

## **NCH: Supporting Families' Mental Health: Special Focus on Parental Depression webinar**

Kelly Towey: Hello and welcome. Thank you, for joining us for today's webinar, "Supporting Families' Mental Health: A Special Focus on Maternal Depression." This webinar is sponsored by the Head Start National Center on Health. My name is Kelly Towey, and I'm a consultant for the National Center on Health.

Before we begin today's webinar, I'd like to highlight a few housekeeping items. First, if you're using Wi-Fi and are not hard-wired, you may experience greater lag time during the presentation. The slides will advance automatically throughout the presentation. Attendees will not have control over the slides. All attendee lines are muted, but if you have a question, we encourage you to type your question in the Ask-A-Question box on your screen. As time permits, there will be a short question-and-answer session at the end of the webinar. If we don't have time to address your question during the webinar, we will send you an answer directly via email, in the next several weeks. To view the presentation in full screen, click on the black button at the upper right-hand corner of the presentation slides.

During this webinar, we'll be having a number of polls for you to do. Please, note that depending on your connection, you may experience a slight lag before the poll appears. When you have completed the poll, select "submit." After you have seen the graph results, please click on the "return to presentation" button to bring yourself back to the presentation slides. After the webinar, you will be redirected to an online evaluation. Please take a few minutes to share your feedback on today's events. Only participants who complete the evaluation will receive their certificate of participation. If you're watching as a group, the person who logged in to the webinar will receive an email with a link to the survey. Please share this link with the rest of your group, so that they can complete the evaluation and receive their certificate. If you need technical assistance during the webinar, please type your question in the Ask-A-Question box, and our technical staff will assist you.

During today's webinar, our speakers will be sharing information on the following: Defining the term "mental health," describing challenges associated with depression and parenting, identifying program strategies for promoting mental health and mental health concerns, and much more. At this point, I'd like to introduce our speakers. First, Dr. Neal Horen is a clinical psychologist who has focused on community-based work for the last 15 years. He is Co-Director of Training and Technical Assistance for the Georgetown University Center for Child and Human Development and serves as Deputy Director of the Early Childhood Team. In that capacity, Dr. Horen has worked closely with numerous states, tribes, territories and communities in supporting their development of systems of care for young children and their families. In addition, he continues to spend time working in direct clinical care, including development of social skills interventions for young children, working in his Fussy Baby Clinic, and is director of a clinic which offers therapeutic and assessment services for young children and families.

His primary interest is in early childhood mental health, and he has lectured extensively on infant mental health, as well as, the impact of trauma on child development. He is also the proud father of three children ages 14, 13, and 13.

Our second presenter is Amy Hunter. She is an Assistant Professor at Georgetown University Center for Child and Human Development. Currently, Amy oversees the mental health section of the Head Start National Center on Health. Previously, Amy served in many positions at Zero to Three, including Director of Program Operations for the Early Head Start National Resource Center and the Project Director for the infant/toddler portion of the Center on the Social/Emotional Foundations to Early Learning project. For 20 years, Amy has been involved in early childhood mental health, including providing training and technical assistance on early childhood mental health to individuals and groups around the country. Amy maintains a small private practice on Capitol Hill in Washington, D.C., where she lives with her husband and two boys. At this point, I would like to turn this over to Neal.

Neal Horen: Thanks, Kelly, and welcome, everybody. So, Amy and I are really excited. We're going to be talking about supporting families' mental health, and we're going to focus most on maternal depression. We probably will not get to sort of every single aspect, but we encourage you to sort of type those questions -- get those questions in, and we'll try and leave time at the end. Given that there's several hundred of you on here, maybe we'll start by having each person introduce -- oh, no, we won't do that, will we? No, I'm joking.

So, we are going to spend most of our time sort of going through -- I think Kelly did a nice job of laying out these learning objectives, so just to reiterate, we'll do a little definitional piece. We will talk a bit about the most common mental health concerns. We'll do little polls, try and sort of see where everyone's at in terms of their knowledge. And then, we'll talk about some of the kinds of strategies that you all can use to address mental health and, in particular, parental mental health concerns.

So, in terms of an agenda, we'll start with the definitional piece around health and mental health. We will talk about some of the common mental health disorders, and we'll talk about what that means, in terms of how you all might address that. In terms of the slides, we -- Amy and I spent a lot of time developing these PowerPoint slide decks, mostly Amy, and I just sort of pretend that I do it, but we -- our emails are at the end, and if you would like a copy, we're happy to give you a copy. They're filled with presenter notes. Our hope is that folks take these and are able to use them. So, at the end, you'll see our email and you'll get a -- you can get a copy of them, by just emailing one of us. So, with that, let's sort of jump in.

Let's talk about what a definition of "health" is, characteristics of health. And we're not going to have each of you sort of write down a definition, but maybe, as we're talking, think about what this means for you. So, when we say "what is health," maybe just jot a few notes down about what your definition of health is, and what you think of, in terms of the characteristics of health.

There's a lot of definitions, and one of the ones that we really do like states that health is a state of complete physical, social, and mental wellbeing. And not merely the absence of disease or infirmity. Health is a resource for everyday life and not the object of living. It is a positive concept emphasizing social and personal resources, as well as physical capabilities. And the point of that is: To think about health is not just whether you're disease-free or have some sort of health issue, but it is a much more overarching sort of concept of how somebody is doing. There's a number of other definitions. We won't go through all of them. Then, if we talk about what mental health is: Same sort of thing -- is to think about if you had to jot down a couple of words about your definition, what is mental health. And this is a really interesting thing to think about, because as we've moved around the country and talked with folks, this really varies. It varies from person to person. It varies from family to family. There's a lot of sort of cultural layers on this. And there's not, sort of, something that we would say is the right definition. We, certainly, think that there are some aspects to this that we'd like people to think about.

And also be clear that it's always viewed through a family and a cultural lens -- that's a really important consideration, as we talk about whether somebody's having mental health issues or not, that we can't just sort of say, "Well, this is how I view it," but also to think about how everybody's viewing it and take that into consideration. You know, sort of similar to that definition of health, when we talk about what is mental health, you know, mental health and mental illness are not the same thing. And we think of mental health as being on a continuum, with mental health on one end of that continuum and mental illness or mental disorders at the other end. And what we'd like you to keep in mind is that people can move along that continuum and that it's important to not just sort of say either you have good mental health or you don't, but there are a number of aspects to consider when we think about mental health.

So, in the next few slides, we're going to talk a little bit more specifically about some of those definitions. You know, what's interesting is that it's really not been that long, and certainly as somebody's who's worked in the early childhood world for some time, it's not really been that long that we've even talked about these kinds of issues. 1999, which -- I don't like to do math in public, but I think was about 15 years ago, right? Yeah, 15 years ago. Good for me. That was the first time that the Surgeon General defined mental health. And in that definition, it was laid out that mental health is the successful performance of mental function resulting in productive activities, fulfilling relationships, and the ability to adapt to change and to cope with adversity.

And so, if we start to think about the children that we work with and their families, and, in particular, about mental health for those children and for the adults who are providing care, think about what it means to engage in productive activities and have fulfilling relationships and really have some ability to cope with adversity.

And those are the kinds of things that as we move through this slide deck, today, we want you to be thinking about, well, so what does that mean for the families that I work with, what does that mean for the adults that I deal with every day. So, you know, if you think about this continuum, you probably could think about times in your life or even today that you felt more mentally healthy versus other times. So, let's talk a little bit about mental health disorders. So, when we talk about this -- Lisa, you're going to bring up a poll for us, if you don't mind -- and we'd like you to sort of get a sense from you: Which one of these do you think is most common? Anxiety disorders, depression, or substance abuse?

So, go ahead and bring that poll up, please, Lisa. So, sometimes there's a little lag. Just bear with us. And Lisa's going to pull this poll up for us. Great. Thanks, Lisa. [Pause as poll appears] So, we'll just give you just a few seconds to sort of lay out -- to sort of vote in the poll about which of these you think is the most common of mental health disorders. [Pause as participants vote] Okay, so we have about -- three-quarters of you have voted. Thank you. And the other quarter, if you could just finish up those emails you're sending. We have about 60 percent said depression. 25 percent said anxiety disorders. There's a lot of math in this presentation. I didn't really realize that. I apologize for those of you, like me, that don't really like math. Okay, so we are going to go ahead and close that poll. Thank you, Lisa.

So, anxiety disorders -- and we'll be getting into a little bit more detail about this -- are the most common. And we'll talk a bit about the percentages. But we want to spend a little bit of time -- sorry. We just want to spend a little bit of time talking about some of these disorders. Sorry, for the clicking back and forth. In terms of anxiety disorders, that's sort of a blanket term. There are a number of sort of clinical diagnoses that sort of fall under this. And it's really characterized by excessive rumination, worrying, uneasiness, apprehension and fear about future uncertainties that are either based on real or imagined events. And those can affect you both psychologically and physically. And while a lot of us feel anxious at different times in our lives, it doesn't necessarily mean you have an anxiety disorder.

It just is, again, on a continuum of the kind of anxiety that many of us have experienced, before we take a big exam, versus the anxiety that really does get in the way of you being able to do sort of activities of daily living and those kinds of things. In terms of depression, and that's the one we're going to spend the most time about talking today, it's the next most common. And I'm guessing that if we asked you to raise your hand, if you have met anyone in your life who's impacted by depression, almost all of you would somehow raise your hand. It may be somebody in your family; it may be somebody at work; it may be somebody that you sort of know in your neighborhood.

But depression is an illness that causes a persistent feeling of sadness and loss of interest in previously pleasurable activities. And, again, that can also lead to some physical -- a number of physical effects as well. Substance abuse, same thing. I'm guessing that if we asked you to raise your hand, if you know somebody who's been impacted by substance abuse issues, you, again, most of us would raise our hands in some way, shape, or form. So, we're not going to spend a lot of time talking about anxiety and substance abuse, today but we will do a little bit more. So, we're going to go ahead and move on. And we're going to do another poll.

And, Lisa, if you could pull that poll up again, the next one for us, please. Thanks so much. And, go ahead and we'll have folks sort of take, you know, 30 seconds and vote. So, the first one is problem drinking in the U.S. population 18 years and older. That impact, is that 15 percent, 22 percent, or 30 percent? [Pause as participants vote] And then, Lisa, if you can let us know where we're at with our folks in terms of sort of responding -- that'll be great. Okay, so it looks like about over half of you said 30 percent, in terms of problem drinking.

So, we're going to go ahead and take that poll down. Oh, you did send it -- good. Fifteen percent of the people living in the United States are considered problem drinkers, and of that 15 percent, five to 10 percent of them are males and about three to five percent are females who could be labeled as alcoholics. Another study listed 30 percent of people in the United States reported experiencing at least an alcohol disorder at one point in their lifetime.

So, let's go ahead and send the second poll, which is, it seems on our slide, and maybe for everybody else; it's missing a middle number which is 18 percent. So, the choices are 5 percent, 18 percent, and 30 percent, in terms of how common are anxiety disorders, in the U.S. population for folks 18 years and older. We're not talking about children. So, just take a minute or so to go ahead and vote on that. [Pause as participants vote] So just take another 10, 15 seconds and vote. We're going to keep moving. [Pause as participants vote] Okay, so let's go ahead and close that up, Lisa, please. I do see it; there we go: 18 percent. So, 5 percent, 18 percent, and 30 percent. And the correct answer is 18 percent. Eighteen percent of adults 18 years and older have an anxiety disorder. So, thank you, guys, for voting.

And we are going to actually not do this as a poll, because we're going to talk in depth about depression, but in terms of how common it is: Fifty-two percent in Early Head Start population of mothers is how common this has been reported in one study. So, 52 percent, which was an unbelievably high number. And every time we say that, people sort of "that can't be." That is. And that is why we're really talking about this today is because it's such a high prevalence rate amongst moms in Early Head Start. So, with that, I'm going to go ahead and turn it over to Amy who's going to sort of talk a bit more in depth about depression.

Amy Hunter: Hi, everyone. It's a pleasure to be here on the phone with all of you. And I'm just going to pick up right where Neal left off. On that same study that he mentioned where the study found that 52 percent of moms in Early Head Start met the criteria for depression, that same study identified 18 percent of Early Head Start fathers had enough symptoms to be considered depressed. When we present this information around the country, at this point, that research is a little bit old. It's about 10 years old, and since then we've had a recession and we've had many people out of work, and so, the sort of anecdotal information that we've had throughout the country is that 18 percent of fathers, if polled today, or, if the survey were done today, or even five years ago would be much higher. Again, that's anecdotal information.

And if folks want a reference for this research, you can find it at OPRE, that's the Office of Planning, Research and Evaluation, if you search "Early Head Start depression." And just for comparison, you have the other two statistics there to show you sort of in a general population what the rates would look like. And really, the highlight here is, as Neal says, the 52 percent is quite high, given the general population. And, you know, we think a little bit about why that might be the case, and generally stress in Early Head Start, among parents, is very high.

Adversity is very high. And, in fact, as you all know, the Early Head Start program selects families who are in the highest need. And so, the point is that the stress and adversity has a great bearing on family mental health. And so, just to dig a little bit deeper in on the research about depression in Early Head Start; when they initially did that research they found that the Early Head Start program did not have much of an impact on parents. While mental health is a part of the Early Head Start program, the Early Head Start and Head Start is not a mental health treatment program. And so, in some ways it makes sense that there was not really an impact on depression for moms.

However, as this is a longitudinal study, they found that two years out, so, at this point in the study, that children were getting ready to go into kindergarten, they found that, in fact, having been in Early Head Start did make a difference in terms of outcomes for parents who are experiencing -- moms specifically who are experiencing depression. And, you know, a couple of really important points -- that I just sort of want to linger on this slide about -- is that one you know, seeing improvement for depression takes time.

And so, staff need to know that message that the work that they are doing does make a difference. They may just not see the impact of the work that they are doing. The other sort of highlight of this message, I think, is that two years is a very long time in the life of a parent who is experiencing depression and for young children to go two years having a parent who's experiencing depression. And so, I put this out there to say we can probably do a little better. And perhaps, by being more strategic, by being more aware, by being more intentional, we may be able to reduce sort of that two-year period and see the effects of our work sooner.

Okay, and so just to spend a couple of seconds here on what depression looks like; the intent here is not to turn all the listeners on this call into clinicians, but really just to sort of raise awareness on what some of the symptoms and signs of depression are. And many folks experience some of these symptoms some of the time. Qualifying for a diagnosis of depression really means that you experience the majority of these symptoms, nearly every day and that having these symptoms is really a change in how you used to feel or a different time where you did not experience these symptoms.

Some folks who are experiencing true depression really need to experience, again, the majority of these symptoms for at least two weeks. And this, again, is not meant to turn anyone into clinicians, but just to raise awareness that, you know, perhaps, if you're on a home visit and you are talking with a parent who seems to be exhibiting some of these, you might just want to begin to think about and ask yourself or maybe ask the mental health consultant if this is something that may require further discussion.

So, Neal made a reference to this earlier. I think, for time's sake, maybe we won't go through this, but I bet many of you are trainers in this audience, so folks who are listening, and it's very interesting, certainly without putting anyone on the spot of folks who have experienced depression themselves, but I would imagine if we were in a live audience, most of you would raise your hand for having either experienced depression yourself or knowing someone who has experienced it.

And the point of this is really to show that this is not something that happens to other people, right? This is something that happens to people we know and that it's quite common. So, we're going to talk a little bit about, especially in the prenatal period, why pregnant moms might be particularly vulnerable. And the first point here we want to make is, the media has really unrealistic, images I think, especially as of late, some of the celebrities, right, who we see who, you know, they show beautiful, pregnant bellies, and fashionable outfits. And if we look at this picture, we might get the impression that being pregnant is sexy -- it's romantic, it's exciting and it's generally a great experience, right? But for some parents, some moms, it is not quite that. And so, if they're feeling sick, if they're feeling tired, if they're not happy about their pregnancy, having those kinds of media images can really be a mismatch for how they feel, and they may begin to think, well, what's wrong with me that I don't have this same experience that I'm seeing in the media.

Similarly, this is an adorable little baby who's got a nice pink bow, and we might imagine from looking at this picture that babies are sweet and they're quiet and they're cute and they're cuddly and you can put bows on their hair and it stays just like that. They might even smell nice. But in reality, it's not always the case. I know folks remember, those of you who are parents, bringing home a brand-new newborn, and you kind of maybe couldn't imagine how loud they can be. They can be messy. They can certainly take up a tremendous amount of energy.

Just a few other pictures. Again, a loving picture of a mom and her son just cuddling, and we think about the television shows that we see and the movie images of what it means to be a parent and people in the grocery store who say, you know, cherish every minute; every minute is a joy. But, in fact, not always, and certainly for parents who are feeling depressed, this kind of unrealistic expectations can make them feel very isolated. And, you know, again, just to sort of drive home the point even more, we see the baby who's being fed and I know most of you who work with babies know that perhaps the first time a baby is fed isn't quite like that. They may not open their mouth so wide and make it be so easy, or, there's a parent working with her baby on the lap. And I don't know; most people I know wouldn't be able to take their infant and get a whole lot of work done.

So, I think the perinatal period, meaning before pregnancy, during pregnancy and after pregnancy can create, sort of, this perfect storm for a vulnerability around depression. There are unrealistic expectations, as we've talked about, in the media, movies, television. It's a period of tremendous hormonal change. That alone can bring about symptoms of depression. Sleep deprivation is very high during this time, and I think most of you probably know that lack of sleep can be an actual form of torture. So, the sleep deprivation alone can create a risk factor for some of these symptoms. Becoming a mother is the biggest identity transition for women, for most women in their lives. There can be complications in pregnancy or the birth that can create an experience that is not what the woman imagined it would be. And then, the biggest risk factor for depression during the perinatal period is having had anxiety or depression prior to that time. So, as you'll see as we go through the presentation, those folks who have had depression in the past are much more vulnerable to have depression going forward.

Neal: So, as Amy was talking about that perfect storm, she mentioned a number of risk factors. So take a look at this list, and as you're looking at this list, think about the families that you're working with, and amongst those families, are you working with folks who have any, several, all of these risk factors? And we know that this is not an exhaustive list, but these are the kinds of things that can contribute to depression. And they obviously all increase stress. So, just sort of take a quick look at that and get a sense of, boy, we are working with some folks who have very high risk for experiencing depression.

Now, the impact on parenting is, in some ways, the most important piece to take out of this is that it is not just having depression that means that you're going to be having difficulty parenting. That sort of depends on a number of factors. That said, what depression and anxiety can do in terms of parenting have a pretty huge impact. And that includes amongst the kind of effects are a reduced capacity to respond sensitively.

So just think about yourself when you're stressed much less if you were experiencing sort of clinical levels of depression or anxiety how easily you are able to respond to the kinds of subtle cues that come up and things like that. Much higher levels of negative interactions, not lots of supportive interactions, and less sort of positive affect. So, you know, one of the things that we've seen in terms of parental depression is that there's reduced capacity to respond to the many, you know, the multitude of cues that infants and toddlers are giving about what they need, what their mood is, and things like that, and having an impact on this can really shift the dynamic between parent and child.

But other research has sort of shown that untreated depression can lead to really poor outcomes for children, and part of that really stems from these kinds of impacts. And so, punitive or sort of negative punish -- use of punishment, reduced gaze at the infant, and then, also not really thinking through the kinds of safety measures that might be helpful are the kinds of things that might be impacted by depression.

Now, what we've seen from research is that children whose mothers were depressed are more likely than other children to have behavioral problems, academic problems, and even health problems. And so, that, in addition to decreased use of preventative types of things, like use of seat belts and car seats and electrical outlet covers and those kinds of things really can lead to very negative outcomes for kids. So just take maybe 30 seconds to think about what you might do if you were concerned about a parent or a loved one's mental health. Just take maybe 30 seconds, jot down some notes for yourself.

Okay, so one of the things that Amy and I know from traveling around the country is that when you're on a plane you get the same speech. Sometimes, on Southwest, they give cute little songs, but you get the same speech. And one of the things in that speech about safety is that you need to put the oxygen mask on yourself before trying to help others. In the same way, when you're concerned about a parent, you first have to make sure that you're okay and taking care of yourself.

And that might seem a little surprising, but the fact is, is that it can be very challenging, and you need to sort of think about how am I taking care of myself, how am I decreasing my stress. That said, when you're concerned about someone's mental health, you have to sort of think about a number of things, and those include asking for help, asking for information and support for yourself, developing your own

support, maybe a reflective supervision in your program or support of supervisor, and you have to care for yourself, things like relaxation and mindfulness and healthy eating and exercise or those kinds of things.

In addition to taking care of yourself, though, you obviously have to help that parent. And so there's a couple of tips here. Again, these are not exhaustive lists. But asking about the kinds of social support that they have and encouraging them to spend time with others. One of the sort of most elegant research designs has been that if we can get folks who are depressed to just do one thing, which is like to get up out of bed in the morning, it can have a really positive impact on the depression. Won't solve everything, but it certainly is a good first step.

Reassuring that adult that this is not his or her fault, that he's not -- he or she is not alone and that he or she will get better can go a long way to helping normalize what's happening for that person. And then, encouraging that person to talk about their feelings and listening without judgment, and we have a number of materials around motivational interviewing that we're developing and that are also available for folks that we'd be happy to share. Those are the kinds of things. Again, that's not the only things.

Helping parents take care of themselves and take time for themselves. As we all know, caring for children can be a really demanding position to be in. My mom was a kindergarten teacher for 30 years, and every day she'd come home and fall asleep at 4:00 on the couch and I thought "What's the matter with this person," until I started going into preschools and Head Starts and Early Head Starts and realize, "I can't believe she was able to stay up until 4:00." So getting breaks.

You know, fatigue is a major factor that sort of makes the depression worse. Encouraging folks to talk with healthcare professionals and helping them to avoid being sort of overly critical are really helpful. You may need to make a referral, and being aware of what are some of the resources in your community is really important. Or, lack of resources and understanding that, you know, we don't have a lot of resources here, so what do we do we do when somebody's having this kind of difficulty. Use of your consultant is obviously going to be a very important and helpful first step. It may be the only step, but more than likely, it's going to be one of the steps.

So this is the idea that having some sense of what you are going to say may be really helpful, and not trying to talk about things that you don't know about, and most importantly, being as supportive as you can be with sort of some script around the kinds of things that you want to say. And this particular script is on ECLKC for folks, and we can -- I don't think we have a direct link but if you got to ECLKC and go into our center and the mental health resources, you'll find it there.

So, just a quote from Maya Angelou that I think is really apropos here, that how you make people feel goes a long way. And so you're not supposed to have all the answers. You're not supposed to be able to solve it and fix it. It's not something to be fixed or solved. It's about how you help somebody feel. So I'm going to turn that over to Amy.

Amy: All right. And just to follow up on what Neal was talking about on the resource on the ECLKC, if you go to the ECLKC and you just put in the search box "talking about depression," it is about a three or four-page resource that kind of gives some tips on how to talk to parents about depression, and it goes through, you know, I think three little scenarios about, you know, if the parent might be open to a conversation about depression, then what would that conversation look like, if the parent isn't really so unsure about it and how you might respond, and then lastly, if the parent is very sort of not open about it and it's not the right time to discuss it, then what might the strategies be to address that.

So, our purpose in putting that together was really to give some suggestions about what to say and what the conversation might actually look like. So, there's a number of barriers that exist certainly to folks getting the help that they may need. Sometimes, families certainly may see getting help or even identifying that they have some concerns around depression as a sign of weakness. And we'll talk a little bit in a minute about sort of the stigma and the labeling that might go on from others or from themselves. Certainly, financial problems or practical concerns can be an issue, you know -- how will I get there? How will I afford it? Sometimes, seeking treatment as being sort of a luxury that, sometimes people feel like they can't dedicate the time for themselves or certainly the money. Insurance can be an issue. Families often may need help sort of navigating through, you know, accessing insurance or accessing low-cost care. Families or individuals may fear being labeled. There certainly may be a number of -- we sort of talked about this before -- of cultural beliefs related to mental health and related to depression.

Support goes a long way. Research has shown that folks who have a lack of support are less likely to get treatment. I want to talk just for a minute about stigma. You know, we do mental health training all over the country, and as Neal said, we often start our presentations by asking what do folks believe mental health is, you know, what's the definition of mental health. It's changing throughout the years. It really is changing, but there still is quite a bit of stigma and stereotypes around the term "mental health," the term "mental illness," "depression." People often have the kinds of opinions about people with mental health that are illustrated here on the slide that really are stereotypes and very much unfounded. Sometimes, people have stigma related to themselves in terms of they begin to feel less about themselves when they're experiencing depression. They may be embarrassed. They may believe they have less value. Certainly, their self-esteem suffers when folks are experiencing depression.

So, this slide is something for you to think about in your programs. And, again, many of you are probably trainers or in charge of professional development in your programs. And if you want to think about what your program is doing in this area, you can think about it in these three ways: What are we doing for promoting families' mental health and even things as basic as building positive relationships with families goes a long way to promoting mental health. Thinking about how you introduce mental health, and the topic of depression and things like that to families.

Those are sort of promotion type activities. What do you do in your programs to not necessarily prevent depression or prevent mental health issues, but perhaps, prevent them from getting worse or certainly accessing services early on. And in many ways, the Early Head Start program and the Head Start program is preventative in and of itself and the support that they provide for families. And then what does your program do for intervention when a concern does exist, not necessarily providing the treatment, but providing referrals and resources for families, providing what we often call as a facilitated referral. So, you're not just handing someone a phone number, but that you're actually saying: "May I introduce you to Mary? She's a colleague that I work with." And you can make that personal introduction much more likely to be successful. But I think this can be a good exercise to use in your programs to think about all the ways you promote mental health and prevent and intervene when concerns exist.

So, this reiterates the point I made earlier and about how important prevention is and all the work that that you do, but recurrence rates are high. So, when you get to know your families and you take a family history when the family is already in a trusted relationship with you, and if you learn that depression has been a part of their experience already, then you know that they're at much higher risk of experiencing that again.

So you can begin to think about what kinds of services to put in place for that family. Then, I just want to talk for a minute, before we go to questions and answers, about screening. Many Early Head Start programs and Head Start programs provide depression screenings for parents, for mothers and for fathers. It is an important piece of identifying who may be experiencing depression and getting the services for them as early as possible. As listed on this slide here, a number of common depression screening tools. The first -- I'll say the first three, and by that I'm referring to the PHQ-2, the PHQ-9 and the CES-D. Those are all free and they all come in multiple languages. The PHQ comes in 30 different languages. And the numbers there refer to -- the number two is simply two questions.

So, the research has identified that by asking these two questions, you are able to begin really to identify who needs further evaluation, and it's a valid screening tool. The nine is just a little bit more elaborate than those two questions. And a list of these screening tools is available on the ECMHC. That stands for the Early Childhood Mental Health Consultation. We have a website where all kinds of information related to mental health consultation and mental health services in Early Head Start and Head Start -- it's a wealth of information. And on that site includes a list of the depression screening tools, so that you can look at those in more depth. I'm going to turn it over to Neal to wrap us up.

Neal: Yup. So, you know, we should probably end by where we should have started in terms of saying we are moving through major clinical diagnoses at a rapid pace on this one-hour phone call. This is something that, you know, oftentimes we spend four or five hours doing training on. So, this is just sort of a broad stroke, so we want folks to at least be aware of the kinds of issues to be thinking about. We're hoping that one of the things that, amongst the things that you took away from this, is that anxiety and depression are more common, not just, then, maybe some folks think, but particularly in terms of the families that we are working with. Addressing the risk factors and stigma is critical. The number of risk factors that we listed on that slide is just a small slice of all the risk factors, and yet, we listed them because a number of them are the ones that we come into contact every day. And I can see by a number of the questions that have come in that these are the kinds of issues that you're dealing with.

And, again, other risk factors like transportation and other, you know, financing and all these other kinds of issues that we didn't even get to but are just as important. You know, the way we are with families can help. There are a number of questions about, well, how do you have this conversation. And we mentioned motivational interviewing because that is a technique that is really -- it started in the field of substance abuse but really has been adopted by a number of different interventions in terms of a way in which we partner with families and see families as not people we're trying to fix or get to stop from doing something, but, really, folks who we're working in partnership with and that what we're trying to do is do the work that they're ready to do in the way that they are comfortable doing.

And while that might mean that it might not go at quite the pace we'd like it to, the way we are with families can really help. When families, both from my experience as a clinician, but also my experience in terms of all kinds of discussions I've had with families, when families feel that we are there to help, they feel supported; they're much more likely to be involved in the kinds of conversations that I think a number of you are asking questions about.

The other piece is that Amy did talk about sort of that continuum of prevention and promotion and intervention, and it's important to think about the kinds of strategies that we can do that are both promotive and preventive. It's not that adults and kids and families will need intervention. It's that we know that the more we do before something becomes a clinical level of one of these kinds of disorders, the more likely we are to prevent that and sort of that will have a number of more positive outcomes for us.

So, we'd like you, before we jump into some questions, to really just think about a few things in terms of what you'll do differently and how you might incorporate this into the work that you're doing. We can see amongst the questions that are sort of flying by that a number of you are trying to think of very concrete ways in which you might want to start to address some of the risk factors that you've encountered or some of the kinds of difficult conversations that have proven more challenging than you'd like them to be.

And then to maybe think about who might help, what are your resources in the community, where are some of the maybe resources lacking and how might you start to address that, so what kind of help you need and from whom and how you might implement that new information.

Last, sort of logistically, as Amy and I mentioned, we're happy to provide you with the PowerPoint slide with all the notes. You can just email one of us. And then, obviously, we're part of a much larger center, and we encourage folks to email us at the center, our info line, or to call, and certainly to go on ECLKC, and you can find just sort of a treasure trove of resources there as well. So, with that, Amy, anything else you want to sort of fill in?

Amy: No, but I see that we have a number of questions, and I think Kelly is going to provide us with a few of those at least to answer in the next ten or so minutes that we have.

Kelly: Thank you, Amy and Neal, for sharing all of this information on maternal depression and mental health. We do have quite a few questions coming in. One of them is: We're interested in doing more in our program to address mental health to address mental health and depression. How can we get started? Are there any special resources to look at? Specific resources?

Amy: That's a great question, and I'm glad it was asked. So, on ECLKC there's a project that was funded by the Office of Head Start a few years ago, although they've been terrific about continuing their project and updating their resources. It's called "Family Connections." So, again, if you just go to the ECLKC and type in the search box "Family Connections," their whole project is a three-year project. Largely, some of the folks from the Parent and Family Engagement Center at Harvard developed in Head Start and Early Head Start programs resources and highlighted some work around maternal -- focusing on maternal depression and depression in programs where they really just -- I mean, they have great resources.

So, if you go to that site, Family Connections, you'll find training; you'll find resources for families, so that you can give handouts to families to talk about depression, training for staff, even circle time discussions for children around mental health issues. There's also a readiness scale there to think about in your program. If you want to do more in this area; there's some things to think about in terms of: "Is your program ready? Do you have a stable director? Is your director changing every six months to a year," you know, things like that, that really need to take into account before you really think about diving in to something like this in a deeper way. But I think you'll find those resources really useful. We also, as I mentioned earlier, have terrific resources on the Early Childhood Mental Health Consultation website. Neal, do you want to add?

Neal: No, no, no. I want to make sure we keep sort of going through in terms of other questions. Are there more questions, Kelly?

Kelly: Yes, sir. The next question is: You mentioned during the presentation that 18 percent of fathers experience depression. What is the percentage of fathers with depression in Early Head Start?

Amy: Well, that was from Early Head Start. So, the 18 percent of fathers who met clinical criteria for depression was out of the fathers in Early Head Start. So, I'm not sure if I'm answering the question correctly, but that percentage -- I sort of read a little bit of the question, and it seems like -- I don't know the percentage of dads who are involved in Head Start or Early Head Start, so that would be an interesting question related to the 18 percent. But just to clarify that the 18 percent is Early --

Neal: Of all the dads.

Amy: Of all the dads in Early Head Start, 18 percent of them.

Neal: Met criteria for depression.

Amy: So, certainly, Early Head Start I think, serves more mothers than they do fathers, although they try as best as possible to include both parents. Are there some more questions, Kelly?

Kelly: Yes. Another question is: Can you please address other barriers like transportation, taking off time from jobs, the abstract nature of social/emotional impairment, and mental health issues in early childhood?

Neal: Sure. I'll start and Amy can jump in. So, you know again as we said, there's a number of barriers. We listed some. And while transportation may not be an issue in some places in this country, there are places where it is a two and a half hour bus ride, a 10-hour sort of experience for a parent and their children to get to one appointment. We're well aware of that. So, one of the things that Amy mentioned briefly that we'll sort of expand a little bit on, is the idea of a facilitated referral: The idea that when we ask somebody to go somewhere else for help, that we need to be aware that we're not just handing a piece of paper to somebody and saying, "Hey, good luck," but really trying to facilitate that process, that the reason that we make a referral somewhere is to try and find a place where that person, that family, that child, that adult, whomever it is, can get what it is that they need.

We have a form that we've developed on facilitated referrals that is on ECLKC, and what it really talks about is what we would want somebody to do, before they ever even ask a family to go somewhere else or ask an adult or an adult is taking a child somewhere else, to try and figure out where am I sending you: Is this the right place? Do they still accept new patients? Are they on a bus line? Is this something that you're comfortable with? -- all kinds of considerations that you do even before somebody would leave your sort of program. We also have recommendations in there about what would happen to wherever the place is that they're going, Does that person sort of get back to you? Do they set up appointments that are convenient? And, when the barriers are things like transportation, it seems sort of intuitive, and yet it doesn't always happen. It seems intuitive that one of the first questions we might say to somebody is: "Do you have a way to get to where I'm sending you?" And if you don't, maybe I'm not going to send you there." So, those kinds of barriers, I think, are really important to keep in mind. Amy, you want to add anything?

Amy: Yeah, I'll add a couple of points here. So, we have heard, again, around the country that waiting lists are very, very long. Sometimes, the services that we wish existed don't exist in certain communities. And I'll just tell you briefly that one program, just something that I thought was just really genius, in terms of bringing in -- this is a very, very rural program, but they brought in all of the mental health agencies to come together, and that Early Head Start program shared with the mental health agencies our Early Head Start and Head Start mandate and desire for making referrals and shared the issues that existed in the community. And over a period of meetings every month, you know, and I think they still meet now, which is years later, they worked together as a community to figure some of these issues out.

So, the mental health agencies really thinking about what they could contribute to serve the needs of the families in the Early Head Start program, and the Early Head Start program really thinking about how they could work better with the mental health programs, and they really began to develop some very innovative services that did not exist prior to them sort of learning about each other's work and really working together as a community. You know, often Early Head Start and Head Start is a catalyst or a leader in communities in terms of helping to develop services and make things easier for families to access the services they need.

Kelly: Thank you, Amy and Neal, for answering these questions. If we did not get to your question, we will be sending you an email answer within the next couple of weeks with an answer. And also, if you have further questions about this topic, please feel free to contact us, again, that email address is [nchinfo \(at sign\) aap.org](mailto:nchinfo@sign.aap.org).

And I'd like to remind you, at this point, when the webinar ends, there will be a short survey poll that can be taken immediately. There will also be a follow-up email sent to everyone who watched live with instructions to share the Survey Monkey link to everyone in your group who watched today's webinar. The ones who took the survey immediately after the webinar will get their certificate immediately. If you use the Survey Monkey link, you'll receive your certificate in about two to four weeks. Remember, each person who would like to receive a certificate of participation for the webinar must complete their own evaluation. If you're watching the webinar as a group, each person in the group should complete the evaluation in order to receive a certificate. Thanks, again, for joining us for this webinar. We look forward to your participation in future events.