Maternal Depression in Home Visiting
Special Thanks to....

- Pence Revington and the University of Wisconsin-Extension Cooperative Extension Family Living Program for sharing their HOME Inventory powerpoint slides and handouts (see slides and handouts with their logos)
- Beth Johns for all of her work in putting this training together
- Mountain Brook Board of Education for hosting the training
- The Department of Children’s Affairs, Dr. Susan McKim and Amy Floyd, for all of their support in making this possible
MATERNAL DEPRESSION

- What is maternal depression?
- What causes or contributes to it?
- How does maternal depression impact mothers, their children, family, and society in general?
- Screening for maternal depression: Edinburgh Postnatal Depression Screen
- What are some effective coping strategies and/or treatments?
Maternal Depression...did you know?

Maternal depression is the #1 complication of childbirth

Depression is the #1 cause of disease-related morbidity in women

Maternal depression is at the top of the list of the “Most significant mental health issues impeding children’s readiness for school”

Mental Health Policy Panel, Department of Health Services, 2002
Unfortunately, very few get treated

- If treatment were provided, an estimated 80% would show benefits in terms of reduced symptom severity.
- Only 52% of those with major depressive disorder receive treatment.
- 38% of those receiving treatment receive what is judged to be “only minimally adequate” treatment.
Today’s Take-Home Messages

1. Untreated postpartum depression unnecessarily hurts mothers, infants, children, and families

2. Adding depression screening to your practice can make a huge difference to the health trajectories of mothers and their families

3. In addition to screening, there is much you can do to support families suffering from depression symptoms
Maternal Depression

- Approximately 12% of all women experience depression in a given year.
- For low-income women, the estimated prevalence doubles to at least 25%.
- For pregnant and postpartum and parenting women, rates are in general range from 5-25%.
- Low-income mothers of young children, pregnant and parenting teens report depressive symptoms in the 40-60% range.
- Leading cause of disease-related disability among women.
Depressive Disorders in Mothers

- Prenatal Depression
- Baby Blues
- Postpartum Depression
- Postpartum Psychosis
# Prenatal Depression

<table>
<thead>
<tr>
<th>Onset</th>
<th>During Pregnancy</th>
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<tbody>
<tr>
<td>Prevalence</td>
<td>10-20% of pregnancy mothers</td>
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<tr>
<td>Symptoms</td>
<td>Crying, weepiness, Fatigue, Appetite disturbance, Anhedonia (loss of pleasure), Anxiety, Poor fetal attachments, Irritability</td>
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[Source: National Institute for Health Care Management (NIHCM) Foundation]
Prevalence major and minor ranges 7-26%
- Higher rates in poor urban women
- Diagnosis complicated by pregnancy symptoms
  - Overlap with fatigue, appetite changes, hypersomnia
  - Common symptoms: Loss of interest/pleasure, guilt, hopelessness, suicidal thoughts
    - Functional impairment is important for diagnosis

Affects fetal development
- Detection and treatment critical for promoting birth outcomes and reducing birth outcomes disparities

(Moses-Kolko & Roth, 2004)
Continuum of Postpartum Mental Health

- Postpartum Blues
- "Baby Blues"
- Sub-clinical depression
- Depression Diagnosis
- Postpartum Psychosis
**Baby Blues**

<table>
<thead>
<tr>
<th>Onset</th>
<th>Begins during the first few weeks after delivery (usually in first week, peaking at 3 to 5 days)</th>
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<tbody>
<tr>
<td>Symptoms usually resolve by two weeks after delivery</td>
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<tr>
<td>Prevalence</td>
<td>As high as 80% of new mothers</td>
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<tr>
<td>Symptoms</td>
<td>Crying, weepiness</td>
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<tr>
<td></td>
<td>Sadness</td>
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<td></td>
<td>Irritability</td>
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<td></td>
<td>Anxiety</td>
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<td>Exaggerated sense of empathy</td>
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<td>“Ups” and “Downs”</td>
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<td>Feeling overwhelmed</td>
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<td>Insomnia; trouble falling asleep; fatigue/exhaustion</td>
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<td></td>
<td>Frustration</td>
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## Post partum Depression

### Onset
- Usually within the first two to three months post-partum, though onset can be immediate after delivery (distinguishable from “baby blues” as it lasts beyond two weeks post-partum)

### Prevalence
- 10 to 20% of new mothers

### Symptoms
- Persistent sadness
- Frequent crying, even about little things
- Poor concentration or indecisiveness
- Difficulty remembering things
- Feelings of worthlessness, inadequacy or guilt
- Irritability, crankiness
- Loss of interest in caring for oneself
- Not feeling up to doing everyday tasks
- Psychomotor agitation or retardation
- Fatigue, loss of energy
- Insomnia or hyper-insomnia
- Significant decrease in appetite
- Anxiety manifested as bizarre thoughts and fears, such as obsessive thoughts to harm the baby
- Feeling overwhelmed
- Somatic symptoms (headaches, chest pains, heart palpitations, numbness)
- Poor bonding with the baby (no attachment), lack of interest in the baby, family, or activities
- Loss of pleasure or interest in doing things one used to enjoy (including sex)
- Recurring thoughts of death or suicide
Symptoms unique to Post Partum Depression

- Intrusive thoughts of harming the infant
- Extreme anxiety
  - Excessive worry, unable to control worry, mind going ‘blank’, poor focus, restless or ‘keyed up,’ tense
- Anger or agitation
- Extreme feelings of guilt
  - Wanting to run away, leave, get away
- Obsessive thoughts of inadequacy as a parent
  - “Wanting to have this baby was a mistake”
- Extreme exhaustion yet difficult sleeping
- Feelings of disconnection from the baby
- Feeling a loss of control over one’s life
  - A fog over my head or living in a fog
  - “If this is what it’s going to be like, I don’t want to do it”
Video on postpartum depression

- Speak up when you’re down:
- [http://www.youtube.com/watch?v=yH3WMQO-ooU](http://www.youtube.com/watch?v=yH3WMQO-ooU)
- 5 minutes
“I never thought I would have postpartum depression... I thought I would be overjoyed... instead I felt completely overwhelmed. This baby was a stranger to me. I didn’t feel joyful. I attributed feeling of doom to simple fatigue and figured that they would eventually go away. But they didn’t; in fact, they got worse. I wanted her to disappear. I wanted to disappear. At my lowest points, I thought of swallowing a bottle of pills or jumping out of the window of my apartment.”

Brooke Shields, July 2005
Major risk factors for Post Partum Depression

#1 Previous maternal or postpartum depression
- Recurrence rate 50-80%

#2 Depression or anxiety in pregnancy
- 23% of women with depression postpartum had depression in pregnancy
- Depression any other time in life

- Family history of depression or mood disorder (e.g., bipolar)
- Current/recent stressful life events
- e.g., trauma, poverty, violence, birth of ill child
- Remember immigrants, refugees may have prior history violence/trauma and isolation in host country
Other Post Partum Depression Risk Factors
Think about how many risk factors home visiting population has

- Inadequate social, familial or financial support
- Minority status
- History of sensitivity to hormonal shifts
- Delivery of premature infant
- History of miscarriage or abortion
- Abrupt weaning
- Childhood sexual abuse
- Controlling or perfectionist personality
- Single parent
- Isolation from family
- Infertility
- Long, difficult labor
- Significant loss in life
- History drug/alcohol abuse
- Multiples (twins, triplets)
Myths of Motherhood

Contribute to stigma, lack of detection and recognition of PPD and are barriers to women seeking treatment

- Pregnancy is wonderful
- Motherhood is instinctive/intuitive mothering capability
- Mothers should be happy when the baby is born
- Perfect baby
- Perfect mother
- Motherhood is mandatory to be a “real” woman
- Babies sleep
- Babies are beautiful
- “Natural” births are better
- Madonna images
Perpetuation of beliefs in myths include...

- Mothers...
  - Feeling of guilt and shame by not being able to live up to mythical expectations
  - Fear of being judged a bad person
  - Fear of baby being taken away
  - Being seen as having a weak character
  - Fear of being a “Bad” mother
- These feelings can be magnified when either dismissed or not acknowledged by professionals as real
Facts about Post Partum Depression

- Remains
  - Under-recognized
  - Under-diagnosed
  - Under-treated
- 50% of all cases go undiagnosed and untreated
- Only 12-20% of women with maternal depression actually receive treatment (Horowitz, 2006)
- Episodic, but without treatment can turn chronic
  - Most moms will feel better in 6 months even without treatment, but then will re-occur.
  - Moms with untreated depression that turns chronic are likely to still have depression symptoms at 2 year (Horowitz, 2007, 2009)
Treatment for Post Partum Depression

- Highly responsive to treatment
- Most common types of treatment are:
  - Psychotherapy
    - Individual, group, or mother-infant/family
  - Medications
    - Antidepressants
  - Goal: Right treatment for the individual woman’s needs, context, and goals
# Post partum Psychosis

**Onset**
- Usually starts within 2 to 4 weeks of delivery, but can start as early as 2 to 3 days after delivery (and can occur anytime in the first year)

**Prevalence**
- 1-2 per 1,000 new mothers

**Symptoms**
- Auditory hallucinations and delusions (often about the baby and often of a religious nature)
- Visual hallucinations (often in the form of seeing or feeling a presence of darkness)
- Insomnia
- Hopelessness
- Feeling agitated, angry
- Anxiety
- Paranoia, distrusting of others
- Delirium
- Confusion
- Mania (hyperactivity, elated mood, restlessness)
- Suicidal or homicidal thoughts
- Bizarre delusions and commands to harm the infant
**Postpartum Psychosis**

- **Medical emergency**
  - Remove baby from mother’s care and transport to emergency room

- **Symptoms:**
  - Extreme agitation
  - **Disconnection from reality**
  - Threats of suicide and/or infanticide “Jesus telling me to x”
  - Racing thoughts
  - Rapid speech
  - Severe insomnia
  - Hallucinations
  - Paranoia
  - Irrational speech or behavior
How does maternal depression impact mothers, their children, family, and society in general?
Post Partum Depression impact on Mothers

- Less affectionate, responsive and active to infant’s cries and demands for care
- Engage in harsher disciplining practices of children ages 2-4 yrs
- Less attentive to hygiene and safety
  - bath water temperature
- Anxious attachment or avoidant attachment style
  - “My baby doesn’t like me”

(Murray et al., 1996; Fields, 2010)

- ↓ playfulness, gazing, talking to infant
- Fewer positive interactions
- ↑ perception of infant as bothersome
- ↑ preoccupation with non-infant things/withdrawal
- Report physically and emotionally separating self from infant
- Display more anger, hostility and disengagement to infant
- ↑ risk for death by suicide
How maternal depression affects their children

- **Depressed mothers:**
  - provide less stimulation, are less responsive to infants, show more parenting difficulties, are less likely to seek appropriate medical care for their child and less likely to use prevention practices (*car seats, smoke alarms*)

- **Children exposed to maternal depression are at higher risk of:**
  - delayed cognitive and language development, mental health problems, suboptimal physical growth and myriad interpersonal, neuroendocrine, and behavioral problems

- Maternal depression associated with poorer outcomes in the child from infancy through adulthood
Mothers may appear:
- Disengaged
- ‘Lazy’ or unmotivated
- Express good intentions, lack follow-through
- Angry, feelings of guilt, disappointment

Reduced memory recall, learning, performance

Slower progress towards goals
- Increased cost of care
Screening for Postpartum depression

You can’t tell by looking that someone has depression
Is *critical* to detect and treat depression early

- Early detection
  - Can reduce symptom duration and severity
  - Reduce negative effects on infants/children

- Reduces the stigma of depression
  - Helps women feel they are not alone

- Health care providers
  - Increases comfort talking about depression and managing positive screens
Screening versus Diagnosis

- Screening tools are not diagnostic tools
- A positive screen does not make a diagnosis
  - 25-40% of persons who screen positive for depression will be diagnosed with depression
- Women who screen positive should be referred to a qualified mental health professional for clinical evaluation and formal diagnosis
Range of Depression Symptoms

- No symptoms
- Few symptoms
- Several symptoms
- Many symptoms

Sub-clinical depression
Depression diagnosis

Increasing severity
Edinburgh Postpartum Depression Scale

- EPDS (postpartum) or EDS (pregnancy)
  - Same questions and scoring
  - Simple to complete
  - It is a screening tool, not clinical diagnostic instrument
  - 10 questions
  - Sum responses
    - 5 items are ‘reverse coded’ Question #3, and #5-10
    - Normal: 0 = 0, 1 = 1, 2 = 2, 3 = 3
    - Reverse: 0 = 3, 1 = 2, 1 = 2, 3 = 0
  - Scores range from 0 to 30
    - Higher score = more severe depression symptoms
Advantages of EPDS

- Question 10 on thoughts of harming self or others
- Well-validated past 25 years, translated into 20+ languages
- Free to use
- Cox et al, 1987
Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Name: __________________________ Address: __________________________

Your Date of Birth: __________________________

Baby’s Date of Birth: __________________________ Phone: __________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- [ ] Yes, all the time
- [ ] Yes, most of the time This would mean: “I have felt happy most of the time” during the past week.
- [ ] No, not very often Please complete the other questions in the same way.
- [ ] No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - [ ] As much as I always could
   - [ ] Not quite so much now
   - [ ] Definitely not so much now
   - [ ] Not at all

2. I have looked forward with enjoyment to things
   - [ ] As much as I ever did
   - [ ] Rather less than I used to
   - [ ] Definitely less than I used to
   - [ ] Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - [ ] Yes, most of the time
   - [ ] Yes, some of the time
   - [ ] Not very often
   - [ ] No, never

4. I have been anxious or worried for no good reason
   - [ ] No, not at all
   - [ ] Hardly ever
   - [ ] Yes, sometimes
   - [ ] Yes, very often

5. I have felt scared or panicky for no very good reason
   - [ ] Yes, quite a lot
   - [ ] Yes, sometimes
   - [ ] No, not much
   - [ ] No, not at all

6. Things have been getting on top of me
   - [ ] Yes, most of the time I haven’t been able to cope at all
   - [ ] Yes, sometimes I haven’t been coping as well as usual
   - [ ] No, most of the time I have coped quite well
   - [ ] No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - [ ] Yes, most of the time
   - [ ] Yes, sometimes
   - [ ] Not very often
   - [ ] No, not at all

8. I have felt sad or miserable
   - [ ] Yes, most of the time
   - [ ] Yes, quite often
   - [ ] Not very often
   - [ ] No, not at all

9. I have been so unhappy that I have been crying
   - [ ] Yes, most of the time
   - [ ] Yes, quite often
   - [ ] Only occasionally
   - [ ] No, never

10. The thought of harming myself has occurred to me
    - [ ] Yes, quite often
    - [ ] Sometimes
    - [ ] Hardly ever
    - [ ] Never

Administrated/Reviewed by __________________________ Date __________________________
Instructions for using Edinburgh

- The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
- All of the items must be completed.
- Care should be taken to avoid the possibility of the mother discussing her answers with others.
  - Goal for the answers to come from the mother or pregnant woman.
- The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
- Build a relationship of trust prior to conducting the screening.
1 of 4 possible responses that comes the closest to symptoms during the previous 7 days

All 10 items must be completed

Items are scored 0, 1, 2, 3

- Note: those requiring reverse scoring have already been reversed on your data collection forms

- Maximum score: 30

- Possible depression: 9 or greater

- Always look at item 10!

  - Warrants immediate discussion if >1 (suicide risk)
Pregnancy and Postpartum

Recommendation: Score of 9 or higher signifies the possibility of post-partum depression

- Mom needs a plan of action, which includes a referral to a health care professional and mental health professional (to be evaluated for diagnosis)
- ANY positive response to Question #10 on suicidal thoughts ("the thought of harming myself has occurred to me") needs immediate attention and referral

Other cut-off scores you may encounter

- 10+ (as noted on author handout), 13+, 15+
The EPDS can detect women with depression reliably
The EPDS can occasionally miss women
- Woman is obviously suffering, but screens negative
The EPDS does not detect other disorders

REMEMBER
These are SYMPTOMS only. It is NOT correct to say ‘You have depression’
How Often/When Should I Screen?

- **General Recommendations are:**
  - Pregnancy
    - 1\textsuperscript{st}, 2\textsuperscript{nd}, 3\textsuperscript{rd} trimester
  - Postpartum
    - Do not screen from birth to 2 weeks – why? _________
    - At least once between 2 weeks and 60 days postpartum
    - Postpartum 1, 3, 6, 9, 12 months is ideal
      - Symptoms may peak at 3 months or may not be seen until much later
  - Be aware of possibility of too much screening

- **Requirements for First Teacher:**
  - Primary caregiver not pregnant at enrollment:
    - 2 months then annually
  - Primary caregiver pregnant at enrollment:
    - Baby’s age 1-8 weeks, then annually
Practice EPDS screening and scoring (10 minutes)

- Role play taking the EPDS
  - Switch the EPDS with your partner to your left
  - Score your partner’s EPDS
  - Return your partner’s scored EPDS and talk about the experience of taking the tool and scoring the tool
Reconvene after group work

- Screening – surprises?
  - Ease of scoring?
  - Questions?
- How did you feel answering the questions?

- Now, let’s think about what happens next...after the completing the Edinburgh
“Your score indicates that you may be depressed. How does that fit with what you’ve been experiencing?”

“Your score isn’t in the range for likely clinical depression, but it sounds like you’re struggling right now. Let’s talk about what kinds of support would feel helpful.”
Notice especially high items and use as discussion starter

- “You marked... could you tell me more about that? Could you tell me about a time when you felt that way?”

- Always check item #10 - thoughts of harming herself
Talk Openly About Safety

- Reassure that you are asking because you want *her* to feel safe & secure
- Matter-of-fact approach
- Openers:
  - “Some women who are feeling depressed or overwhelmed have thoughts of hurting themselves. Do you ever have these kinds of thoughts?”
  - “How about your baby? Do you worry about his safety or that you might hurt him?”
  - “Tell me more about these thoughts….”

- Normalize that it is difficult to talk about
- Provide emergency resource information, even if not needed now
Practice Discussion of EPDS Results
**Boundaries:** You are **not** responsible for managing or treating symptoms of PPD, but you can **facilitate** a connection to a mental health professional.

**Resistance from mom**
- This is just how my mom, grandma, sister, cousin felt after having a baby
- I’m not crazy! I won’t answer your questions, no way
- Know how to answer the questions “right”, but obviously suffering

**First make sure the discomfort is with the mother/family not with you**
- Practice your responses. Learn from each encounter.
- Know that mothers may soften to the discussion as you develop your relationship.
Making the Connection

- Remind Her:
  - To be the best mom she can, she needs to take care of herself.
  - She isn’t “crazy, weak or to blame”. PPD is real, affects hundreds of thousands of women & and is usually a combination of biological factors and stress.
  - Getting outside input or another perspective may help her find the best way to take care of herself during this difficult time.

- Recognize that in addition to fear about treatment, it is difficult to follow through when depressed due to symptoms such as fatigue:
  - Call to make referral from mom’s home with her present
  - Or get her permission to have provider contact her directly
  - Offer to take her to first appointment
Discussion
The Role of the Home Visitor

- In maternal mental health?
- Therapy versus a therapeutic relationship
  - What does this mean to you?
- What is the scope of your role?
- What steps, safeguards, or back-ups might you put into place when questions come up or for difficult cases?
Guidelines for Practice for Home Visitors Working with Parents Affected by Mental Illness
Be alert to “red flags” that a person may be considering or planning suicide:

- Ask, “Are you thinking of suicide?” Or, “Have you been feeling so hopeless that you find yourself thinking about death?” (Asking these questions will not make a person any more likely to commit suicide.)

- Statements and actions to watch for include:
  - Vague statements such as “Sometimes I don’t want to be here anymore,” or “I feel like giving up.” These vague statements should not be ignored – it may be the person’s way of reaching out for help.

- Sudden change in feelings or behavior, including sudden lack of concern about things that had previously been important or upsetting to them.

- Giving away prized belongings.
Helping families.....

- Inform families of appropriate resources and refer; support their choices and encourage follow through.
- Identify and address barriers to treatment
  - transportation, child care, lack of understanding of what happens during treatment, stigma of seeking mental health treatment, etc.
- Encourage parents who have a primary care provider to see that provider as a first step if they are reluctant to seek treatment.
  - May be less threatening to the parent. It may also provide faster access to treatment in some cases.
- Provide a family with general assistance regarding options to fund treatment and any preferred providers that must be used because of HMO or Medicaid requirements.
- Connect parents and other affected family members to informal supports for PPD and mental illness
Create an Action Plan

- Components
  - Referral
  - Ensure Safety
  - Social Support
  - Nutrition-Diet
  - Sleep
  - Exercise-Activity
  - Support to Family
Screening and Referral Care Path

Conduct Edinburgh Postpartum Depression Screen (EPDS)

- Screening Results: Less than 9
  - Provide maternal mental health tip sheet
  - Re-screen annually

- Screening Results: 9 or higher
  - Discuss need for further assessment and evaluation
  - Document plan in mom's record

- Question 10 has response: Hardly ever; Sometimes; Or yes, quite often
  - Discuss with mom her responses and the need to assess her safety;
  - Coordinate with supervisor; Document safety plan
Referral Considerations

- **Referral For Evaluation of a Diagnosis**
  - The client may require your support to access the referral
    - Consider helping woman make the first call
  - Result of referral may include psychotherapy, medications, both, or none if a diagnosis isn’t identified
    - Remember 25-40% of those who screen positive will be diagnosed
  - Does the client have insurance?
  - Does the client have the ability to pay for services?
  - Does the client have support from family and/or friends?
  - Are there other factors that may impact if/where she seeks mental health services (e.g., transportation, childcare).
  - **Consider giving multiple referral options, not just the # to one mental health professional**
3 questions commonly used to guide decision-making around possible risk for suicide:

- Does the person **have a plan** to commit suicide/self-harm (i.e., can the individual answer questions about what, when, where, and how)
- Does the person **have means** available for carrying out the plan
- Are there **any factors that are keeping** the person from carrying out their plan?

Create a clear plan to address all responses:
- See “Concerns about Depression and Possible Suicide Risk” example; “Documentation of Concern Regarding Risk of Harm to Participant or Others;” “Consent to Share Information;” and flowchart example
RESPONDING TO CONCERNS ABOUT SELF-HARM AND POSSIBLE SUICIDE RISK

If person reports thoughts of self-harm/death (Items #7 or #14 on the Beck, Item #15 on the SCL-90, or spontaneously)

Check for a plan and protective factors:
"I noticed that you agreed with the statement...". I'd like to talk with you a little more about that. Have you actually had any thoughts of harming yourself?"

If Yes, ask:
--What kinds of thoughts have you been having?
--Have you thought about how you might do that? How?
--Do you have access to that (method mentioned- e.g., gun, pills, etc.)
--Have you thought about where you might do that/Where?
--Any things keeping you from carrying out plan? What? Anything Else?

1. Highest Risk:
   Person states that:
   A. They are thinking about suicide
   B. They have a clear plan (how, when, where)
   C. Means are available (guns, pills, nobody home, etc)
   D. They cannot identify things stopping them from carrying out their plan

2. Medium Risk:
   Person acknowledges thoughts about suicide but
   --Lacks a clear plan
   --States that they would not carry it out and identifies reasons why they wouldn't

3. Lowest Risk:
   Person is showing signs of depression but denies any thoughts about self-harm/suicide or
   -Has had thoughts but no plan and
   -Says they would not do it and identifies reasons why they wouldn't

If you are an ASSESSOR or an INTERVENTIONIST:
1. Do Not leave person alone unless your safety is threatened
   --Call your supervisor until you make contact. Wait for your supervisor to respond before intervening unless the situation is so dangerous that your immediate safety or the safety of another is presently jeopardized).

2. If your safety is threatened, go to nearest safe place, call 911 & state exact concern
   --Call your supervisor for immediate support
   --Do not leave until told by EMS that they do not need to speak to you at the scene.

3. If you cannot reach a supervisor and must intervene, do the following:
   --Stay calm, be empathetic, and state your concern ("I'm concerned about your safety)
   --State that the person needs to see a doctor right away
   --Share NIMH materials
   --Give 3 choices and follow through
   a. They can call 911 and ask for a ride to nearest hospital for emergency behavioral health services to find a way to feel better/not hurt self
   b. You can place the call to 911 or
   c. They can have another adult join the 2 of you to see if that person is willing to help to get immediate emergency behavioral health services.

If you are an ASSESSOR:
-Consult your supervisor to identify a plan of action before intervening.

If you are an INTERVENTIONIST:
--Use gentle, reflective & empathetic statements. Be clear that you are not a therapist, but there are people out there who can help. Share NIMH materials and encourage the person to share materials with and talk to doctor. Contact your supervisor immediately.

If you are an ASSESSOR, don't intervene.

If you are an INTERVENTIONIST:
--Discuss concern with your supervisor to determine plan
Ensuring Safety

- Assess the mother’s risk for harming herself or her infant
  - “Sometimes mothers feel so down and depressed they think life isn’t worth living or that they would be better off dead. Have you had thoughts like that?”
    - This is known as suicidal ideation.
  - Next: Ask if she has a suicide plan.
    - ‘Do you have a plan for how you might hurt yourself?’
    - If so, refer for psychiatric emergency services immediately (i.e., you call a behavior services hospital or 911 if needed)
  - Thoughts of harming the infant in some way without the intent to do so are common with maternal depression, obsessive-compulsive disorder but are not assessed by the EDS. Harm to infant is common in psychosis and is a medical emergency (duty to report).
Social Support

- From Community
- From Family
- From Home Visitor (you!)
Social Support From Community

- Refer to a mom & baby support group (in-person or online)
- Refer to a mom and baby play group (e.g., at local library, church) if woman could benefit from more social interaction.
  - If child has special needs, seek support group specific to the child’s condition (e.g., Down’s Syndrome support group)
- A woman is diagnosed with depression may need a depression-specific support/therapy group when available.
  - See resources handout
  - Postpartum Support International can help find online support if in-person support is not available or feasible.
Social Support from Family

- Determine which friends or family are available to help and in what ways
  - May not realize extent of network available

- Ask mother if there is a difference between how much help she needs versus how much help she gets. Work to reduce any gap
  - Identifying the gap between perceived and actual support can direct efforts to ask people for the help the mom actually needs

- Provide concrete guidance about how to ask for help
  - Many women are so exhausted/fatigued that they may not have the energy to mobilize support. Specific words/phrases can be very helpful.
Rest and Sleep

- Rest
  - Listen to mind and body when tired – allow self to rest
  - Let go of non-essential activities (dishes, cleaning) when fatigued
  - Recognize when fatigue/exhaustion so severe that woman turns inward (withdraws) rather than outward (asking for help). Try to prevent this. Establish sleep routine
    - Treating the symptom (caffeine) versus treating the problem (getting more/better sleep)
Exercise

- Encourage daily activity and exercise after the first couple weeks postpartum
  - Morning/early pm exercise ↑ body temperature, regulates circadian rhythm
  - Exercise is the most effective non-pharmacologic intervention for depression....mood regulator
  - Great resource on how exercise and food can affect sleep ([http://www.sleepfoundation.org/article/sleep-topics/diet-exercise-and-sleep](http://www.sleepfoundation.org/article/sleep-topics/diet-exercise-and-sleep))
  - Problem-solve weather issues
Encourage mom to make time for herself once/day to once/week as able. (e.g., get hair done, go out with friends, read a book, be alone to think)

- Time to self can help woman regain sense of self in midst of 24-hour care giving of baby and help see herself as a priority.

Healthy/happy mom = healthy/happy family!
Support to Families

- Acknowledge effect that a mother’s symptoms can have on relationships within the family
- Ask how families are feeling and coping
  - Provide positive reinforcement to the family for their support to this point.
- Consider providing the HRSA “Depression During and After Pregnancy” booklet to families
- Caution: Be respectful of family dynamics as well as the stigma associated with depression symptoms
A BIG ISSUE....

Most Know or Are Taught:

• Basic First Aid and CPR
• Universal sign for choking
• Facial expressions of physical pain
• Basics to recognize physical symptoms of illness and injury
• Basic nutrition and physical health care requirements
• Where to go or who to call in an emergency

Most Do Not Know and Are Not Taught:

• Signs of suicide, addiction or mental illness
• What to do about mental illness or suicide or how to find help for self or others
• Relationship of mental health to individual or community health or to health care costs
• Relationship of early childhood trauma to adult physical & mental illness
FOCUS EFFORTS

PHYSICAL HEALTH

What It Takes

• Nutrition
• Exercise
• Rest
• Good Genes

Reducing Risks

• Hand-washing
• Covering cough
• Protecting v food-borne illnesses
• Getting immunizations
• Taking universal precautions
• Avoiding unprotected sex

MENTAL HEALTH

What It Takes

• Understanding/managing emotions
• Managing stress
• Positive social relationships
• Hope – Spirituality

Reducing Risks

• Trauma
• Chronic stress, esp. in childhood
• Non-supportive or destructive relationships
• Uninformed parenting
• No or limited skills
FOCUS EFFORTS (CONTINUED)

PHYSICAL HEALTH

➔ Recognizing Signs
  • Temperature
  • Cough
  • Fever
  • Pain
  • Avoiding Behaviors That Increase Risks

➔ Knowing When & How To Get Help
  • Early detection – tests/screening
  • Stop the bleeding and pain
  • Save life first

MENTAL HEALTH

➔ Recognizing Signs
  • Suicidal thinking
  • Depression and anxiety
  • Post-traumatic stress
  • Substance abuse
  • Underage drinking or inappropriate amounts in adults

➔ Knowing When & How to Get Help
  • Early detection – screening/brief interventions
  • Stop emotional pain
  • Keep safe – for individual and for community
Mental Health Resource Directory for Alabama
AN ONLINE MENTAL HEALTH RESOURCE DIRECTORY FOR OUR COMMUNITY

Search Now: Service, treatment, diagnosis

JOIN THE DIRECTORY
If you are a mental health resource provider who would like to be included in our directory please click here:

Welcome to the website for people seeking information about mental health resources in Alabama!

MATERNAL DEPRESSION WORKSHOP, MAY 10, 2013, Mtn Brook Board of Education. For more info, go to www.alapsych.org, Calendar page.

Managing Traumatic Stress: Tips for recovering from disasters and other traumatic events.
Mental Health Resource Directory for Alabama
www.alabamamentalhealth.org

Crisis Center: 205-323-7777

2-1-1 Connects Alabama (or 1-888-421-1266)
Free number to dial for information about health and human service organizations in your community

HOTLINES

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jefferson County DHR Child Abuse Hotline</td>
<td>(205) 423-4850</td>
</tr>
<tr>
<td>AIDS/HIV Nightline</td>
<td>(800) 628-9240</td>
</tr>
<tr>
<td>Alabama AIDS Hotline</td>
<td>(800) 228-0469</td>
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<tr>
<td>Alabama Domestic Violence Hotline</td>
<td>(800) 650-6522</td>
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<tr>
<td>Alcohol/Drug Info Line</td>
<td>(800) 662-4357</td>
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<tr>
<td>Battered Women's Hotline</td>
<td>(800) 650-6522</td>
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<tr>
<td>Boys Town National Hotline</td>
<td>(800) 448-3000</td>
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<tr>
<td>CDC National Aids Hotline (Spanish)</td>
<td>(800) 344-7432</td>
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<tr>
<td>Child Abuse Hotline (US)</td>
<td>(800) 422-4453</td>
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<tr>
<td>Childhelp USA Hotline/ National Child Abuse Hotline</td>
<td>(800) 422-4453</td>
</tr>
<tr>
<td>Cocaine Anonymous National Referral Line</td>
<td>(800) 347-8998</td>
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<tr>
<td>Crisis/Runaway Hotline</td>
<td>(800) 999-9999</td>
</tr>
<tr>
<td>CSAT Hotline</td>
<td>(800) 729-6686</td>
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<tr>
<td>Depression Awareness: National Institute of Mental Health</td>
<td>(800) 421-4211</td>
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<tr>
<td>Domestic Violence Hotline (AL)</td>
<td>(800) 650-6522</td>
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<tr>
<td>Domestic Violence Hotline (US)</td>
<td>(800) 799-7233</td>
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<tr>
<td>Drug/Alcohol Reporting Hotline</td>
<td>(800) 392-8011</td>
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<tr>
<td>Missing/Exploited Children Hotline</td>
<td>(800) 843-5678</td>
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<tr>
<td>National Drug Treatment Hotline</td>
<td>(800) 662-4357</td>
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<tr>
<td>Parent Assistance Helpline</td>
<td>(866) 962-3030</td>
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<tr>
<td>Agency on Aging Hotline</td>
<td>(800) 243-5463</td>
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<tr>
<td>STD Hotline (CDC Natl Info)</td>
<td>(800) 232-4636</td>
</tr>
<tr>
<td>National Substance Abuse Hotline</td>
<td>(800) 729-6686</td>
</tr>
<tr>
<td>Suicide Prevention Lifeline</td>
<td>(800) 784-2433</td>
</tr>
</tbody>
</table>
Thank You!!!!!!!!!!