

Colorado
Department
of Public
Health and
Environment

Nationwide Initiatives on Pregnancy-Related Depression



A Summary of 16 Key Informant Interviews

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and Environment

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Introduction

Pregnancy-related depression is depression that occurs either during pregnancy or up to one year postpartum. Also known as maternal, postpartum or perinatal depression, pregnancy-related depression can have devastating effects on a mother, her child and her family. The issue is complex and finding adequate support for individuals who suffer from it can be difficult.

Historically, the effects of depression during pregnancy or postpartum, or after a pregnancy loss, have been primarily associated with the mother. However, mounting evidence suggests that depression during this time in the life course also affects the child and other family members, often with delayed effects that impact the child's developmental years. In response to this body of evidence, states working on pregnancy-related depression have moved toward a more comprehensive approach to address screening, referral and treatment barriers, as well as associated stigma. From home visitation to public awareness campaigns, the experiences of these states provide a wealth of information to help others successfully tackle this challenging issue.

Background

Depression is the most common complication of pregnancy for mothers, both in Colorado and nationwide. According to Colorado's Pregnancy Risk Assessment Monitoring System (PRAMS), nearly one in every nine Colorado women who give birth (11.0 percent) will experience signs and symptoms of depression (PRAMS, 2009-2010). The Centers for Disease Control and Prevention have noted that anywhere from 8-19 percent of women nationwide report having postpartum depressive symptoms.¹

Colorado's 2011-2015 Maternal and Child Health Block Grant needs assessment identified pregnancy-related depression as one of nine priority areas for Colorado's Maternal and Child Health program. The priority focuses on a population-level approach by promoting timely screening, referral and support for pregnancy-related depression through improvements to the health care and mental health systems. This priority also aligns with Colorado's mental health and substance abuse "winnable battle," one of 10 identified public health and environmental priorities Colorado has committed to addressing in the coming years.

The Maternal Wellness team at the Colorado Department of Public Health and Environment coordinates the state's pregnancy-related depression efforts. As a foundation for multi-year program planning, Maternal Wellness staff members identified the need to learn more about other states' experience in addressing the public health issue of pregnancy-related depression.

Method

During the summer of 2012, Colorado's Maternal Wellness team developed and administered an online survey with every state and territorial maternal child health and behavioral/mental health director. Additionally, a handful of community-based support organizations were identified and included in the survey.

¹ Centers for Disease Control and Prevention (2013). Depression among women of reproductive age. Retrieved April 2013 from <http://www.cdc.gov/reproductivehealth/Depression/index.htm>.

A total of 125 individuals were invited to complete the survey. The survey received 61 individual responses representing 38 separate states and territories. Of those states and territories responding, 28 reported they were implementing, or had recently implemented, initiatives focused on pregnancy-related depression. A copy of the survey can be found [here](#).

Results from the survey were then reviewed to prioritize states for key informant interviews. The Pregnancy-Related Depression State Advisory Committee, comprised of experts and key stakeholders from across Colorado, helped identify the 16 most relevant states to interview. Each state was contacted to participate in a brief telephone interview with an independent contractor. Interviews were completed primarily with representatives from state health departments. However, representatives from a community-based organization, insurance provider and mental health department were also included. A list of states and representatives interviewed can be found at the end of this report. Individual state interview summaries can be found by clicking [here](#) to access an addendum to this report.

For the purpose of this report, the term “pregnancy-related depression” will be used to encompass postpartum depression, perinatal depression and maternal depression. Individual states may have used various terms to describe strategies, but all survey and interview questions were framed using the term pregnancy-related depression.

This report discusses the notable strategies, key themes, challenges and successes identified by states during the interviews.

Notable Strategies

The 16 state representatives interviewed discussed a variety of strategies to strengthen pregnancy-related depression screening and referral systems. Many states worked within existing programs focused on maternal and child populations to implement screening, referral and in some cases treatment, at the service delivery level. The development of cross-sector collaborations, the use of hotlines as referral resources, the training of providers and public awareness campaigns were also common strategies.

Home Visitation

For many states, work in pregnancy-related depression began with the inception of home visitation programming. Recent funding for home visitation programs through the Affordable Care Act’s Maternal, Infant and Early Childhood Home Visitation program (MIECHV) expanded access to these services in many communities. States most often focused on the integration of screening and referral protocols into the existing framework. A handful of states integrated treatment into programming for mothers who screen positive for symptoms of depression, and who are receptive to a short intervention delivered by program staff members.

Iowa – This state instituted “listening visits” as part of its home visitation program. Public health nurses are trained to implement the listening visits curriculum when conducting home visits to help a mother identify at least two things causing stress in her life. These nurses then work with the new mother to develop solutions to these issues. The Edinburgh Postnatal Depression Scale is used to determine if a listening visit is indicated for a woman based on how she answered the questions. The intervention’s effectiveness has been evaluated using postpartum depression screenings directly after receiving the visit and at a one month follow-up visit. On average, women’s scores dropped up to 5 points after receiving the visits and continued to

decrease on future screens.

Louisiana and Massachusetts – These states have interdisciplinary teams that provide mental health support using licensed practitioners or social workers. Both states provide in-home interventions, referral and support for mothers exhibiting symptoms of depression. In Louisiana, infant mental health consultants serve a dual role of providing direct services to program participants and consulting with staff members.

Michigan – The Maternal Infant Health Program (MIHP) works in collaboration with obstetric and pediatric programs to coordinate care for mothers. MIHP is a direct-service, home visitation program that promotes healthy pregnancies to improve birth outcomes and supports the health of infants. It is administered by the Michigan Department of Community Health and available to all pregnant Medicaid beneficiaries and their infants statewide.

Healthy Start

Healthy Start is a national program funded by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The program focuses on decreasing health disparities and increasing access to health services to improve maternal and child health outcomes. Many states awarded this funding have integrated pregnancy-related depression screening and referral into program benchmarks.

Alaska – Its Healthy Start program operates in the northwest region of the state, largely comprised of Alaskan Natives/American Indians identified as experiencing high rates of perinatal and postpartum depression. The program requires perinatal and postpartum depression screenings as part of its case management and home visitation programs, and also provides community education classes that address depression and other behavioral health issues.

Florida – This state's Healthy Start program operates through 32 coalitions statewide. The program provides universal screening to pregnant women enrolled in the program, using the Edinburgh Postnatal Depression Scale.

Cross-Sector Collaborations

Driven by a lack of targeted, sustainable funding streams, public and private agencies have collaborated to move pregnancy-related depression work forward in many states. Several states organized cross-sector workgroups and collaborations as a result of state-mandated legislation. States have found ways to maximize resources by networking across government agencies, education institutions, hospitals, private practices, health insurance providers, Medicaid providers and mental health agencies. For example, partnerships with local universities allow for collaboration on research and technical assistance programming for providers. This strategy has increased awareness of pregnancy-related depression among providers, and provided a more cohesive vision for state priorities through the inclusion of diverse partners.

Vermont – The Vermont Child Health Improvement Program (VCHIP) has provided a blueprint for cross-sector collaboration. VCHIP is a 10 year-old quality improvement arm operating from the University of Vermont's College of Medicine that institutes protocols for high-quality pregnancy and postpartum care. VCHIP focuses on population-level maternal and child health services research and facilitates cross-functional partnerships between researchers, practitioners, insurers, professional organizations and government. The program empowers providers with the knowledge and skills needed to deliver high quality services and develops educational materials to better inform practitioners on how to integrate best practices into

current systems. VCHIP supports the state's focus on maternal and child health outcomes, including pregnancy-related depression.

Michigan – A group of statewide stakeholders met for several months and developed recommendations to improve access to mental health services for expectant and new mothers.

New Jersey – In 2005, this state formed a work group in collaboration with the Commissioner of Health to plan a statewide postpartum depression project in accordance with newly passed legislation.

Oregon – The Maternal Mental Health Work Group has a legislative mandate to review maternal mental health issues and develop recommendations for the legislature on how to improve statewide maternal and child mental health systems.

Hotlines

Often women and family members seek out information and referral resources in a time of crisis. For this reason, a number of states use hotlines to provide resources on pregnancy-related depression.

Illinois, Iowa, Nebraska and Missouri – These states provide guidance, support and resources to depressed mothers through a hotline staffed by volunteers, including trained mothers or professionals.

Oregon and Missouri – These states either provide specific depression-focused hotlines or work in collaboration with state-run, toll-free Maternal and Child Health information numbers to connect mothers directly with designated support hotlines and other resources.

New Jersey – A state-run, toll-free hotline provides multiple health resources for callers. Staff members screen callers and refer them to appropriate resources. Callers with insurance who desire mental health services are referred within their networks. Callers without insurance are connected to a referral source that serves uninsured clients. Three staff members are dedicated to postpartum depression phone calls.

Provider Education and Trainings

As part of the survey, states were asked to comment on technical assistance and training opportunities for providers, including how these opportunities were implemented and resulting successes. Many states developed comprehensive websites that not only provide accessible information for consumers and providers, but also serve as avenues for training. Providing continuing education credits was a critical element of successful training programs, most likely due to the incentive for the provider to attend.

Florida, Iowa, Massachusetts, Michigan, New Mexico, Nebraska and Ohio – These states use web-based trainings for providers. Florida's webinars address the varying degrees of depression and different levels of intervention available to a mother. The goal is to help providers recognize other effective and available interventions beyond medication. New Mexico has provided interactive webinar trainings on pregnancy-related depression that have reached providers in Illinois, Oklahoma and Texas.

Louisiana – This state provides an introduction to perinatal depression within a comprehensive, 36-hour continuing education program. The program provides an overview of various topics, including segments on recognizing maternal depression, its impact on infants, interventions and other high-risk/co-occurring issues, such as substance abuse and domestic

violence.

Michigan and Nebraska – Both states provide trainings that include continuing education credits. While Michigan offered continuing medical education credits for medical doctors, in addition to nursing and social worker continuing education credits, Nebraska recognized that the audience was largely comprised of nurses and social workers and chose to solely offer continuing nursing education credits. Both states' curriculums are web-based and focus on the topic of depression during and after pregnancy, as well as the importance of screening, referral and treatment. Michigan's training includes a curriculum on motivational interviewing and program intervention theories. Both initiatives measure training utilization through post-course surveys and regular reports identifying the number of users and licensure status.

Public Awareness Campaigns

Many of the states interviewed identify public awareness campaigns or consumer marketing initiatives as part of their efforts to address pregnancy-related depression. Communication channels included specialized websites, social media, informational packets and mass media, including billboards, bus ads, etc. The target audience for most efforts was general, with many states targeting moms who had suffered from pregnancy-related depression as a way to generate awareness.

Oklahoma – The Oklahoma Department of Health partnered with a local advertising agency to develop a public service announcement titled *Quicksand*. The campaign used actors of diverse ethnic backgrounds to create a visual and audio representation of symptoms associated with postpartum depression using language captured from mothers who had experienced the illness.

Nebraska – This state collaborated with local partners and a social marketing firm to develop the *Moms Reach Out Campaign*. This campaign uses a website as its communication outlet and peer stories to engage its audience.

Massachusetts – This state developed a comprehensive public awareness campaign to target providers and new parents. The *New Parent Initiative* uses peer stories from new parents and providers to build empathy, create support and share information about issues new parents may experience. Topics include parenting expectations, child development, maternal depression, substance abuse, premature birth, adoption and family planning.

Key Trends

States with successful pregnancy-related depression initiatives often had policy changes and/or legislation in place to help move the work forward. Reimbursement was also identified as a key factor in improving the uptake of screening efforts among practitioners. Additionally, recommending a screening tool (or tools) and bundling payment for depression screening with other risk factor screenings has improved the success of universal screening efforts either program-wide or system-wide.

Legislation and Policy

Numerous states have successfully leveraged legislation to increase statewide support for and impact of depression initiatives.

Illinois – *Senate Bill 15: Postpartum Mood Disorders Prevention Act*, enacted in 2008, supports the development of policies and procedures to address perinatal depression and calls for the early screening of women by health care workers. The Governor's office each year proclaims May Perinatal Mood Disorders Awareness Month, to increase the public awareness of the impact perinatal mood disorders have on mothers, children and families.

Massachusetts – In 2010, the state enacted *An Act Relative to Postpartum Depression*. This legislation developed from the Perinatal Connections Program, a grant-funded program implemented to address policy implications, programming, data collection, systems and technical assistance for maternal depression. This legislation gave the Massachusetts Department of Public Health authority to improve the screening and treatment of perinatal depression. This authority allowed the department to develop effectiveness standards for depression screening, as well as regulate data submission by providers and health insurance carriers that conduct depression screenings.

New Jersey – The 2006 *Postpartum Depression Screening Bill* requires all health care professionals who provide prenatal care to educate women about postpartum depression and obtain a history of postpartum depression prior to delivery. Additionally, the law requires facilities and providers delivering postnatal care to screen new mothers for postpartum depression when leaving the birthing facility and at the postpartum check-up. Compliance is tracked through the Electronic Birth Certificate Program.

Oregon – This state successfully used legislative efforts to address stakeholder engagement, public awareness and provider education. *House Bill 2666: Maternal Mental Health Work Group* required the development of a statewide work group on maternal mental health disorders appointed by the Department of Human Services director. The work group was charged with identifying vulnerable populations and developing recommendations for accessible and effective strategies to improve maternal mental health. *House Bill 3625: Maternal Mental Health Month* declares May as Maternal Mental Health Month in Oregon. *House Bill 2235: Maternal Mental Health Patient and Provider Education Program* created a program to deliver provider education to help prevent the associated long-term negative outcomes of depression on women, children and families. Oregon's ability to develop diverse legislation targeting a spectrum of pregnancy-related depression issues has successfully sustained momentum on improving maternal mental health.

Reimbursement for Screening

As part of the initial survey, each respondent was asked whether the state's Medicaid program had an open Current Procedural Terminology (CPT) code or International Statistical Classification of Disease and Related Health Problems (ICD) code for any of the following: postpartum depression screening, adult depression screening or general preventative screening that can include depression. The goal of this question was to identify states that had successfully tied a reimbursement code(s) to screening and further discuss how this effort supported a state's overall depression work.

Many of those surveyed were unclear on whether open reimbursement codes existed. This is likely due to the survey's outreach to public health staff members rather than those in charge of public insurance programs. However, a small sample of states noted their efforts to achieve screening reimbursement codes, and this achievement, in combination with additional state

initiatives, clearly supported the increased use of screening by providers.

Oklahoma – A qualified Medicaid practitioner who provides prenatal care services may be reimbursed for a psychosocial assessment. Any traditional Oklahoma Medicaid member or SoonerCare Choice member (the state’s managed care plan) is eligible to receive the screening. The assessment includes two forms: the American Congress of Obstetricians and Gynecologist’s Obstetric Medical History Form and the Oklahoma Health Care Authority’s Prenatal Psychosocial Assessment Form. Providers have a reimbursement limit of one per pregnancy at a rate of \$30. Medicaid members who change providers during pregnancy are limited to reimbursement for two assessments per pregnancy.

Virginia – As part of the BabyCare program, a Medicaid provider can use a universal screening form containing evidence-based questions to screen for interpersonal violence, substance abuse and maternal depression. Providers can use this screen during pregnancy and up to two years after delivery. Providers may screen under either the mother’s or infant’s plan, with as many as four screenings per pregnant member and four screenings per infant member per year.

Michigan – Women enrolled in the Maternal Infant Health Program, a Medicaid program for eligible pregnant women and women as much as 60 days postpartum, receive a risk identifier tool during pregnancy and immediately postpartum. This risk identifier tool includes the Edinburgh Postnatal Depression Scale and is reimbursable as part of the program.

Illinois – While not referenced on the survey, any physician or other provider enrolled in the state’s Medicaid program may complete a perinatal depression screening during a prenatal, postpartum, infant well-child or episodic visit. Reimbursement is available for this screening; it is classified as a “risk assessment” at \$14.60. If a mother is no longer covered under Medicaid, a provider may bill the child’s Medicaid number.

Recommending Specific Screening Tools

Many of the states interviewed have conducted reviews of screening tools to improve screening standardization and increase use of evidence-based practices. The screening tool most commonly used by the states interviewed was the Edinburgh Postnatal Depression Scale.

Oklahoma and Vermont – Both states have completed studies evaluating the efficacy and relevance of the Edinburgh Postnatal Depression Scale. Vermont had a study published in the *Journal of Women’s Health* illustrating that, while the professional understanding of the importance of screening has increased over time, confidence in delivering the screening has not. The article recommended training as a way to build confidence among practitioners².

Oklahoma – An Oklahoma work group completed a five-month pilot project using the Edinburgh Postnatal Depression Scale in clinical settings. The goal of the pilot project was to determine the efficacy and logistics of using this screening tool in clinic settings statewide. The pilot project determined that the Edinburgh Postnatal Depression Scale was the most appropriate tool due to ease of use and accessibility.

Massachusetts – The Massachusetts Department of Public Health developed the Postpartum Depression Screening Grid to help providers determine the most effective screening tool for their purposes. The grid provides a listing of appropriate screening tools for postpartum depression and includes administration, completion time, validity and electronic availability for each tool.

²Price, SK. et al. (2012). Perinatal depression screening and intervention: enhancing health provider involvement. *Journal of Women’s Health*, 21(4), 447-455.

Bundling of Screening Assessments

Many states have been forward-thinking in the use of screening assessments by bundling depression screening with other associated risk screens. The two most notable pairings include substance abuse and domestic violence screening. Many states that bundled screening assessments were successful in obtaining reimbursement.

Louisiana – The state’s Birth Outcomes Initiative is developing a screening tool entitled La HART (Louisiana Health Assessment, Referral and Treatment). This screening tool currently focuses on substance use and domestic violence, but plans are underway to add depression screening and resources.

Michigan – All Medicaid-eligible women in Michigan’s Maternal Infant Health Program are administered the Edinburgh Postnatal Depression Scale, Perceived Stress Scale and T-ACE Substance Abuse Screen. These screens are embedded within the program’s risk identifier tools. The results of each screening are entered into a state database and a score is generated based on an algorithm. If a woman scores moderate or high risk, a set of interventions are provided by program staff.

Virginia – The Virginia Department of Health worked with an expert panel to effectively bundle screenings. This panel was part of a grant funding requirement and included Medicaid representation. It focused on screening and referral, and determined that a triad of issues commonly co-existed with mothers: interpersonal violence, substance abuse and depression. After three years of work, the panel was able to bundle screenings and seek reimbursement for this package.

Challenges and Key Lessons Learned

As part of the interview process, key informants were asked to share challenges encountered and recommendations for addressing those challenges. The most frequent barriers noted by states in effectively addressing the issue of pregnancy-related depression were related to health care providers incorporating the issue into their practice and the stigma associated with a mental health diagnosis.

Many states noted that health care providers have not been able to appropriately assist patients suffering from pregnancy-related depression, often due to a lack of awareness and skills to support women who express symptoms. In most cases, providers respond within their professional limitations or the limitations of their respective institutions or agencies. As previously described, many states have worked diligently to provide direct educational support through face-to-face trainings or web-based curriculum. Other states have invited health care providers to join collaborative efforts to continue to disseminate information through their professional channels. Ultimately, it appears that affecting cultural change among providers may mean legislation or policy mandating screening or screening reimbursement for health care providers who work with mothers of childbearing age.

The stigma associated with mental health diagnoses is a common national theme. The stigma of mental health is even greater among postpartum women due to the pressures and expectations associated with motherhood. This stigma, along with many other existing cultural norms and expectations, has made it difficult for mothers to accept a diagnosis and follow through with treatment — a common barrier noted by many of the interviewed states. Efforts to provide varying levels of intervention allow mothers with low to moderate depression to find

relief without the need for a referral to additional mental health services. This strategy addresses both stigma and lack of referral sources.

Conclusion

A great deal of innovative work in pregnancy-related depression is taking place around the country. Work groups and collaborations have helped move the work forward, pooling resources and talents to further initiatives in creative ways. Technology has become a cost-effective and accessible way to provide information to mothers and providers in the community. Many states use websites with peer stories to reach consumers. Others have developed web-based provider training modules, including continuing education credits, to provide incentives to attend. Partnerships with state Medicaid programs and administrators have proven successful as well. Whether combined with legislation or as an individual connection, these collaborations have been key to furthering universal and standardized screening, reimbursement and data collection efforts. Despite many of the stated successes, more work needs to be done to evaluate these strategies to ensure future efforts focus on those approaches with the greatest potential to improve the rates of pregnancy-related depression among new mothers.

Addressing maternal mental health is complex, but the various examples highlighted here demonstrate a critical role for public health in bringing awareness to the issue at the population level and promoting standard screening and referral throughout health systems. Successfully addressing pregnancy-related depression today is key to improving the health and mental health of women, children and their families tomorrow.

Appendix A: List of State Interview Participants

Alaska Debra Golden	Perinatal Nurse Consultant	Alaska Department of Health and Social Services
Florida Susan Potts	Infant, Maternal and Reproductive Health	Florida Department of Health
Illinois Sarah Allen, D Clin Pysch	Founding Director and Clinical Advisor	Postpartum Depression Alliance of Illinois
Iowa Stephanie Trusty	Coordinator of Maternal Health Title V Grant	Iowa Department of Mental Health
Louisiana Paula Zeanah, PhD	Clinical Director of LA Nurse Family Partnerships (NFP)	Louisiana Office of Public Health Maternal Child Health Program
Massachusetts Karin Downs	Assistant Clinical Director MPH Director for Title V Program	Bureau of Family Health and Nutrition
Michigan Joni Detwiler, BS, SW	Public Health Consultant Maternal Infant Health	Michigan Department of Community Health
Missouri Sharmini Rogers, MPH, MBBS	Chief of Bureau of Genetics Senior and Healthy Childhood	Department of Health Services
Nebraska Kathy Karsting, RN, MPH	Program Manager	Maternal Child Adolescent Health DHHS-Division of Public Health
New Jersey Elizabeth Dahms	Public Health Consultant	NJ Department of Health
New Mexico Sharen Kimmet, RN, BSN, CCM	Nurse Case Manager	Blue Salud
Ohio Maria Himmeger	Office of Children and Families and Prevention	Ohio Department of Mental Health
Oklahoma Julie Dillard	Public Health Social Work Coordinator	Oklahoma State Department of Health
Oregon Nurit Fischler, MS	MCH Systems and Policy Specialist, Maternal and Child Health Section	Center for Prevention and Health Promotion, Oregon Health Authority
Vermont Dr. Breena Holmes	Maternal and Child Health Director	Vermont Department of Health
Virginia Joan Corder-Mabe	Program Manager for Reproductive Health Unit	Virginia Department of Health