

***Parental Depression Screening for Pediatric Clinicians:
An Implementation Manual***

***Based on the Parental Well-Being Project
at Dartmouth Medical School
Lebanon, New Hampshire
Funded by The Commonwealth Fund***

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INTRODUCTION

“I felt like I was always overwhelmed and often sad. I was irritable with my children and husband and felt like I was never a good enough parent. I didn’t know a way out. I appreciated the help from my pediatrician.” —A mother in one of the Parental Well-Being Project’s practices

This mother's description of her experience with depression—and of the role her child's pediatrician played—remind us that pediatric health providers can help parents and children by screening for parental depression. After all, the pediatrician is often the health care provider who has the most contact with the parent during the childhood years. Yet, for pediatric health providers to be truly effective in detecting and intervening in parental depression during the well-child office visit, systematic screening methods are needed.

With the support of The Commonwealth Fund, the Dartmouth Parental Well-Being Project has created a realistic way for pediatric health providers to routinely screen for parental depression and refer parents for help. Through our practice-based research network, we have developed and tested practical approaches that can be implemented at well-child visits. While 90 percent of the contacts were with mothers, this approach was also used when fathers attended the visit.

This manual and its support materials are based on our experience with screening more than 9,000 parents in six different pediatric primary care practices over six months. The manual is divided into four sections: a summary of the Well-Being Project; a review of the role of the pediatric provider in the screening process; the five steps for implementing screening in pediatric practices; and a guide for the practice's parent organization or an outside organization or agency, such as a practice network, to assist primary care practices in designing and implementing parental depression screening.

These materials are intended to be used:

- by individual providers seeking to improve how they recognize and assist depressed parents—these tools can be used by health providers in a variety of settings;
- by primary care practices seeking to make practice-level change in how they meet the needs of depressed parents and their vulnerable children; and
- by external organizations seeking to change primary care detection of maternal or paternal depression in multiple practices. This includes health departments, learning collaborative organizations, health plans, and other social service agencies.

The Parental Well-Being Project staff are available to consult on the implementation of any aspect of this project.

SECTION ONE

SUMMARY OF THE PARENTAL DEPRESSION PROJECT EXPERIENCE

Project Design

The Parental Well-Being Project was developed by a working group of primary care pediatricians and academic colleagues within the Clinicians Enhancing Child Health (CECH) regional practice-based research network at Dartmouth Medical School. The recent U.S. Preventive Services Task Force recommendation that all adults undergo brief screening for depression, and the accumulating data about the adverse effects of parental depression on child health, development, and behavior, provided the impetus for changing clinical care.¹ The working group collaborated with a regional managed behavioral health plan to develop a realistic approach to primary care screening for parental depression in pediatric practices.

Initially, CECH clinical trials tested the use of interview versus paper screening and determined that there was a better yield with a paper screener that had an introduction.² This served to explain to parents why their pediatric provider was performing the screen. The PHQ-2 screener used in our project has been well validated and performs as well as longer measures. The screener was pilot tested in two phases: a one-month phase and a six-month phase a year later, in 2004.

From the start of the project, pediatricians expressed concern that they had insufficient resources to assist parents. The Parent Support Line (PSL), a centralized phone service, was therefore established with the behavioral health organization for parents who wished to discuss their symptoms and receive help with referrals to local community, primary care, or mental health resources. Initially, the PSL only received calls, but later in the project PSL staff reached out to parents who agreed to a call during the office visit.

The role of the pediatric provider after screening was clarified over the course of the project. Their role was not to diagnose depression but rather to support and motivate the parent to get help if he or she screened positive. The pediatrician's other role was to help the parent address how her or his depression affected their child. During the project, family behavioral issues and communication, the impact of depression on the child's well-being, and the development of parenting skills to promote child resiliency were among the topics discussed during the well-child visit. Pediatricians then referred parents who thought they might be depressed to other services and followed up during routine care.

A key aspect of the program implementation was utilizing an office-wide approach that educated and involved all staff. Staff were educated about the importance of the maternal depression on child outcomes; encouraged to change the office environment to educate

¹ Pignone M, Gaynes B, Rushton J, et al. Screening for depression in adults: a summary of the evidence for the US Preventive Services Task Force. *Ann Intern Med.* 2002;136 :765

² Olson AL, Dietrich AJ, Prazar G, et al. Two approaches to maternal depression screening in well child visits. *J Behav Dev Pediatr.* 2005;26 :169–176

parents about the issues; and provided with educational materials to give to parents as appropriate.

Audience

The program implemented screening of all mothers at well-child visits since depression occurs commonly in mothers throughout the childbearing years, not just during the postpartum period. Fathers were also screened if they attended well visits. Regular screening was implemented at well-child visits rather than selected visits because it was easier for staff to have the same routine for health visits.

The Screening Implementation Trial

Routine parental depression screening at well-child visits was implemented with 37 providers in six community pediatric practices in New Hampshire and Vermont communities with town populations ranging from 2,000 to 150,000. Parental gender, screening results, and referrals were collected without identifiers. Overall, 9 percent of visits had only fathers attending. When fathers accompanied mothers, only mothers were screened for depression. Detailed data collection determined the amount of time spent on discussing the results, how mothers responded during discussion of the results, and provider actions for three one-week periods during the screening project. Throughout the project, screening rates were collected weekly and practices received support from the project staff in overcoming barriers to screening.

Over six months, parental depression screening was conducted in nearly half of 16,000 well-child visits. This rate of screening included time periods when screening was on hold. Across all of the practices, there was a total of 10 weeks when a key staff member responsible for organizing the screening was away and screening did not occur. When these weeks are not counted, parental depression screening occurred in 67 percent of the well visits. Parental nonresponse was rare; only 6 percent of parents refused to answer, had recently completed the screener in the same office at a visit for a sibling, or were not in attendance at the child's visit. For 27 percent of parents, the office visit screening routine was disrupted.³

Depression Screening Results

In these community private practice settings, about one of seven parents (14%) reveal mood or anhedonia (lack of interest or pleasure in usual activities) symptoms during routine screening. One of 20 parents (5%), both mothers and fathers, screened at-risk for major depression.

In these practices, Medicaid insured 30 percent of families. In clinical settings that serve predominantly low-income rather than middle-class families, we anticipate, based on

³ Olson, A., et al. Brief Maternal Depression Screening at Well-Child Visits, *Pediatrics*, Jul 2006; 118: 207–216.

other depression screening studies, that the rates of parents screening positive for depression are likely to be 50 percent higher than our results.⁴

Parental Responses

Fifty-two percent of mothers in the project who screened positive (score ≥ 3) felt they might be depressed and 85 percent of them wanted to take action. Among mothers with lower screener scores (1–2), 30 percent thought they might be depressed and two-thirds of them wanted to take action. Twenty-seven percent of mothers who screened positive saw themselves as stressed rather than depressed. This information is not known for fathers due to the small numbers of male guardians seen during the weeks of detailed data collection.

Pediatric providers referred 40 percent of mothers and 21 percent of fathers who screened positive to mental health providers or adult primary care providers. The strongest predictor of referral was the parent telling the pediatrician they might be depressed. Providers planned follow-up calls with 36 percent of parents who screened positive. PSL referrals occurred in 26 percent of parents.

Pediatrician Time for Discussion of Screening Results

Providers did not see time for discussion as burdensome. The providers' accounts of time spent are below:

- in 69 percent of well-child visits, no discussion occurred;
- in 22 percent of visits, discussions lasted fewer than three minutes;
- in 5 percent of visits, discussions were three to five minutes;
- in 3.5 percent of visits, discussions were five to 10 minutes; and
- in 1.5 percent of visits, discussions were more than 10 minutes.

Included in the under-three-minute discussions were brief conversations with parents who screened negative about why the practice was conducting screening. Pediatric providers reported that longer discussions reflected the magnitude of the parent's issues and their potential to impact the child.

Lessons Learned

Practice characteristics: Practice flow and clinical care are complex and delicately balanced. Introducing even what appears to be a simple screener of less than one minute will shift care burdens. The office administrative staff and clinicians need to be engaged. When there are underlying conflicts—and/or no collaborative decision-making processes in place—minor challenges in implementing screening will be magnified. It is key to interact with a provider leader as well as nursing and administrative staff.

⁴ McLennan JD, Kotelchuck M, Cho H. Prevalence, persistence, and correlates of depressive symptoms in a national sample of mothers of toddlers. *J Am Acad Child Adolesc Psychiatry*. 2001;40 :1316–1323

Provider and staff buy-in: During the project, some clinicians and administrative staff were not comfortable dealing with parents' mental health issues. These providers were more likely to see barriers than benefits in the program and less likely to consistently participate. Some providers expressed concern about their liability if they discussed depression with the parent. For these providers, it was not easy to acknowledge that a child could be helped by a parent getting help. Nurse practitioners, however, were especially attuned to parental issues and were more likely than other staff to refer parents to outside help.

Parental acceptance: Parents generally accepted the screening and frequently commented that they were pleased that the pediatrician cared. Still, there are barriers to screening, especially among economically and culturally diverse populations. Parents who are socially disadvantaged need to know the screening is routine for all parents, and that the practice is trying to help rather than judge them. In some settings, the parent may see many different providers and not feel comfortable discussing issues outside of an established relationship.

Use of an outside referral assistance service: While 26 percent of mothers accepted referral information to the Parent Support Line (PSL) from the pediatricians, we found that few parents called it. In fact, no fathers used the PSL. When a parent did call, the first step was a confidential 10-item automated depression assessment to give the parent feedback about the likelihood that she was depressed. If desired, the parent was then connected by telephone at that time, or at a later time if desired, to a social worker. Fifteen percent of parents referred used the 10-item screener.

While 60 percent of these mothers were informed by the automated assessment that they were likely or very likely to be depressed, only 35 percent of them chose to connect to the PSL social worker. Therefore, only 5 percent of mothers referred interacted with the PSL social worker. When a subgroup of these mothers who did not use the system was contacted, the mothers gave a variety of reasons for not calling the support line: they lost the number; were feeling better; meant to call but just hadn't yet; or were already getting help. It was not clear whether inertia accompanying depression also played a role in parental inaction.

We also learned that if parents were ready to call they wanted to talk directly with an individual rather than first complete the automated screener. Three of our practices changed their approach as a result. The PSL services in these practices used a proactive format, having the provider obtain the parent's permission for support line staff to call them. After this change, 29 percent of parents agreed to be called by the support line staff and 90 percent were reached and assisted. Based on these results, it is clear that proactive personal contact is needed.

Practice referral preferences: We also learned that providers made more direct referrals to primary care and mental health providers than initially anticipated. Practices that developed strong linkages to local mental health providers preferred sending parents

there over using a support line. Primary care providers also frequently referred mothers to their primary care provider for further evaluation. Thirty percent of parents who screened positive were already being treated for depression; in these cases, providers encouraged them to revisit their provider.

Practitioner comment:

“Screening for depression routinely has changed the practice. It helps us be much more proactive in addressing the mental health needs in families. In particular, we are addressing effective parenting and family concerns.”

Dr. Greg Prazar
Exeter Pediatric Associates

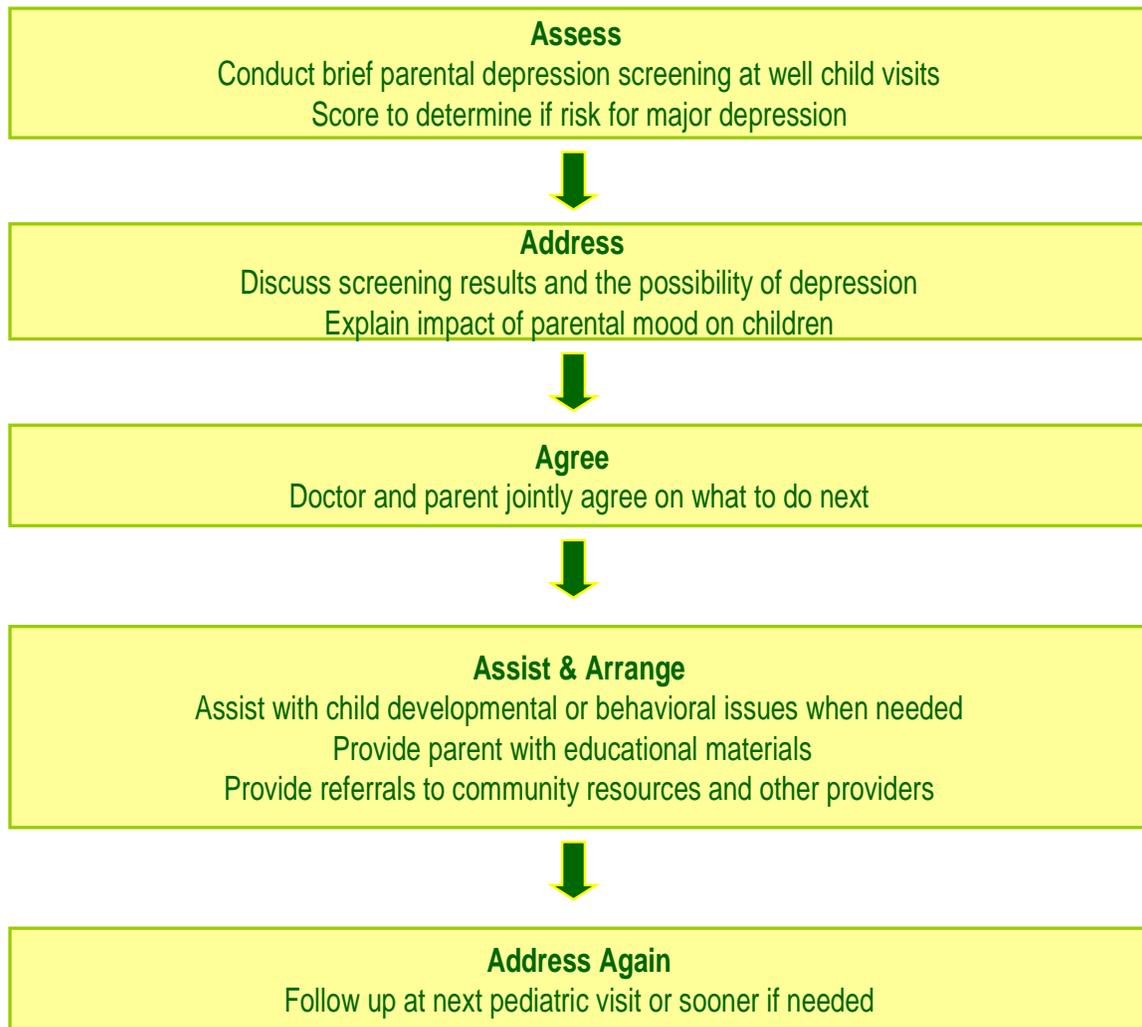
SECTION TWO

ROLE OF PEDIATRIC PROVIDER IN THE SCREENING PROCESS

Our project has defined five required steps for a clinician to screen parents of their pediatric patients for depressive symptoms and assist these parents (Figure 1). Parental depression screening identifies mothers and fathers with depressive symptoms who are at increased risk for major depression. It does not provide a diagnosis of depression. Subsequent administration of the nine-item questionnaire (PHQ-9) as a follow-up diagnostic measure can determine if DSM-IV criteria for major depression diagnosis are met. It also can be used to monitor severity of symptoms.

Figure 1. PDP Five As

Pediatric Clinician's Guide to Parental Depression Screening



ASSESS:

We recommend using the PHQ-2 to systematically screen parents who accompany their child at all well visits. The two questions are scored by simply adding up the numbers for frequency of symptoms for each question for a total score of six. An adult who scores three or higher is considered at high risk for a depressive disorder. A copy of the PHQ-2 with an introduction to the parent is provided in the appendices.

ADDRESS:

The pediatric provider reviews the results and discusses positive scores (3 or greater) with the parent. If the parent has a low level of symptoms (1–2 score), the provider should only explore these issues further if a parent desires. If a parent with a low score is still concerned he or she may be depressed or has a borderline score, providers should discuss the possibility of depression, because lower levels of symptoms in parents can significantly affect parenting. This discussion may also provide an opportunity for parents to share social stressors in the family, current depression treatment, and other issues that may affect their parenting.

If the parent acknowledges he or she might be depressed or has a high level of depressive symptoms, the provider should offer information about how the parent's mood or mental health might impact the health and well-being of the child. The pediatric provider plays a key role in motivating parents to address depression. Many parents will get help if they understand it will help their child as well.

AGREE:

If the parent acknowledges depressive symptoms or that depression is a concern, then the provider should discuss options for further assessment and/or treatment. Coming to a joint decision that depression might be an issue is a good starting point for getting parents to take appropriate action.

ASSIST and AGREE:

The pediatric provider can refer the parent to his or her primary care provider, a mental health clinician, or other community resources for further evaluation and assistance. Providers can offer parents educational materials about the impact of parental depression on children's health. Information about handling stress is particularly helpful because one-third of parents who screen positive say they have problems with stress.

The provider should also explore whether the parent has any concerns about how their child is doing. The provider can offer assistance with the child's developmental, behavioral, or emotional problems. The provider can also provide information about parenting approaches that will help children thrive even if the parent is having difficulties.

Be sure to note parental stresses and mental health screen results in the patient's chart, so it can be followed up at later visits.

ADDRESS AGAIN:

Schedule a follow-up visit with the child if the level of parental dysfunction is likely to have a major impact on their child's development or behavioral/emotional status. If it's unlikely to have a major impact, plan to follow up at the next pediatric visit.

Practitioner Comment:

“I found that mothers with depression symptoms were really concerned about how to not have depression affect their child. I was able to give mothers specific ways to help their parenting while they were getting help. At the next visit I would see how treatment was going as well as how the child was coping.”

Dr. Viking Hedberg,
Plymouth Pediatrics

SECTION THREE

IMPLEMENTATION GUIDE FOR DEPRESSION SCREENING AT THE PRACTICE LEVEL

Brief parental screening for depressive symptoms is designed to be incorporated into the routine well care of pediatric patients. As with any substantial change in a practice, it is easier to implement if the entire practice is involved. It is important to define the tasks involved in the screening and assign responsibilities to various staff members. The following steps are designed to assist the lead clinician and other staff in setting up a screening program in their practice.

A senior pediatric provider who wishes to add parental depression screening to their practice must champion the program with their colleagues and staff. We recommend forming a small group of about three people (one clinician and one to two staff) to lead the practice through the process of designing and implementing the new screening procedures. Every person in the practice plays a critical role in implementing the screening program, so representatives from all aspects of the operation should be included in the small leadership group.

Figure 2 is a worksheet that summarizes the steps needed to prepare to implement depression screening for parents. These steps are described in more detail below. A copy of the worksheet is found in the appendices.

Figure 2. Prepare Your Practice

Implementation Guide for Depression Screening Part 1 “Prepare Your Practice” <i>*Before you begin screening, you need to prepare your practice. Consider the following list of tasks.</i>		
WHAT	WHO <i>(In the space provided, write the person who will be responsible for performing the task)</i>	HOW
Engage Your Practice 1. Identify Champions 2. Motivate Staff 3. Educate Staff	Who: _____ Who: _____ Who: _____	1. Identify a provider and a member of the practice staff who together will champion the screening program. Who are the practice champion(s)? _____ 2. Get your staff involved by setting the expectation that helping depressed parents is important part of routine care, and seek their ideas about helping families understand and cope. 3. Educate your staff about parental depression and its impact on children. Determine attitudes or misconceptions that may influence screening.
Develop Practice Approach 1. When and Who to Screen 2. Choose Screening Tool 3. Explore Available Resources 4. Network with Colleagues 5. Establish Triage/Referral Mechanism	Who: _____ Who: _____ Who: _____ Who: _____ Who: _____	1. Decide if screening is at all well child visits or limited by age or parent gender. 2. Select screening tool. 3. Develop a list of mental health referral options, community agencies, parental support groups, support lines, and Web sites. 4. Contact area providers and mental health agencies to inform them your practice will be screening for parental depression. Ask them if they are willing to accept referrals and provide clinical support. 5. Determine practice role in linking parent to resources A. Options for practice 1) Individualized referral to outside resources 2) Partner with outside agencies who will perform these services 3) Utilize behavioral health clinician within practice setting for these services
Develop Office System 1. Train Staff 2. Develop System to Distribute and Record Screener 3. Select Monitor 4. Change Office Environment	Who: _____ Who: _____ Who: _____ Who: _____	1. Train staff to introduce screening tool and respond to parents' questions. 2a. Develop a system to have screening tool available at the beginning of the visit. 2b. Choose a method to indicate screening occurred and how to document results. 3. Select a person to check and order materials for screening, and to stock exam rooms with brochures. 4. Place posters in waiting areas, exam rooms, by scales, etc.

Key: Provider = Blue Clinical Staff = Green Office Staff = Orange

Practitioner Comment:

“My partners all went along with screening but we needed one person to rally the team and the staff. Our nursing staff really got behind the screening effort—as mothers, they knew how tough the job could be.”

Dr. James Hurley,
Monadnock Pediatrics

PART 1: PREPARE YOUR PRACTICE**Engage Your Practice**

Practice staff or other clinicians may have concerns about adding depression screening to routine well care. The first step is to meet with everyone in your practice and engage them in a discussion about the reasons for screening parents for depression and how it will improve patient care. Every person in the practice contributes to patient care, so it is important for every person to understand their role in the process. The clinician champion can present the benefits of screening based on materials in this manual. (A fact sheet for distribution is available in the appendices.)

Staff or clinician burden is a primary consideration in deciding when to implement a change in a practice. Issues such as staff or clinician turnover or being in the middle of a change to an electronic medical record system can affect a practice’s ability to initiate and maintain change. Practices should start parental depression screening when other aspects, such as clinical volume, staffing, and medical records systems, are relatively stable.

Develop Your Practice Approach*1. When and Who to Screen*

Effective screening requires a systematic method of identifying parents to screen and conducting the screening. Who will be screened? We recommend routinely screening parents who present with their children for well visits. Since depression and depressive symptoms can occur at any time and their severity may fluctuate, screening should be ongoing. If a parent has numerous children in the practice and is seen several times over a few months, you may choose not to screen each time.

Although the screening questionnaire is very brief, discussion with parents who are symptomatic or have concerns may require additional time that is best incorporated into well visits. The well-child visit is also the setting where parents expect to discuss parenting, their child’s behavior, and development. All of these areas may be adversely affected by parental depression. In addition, since continuity may foster trust, parents may be more comfortable discussing these issues with their child’s regular provider rather than the clinician seeing their child when he/she is sick.

2. Choose a Screening Tool

We recommend a two-question paper survey, the Patient Health Questionnaire 2 (PHQ-2), with a written introduction. These questions have been widely tested and shown to accurately identify adults at high risk for a depressive disorder. Using the two questions in an interview format requires that the pediatric provider remember the two questions, weave them into the interview, and ask them consistently. A copy of our recommended screening form and information on scoring the PHQ-2 is provided in the appendices. The form includes a brief introduction about why their pediatric provider is screening.

The PHQ-2 is a screening tool and does not diagnose depression. Parents who report symptoms or score at risk need to complete a more comprehensive assessment or be referred for assessment and treatment with another clinician. Pediatricians who want to assess the parent further to guide their referral may use the Patient Health Questionnaire 9 (PHQ-9). It asks about each of the DSM-IV diagnostic criteria, and the score provides provisional diagnoses and treatment recommendations. A copy of the PHQ-9 and directions on how to score it are found in the appendices.

A popular depression screening tool for postpartum women is the Edinburgh Postnatal Depression Scale (EPDS). This 10-question scale is designed to identify mothers at risk for perinatal depression. It detects anxiety and depressive symptoms and, if used, the provider should expect more women to screen positive. Some pediatric providers may choose to use this tool during the child's first year. Information on scoring and the questions for the EPDS tool are found in the appendices.

3. Explore Available Resources

One way to identify resources for your patients is to contact mental health and primary care clinicians in your community. After describing the proposed change in your practice, discuss your referral needs and how the referral process would work when you have a parent with an urgent need and one with a routine need. Contacting your local public mental health center about their programs is important as well. A discussion at grand rounds at your local hospital or other medical staff meetings might identify other providers in your community who are interested in addressing this critical issue.

Resources for parents with depression vary widely by community. If the parent is uninsured and does not have a primary care provider there may be services available on a sliding scale or through state-funded programs. You should assign a staff person to review resources and develop a list that includes the type of resources below:

- community mental health centers that offer counseling for parents, children, and families;
- child and family service agencies that offer counseling and support groups;
- community hospital education programs that offer parenting groups;

- child abuse prevention hotlines;
- youth council agencies;
- pastoral counseling agencies that may have a sliding fee schedule;
- information and referral lines in your community to answer questions about mental health resources;
- the telephone book (look under social and human services); and
- newspapers, which may list local support groups.

Additional information is available on the following Web sites:

- National Institute of Mental Health: www.nimh.nih.gov
- American Psychological Association: www.apa.org
- National Alliance on Mental Illness: www.nami.org

4. Establish Triage/Referral Mechanism

Before you establish the details of how your office will systematically screen, you need to establish mechanisms to respond efficiently to positive screens within the practice. The majority of those patients will have a primary care provider and may be referred to them for additional assessment and treatment. If you do not identify an organization that can provide additional assessment, a staff member may be trained to score the PHQ-9 and refer the patient as needed. If your practice has a social worker or case manager, this person could assume the task of further assessment of depression and referral as appropriate.

Develop an Office System

After developing a protocol for who to screen, when to screen, what screening questionnaire to use, and how to support parents who screen positive, the next step is to define a systematic office-wide approach or “office system.” This process consists of defining each step or task, the roles of clinicians and staff, and “tools” (e.g., screening questionnaire, handouts, and posters) and considering how to integrate these new tasks into existing patient care. The role of the pediatric provider in parental depression screening has been described earlier. However, many of these tasks can be delegated to staff. This process is outlined on the worksheet “Part 2: The Visit and Beyond” and described in more detail in the following section of the manual.

1. Train Staff

Introduction of the screening is important to your patients’ acceptance of this process. Below is a sample script that has been used to inform parents about depression screening during their child’s visit. If the screen is asked on a separate paper survey, an introduction can be included on the survey.

“Since you were last here, we have implemented a new program that includes a depression screening tool. We know that a parent’s mood and emotional health

significantly affect children, so we are interested in identifying and referring parents who might be depressed. I will leave this short questionnaire with you and I would like you to discuss it with Dr. Jones when s/he comes in to see Johnny. There are also some educational brochures on the table for you to read. Please feel free to take any that interest you.”

“As part of our routine care of your child, we are asking all parents who come in with their children to complete a depression screening form. We know that depression affects both parents and their children, so we are asking for this information as a part of your child’s routine care. After you complete the form, Dr. Jones will discuss the results with you and offer some resources that can be helpful if you are interested.”

It is important that practice staff who distribute or collect the survey information are comfortable dealing with common patient questions. A list of frequently asked questions and possible responses is included in the appendices. If your practice decides to offer parents further assessment or referral assistance, appropriate staff will need to receive training on the PHQ-9 and referrals procedures.

2. Develop System to Distribute Screener and Record Results

Once your practice decides which parents will be screened, it is necessary to develop a system to identify those parents when they present at the practice. Your practice probably has a system for identifying types of visits and paperwork for each type of visit. Your decision about when you will screen the parent and which tools you will use may be determined, in part, by your current processes, such as using a paper health history or an electronic medical record (EMR). As with other assessments, the results need to be documented in a consistent manner. If a paper screener is used this may be charted or results of the screener may be noted in a problem list, visit notes, or other location based on other documentation of the events of a visit.

3. Change Office Environment and Select Monitor

In addition to discussing parental depression during visits, a practice can heighten parental awareness and education about depression by placing posters and brochures in waiting rooms, hallways near scales, bathrooms, and exam rooms. Posters and other educational materials are provided in the appendices. As with all patient education materials, a staff member needs to monitor their availability and keep adequate supplies in designated areas.

PART 2: THE VISIT AND BEYOND

It is important to involve the entire office in developing the office systems. A simple method for determining how to incorporate parental depression screening into your

practice is a “walk through.” Pretend that you are a parent coming to a well visit and examine the activities that occur at each encounter during the visit. Ask yourself the following: Who does the parent speak with first? What is the parent asked during this first encounter? Do you want to add a screening task to this encounter? How would you do that? Repeat this process for each person the parent encounters: the individual who prepares the child for the visit, the clinician, the check-out person, etc.

Figure 3. Part 2: The Visit and Beyond

**Implementation Guide for Depression Screening
Part 2 “The Visit and Beyond”**

WHAT	WHEN	WHO	HOW
Assess 1. Introduction 2. Review	In exam room, distribute screener to the parent before s/he sees the provider Before going into the exam room or during the visit.	Nurse or MA performs this role Physician, NP, or other provider performs this role	1a. Explain the purpose of the screener to the parent 1b. Make sure parent has a pen, and a place to write 1c. Clip screener to chart or develop a method that ensures the health provider sees the completed screener 2. Review and score the screener
Address & Agree 1. Discuss Results 2. Educate 3. Discuss Current Situation 4. Agree on a Plan of Action	During the visit	Physician, NP, or other provider performs these roles	1. Advise parent of negative or discuss positive screening results 2. Discuss with parent the significance of a positive result and the impact of parental moods on his or her child 3a. Talk with parent about stresses and issues that may influence his/her mood and also affect the child 3b. Explore how the child is coping if parent has symptoms 4. Jointly agree on what to do next (parent may not wish to take action)
Assist, Arrange & Address Again 1. Discuss Referral Options 2. Provide Referral 3. Provide Information 4. Record 5. Arrange Referral 6. Follow-up visit	During the visit At the end of the visit At the end of the visit At next visit	Physician, NP, or other provider performs these roles Designated staff member to perform this role	1. If parent thinks s/he might be depressed, discuss options for treatment/assistance 2. Provide referrals as indicated 3. Provide the parent with educational materials 4. Record screening results and actions taken 5. If necessary, arrange referral or contact referral provider 6. Arrange to follow up with the parent during a specified time period, or at next visit inquire about how s/he is getting along and about the child's well-being

Key: Provider = Blue Clinical Staff = Green Office Staff = Orange

The steps described in "Part 2, The Visit and Beyond" are based on our experiences in primary care practices that implemented parental screening. A copy of this worksheet is included in the appendices. The worksheet is color-coded to suggest which person in the practice might complete each task. One way to ensure consistent screening is to incorporate screening tasks into a job description, just as measuring height, weight, and blood pressure are incorporated into the job of a roomer, who prepares the child for the visit.

This manual includes a set of tools to help your practice carry out the tasks required to screen for parental depression. All staff involved in the planned approach should be trained in the use of the tools and the approach. Most practices will be able to integrate the defined tasks into existing procedures rather than developing new steps or tools. For example, the PHQ-2 can be added to a paper health history, the results noted in the problem list, etc. If an EMR is used the system can be set up to prompt discussion of the PHQ-2, recording the results in the problem list, or tracking referrals.

Practices found that some of the posters that were strategically placed in the rooms, lobby, or by the baby scales prepared families for the screening and discussion. Access in the rooms to educational materials and Web resources made the clinician's discussion of both parental depression and parenting issues more efficient.

Figure 4: Tools for Training and Implementation

Guide to Tools for Implementing Primary Care Parental Depression Screening

Tools are available for download at:

http://www.cmwf.org/topics/topics_show.htm?doc_id=416724

<p>Training Tools Monograph and Training Manual – a guide to assist practices to implement parental depression screening. The guide includes training tools for providers and staff, and resources to implement screening. Implementation Manual – a step-by-step guide for individual practitioners, practices, and organizations to implement parental depression screening. Parents’ Frequently Questions – a list of frequently asked questions for staff who will screen. Fact Sheets – two educational fact sheets on the benefits of screening for parental depression and why to routinely screen.</p>	<p>Screening Tools PHQ2 – Depression Screened & Diagnostic Assessment sheet /provided with and without Introduction for parents PHQ9 – Depression Screener & Diagnostic Assessment sheet EPDS – Edinburgh Post Partum Depression Scale & Score sheet Family Psychosocial Screener and Score sheet – contains the Rand brief depression screener Summary table – reviews screening tools and their characteristics</p>	<p>Reference Tools Parenting During Depression, A Guide for Clinicians – this guide provides background information about mental health, tips on interviewing and counseling. Parenting During Depression, A Guide for Clinicians Pocket Version – using “keywords” this pocket version prompts providers with interview and counseling techniques. A favorite among providers.</p>
<p>Educational Tools Lower Your Stress, Stress and Parenting – developed by Journey Works, this brochure lists activities to reduce stress. To order: 1-800-775-1998 Guide for Parents, When Times Are Tough – a comprehensive brochure that gives parents background on depression, how it impacts their child, and a list of changes a child make through each stage of his/her life. Can a Depressed Parent be a Good Parent? – this brochure includes background about depression, and lists the several types of depression and communication tools for discussing depression with family members. Tips on Parenting for Mothers with Depression – a one-page handout from the National Mental Health Association. Facts About Depression – Poster What to do when you feel blue.... – Poster Family Mental Health is Spoken Here – Poster Feeling Blue – Poster</p>	<p>These tools to support implementation have been developed and compiled from public access sources by The Clinicians Enhancing Child Health Network at Dartmouth Medical School with the support of The Commonwealth Fund.</p>	<p>Web Tools: National Institutes of Health: http://health.nih.gov/result.asp/183 National Institute of Mental Health: http://www.nimh.nih.gov/healthinformation/depressionmenu.cfm National Mental Health Organization: http://www.nmha.org/index.cfm National Alliance for the Mentally Ill: http://www.nami.org American Academy of Pediatrics: http://www.aap.org/ American Psychiatric Association: http://www.apa.org</p>
<p>Tools are available for download at: http://www.cmwf.org/topics/topics_show.htm?doc_id=416724</p>		

SECTION FOUR

Guide for Organizations to Assist Practices Implementing Depression Screening

Introduction

Many primary care practices do not have a well-organized system for changing how clinical care and screening are delivered. In addition, practices often do not have the internal resources to follow up on positive depression screens. Thus, there is a role for either the practice's parent organization or an outside organization or agency, such as a practice network or public health department, to assist primary care practices in designing and implementing parental depression screening.

Provision of Referral and Treatment Services

In many communities, it is necessary to bring together several organizations to provide parental depression screening and treatment.

Figure 5 is a worksheet that summarizes the steps needed to prepare to implement community-wide or statewide screening. These steps are described in more detail below. A copy of the worksheet is found in the appendices.

Figure 5: Prepare Your Community

**Implementation Guide for Depression Screening
“Prepare Your Community”**

*Before you begin screening, you need to prepare your community. Consider the following list of tasks.

WHAT	WHO <i>(In the space provided, write the person who will be responsible for performing the task)</i>	HOW
Engage Your Partners 1. Identify champions 2. Motivate partners 3. Educate partners	Who: _____ Who: _____ Who: _____	1. Identify a key person at other organizations or agencies who will champion the screening program. Who are these champion(s)? _____ 2. Get your partners involved by setting the expectation that helping depressed parents is an important health care service, and seek their ideas about helping families. 3. Educate your partners about parental depression and its impact on children. Determine attitudes or misconceptions that may be barriers to collaboration.
Develop a Community Approach 1. Explore available resources 2. Network with potential collaborators 3. Establish triage/referral mechanism 4. Materials development	Who: _____ Who: _____ Who: _____ Who: _____	1. Develop a list of mental health referral options, community agencies, parental support groups, support lines, and Web sites. 2. Contact area mental health providers and agencies to invite them to take part in this community-wide effort to screen for parental depression. Ask them if they are willing to accept referrals and provide clinical services. 3. Describe the system for screening, triage, referral, and treatment, as well as ways to provide feedback to referring clinicians. What are the all roles of partner organizations? 4. Develop or identify patient educational materials and referral forms, and develop packets of these materials to provide to primary care clinicians within practice settings.
Recruit/Train Primary Care 1. Recruit clinicians 2. Provide training for practices 3. Select oversight committee or person 4. Change community environment 5. Institutionalize change	Who: _____ Who: _____ Who: _____ Who: _____ Who: _____	1. Invite clinicians to a presentation with key collaborating agencies/organizations to present proposal. 2a. Train staff at collaborating organizations to work with practices to implement screening and referral protocol. 2b. Choose a method to work with individual practices to tailor the protocol to their systems and capacity. 3. Select a group or person who will contact collaborators and monitor the processes regularly. Might involve quarterly reports to an oversight group or key persons at collaborating organizations. Maintain adequate supplies of educational and screening materials. 4. Publish public interest articles in local papers to inform community members about efforts and the importance of treating parental depression. 5. Review protocol and referral and treatment systems and modify as need to maintain community level screening.

Key: Company leaders = Blue Managers= Green

Engage Your Partners

1. Identify Champions

A senior executive who wishes to implement a community-wide screening effort needs to champion the program within their institution. This person then recruits others at a similar level at other key organizations or agencies that have a stake in parental depression screening. This small group leads a process to develop the screening. As many representatives of the process as possible should be included, from adult and pediatric primary care clinicians to mental health providers and insurance companies.

2. Motivate/Educate Partners

The impact of parental depression on the health and well-being of their children may not be well understood. An important part of implementing screening is to dispel any stigma or myths about depression and to help potential partner organizations understand that identifying and treating parental depression will benefit their institution and community.

Develop a Community Approach

1. Explore Available Resources and Network with Collaborators

Once you have decided what group of practices you will work with to implement screening, it is important to determine the mental health services and providers available to help practices assess, diagnose, and treat depression. These may be local or state-level resources that are private or public. These partners will need to help others understand that helping the parent get timely services benefits both the parent and child.

2. Establish Triage/Referral Mechanism

Simply identifying resources will not ensure that depressed parents identified by their child's clinician will seek and receive assessment and a diagnosis of depression. The Parent Support Line, however, is an example of a system that reaches out to depressed parents, assesses their symptoms, and refers them to appropriate care and services.

Parent Support Line

The Parent Support Line (PSL) of the Parental Well-Being Project utilized the resources of a behavioral health employee assistance triage team for parents who were referred by participating practices. The triage team had licensed MSW staff. Their assessments began with the chief complaint/or initial request. Within that context, triage was conducted to determine the level of functioning, particularly neuro-vegetative signs of mood disorders. Particular attention was paid to risk factors such as substance issues, violence, and suicidal/homicidal ideation. Triage explored psychosocial stressors in the work, home, and social environment, paying close attention to support systems in place or needed. Special attention was paid to how well the caller thought they were parenting while experiencing depression or stress. Triage might include one or all of the following: assessment or brief treatment by a licensed independent master's level clinician, referral to community resources, and information and resources that may be helpful in educating or informing the parent about how to cope or solve their various issues. Follow-up calls to the parent were made to ensure a satisfactory outcome.

A centralized approach—using an institutional- or community-based social worker or practice-level care manager—is another way to ensure that there is follow-up and assistance in getting treatment and support for parents who screen at risk for depression.

Recruit and Train Primary Care Providers

Organizations such as insurance companies, health agencies, hospitals, or groups of practices that want to support parental depression screening at multiple practices can do the following:

- 1) Increase awareness of clinicians about the impact of parental depression.

Many clinicians are unaware of the continuing impact of parental depression on children throughout childhood. Including this topic in local pediatric conferences can help create an environment where clinicians will consider changing their behavior. Only 57 percent of pediatricians who participated in a national survey considered it their responsibility to recognize maternal depression.⁵

- 2) Provide materials to clinicians needed to implement screening in their practice.

Screening tools, posters, and parental handouts are all helpful for practices to implement screening, though few clinicians will start screening because they received educational materials. In the Parental Depression Project, 13 additional regional practices were provided with detailed educational materials and an implementation guide. Follow-up after six months showed that no practice had implemented routine screening at well-child visits. Due to competing demands, a systematic effort is needed.

- 3) Assist practices in changing their office system to support screening and referral.

⁵ Olson AL, Kemper KJ, Kelleher KJ, Hammond CS, Zuckerman BS, Dietrich AJ. Primary care pediatrician's roles and perceived responsibilities in the identification and management of maternal depression. *Pediatrics*. 2002;110 :1169–1176

A number of approaches have been used within the clinical quality improvement field to change the process of ambulatory care. For example, a team approach offers clearly defined roles and responsibilities for different staff, tools, and mechanisms to monitor the success of the implementation (see Section 3). This has been done by providing on-site consultation to the practice team and by bringing several practice teams together in a "learning collaborative." Both of these approaches entail follow-up in person or by phone conference to keep the process going. Although time-consuming, the learning collaborative has the advantage of sharing solutions between practices.

There are several ways the external organization can support the continuation of screening programs in pediatric care practices. One is by periodically reviewing the screening and referral process and assessing the satisfaction of both the parents and the providers. Also, the external organization can educate and help to de-stigmatize depression through informational articles in local papers or local parent meetings. Information for new providers who join the mental health and primary care communities can help continuation of a broad approach. Periodic phone conferences or meetings between practice champions can offer an avenue for support and problem-solving.

Comments from Project Leader:

“It was very helpful for clinicians to share their approaches to discussing maternal depression and how they addressed the issues resulting with the child. These shared discussions usually led to descriptions of instances where the parent was very appreciative of this approach to depression and reinforced their efforts.”

Dr. Ardis Olson,
Dartmouth Medical School

Acknowledgements: The Parental Well-Being Project could not have taken place without the practices of Clinicians Enhancing Child Health research network. We would like to thank all the clinicians and staff for their participation and insightful input into implementation.

- Exeter Pediatric Associates, Exeter, New Hampshire
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- Upper Valley Pediatrics, Bradford, Vermont
- Dartmouth-Hitchcock Clinic, Manchester, New Hampshire
- Dartmouth-Hitchcock Clinic, Bedford, New Hampshire

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Appendices

Full-page versions of the following tools referenced in the implementation manual

- 1) PDPs Five A's
- 2) Implementation: Prepare Your Practice, Part I
- 3) Implementation: Prepare Your Practice, Part 2
- 4) Guide to tools for training and implementation
- 5) Implementation: Prepare your community

Pediatric Clinician's Guide to Parental Depression Screening

Assess

Conduct brief parental depression screening at well child visits
Score to determine if risk for major depression



Address

Discuss screening results and the possibility of depression
Explain impact of parental mood on children



Agree

Doctor and parent jointly agree on what to do next



Assist & Arrange

Assist with child developmental or behavioral issues when needed
Provide parent with educational materials
Provide referrals to community resources and other providers



Address Again

Follow up at next pediatric visit or sooner if needed

Figure 2. Prepare Your Practice

<p style="text-align: center;">Implementation Guide for Depression Screening Part 1 “Prepare Your Practice”</p> <p style="text-align: center;">*Before you begin screening, you need to prepare your practice. Consider the following list of tasks.</p>		
WHAT	WHO <i>(In the space provided, write the person who will be responsible for performing the task)</i>	HOW
<p>Engage Your Practice</p> <p>1. Identify Champions</p> <p>2. Motivate Staff</p> <p>3. Educate Staff</p>	<p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p>	<p>1. Identify a provider and a member of the practice staff who together will champion the screening program. Who are the practice champion(s)? _____</p> <p>2. Get your staff involved by setting the expectation that helping depressed parents is important part of routine care, and seek their ideas about helping families understand and cope.</p> <p>3. Educate your staff about parental depression and its impact on children. Determine attitudes or misconceptions that may influence screening.</p>
<p>Develop Practice Approach</p> <p>1. When and Who to Screen</p> <p>2. Choose Screening Tool</p> <p>3. Explore Available Resources</p> <p>4. Network with Colleagues</p> <p>5. Establish Triage/Referral Mechanism</p>	<p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p>	<p>1. Decide if screening is at all well child visits or limited by age or parent gender.</p> <p>2. Select screening tool.</p> <p>3. Develop a list of mental health referral options, community agencies, parental support groups, support lines, and Web sites.</p> <p>4. Contact area providers and mental health agencies to inform them your practice will be screening for parental depression. Ask them if they are willing to accept referrals and provide clinical support.</p> <p>5. Determine practice role in linking parent to resources</p> <p style="padding-left: 20px;">A. Options for practice</p> <p style="padding-left: 40px;">1) Individualized referral to outside resources</p> <p style="padding-left: 40px;">2) Partner with outside agencies who will perform these services</p> <p style="padding-left: 40px;">3) Utilize behavioral health clinician within practice setting for these services</p>
<p>Develop Office System</p> <p>1. Train Staff</p> <p>2. Develop System to Distribute and Record Screener</p> <p>3. Select Monitor</p> <p>4. Change Office Environment</p>	<p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p>	<p>1. Train staff to introduce screening tool and respond to parents' questions.</p> <p>2a. Develop a system to have screening tool available at the beginning of the visit.</p> <p>2b. Choose a method to indicate screening occurred and how to document results.</p> <p>3. Select a person to check and order materials for screening, and to stock exam rooms with brochures.</p> <p>4. Place posters in waiting areas, exam rooms, by scales, etc.</p>

Key: Provider = Blue Clinical Staff = Green Office Staff = Orange

Figure 3. Part 2: The Visit and Beyond

**Implementation Guide for Depression Screening
Part 2 “The Visit and Beyond”**

WHAT	WHEN	WHO	HOW
Assess 1. Introduction 2. Review	In exam room, distribute screener to the parent before s/he sees the provider Before going into the exam room or during the visit.	Nurse or MA performs this role Physician, NP, or other provider performs this role	1a. Explain the purpose of the screener to the parent 1b. Make sure parent has a pen, and a place to write 1c. Clip screener to chart or develop a method that ensures the health provider sees the completed screener 2. Review and score the screener
Address & Agree 1. Discuss Results 2. Educate 3. Discuss Current Situation 4. Agree on a Plan of Action	During the visit	Physician, NP, or other provider performs these roles	1. Advise parent of negative or discuss positive screening results 2. Discuss with parent the significance of a positive result and the impact of parental moods on his or her child 3a. Talk with parent about stresses and issues that may influence his/her mood and also affect the child 3b. Explore how the child is coping if parent has symptoms 4. Jointly agree on what to do next (parent may not wish to take action)
Assist, Arrange & Address Again 1. Discuss Referral Options 2. Provide Referral 3. Provide Information 4. Record 5. Arrange Referral 6. Follow-up visit	During the visit At the end of the visit At the end of the visit At next visit	Physician, NP, or other provider performs these roles Designated staff member to perform this role	1. If parent thinks s/he might be depressed, discuss options for treatment/assistance 2. Provide referrals as indicated 3. Provide the parent with educational materials 4. Record screening results and actions taken 5. If necessary, arrange referral or contact referral provider 6. Arrange to follow up with the parent during a specified time period, or at next visit inquire about how s/he is getting along and about the child's well-being

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Figure 4: Tools for Training and Implementation

Guide to Tools for Implementing Primary Care Parental Depression Screening

Tools are available for download at:

http://www.cmwf.org/topics/topics_show.htm?doc_id=416724

<p>Training Tools Monograph and Training Manual – a guide to assist practices to implement parental depression screening. The guide includes training tools for providers and staff, and resources to implement screening. Implementation Manual – a step-by-step guide for individual practitioners, practices, and organizations to implement parental depression screening. Parents’ Frequently Questions – a list of frequently asked questions for staff who will screen. Fact Sheets – two educational fact sheets on the benefits of screening for parental depression and why to routinely screen.</p>	<p>Screening Tools PHQ2 – Depression Screened & Diagnostic Assessment sheet /provided with and without Introduction for parents PHQ9 – Depression Screener & Diagnostic Assessment sheet EPDS – Edinburgh Post Partum Depression Scale & Score sheet Family Psychosocial Screener and Score sheet – contains the Rand brief depression screener Summary table – reviews screening tools and their characteristics</p>	<p>Reference Tools Parenting During Depression, A Guide for Clinicians – this guide provides background information about mental health, tips on interviewing and counseling. Parenting During Depression, A Guide for Clinicians Pocket Version – using “keywords” this pocket version prompts providers with interview and counseling techniques. A favorite among providers.</p>
<p>Educational Tools Lower Your Stress, Stress and Parenting – developed by Journey Works, this brochure lists activities to reduce stress. To order: 1-800-775-1998 Guide for Parents, When Times Are Tough – a comprehensive brochure that gives parents background on depression, how it impacts their child, and a list of changes a child make through each stage of his/her life. Can a Depressed Parent be a Good Parent? – this brochure includes background about depression, and lists the several types of depression and communication tools for discussing depression with family members. Tips on Parenting for Mothers with Depression – a one-page handout from the National Mental Health Association. Facts About Depression – Poster What to do when you feel blue.... – Poster Family Mental Health is Spoken Here – Poster Feeling Blue – Poster</p>	<p>These tools to support implementation have been developed and compiled from public access sources by The Clinicians Enhancing Child Health Network at Dartmouth Medical School with the support of The Commonwealth Fund.</p>	<p>Web Tools: National Institutes of Health: http://health.nih.gov/result.asp/183 National Institute of Mental Health: http://www.nimh.nih.gov/healthinformation/depressionmenu.cfm National Mental Health Organization: http://www.nmha.org/index.cfm National Alliance for the Mentally Ill: http://www.nami.org American Academy of Pediatrics: http://www.aap.org/ American Psychiatric Association: http://www.apa.org</p>
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<p>Develop a Community Approach</p> <p>1. Explore available resources</p> <p>2. Network with potential collaborators</p> <p>3. Establish triage/referral mechanism</p> <p>4. Materials development</p>	<p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p>	<p>1. Develop a list of mental health referral options, community agencies, parental support groups, support lines, and Web sites.</p> <p>2. Contact area mental health providers and agencies to invite them to take part in this community-wide effort to screen for parental depression. Ask them if they are willing to accept referrals and provide clinical services.</p> <p>3. Describe the system for screening, triage, referral, and treatment, as well as ways to provide feedback to referring clinicians. What are the all roles of partner organizations?</p> <p>4. Develop or identify patient educational materials and referral forms, and develop packets of these materials to provide to primary care clinicians within practice settings.</p>
<p>Recruit/Train Primary Care</p> <p>1. Recruit clinicians</p> <p>2. Provide training for practices</p> <p>3. Select oversight committee or person</p> <p>4. Change community environment</p> <p>5. Institutionalize change</p>	<p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p> <p>Who: _____</p>	<p>1. Invite clinicians to a presentation with key collaborating agencies/organizations to present proposal.</p> <p>2a. Train staff at collaborating organizations to work with practices to implement screening and referral protocol. 2b. Choose a method to work with individual practices to tailor the protocol to their systems and capacity.</p> <p>3. Select a group or person who will contact collaborators and monitor the processes regularly. Might involve quarterly reports to an oversight group or key persons at collaborating organizations. Maintain adequate supplies of educational and screening materials.</p> <p>4. Publish public interest articles in local papers to inform community members about efforts and the importance of treating parental depression.</p> <p>5. Review protocol and referral and treatment systems and modify as need to maintain community level screening.</p>

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