Evaluation of Providers Screening and Referral Practices for Perinatal Depression

A Report of Initial Site Findings

Avril S Albaugh LISW
Perinatal Depression Project Coordinator

Cleveland Regional Perinatal Network

University Hospitals Case Medical Center
University MacDonald Womens Hospital

Cleveland, Ohio

2009

Acknowledgements:

The CRPN Perinatal Depression Project gratefully acknowledges the following who contributed their time and expertise:

Faye Smith Alexander, MSSA, LISW
Director, Social Services and Special Programs
Northeast Ohio Neighborhood Health Services, Inc

The Social Work Staff
Northeast Ohio Neighborhood Health Services, Inc

Marilyn Benjamin RN, MSN
Project Director
Cleveland Regional Perinatal Network

Cuyahoga County Child & Family Health Services grant program
Epidemiology, Surveillance and Informatics Department

Funding provided by:

Ohio Department of Health/Federal Government
Bureau of Child and family Health Services
Regional Perinatal Center Program

MomsFirst
City of Cleveland Department of Public Health
Supported in part by project H49MC000082
US Department of Health and Human Services Administration
Maternal and Child Health Bureau (Title V, Social Security Act)

Cuyahoga County Child & Family Health Services grant program

For a Copy of this report, please contact The Cleveland Regional Perinatal Network, 10524 Euclid Avenue, Suite 3000, Cleveland, Ohio, 44106
(216) 844-3391
Avril.Albaugh@UHHospitals.org

Background

Depression has been identified as the leading cause of disease-related disability among women (Kessler, 2003). Women of childbearing years are at high risk for major depression (Robins L, Regier D., 1991; Burke KC, Burke JD Jr, Rae DS, 1991). The incidence of major depression during pregnancy is estimated to be between 5% and 15% with additional 10% and 50% of women having depressive symptoms (Affonso et al.,1992; Weissman & Olfson, 1995). Depressive symptoms are milder than major depression and include symptoms such as depressed mood, anxiety, anger and hostility (Affonso et al.).

Depression during pregnancy and depressive symptoms has been associated with increased obstetric risk (Hedegaard, Henriksen, Sabroe, & Secher, 1993: Orr & Miller). Untreated depression during pregnancy has been linked with missed prenatal care appointments, substance abuse and poor obstetric outcomes. (Gupton, Heaman, & Ashcroft, 1997; Maloni et al.,2004; Stainton, Harvey, & McNeil, 1995). Other studies have documented the adverse effects of maternal depression on fetal and infant well-being and disturbances in mother-infant interaction and child development (Beck, 1995, 1996; Field, 1995; O'Hara & Swain, 1996).

Early identification and treatment of depression during pregnancy could decrease the risk of developing postpartum depression. However, depression during pregnancy often goes undiagnosed and untreated due to lack of provider awareness, identification and referral.

During 2002 the Cleveland Healthy Family /Healthy Start (HFHS) Perinatal Depression Project screened approximately 386 African-American women for depression during the prenatal and postpartum period. In the sample, 21% of pregnant women residing in the city of Cleveland scored "at risk" for depression and 14% scored "at risk" for depression in the postpartum period.

Another finding from the HFHS Perinatal Depression Project showed that there were several barriers to provider screening and referral for perinatal depression. Some of these barriers identified were lack of provider awareness about perinatal depression, lack of training, and limited knowledge about mental health community resources. The following recommendations from the HFHS project were identified as future planning goals for the Cleveland Regional Perinatal Network (CRPN):

- Increase provider awareness about perinatal depression.
- Develop provider and consumer materials about perinatal depression and available community resources
- Provide training for providers to screen, identify and refer for perinatal depression.

In 2005, the Cleveland Regional Perinatal Network (CRPN) received funding from Cuyahoga County Child and Family Health Services to improve the identification and referral of pregnant women at risk for depression. The purpose of the CRPN Perinatal Depression Project has been to:

- increase pregnant women's access to mental health treatment by educating healthcare and community providers to recognize signs and symptoms of depression in pregnant women,
- assist frontline providers and health care providers with developing and incorporating a care path into clinical practice for screening and referral for perinatal depression.

A two hour training program was developed for training frontline providers, which included a powerpoint presentation, handouts, bibliography, "Guide for Moms" (resources for mothers-to-be and mothers of young children), program evaluation and continuing education credits.

The training recommended using the Edinburgh Postpartum Depression Scale (EPDS) as a screening tool for perinatal depression. (See Appendix A for EPDS) Providers were informed about other available options for screening tools.

The training program also included how to incorporate a perinatal depression screening and referral care path into clinical practice. (See Appendix B for sample care path) There is documented evidence to show that women who suffer from perinatal depression feel guilt and shame and are uncomfortable voluntarily discussing this issue with their providers. (Heneghan,Silver, Bauman & Stein: 2000**)** The rationale for using a care path is to:

- Reduce the stigma of perinatal depression by establishing a standard of care for all pregnant and postpartum women.
- Assist providers with guidelines so that they feel comfortable approaching and assisting their patients through the process.

The care path gives providers options on when to screen during the prenatal and postpartum period and what steps to follow when a client scores "at risk" (ie, a score of 12 or above on the EPDS) for depression. When this does occur the provider would either encourage the client to accept a referral to a community mental health provider or in some cases providers had access to on-site psychiatric services.

Objectives

The specific objective of this descriptive study was to determine the effectiveness of implementation of a perinatal care path to guide identification and referral of perinatal depression. This study assesses:
a) incidence of health care provider screening for depression among pregnant clients,

b) the number of screened clients who are at risk for depression, and,
c) the number of clients referred to mental health services

Study Design

This is a descriptive study of health providers' screening and referral practices for perinatal depression of pregnant clients receiving prenatal services at a community health services agency. The study also identifies the number of clients at risk for perinatal depression and the number of clients referred for services.

Providers who participated in this study consisted of licensed social workers and one social work intern who attended a two hour educational program provided by the principal investigator regarding the importance of screening and referring for perinatal depression during the prenatal period**.** A specific care path for depression screening and referral was developed for the agency with technical assistance provided by the principal investigator. The care path (See Appendix B) was incorporated into perinatal practice by the agency before the study begins.

The study took place in two phases; the screening period and the retrospective data collection period. The first phase was the three month screening period in which the social work providers were to screen all new pregnant clients using the care path specifically designed for the agency.

The data collection (See Appendix C) took place during the second phase. During the 3 month period of data collection, charts were reviewed by the same social work providers who were responsible for screening in the first phase of the study. Data was collected only on pregnant clients who had a delivery date after the three month screening period was completed.

Setting:

The site chosen for this research project was a community health services agency which has provided comprehensive health care services to the Greater Cleveland's uninsured and underinsured residents for forty years. The agency is a non-profit community health center with a network of six health care facilities. The agency's network provides primary care services including adult medicine, pediatrics, ob/gyn, dental, optometry, behavioral health, nutrition and podiatry services. Ancillary services include laboratory, ultrasound, X-ray, mammography and pharmacy services. The agency has been accredited by the Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) for over 30 years. In 2006, the agency served over 43,000 patients. The patient population is 99% African American.

Enrollment criteria:

There were two populations enrolled in this study; the social work providers who were responsible for screening their clients and collecting the data, and pregnant clients seen at the six participating agency sites during the three month screening period.

The inclusion criterion for providers at participating sites was the completion of the two hour perinatal depression educational program provided by the Principal Investigator.

The inclusion criteria for pregnant clients were as follows:

- Be 18 years of age or older
- Have a screening visit during the designated three month screening period
- Give birth during the three month data collection period following the screening period

Instruments/Measures:

Edinburgh Postnatal Depression Scale (EPDS):

The EPDS (See Appendix A) is an effective screening tool for identifying clients 'at risk" for perinatal depression. The tool is easy to administer by both the provider and by the client. There are 10 questions that measure how the client has felt over a 7 day period.

Clients who score between 0 – 11 are not considered to be at risk for major depression. Clients who have a total score of 12 and above are considered to be at risk for depression and require a mental health assessment by a mental health provider to determine if they are experiencing a clinical diagnosis of major depression.

Perinatal Depression Screening and Referral Care Path:

The purpose of the care path is to guide providers through a step by step process of screening and referring pregnant and postpartum clients for perinatal depression. The CRPN Perintal Depression sample care path was modified and adapted to the specific needs of the agency that participated in this research study.

In applying their agency-specific care path, the social work providers participating in the study administered the EPDS as a consistent standard of care during the 3rd trimester of pregnancy. However the social workers decided to include the option to administer the EPDS at a different time during the pregnancy if there was a concern that the patient might be experiencing perinatal depression. A copy of the EPDS would then be placed in the client record. If the client refused the screen, the social worker would attempt to screen at the next visit and document the refusal in the client record.

If the client scored a total of 11 or less, the social worker would provide appropriate resources and if necessary attempt to re-screen the client at a later point during the pregnancy. If the client scored 12 and above, the social worker would discuss the need for further assessment and referral and offer the client the following referrals:

- An on-site referral to social work or mental health
- A community mental health referral
- Patient self-referral

If the patient agreed to a Community Mental Health Referral, the social worker would:

- Complete the Maternal Behavioral Health Referral Fax Form
- Telephone and fax the referral form the appropriate mental health agency

The social worker would provide all patients, regardless of their scores, with a "Guide for Moms". The "Guide for Moms" is a resource brochure produced by the Cleveland Regional Perinatal Network for mothers-to-be and mothers of young children.

For those patients who refused all referrals the social worker would:

- Provide resources
- Provide information on perinatal depression

If the patient responded to Question 10 "Thought of Harming Self" with either **Yes, quite often**, or **Sometimes,** or **Hardly Ever**, the Social Worker would formulate a safety plan. This would include either facilitating an on site psychiatric evaluation (if available) or contacting Mental Health Services Inc, Mobile Crises, a crises and suicide team in Cuyahoga county, to assess her safety before she left the agency.

All interventions completed by the social worker would be documented in the patient record including if the patient refused any referrals for further assessment.

Data Collection Sheet:

The data collection sheet consisted of 12 questions to be completed by the social work providers from the patient's chart in the second phase of the study.

Information collected from the data sheet was grouped into three categories in the database:

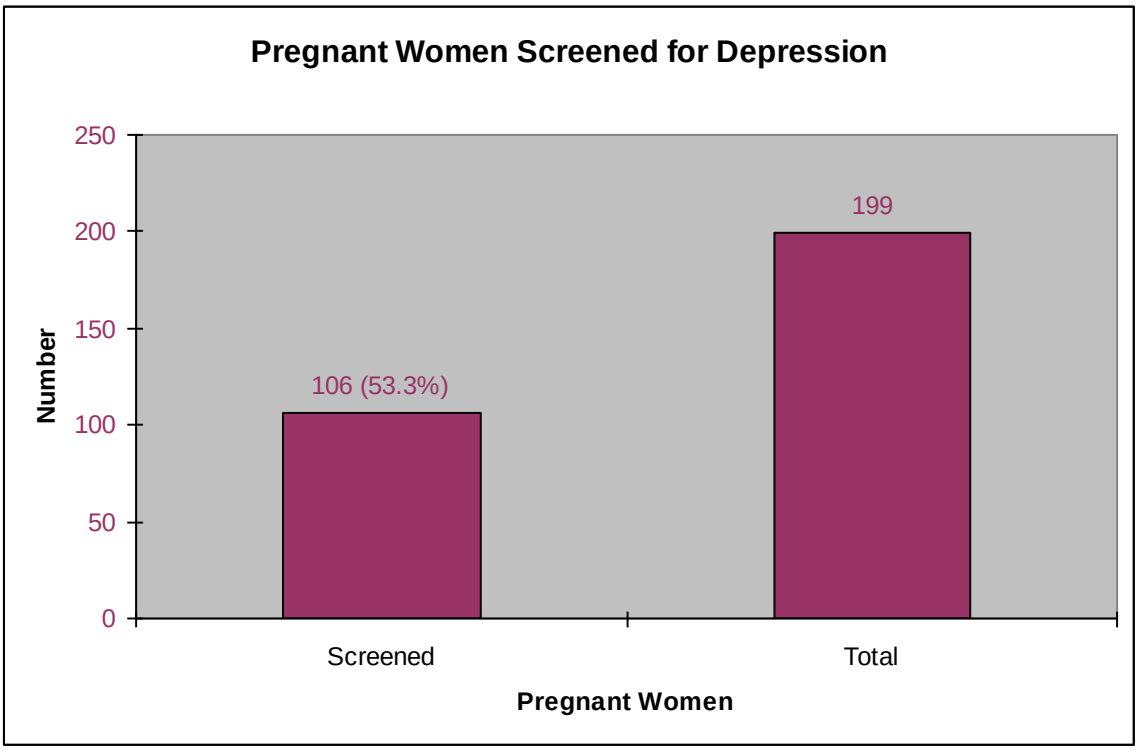
1) Screening
2) Intervention
3) Provider Information

Study Findings

Screening

Number of Pregnant Women Screened for Depression:

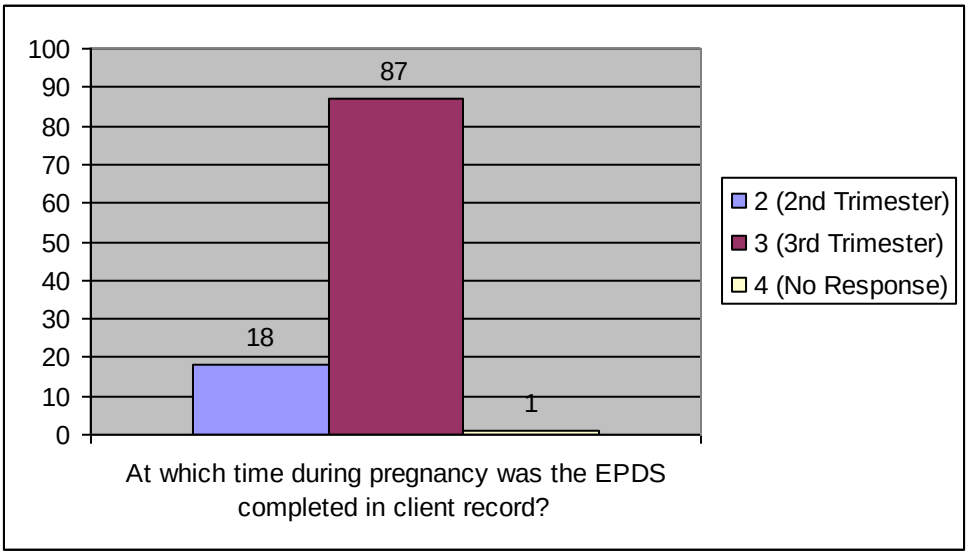
The number of patients seen at the agency during the 3 month screening period from August 27, 2007 through November 27, 2007 was **199**. Out of 199 patients seen, a total of **106** data sheets were completed by the social work providers, which indicated 106 clients were screened by the providers using the Edinburgh Postnatal Depression Scale (EPDS). The percentage of patients screened during this time was **53.3%.** Of the 106 Edinburgh screens competed, **105** copies were placed in the patients' charts. The data sheets were completed by the same social work providers who completed the perinatal depression screening.



Trimester of Pregnancy the EPDS was Administered:

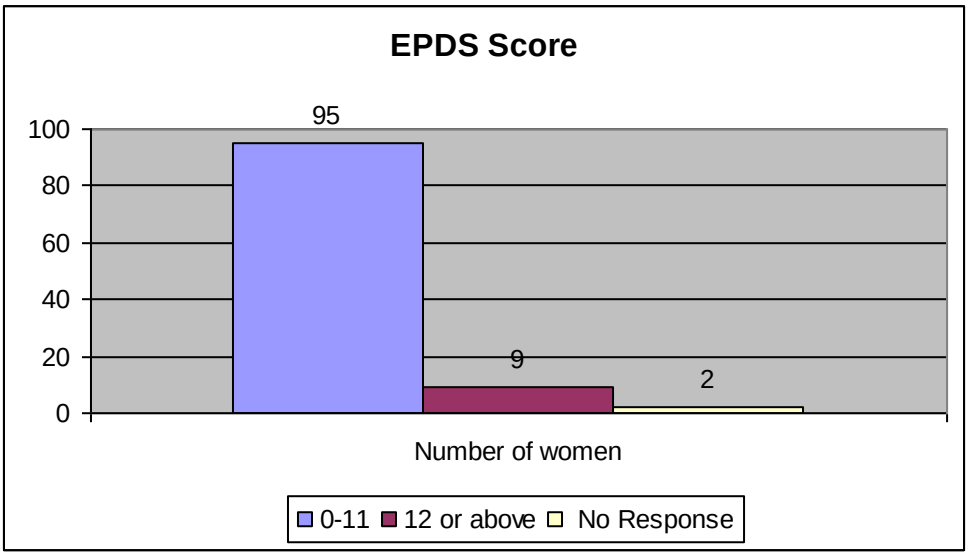
According to the agency's care path, the EPDS was to be administered as a standard of care during the 3rd trimester. The EPDS could be administered during either the 1st or 2nd trimester as a result of the social worker's concern that the client could be experiencing perinatal depression during these first two stages of pregnancy.

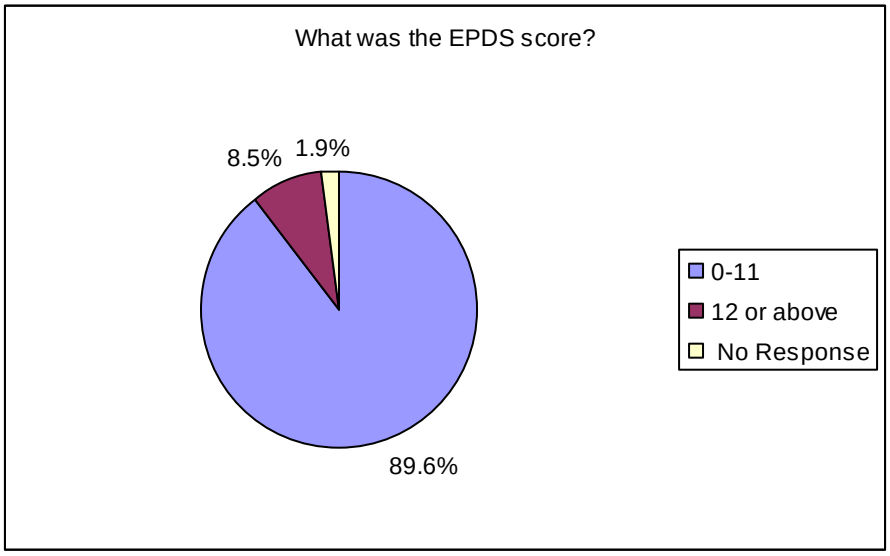
Of the 106 data sheets completed, **0** EPDS screens were completed during the 1st trimester, **18** EPDS screens were completed during the 2nd trimester and **87** EPDS screens were completed during the 3rd trimester.



Edinburgh Postnatal Depression Scale (EPDS) Scores:

Out of 106 screened:
95 clients or 89.6 % scored between 0 – 11;
9 clients or 8.5 % scored 12 or above
2 data sheets or 1.9 % were incomplete





Interventions For Clients Who Scored 12 or Above:

According to the care path if the patient scored 12 or above the provider needed to:

- Discuss further assessment
- Document interventions in client record

For the 9 clients who scored 12 or above, all provider responses indicated “Need for further assessment discussed” and “Interventions documented in client record”.

According to the care path, patients scoring 12 or above who refused any referrals were to be given the following:

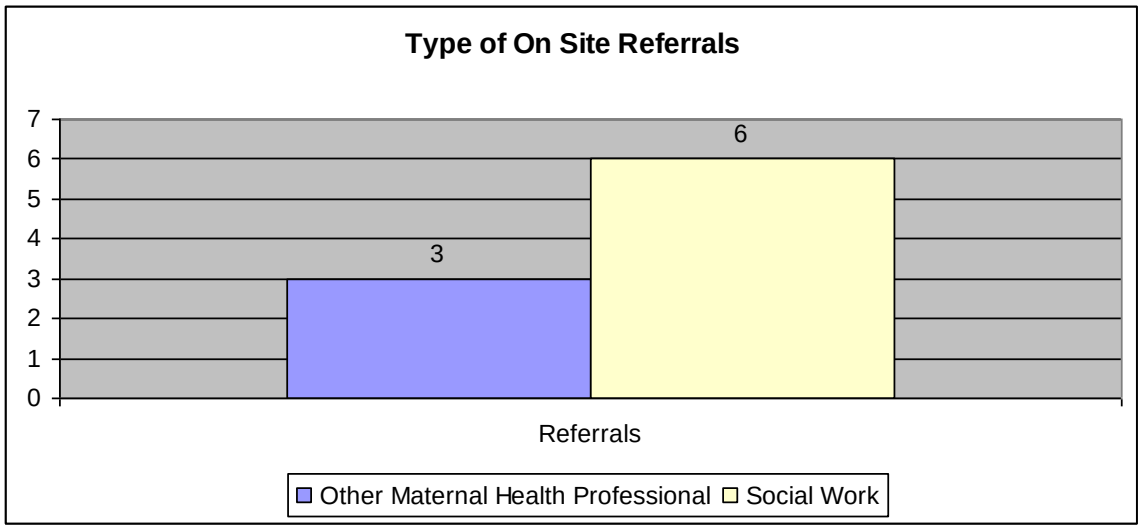
- resources
- information on perinatal depression

For the 9 clients who scored 12 or above, there was **1** provider who gave resources, **2** providers who provided information on perinatal depression and 1 provider who indicated that they documented interventions in client record.

According to the care path if the client preferred self-referral, resources were to be given. There was **1** "yes" response that the client preferred self-referral and was given resources.

According to the care path if the patient scored 12 or above the provider was to refer to on-site services if available.

For the 9 patients who scored 12 and above and on-site services were available the following referrals were made:
6 social work referrals
3 other mental health professional referrals



According to the care path, if the client scored 12 the provider has the option of referring the client to off-site community mental health services. **1** provider indicated that an off-site referral was made and **1** indicated that resources were given.

Conclusions:

According to the data collected, implementation of a provider perinatal care path appeared to be effective in guiding identification and referral of perinatal depression. Furthermore, the study was able to collect data on:
a) the incidence of health care provider screening for depression among pregnant women,
b) the number of screened women who are at risk for depression, and,
c) the number of women referred to mental health services.

There were 106 data sheets completed and 106 clients screened during this study. This was 53% of the total number of clients (199) seen during this time for prenatal services. This may not necessarily reflect the total number of clients screened during this time. There could have been additional clients screened who did not have data sheets completed.

There were 9 clients who scored 12 and above or “at risk” on the EPDS. This is 8.5%, which is lower than the 21% reported by the Cleveland Healthy Family /Healthy Start (HFHS) Perinatal Depression Project. In 2002 the HFHS Project screened 386 African-American women living in the city of Cleveland for depression during the prenatal and postpartum period. In comparing these two studies the smaller sample size of 106 in the current study could be a factor for the lower number of women scoring “at risk”. Another possible reason to consider for the difference in the data might be due to inconsistency in administering of the EPDS. Some providers may have had the client self-administer the screen verses the provider administering the screen. An additional reason for the lower than average “at risk” score could have been due to an ongoing relationship between the client and provider from a previous pregnancy, whereby issues could have been previously resolved. A meeting will be held with the providers to explore other possible factors influencing the results.

There were data sheets that were not fully completed by providers. This may have been due to misinterpretation or ambiguity of questions. A future consideration would be to reexamine the data collection sheet and to carefully determine each question for its usefulness and clarity for further data collection.

For those 9 clients who scored 12 and above, the need for further assessment was discussed by the social worker and the interventions were also documented in the client record. All clients who were identified with a score of 12 and above were given a referral for further follow up. This indicated that the care path was followed for all patients who scored “at risk”.

Early identification and treatment of depression during pregnancy can decrease the risk of poor obstetrical outcomes and the development of postpartum depression. Increasing provider awareness along with the incorporation of a

perinatal depression screening care path can be valuable strategies in identifying and referring women “at risk “for perinatal depression.

Bibliography

Affonso, D.D., Lovett, S., Paul, S., Sheptak, S., Nussbaum, R., Newman, L., et al. (1992). Dysphoric distress in childbearing women. Journal of Perinatology, 12, 325-332.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders. (4th Edition). Washington, D,C: Author.

American College of Obstetricians and Gynecologists. Depression in Women. Clinical Updates in Womens Health Care. Volume1, Number 2, Spring 2002.

Beck, C.T. (1995) The effects of postpartum depression on maternal-infant interaction: A meta-analysis. Nursing Research, 44, 298-304.

Beck, C.T. (1996). Postpartum depressed mothers' experiences interacting with their children. Nursing Research, 45, 98-104.

Burke KC, Burke JD Jr, Rae DS, et al. Comparing age at onset of major depression and other psychiatric disorders by birth cohorts in five US community populations. Arch Gen Psychiatry 1991; 48(0): 789-95.

Chaudron, L, Szilaguy, P, Kitzman, H, Wadkins, H, Conwell, Y. Detection of postpartum depressive symptoms by screening at well-child visits. Pediatrics. 2004; 113, 551-558

Cleveland Healthy Family Healthy Start Perinatal Depression Project. Feelings of African American Women: 2003.

Cox, J.L., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry, 150, 782-786

Gaynes, B.N., Gavin, N., Meltzer-Brody, S., Lohr, K.N., et al. (2005). Perinatal depression: prevalence, screening accuracy, and screening outcomes. Agency for Healthcare Research and Qualtiy. Evidence Report. Number 119.

Field, T. (1995) Negative effects of maternal depression: Infant depression continues after one year. Infant Behavior and Development, 18, 1-13.

Goodman, J. Postpartum depression beyond the early postpartum period. J Obstet Gynecol Neonatal Nurs. 2003: 33, 410-420.

Goodman, S, Gotlib, I.Children of depressed parents: mechanisms of risk and implications for emergency and primary care: impact on mothers' perceptions of caring for their children. Ambulatory Peidatrics: 2003; 3: 142-146.

Gupton, A., Heaman, M., & Ashcroft, T. (1997) Bed rest from the perspective of the high-risk pregnant woman. Journal of Obstetrics, Gynecologic, and Neonatal Nursing, 26, 423-430.

Hedegaard, M., Henriksen, T.B., Sabroe, S., & Secher., N.J. (1993). Psychological distress in pregnancy and preterm deliver. BMJ., 307, 234 – 239.

Heneghan, A, Sivler, E, Bauman, L, Stein, R. (2000). Do pediatricians recognize mothers with depressive symptoms? Pediatrics. 2000; 106 (6) : 1367-1373.

Kessler, RC. Epidemiology of women and depression. J Affect Disorders 2003: 74(1); 5-13.

Maloni, J.A., Park, S., Anthony, M.K., Musil, C.M. (2004). Measurement of antepartum depressive symptoms during high risk pregnancy. Research in Nursing & Health, 28, 16-26.

O'Hara, M.,& Swain, A. (1996). Rates and risk of postpartum depression: A meta-analysis. International Review of Psychiatry, 8, 37-55.

Robins L, Reigier D. Psychiatric Disorders in America. New York: Free Press; 1991.

Stainton, M., Harvey,S., & McNeil, D. (1995). Understanding uncertain motherhood: a phenomenological study of women in high-risk perinatal situations. Calgary, Alberta, Canada: Faculty of Nursing, University of Calgary.

Weissman, M.M., & Olfson, M. (1995). Depression in women: Implications for health care research. Science, 269, 799-801.

Wisner, K, Parry, B Pointek, C. Postpartum depression. New England Journal of Medicine. 2002; 347; 194-199.