

# CONSIDERING INTERVENTIONS FOR DEPRESSION IN REPRODUCTIVE AGE WOMEN IN FAMILY PLANNING PROGRAMS

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## Introduction

Depression is a significant public health problem that affects approximately 18 million Americans annually.<sup>1</sup> It is the leading cause of disability for the 15-44 year old age group and is the leading global cause of disability for individuals over the age of five.<sup>1,2</sup> In both the U.S. and other countries, research has consistently shown that twice as many women experience major depression and dysthymia, or chronic low-level depression, than men, most commonly during their reproductive years. It is estimated that one in five women in the U.S. will develop depression at some point in her life.<sup>3-6</sup>

**Table 1 – Overview of Different Types of Depression**

Major Depression	Dysthymia <sup>1,7</sup>	Perinatal Depression <sup>9</sup>	“Baby Blues” <sup>10</sup>
<p>Affects about 6.7% of U.S. adult population per year (14.8 million people)<sup>1</sup></p> <p><b>Symptoms</b><sup>7,8</sup> At least five of the following for two weeks:</p> <ul style="list-style-type: none"> <li>• Depressed or irritable mood</li> <li>• Decreased pleasure or interest in activities</li> <li>• Not feeling up to doing daily tasks</li> <li>• Change in appetite or weight</li> <li>• Sleeping more or less than usual</li> <li>• Feeling restless or slowed down</li> <li>• Fatigue or loss of energy</li> <li>• Feelings of guilt or worthlessness</li> <li>• Decreased concentration</li> <li>• Persistent physical symptoms that do not respond to treatment</li> <li>• Sense of hopelessness</li> <li>• Thoughts of suicide</li> </ul>	<ul style="list-style-type: none"> <li>• Affects about 1.5% of U.S. adult population per year (3.3 million people)</li> <li>• Similar symptoms to depression but less severe</li> <li>• Long-term, chronic symptoms (minimum duration of 2 years) that do not disable, but keep one from functioning well or from feeling good</li> <li>• Many people with dysthymia also experience major depressive episodes at some time in their lives</li> </ul>	<ul style="list-style-type: none"> <li>• Symptoms similar to depression</li> <li>• Somatic signs, like troubles with sleeping, changes in appetite or weight, and fatigue, not always considered to be signs of depression since they can be a normal part of pregnancy and/or new motherhood</li> <li>• May also include excessive worrying about the pregnancy or baby and fears of being alone with the baby or not caring about the baby</li> </ul>	<ul style="list-style-type: none"> <li>• This is not considered a disorder since the majority of mothers experience it</li> <li>• Occurs in about 80 percent of mothers</li> <li>• Usual onset within first week postpartum</li> <li>• Symptoms may persist up to three weeks</li> </ul> <p><b>Symptoms</b></p> <ul style="list-style-type: none"> <li>• Mood instability</li> <li>• Weepiness</li> <li>• Sadness</li> <li>• Anxiety</li> <li>• Lack of concentration</li> <li>• Feelings of dependency</li> </ul>

## Executive Summary

*Depression is a significant public health problem in the United States and around the world, with women experiencing depression at twice the rate of men, both in terms of annual and lifetime prevalence. It has been recommended that routine screening take place as a part of primary care services. However, like depression in general, depression in women, including depression during the perinatal period, is often undiagnosed and/or untreated. Opportunities may exist for family planning providers to address this system deficiency, since they often serve as a source of primary care for women during their reproductive years. Such interventions may be especially important for young, low-income, and uninsured women who are often at greater risk of depression.*

Depression in women during the perinatal period that includes pregnancy and the twelve months following delivery has received increasing attention in recent years. Interest of the federal Maternal and Child Health Bureau (MCHB) was sparked in 2000, following the release of the Surgeon General's Report on Mental Health and increased media attention focused on postpartum depression and postpartum psychosis.\* In 2004, Congress earmarked MCHB funding to address perinatal depression, and MCHB is now funding activities in several states and communities across the country.<sup>11</sup>

Estimates of the prevalence of perinatal depression vary widely. However, one recent meta-analysis suggests that the prevalence of depression during this period is similar to the prevalence of depression overall in reproductive age women.<sup>12,13</sup> While perinatal depression can have adverse effects on a woman's pregnancy, her children, and her family, depression in general can affect her overall well-being at any stage of her life. It is thus an important aspect of women's health to address in a variety of settings, including family planning clinics.

This brief reviews the literature, which along with the author's direct experience in the family planning field and key informant interviews, shaped the ideas presented below. The brief focuses on interventions for depression within family planning settings for several reasons:

- women of reproductive age are at high risk for depression, and they are the primary population seeking family planning services
- for many women, a family planning provider may be her only source of health care – many family planning programs have responded by successfully integrating additional primary care services
- women who seek services at publicly funded family planning clinics are more likely to be low-income and to have other risk factors that put them at higher risk for depression

- family planning seeks to ensure healthy, wanted pregnancies, and depression can negatively impact a pregnancy
- many family planning providers focus on women's health more generally, and mental health is an important dimension of overall health, especially for women, given their higher prevalence and incidence of depression.

## **Depression in Reproductive Age Women**

**PREVALENCE & INCIDENCE:** Although a variety of studies have shown that women experience rates of depressive disorders double those of men, the exact reasons for this disparity are not clear. Possible explanations include the differential stress experienced by women, as well as biological and hormonal factors. Depression in women is more prevalent during their reproductive years, and many have theorized that hormonal changes during various reproductive events, including during and after pregnancy, may play a role in the development of depression. Pregnancy can itself be a source of stress, especially if the pregnancy was unintended, and new motherhood can be a period of enormous change.<sup>4,14,15</sup>

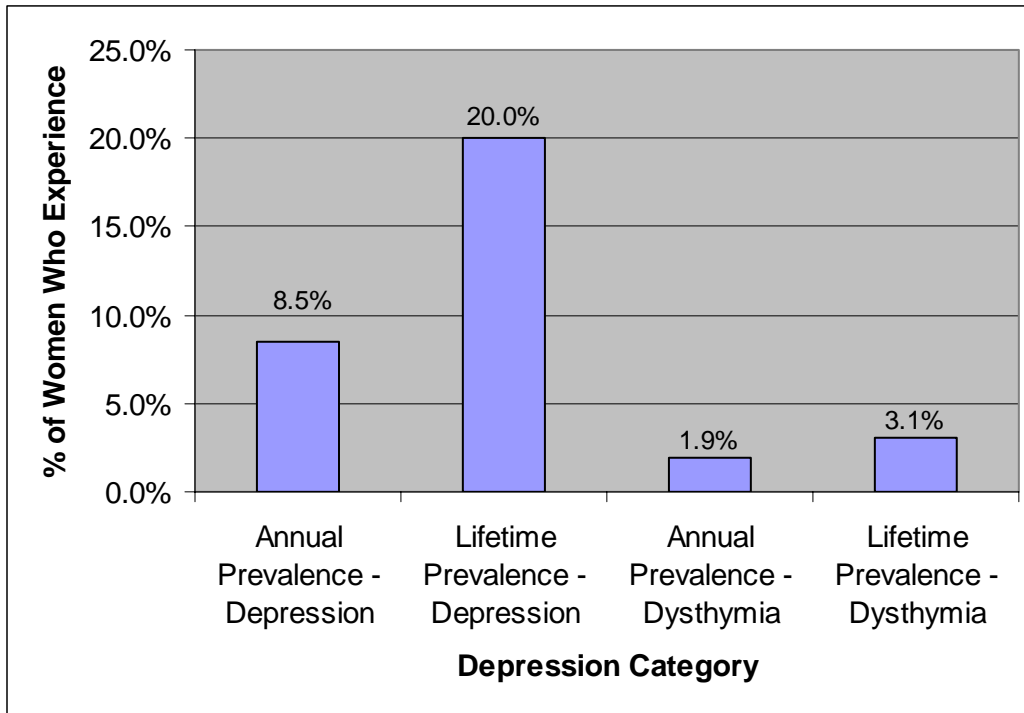
Recent estimates (see Figure 1) show that among all women in the U.S., the twelve-month prevalence is 8.5% for major depressive disorder and 1.9% for dysthymia. Twenty percent of women experience major depression, while 3.1% experience dysthymia during their lifetime.

In three recent studies that screened women for depression at publicly funded family planning clinics, the rates were higher than national rates, as a result of the overlap of risk factors for depression (discussed below) and the clientele seen at family planning clinics.<sup>3,17,18</sup> In a study conducted at health department family planning clinics in North Carolina, almost half the patients surveyed had scores on a screening instrument at a level indicating depressive symptoms.<sup>17</sup> While other studies found lower rates, they were still higher than national rates and underscore that this population is at high risk of depression and depressive symptoms.

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\* Postpartum psychosis is a much rarer disease with significant psychotic symptoms and has been implicated in some of the high-profile cases of mothers killing their children in recent years. A discussion of postpartum psychosis is outside the scope of this brief.

**Figure 1 – Prevalence of Depression among Women in the U.S.**



Source: National Comorbidity Replication Survey <sup>16</sup>

There are fewer sources of data for perinatal depression. In a recent review of studies that conducted clinical assessments of depression rather than relying on self-report scales, Gavin et al. express concern about the wide confidence intervals of incidence and prevalence seen in most studies, leading to imprecise estimates of the extent of perinatal depression. This meta-analysis calculated a point prevalence for overall depression of 8.5 – 11.0% (3.1 – 4.9% for major depression only) during the pregnancy and 6.5 – 12.9% (1.0 – 5.6% for major depression) during the first year postpartum.<sup>12</sup>

Limited data are available on incidence, but estimates range as high as 14.5% of women experiencing a new depressive episode during pregnancy and again during the first three months postpartum. The prevalence does not appear to be substantially different than what would be seen in a similarly aged group of women who had not recently experienced pregnancy.<sup>12,13</sup> However, a study by Cox et al. suggests that incidence might rise in

postpartum women, as the stress of the pregnancy and new motherhood may be more likely to trigger a new depressive episode at that time.<sup>19</sup> Clearly, more research is needed to ascertain better estimates of how many women are affected by perinatal depression and at what point in the perinatal period.

**CONSEQUENCES OF DEPRESSION:** Depression is a chronic, personally debilitating illness that can affect day-to-day functioning and an individual’s relationships with others. Major depression is considered to have significant effects on functioning, while dysthymia may have less severe effects but persists for at least two years. Depressive disorders diminish quality of life, cause personal suffering, and often increase the use of other health care services, since depressive symptoms can manifest somatically.<sup>7, 20, 21</sup> There is also evidence that symptoms of depression may manifest themselves differently in women, and they may experience more symptoms than men, as well as a lower quality of life.<sup>4, 22</sup> Other consequences of untreated depression are listed in Table 2.

**Table 2 – Selected Consequences of Depression at Different Points in the Lifecourse**

During the Reproductive Years	During Pregnancy	Postpartum
Associated with sexual and other risk behaviors <sup>3</sup> , including: <ul style="list-style-type: none"> <li>• unprotected intercourse</li> <li>• sexual activity while under the influence of drugs and alcohol</li> <li>• having had a sexually transmitted infection</li> <li>• substance use</li> <li>• reduced compliance with contraceptive regimens<sup>24</sup></li> </ul>	Associated with: <sup>24, 25</sup> <ul style="list-style-type: none"> <li>• Poor self-care and decreased use of and compliance with prenatal care</li> <li>• Lower than expected weight gain during pregnancy</li> <li>• Higher risk of using alcohol or drugs</li> </ul> Increases risk of postpartum depression <sup>25</sup>	Associated with <sup>12, 24, 25</sup> : <ul style="list-style-type: none"> <li>• Lower quality interactions between mother and child</li> <li>• Disruption in mother-infant bonding and attachment</li> <li>• Disruptions in infant's cognitive and emotional development</li> <li>• Missed pediatric appointments and greater use of emergency department services<sup>26</sup></li> </ul>

**RISK FACTORS FOR DEPRESSION:** The exact etiology of depression is unclear, though it is thought that genetic, biochemical and hormonal, environmental, psychological, and social factors all play a role. Stressors, whether biologic or social, are also thought to be important. As discussed above, women may exhibit higher rates of depression because of the differential stress that they experience compared to men. Hormonal factors and reproductive events also seem to be associated with depression, as women are at higher risk during their reproductive years; times of high vulnerability include adolescence, pregnancy, postpartum, and perimenopause.<sup>27, 28</sup> In addition, many women experience premenstrual dysphoric disorder (PMDD) that can include depressive symptoms. There is also significant comorbidity of PMDD and depression, as women with PMDD are more likely to have experienced past major depression and at increased risk for future depressive episodes.<sup>4</sup>

Additional factors that may influence depression include race, socioeconomic status, employment status, previous trauma, and chronic illness.<sup>5, 17, 29</sup> These factors are important because of their intersection with the client population of publicly funded family planning programs, who are more likely to be young, black or Hispanic, uninsured or on Medicaid, and to have not completed high school.<sup>30</sup> A family history of depression is also a risk factor. Depression tends to be recurrent and sometimes chronic; someone who has experienced one episode of depression is more likely to experience another.<sup>17, 20</sup>

Perinatal depression shares similar risk factors with depression in general, although stresses specific

to pregnancy and the postpartum period are also considered possible triggers. A recent study by Rich-Edwards et al. found that the biggest predictors of antenatal depression were financial hardship, lack of a partner, unwanted pregnancy, and previous history of depression. Previous history of depression led to a four-fold higher chance of experiencing depression during pregnancy. The higher rates of antenatal depression seen among women of color and young women were largely explained by the first three factors.<sup>5</sup> There is an obvious symmetry between these risk factors and clients of publicly funded family planning clinics.

For postpartum depression, the same study found that the largest predictor was previous depression before or during pregnancy. Financial hardship also remained a strong predictor, though partnership status and pregnancy intendedness were not. Social support appeared to be a protective factor, and the lack of social support disproportionately experienced by low-income women seemed to be a more important determinant than the financial hardship itself.<sup>5</sup> Similarly, a recent study by Howell et al. found that the strongest predictors of early – 2-6 weeks – postpartum depressive symptoms were nonwhite race, physical symptom burden, infant colic, lack of social support, and low self-efficacy.<sup>31</sup>

The risk factors discussed above are diverse and common among the population. In addition, not everyone who has one or more risk factors will develop depression. This makes it difficult to assess depression by the presence of risk factors alone, which points out the need for more pro-active screening in order to identify individuals that are depressed.<sup>32</sup>

**SCREENING:** Depression is largely undiagnosed in health care settings, even though the U.S. Preventive Services Task Force (USPTF) in 2002 recommended routine screening of adults for depression in primary care settings. However, they did include the caveat that it should be done in settings “that have systems in place to assure accurate diagnosis, effective treatment, and follow-up.”<sup>32</sup> The American College of Obstetricians and Gynecologists (ACOG) released a statement in 2002 that obstetrician-gynecologists (ob-gyns), as primary care providers, should be alert to depressive symptoms among their patients; however, they did not recommend formal screening of all patients.<sup>33</sup> A 2003 study found that 44% of ob-gyns reporting that they always or often screen patients for depression, while 41% reported that they sometimes screen and 15% reported that they never screen. Most reported using their own questions, rather than a screening instrument.<sup>22</sup> Another 2003 study found that while ob-gyns overwhelmingly see themselves as having responsibility for recognizing depression, substantially fewer felt comfortable being able to treat depression. However, current ob-gyn residents expressed more confidence in their ability to recognize and treat depression and reported receiving more training in mental health than recent graduates.<sup>28</sup>

There are no data available on the number of publicly funded family planning clinics that screen for depression, but based on a review of the literature, it seems to be the exception rather than the rule. Only three recent studies were found that discuss depression screening in family planning settings<sup>3, 17, 18</sup> and a fourth was conducted in public-sector gynecological clinic.<sup>29</sup> This is a particular concern because low-income women are more likely to get their gynecological care from a family planning clinic than a private provider, and family planning clinics are often the only or main source of health care for the clients they serve.<sup>29, 30, 34</sup>

There are several short, self-report instruments that can reliably be used to identify depressive symptoms at any time, during pregnancy, and postpartum (see Table 3). In particular, the Edinburgh Postnatal Depression Scale (EPDS) is often used in postpartum women because it removes questions related to normal life changes and somatic symptoms that may accompany the birth of a child.<sup>35</sup> The EPDS has also been validated for use during pregnancy but appears to be less commonly used in the postpartum period. These instruments are screening tools, and true diagnosis of depression relies on a subsequent

clinical interview among women identified as potentially depressed through screening.

Despite the brevity of these screening tools, Whooley et al. found that a simple two-question screen (see Table 3) provides similar results as the longer screening instruments discussed above and is a quick and easy guide for identifying patients who should undergo additional assessment for depression. The advantage of this tool is that it saves time while providing a similar level of sensitivity without a significant decrease in specificity.<sup>32, 36</sup> Such a screen, when the questions are asked rather than written, can be useful in settings where there are concerns about the level of literacy among the patient population, as may be the case in many publicly funded family planning programs.

The USPTF reported that they found “little evidence to recommend one screening method over another, so clinicians can choose the method that best fits their personal preferences, the patient population served, and the practice setting.”<sup>32</sup>

**TREATMENT:** Effective treatment is available for depression, including the use of medication and/or psychotherapy. Medication is generally recommended for treatment of major depression and may be used in conjunction with psychotherapy. The most common types of medications used are selective serotonin-reuptake inhibitors (SSRI’s) and tricyclics. The SSRI’s typically have fewer side effects.<sup>27</sup>

There is ongoing research about the safety of using antidepressants during pregnancy, because of the need to balance the possible risks of medication on the fetus with the risks of untreated depression during pregnancy.<sup>38, 39</sup> Women with a history of depression or those who develop depression during pregnancy are advised to discuss their individual situation with their health care provider to decide on the best course of action in terms of staying on antidepressants and/or switching to one that has a lower risk of negative effects on the fetus. The same caution is recommended during the postpartum period while breastfeeding. At this point, the SSRI’s seem to have fewer risks associated with them during the pregnancy and postpartum and may be the preferred treatment. A full discussion of this issue is beyond the scope of this brief, but there are several recent articles that summarize current knowledge about the use of antidepressants during the perinatal period and discuss the weighing of risks vs. benefits.<sup>24, 25, 38</sup>



**Table 3 – Commonly Used Depression Screening Tools**

*Edinburgh Postnatal Depression Scale (EPDS)*

- 10-item self-report scale, takes 5 minutes to complete
- developed to be used postpartum but has also been validated for use during pregnancy – takes out most questions about somatic symptoms
- free and available online – [www.perinatalweb.org](http://www.perinatalweb.org)

*Center for Epidemiological Studies-Depression (CES-D) Scale*

- 20-item self-report scale
- developed to assess depression in the general population (includes somatic symptoms)
- free and available online – [www.perinatalweb.org](http://www.perinatalweb.org)
- shorter versions are available, including a 10-item scale

*Beck Depression Inventory (BDI)*

- 21-item self-report scale for general depression
- helpful in measuring severity of depression
- more focus on somatic symptoms so may not be as appropriate to use for perinatal depression
- copyrighted, licensing fee to use – more information available at [www.harcourtassessment.com](http://www.harcourtassessment.com)

*Primary Care Evaluation of Mental Disorders (PRIME-MD)*

- several versions available, including a short interview format (takes about 8 minutes to administer) and longer and shorter patient questionnaires
- developed for use in primary care settings and has been validated in ob-gyn & other settings
- includes specific questions related to reproductive events
- available free to health care providers from Pfizer - <http://www.pfizer.com/pfizer/phq-9/index.jsp>

Two-question screen (validated by Whooley, et al.):

- Over the past two weeks, have you felt down, depressed, or hopeless?
- Over the past two weeks, have you felt little interest or pleasure in doing things?

## Reproductive Age Women & Health Care

**USE OF FAMILY PLANNING CLINICS:** Although it is difficult to assess how many women of reproductive age use publicly funded family planning clinics as their only or primary source of health care,<sup>\*</sup> there is substantial anecdotal evidence among clinic staff that this is the case. In addition, the program guidelines for Title X, the only federal program specifically devoted to family planning, state that “for many clients, family planning programs are their only continuing source of health information and clinical care.”<sup>30</sup> In a study conducted in a public gynecological clinic, 40% of patients indicated the clinic was their regular source of care, despite the fact that it was not set up as a primary care facility,

<sup>\*</sup> Many surveys ask whether a woman has a primary source of health care and may ask whether it is a private doctor or a clinic, but there is often no information about what type of clinic is meant. Other studies, like the National Survey of Family Growth, ask where women receive certain services with family planning clinics as an option for reproductive health services, but not for other primary care services.

and an additional 20% reported having no regular source of care.<sup>29</sup>

In 2004, Title X served over 5 million patients at over 4,500 clinic sites. Clinics are primarily operated by state, county, and local health departments (57% of sites). Planned Parenthood operates 14% of the sites, and the rest are operated by hospitals, family planning councils, and other non-profit organizations. The majority of clients served by Title X are:

- female (95%)
- low-income – three-quarters have incomes at or below the federal poverty line (FPL); an additional 17% are between 101% and 150% of FPL
- young – three-quarters are under age 30, with 50% between 20 and 29
- disproportionately racial or ethnic minorities, though whites make up 64% of the client base
- uninsured and not eligible for Medicaid<sup>41, 42</sup>

One in ten women of reproductive age (15-44) is covered by Medicaid, the largest single payor for family planning services in the U.S., representing over 60% of public funds for family planning.<sup>43</sup> Many states have recently expanded access to Medicaid coverage for family planning services for women who would otherwise be ineligible through the use of the Medicaid waiver process. With Medicaid, a woman can receive family planning services from a range of providers and does not have to use Title X-funded clinics, though many do. Planned Parenthood affiliates also serve almost 5 million patients a year at 850 health centers nationwide, though many of these patients are also included in the number of Title X patients and Medicaid recipients.<sup>44</sup>

#### **FAMILY PLANNING PROGRAMS & PRIMARY CARE:**

Because family planning clinics tend to serve a low-income, uninsured client base with few other sources of health care, Title X clinics are required to offer additional preventive services beyond family

planning, pregnancy testing, pelvic exams, and STI treatment and testing, including breast and cervical cancer screening and screening for blood pressure, anemia, and diabetes.<sup>41</sup> Many have incorporated additional primary care services into their programs, such as school and employment physicals, immunizations, and cholesterol screening. One example from Maryland is outlined in Figure 2.

Conversely, family planning services, which may be funded by Title X and/or Medicaid, are often provided by state and local health departments, which can include other health services, and community health centers, which operate under a primary care model. As noted above, the USPTF guidelines suggest that primary care providers incorporate routine depression screening for adults. Since family planning providers are often functioning, either by default or by design, as primary care providers, there should be greater thought given to the opportunities and challenges that associated with screening for depression in these settings.

### **Figure 2 – Maryland’s WELL Project: Testing the Potential for Integrating Primary Care Services into Family Planning Programs**

In 2001, Maryland was one of six states selected for a demonstration project, funded by the federal Health Resources and Services Administration (HRSA)’s Maternal and Child Health Bureau (MCHB), aimed at including primary care services within family planning. The Women Enjoying Life Longer (WELL) Project was implemented at three state Family Planning Program sites in Baltimore County and focused on integrating the following primary care services into the clinics’ other services:

- adult immunizations
- smoking cessation
- physical activity and nutrition counseling
- laboratory screening for thyroid stimulating hormone (TSH), lipids, and blood glucose levels

The program reported success at reaching the target population with these interventions, with little effect on the provision of family planning services, and patients and staff reported satisfaction with the program.<sup>45</sup>

Services for depression, including screening and treatment or referrals, were initially included, but there was less success with their integration. Possible reasons for this include the fact that so many new activities were being added at once and depression is a more complicated health problem than the others that were being addressed. A lesson learned may be that integrating services related to depression requires a different level of preparation, training, and investment than incorporating other primary care components.

## Issues to Consider

**RESOURCES:** The most frequent concern raised about screening for depressive symptoms in key informant interviews was “time and money.” Family planning providers are already financially-strapped, as the costs of providing health care rises, with little increase in federal funding for Title X (which has not even kept pace with inflation) and often no increases at the state level either. This is despite the fact that the number of clients seen by Title X clinics has grown, and newer methods of contraception and screening tests are more expensive.<sup>41</sup> Because of funding constraints and increased demand for services, providers are working to serve more patients in less time, with fewer financial resources. Adding services to address depression may be particularly difficult because of the amount of follow-up required if there is a positive screen for depressive symptoms. In that situation, clinics would then have an obligation to at least provide referrals and document that action. As one key informant said, “screening isn’t the issue – what to do with a positive screen is.”

Thus, even though there appears to be overall agreement that depression is an important women’s health issue, especially for family planning clinics’ clientele, time and money are major obstacles to incorporating interventions for depression more broadly. In addition, Title X is a categorical program intended to fund specific services, decreasing its flexibility to address a wider range of health care needs. Title X, however, does support a fairly broad range of services and has added services and program emphases over time that clinics have had to adopt, including awareness of domestic violence and encouraging parental involvement for adolescent patients. Unless depression becomes one of these issues, it may be difficult to encourage family planning clinics to undertake the task, when there are so many competing needs and priorities.

**TRAINING:** Related to the issue of resources is the need to train staff to appropriately address depression, especially to implement screening, minimal diagnostic follow-up, referrals, and/or treatment. Many of the clinicians and staff who work at family planning clinics do not have training in mental health and would require additional training to help them take on these new tasks sensitively and effectively. An encouraging trend is the number of new obstetrician-gynecologists who are reporting increasing levels of training and confidence about addressing depression.<sup>28</sup> However,

in looking at the training primary care providers receive around postpartum depression, Logsdon et al. found little evidence of good training in medical and nursing textbooks and reported that no studies had been done among nurse practitioners or nurse midwives to assess their knowledge and treatment of postpartum depression.<sup>46</sup> Training in the identification and management of depression and other mental health issues seems particularly important for providers who will be involved in women’s health care, including at family planning clinics.

**SELECTING A SCREENING TOOL:** There has been substantial work in designing and validating various self-screening and provider screening tools for depression. Most are short and provide good levels of sensitivity and specificity. Nonetheless, family planning program staff expressed concerns about how long a good screening tool would have to be and how to choose one to use. Although there has been validation of the two-question screen discussed above, the family planning staff interviewed seemed to find it difficult to believe that such a simple screening tool could be effective, especially since depression is such a complex and multi-faceted issue. In part, this is an issue related to lack of training, but it suggests that there are misperceptions about how difficult it would be to screen that may prevent family planning providers from even considering adding such services.

**TREATMENT & REFERRALS:** As already discussed, many of the health care providers seeing women at family planning clinics do not feel comfortable with providing treatment themselves or may not be able to do so within the context of the program, often due to financial constraints. This means that screening would mainly be used to offer referrals. This can be challenging if few resources exist in the community, which is often the case for mental health care, especially for people without insurance. Even patients with insurance may find barriers to accessing care.

An additional concern is that in two of the depression screening projects at family planning clinics, referrals did not ensure treatment. In Lee et al.’s study, among the women with CES-D scores indicating likely depression and referred to a clinical social worker for additional mental health evaluation, 29% did not follow through with the referral, and an additional 49% of the women were lost to follow-up so it is unlikely that many of them



followed through on the referral. Most of the women who were further evaluated were found to need mental health treatment, but even among that group, only two-thirds of them actually received services.<sup>17</sup> Miranda et al.'s study in the DC suburban area, using a randomized trial design, found that providing medication services or psychotherapy onsite showed effectiveness in treating depression, but 83% of the women who were assigned to the control group where they were only given a referral for care did not follow through with their referrals and received no services.<sup>18</sup> These results suggest that even though referrals are an option, they may not be the best way to provide services to women screened at a family planning clinic.

Access to appropriate mental health care is a major challenge, with few easy answers. Ultimately, there needs to be more advocacy for increasing public mental health services, as well as perhaps movement toward providing treatment onsite in some way. Onsite mental health services may be more feasible in some settings (i.e. health departments, community health centers, and hospitals) where other health care services and professionals are available in the same place and a more comprehensive set of primary care services is offered. It may be more difficult to co-locate mental health services in free-standing reproductive health clinics. It is important, however, to continue to think through ways this vulnerable population can get the services they need to treat their depression.

#### **EMPOWERING WOMEN AS HEALTH CARE CONSUMERS:**

In general, women's health care, especially for young women, tends to be fragmented. Young women tend to have frequent provider changes, as well as multiple primary care providers. For example, there may be a transition from a pediatrician to a family planning clinic or ob-gyn; geographic or insurance changes that necessitate provider changes; or the use of both a primary care and family planning or ob-gyn provider. Also, few family planning clinics provide prenatal care. Therefore, when a pregnant woman decides to carry to term, she must secure prenatal care from a different provider. This makes it especially important to empower women as owners of their own health care information so that they can pass on relevant pieces of their medical history to another provider, since information transfer among providers may not happen well or at all. For example, this means educating a woman who has suffered from

depression that she should discuss that history with her prenatal care provider, a message that could be incorporated into preconception and/or options counseling in the family planning setting, even if the prenatal care will not take place there. That way, when a woman goes to her next provider, she will be armed with the knowledge that this is an important piece of her medical history to share, even if the provider does not specifically ask about it.<sup>49</sup>

### **Potential Interventions at Family Planning Clinics**

With the above issues in mind, a continuum of minimal to more intensive interventions for use in the family planning setting is outlined below. This set of options is not intended to be comprehensive but rather to stimulate discussion and creative thinking about ways to address mental health issues within specific family planning contexts.

- Include depression as part of health education and awareness-raising that already takes place in most family planning clinics. This can include putting posters or brochures about depression in waiting and patient rooms. For example, the Maryland Department of Health and Mental Hygiene, with the Depression and Related Affective Disorders Association (DRADA) published a simple brochure<sup>9</sup> on postpartum depression that is available in several languages and can be ordered from <http://www.fha.state.md.us/mch/html/women.html>. DRADA ([www.drada.org](http://www.drada.org)) and the health department also collaborated to produce a brochure<sup>8</sup> on "Women and Depression Across the Lifespan."
- Include a question about history of depression on intake and other patient forms so the provider can be aware of this part of a patient's medical history.
- Include a self-screening tool in patient forms to be filled out as part of the pre-visit paperwork. Have a provider or counselor go over the results if patient score indicates possible depression.
- Encourage providers to screen high-risk patients, based on overall characteristics and/or affect at the time of the visit. This can be done with the two-question screen or a more structured clinical interview, depending on provider expertise and comfort.

- Incorporate information about depression during the perinatal period into pre-conception and pregnancy options counseling visits, as well as the woman's final visit before prenatal care if it is not taking place onsite. Providers tend to discuss a wide range of issues during this type of counseling, including nutrition, exercise, smoking, and other healthy behaviors – depression may be relatively easy to add to the checklist. The Wisconsin Perinatal Foundation has created a one-page fact sheet entitled “Planning for Pregnancy: Women with Depression”<sup>47</sup> and an extensive preconception checklist<sup>48</sup> for couples planning a pregnancy. These documents are good examples of how one can incorporate this kind of information into the clinical setting. They can both be found at [www.perinatalweb.org](http://www.perinatalweb.org).
- Increase attention to postpartum women returning for family planning services. Consider formal or informal screening for depression.
- Maintain referrals for mental health providers and other community organizations to assure that women with depression receive care.
- If family planning is part of a primary care model or a more comprehensive health care network, either at a community health center or at a health department, consider how self-referral for mental health services can be accomplished for family planning patients identified as depressed. Some states may even be willing to allow family planning funding to be used to pay for these services.
- Consider adding mental health services to the range of services offered at a family planning clinic. For example, Planned Parenthood of Metropolitan Washington recently became certified as a core service agency by the DC Department of Mental Health and can provide mental health services to Medicaid recipients.

### **Some Recommendations for Future Action FOR FAMILY PLANNING PROGRAMS & PROVIDERS:**

- Join coalitions addressing mental health issues – family planning providers should be part of the “team” of stakeholders mobilized around depression and how it affects women..
- Advocate for more comprehensive mental health care services available to people of all income levels

- Establish ongoing relationships with mental health providers to build a strong referral network and help create continuity of care for patients.
- Incorporate information on mental health issues and their connection to reproductive events into staff training opportunities and community education.
- Consider providing mental health services onsite.

### **FOR STATE & LOCAL PUBLIC HEALTH AGENCIES:**

- Collect and analyze data on screening and referrals for depression in family planning programs.
- Incorporate findings into state or local needs assessments.
- Coordinate activities addressing depression in reproductive age women with mental health and other relevant government agencies.
- Consider ways to better integrate mental health and family planning services – for example, if the family planning program has access to a counselor or social worker, investigate ways he/she can help with screening, referrals, and treatment.
- Provide training for health care providers and professionals about mental health issues, including depression and perinatal depression.
- When involved with projects addressing perinatal depression and other women's mental health issues, invite family planning providers to be part of the efforts.

### **FOR MENTAL HEALTH PROVIDERS:**

- Establish relationships with family planning providers to facilitate exchange of expertise and possible linkages that could be developed.
- Invite family planning providers to professional trainings on depression and other mental health issues in reproductive age women.
- When involved with projects addressing perinatal depression and other women's mental health issues, invite family planning providers to be part of the coalition.
- Provide educational materials about depression that can be used in family planning clinics.

## Conclusion

With depression affecting one in five women during their lifetime, it is clear that this is an important public health problem for those concerned about women's health to address. Publicly funded family planning clinics provide health care services to millions of women every year, including many women disproportionately at risk of depression, and may be their only source of health care. Many issues need to be addressed when integrating screening, referrals, and treatments for depression into other reproductive health care services, especially regarding access to appropriate follow-up care for positive screens. Nonetheless, family planning clinics have the potential to improve the mental health and well-being of a significant number of women.

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*Considering Interventions for Depression in Reproductive Age Women in Family Planning Programs*

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