

Identifying and Treating Perinatal Depression: Views of Brooklyn Healthcare Providers



A Neighborhood Report by the Brooklyn District
Public Health Office and Healthy Start Brooklyn



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Key Findings

1. Primary care and mental health providers report that institutional and system barriers prevent women with perinatal depression from being screened and treated.
 - System capacity to identify, refer and treat most mental health needs is limited.
 - Health care facilities often lack a perinatal depression screening protocol.
 - Insurance coverage for patients with perinatal depression is inadequate.
2. Improving provider knowledge around perinatal depression could increase screening, referral and treatment rates.
3. Hospitals in Brooklyn should consider strategies to integrate primary care and mental health services.
4. Public information campaigns to elevate community awareness about mental health issues, in general, and perinatal depression, specifically, are needed.

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Editorial

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This Report

Depression is a chronic health condition that affects approximately 15.8 million adults in the United States, or about 7.3% of those aged 18 or older, each year. Depression is more common in women than men, with 9.3% of women experiencing depression in the past year compared to 5.2% of men. One out of every four women has experienced depression during her lifetime.¹⁻³

The perinatal period—during pregnancy and after delivery—can be a time of increased risk. Perinatal depression encompasses a broad range of mood disorders that arise either during pregnancy or in the first 12 months following delivery, and it is estimated to occur in 5 to 25% of women.⁴ Risk factors include low educational attainment, low socioeconomic status, delivery of a low-birth weight infant, domestic violence during pregnancy, history of major depression and lack of support from a spouse/partner.⁵

Depression goes undetected and untreated in nearly half of all patients despite the availability of validated screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ-2 or PHQ-9).⁶ Depression may be missed during pregnancy because symptoms can be difficult to distinguish from normal concerns in the pre- and post-natal periods. Postpartum depression, which occurs in 10 to 20% of women, also can be confused with common postpartum blues, which occur in up to 85% of women (but always resolve within the first 2 weeks postpartum).⁷ Even when pregnant women are properly diagnosed, treatment rates can be low.⁸ Women may not receive treatment for a variety of reasons, including cost, limited access to treatment and reluctance to use medication during pregnancy.⁹ Untreated perinatal depression can lead to a range of health and social problems for both mother and child, including physical illness, child injury, poor bonding and attachment between mother and infant, impaired emotional and cognitive development of the child, behavioral problems, and in rare cases, suicide and infanticide.^{5,10,11} There also is evidence linking depression during pregnancy with preterm delivery and other poor birth outcomes.¹¹

The goal of this report is to describe current practices for depression screening, referral and treatment of pregnant women and new mothers in clinic settings of Brooklyn hospitals and to make recommendations for improvements.

Study Methods

Two focus groups composed of administrators, primary care clinicians and mental health providers were conducted. In all, 15 participants represented 7 Brooklyn hospitals. Participants were asked to describe their current practices for screening, referral and treatment of depression among pregnant women and new mothers. A multidisciplinary team of researchers analyzed the transcripts of the sessions for major themes and lessons learned.

1. Primary care and mental health providers report that institutional and system barriers prevent women with perinatal depression from being screened and treated.

Many providers noted that there are often delays in identifying, referring and treating patients with perinatal depression due to a limited capacity to address mental health needs. Staff shortages (especially in the areas of translation services, social work and psychology/psychiatry), high case loads for doctors and lack of both outpatient services within hospitals and mental health services in the community all contribute to these delays.

The participants also asserted that the lack of a clear perinatal depression screening protocol in their hospitals, as well as inadequate procedures for addressing the needs of those who screen positive, constrain their ability to effectively screen and manage perinatal depression in their patients. Providers worried that the screening process is often too complicated and not formalized, and they have little time to screen clients during their scheduled visits. Some participants also questioned the precision of the screening instrument used.

Another barrier identified was the lack or inadequacy of insurance coverage among patients. Most patients receiving care from the Brooklyn hospitals represented in the focus groups get their health insurance through Prenatal Care Assistance Program (PCAP), the New York State health insurance program for pregnant women. PCAP provides limited coverage for mental health care. The limited availability of and access to community mental health clinics is also a concern.

2. Improving primary care provider knowledge around perinatal depression could help increase screening, referral and treatment rates.

Another issue that emerged in the focus groups concerned the inadequate training of some providers in recognizing and addressing mental health needs. As a result, some participants expressed discomfort with prescribing antidepressants during pregnancy, while others described difficulties in distinguishing between social issues (e.g., loss of housing, friction with partner) and mental health problems. Another concern expressed was that if providers did screen routinely, they were unsure what the next steps were, either because of the limited availability of mental health services or because of uncertainty about the severity of the problem. The participants believed that some providers—especially residents, older physicians and support staff—could benefit from training on recognizing symptoms of depression, using screening tools and knowing when to seek immediate consultation and treatment.

“...I will see [patients] whether there’s reimbursement or not... I end up seeing people for free, and then the hospital doesn’t get reimbursed, although they’re trying to work that out... So, somebody will be seen at least once or until we can find someplace for them to be seen on a regular basis.”

– Mental health provider

“There is a bit of apprehension from the primary care physician to elicit certain information because they don’t know what to do with it once they get it... They ask, ‘So, what do I do if I ask the patient, ‘Have you had any thoughts of killing yourself?’ Say the patient says, ‘Yes,’ and he’s in my office. What do I do next?’ I don’t want to be negligent. So, what do I do?’”

– Mental health provider

3. Hospitals in Brooklyn should consider strategies to integrate primary care and mental health services.

Participants noted that fragmentation of services was preventing patients with perinatal depression from being identified and treated, as some of the hospitals represented in the focus groups did not provide outpatient mental health services. The providers recommended fully integrating outpatient and inpatient health services so that all health needs—physical and mental—can be addressed. In the co-location model of service integration, both primary care and mental health services exist in physical proximity and are organizationally integrated, facilitating referrals and follow-up. Another benefit of service integration noted by the participants is that patients may feel more comfortable being referred to mental health services if such services are provided in the same clinical setting.

“...[W]hen the primary care physician integrates [mental health services] into his or her treatment, there’s less stigma on the patient. And if [the primary care provider] suggests that they should see another provider, it’s like another referral like any other provider... especially if it’s staying right in the clinic. ‘This is just another one of my colleagues. It’s another specialist I want you to speak to.’”

– Primary care provider

4. Public information campaigns to elevate community awareness about mental health issues, in general, and perinatal depression, specifically, are needed.

Participants believed that media and other public information campaigns on perinatal depression could do much to elevate public awareness and reduce the stigma associated with receiving mental health services. Participants also recognized that culture may play a role in shaping beliefs and attitudes about depression and its treatment, suggesting that such views be taken into account when developing educational campaigns. The importance of educating legislators about perinatal depression was also expressed – to ensure that they appreciate the financial resources needed to provide adequate care.

“But we have cultural issues that add to the notion of stigma that [are] very ingrained...and they’re difficult to resolve. We can do education, we can work on their misconceptions. But the culture has a lot to do with how soon someone decides to seek help when we’re offering the help.”

– Mental health provider

Recommendations for improving perinatal depression screening, referral and treatment outcomes

Hospital- and clinic-level

- Train primary care clinical staff to recognize, screen for, diagnose and treat perinatal depression.
- Develop specific protocols for screening for perinatal depression and for responding to positive screens in settings frequented by perinatal women, such as OB/GYN, pediatric and other primary care clinics.
- Use electronic health record systems to:
 - Offer providers easy access to depression screening tools and depression evaluation guidance.
 - Make referrals and monitor follow-up.
 - Create registries for targeting outreach and to monitor depression symptom scores over time.
- Create an interdisciplinary treatment system into which psychologists and social workers are integrated. The treatment system should address case management needs of patients and identify who will coordinate these efforts.
- Ensure coordination between hospital-based primary care services and community mental health providers who are serving patients.
- Partner with mental health services in the neighborhood to develop a network of local mental health services that accept referrals for perinatal depression.
- Share best practices and model programs with other hospitals in Brooklyn and citywide.

Community-level

- Create and evaluate the effectiveness of public awareness campaigns to educate the general public, as well as high-risk groups (e.g., low-income women, immigrant women) who may be unaccustomed to addressing mental health needs or lack access to quality care.
- Encourage elected officials to pass legislation that promotes mental health parity in insurance coverage and the integration of primary and mental health care systems.

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Brooklyn District Public Health Office

New York City Department of Health and Mental Hygiene

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Resources

BROOKLYN MENTAL HEALTH PROVIDERS

AstroCare Outpatient
Mental Health Program
1669 Bedford Avenue
(at Montgomery Street)
718-467-7200 x 229

Beverly Mack Harry
Consulting Services, Inc
738 Crown Street, 1st Floor
718-363-0100

Brooklyn Center for
Families in Crisis
1309-1311 Foster Avenue
718-282-0010

Brooklyn Center for
Psychotherapy
300 Flatbush Avenue
718-622-2000

Brooklyn Psychiatric Centers
Bushwick Mental Health Center
New York Psychotherapy
and Counseling Center
1420 Bushwick Avenue
[between Chauncey and Moffat]
718-602-1000

Center for Psychotherapy
123 Linden Blvd.
718-940-2812

Institute for Community Living,
Highland Park Center
2581 Atlantic Avenue
[between Georgia and Alabama]
718-290-8100

Interfaith Behavioral Health
Program: Adult Clinic
1475 Fulton Street
[just west of Kingston]
718-613-7288

Interfaith Behavioral Health Program:
Child/Adolescent Clinic
1473 Fulton Street
[just west of Kingston]
718-613-7251

Park Slope Center for Mental Health
348 13th Street, Suite 203
718-788-2461

Paul J. Cooper Center for Human
Services: Mental Health Program
887A East New York Avenue
718-467-6441

Puerto Rican Family Institute
Brooklyn Mental Health Clinic
217 Havemeyer Street, 4th Floor
718-963-4430

Sunset Terrace Family Health
514 49th Street
[between 5th and 6th Aves]
718-437-5210/718-437-5260

HOTLINES

Growing Up Healthy Hotline
(to find mental health provider)
800-522-5006

LIFENET 24-hour Hotline
(phone consultation with mental
health specialists)
800-LIFENET or 800-543-3638

Mental Health Association of New York City
800-273-TALK

FOR MORE INFORMATION ON DEPRESSION/PERINATAL DEPRESSION

MacArthur Depression Initiative
www.depression-primarycare.org

New York City Department of Health
and Mental Hygiene Depression Initiative
www.nyc.gov/html/doh/html/dmh/dmh-depression-initiative.shtml

Postpartum Resource Center of New York
www.postpartumny.org

Postpartum Education for Parents
www.sbpep.org/index.php?content=ppd/pepppdlinks.htm

Neighborhood Reports

To help reduce health disparities and improve the health of all New Yorkers, the New York City Department of Health and Mental Hygiene established **District Public Health Offices** (DPHOs) in 2003. These offices target public health efforts and resources to New York City neighborhoods with the highest rates of illness and premature death: North and Central Brooklyn, the South Bronx and East and Central Harlem.

An important part of our work is collecting and interpreting neighborhood health data. We hope this report fosters dialogue and collaboration among our many partners: other city agencies, community-based organizations, hospitals and clinics, businesses and, most important, the New Yorkers who live and work in Brooklyn.

For more information on the District Public Health Offices, visit: nyc.gov/health/dpho

Healthy Start Brooklyn provides outreach, case management, education and training aimed at improving the health of women, infants and their families in Central Brooklyn. It is a collaborative effort of the NYC DOHMH, the Fund for Public Health in New York, SCO Family Services, Bedford-Stuyvesant Family Health Center and CAMBA.

For more information on Healthy Start Brooklyn, visit www.fphny.org/p_healthy_start.php.



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