

# Postpartum Depression: A Chronicle of Health Policy Development

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## ABSTRACT

The current report presents an example of the path taken from identification of a public health problem at the primary health service level, to conducting research documenting the scope of the problem and nature of the risk factors, disseminating the findings, and fostering development and application of relevant policy. The example presented is the case of postpartum depression, an issue with bio-psycho-social implications. Public health nurses identified the problem, prompting epidemiological research. The findings encouraged the Ministry of Health (MOH) to conduct a pilot program for screening and early intervention among pregnant and postpartum women reporting depressive symptoms. Based on the results of the pilot program, the MOH is expanding the program to all Mother-Child Health (MCH) clinics. Israel's largest Health Maintenance Organization has followed suit and is including this program in its own clinics. This Israeli experience may serve as an instructive example of a locally identified problem evolving into a national policy.

## INTRODUCTION

Epidemiological research should serve as a basis for identifying and addressing public health issues, health promotion, disease prevention and clinical practice (1). However, the results of such research often take years to find their way to fruition in the field. The road from research to application is even more difficult when it must cross the conceptual border that many consider

to divide physical from emotional health. The current report presents the developments leading to such change in the case of postpartum depression (PPD).

PPD, a condition with bio-psycho-social implications and consequences, may be the most common complication of childbirth (2, 3), with prevalence estimated at 10-20% (cf. 3-5). Findings in this range have been reported in Israel (6) as well as in many countries and cultures, including Dubai (7), England (8, 9) Sweden (10, 11), Malta (12), New Zealand's Pacific Islands (13), China (14), and Portugal (15). Goldbort (16) conducted a transcultural analysis of PPD research, concluding that it is a universal experience, although labeled variously in different cultures.

PPD can have serious consequences for the mother, infant and family (17-23), placing it within the realm of public health concerns (24). Despite the prevalence of PPD and the frequency of contacts between women and health personnel during pregnancy and postpartum, most cases are not identified, diagnosed or treated (10, 25-29). Thus, the potentially negative influences on the mother, on the infant's physical, emotional, and cognitive development, and on the entire family, are often unattended.

The prevalence, severity and consequences of PPD make early identification and intervention a high-priority case for action (24), with programs for this purpose reported in many countries. For example, in the U.S. Georgiopoulos et al. (30) found that routine screening for PPD at the sixth-week postpartum visit was associated with increased diagnosis, while in the U.K. MacArthur et al. (31) found that midwifery-led care resulted in improved maternal mental health at four months postpartum. In Sweden, Wickberg and Hwang (32) found that counseling visits by public health nurses were very effective in reducing depressive symptoms among women screened for PPD. Each of these

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studies had somewhat different foci and methodology, but shared many aspects of approach and purpose. Differences were usually not conceptual, but due to the effort to facilitate implementation in existing health care frameworks. As will be seen, the Israeli program presented here has much in common with these efforts.

While awareness of the problem of PPD has heightened over the past few decades, strategies for identification and treatment of cases have generally been developed on a local basis. The Israeli experience in this area may be instructive as an example of a locally identified problem evolving into a national policy. The purpose of this report is to describe an example of the steps taken from identification of a public health problem in the field (in this case PPD), to conducting research documenting the scope of the problem and nature of the risk factors, to disseminating the findings, and fostering development and application of relevant public health policy.

### I. FROM PRACTICE...

During 1983-1984 a developmental psychologist (SG) was employed by the Health Services Research Unit<sup>1</sup> (HSRU), on behalf of a special intervention program (33) at three Mother-Child Health (MCH, *Tipat Chalav*) clinics covering service for a small city (pop. approx. 20,000). Noting her presence in the clinics, the nursing staff often requested that she meet with women who seemed to be suffering what might be PPD, saying: "she hasn't 'returned' to herself"; "she isn't relating to the baby," etc. The nurses were disturbed by these cases and felt lacking in skills or resources to deal with them. The psychologist would meet these new mothers for short-term counseling and/or referral to mental health clinics. When the psychologist moved on to other projects in the HSRU, she was contacted repeatedly by the same nurses, requesting advice on these suspected "PPD" cases.

### II. ...TO RESEARCH...

In response to these requests, the late Vita Barell (then Head of the HSRU), stressing the Unit's policy role as a Ministry of Health (MOH) research unit, suggested planning an epidemiological study to document the scope of the problem and investigate possible solutions. The literature was searched for similar Israeli studies on this topic, but none was found. Thus a prospective study of PPD was conducted.

The research aimed to: (a) document the prevalence of PPD in a community cohort; (b) identify PPD risk factors; and (c) ascertain the feasibility of PPD screening in the primary health clinic using the Edinburgh Postnatal Depression Scale (EPDS) (34).

### The study's main findings were:

1. A rate of 22.6% of PPD symptoms, as determined by a >10 cutoff score on the EPDS (6).
2. Psycho-social risk factors, as recorded during pregnancy, were the main predictors of PPD. These included poor marital satisfaction, lack of social support, depression symptoms during pregnancy, and previous emotional problems (35).
3. The EPDS was found acceptable by both MCH patients and staff.

From 1998 to 2000 peer-reviewed articles were published based on this research (6, 35) and the Hebrew EPDS translation was published in *Harefuah*, the Israel Medical Association's Hebrew-language journal (36), to raise awareness of the issue among local professionals and encourage utilization of the same translation, making findings more readily comparable and facilitating accumulation of knowledge. This translation was subsequently validated (37) and incorporated in a book about the use of the EPDS (38).

### III. NETWORKING...

In addition to publication of the findings, the research was presented at local, national and international professional conferences, as well as professional meetings and academic seminars. Graduate students in psychiatry, psychology, nursing and social work were referred to the Unit for mentoring of theses or doctoral work, further increasing awareness and expanding knowledge about PPD in Israel among a growing group of professionals.

Special emphasis was placed on communicating the research findings and disseminating other relevant literature about PPD and intervention programs to key persons at the MOH and the Knesset (Israel's Parliament). Two sessions dedicated to PPD information and policy were held by the Knesset's Sub-Committee on Women's Health serving to further increase awareness and encourage policymakers to take a stand promoting early identification and intervention with women at-risk, as well as inclusion of the topic in medical schools' curricula (39, 40).

It is important to note that in addition to the empirical findings in an Israeli cohort, the case for a PPD screening program was strengthened by other research find-

<sup>1</sup>The Health Services Research Unit is currently known as The Unit for Mental Health Epidemiology and Research on the Psychosocial Aspects of Illness, Gertner Institute for Epidemiology and Health Policy Research.

ings regarding prevalence of PPD, risk factors, and the value of screening for signs of depression in primary care clinics, which generally recommended similar programs (cf. 27, 28, 30). Further, legislative activity, particularly in the U.S. Congress, urged such screening in recognition of PPD as a major public health concern (41). As this information was published or disseminated (via internet, etc.), our team made it a point to forward relevant findings and recommendations to Israeli policymakers, keeping them “in the loop,” and maintaining awareness and interest in the issue. While there is no “hard proof” that these activities were the impetus of change, they may have contributed to focusing attention on the issue and fostering the changes that occurred.

#### IV. POLICY DEVELOPMENT...

In May 1999, the directors of MOH Mother, Child and Adolescent Health Service and Public Health Nursing Department decided to institute screening for PPD and PPD-risk in the national network of MCH clinics. It was determined that: (a) this policy decision would first be implemented as a pilot program in selected clinics; (b) nurses would screen with the EPDS at about 32 weeks pregnancy and six weeks postpartum; (c) clinical guidelines would be prepared for screening and intervention; (d) nurses in these clinics would be trained in the use of the EPDS, the clinical guidelines and content of intervention; (e) a Mental Health Coordinating Nurse would be available to serve as advisor to both nurses and mothers participating; (f) the head of the MOH Mental Health Service would be included in this effort, to facilitate referrals to mental health clinics when necessary; and (g) the pilot program would be monitored and evaluated. During 2001 the pilot program was conducted at clinics in five cities. The evaluation report was presented to the MOH in May 2002, and the recommendation to continue and expand the program was adopted.

At the same time an information brochure on postpartum emotional difficulties was prepared as well, and submitted to the MOH Printing Office, but was not published. However, several services photocopied the draft of the brochure and distributed it in local clinics.

#### V. TRANSLATING POLICY INTO PRACTICE

Ministry of Health: Although the screening and intervention program continued in some MCH clinics that participated in the pilot program, the MOH was then unable to train more nurses due to more pressing issues. However in response to consistent

positive feedback from those pursuing the program, in October 2003 the Public Health Nursing Service undertook expansion. Several training courses were subsequently conducted and the program has been implemented in about 175 MCH clinics throughout the country. Furthermore, a six-hour unit of study about PPD (theory, screening, supportive intervention) was instituted in MOH continuing education courses for accreditation of public health nurses and has been offered regularly since 2004.

Health Maintenance Organizations (HMO): Parallel to MOH activity, *Clalit* HMO instituted a similar PPD screening and supportive intervention by nurses country-wide, supported by Program Coordinators and/or social workers. Our Unit served as consultant for planning nurses' training and EPDS data collection methods. *Clalit* Health Services insures 55% of the Israeli population, (42) and by May, 2005, about 160 *Clalit* clinics were participating in the program. Israel's three remaining HMOs have also expressed interest, but not yet implemented the program.

The PPD Brochure: In September, 2006, the MOH published and distributed to all Ministry MCH clinics the informational brochure on PPD entitled: “*What you should know about Postpartum Depression: Information for women who are pregnant or after delivery.*” The brochure is in Hebrew and an Arabic version is being prepared. Plans include distribution to additional sites, such as hospital maternity departments. The brochure can be requested in quantity by individuals or organizations free of charge. In addition, the MOH is currently preparing information regarding PPD for its website.

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#### CONCLUSION

As recently as December 2006, Wisner et al.'s editorial in *JAMA* described PPD as “A Major Public Health Problem,” and called for screening to be implemented no later than 12 weeks postpartum, noting the EPDS as a useful instrument for this purpose (24). Considering the legal and ethical aspects of pediatric providers screening for PPD among mothers of children in their care, Chaudron (43) concludes that the benefits of such a process outweigh the risks, on condition that caregivers be educated to implement and respond appropriately. It is, however, vital that mental health services are involved in provision of training, support and treatment to programs such as these.

Similar PPD screening and intervention programs in primary care settings throughout the world have reported

favorable results, with nurses/midwives generally the service providers (cf. 30, 31, 44-47) and back-up by mental health services. An analysis of PPD prevention research from the Cochrane Pregnancy and Childbirth Group trials register (48) noted that a "... promising intervention appears to be the provision of intensive postpartum support provided by public health nurses or midwives" (p. 1), and that although prevention programs begun prenatally were not found by them to be more effective than those begun postnatally, identifying "at-risk" mothers assisted in prevention of PPD. Further, studies have found routine EPDS screening acceptable to most women and health professionals (49, 50). In a recent study of women before, during and after pregnancy, Dietz et al. (51) found that among those identified with depression there was a high degree of willingness to obtain treatment, thus providing support for a program of routine screening, ... "which could uncover undetected depression and, with appropriate treatment, mitigate the devastating effects of this disease on the mother, infant and other siblings" (p.1520). Goldbort's transcultural analysis (16) led to the recommendation to screen and/or teach all women about depressive disorders prenatally and postnatally, to "open up dialogue and communication...giving them permission to express their feelings, to ask for help...to decrease the stigma..." (p. 126).

The constellation of health policy hierarchy is different in every country; however there is usually a "top of the pyramid." If policy is mandated from that peak, be it the legislature or the executive branch, the likelihood increases that the largest number of citizens will benefit. The MOTHERS Act was introduced in the U.S. Senate (52) to ensure education, screening and services relating to PPD, and in October, 2007 the House of Representatives passed the Melanie Blocker Stokes Postpartum Depression Research and Care Act by a vote of 382-3 (53). In addition, several states have mandated such activities. (54) In February 2007, the U.K.'s National Institute for Health and Clinical Excellence published guidelines for antenatal and postpartum mental health, which although non-binding, provide detailed recommendations for care of women during these periods of life, and are likely to set standards for such care (55). In Australia the National Post-Natal Depression Research Program (56), conducted from 2001 to 2005, reported favorable results and is developing a national action plan to turn the research into policy and practice. The Scottish Intercollegiate Guideline Network has recommended depression screening during pregnancy and postpartum as part of their detailed and comprehensive approach to

dealing with PPD (57), and Lee et al. (14) recommended universal PPD screening for early detection in women in China, although no steps to this effect have been reported. An Icelandic national study (58) employing web-based courses in diagnosis and intervention with distressed postpartum women found the use of internet successful in training nurses, and in turn reducing the rates of PPD. This model could be important in rural areas and in countries with dispersed populations. These steps serve to increase the exposure and public awareness of the issue of PPD, generating in themselves a positive atmosphere for influencing policy. In sum, considering the experience in many countries, Almond (59) has concluded that from a global perspective, PPD is clearly a public health problem, and recommends further research and encourages routine assessment of all women in the postpartum period.

The Israeli experience with PPD is a clear example of the cycle in which problem identification at the community level led to research, and research findings led back to application in the community. This is a mutually beneficial transaction, which can contribute to fostering evidence-based public health policy (60). The time-line for this "chronicle" may seem long; however, from publication of the first research findings in 1998, to actual implementation – 2002 when the results of the pilot screening study were endorsed by the MOH, and 2003 when implementation by the *Clalit* HMO began – it was relatively short for such a widespread shift in viewing and dealing with PPD as a public health issue.

To our knowledge this is the first instance in Israel in which a screening program has been instituted for a mental health problem within the primary health system, and it is hoped that this bodes well for a future more holistic approach to public health. As Gordis (1) stated: "Indeed, one of the major sources of excitement in epidemiology is the direct applicability of its findings to the alleviation of problems of human health" (p. 247).

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