

Attendance at Mental Health Appointments by Women Who Were Referred During Pregnancy or the Postpartum Period

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Keywords

depression
engagement
intake
mental health
perinatal

ABSTRACT

Objective: To describe characteristics of women referred to mental health care during pregnancy or the year after giving birth and to identify characteristics associated with attendance at mental health intake visits.

Design: Retrospective record review of referral documentation.

Setting: Women's health practices and perinatal mental health clinics in urban areas.

Participants: The sample included 647 women during pregnancy or the year after giving birth who were referred for mental health treatment.

Methods: We reviewed the referral data sent from women's health care providers to perinatal mental health clinics to determine if mental health visits occurred.

Results: Fifty percent of the 647 women who accepted perinatal mental health referrals had intake appointments. Women were more likely to participate in an intake appointment if in-home services were offered ($p < .01$). Those with lower income were also more likely to participate ($p < 0.05$). Those with histories of perinatal loss and those who self-referred tended to be more likely to participate, although these relationships were statistically nonsignificant.

Conclusion: Even among women who accepted referrals to mental health services, only half attended intake appointments. For this group of pregnant women and those in the first year after birth, in-home mental health visits were most likely to result in care engagement, which has important implications for service delivery.

JOGNN, 47, 3–11; 2018. <https://doi.org/10.1016/j.jogn.2017.11.001>

Accepted November 2017

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The authors report no conflict of interest or relevant financial relationships.



Depression is a common complication of childbirth that may adversely affect mother and infant. Prenatal depression occurs in approximately 7% to 13% of women (Bennett, Einarson, Taddio, Koren, & Einarson, 2004) and has been associated with preterm birth (Wisner et al., 2009), disrupted maternal attachment (Hayes, Goodman, & Carlson, 2013), irritability in newborns (Pearlstein, 2015), and increased risk of developmental delays (Deave, Heron, Evans, & Edmond, 2008). Even in utero, fetuses of women who are depressed and anxious show an increased sensitivity to stress (Monk et al., 2011). In a systematic review, point prevalence estimates for depression ranged from 6.5% to 12.9% in the three trimesters of pregnancy and the first year after birth, and as many as 19.2% of women experienced depression in the first 3 months after birth (Gavin et al., 2005).

The definition of postpartum depression is varied in the mental health literature. For example, although the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) allows for the specifier *with peripartum onset* only if the mood disruption begins during pregnancy or the first 4 weeks after birth, increased vulnerability to depression extends beyond that period to at least the first 6 months after birth (Stowe, Hostetter, & Newport, 2005). Maternal depression has been associated with less positive mother–infant interaction (Tronick & Reck, 2009) and delayed language acquisition (Quevedo et al., 2012) and adverse emotional sequelae in the child (Foster, Garber, & Durlak, 2008).

Despite these risks, depression among women during the perinatal period often goes

undiagnosed. Researchers who conducted studies in obstetric and pediatric practices found that 75% to 85% of pregnant women and mothers of infants who had positive screening results for symptoms of depression were not recognized as having these symptoms by their health care providers (Goodman & Tyer-Viola, 2010; Smith et al., 2004). In Cleveland, Ohio, where our study was based, a 2002 inquiry showed that although 21% of urban pregnant women had positive screening results for symptoms of depression, only 2% received mental health treatment (Cleveland Healthy Family Healthy Start Perinatal Depression Project, 2003). Barriers to mental health screening in primary care settings include lack of time and comfort with mental health issues for providers and lack of mental health resources available for referral (Gjerdingen & Yawn, 2007).

Recently, the American College of Obstetricians and Gynecologists (2015) and the U.S. Preventive Services Task Force (Siu et al., 2016) recommended universal screening for perinatal depression. Although routine screening increases the detection of perinatal depression, increased detection is not the ultimate goal; if detection does not lead to treatment and reduction of suffering, it is of limited value (Avalos, Raine-Bennett, Chen, Adams, & Flanagan, 2016). Carter et al. (2005) found that only 30% of pregnant women who had positive screening results for symptoms of depression agreed to contact by a mental health professional, and of these, only 47% attended initial assessments. Smith et al. (2009) similarly found that only 38% of women who were referred to mental health clinics during pregnancy or the postpartum period attended even one visit, and only 6% remained in treatment after 6 months.

Concerns about lack of engagement in care after screening have led to recent efforts to identify barriers women face in seeking mental health treatment during pregnancy and the postpartum period. Although women's employment status and cultural background appear to influence their decisions to seek mental health care (Smith et al., 2009), a major barrier may be the need to seek services at a mental health agency outside the primary care setting. For example, when mental health services were provided at the same site as obstetric care, women were four times (95% confidence interval [1.68, 9.66]) more likely to attend the initial mental health visit than when referred to an outside agency (Smith et al., 2009). Miller, Shade, and Vasireddy (2009) found that when

mental health services were integrated into perinatal care at a federally qualified health center, 72% of women who had positive screening results for symptoms of depression received diagnostic assessments, and only 1.4% refused; the remaining 26.6% were agreeable to assessment, but the assessment was not completed because of lack of provider time. In a meta-analysis of postpartum depression screening and management programs from 2000 through 2010, Yawn et al. (2012) found that referring women to off-site providers was a predictor of less treatment engagement.

There has also been a growing interest in the effectiveness of in-home screening and treatment for perinatal depression. In 2001, the Head Start Program began to implement routine depression screening within a well-established home-visiting program for at-risk mothers. Data from various Head Start programs support the feasibility and acceptability of screening for depression during home visits (Kotelchuck, 2010). Rates of engagement in mental health treatment have been more variable. Programs in which mental health treatment is integrated into the home visiting program have had more successful engagement than programs in which women with symptoms of depression are referred to outside mental health agencies (Segre, O'Hara, Brock, & Taylor, 2012). A 6-week cognitive-behavioral intervention within an established home-visiting program targeted to women who were pregnant or had given birth up to 6 months earlier and who were at risk for depression had a 67% retention rate (Tandon, Leis, Mendelson, Perry, & Kemp, 2014).

Since 2005, the Cleveland Regional Perinatal Network (CRPN) has worked in Cuyahoga County (the county that encompasses the Cleveland metropolitan area) to address under-identification and treatment of depression in women during pregnancy and the first year after birth. The Edinburgh Postnatal Depression Scale (EPDS) is commonly accepted as a valid screening tool for perinatal depression prenatally and after birth (Cox, Holden, & Sagavosky, 1987; Murray & Cox, 1990). The CRPN developed screening and referral protocols for health care institutions and community agencies to encourage the use of the EPDS. Implementation of these protocols has facilitated effective and increased identification of symptoms of perinatal depression and has led to a significant increase in referrals to mental health care.

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