in the postpartum period.

The reasons for a mandate to screen during pregnancy on a routine basis are linked to the consequences if women's mood disorders are not detected and treated. This has extraordinary implications: the identification of women at high risk for major mood disorders is linked to intervention, treatment, and prevention of further trauma. According to these findings, there appears to be a valuable window of opportunity waiting for action. The woman needs to know that she can turn to her midwife, obstetrician, or family doctor and their nursing staffs for consultation about treatment and/or referral. She must not be abandoned or left to wander through a maze of unrelated professionals. Childbearing is a time of vulnerability and therefore becomes an opportunity to build trust between the consumers and providers of health care.

Once a suffering pregnant woman or a new mother has been identified with a screening tool, who will follow up to guarantee that she and her family get the help they need" The primary-care provider during her pregnancy has this responsibility. An appropriate referral for assistance includes the "mothering" of the entire family unit. In virtually every community there are many agencies ready to offer assistance, but they must be brought into the team effort to support the woman and her family. Current literature suggests that parental depression is associated with behavioral and emotional problems in children of all ages. Consequently, by identifying and treating depressed women of childbearing age, we can reduce and perhaps ultimately eliminate unnecessary suffering. This has a long-range impact as well, since PPD has a high relapse rate.

The stress of having a depressed or anxious partner and mother takes a toll on relationships. Routine and regular screening for depression during pregnancy will actually decrease the likelihood that a child will be exposed to a depressed mother over a long period of time. This is a formula for long-term mental health. It includes preventing mental illness whenever possible and early intervention at other times. To accomplish these goals, a concerted screening program must be in force that is sensitive and specific to this population. Physicians and nurses must continue their own education about these complex disorders and speak out consistently about the

impacts if they are left unidentified and untreated. Specific treatment protocols, including the issue of breastfeeding and medications, must be written and implemented. Literature and audio- and videocassettes are available, but are not uniformly in use by practitioners. These gaps in consumer education must be closed. For the sake of our society, maternal mental-health issues must become part of every obstetrical, midwifery, family practice, and pediatric office.

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