Identifying and Addressing Maternal Depression

Steve Shuman: It's my pleasure to introduce Dr. Darius Tandon, the presenter for today's session, Identifying and Addressing Maternal Depression. Darius?

Dr. Darius Tandon: Thanks so much, Steve. And thanks to the 996 folks who have joined so far. Really – 999 – really delighted to see the interest in this topic. Got a lot of ground that we're going to try to cover today, and I have intentionally put a lot of content in here knowing that there are a lot of topics that are important to discuss, but we still will have time at the end for questions. Really do encourage folks to ask questions of me in the chat.

Let's advance these slides. That is me. I am a faculty member at Northwestern University's Feinberg School of Medicine. Just a little bit about me. I'm a psychologist by training and have done a lot of work in maternal and child health space over the last couple decades, including a lot of work focused on identifying and addressing maternal depression, which is the focus of the presentation today.

Let's start by getting everybody on the same page in terms of some statistics related to depression among pregnant people and new mothers. Couple of pieces of data that are important for me to share. The first is the prevalence of major clinical depression is estimated at 10% to 20%. Those are individuals who are experiencing major depression or clinical depression. We also know that there are roughly 20% to 30% of individuals in addition to that who exhibit clinically relevant depressive symptoms. They would not meet criteria for major depression but there's something going on. There's some elevated symptom levels. We know that rates of both clinical depression and depressive symptoms are higher among women with low income. And we also know that both major depression and elevated depressive symptoms are associated with an array of negative outcomes, and I really want to emphasize that.

I think even a few years ago, we often talked about the impact of maternal depression – clinical depression on maternal and child health outcomes. But we now know that even, as the slide says, elevated symptoms are associated with this array of negative maternal and child outcomes.

What do we do? What do we do as a community of service providers to try to identify and address maternal depression. Well, it really boils down to these last two boiling points. Screening is being used to identify women who require services supports. And then finally, once we've identified individuals who could benefit from those services and supports putting in place those concrete strategies and using concrete resources to meet the needs of those families.

This slide relates to the prevalence data that I just mentioned a second ago, and it's just a way of depicting this visually. If you take a look at this slide, what you see is on the far right side where it says, "Diagnosed depression." That's a smaller group of individuals. That's the 10% to 20% of individuals who are exhibiting major depression or clinical depression. But we also know if we sort of back up, we have that larger group of individuals in that mild to moderate

symptom range. And again this is just a way of showing that all of these individuals could potentially benefit from services and supports, not just the folks who are in that diagnosed depression range.

We do know that there are barriers to screening, and there are barriers to referral for services. Without going into a lot of detail – and I'm sure many of you are familiar with some of these barriers – screening barriers, lack of the ability to do repeat screening, not systematically screening all individuals within your agency or organization. The perception that there may be inadequate resources for those who screened positive. Some service providers will say, "Well, if we don't have resources, then why are we bothering to screen?" Discomfort with the topic on the part of providers and also on the part of clients. And also, some providers feel like screening may make the problem worse by talking about maternal depression.

We also know that there are referral barriers, and again, I'm sure many of you are familiar with these barriers or have experienced them in the work that you do. A lack of referral sites. If we identify somebody who can benefit from services and supports, are there sites, are there providers who can provide mental health services and supports? Even if there are referral sites, are there slots or slots available at those referral sites? And then above and beyond that, if there are referral sites, if there are slots or spots for services at those referral sites, there may be stigma that clients possess around mental health services, which means that a family may not initiate or fully engage in services. And we also know that there are some disparities in terms of engagement and mental health services by race, ethnicity.

Important to acknowledge that this is not an easy task. It is not easy to systematically screen and refer because of these barriers. But over the next few minutes, what I'll hopefully be providing are some concrete suggestions and strategies for both doing screening and referral. Related to screening for maternal depression, we do know – and this is a really important point for me to emphasize – that there has been considerable progress in the last decade incorporating screening into early childhood services.

If I were to be giving this presentation about a decade ago, I think we would be spending far more time talking about the need to screen for maternal depression and how that may look. The good news is many service providers are now in the business of doing screening. But what we have here on the bottom of the slide, there tend to be four questions that come up related to screening that I know I'm asked, and others are asked by service providers.

We're going to talk about each of these in subsequent slides. Appropriate screening tools to use, the timing of screening, how do you communicate with families about screening, and once you have identified somebody who can benefit from mental health services or supports, what are the protocols for referral and follow up based on the screening results? Let's start with identification and use of appropriate screening tools.

We recommend four tools for depression screening. The Edinburgh, or EPDS, the Patient Health Questionnaire – either 2- or 9-item version – the Beck Depression Inventory, BDI, or the CES-D. Why do we recommend these four tools? Well, really three main reasons, and those are at the

bottom. Each of them is free, each of them is available in English and Spanish, and importantly, each of these tools has been widely used with diverse populations.

If some of you are using other tools, it's not to say that those tools are inappropriate. Happy to have that conversation about the appropriateness of a tool that you might be using. And certainly, I don't want to be making the case that you are using a tool that's not listed here, that seems to be working for you, that you need to go in a different direction. But I will say that these four screening tools, for the reasons you see here, are tools that many service providers use and are largely successful in using these tools.

Now a question around timing and periodicity of screening. Translate it into more lay language, what does this mean? It means when, that's the timing. And how often? That's the periodicity should you be conducting screening. Many service providers do screening at one point in time when a family or a client is entering a program for services. And while that is important, there is a recommendation that we have to screen prenatally, if you're starting to see that client prenatally, and to re-screen three to six months postnatally.

Why do we say that? We say that because postpartum depression prevalence is greatest three to six months postpartum. For those of you who are not enrolling clients prenatally, or if you are working with a client who does not enroll prenatally, the idea of repeated screening is still important. And why is that? And this is really at the bottom slide. We know that the symptoms change over time. Even if you are doing your first screening with the client three months postnatally, there may be value in doing another screening a few months later because symptoms change over time, often in association with major life changes or stressors. We also know that there may be some under-reporting on the part of a client when a client is newly enrolled in a program. This is to say that one-time screening, if that is all you are doing keep doing it, but there really can be value in this repeated screening because the life circumstances of the families you're working with do change so quickly.

What about communication with families about screening? I think the bottom line for us here is to be matter of fact but genuine about the importance of depression and mental health. In the same way that you may be screening for other issues when a client is joining your program and you talk about the importance of doing a developmental screening, talk about depression screening in the same way. That this is something that is important for us to understand.

And we give some language here. These are some phrases or wording that we have suggested to service providers, and we know that around the country, service providers that we've recommended these phrases to have used them with success. To normalize the experience of mental health screening, you can use phrases like, "We ask all our mothers how they're feeling because it's important to mothers and babies health." “Our program believes there's no health without mental health.” Really highlighting the idea that physical health and mental health are really important to screen for and address. "We screen all our mothers because depressive symptoms happen to a lot of mothers, and we think your mental health is as important as other things we screen for like home safety or child development." Again, this is not intended to be

an exhaustive list of suggested phrases, but they can be useful in terms of introducing to families the importance of screening and normalize the experience of screening.

And finally, there's an issue around communication and interpretation of screening results. In my experience, many service providers are well trained on what is the tool that we're using, and thinking about what is the timing of the tool that we're using. But there may not be as much emphasis placed on training service providers on how to communicate the results of the screening, which obviously, is important. We want to make sure that we are not doing any harm in communicating results and that we are communicating those results clearly and in a timely fashion.

We say here, “Communicate results to families in a timely, accurate, specific and sensitive manner.” And a few things to consider. At an agency level, who communicates results to families? Is it the individual who is doing the screening? Is it somebody else? Sometimes service providers have identified who that person is who is communicating results, but you would be surprised. Many agencies that I know I've worked with they may do systematic screening, but they don't systematically have one individual or designated individuals who are communicating results to families.

Our results being communicated in real time. If you think back to the previous slides, all of those screening tools that I mentioned are brief. They are easy to score in real time with a small amount of training, and we really do recommend trying to communicate in real time or as close to real time as possible the results of the screening that you are conducting. Important to think about what type of training staff received on communicating screening results – this is something I mentioned a second ago. Many service providers will say, “Well, we want to be trained to use the Edinburgh or to train to use the PHQ.” But as part of the training, there is not as much emphasis on how do we communicate the results of the screening back to our families. And something else that is very important to acknowledge here is this idea of distinguishing urgent from non-urgent needs. Many of the screening tools, including the tools that I mentioned on the previous slides, ask about suicidal ideation.

And it just is important to have a protocol in place at your agency to understand what you will do if somebody endorses suicidal ideation. There typically is sort of a two-level response. Somebody who might be thinking about suicide – that's a suicidal ideation. But then there are some individuals who may actively be contemplating a suicide plan, which definitely involves a more intensive and aggressive response, including involving making sure that you're staying connected with the client and not letting them out of your eye or your earshot. Again, this is not to scare folks off from doing depression screening but acknowledging that there are questions around suicidal ideation. And really important to make sure that your agency has a protocol in place and understands what do you do in the event that somebody endorses items related to suicidal ideation.

Those last few slides really talked about issues related to identification or screening for maternal depression. Let's transition now and spend a few minutes talking about, what do we do when we have identified an individual who could benefit from mental health services and

supports? You know, what we're talking about here is protocols for doing referral and follow up for those individuals who could benefit from those mental health services and supports. What we know is that a lot of agencies and organizations do referrals in a non-standardized manner. And what I mean by that is many of the bullet points that you see below are not done in a consistent manner by a provider. And what we really want to emphasize is this idea that in the same way that screening should be done systematically, we really encourage referral and follow up, or referral and monitoring, to be done in that systematic, standardized process as well.

What are some things that need to be taken into consideration as you're thinking about standardizing your referral process? Who conducts the referral? Again, is it the individual who's conducting the screening, who's doing the referral? Is it another service provider who maybe has different type of contact with the families you're working with? How is the referral information shared? How is it shared both with the client, but also with the provider that you are referring the client to? When is follow up or monitoring conducted? If you are making a referral to community mental health provider, when are you following up with that mental health provider? Or when are you following up with the client to see whether or not there is uptake in terms of service receipt? How is follow up monitoring conducted? If a client does initiate services with that provider, what sort of ongoing contact is being done with the client and with the service provider? And how is it being done? Is it being done by email? Is it being done by phone? Is it being done by text message?

Who's the contact person at the agency to which a Head Start family is referred? Again, this gets back to this issue of systematic or standardized processes. If there is an identified contact person or contact persons at the given agency that's going to make that referral process go more seamlessly. And something that we certainly have seen agencies do with great success is to develop a memorandum of understanding, or MOUs, with agencies to which families are referred. This is a host of different considerations. By no means are these the only considerations, but really what I'm trying to push folks to think about here is this idea that it's not sufficient to say, “OK. We know that somebody could benefit from an external resource. Let's make a referral.” It's to really put on paper what that referral process and that monitoring process looks like so that it is being done in largely the same fashion across individuals.

There are a couple resources for doing some of the protocol – for doing some of the referral and then follow up work that I just mentioned. Myself and some of my colleagues have developed a protocol, and this was done largely in partnership with home visiting programs that serve pregnant people and women who have just delivered. And this protocol that we developed describes key considerations for systematic screening, developing partnerships with outside agencies, and establishing the processes for client referral and monitoring.

That last bullet point, bullet point C, really speaks to many of the issues that I talked about on the previous slide. Sarah Dauber and her colleagues have developed a similar screen and referral protocol. She did this work again in home visiting programs, and her protocol includes considerations for screening, for doing motivational interviewing, and then for also doing case management and at linking clients to treatment resources. There's references to both of the

articles here, and again, happy to talk more about what these protocols might look like. But the punch line here or the takeaway that, again, I just want to emphasize is that in both of these examples, the work that we've done and the work that Sarah Dauber has done, we're really trying to provide a framework for all of the tips and considerations related to referral and follow up so that work is being done in a systematic fashion.

Other important considerations related to referral and follow up. Important to use a strengths-based, client- focused approach in preparing a client for a referral. Sometimes the client may not be totally ready to engage in services for their mental health. Important to do some education for the client about different referral options and to also understand the client's readiness for change. Particularly, if you have a new client, a client that you might be getting to know a little bit better, a client may not be ready for that external referral right now. But over a period of a month or two, as they become more comfortable with your Head Start program, a bit more comfortable with your staff, at that point they might be more ready to engage in that referral. We also recommend, if possible, the use of a warm handoff. This is recommended in which a client is directly introduced to a new agency in person by her home visitor or family support worker.

We realize that this does require a little bit more effort to do the warm handoff. But as we say here that warm handoff really helps to confer trust and rapport that the client has developed with their home visitor or Head Start provider on the new agency to which she's referred. Certainly, we acknowledge that there are challenges with this warm handoff model during the COVID-19 pandemic, such that it may not be possible to do that warm handoff in person, it may move to more of a virtual handoff.

Let's talk a little bit about referral sources. Typically, early childhood providers, like Head Start programs, rely on external resources to provide mental health services to families who screened positive. What are some examples of those external resources? Community mental health providers, primary care providers, behavioral health specialists. Really important – this is the third bullet point – to understand what types of services each external provider offers. A community mental health provider may provide certain types of services. They may do some individualized work for depression. They may do group work for depression. Sometimes, certain providers do not have specialty in certain areas, or do not provide certain types of services. Really important for you at an agency level to understand if you are making a referral, particularly if it's for maternal depression, do these referral sites have staff and have capacity to address depression among the families you're referring them?

And then finally, this bottom bullet point – do the external providers understand what Head Start and Early Head Start programs do? And do the processes need to be established for doing referral and monitoring? This is certainly something that we've seen in our work with home visiting and other early childhood programs that community mental health providers, primary care providers, behavioral health specialists, may have a cursory understanding of what Head Start or Early Head Start does. You may need to actually do a bit of education around, “Alright. Here are our clients. Here are the things that we provide, and here's why we are making this

external referral to you a community mental health provider, because we may not have on site resources to address these issues."

Now we do know that there are barriers to initiating and engaging in external resources. And think back to that earlier slide – one of those first slides where I talk about barriers to referral – many of those are listed there. Because many home visiting, Head Start, Early Head Start service providers have ongoing relationships with clients, something else that we like to encourage is to think about embedding or integrating mental health services into your program or into your agency. And what I'm going to do over the next couple slides, is to talk about two resources or two interventions that can be integrated into your Head Start, Early Head Start program to meet the needs of your families.

And some of the examples that I'll be providing – one is a treatment intervention called Moving Beyond Depression, and the other is a preventive intervention called Mothers and Babies. Moving Beyond Depression was developed in Ohio by Bob Ammerman and his colleagues. It uses in-home cognitive behavioral therapy, or CBT, to provide depression treatment. 15 weekly sessions that are provided in a client's home by a licensed master's level clinician, and a home visitor or a Head Start staff member and clinicians would work closely together to coordinate intervention delivery. And I provided the link to Moving Beyond Depression here on the slide for you to link to later if you're interested.

Now, Moving Beyond Depression, like I said, is more focused on depression treatment. Mothers and Babies also uses cognitive behavioral approaches but is really more focused on prevention. If you think back to that earlier slide that I showed, that 10% to 20% of individuals who have major depression those would be candidates for Moving Beyond Depression. That additional 20% to 30% of women who have elevated symptoms who are at risk for developing major depression, those would be appropriate candidates for Mothers and Babies. Mothers and Babies uses cognitive behavioral approaches, such as encouraging pleasant activities, re-framing unhelpful thoughts, increasing social support. It really emphasizes attachment between caregiver and infant. And importantly, it is framed as a stress reduction intervention. It is not called a postpartum depression preventive intervention because we know there's a lot of stigma around that terminology – postpartum depression.

There are two modalities for delivering Mothers and Babies – a group format which consists of six sessions, and an individual format, which consists of nine sessions. And full disclosure: Mothers and Babies is an intervention that I have been working with colleagues over the last 10 or so years. And in September, there's going to be another presentation for the Head Start network specifically around Mothers and Babies, and how Mothers and Babies could be a possible intervention that you all would integrate into your agencies.

In terms of external and internal mental health resources, important to also think about perhaps using a blended or a hybrid approach. There may be external resources that are available – the community mental health providers, the behavioral health specialists that you can refer some clients to – and maybe you refer some clients for treatment to those external providers. But the question that I would ask you to think about is, how can your internal

resources complement the external resources that you have available to you? And how can we establish a continuum of care that uses both internal and external resources? And again, just to reiterate that there will be additional information on Mothers and Babies in an upcoming September webinar.

Moving to the last few minutes of the presentation. A few additional considerations in terms of how best to be addressing maternal depression at your agency level. I think it's also important to think about ways in which we can develop staff capacity to address maternal depression. As I say here, in concert with developing procedures and protocols for screening, referral, and monitoring, really important to think about how do we develop staff that are feeling more comfortable, more confident, more efficacious. Talking about maternal depression and perinatal mental health with the families that you're working with. And I provided three examples of ways in which others have tried to develop staff capacity.

Mental Health First Aid – I'm guessing many of you – given we have such a large number of folks on the Zoom today – I'm guessing many of you or at least some of you are familiar with Mental Health First Aid, and may even have been trained in Mental Health First Aid, which is a very sort of useful and quick way to provide greater understanding of signs and symptoms of depression as well as other mental health issues. Mental Health First Aid is a really, really viable first line of training and capacity building around signs and symptoms of a perinatal mental health.

There are also other resources. There is mindfulness-based stress reduction that has been taught to home visitors who are working with perinatal families to offset the stress that home visitors and early childhood providers may have in discussing sensitive topics with their families.

And then finally, there's a host of resources that are part of the Head Start Heels campaign. Again, these resources are here for you to take a look at. And really, what I want to emphasize here before moving to the next slide is this idea that along with thinking about how best to identify clients and refer clients, also important to think about, is there a need to develop staff capacity more fully so that staff are feeling confident and comfortable talking about mental health with their families.

Also important to consider reflective supervision. I'm guessing that some or perhaps even many of you are familiar with reflective supervision maybe even using it at your agency level. As it relates to discussions around perinatal mental health and maternal depression, reflective supervision can be helpful in understanding how working with families may affect your provider's own mental health. Really important point here – determining boundaries for how much and how far your staff should be discussing mental health with families. Sometimes, a provider may feel very comfortable talking initially about mental health but sometimes those conversations can get pretty heavy, pretty quickly. Reflective supervision can be very useful in establishing where is a Head Start staff member comfortable talking about mental health and where they may not be comfortable talking about mental health.

This idea of boundaries is really – really important. And then finally, decompressing by allowing staff to talk about emotions and challenges in working with families who are experiencing mental health issues. Again, many of you, I'm sure, are familiar or perhaps already using reflective supervision. Reflective supervision can certainly be very useful in the context of talking about addressing maternal depression.

A couple of other considerations. First, is this idea of the importance of normalizing discussion of mental health. You've heard me say this a couple of times, and I know all of you are familiar with this first bullet point that there is considerable stigma that exists around discussing depression and mental health more generally. What are some strategies for overcoming that stigma? First, and you heard me talk about this as it related to our Mothers and Babies intervention, don't use the term depression. Use the term stress management. And we found that to be really – really useful. Everybody can benefit from stress management approaches; Everybody can benefit from stress management techniques. That can be a really useful way of opening a conversation around emotions and feelings.

Discuss the importance of emotional and mental health in the same way one talks about the importance of addressing physical health. In the same way that it's important to talk about the different issues around physical health and the perinatal period, to talk about the importance of emotional or mental health for the pregnant individual. And then, to also emphasize the positive mental health for parents has significant benefits for one's children. Sometimes this is talked about as sort of a two generation effect, so that if we are addressing maternal depression in the caregiver, that is also going in turn and have significant positive benefits for the caregiver's children.

Paternal depression – or depression in male partners – is something that is getting more and more attention. And as I say here, paternal depression is a real thing. There have been studies showing that about 10% of new fathers are experiencing paternal depression. What are we doing to address depression among male partners? A couple thoughts here: We do know of some examples to address paternal depression and discuss stress in the context of co-parenting or preparing for a new child. There was review a few years ago in the Journal of Pediatrics that discussed a lot of those interventions that, as I say, got at the issue of maternal depression and more of a circuitous way talking about co-parenting or talking about preparing the home for a child.

What our team has done over the last few years is to actually develop an intervention that is specific to fathers' mental health. We're not the most creative with our names, so we called it Fathers and Babies, which is intended to complement our Mothers and Babies intervention. And we just literally in the last month, published a paper that shows results from our pilot study showing that Fathers and Babies, which uses many of those same cognitive behavioral approaches that we use of Mothers and Babies, Fathers and Babies were successful in reducing depressive symptoms and also reducing perceived stress in fathers.

More broadly, family members like a spouse, a partner, a mother, or a grandmother – they could all support a new mother's attempts to engage in stress management techniques.

Thinking about ways in which you can potentially work with that sort of larger family ecology. Can we work with a mother or grandmother to take over caregiving responsibilities to provide time for a new mother to go for a short walk or talk with a friend? Really important to think about ways to engage the family ecology so that mom is able to find time to engage in some of those activities to improve her own emotional and mental health.

Couple last additional considerations. There's some emerging evidence that addressing maternal mental health may promote greater engagement in early childhood services. When I say greater engagement, I mean a couple of things. Meaning more contacts or more visits between a provider and client but also, greater length of stay, or greater length of time staying enrolled in a program. The reasons that will be important are fairly obvious, I think. If you are able to keep a client engaged in your early childhood service longer, you're able to get more core material from your program to that client. Addressing maternal mental health may have those additional benefits in terms of being able to more greatly engage with your families.

We also know that depression is often comorbid or coexists with anxiety, substance use, or partner violence. If you are addressing depression with some of the cognitive behavioral techniques or other techniques that I shared today, you may also be addressing some of these other comorbid issues.

And then, the final bullet point I think is really important for us to think about this idea of, how do we reach the hardest to reach families? Sometimes, we do our best to reach as wide an array of families as we can. But we do need to think about whether or not we need to make additional adaptations or modifications to the way we're providing services for women who may be experiencing traumatic childbirth, for same sex couples, for fathers who are the primary caregivers. Again, many of the same techniques for screening, for referral, for monitoring may apply here. But some of the language, some of the phrasing may need to be modified somewhat for these populations.

Couple other things to point out. There is this movement over the last few years to what is referred to as task shifting. And this is a really important idea which is saying that we should be thinking about moving away from formal mental health providers doing all of the work. And we know that there is a mental health workforce shortage in the US. To be able to provide mental health services by a traditional mental health provider to everyone who needs it, may not be a viable option. This idea of task shifting and having individuals who don't have formal mental health training deliver services and supports is really something that is gaining increasing traction. We just published an article earlier this year which was explicitly looking at this idea of task shifting in the context of home visiting, where we compared mental health professionals like clinical social workers and psychologists to home visitors who didn't have formal mental health training to see whether or not they could deliver our Mothers and Babies intervention with similar fidelity and get similar outcomes.

And what we found was, yes. Those individuals without formal mental health training can deliver with similar fidelity and get similar outcomes. Also important to mention the American Rescue Plan of 2021, which is giving states options to extend Medicaid prescribed coverage to

12 months. Again, this varies by state, but this provision may allow states to more fully use funds for mental health screening service delivery.

Couple last thoughts. There's a growing emergence of apps and online tools to help with postpartum depression. Certainly, to think about these online tools and apps as a resource for families. Particularly, for families who may be hesitant to engage in more formal sort of in-person treatment, doing something that is self-guided or online might be a good starting point or a stepping stone to engage in more formal services.

The importance in recognizing paternal depression, so we talked about that earlier. This is to say that your efforts to address maternal depression are certainly important, but to the extent that you have the capacity and the bandwidth to also be thinking about paternal depression certainly would be a worthwhile undertaking. And then the last point that I'll make here is perhaps a controversial point. A lot of us, including myself, we tend to be tackling or addressing mental health by a specific sort of mental health interventions.

But we also know that there are other approaches that may be really useful in terms of improving one's mental health. Things like earned income tax credit, baby bonds, universal basic income – these can all be conceptualized as helping to distress families. We know that financial stress is one of the biggest things that contributes to poor mental health among families. Should we be thinking about some of these alternative approaches that are not formal mental health interventions? And should we be, as a community of service providers, be thinking about ways to try to expand these alternative approaches?

Concluding thoughts. Addressing maternal depression has the potential to have a two generation effect on both mother and child. Importance of doing systematic screening to identify families who may benefit from mental health services supports. Thinking about both external and in-house resources to address maternal depression. Recognizing that discussions about mental health can be challenging for staff, so what can we do to build capacity staff to have those conversations? And then, prevention and treatment for maternal depression should attend to that parent-child relationship as well as adult mental health.

This is and again these slides will be accessible to you – these are an array of maternal depression resources that I know I find useful and suggest to many individuals. Many of the things that you heard me talk about today are going to be found here perhaps with some additional detail. I really do encourage you to take a look at those resources. References are here for you, and we've now come to the part where I'm going to be quiet and take any questions that folks have.

Steve: Well, I don't think you're going to be too quiet, Darius. We got lots of questions, but thank you. For those of you who joined us after we got started, I'm Steve Shuman, the director of Outreach and Distance Learning from the National Center on Health, Behavioral Health, and Safety. And we're so lucky to have Darius Tandon on our team. Not surprisingly, the very first question was about COVID-19, Darius. Have you seen any changes in maternal depression since the pandemic started?

Darius: Yeah, there have been some studies. Initially, the study started in Europe where the pandemic sort of started first and then as it moved to the US, we're getting more data from North America. There certainly have been studies to show that there is greater prevalence of depressive symptoms as a result of COVID. But the important thing that I want to point out is it's not just depression, but we're actually seeing a very big increase in anxiety. I would say the increases in anxiety are even greater than the increases in rates of maternal depression. And intuitively, I think we can understand that there's just so much ambiguity that we all have right now about our lives in the pandemic. And I think that is just naturally contributing to a lot of anxiety that families are having.

Steve: Thank you. We have a lot of people on the call today that live in rural or even frontier areas. Many of our tribal programs, some of our migrant and seasonal programs, have difficulty accessing qualified mental health folks to do some of the work that you describe, and families aren't always willing or able to drive quite a ways. Do you have any advice for identifying the kinds of folks that could do some of this screening work in particular?

Darius: Yeah. I really do think that my bias is that we do not need formal mental health providers to do this work. And I realize that some mental health providers might be throwing tomatoes at me through your virtual Zoom screen right now for saying that. But I really do believe that with appropriate training and support, individuals without formal mental health training can do the screening. With training, folks can do our Mothers and Babies intervention. I think some of the other resources that you saw on the previous slide, those are things that providers can do as well. I would just encourage you to think about ways that you might be able to bring in resources to your agency instead of relying on those external resources. And the other thing that I would say would be particularly relevant for more rural areas.

And again, I just talked about this briefly is the emergence of some of the online tools that exist. Using apps, using online tools. I have a colleague who has developed an online version of the Mothers and Babies intervention. In the same way that we could train your providers at your agency to deliver Mothers and Babies in a house, there may also be value in providing Mothers and Babies as an online self- guided intervention. I do think that there's a lot of value in encouraging folks to engage with some of the apps and online tools. Some of them certainly cost, but there are so many that are available for free as well. And I think that would be my best suggestion in terms of a starting point.

Steve: Thanks, Darius. And to piggyback on that, and I think you covered it. But someone's asked, have you seen Head Start mental health consultants, you know that mental health consultants are required as part of our Head Start programs, be utilized in either the process of screening or making referrals?

Darius: Absolutely. I've seen – I've seen both, and perhaps less so in doing the screening. But certainly in terms of doing the referrals, doing the follow up on referrals, perhaps working closely with the referred client to destigmatize to normalize the experience of talking to a mental health provider. Yes, I think that's a great point to the folks who raised. Utilize the

resources that you have within your agency. And I know that the mental health providers are a fabulous resource that definitely should be tapped into.

Steve: Thank you. A number of questions about recommendations of when to screen, and how frequently to screen, and how often. Maybe you can address that.

Darius: Yeah. I wish I had sort of this magic algorithm that I could provide everybody to say, "This is how you do it for everybody." But I think there's challenges. We know that families you're working with are entering your services at different points in time. Some might be entering while they're pregnant; Some might be entering after they've delivered; Some might be entering when they have a child that might be a year or 2 years of age.

What I would say is, at a very high level, my recommendation would be to try to figure out a way to do at least two screens. If you are able to first see a client prenatally, I would say that first screen should be done prenatally, and that second screen should be done three to six months postpartum, which is what I put on my slide. If you're not seeing that first – if you're not having that first visit prenatally, then I think it's really up to you in terms of what the timing would be between your repeat screenings.

I would probably give it at least three months between screens. I think that would allow you to be able to pick up on any changes that client might be experiencing in her life. But I don't think that there is any sort of hard and fast rules about when that screening would take place. And certainly, the other thing that I would really encourage you to do, is to think about ways the screening can be built into other contacts, other touch points that you already have with families.

That's really important. Instead of setting up, "Oh, we now have to do this depression screening at this time point," and it's the only thing you do at that time point. Well, if you know you're going to have contact with a client a month later or two months later to do another screen – an ASQ or whatever it might be – well, build in the screening at that time point. So I'm all about promoting efficiency and not just building in something else that might be disruptive to one's workflow.

Steve: Thanks. I know you touched upon it briefly today. And I know you're going to talk about it in the September webinar, but people got very excited about Mothers and Babies. Ka-Ching. Ka-Ching. And folks wanted to know do you need to be a master's level? Clinician? Do you need a license? What are the requirements?

Darius: You do not need any of those requirements. My bias is that I believe that with appropriate training and to which our team would provide, regardless of what sort of formal mental health training you have, you are going to be successful delivering Mothers and Babies. I don't have a reason to think that we need to limit who would be trained to deliver Mothers and Babies. I think the core issue would be just making sure that whoever would be trained to deliver the intervention, obviously has comfort talking about perinatal mental health, and also

is going to have the time to interact with the client to be able to fully deliver the intervention. But no real restrictions in terms of the qualifications of the individuals.

Steve: Thanks. I'm going to tell people that we're running out of time. If you have more questions, send them to health@ecetta.info. I'm going to ask Darius as many questions that have already been submitted as I can, but you can always reach the National Center at that address and may be you will pop it into the chat as well. Early in the presentation, Darius, you mentioned a protocol for screening and someone's asking, is there a particular document that references that protocol?

Darius: Yes. I believe both of the articles that I mentioned, the article that we published and the article that Sarah Dauber published, there are appendices that are attached to those articles that show in detail those different considerations for screening, relationship-building, referral, monitoring. If you look at those articles, you'll see a description of the process that both teams use to develop their protocols. But I believe, if I'm remembering correctly, those sort of specific bullet points are considerations that you would use are also there as appendices.

Steve: Thanks. You've got people interested in this idea of task shifting? One question is about a task shifting and relating it to Early Head Start home-based services. And another is about what are some of the mental health interventions that can be task shifted? Do they include the modalities you mentioned earlier in the presentation?

Darius: Whoever posed that last question, that's really great question. Again my bias is I believe that tasks can be shifted. Do all of my mental health colleagues believe that? I think that there's a little bit more resistance. The question about which interventions or programs could be task shifted, I would argue that a lot of the work can be task shifted. For example, I don't believe you need to have formal mental health training to effectively screen for maternal depression.

I think the screening, all of the screening that we talked about today I think, again, with appropriate training, somebody with that formal mental health training could task shift the screening to non-mental health provider. I think where it gets a little bit trickier, a little bit thornier is with the interventions themselves. Folks who have developed interventions may not believe that their intervention could be task shifted.

I do think that that is going to be more of a case by case basis. But I do think that this idea of task shifting is just getting a lot of support, and the task shifting can be from mental health professionals to Early Head start staff. It could also be task shifting to peers. We have seen that as a task shifting approach as well. There are certainly examples of peer led interventions that could be useful. Again, sorry to say that I think that the delivery of tasks shifted interventions is going to be a little bit more case by case in terms of whether a provider is comfortable with their intervention not having a mental health provider delivering it.

Steve: Thanks. There's an interesting question. I've never thought about this. Do adoptive mothers and fathers experience the same forms of depression? And if they do, are there any resources specifically for them?

Darius: I think what – let me back up and say – I think that is a specialized family constellation or composition. I have colleagues who work more specially or specifically with that population. What I would say is that there are some considerations that certainly do overlap. But I do think that there are some unique or specific considerations.

I know that right now, with our Mothers and Babies work, we literally are starting to engage in a process of developing a whole new manual just for different family compositions. Acknowledging that it's not always going to be a traditional family structure for individuals who received the intervention.

I do think that there are some potentially unique considerations. I don't know if I'm the best person to sort of delineate what those are, but I do think it's a really important point that's being raised. And I think that if you are working with a sizable population who would fit that sort of definition, I would encourage you to think about just even if it's wording changes or phrasing changes, you want to make sure that you're not using phrases that inadvertently would be sort of turnoffs or just insensitive. I think that's the big consideration that I would point to.

Steve: Darius, you've answered as many questions as we still have left in this, so I'm going to encourage people to please write to the National Center. We will reach out to Darius for his expertise, health@ecetta.info. And let me take us to the next slide. Darius, if you wouldn't mind moving us along. Thank you. This is the link to the evaluation. Libby will pop it into the chat. It will also appear when the webinar closes. This link, once it's submitted, will lead the user to another link that will allow you down access download, save, and print a certificate.

Whether you were on today or whether somebody you know registered and wasn't able to attend, everyone will get a copy of the recording for today's session as well as the handout, copy of the slides, a link to the certificate in evaluation. Not to worry, that will go out in another day or two, so don't worry. If you want to hear this again, you'll get a chance to do that. And eventually, it will be, within a few weeks it'll be on the ECLKC archived as well.

Next slide, please. Thank you. Darius, this was so great, and I love seeing the skyline of Chicago in a beautiful purple tone the evening. I think it's an hour earlier there than it is out here on the East Coast. It's not quite nighttime yet, I don't think, but it looks good. I would say Chicago never looked so good. Folks can subscribe to … And thank you everybody for your great questions. We had over 1,300 people on today. Thank you, thank you, thank you, for sticking with it.

We do have a mailing list and that link is on the handout, and it's been posted a number of times in the chat. And if you bring us to the very last slide, Darius. I just want to tell people that they can call, they can write, they can go to the website and find us there. And many of the resources that can help them in their work. We're almost at the top of the hour. I see people thanking you, Darius. There were some fans from previous Mother and Babies training to relate to you, and they're still using Mothers and Babies, so you have sustainability there. People love

the information and the idea that we can be even more responsive to families, which is really such a potent part of the DNA of Head Start.

We're going to close the webinar, and a link to the evaluation should appear there as well. Thank you everybody. Thank you, Martine and Laura. Thank you, Kate and Olivia. And special thank you to Darius.