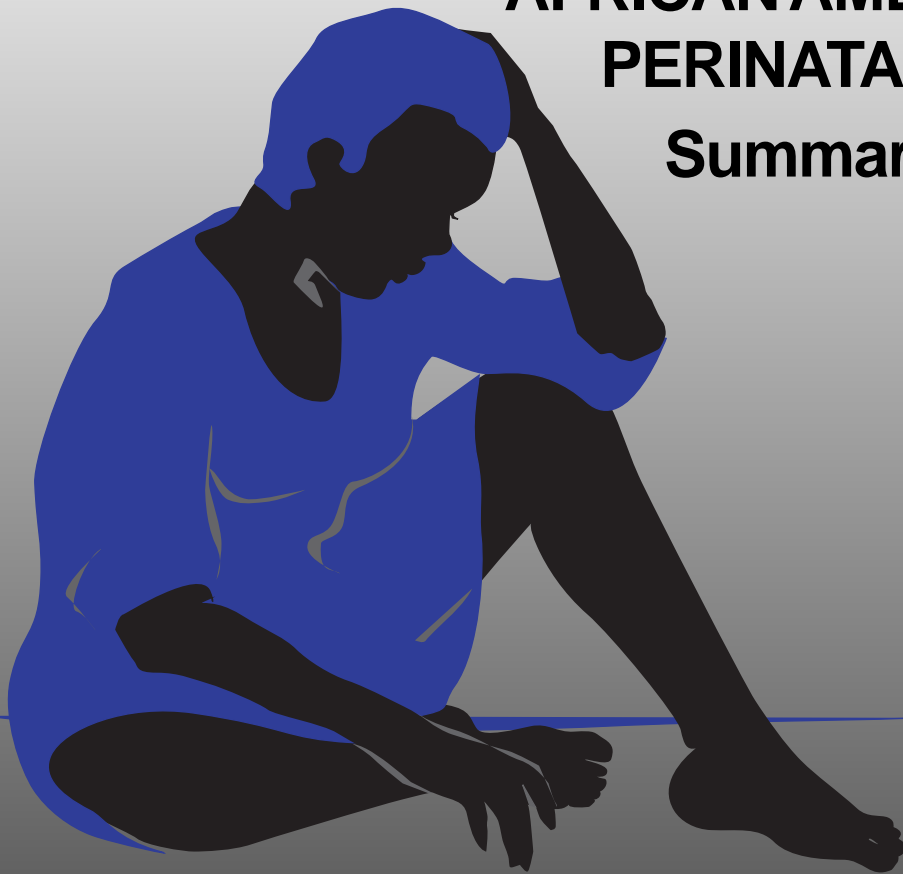


*Cleveland Healthy Family/Healthy Start
Perinatal Depression Project*

**FEELINGS OF
AFRICAN AMERICAN
PERINATAL WOMEN:
Summary Report**



A Collaborative Effort of:

- The Cleveland Regional Perinatal Network
- MetroHealth Medical Center and
MetroHealth Center for Community Health
- NorthEast Ohio Neighborhood Health Services, Inc.
- United Way First Call for Help
- University Hospitals of Cleveland

□ Funded by the City of Cleveland,
Department of Public Health,
Healthy Family/Healthy Start Project.

Supported in part by the Healthy Start Initiative, Division of Perinatal Systems and Women's Health, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

*Cleveland Healthy Family/Healthy Start
Perinatal Depression Project*

**FEELINGS OF
AFRICAN AMERICAN
PERINATAL WOMEN:
Summary Report**

A Collaborative Effort of:

- The Cleveland Regional Perinatal Network
- MetroHealth Medical Center and
MetroHealth Center for Community Health
- NorthEast Ohio Neighborhood Health Services, Inc.
- United Way First Call for Help
- University Hospitals of Cleveland

- Funded by the City of Cleveland,
Department of Public Health,
Healthy Family/Healthy Start Project.

Supported in part by the Healthy Start Initiative, Division of Perinatal Systems and Women's Health, Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.



City of Cleveland

Jane L. Campbell, Mayor

Department of Public Health
1925 St. Clair Avenue
Cleveland, Ohio 44114-2080
216/664-2324 • Fax 216/664-2197
www.city.cleveland.oh.us

On behalf of the City of Cleveland Department of Public Health and the Healthy Family/Healthy Start Project, I am pleased to present the findings of our collaborative Perinatal Depression Project. This project was made possible through the dedication of many individuals and organizations, especially the Cleveland Regional Perinatal Network.

As a clinician, I have seen too often the subtle signs of perinatal depression in my patients: the new mother with a downward gaze and flat affect at her child's two month visit; the pregnant factory worker buckling under the stress of trying to keep her job, take care of her family and make all of her prenatal visits; the single mother approaching the end of her pregnancy with trepidation as she wonders how she will manage. The stories are all unique, but they are not revealed unless someone takes the time to notice the subtle signs and ask the right questions with compassion and empathy. As this Project confirms, perinatal depression is pervasive and under-diagnosed. Even when we are able to recognize the signs and symptoms, we lack the resources as a community to respond adequately to depressed women's needs.

As a public health professional, I am increasingly concerned about the effect of unrecognized and untreated depression on maternal and child health. As we learn more about perinatal depression, we have discovered that the problem is not limited to the post-natal period. New research now points to depression as one factor influencing prematurity and low birth weight rates. Finally, there is little research on the extent of the problem in marginalized and underserved communities, especially those populations that lack access to comprehensive health care. In response to these concerns, our project focused on African-American women of reproductive age living in Cleveland and attempts to quantify both the magnitude of the problem and the gaps in clinical screening practices and referral services.

As we better understand our community's needs, we can work together to create a healthy environment for every family and provide the support and services that mothers need. I commend all our partners for taking the first step toward creating that environment, especially the Cleveland Regional Perinatal Network, University Hospitals of Cleveland, MetroHealth Medical Center and Center for Community Health, NorthEast Ohio Neighborhood Health Services, Inc. and United Way First Call for Help.

Sincerely,

A handwritten signature in black ink that reads "Wendy Johnson".

Wendy Johnson, MD
Director of Community Health

Table of Contents

Project Team	ii
Introduction	1
Goal 1	3
Goal 2	11
Goal 3	15
Goal 4	19
Appendices	23

Appendices

Appendix A: Participating Organizations	23
Appendix B: List of Screening Tools with References	27
Appendix C: Edinburgh Postnatal Depression Scale	31
Appendix D: Health Care and Social Services Agencies Contacted	35
Appendix E: Potential Mental Health Agencies Identified	39
Appendix F: Mental Health Agencies Referrals to Other Providers	43

Project Team

Avril Albaugh, LISW	Cleveland Regional Perinatal Network and University Hospitals of Cleveland
Marilyn Benjamin, MSN, RN	Cleveland Regional Perinatal Network
Monica Fundzak, MSN, RN	Cleveland Regional Perinatal Network and MetroHealth Medical Center
Susan Gerard, MBA, RN	University Hospitals of Cleveland, MacDonald Women's Hospital
Faye Smith Jones, LISW	NorthEast Ohio Neighborhood Health Services
Marlene Perdan	First Call for Help
Nikki Polis, PhD, RN	University Hospitals of Cleveland, MacDonald Women's Hospital
Miriam Rosenthal, MD	University Hospitals of Cleveland
Janet Weiner, MS	MetroHealth Center for Community Health

Introduction

In 2001, the Cleveland Healthy Family/Healthy Start program requested proposals to address and promote systems of care that would address gaps in routine screening and skilled assessment for depression during and around the time of pregnancy and to enhance linkages to community-based intervention services. Perinatal African American women residing in the city of Cleveland between the ages of 15 and 44 were the target population. The intent of the grant was to facilitate early identification and increased capacity to effectively screen, perform skilled assessments, and successfully engage pregnant and postpartum women who were experiencing depression into treatment.

Marilyn Benjamin, Coordinator of the Cleveland Regional Perinatal Network, invited organizations with a common goal - improving the health of mothers and infants living in the city of Cleveland – to collaborate on a proposal. Six organizations agreed to participate (Appendix A). These organizations provide health care services to over 50% of the estimated 5000 African American women in the city of Cleveland that give birth each year.

The project from the Cleveland Regional Perinatal Network was funded. This project, “The Feelings of African American Prenatal Women,” had four goals:

1. Estimate occurrence of perinatal depression in African-American perinatal women, aged 15 to 44, residing in Cleveland.
2. Identify existing screening and referral practices related to perinatal depression among health care and social service providers in key agencies.
3. Identify mental health services in the Cleveland area for women with perinatal depression.
4. Develop an implementation plan to address the gaps in services for perinatal women with depression.

Background

Compared to men, women have about twice the prevalence of depression and anxiety disorders. These rates are observed in all cultures.

The childbearing years are times of special vulnerability for women and for the impact that untreated depressive and anxiety disorders may have on their children and families. Women are more likely to experience mood and anxiety disorders during and after a pregnancy than at any other time in their lives. These disorders are considered to be among the least recognized and, at the same time, the most treatable. Pregnancy-related and postpartum mental disorders affect about 10 to 20% of women having a healthy baby, with figures being higher in women who have experienced pregnancy losses or babies with illness or abnormalities and/or with a previous history of depression.

Pregnancy is a major developmental life transition involving biological, psychological, and social changes. Although pregnancy and the postpartum periods are supposed to be times of happiness, for some women these are times of mood liability and anxiety about the health of the fetus/infant and the well being of the family.

Definition of Perinatal Depression

Women can have the temporary “blues” or more serious and debilitating emotional illnesses surrounding pregnancy and the postpartum period. The blues are not considered a mental illness. Postpartum blues, a state of heightened emotions, occur within the first 2 to 3 weeks after birth in up to 70% of women worldwide. The baby blues are temporary and rescind on their own.

Perinatal depression can be devastating for the woman and/or her family and should not to be confused with the baby blues. Perinatal depression is defined as a major depression and has symptoms that include: a disturbance of mood (e.g., feeling irritable, sad, or excessive crying) lasting more than 2 weeks; a lack of pleasure in anything accompanied by changes in sleep, appetite, thinking, libido; possibly obsessive compulsive ideas (e.g., of harming self or baby); and sometimes feelings of guilt and/or suicidal ideas. A woman experiencing perinatal depression may complain of having no energy and numerous physical complaints, such as headaches, heart palpitations, and hyperventilation. The symptoms of perinatal depression may occur during the pregnancy or in the first 3 months after delivery. In nursing mothers, depression may occur at the time a mother stops breastfeeding.

Perinatal depression affects women of all ages, socio-economic status, and racial/ethnic backgrounds. Past and/or family history of depression and inadequate social supports are risk factors for perinatal depression.

Assessment

Screening tests, such as the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987), Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and others (Appendix B) are useful in the identification of perinatal depression. However, perinatal depression is often underdiagnosed and consequently undertreated. Without treatment, perinatal depression may last up to 9 to 12 months, leaving lifelong emotional scars for both the mother and her baby.

A face-to-face assessment is necessary to diagnose perinatal depression. In addition to a psychological evaluation, assessment for perinatal depression should include a thorough physical examination and appropriate laboratory testing, such as monitoring thyroid function levels and a complete blood count.

Treatment

Treatment for perinatal depression includes use of medications, individual psychotherapy, group therapy, support groups, and involvement of family for emotional support. The antidepressant medications have been an invaluable addition to treatment. Estrogen has also been used with some success for perinatal depression.

Summary

Perinatal depression is a condition that includes a range of physical and emotional symptoms during or after pregnancy. If identified, it can be treated successfully with a variety of interventions, including medication, psychotherapy, and group support.

GOAL 1

Estimate occurrence of perinatal depression in African American perinatal women, aged 15 to 44, residing in Cleveland

Project Design

Sample

A convenience sample was used for this project. The sample included African American women, aged 15 to 44, between 28 weeks pregnant and 3 months postpartum who resided in the city of Cleveland. These sample characteristics were defined by the request for proposal. In consideration of the common, yet temporary, baby blues, women were excluded from the sample if they were less than 2 weeks postpartum.

Measurement

After evaluation of several screening instruments, the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) was selected for use in this project (Appendix C). The scale is easily and quickly administered, readily available, and a valid and reliable tool. The Edinburgh Postnatal Depression Scale includes 10 questions addressing “how you have felt over the past 7 days.” Each question includes four responses, scored 0 to 3. A total score of 13 or greater indicates “at risk” for perinatal depression. A diagnosis of perinatal depression requires a complete evaluation by a trained professional.

Prior to administration of the Edinburgh Postnatal Depression Scale, subjects were asked five questions: (a) Have you ever participated in this survey before? (b) Do you consider yourself African American? (c) Do you live in the city of Cleveland? (d) How old are you? and (e) When is your baby due? or If postpartum, when was the baby born? These questions were used to determine eligibility for study participation – women could participate once, had to consider themselves African American, must be aged 15 to 44, and were either 28 weeks or greater pregnant or between 2 weeks and 12 weeks postpartum. Additionally, demographic information related to number of pregnancies, number of living children, and mental health services use was collected.

Procedure and Settings

Data were collected at four healthcare organizations during a 3 ½-month time period. These organizations were in different areas of the city of Cleveland and provide health care services to over 50% of the estimated 5000 African American women living in Cleveland that give birth each year.

The intent was to have approximately equal number of participants from each organization. Two organizations (University Hospitals of Cleveland/MacDonald Women’s Hospital and MetroHealth Medical Center) had data collected in one location, and the other two had data collected in multiple locations (MetroHealth Center for Community Health and NorthEast Ohio Neighborhood Services).

Two organizations used their own staff (MetroHealth Medical Center and NorthEast Ohio Neighborhood Services) to collect data, and two used hired data collectors (University Hospitals of Cleveland/MacDonald

Women’s Hospital and MetroHealth Center for Community Health). All data collectors were provided with training related to approaching potential subjects, obtaining informed consent, and completing the tool.

Data collection involved face-to-face contact in a clinic setting (during the obstetrical, postpartum, or newborn appointment) or telephone contact. There was concern that women who were experiencing perinatal depression may be unable to keep their scheduled appointments. To address this, data were collected, via the telephone, for at least 15% of the sample. This subset included women who were scheduled for an antepartum or postpartum appointment but did not reschedule it or come to the clinic for the appointment. In an attempt to address literacy issues, participants in the clinic setting were given the option of either completing the survey on their own or having the survey read to them.

Eligible participants signed the informed consent form and then completed the survey tool. Subjects received a \$15 gift certificate at the conclusion of the data collection process as compensation for their time. Pregnant and/or postpartum women who missed an appointment were identified at the end of a clinic day by the site liaisons. Data collectors called these potential subjects and followed a process similar to that described above, with two exceptions. Informed consent was obtained by having two people listen on the telephone to a subject agree to participate in the project, and the \$15 gift certificate was mailed.

Demographics of the Sample

All participants in the study were African Americans women, between the ages of 15 and 44 years, residing in the city of Cleveland, and between 28 weeks pregnant and 3 months postpartum. The vast majority of women in the sample were Medicaid eligible.

Most studies conducted on perinatal depression focus on women during the postpartum period. Perinatal depression may occur from week 28 in the antepartum period up to 3 months postpartum. For purposes of this project, both the experiences of antepartum women and postpartum women were of interest. A total of 386 women were surveyed – 248 (64%) antepartum women and 138 (36%) postpartum women.

Ages of participants ranged from 15 years of age to 42 years old. Table 1 shows the breakdown by maternal age of antepartum and postpartum participants.

Table 1. Maternal Age of Antepartum and Postpartum Participants

Maternal Age	Antepartum Participants (%) <i>n</i> = 248	Postpartum Participants (%) <i>n</i> = 136
15 to 17	20 (8%)	6 (4%)
18 to 21	84 (34%)	44 (32%)
22 to 29	95 (38%)	61 (45%)
30 to 35	38 (15%)	14 (10%)
36 to 42	11 (4%)	11 (8%)

The largest group of participants was pregnant for the third or fourth time (*n* = 123). The other women were distributed into three categories: first pregnancy (*n* = 97); second pregnancy (*n* = 91); and fifth or more (*n* = 74). For the overall sample, study participants had an average of 3.04 pregnancies (*SD* = 2.03) (Figure

1). In the antepartum group, the number of pregnancies was fairly evenly distributed: first, $n = 68$ (27%); second, $n = 52$ (21%); third or fourth, $n = 72$ (29%); and five or more, $n = 56$ (23%). For postpartum women, 29 (21%) were pregnant for the first time, 39 (29%) were pregnant for a second time, 51 (37%) were pregnant for the third or fourth time, and 18 (13%) were pregnant for the fifth or greater time.

Women who participated in this project had a range of 0 to 12 children, with a $M = 1.87$ children ($SD = 1.71$) and a median of two children for the total sample. About one-fifth of the participants had no children at the time of the survey ($n = 82$). The greatest number ($n = 109$) had one child. Approximately equal numbers had two children or three to four children. Only 24 women had five or more children. The number of children by group, antepartum versus postpartum, is included in Table 2.

Figure 1. Number of Pregnancies

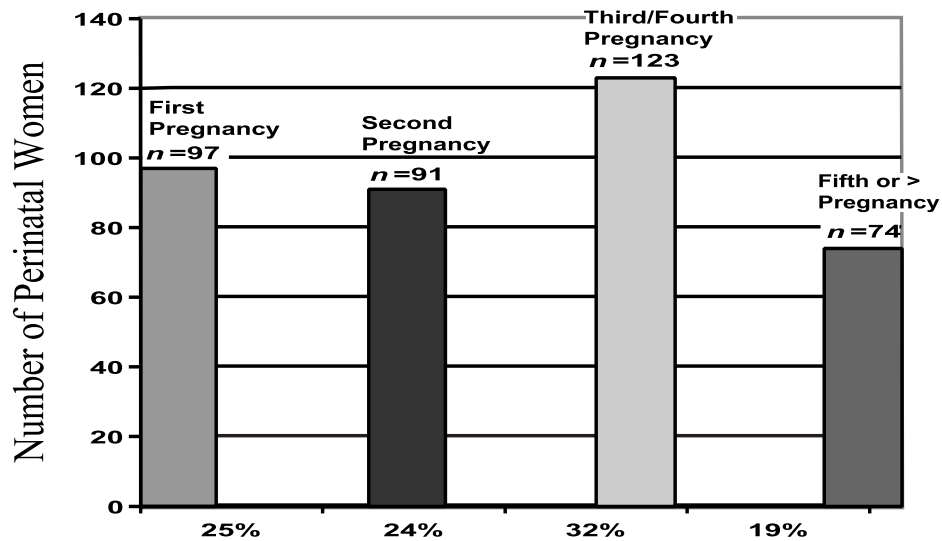


Table 2. Number of Children for Antepartum Versus Postpartum Women

Number of Children	Antepartum Women (%) $n = 248$	Postpartum Women (%) $n = 137$
No children	75 (30%)	7 (5%)
One child	69 (28%)	40 (29%)
Two children	51 (21%)	31 (23%)
Three or four children	38 (15%)	50 (37%)
Five or more children	15 (6%)	9 (7%)

Most women were surveyed during the last 6 weeks of their pregnancy, followed by women who were 32 to 35 weeks pregnant. For postpartum women, the average age of their infants was 5.47 weeks ($SD = 2.93$). Table 3 includes a summary of the total sample demographics.

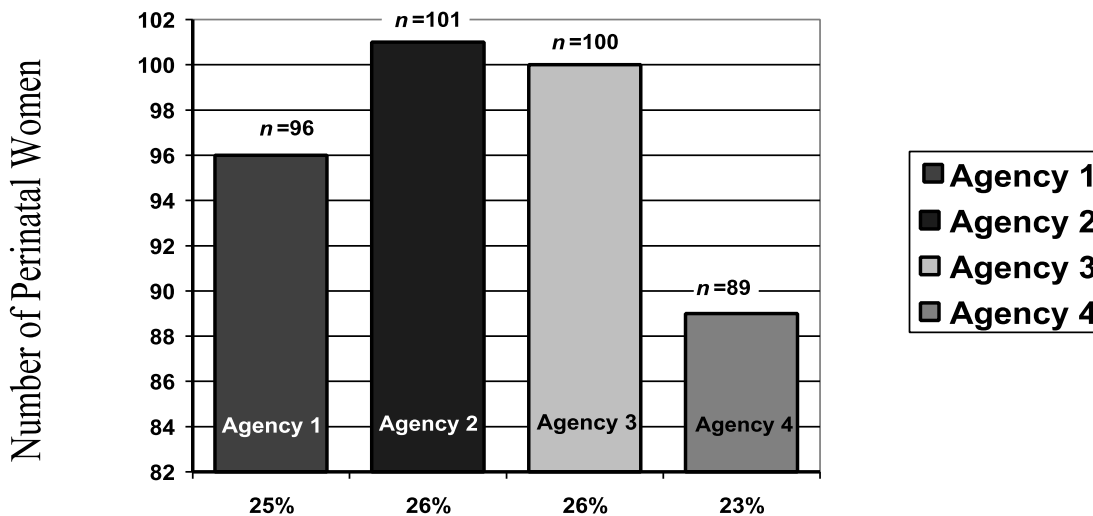
Table 3. Overall Sample Demographics

	<i>N</i> or <i>n</i>	<i>M</i>	<i>SD</i>	Median	Range
Maternal age	384	24.16	5.78	23	15-42
Number of pregnancies	385	3.04	2.03	3	1-14
Number of children	385	1.87	1.71	2	0-12
Antepartum: Gestational age at time of survey	248	33.91	3.51	34	24-42.5
Postpartum: Infant's age at time of survey	138	5.47	2.93	6	2-12

Process Variables

Participants were recruited from four different healthcare agencies, representing diverse neighborhoods within the city of Cleveland. The intent was to survey approximately equal number of participants from each organization (Figure 2). Two organizations had data collected in one location, and the other two had data collected in multiple locations.

Figure 2. Number of Participants by Agency



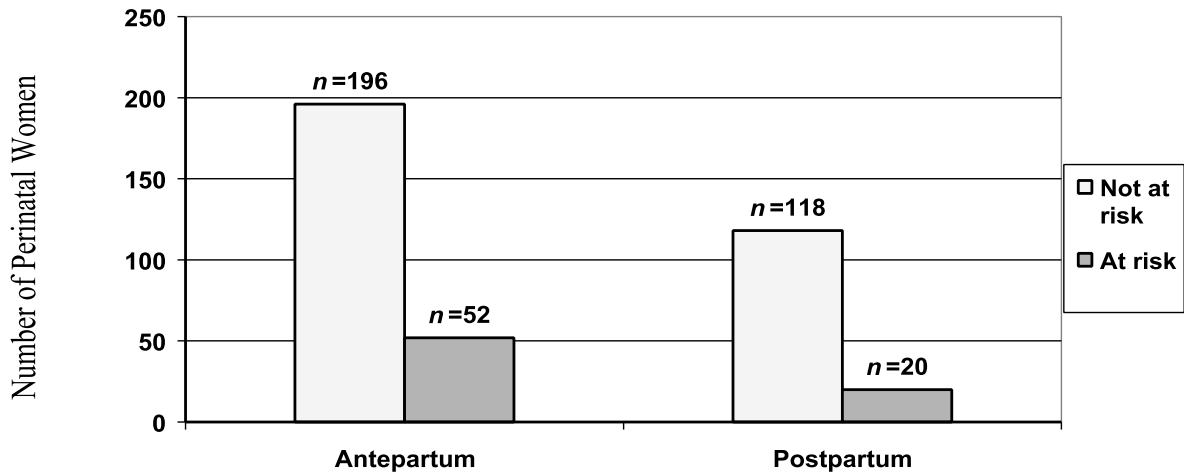
Eighty-one percent ($n = 313$) of the surveys were completed in person at a healthcare site, and 19% ($n = 73$) were completed by telephone. For those surveys done in person, participants were given the option of either completing the survey on their own or having the survey read to them. The majority of participants completed the survey on their own ($n = 242$). For those surveys read to subjects, this occurred either in person ($n = 46$) or via the telephone ($n = 73$).

Perinatal Depression

Thirteen or greater was used as the cut-off point for identifying women “at risk” for perinatal depression. For the overall sample, 19% ($n = 72$) of the women scored as “at risk” for depression. Just as important, 81% ($n = 314$) did not. The percentages from this study are in line with numbers reported in the literature and appear to be independent of socio-economic variables or ethnicity.

Antenatal women scored as “at risk” for perinatal depression at a higher rate than postpartum women. Twenty-one percent ($n = 52$) of the antepartum women scored as “at risk” for perinatal depression compared to 14% ($n = 20$) of the postpartum women (Figure 3). Caution is urged in interpreting the findings beyond suggestive given the unequal sample size.

Figure 3. Antepartum Versus Postpartum Comparison of “At Risk” for Perinatal Depression



As the number of pregnancies increased, the percentage of women scoring as “at risk” for perinatal depression increased – 16% of women’s with their first pregnancy scored 13 or greater on the Edinburgh Postnatal Depression Scale; 17% of women pregnant for the second, third, or fourth time scored as “at risk;” and 26% of those who had been pregnant five or more times scored as “at risk” (Figure 4).

Women with one child had the lowest percentage (10%) of risk for perinatal depression. Comparatively, one third (33%) of the women with five or more children scored as “at risk” for perinatal depression (Figure 5).

Figure 4. “At Risk” Versus “Not At Risk” for Perinatal Depression in Relation to Number of Pregnancies

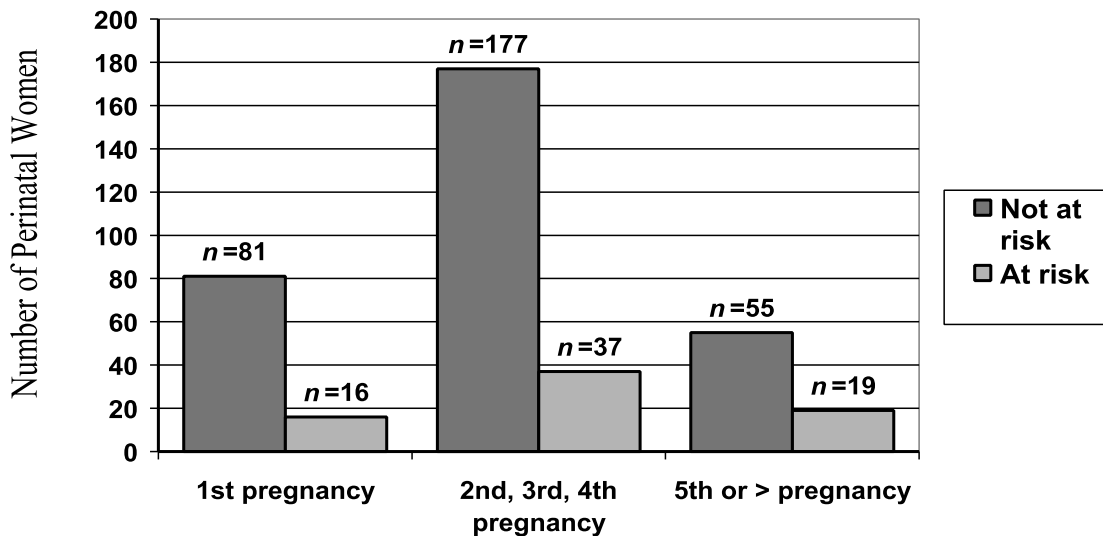
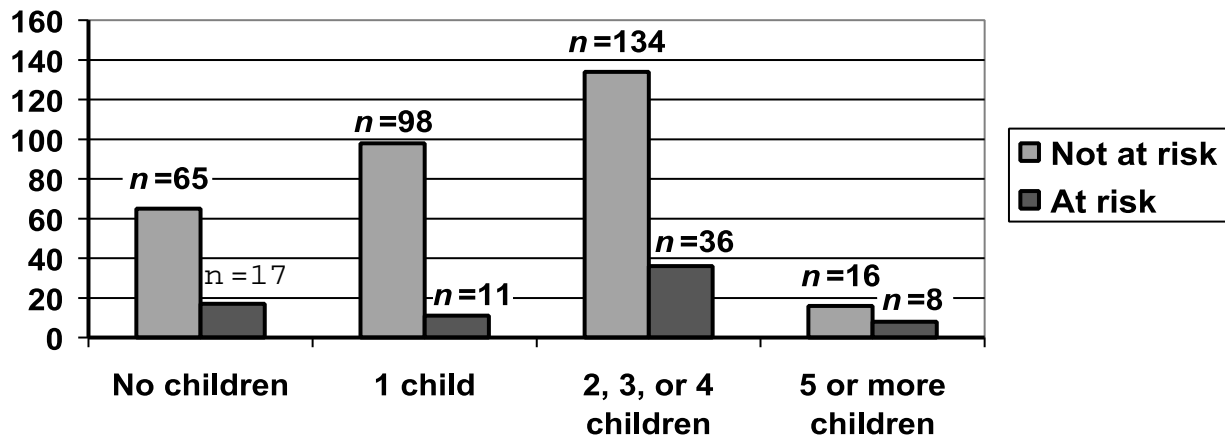


Figure 5. “At Risk” Versus “Not At Risk” for Perinatal Depression in Relation to Number of Children



The percentage of participants who scored as “at risk” for perinatal depression was greater for those who completed the survey via telephone (23%, $n = 17$ of 73) compared to those who completed the survey at a scheduled appointment (18%, $n = 55$ of 313). These data provide some **beginning** evidence that symptoms of perinatal depression may be related to a pregnant or postpartum woman keeping versus not keeping a scheduled healthcare appointment. There were similar numbers of antepartum ($n = 40$) and postpartum women ($n = 33$) in the telephone sample, but twice as many antepartum women ($n = 208$) than postpartum women ($n = 105$) in the face-to-face (clinic) group. Given the uneven sample size between the two groups and the small number of women in the telephone group, caution is recommended in making causal relationships or definitive conclusions about the findings.

Perinatal depression is often not identified and consequently untreated, despite effective interventions for the condition. Participants were asked if they were currently receiving any mental health services as an approximate measure of the number of women who may be receiving treatment for perinatal depression. Only seven or 2% of the women surveyed indicated that they were currently receiving mental health services. This is a small number given that 19% of the participants were screened as “at risk” for perinatal depression. Three participants identified some type of mood disorder as the reason for receiving mental health services (Table 4). Three of the seven scored as “at risk” for perinatal depression.

Table 4. Reasons for Currently Receiving Mental Health Care Services

Reasons	Number (%)
Bipolar/mood swings	1 (14)
Depression	2 (29)
Other	1 (14)
No answer	3 (43)
TOTAL	7

In response to the question, “Have you ever received mental health services,” 25 women responded yes. Twelve of the 25 scored as “at risk” for perinatal depression whereas 13 did not. A past history of mental

health issues is a risk factor for perinatal depression. Again, given the number of women who screened as “at risk” for perinatal depression, this low number is surprising. A variety of reasons were identified, including mood disorders, abuse, family issues, and other (Table 5).

Table 5. Reasons for Previous Mental Health Services

	Number	Percent (%)
Bipolar/mood swings	2	8%
Child abuse	1	4%
Depression	10	40%
Postpartum/perinatal depression	1	4%
Family/parenting/domestic issues	3	12%
Attempted suicide	1	4%
Other	4	16%
No answer	3	12%
<i>TOTAL</i>	25	

Summary

For the overall sample, 19% of the women scored as “at risk” for depression versus 81% who scored “not at risk.” Antenatal women scored as “at risk” for perinatal depression at a higher rate than postpartum women, 21% versus 14% respectively. The percentage of participants who scored as “at risk” for perinatal depression was greater for those who completed the survey via telephone (23%) compared to those who completed the survey at a scheduled appointment (18%). There was little variation in the percentage of women scoring “at risk” for perinatal depression based on data collection agency.

These data provide some **beginning** evidence that symptoms of perinatal depression may be related to a pregnant or postpartum woman keeping versus not keeping a scheduled healthcare appointment. Overall, the findings from this project seem to be consistent with numbers reported in the literature and appear to be independent of socio-economic variables or ethnicity.

GOAL 2

Identify screening and referral practices related to perinatal depression among health care and social service providers

The intent of goal 2 was to determine what the existing screening and referral practices were among health care and social service agencies. The social work educator for the Cleveland Regional Perinatal Network conducted the telephone interviews to address this goal.

Survey Tool and Procedure

An investigator-developed survey tool was used. The tool consisted of 11 questions plus identifying information such as name, address, and telephone number of the agency and contact person. The first question of the survey addressed whether the agency screened for depression. The survey was terminated with a no response. Given a positive response, additional data were collected, including the types of questions or any formal tools used to screen for perinatal depression, the agency person asking the screening questions, and where clients identified as being depressed were referred for mental health services.

The surveys were completed via a telephone interview during a 3-month time period. A clear explanation was given to the agency respondent regarding the goals of the overall project and purpose of the survey.

Agencies Contacted

A purposeful delineation was attempted to differentiate health care, social service, and mental health organizations. To this end, a meeting was held between the social work educator and a representative from First Call for Help to separate the purposes of goals 2 and 3 and to identify the appropriate agencies for each to contact.

Thirty-five health care and social service agencies were contacted (Appendix D). All 35 agreed to participate. The agencies included health care ($n = 11$), social service ($n = 22$), and home health care ($n = 2$). Personnel interviewed included nurses, nurse midwives or practitioners, social workers, counselors, service coordinators, executive directors, and supervisors.

Findings

A total of 29 agencies screened for perinatal depression. Twenty-eight health care and social service agencies routinely screened for perinatal depression. One social service agency only screened for depression when it was indicated in the referral that there were risk factors. The six remaining surveys were not completed for various reasons: one social service agency no longer saw pregnant clients; another one is a registered mental health agency; three agencies did not provide any clinical services to pregnant women; and one did not have any pregnant women or infants in their caseload.

Health care agencies generally screened for depression at one or more of the following - the first prenatal visit, a pregnancy follow up visit, postpartum visit, and/or pediatric visit. The majority of social service agencies screened for depression at the first visit or prescreening contact, which sometimes occurred via telephone (Table 6).

Table 6. Visits When Screening for Perinatal Depression Occurred

	Health Care (n = 11)	Social Service (n = 16)	Home Care (n = 2)
Pregnancy	11	15	1
Postpartum	9	2	2
Pediatric	7	0	0

Agencies used various questions to screen for depression (Table 7). The most common questions asked were about a history of mental health problems, treatment of mental health issues, and medication use. In addition to asking questions, agency respondents reported that nonverbal cues were also observed, such as client’s appearance, mood, and cooperation.

Table 7. Questions Used to Screen for Perinatal Depression

<ul style="list-style-type: none">• Are under any stress?• Are you taking any medication?• Have you ever been in counseling?• Do you have a history or been treated for mental health problems?• Have you ever been hospitalized for psychiatric reasons?• Do you have a family history of depression and/or anxiety?• How are you functioning?• Are you able to care for yourself?• Have you had any changes in your eating and/or sleeping patterns?• Do you have feelings of hopelessness? suicidal/homicidal ideation? isolation?• Are you less interested in activities that you used to be interested in?• Do you feel detached from others?• Are you having or have you had any problems during the pregnancy?• Do you have a history of hallucinations?• Are you feeling low, blue, depressed, or any changes in mood during the pregnancy? after the pregnancy?• What is your support system?• Are you able to cope with stressful situations?• Do you have any severe fears?• Do you find yourself crying?• Do you have problems completing everyday tasks?
--

Only two agencies used a formal tool for perinatal depression screening. One agency used the Edinburgh Postnatal Depression Scale for screening when they visited postpartum mothers and their infants in the home soon after delivery. These visits sometimes occurred before the period of postpartum blues ended. Another health care agency used the Beck Depression Inventory sporadically.

Physicians, midwives, nurse practitioners, nurses, social workers, licensed dietitians, and prenatal intake specialists were the providers responsible for asking the perinatal depression screening questions in healthcare facilities. In social service agencies, social workers, counselors, art therapists, intake coordinators, Early Start specialists, program coordinators, community care coordinators, and assessment specialists were responsible for asking the questions to the clients.

Some prenatal and pediatric clinics had a mental health providers or a social worker on site who could assess perinatal patients who might be depressed, while others referred patients directly to either a community mental health agency or a hospital's psychiatric department. One of the home health agencies has a certified mental health program so that clients could be assessed in the home.

Patients seen at prenatal clinics at hospitals who appeared to be depressed were usually referred to the facility's psychiatric department for further evaluation and follow up. Occasionally referrals were made to community mental health agencies.

The majority of social service agencies referred their perinatal clients directly to a community mental health agency or hospital for further assessment of depression and follow up. One substance abuse agency had recently merged with a mental health agency. Their perinatal clients could be assessed and followed within the agency for mental health services but at a different site. Another social service agency referred their pregnant and postpartum clients for counseling to their own mental health department. One agency reported that perinatal clients were given a list of resources if they were identified as being depressed. Some social service agencies reported that they had social workers on staff with mental health backgrounds who could assess clients for perinatal depression before referring them to the appropriate resource, that is, emergency room verses mental health agency.

All social service agencies referred their clients to community mental health agencies. Those prenatal care and pediatric outpatient clinics not attached to a hospital also referred patients to community mental health agencies, based on patient/clients' medical insurance and the area in which they lived.

The majority of social service agencies did not provide any services specifically for depressed pregnant or postpartum women. Some agencies had social workers or counselors who could follow the client and provide counseling, support groups, or education related to issues such as domestic violence, rape, substance abuse, and adoption. One agency, certified as a mental health agency, provided in-home assessment, referral, crises intervention, and short-term counseling. Another agency, also a certified mental health provider, offered individual counseling, group work and medication. At prenatal clinics the obstetrician assessed and provided medication.

Summary

Thirty-five health care and social service agencies were contacted. A total of 29 agencies screened for perinatal depression. Referrals tended to be directly to either a community mental health agency or a hospital's psychiatric department.

GOAL 3

Identify mental health services in the Cleveland area for perinatal women with depression

The purposes of goal 3 were to identify and catalogue the agencies that provided mental health services for perinatal women with depression. First Call for Help conducted this component of the project. Data were collected using a structured, telephone interview.

Interview Tool and Procedure

The interview tool was a questionnaire about services provided. Data collected included a brief synopsis of services provided and the steps taken regarding screening and assessment. The categories of professionals providing services, such as psychiatrist, social worker, etc., were identified. Additionally, information about treatment modalities, assessment tools, eligibility, hours of service, and fees were gathered. Questions were read over the telephone, and the responses were transcribed on the form by the interviewer.

Agencies Identified for this Project

Using the “Taxonomy of Human Services: A Conceptual Framework with Standardized Terminology and Definitions for the Field,” 88 agencies (Appendix E) in the Cleveland area were identified as possibly offering some type of mental health services. Telephone calls were made to agencies, both general and specialty, that offered the following services: adolescent psychiatric inpatient units, adult psychiatric inpatient units, clinical evaluation, community clinics, general counseling services, health problems counseling, home-based psychiatric services, hospitals, mutual support groups, outreach programs, pregnancy counseling, psychiatric day treatment, psychiatric disorder counseling, psychiatric emergency rooms and public clinics.

Of the 88 agencies, 79 were contacted by a First Call for Help research analyst. Nine were not contacted for the following two reasons. Seven were considered social service or health care organizations and were included in the goal 2 assessment, which was described in the previous section. The other two agencies were determined to be inappropriate for this evaluation.

Contacted Agencies

Agencies contacted were asked the question “Would you see women who are experiencing depression during pregnancy or postpartum?” Forty-four percent ($n = 35$) of the agencies answered yes to this question, 46% ($n = 36$) answered no, and 10% ($n = 8$) did not complete the assessment process. Of the eight not completing the process, three agencies did not return calls, one agency requested the questionnaire by fax but did not return it, two agencies gave incomplete information, one agency did not offer services at the time of data collection, and one agency referred perinatal women with depression to another provider.

Agencies that did not provide services for perinatal women were asked if they would refer these clients to another provider, and if so, to whom (Appendix F). The interview was then ended. For agencies that indicated that they would see women with depression during pregnancy or postpartum, the interview continued and a series of questions were asked.

Generally, persons contacted at the agencies worked in intake or assessment. Others who participated in the interview included assessment specialists, clinical supervisors, intake specialists, therapists, and psychologists.

Findings

Almost half of the agencies said they provided services to women with perinatal depression whereas 41% did not. However, no agency that was contacted had a program or service designed specifically for this group of women.

Agencies that did not see perinatal women for depression referred to other agencies and providers. Unfortunately some of the referral agencies did not provide the needed services.

Although a client could generally have an intake appointment within a few days, it took a few weeks to be seen by a therapist and a few weeks to 2 to 3 months for an appointment with a psychiatrist, who would prescribe any required psychotropic medications. This potentially extended time period to obtain counseling and/or medications is problematic. Women with perinatal depression have a need for immediate intervention.

Once seen by a psychiatrist, agencies indicated that psychotropic medications would be prescribed for perinatal women. Some would only prescribe such medications in collaboration with a client's obstetrician.

In response to the question, "What treatment modalities do you offer?" agencies were given a list of possible choices. There were many different opinions about what an assessment includes. Most agencies that offered assessment used a psychosocial assessment. Psychosocial assessment was not a choice on the list; however, it was written on the questionnaire if an agency indicated that such service was provided. Only those services that are considered entry level were marked on the questionnaire. Many agencies indicated that psychological assessments are offered only when deemed appropriate and after a psychiatrist and/or psychologist saw the client. Because this type of assessment would typically be after a client's initial visit, psychological assessments were not marked as a service. Clinical assessment was added to the list of treatment modalities after interviews were started. Thus, not all agencies were given clinical assessment as a choice of treatment modalities. However, all agencies were asked what other assessments/services were provided. No one who was not asked specifically about a clinical assessment said that they provided one. Again, there were many different opinions of what a clinical assessment entailed. Some agencies said they offered a clinical assessment if a clinician performed the assessment. For the purposes of this project, agencies were told that clinical assessments included both a mental health evaluation and a physical evaluation.

Agencies were given a list of assessment tools and asked which tool, if any, they used to assess perinatal depression (Table 8). If an agency responded other, the respondent was asked to name it (Table 9). Several agencies said they had developed their own tool in the form of a psychosocial assessment.

Table 8. Assessment Tools Used by Agencies to Assess Perinatal Depression

Assessment Tools Used	No. of Agencies
Beck's Depression Inventory	5
Center for Epidemiologic Studies Depression Scale	0
Clinical Assessment	8
Edinburgh Postpartum Depression Scale	2
General Health Questionnaire	2
Hamilton-D	0
Psychiatric Symptom Index	0
Other (see Table 9)	25

Table 9. Other Assessment Approaches Used to Assess Perinatal Depression

Other Assessment Tools Used	No. of Agencies
Burns	1
Basic 32	1
Diagnostic Assessment	6
Health History	1
Psychiatric Evaluation	1
Psychosocial Assessment	15
Own Assessment – Similar to the Hamilton-D	1
Own Assessment	1

A question was added after calls had begun related to fees. None of the agencies that were asked said that they required a personal or individual guarantor.

Finally, agencies were asked if they would be interested in taking part in a focus group about perinatal depression. Those that responded positively were invited (goal 4).

Summary

Of concern were the absence of agencies that had programs dedicated to the special needs of pregnant and/or postpartum women experiencing depression and the difficulty in maneuvering the healthcare system. Even for a skilled data collector, finding the right person to speak with in an agency was problematic. Additionally, agencies that did not see perinatal women for depression sometimes referred to other agencies that did not provide the needed services. However, as a result of this project, United Way First Call for Help now has a more detailed database of resources for perinatal depression in Cuyahoga County. First Call for Help can be contacted at (216) 436 - 2000 or via the Internet at www.uws.org/fcfh.

GOAL 4

Develop an implementation plan to address the gaps in services for perinatal women with depression

Design

A focus group model was used to address the above goal. The list of invitees included staff from agencies that responded positively to the mental health survey, individuals task force members identified as “critical” to building a community infrastructure for perinatal depression services, and/or those interested and concerned about perinatal depression. The meeting was held at the Visiting Nurse Association of Cleveland building because of its central and neutral location. The agenda for the focus group session included a brief presentation related to perinatal depression and a report of project findings. Participants were then asked to convene into breakout groups and charged with addressing the following issues: an assessment of the current system of services; a description of services that would exist for perinatal depression in an ideal world; and recommendations

Participants

In all there were 41 participants representing 18 agencies. Useful to the focus group intent, the participants were professionally diverse. There were 18 nurses, 6 physicians, 2 social workers, and 15 administrators.

Results

System

In response to the question about the current system, the groups identified a variety of issues. First of all, the participants were not convinced there was a system to address perinatal depression. And if a system did exist, it was fragmented, lacked continuity, confusing, complex, haphazard, and impersonal. Such system characteristics would make access difficult for any perinatal woman who needed care for depression.

Gaps and Barriers

A variety of system gaps and barriers were identified (Table 10). Some were broad and related to health care in general. Others were specific to pregnancy and/or mental health. For example, transportation is a barrier that is common to health care in general whereas lack of coverage for mental health services is a gap particular to the current mental health care system. Stigma and cultural differences relate particularly to the reluctance of African Americans to seek assistance for mental health issues and the lack of resources that address the stigma, for example, faith-based interventions. Provider reluctance to screen may be related to concern about a professional’s responsibility once a potential mental health issue is identified. This may be a particularly salient barrier in Northeast Ohio given the current malpractice crisis for those who provide obstetrical care. Certainly the surveys of health care, social service, and mental health care agencies validated the limited resources for perinatal depression services and the inadequate referral options in the Cleveland area.

Table 10. Gaps and Barriers Related to Services for Perinatal Depression

- Provider reluctance to screen
- Inconsistent screening
- Lack of knowledge of resources
- Lack of specific resources/services
- Stigma associated with mental health care
- Poor referral mechanisms
- No follow-up for referrals
- Lack of insurance coverage (including government programs) for mental health care services
- Lack of transportation
- Cultural issues

Resources and Improvements Needed

Education and training for health care providers and consumers about perinatal depression were identified as needed resources. Additionally, focus group participants recognized that improved communication among those involved in the care of pregnant and postpartum women was essential for the identification and effective treatment of perinatal depression.

Participants agreed that a focus on prevention of perinatal depression and enhancing public awareness of this health care issue were warranted. A prevention campaign could focus on risk factors of perinatal depression and the benefits of adequate social supports during the pregnancy and the postpartum period.

Focus group members recommended standardized screening tools and processes as well as qualified screeners as improvement strategies. In terms of referral and intake, participants identified the usefulness of a central list of resources for perinatal depression services and suggested that the referral process needed to be simplified with referral protocols, one central number, and reduced wait times for services. Participants believed that women with perinatal depression would benefit from better information about treatment choices and from consulting psychiatrists or other mental health care providers being part of obstetrical care system.

Ideal World

In the ideal world, there would be adequate resources provided via a central intake, no insurance issues, and collaboration between obstetrical providers and mental health care providers. Obstetrical care and mental health care services and resources would be available in the same location.

Recommendations

Focus group participants recommended the following to address the gaps in services for women with perinatal depression:

- Actively educate providers and consumers about perinatal depression
- Develop a public service campaign regarding the prevention and treatment of perinatal depression and create a public information line
- Establish a central number for resources related to perinatal depression
- Reduce time between initial intake and needed services for women with perinatal depression
- Set up need-based financial help to cover treatment for perinatal depression
- Advocate at the state level for coverage of mental health care
- Reduce stigma with the provision of mental health services at the same location as obstetrical and pediatric care
- Provide psychiatric consultation to obstetrical and pediatric providers
- Improve feedback to referring agencies

Summary

A diverse group of interested professionals recommended needed improvements to the current system of services for perinatal depression. These included education for providers and consumers about perinatal depression, a focus on prevention, and strategies for streamlining access.

Appendix A
Participating Organizations

Participating Agencies

Cleveland Regional Perinatal Network (CRPN)

A multidisciplinary regional outreach program funded by a grant from the Ohio Department of Health since 1978, the CRPN contributes to state perinatal performance measures through professional education consultation. The CRPN provides forums for networking, sharing expertise, and facilitates regional planning and problem solving. The multidisciplinary team, based at University Hospitals of Cleveland and MetroHealth Medical Center, coordinates and designs programs to meet the needs of perinatal provider groups and acts as a catalyst and conduit for state initiatives to improve maternal and infant care.

MetroHealth Medical Center and MetroHealth Center for Community Health

MetroHealth Medical Center and MetroHealth Center for Community Health are part of the MetroHealth System, which offers an integrated program of patient care services, supported by education and research programs. MetroHealth is committed to responding to community needs, improving the health status of the region, and controlling health care costs. An identified core value is the provision of service to any resident of Cuyahoga County. The main campus of MetroHealth Medical Center contains inpatient beds and four pavilions for outpatient care, including obstetric and pediatric services.

MetroHealth Center for Community Health provides community-based services to families. As one of its services, MetroHealth Center for Community Health administers the Cuyahoga County Child and Family Health Services Program, which seeks to improve the health of pregnant women, infants, children, and adolescents. Community-based services for pregnant women and infants include health and education, nutrition, and social services.

NorthEast Ohio Neighborhood Health Services, Inc. (NEON)

NEON is a network of community health centers, organized in 1967, which offer accessible, comprehensive, primary care services, including obstetric and pediatric care, to families residing in the Greater Cleveland area. NEON providers are committed to a service delivery model that emphasizes accessible personalized care. Care is coordinated by a primary physician and includes access to social work, health education, family planning, nutrition, and dental care. NEON has maintained a history of collaboration with community providers to assure the provision of quality health care services to residents of Northeast Ohio.

United Way First Call for Help

First Call for Help provides information and linkages to a wide range of health and human services in Cuyahoga County. Trained information specialists are available by phone 24 hours a day and have access to a comprehensive electronic data base of more than 1000 agencies 4000 programs and other resources.

University Hospitals of Cleveland, MacDonald Women's Hospital

MacDonald Women's Hospital is a regional perinatal care center offering inpatient and outpatient maternity services for both uncomplicated and high-risk deliveries. The Women's Health Center (WHC) is the hospital-based clinic located on the campus of University Hospitals of Cleveland. The WHC provides obstetrical, gynecological, and family planning care to women in their reproductive years. Special services exist for teens and women with high-risk pregnancies. An interdisciplinary team works collaboratively to deliver care and WIC services are on site. A majority of the patients seeking services reside in the city of Cleveland and are African American.

Appendix B
List of Screening Tools with References

Depression Instruments

Authors: C. T. Beck & R. K. Gable
Title of Instrument: Postpartum Depression Screening Scale
Description: The Postpartum Depression Screening Scale (PDSS) is a 35 item, self-report instrument, with a Likert-type, 5-point response format. The PDSS addresses seven symptom areas: sleeping/eating disturbances; anxiety/insecurity; emotional lability; mental confusion; loss of self; guilt/shame; and suicidal thoughts. The instrument is designed to identify women who need to be referred for additional diagnostic evaluation.
Source: Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025-1251

Authors: J. L. Cox, J. M. Holden, & R. Sagovsky
Title of Instrument: Edinburgh Postnatal Depression Scale
Description: The Edinburgh Postnatal Depression Scale (EPDS) is a 10 item, self-report instrument, with a 4-point response format. The EPDS assesses common depressive symptoms over the past 7 days.
Source: "Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale." *British Journal of Psychiatry*, 1987, 150, 782 – 786.

Authors: R. L. Spitzer, J. B. W. Williams, K. Kroenke, M. Linzer, F. V. deGruy, & S. R. Hahn
Title of Instrument: The Primary Care Evaluation of Mental Disorders (Prime-MD)
Description: The Prime-MD uses *Diagnostic and Statistical Manual of Mental Disorders* criteria to assess eight categories of mental disorders, specifically, major depressive disorder, other depressive disorders, panic disorder, other anxiety disorder, probable alcohol abuse/dependence, somatoform, bulimia nervosa, and binge eating.
Source: "Utility of a new procedure for diagnosing mental disorders in primary care: The Prime-MD 1000 study. Diagnosing mental disorders." *Journal of the American Medical Association*, 1994, 272, 1749 – 1756.

Authors: A. T. Beck, C. H. Ward, M. Mendelson, J. Mock, & J. Erbaugh.
Title of Instrument: Beck Depression Inventory
Description: The Beck Depression Inventory is a 21-item self reporting scale measuring manifestations of depression. It takes about 10 minutes to complete.
Source: “An inventory for measuring depression.” *Archives of General Psychiatry*, 1961, 4, 561-571. This instrument must be purchased/permission requested. Available through The Psychological Corporation, 1 – 800 – 872 – 1726.

There is now a Beck Depression Inventory II. It takes 5 minutes to complete and assesses depression symptoms over a 2-week time frame. It is also a 21-item instrument. Items are consistent with the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. This instrument must be purchased/permission requested. Available through The Psychological Corporation, 1 – 800 – 872 – 1726.

Authors: L. Radloff
Title of Instrument: Center for Epidemiologic Studies Depression Scale (CES – D)
Description: The CES – D is a 20-item questionnaire. Using a 1-week time frame, respondents self-report duration and frequency of depressive symptoms. Developed to test depression in the general public.
Source: “The CES-D Scale: A self-report depression scale for research in the general public.” *Applied Psychological Measurement*, 1977, 1, 385 – 401.

Appendix C
Edinburgh Postnatal Depression Scale

Today's Date _____

PERINATAL SURVEY
ELIGIBILITY CRITERIA

Data Collected By _____

In person _____
By Phone _____
Withdrew _____
Reason _____

Have you ever participated in this survey before? Yes. No. If Yes, Stop.

Do you consider yourself African American? Yes. No. If No, Stop.

Do you live in the City of Cleveland? Yes. No. If No, Stop.

How old are you? _____ If < 15 or > 44, Stop.

When is the baby due? _____ If < 28 weeks, Stop.

Or if postpartum, when was the baby born? _____ If < 2 weeks or > 12 weeks, Stop.

SURVEY

Read Self _____ Read To _____

Which pregnancy is this for you? _____ # of living children _____

Are you currently receiving mental health services? Yes. No. If Yes, For What _____

Have you ever received mental health services in the past? Yes. No.

If Yes, When _____ For What _____

Please circle the answer that best describes how you have felt over the past 7 days.

- | | |
|--|---|
| <p>1. I have been able to laugh and see the funny side of things.
0 As much as I always could
1 Not quite so much now
2 Not so much now
3 Not at all</p> | <p>6. Things have been too much for me.
3 Yes, most of the time I haven't been able to cope at all.
2 Yes, sometimes I haven't been coping as well as usual
1 No, most of the time I have coped well
0 No, I have been coping as well as ever</p> |
| <p>2. I have looked forward with enjoyment to things.
0 As much as I ever did
1 Somewhat less than I used to
2 A lot less than I used to
3 Hardly at all</p> | <p>7. I have been so unhappy that I have had difficulty sleeping.
3 Yes, most of the time
2 Yes, sometimes
1 Not very often
0 No, not at all</p> |
| <p>3. I have blamed myself unnecessarily when things went wrong.
0 No, not at all
1 Hardly ever
2 Yes, sometimes
3 Yes, very often</p> | <p>8. I have felt sad or miserable.
3 Yes, most of the time
2 Yes, quite often
1 Not very often
0 No, not at all</p> |
| <p>4. I have been anxious or worried for no good reason.
3 Yes, often
2 Yes, sometimes
1 No, not much
0 No, not at all</p> | <p>9. I have been so unhappy that I have been crying.
3 Yes, most of the time
2 Yes, quite often
1 Only occasionally
0 No, never</p> |
| <p>5. I have felt scared or panicky for no good reason.
3 Yes, often
2 Yes, sometimes
1 No, not much
0 No, not at all</p> | <p>10. The thought of harming myself has occurred to me.
3 Yes, quite often
2 Sometimes
1 Hardly ever
0 Never</p> |

Appendix D
Health Care and Social Services Agencies Contacted

List of Health Care and Social Services Organizations Contacted

Alternaterm Pregnancy Services
Applewood Adoption Center*
Bellfaire Jewish Children's Bureau
Bellflower Parenting Center*
Birthright, Inc.*
Clement Center for Family Care
Cleveland Clinic, Obstetrical and Gynecological Outpatient Clinic
Cleveland Pregnancy Center*
Cleveland Rape Crisis Center
Cleveland Treatment Center
Continue Life
Cuyahoga Department of Children and Family Services
Domestic Violence Center
Early Intervention, Help Me Grow*
Early Start, Help Me Grow
East Side Catholic Shelter
Faith Wellness and Pregnancy Center
Hitchcock Center for Women
J. Glen Smith Health Center
Kaiser Permanente
MetroHealth Medical Center, Women's and Children's Pavilion
Miles Broadway Health Center
Neighborhood Centers Association
NorthEast Ohio Neighborhood Health Services
Open Door Maternity Home
Orca House
Recovery Resources
Transitional Housing*
Visiting Nurse Association of Cleveland
Welcome Home, Help Me Grow
Witness Victim Service Center
Womankind Maternal and Prenatal Care Center
Women's Center of Greater Cleveland
University Hospitals of Cleveland, Women's Health Center
Women, Infants, and Children (WIC)

*Surveys not completed

Appendix E
Potential Mental Health Agencies Identified

Agencies Identified as Possible Mental Health Providers (88)

AAA Christian Counselors
Alternaterm Pregnancy Services
Applewood Centers
Bay Presbyterian Church
Beech Brook
Bellefaire Jewish Children's Bureau
• Belleflower Center for the Prevention of Child Abuse
Berea Children's Home and Family Services
Birthright of Greater Cleveland
Bridgeway
Care Alliance
Catholic Charities Health and Human Services – Parish Services
Catholic Charities Services of Cuyahoga County
Center for Families and Children
Children's Aid Society
Cleveland Center for Research in Child Development
Cleveland Clinic Foundation
Cleveland Heights, City of – Dept. of Community Services
Cleveland Pregnancy Center
Cleveland Psychoanalytic Society
Cleveland, City of – Dept. of Public Health
Council for Economic Opportunities in Greater Cleveland
Cuyahoga, County of – MetroHealth System
East Cleveland Neighborhood House
East End Neighborhood House
Emotions Anonymous
Euclid Hospital
Fairview Hospital
Faith Baptist Community Center
Far West Center
Free Clinic of Greater Cleveland
Friendly Inn Settlement
Garfield Heights Community Center
Goodrich-Gannett Neighborhood Center
Grace Specialty Hospital
Harvard Community Services Center
Hillcrest Hospital
Home Birth Option of Cleveland
Huron Hospital
Informing Our Children
Jewish Family Service Assn. of Cleveland
Lakewood Depressive/Manic Depressive Support Group
Lakewood Hospital
Lakewood, City of – Dept. of Human Services

Lutheran Children's Aid and Family Services
Lutheran Hospital
Lutheran Metropolitan Ministry
Marymount Hospital
May Dugan Center
Mental Health Services
Merrick House
Murtis H. Taylor Multi-Service Center
National Depressive and Manic-Depressive Assn.
NBA Cleveland Christian Home
Neighborhood Family Practice
North Coast Health Ministry
North East Ohio Health Services
North Olmsted, City of – City Hall
North Olmsted, City of – Dept. of Human Resources
Northeast Ohio Neighborhood Health Services (NEON)
Ohio, State of – Northcoast Behavioral Health Care System
Olivet Institutional Baptist Church
Parma Community General Hospital
Parma Health Ministry
PHS Deaconess Hospital
Planned Parenthood of Greater Cleveland
Positive Education Program
Recovery Resources
Recovery, Inc. – Self-Help Mental Health Since 1937
Salvation Army, The
Shaker Family Center
South Pointe Hospital
Southwest Bipolar and Depressive Support Group
Southwest General Health Center
Southwest Youth Council
St. John West Shore Hospital
St. Joseph Wellness Center
St. Michael Hospital
St. Vincent Charity Hospital
Tender Loving Care, A Place Called Home
Tourette Syndrome Assn. of Ohio
University Hospitals Health System/University Hospitals of Cleveland
University Hospitals Health System Richmond Hts. Hospital
Ursuline Sophia Center
Visiting Nurse Assn. of Cleveland
West Side Ecumenical Ministry
Windsor Hospital – Center for Psychiatric Health
Womankind Maternal and Prenatal Care Center

• Added to Original List of Agencies for a Total of 88

Appendix F
Mental Health Agencies Referrals to Other Providers

Referred Service Providers

Agencies that do not provide services for women with prenatal or postpartum depression were asked if they would recommend another service provider. The following is a list of the recommended providers.

Applewood Centers (2)
Bellefaire Jewish Children's Bureau
Bellflower Center for the Prevention of Child Abuse
Bridgeway (2)
Client's OB/GYN
Cuyahoga County Mental Health Services Board
Early Start (program)
GRADS Graduation, Reality and Dual-Role Skills Program (in schools) (2)
Far West Center
Healthy Family/Healthy Start (4)
Lutheran Hospital
Mental Health Services (3)
MetroHealth System (3)
Southwest General Health Center
UHHS Laurelwood
University Hospitals (3)
University Hospital Prenatal Clinic
Womankind Maternal and Prenatal Care Center
Women's Center of Greater Cleveland

For additional copies of this report or to comment on its contents, contact:

Cleveland Regional Perinatal Network
11001 Cedar Ave., Suite 300
Cleveland, OH 44106
216-944-3391

or

Cleveland Healthy Family/Healthy Start Project
City of Cleveland Department of Public Health
1925 St. Clair Ave., Cleveland, OH 44114
216-664-4194

*For additional information on
Perinatal Depression and A Guide for Moms local referral resources
visit www.crpn.net*