Community Health Association of Mountain/ Plains States

PARTICIPANT HANDOUTS
Maternal Health Learning Collaborative: Perinatal Mental Health Awareness, Screening and Treatment

Thank you for attending today's training. By doing so you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, culturally competent, high-quality primary health care services. The CHAMPS 2022 Maternal Health Learning Collaborative: Supporting and Advancing Perinatal Health is a free series that was created in partnership with the HRSA Office of Intergovernmental and External Affairs (IEA) Region 8 Office.

Presented by:
Maridee Shogren, DNP, CNM, CLC/SAMHSA Mountain Plains Addiction Technology Transfer Center (MPATTC), and the Mountain Plains Mental Health Technology Transfer Center (MPMHTTC) and Robin Landwehr, DBH, LPCC, NCC

Live Broadcast Date/Time:
Thursday, February 10, 2022
11:30AM–1:00PM Mountain Time / 12:30–2:00PM Central Time

Target Audience:
This series is intended for integrated clinical care teams that may include clinical leadership, clinicians, and clinical support staff at Region VIII (CO, MT, ND, SD, UT, WY) health centers.

Event Overview:
This session brings awareness about common perinatal mental health concerns often experienced by persons during pregnancy and in the first year postpartum. Information about validated screening tools appropriate for use in various settings will be discussed along with a brief overview of treatment options. This session will also include a brief overview from a HRSA maternal health grantee about the MOMS (Montana Obstetrics and Maternal Support) Program, presented by Sarah Reese, PhD, LCSW – Principal Investigator, University of Montana – School of Social Work and Stephanie Fitch, MHA, MS, LAC – MOMS Demonstration Project Manager, Billings Clinic.

Learning Objectives:
Upon completion of this session, participants should be able to:

1. Describe three differences between Baby Blues and Perinatal Depression.
2. Consider other persons, besides the biological mother, who may be impacted by perinatal mental health concerns.
3. Identify two perinatal depression screening tools appropriate for use during pregnancy and postpartum.
4. Discuss an initial perinatal suicide risk assessment.

CONTENTS

CHAMPS ARCHIVES

This event will be archived online. This online version will be posted within two weeks of the live event and will be available for at least one year from the live presentation date. For information about all CHAMPS archives, please visit www.CHAMPSonline.org/events-trainings/distance-learning.

DESCRIPTION OF CHAMPS

Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-designated Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, policy and funding communications, and the collection and dissemination of regional data. Staff and board members of CHAMPS Organizational Members receive targeted benefits in the areas of business intelligence, networking and peer support, recognition and awards, recruitment and retention, training discounts and reimbursement, and more.

For over 35 years, CHAMPS has been an essential resource for Community Health Center training and support! Be sure to take advantage of CHAMPS' programs, products, resources, and other services. For more information about CHAMPS, please visit www.CHAMPSonline.org. The Happenings box on the lower left side of the CHAMPS home page highlights the newest CHAMPS offerings, while the CHAMPS Membership box on the lower right side of the page lists current benefits for CHAMPS Organizational Members.

SPEAKER BIOGRAPHY

Dr. Maridee Shogren is a Clinical Professor at the University of North Dakota and a Certified Nurse-Midwife. She has practiced women's health, obstetrics, and family planning in a variety of settings where she shares her passion for women's health with her colleagues and her patients. Maridee has been a faculty member at the UND College of Nursing and Professional Disciplines since 2008. Maridee has also been involved in SAMHSA funded grant work at UND where she spent three years on an interprofessional SBIRT training grant and currently works with the Region 8: Mountain Plains Addiction Technology Transfer Center and the Mountain Plains Mental Health Technology Transfer Center Network grant teams. In 2020, Dr. Shogren began work as the principal investigator on the Foundation for Opioid Response Efforts grant funded program, Don't Quit the Quit, where she is working to increase access to care and grow community support for persons who are pregnant or postpartum and in recovery from opioid use disorder. Dr. Shogren has published and has presented nationally on the impact of stigma and substance use disorders in pregnant and parenting persons.

Robin Landwehr is a Licensed Professional Clinical Counselor (LPCC) who holds a Master of Science degree in mental health counseling from Capella University, and a Doctor of Behavioral Health (DBH) degree from Arizona State University. Dr. Landwehr spent several years providing counseling and advocacy to survivors of intimate partner violence and managed a 110-bed shelter for survivors. She also coordinated a unit at a homeless shelter and served as the behavioral health director at a Federally Qualified Health Center where she helped establish a Medication Assisted Treatment Program for people with opioid use disorder. During her career, Dr. Landwehr has been fortunate enough to be involved in numerous writing projects, provided many trainings, practiced as part of a collaborative care team, and provided clinical supervision. Dr. Landwehr's experience as a clinical counselor includes assisting individuals struggling with trauma, depression, anxiety, health behaviors, substance abuse, and other issues. She is a certified instructor in the Question, Persuade, Refer (QPR) and Counseling on Access to Lethal Means (CALM) suicide prevention programs. Some of the work she has been most proud of was working as a volunteer for the Disaster Mental Health (DMH) team at the American Red Cross.

CHAMPS 2022 Maternal Health Learning Collaborative Series

Perinatal Mental Health Awareness, Screening and Treatment

Maridee Shogren, DNP, CNM, CLC/SAMHSA

Robin Landwehr, DBH, LPCC, NCC

Thursday, February 10, 2022

11:30AM-1PM MT | 12:30-2PM CT

The AAFP has reviewed CHAMPS Maternal Health Learning Collaborative Series: Supporting and Advancing Perinatal Health, and deemed it acceptable for AAFP credit. Term of approval is from 01/13/2022 to 02/10/2022. This session is approved for 1.5 AAFP Prescribed credits.

The CHAMPS 2022 Maternal Health Learning Collaborative: Supporting and Advancing Perinatal Health is a free series that was created in partnership with the HRSA Office of Intergovernmental and External Affairs (IEA) Region 8 Office.

Perinatal Mental Health Awareness, Screening, and Treatment

Presenters

Maridee Shogren, DNP, CNM, CLC

Robin Landwehr, DBH, LPCC, NCC

Mountain Plains (HHS Region 8)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

SAMHSA
Substance Abuse and Mental Health Services Administration

Disclaimer and Funding Statement

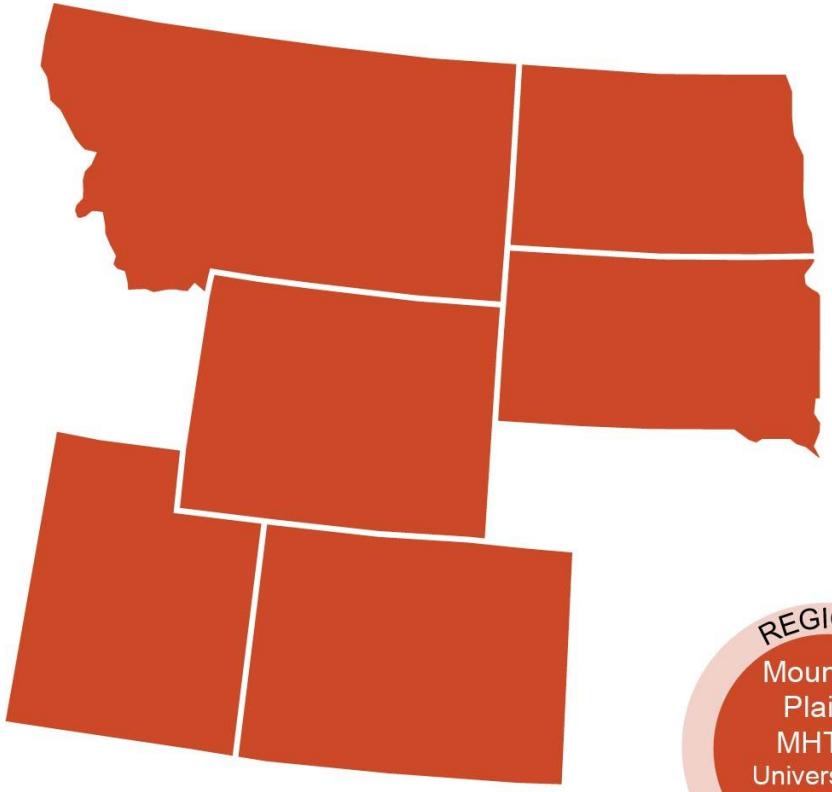
At the time of this presentation, Tom Coderre served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Maridee Shogren and Robin Landwehr and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

The work of the Mountain Plains MHTTC is supported by grant H79SM081792 from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



REGION 8
Mountain Plains MHTTC
University of North Dakota

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Healing-centered/ trauma-responsive
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

Objectives

- Describe three differences between Baby Blues and Perinatal Depression
- Consider other persons, besides the biological mother, who may be impacted by perinatal mental health concerns
- Identify two perinatal depression screening tools appropriate for use during pregnancy and postpartum
- Discuss an initial perinatal suicide risk assessment

What is Perinatal Mental Health (PMH)?

- Mental Health:
  - A state of well-being
  - Person realizes their abilities and can cope with stressors in life
  - Works productively
  - Contributes to society (Shorey and Chan, 2020)
- Perinatal Period:
  - Time frame that includes pregnancy and ***first year*** postpartum
- Perinatal Mental Health:
  - The state of well-being during the perinatal period

Perinatal Mental Health

- For years perinatal mental health seemed to be discussed only as postpartum depression
- Now we have a better understanding
  - A person goes through many hormonal, physical, emotional, and psychological changes during the perinatal period…ALL impact PMH
  - PMH does not impact just one person
    - PMH affects many people and potentially many generations
- PMH disorders are a spectrum of experiences and conditions
  - Include anxiety, depression, psychosis, suicide, perinatal substance use disorders, complicated grief after perinatal loss, and more
  - Without treatment PMH disorders can become chronic and persist through more than one pregnancy (MHTTC, 2021)

PMH Stigma May Lead to Lack of Care

- PMH is still stigmatized; many persons are still not coming forward to seek help
  - Stigma may hinder a person's recognition of the presence of PMH distress and may reduce likelihood that they disclose their symptoms to a loved one or health care professional (O'Mahen & Flynn, 2008)
  - People report feeling ashamed that their perinatal mental health concerns and symptoms may be seen as signs of personal failure; they fear their social network will disapprove (Fonseca et al., 2018)

- Stigma noted to be the most important barrier to the help-seeking process (Silva, 2015; as cited in Fonseca et al., 2018)

- Up to 50% of mothers will not seek treatment for PMH concerns (CDC, 2008)
  - Stigma strongly associated with shame, fear of being labeled as "mentally ill" or being judged by health care providers (Bilszta et al., 2010)
    Stigma is enhanced if pregnant person also has a substance use disorder
    - Many report fear of social service or child protection involvement (McLoughlin, 2013)

- Society often has unrealistic, idealized expectations of motherhood (McLoughlin, 2013)
  - Persons may experience guilt for not meeting their OWN expectations of motherhood AND the expectations of others

Perinatal Mental Health Disorders

- **Postpartum Blues ("Baby Blues"):** Mild and short-term mood experience that results after pregnancy and resolves without intervention
- **Perinatal Depression:** Major depressive disorder that occurs during pregnancy or within a year after delivery
    - **Antenatal Depression (AND):** Major depressive disorder that occurs during pregnancy
    - **Postpartum Depression (PPD):** Major depressive disorder that occurs after delivery
        - It is believed that majority of cases of PPD are preceded by depression during pregnancy
        - Most experts now argue that the time of onset for symptoms should really be extended through the ***first year*** after delivery (Howard & Khalifeh, 2020)

Multifactorial Risk Factors for PMH Disorders

- Trauma History
  - Adverse childhood experiences (ACES) (Byatt et al, 2020)
  - Includes interpersonal violence, intimate partner violence
- Personal history of depression/anxiety/PMS or family history of depression
- Personal History of physical or sexual abuse
- Lack of social support
- Higher risk pregnancy: gestational diabetes, pre-term labor/birth*, pregnancy loss, adolescent parent
- Poverty, lack of financial support
- Substance misuse and substance use disorders (Prevatt et al., 2017)
- Sometimes there may not be significant risk factors!

The Baby Blues

- Not considered a disorder; the most common experience affecting pregnant persons after delivery
  - Will impact between 50-80% of people within 1-2 weeks after birth; severity can vary
- Why do the Blues happen?
  - Biological
    - Hormonal changes after delivery
      - Estrogen and Progesterone decrease quickly by up to 90% over first few days
    - Physiological pain associated with healing, uterus contracting, breast pain with lactation
    - Sleep changes
  - Psychological
    - History of anxiety or depressive disorders or PMS
    - Fear about health and life of infant
    - Uncertain about change to maternal life (family dynamics, career, financial)
    - Concerned with physical changes (weight, “reduced attractiveness”) (Banasiewicz et al., 2020)

The Baby Blues

- Environmental
  - Support systems and living circumstances
- Symptoms
  - Crying, anxiety, emotional lability (“rollercoaster”), irritability, fatigue and trouble sleeping, lack of interest in food
  - Usually begins about 3-4 days after delivery, peaks within 2-5 days of onset
    - Occasionally symptoms can last longer but symptoms do not tend to worsen
  - Typically, does not interfere with daily functioning
  - **Baby Blues do not progress in severity and typically resolve on their own within 10-14 days**

Maternal Perinatal Depression (MPND)

- MPND is most under-diagnosed obstetric complication in U.S.
  (Dagher et al., 2021; PSI, 2021)
  - Affects at least 1 in 7 pregnant persons
    - Estimated that up to 26% of adolescents are affected
    - 50-70% of mothers go undetected & 85% go untreated
- Some studies have estimated PPD to be as high as 40-60% among teenagers or those of lower socioeconomic status
- Emerging research suggests more mothers developed MPND during the COVID pandemic (~34%)

Maternal Perinatal Depression

- Symptoms are identical to non-perinatal major depression
  - Depressed mood (self-report or observed) present most of the day
  - Loss of interest in usual activities or pleasure
  - Changes in sleep patterns
  - Agitation
  - Feelings of worthlessness or guilt
  - Loss of energy or fatigue
  - Inability to concentrate
  - Change in weight or appetite
  - Suicidal ideation, attempt or recurrent thoughts of death

Maternal Perinatal Depression

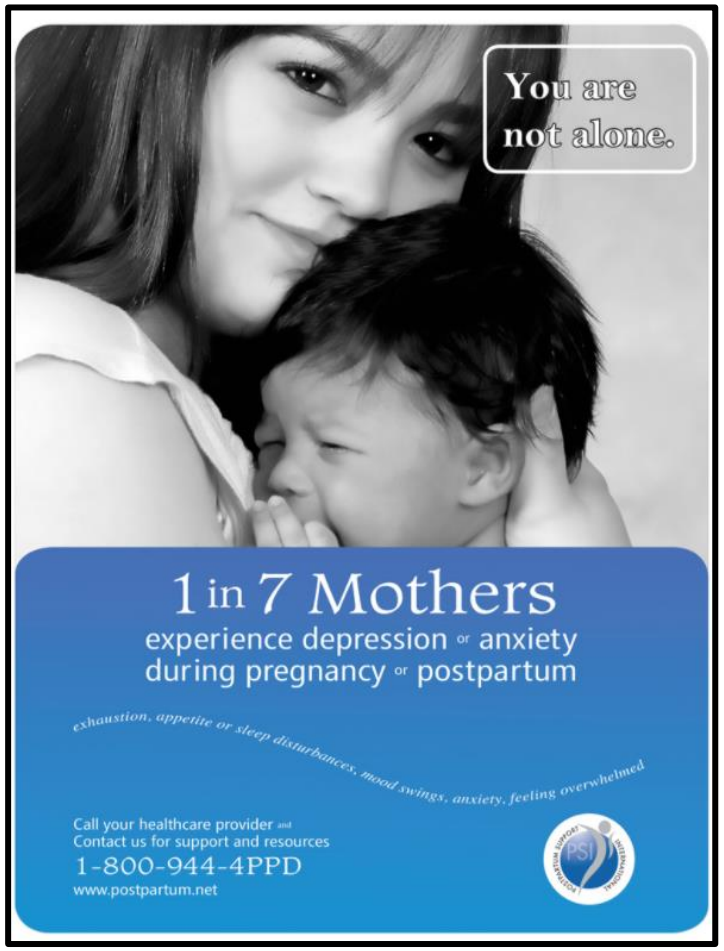
- Persons with MPND may experience decreased social support, more difficulty with self-care, poor nutrition and weight gain, and increased partner conflict
- MPND is a risk factor for perinatal substance use disorders and vice versa
  - Perinatal depression and anxiety are significantly associated with binge drinking and use of tobacco and other drugs
- Untreated MPND associated with:
  - Higher incidence of preeclampsia
  - Failure to initiate breastfeeding or shortened duration of breastfeeding
  - Maternal suicide (Van Niel & Payne, 2020)

Antenatal Depression

- Less focused on in practice
- Persons often reluctant to share symptoms of sadness because of expectation of happiness during pregnancy
    - What about emotions of persons with mistimed pregnancies?
- Higher tendency to focus on physical health during pregnancy
    - Providers and clients may misinterpret depression symptoms as complaints about common discomforts of pregnancy
        - Sleep, body aches, headaches, “pregnancy brain”
            - Worries about previous pregnancy history, complications, and/or losses might trigger more anxiety or depression (Biaggi et. al, 2016)

Postpartum Depression (PPD)

- Affects ALL cultures, ages, incomes, & ethnicities
  - First time mothers, & those who deliver prematurely, have higher rates of PPD (Banasiewicz et al., 2020)
- 1 in 7 people will develop
  - ~20% of persons with Baby Blues will develop PPD
- Symptoms usually present within 3 weeks to 3 months after birth
  - Peak: 2nd month PP
  - Risk remains up to 1 yr
    - Some evidence suggests the accumulation of stressors in the first year after delivery contributes to the onset or recurrences of depressive episodes (Dagher et.al., 2021)
    - Think about all of the changes going on!



PSI, 2021

Potential Concerns if PD is NOT Treated

Antenatal Depression

- Maternal Impact
  - Poor sleep
  - Less likely to breastfeed
  - Paternal depression
  - Potential impact on bonding
  - Increased risk of preeclampsia, placental abnormalities, miscarriage
  - Associated with development of PPD
- Fetal Impact
  - Delayed fetal development
  - Higher rates of prematurity
  - Low birth weight

Postpartum Depression

- Unplanned weaning from breastfeeding or lactation failure
- Newborn stress
- Impaired bonding and attachment
- Children's emotional health can be adversely affected through the school-age years
- May trigger onset of chronic major depressive disorder:
  - 1 in 3 will struggle with depressive symptoms at least four years after delivery
- GREATEST risk factor for maternal suicide and infanticide

Treatment for Maternal Perinatal Depression

- MPND does not usually resolve without treatment
  - Can become a chronic disorder that persists through more than one pregnancy (Meltzer-Brody & Steube, 2014)
  - Symptoms can worsen quickly!
- Treatment options often include a combination of
  - Counseling
    - Cognitive behavioral therapy, individual and group therapy
  - Medication
    - Many options, even with breastfeeding!
    - Typically SSRIs are first line (most work well with breastfeeding)
  - Support from others
  - Exercise & a healthy diet
  - Adequate sleep
  - Relaxation techniques (Kroska & Stowe, 2020)
- Usually encourage treatment for at least 6 months after symptoms resolve

Fathers, Partners, Non-Gestational Parents

- Paternal Perinatal Depression is less researched and not as defined
  - About 8-25% of fathers will experience PPND (Bruno et al, 2020; Scarff, 2019)
    - Up to 50% if concomitant depression in partner
  - Highest rates occur within 3-6 months postpartum, but can develop over the first year
  - Some may experience “Daddy Blues”
- Male risk factors
  - History of depression, unstable relationships, financial concerns, sick or premature baby; mistimed pregnancy
- Common paternal PPD symptoms
  - Typically, less sadness than mothers express
  - Fatigue and exhaustion
  - Irritability, agitation, and/or anger
  - Feel of worthlessness; self-criticism
  - Loss of interest in activities that used to bring them joy; restlessness
  - Engagement in risky behaviors like abusing substances
  - Shortness of breath or heart palpitations

Fathers, Partners, Non-Gestational Parents

- Less research available regarding experiences of non-gestational and non-biological parents (second parent in a same-sex relationship, multiple parents in a polyamorous family, foster parents, or adoptive parents)
    - One meta-analysis: 3-6 months postpartum had highest rate of depression for partners (Paulson & Bazemore, 2010)
    - Perinatal period may be especially challenging for sexual minority mothers
        - Additional associated stressors with belonging to a sexual minority group include higher general risk for depression, anxiety, suicidality and substance misuse
        - Stigma and discrimination might increase vulnerability to perinatal depression
    - Greater likelihood of planned pregnancies and more equitable distribution of parenting duties often observed in two-mother families might be protective (Marsland, Treyvaud, & Pepping, 2021)

Adoptive Parents

- About 10-30% of adoptive parents may experience postpartum depression
  - This is sometimes called, Post-Adoption Depression (Foli et al., 2017; Mott et al., 2011)
- Unique challenges to the transition to parenthood:
  - Loss of gestational experience
    - Family and friends
      - Don’t recognize outward signs of pregnancy or impending parenthood
      - May not appreciate need for and importance of still providing support
  - Stigma
    - Societal approval or disapproval of adoption
  - Uncertain or traumatic adoption process
    - Long wait times
  - Contributing factors often surround expectations
    - Parents, “mothers”, must know how to do this
    - Child may have difficulty with attachment, bonding, needs

Perinatal Suicide

- Leading cause of maternal death
  - Estimated maternal suicide rate of 1.5-4.5 per 100,000 people
    - About 40% of those who complete perinatal suicide have seen a PCP within one month of attempt
    - U.S. does NOT have a good system for identifying maternal deaths from suicide (i.e. some states include accidental overdose in this category); especially beyond first 6 months PP
    - Perinatal people most frequently complete suicide between 9-12 months postpartum
    - Of those who die by suicide in first 6 months PP, primary diagnoses:
      - 21%-severe depression
      - 31%- substance use disorders
      - 38%- psychosis (Sit et al., 2015)
- Suicidal ideation is predictor of suicide and postpartum depression

Perinatal Suicide

- Risk factors
  - History or psychiatric illness
    - Those with history of bipolar disorder at higher risk than those with unipolar depression
  - History of suicide attempts
  - Abrupt stopping of psychotropic medications during pregnancy
  - Postpartum sleep disturbances
  - IPV
  - Stillbirth (Lisette & Crystal, 2018; PSI, 2021;Mangla et al., 2019)
  - Possible behavioral clues
    - Decreased responsiveness to infant cues and less infant engagement with mothers

Suicide Warning Signs and Cues

- **Verbal**
  - Direct – “I’m going to kill myself.” “If my wife leaves me, I’m going to kill myself.”
  - Non-Direct – “I can’t handle this anymore.” “I useless for my family anyway. They would be better off without me.”
- **Behavioral**
  - A relapse
  - Stockpiling meds/purchasing a weapon
  - Giving things away
  - Demonstrating anxiety/sleep deprivation
- **Situational**
  - An embarrassing situation
  - Fear of consequences/Loss of freedom
  - Relationship / Financial crisis
  - Terminal diagnosis
  - Move/death
  - **Knowing someone who has died by suicide**

The Three ‘I’s of Depression (Chiles, J. & Strosahl, K. (2005).

- Intolerable – “This pain is too great to bear.”
- Interminable - “This pain will never end.”
- Inescapable – “There is no way out.”

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

Screening for Perinatal Depression

- The **United States Preventive Services Task Force**
  - Recommends all adults be screened for depression, including pregnant and postpartum people, and that clinicians provide or refer pregnant and PP people who are at increased risk to counseling
- The **American College of Obstetricians and Gynecologists**
  - Recommends obstetric care providers screen patients for depression and anxiety symptoms at least once during the perinatal period and conduct a full assessment of mood and emotional well-being during the comprehensive postpartum visit
- The **American Academy of Pediatrics**
  - Recommends routine screening for maternal postpartum depression be integrated into well-child visits (Bauman et al., 2020; Van Niel & Payne, 2020)

However, According to the CDC

- About 1 in 5 people were not asked about symptoms of depression during a prenatal visit
- 1 in 8 were not asked during a postpartum visit
- As a result:
  - 50-70% of persons with MPND continue to go undetected
  - 85% of persons with MPND continue to go untreated (CDC, 2020; Dagher et al., 2021; PSI, 2021)

Screening for Perinatal Depression

Who & How to Screen?

- Healthcare providers are encouraged to screen all clients for depression
  - We shouldn't "Pick and Choose" who gets screened based on appearance, bias
    - Asian women were 19% less likely, African-American women 36% less likely, and Native American and multiracial women were 56% less likely to be screened
  - We should use a screening tool to help ask the questions
    - Edinburgh Postnatal Depression Scale
    - PHQ-2 & 9

When to Screen?

- First prenatal visit
- At least once in the third trimester
- Postpartum visit
  - 2weeks
  - 6+ weeks
- Well-woman/Primary Care visit 1 year after delivery
- Even at newborn/pediatric appointments!
  - 3, 9, 12 -month visits

(PSI, 2021)

Edinburgh Postnatal Depression Scale (EPDS)

- Most frequently used in research settings and clinical practice
- Translated into 50 languages
- Cross-culturally validated
- 10 self-reported questions that are health literacy appropriate
  - Takes 2-3 minutes to complete
  - Includes anxiety symptoms
  - Excludes changes in sleeping patterns which are common in pregnancy and postpartum
- Sensitivity and Specificity range from 70-88%
- Many studies found that the EPDS is twice as effective as a clinician's interview in detecting depression (Van Niel & Payne, 2020)

EPDS

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Cox, J., Holden, J.M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh postnatal depression scale, Br. J. Psychiatry, 150(6), 782-786

PHQ – 9 Review

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

Screens for major depression

Inquires about the most common physical symptoms and includes questions pertaining to mood, anxiety, and sleep

Considered a reliable and valid measure of depressive symptom severity

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

PHQ – 9 Review

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✔s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✔s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✔s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✔s by column. For every ✔: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✔ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

PHQ-9 Vs. DSM 5 Depression Criteria

PHQ-9 Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001).

Patient Health Questionnaire (PHQ-9)

Name:_____ MRN# _____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add Columns _____ + _____ + _____

Symptom Total_____ Severity Total _____

If any problems noted, how difficult have these problems made it for you to do your work, take care of the things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
_____	_____	_____	_____

If these problems have caused difficulty, have they caused you difficulty for two years or more?

Yes _____ No _____

DSM 5 (American Psychiatric Association, 2013)

Major Depressive Disorder (Diagnosis)

These are the DSM V diagnostic criteria for Major Depressive Disorder. Please review your diagnostic assessment using this checklist. IF the symptom is "clearly present" mark that box. If the symptom has been sustained for at least for at least two weeks, every day, most of the day mark the box "sustained". For a diagnosis of MDD to be present, 5 of 9 criteria from Section A must be marked as BOTH "clearly present" and "sustained". As well, criteria B and criteria C must be met. As well, items C, D and E must be clearly present.

Clearly Present	Sustained	
		A) Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. *(Note: Do not include symptoms that are clearly attributable to another medical condition)*
		1) Depressed mood most of the day, nearly every day as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). *(Note: In children and adolescents, can be irritable mood).*
		2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
		3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. *(Note: In children, consider failure to make expected weight gain.)*
		4) Insomnia or hypersomnia nearly every day.
		5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
		6) Fatigue or loss of energy nearly every day.
		7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
		8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
		9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
		B) The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
	C) The episode is not attributable to the physiological effects of a substance or to another medical condition.	
	Note: Criteria A-C represent a major depressive episode *Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.*	
	D) The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.	
	E) There has never been a manic episode or a hypomanic-like episode. *Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributes to the physiological effects of another medical condition.*	

Brief Intervention: What Do I Say to Someone I am Worried About?

- I may use a direct or indirect approach, but I ask. Keeping in mind what I know about the situation.
- If they affirm, I ask
  - Currently? Like now? When?
  - How? Is it something they have access to?
  - Then I may CUS, or something similar.
- If the answer is no, or sometimes but not right now, I say
  - This is a good time to talk about help
  - Begin persuasion (Offer hope)

Most important though, I listen, listen, listen.

How do you ask, “the question”?

- Direct?
- Indirect?
- Oops
- Key things to consider:
  - Avoiding judgement
  - Major life advice
  - Getting so focused on their thoughts of suicide, you forget to listen to the problem

Acceptable Risk?

- This doesn’t even sound good.
- A model:
  - PHQ-2. Score of 3 or greater leads to the PHQ-9
  - Patients with a known diagnosis of depression automatically get the PHQ-9
  - Score of 10 or greater = Internal referral to BH
  - Any number endorsement of question 9 except ‘0’ = Internal referral to BH

  - When something is obvious…

Screening Limitations / No blame

Screening is not a full suicide risk assessment (Risk factors, protective factors, suicidal behaviors like aborted attempts and rehearsals).

- Suicide Prevention Training: Presentation and Panel Discussion
- Suicide Prevention in Rural Primary Care: Two-Part Series
- SAFE-T

- Remember scope and ethics when screening or doing assessments
  - Ethics in Practice - HHS Region 8
- Even full screenings MISS things, or things are not disclosed

Suicide Risk Assessment

RESOURCES

- Download this card and additional resources at **http://wwww.sprc.org**
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide **http://www.sprc.org/library/jcsafetygoals.pdf**
- **SAFE-T** drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors **http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx**
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

ACKNOWLEDGMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

http://www.sprc.org

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

HHS Publication No. (SMA) 09-4432 • CMHS-NSP-0193

Printed 2009

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live
- * *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
- * *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT

Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

When We Prevent Suicide…

We prevent suffering and more loss.

- 4-Fold increase in risk for suicide in children if their parent dies by suicide.
- For every suicide, 135 are impacted. So, 48,000 (130 daily) suicides per year = over 1 MILLION seriously impacted by suicide loss. (QPR Institute, 2021)

Policies and Procedures for Suicide Crisis

- **Policy should include**
  - In-Person or Over the Phone
  - Mention of an assigned designated person
  - Who to call for help/further assessment
  - Transportation
  - Willing vs. Unwilling client
  - Emergency and Non-Emergency Procedures (Referrals)
- **Designate the person responsible during shifts** (charge nurse, supervisor)
  - Where is the client now?
  - Assuring someone is present
  - Knows policies about contacting help/transport
  - Awareness of staff well-being / Back-up for them
  - After the crisis

Policies and Procedures Cont.

Managing Suicide Crisis Calls Procedure

Try to remain calm. Be genuine. Try to speak slowly and calmly.

Try to get the name, call-back number, and location of the caller. It is best to not transfer the call. Ideally, the person taking the call should be the person to stay on the phone with the caller.

Listen. Let the person vent. Sometimes that is all it takes for the person to feel better.

Be sympathetic and try not to debate or argue with the caller. Try not to offer solutions or minimize how they are feeling.

Begin to get the specifics of the suicide plan if you haven't already: Have you thought about how you would do it? **(PLAN**); Have you got what you need? **(MEANS);** Have you thought about when you would do it? **(TIME SET).** If you get affirmative answers, **try to get someone who can call 9-11 on another phone line while you are talking with the caller. Try to flag down a co-worker.**

If you can't find help, see if you can mute the caller and call 9-11 on a cell phone or another office phone. Keep trying encouraging the caller to vent until you can find help.

Policies and Procedures Cont.

Managing Suicide Crisis Calls Procedure Continued

Ask the caller if they want to speak with a BHC or nurse and explain to them their role. **If their answer is yes, make sure you have the patient's call-back number and preferably address, place the caller on hold and transfer the call to the appropriate person (Ideal not to put the caller on hold).**

If the caller says NO, **do not** hang up or transfer them. Remain on the line until you can get help. Try to keep them talking.

Offer to call 9-11 and send help, if they refuse help, remain non-judgmental and sympathetic and keep talking. If the caller is suicidal and you have the caller's location, **you may legally call or have someone call 9-11** without violating confidentiality. Do not inform the caller that you called 9-11 if you have reason to believe they will hang up or leave that location.

If the person is ingesting drugs, get as many details as you can (what, how much, alcohol, other medications, last meal, general health) and have someone **call Poison Control at 1-800-222-1222**. If you reach Poison Control and they recommend immediate medical assistance, ask if the caller has a nearby relative, friend, or neighbor who can assist with transportation or the ambulance. You may also call 9-11 if you have the caller's address or location. Remain with the caller until either help arrives, or someone else takes the call.

Once your call is over, talk to someone. Suicide calls are very stressful, and we all need support.

After a Crisis

- Postvention (this doesn't have to be formal or immediate). Did we do things right? Can we improve? If we want a better outcome next time, what can we try?

- Staff Support
  - Awareness of secondary traumatic stress (working with a patient who is suicidal, or learning that patient/client has died by suicide)
  - Create a space to talk about it
  - Provider Well-Being

Referral Pathway

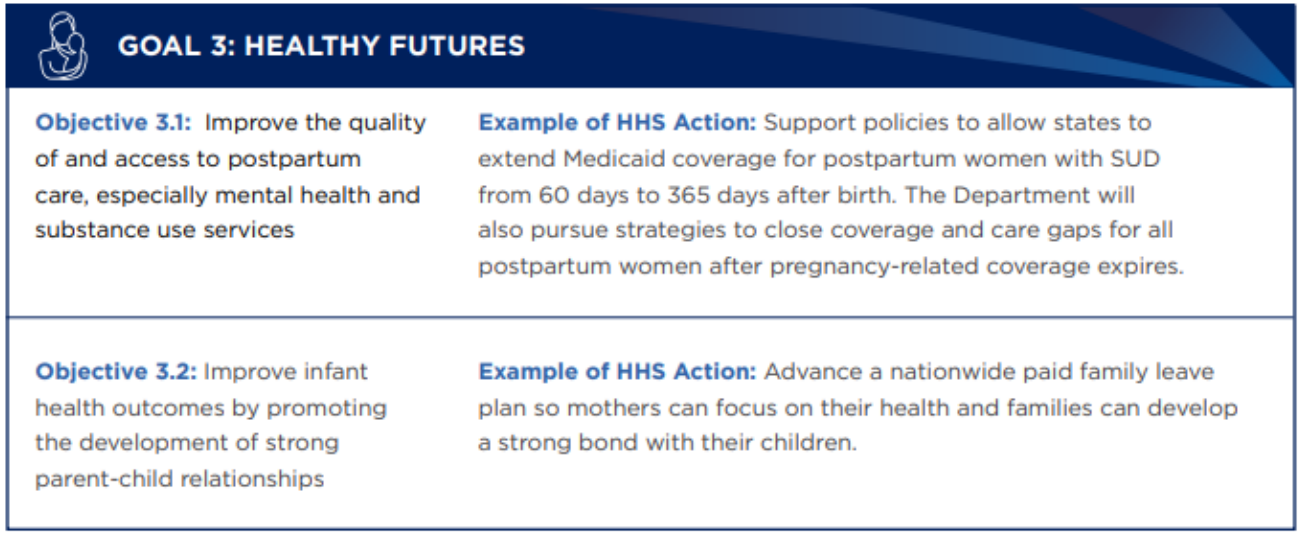
- Immediacy is important. Consider emergency and urgent options that may be available. Warm handoffs are best.
- Keep a real-time accounting of your internal and external resources
  - Health systems
  - Social service organizations
- Continued education with staff
- Speak with your partners about how you would like to utilize their services.
- Consider having written material ready

Referral challenges for the Perinatal Population

- Where should the referral go?
  - Primary care vs OB vs behavioral health
  - May depend on time frame, preference, availability
- Do they have someone to help with infant, other children at home so that they can attend a follow up appointment?
- How long does insurance cover their PP care, PPD screening visit?
  - US Department of Health and Human Services Action Plan (12-20)
  - Ongoing advocacy to extend the

postpartum period to 1 year

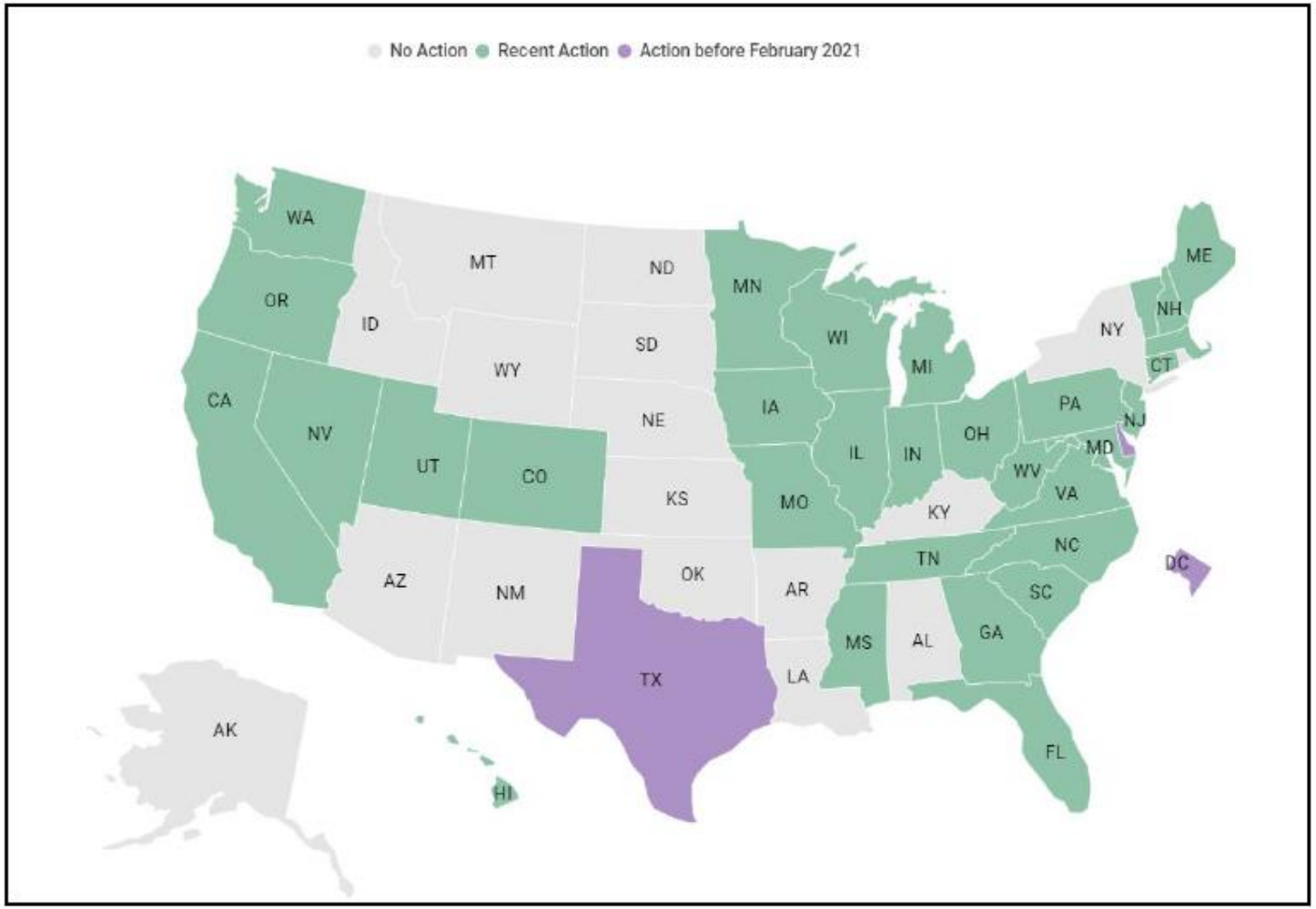
for insurance/Medicaid coverage



GOAL 3: HEALTHY FUTURES

Objective 3.1: Improve the quality of and access to postpartum care, especially mental health and substance use services	**Example of HHS Action:** Support policies to allow states to extend Medicaid coverage for postpartum women with SUD from 60 days to 365 days after birth. The Department will also pursue strategies to close coverage and care gaps for all postpartum women after pregnancy-related coverage expires.
Objective 3.2: Improve infant health outcomes by promoting the development of strong parent-child relationships	**Example of HHS Action:** Advance a nationwide paid family leave plan so mothers can focus on their health and families can develop a strong bond with their children.

Medicaid Expansion:
Does This Impact Your Postpartum Referrals?



(NASHP, 2-8-22)

https://www.nashp.org/view-each-states-efforts-to-extend-medicaid-coverage-to-postpartum-women/

ND	No current action to extend Medicaid coverage to PP people beyond 60 days
SD	No current action to extend Medicaid coverage to PP people beyond 60 days
MT	No current action to extend Medicaid coverage to PP people beyond 60 days
WY	No current action to extend Medicaid coverage to PP people beyond 60 days
CO	Legislation: SB21-194 requires the Department of Health Care Policy and Financing (HCPF) to seek an amendment to the state medical assistance plan to provide 12 months of postpartum medical benefits to persons who qualified for benefits while pregnant.
UT	No current action to extend Medicaid coverage to PP people beyond 60 days

Referral Challenges for the Perinatal Population

- Breastfeeding and medications
  - Additional education may be needed if the mother is prescribed medications to treat PPD
  - Should a follow up appointment be scheduled with WIC, Peer BF Counselors to address any BF questions/concerns if medications are prescribed?
- Are additional referrals available for community support resources?
  - Moms' groups
  - La Leche League
  - What local groups are YOU aware of in YOUR community?

Questions?

Stay Connected

mhttcnetwork.org/centers/mountain-plains-mhttc/home

@Mountain-Plains-MHTTC

@MPMHTTC

mhttcnetwork.org/centers/mountain-plains-mhttc/subscribe-our-mailing-list

The MOMS Grant

Stephanie Fitch, MHA, MS, LAC

Sarah Reese, PhD, LCSW

The Montana Obstetrics and Maternal Support (MOMS) Grant

- MOMS is a Health Resources and Services Administration (HRSA) funded maternal health innovations initiative aimed at elevating maternal health as a priority in Montana.
- MOMS is a collaboration between the Montana Department of Public Health and Human Services (DPHHS), Billings Clinic and the University of Montana's Rural Institute for Inclusive Communities.
- Montana has the sixth-highest rate of maternal mortality in the United States and significant severe maternal morbidity. Racial and geographic disparities create siloes in maternal healthcare, negatively impacting outcomes for moms in Montana's rural and tribal communities. By improving access to quality healthcare services, MOMS strives to make "The Last Best Place" the first best place to have a baby.

MONTANA DPHHS

Billings Clinic

Rural Institute
Inclusive Communities

Program Objectives

- Establish a state-focused Maternal Health Task Force to create and implement a strategic plan that incorporates activities outlined in the state's most recent State Title V Needs Assessment;
- Improve the collection, analysis, and application of state-level data on maternal mortality and SMM; and
- Promote and execute innovation in maternal health service delivery, such as improving access to maternal care services, identifying and addressing workforce needs, and/or supporting postpartum and interconception care services, among others.

Maternal Mortality and Severe Maternal Morbidity in Montana

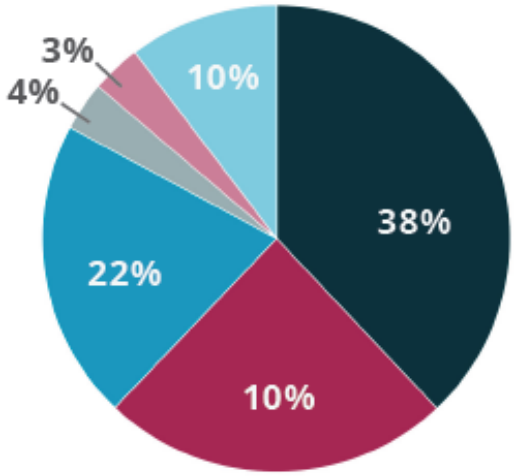
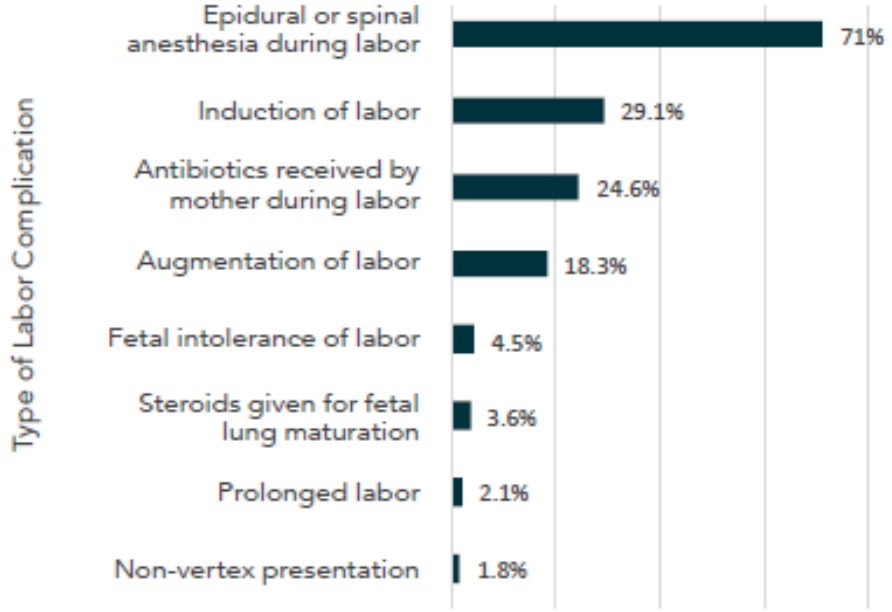


FIGURE 1: CAUSES OF MONTANA PREGNANCY-ASSOCIATED DEATHS (2014-2016 MONTANA VITAL STATISTICS)

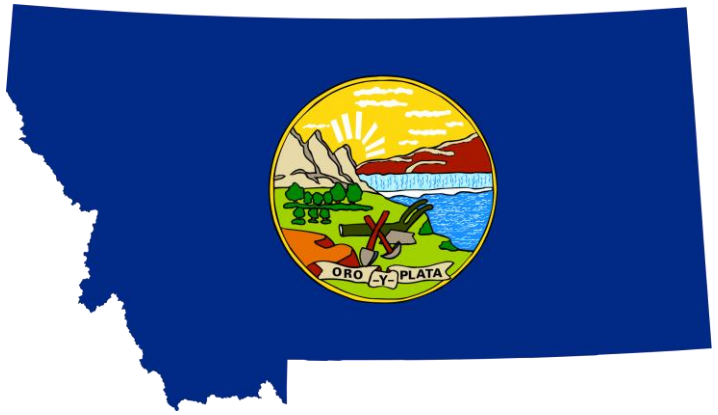
- Motor Vehicle Accidents
- Substance Use Disorders
- Suicide
- Spontaneous Coronary Artery Dissection
- Pulmonary Embolism
- Unknown or Undetermined

FIGURE 3: LABOR COMPLICTIONS (% OF LIVE BIRTHS, 2018 MONTANA VITAL STATS)



Substance Use and Mental Health: Montana Context

- 55 of our 56 counties are designated as Mental Healthcare Provider Shortage Areas
- Montana's suicide rate is more than twice the national average.
- Montanans' substance use is among the top 12 in the nation, ranking 10th in illicit substance use, 11th in marijuana use, and 12th in binge drinking rates in the past month.
- The number of infants born in Montana with neonatal abstinence syndrome or neonatal opioid withdrawal syndrome increased 78% between 2012 and 2014
- Substance-exposure in newborns has increased from 3.7% (2010) to 12.3% (2016)
- The number of MT children in foster care more than doubled from 2011-2016
  - 64% of these children were removed because of parental substance use
- Only 6% of MT's SUD treatment programs serve pregnant women
- Lowest rate of buprenorphine treatment capacity in the United States



- Montana Healthcare Foundation (2017)
- Glover et. All (2020)

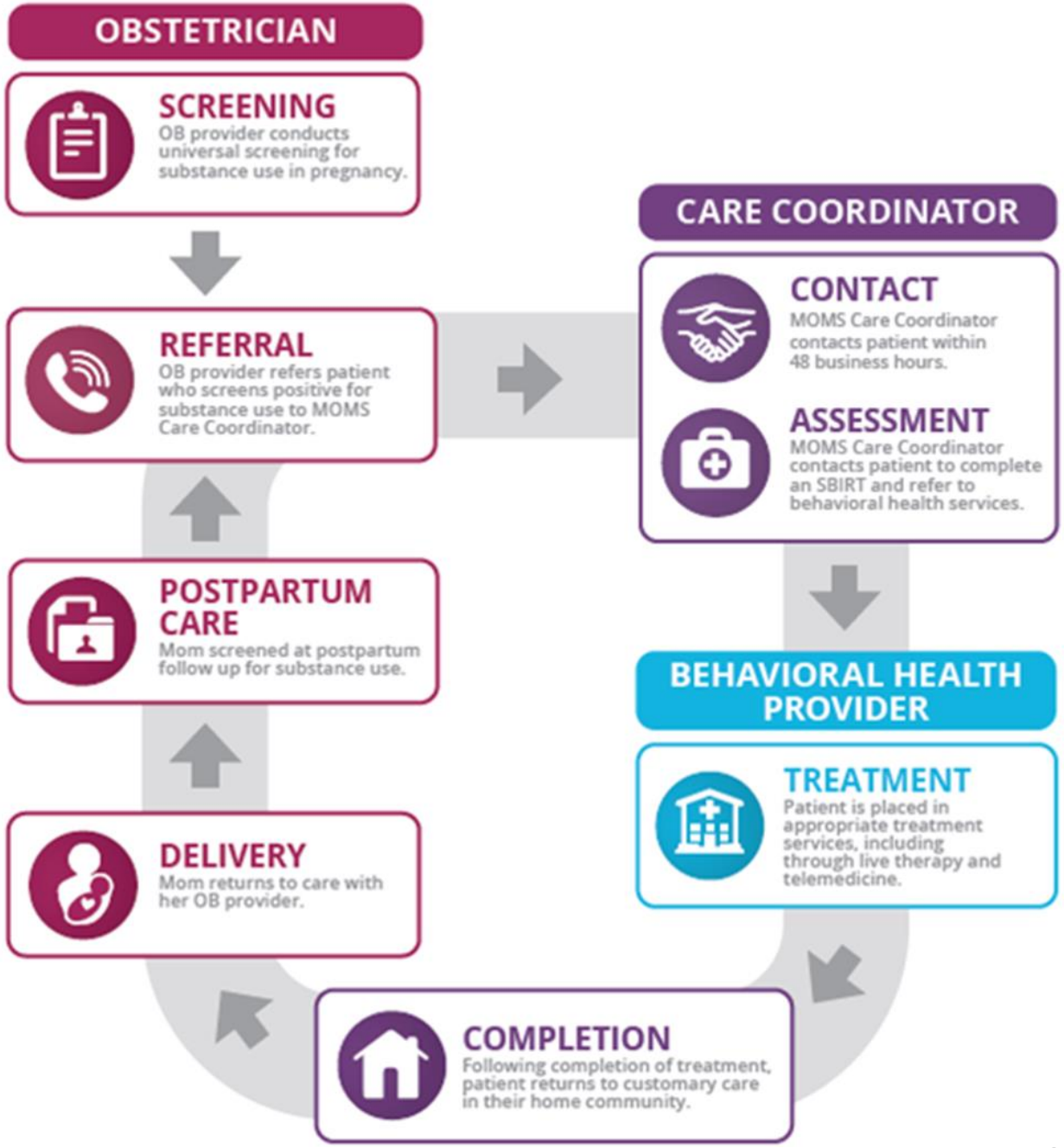
The Empaths Perinatal Substance Use Pilot Study

- The Empaths study is a healthcare system-level treatment model in which universal screening for substance use in pregnancy is implemented in the OB/GYN setting.
- Patients that screen positive for substance use concerns are referred to a centralized care manager who conducts Screening, Brief Intervention, and Referral to Treatment (SBIRT) sessions via live and telehealth appointments.
- Piloted out of Billings Clinic and expanding to rural sites in the region.

Evidence for Implementing Universal Screening for Substance Use in Pregnancy

- ACOG recommends early universal screening, brief intervention, and referral to treatment for pregnant women with substance use disorder. (ACOG, 2017).
- Universal screening assures all women are assessed.
  - Screening vs. Drug Testing
- Routine screening should rely on validated screening tools, such as questionnaires, including 4Ps, NIDA Quick Screen, CRAFFT (for women 26 years or younger), etc.

https://gasubstanceabuse.org/sbirt/



RIMROCK

Billings Clinic

Rural Institute
Inclusive Communities

The 5Ps Screening Tool

Question	Yes	No
1. Did any of your parents have problems with alcohol or drug use?	☐	☐
2. Do any of your friends have problems with alcohol or drug use?	☐	☐
3. Does your partner have a problem with alcohol or drug use?	☐	☐
4. Before you were pregnant, did you have problems with alcohol or drug use?	☐	☐
5. In the past month, did you drink beer, wine or liquor, or use other drugs?	☐	☐
Total:		

Patient Signature: _____ Date: _____ Time: _____

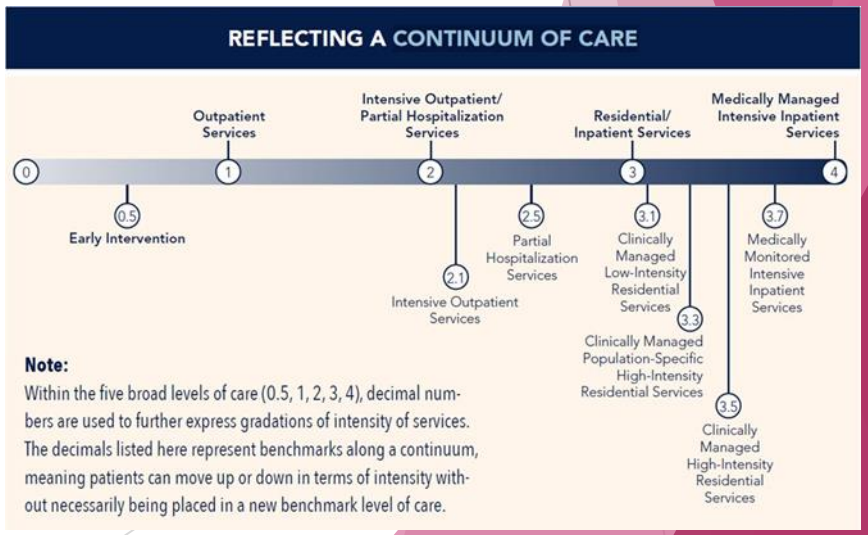
Nurse Reviewer: _____ Date: _____ Time: _____

Billings Clinic

Patient Label

Empaths Care Management

- The Empaths Care Management team can provide:
  - ASAM Dimensional Screening
  - Referral to substance use and mental health treatment programming
    - Recommendations on facilities, including links and contacts for admissions
    - Assistance scheduling appointments
    - Provide information regarding what records the referring provider may need to provide to the treatment agency
  - Connection to self-help services and/or peer support
  - Connection to legal aid services
  - Connection to social services programs



https://www.asam.org/asam-criteria/about

Empaths Participating Sites:

01

Commit to universally screening all pregnant and postpartum patients for SUD concerns utilizing the 5Ps tool.

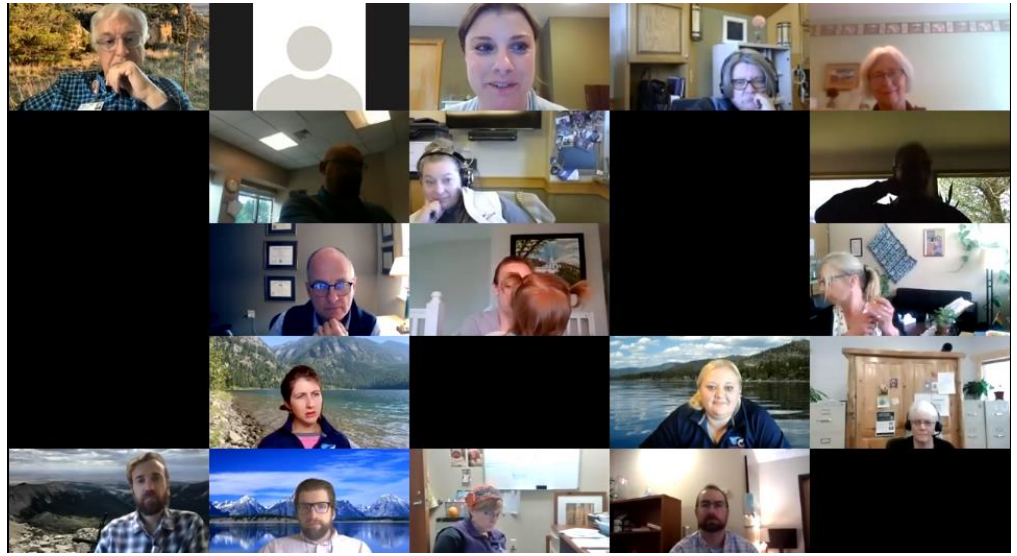
02

Refer patients to the EMPATHS team when SUD and associated behavioral health and social needs arise.

03

Provide completed screening tools to the EMPATHS team for inclusion in the EMPATHS research study.

- Complete necessary data-sharing agreements for sites outside of the Billings Clinic affiliate network



Project ECHO
(Extension for Community Health Outcomes)

- Remote learning opportunity that connects urban-based specialists to rural-based generalists.
- Medical education and care management collaborative that empowers clinicians in remote settings to deliver better care to more people locally.
- Project ECHO promotes knowledge-sharing, expands treatment capacity, and offers peer support to otherwise regionally isolated clinicians.
- Occurs every 2nd and 4th Tuesday of the month at noon over Zoom.
- In the first year, MOMS Project ECHO has attracted more than 150 unique participants.

Project ECHO®

Billings Clinic - Montana

Simulation Leadership Academy (SLA)

- The Academy is a cohort-model educational offering designed to provide physicians, midlevel providers, nurses and other clinical leaders at rural health centers the opportunity to:
  - learn the science of obstetric simulation
  - practice design and implementation of various types of simulation
  - learn to train specific management skills and maneuvers for a variety of obstetric complications.
- This program is offered free-of-charge and participating facilities will receive a PROMPT Flex birthing manikin with a postpartum hemorrhage module to be used throughout the course.
- SLA includes training on behavioral health simulation and use of standardized patients.

Other Training and Education Opportunities

- MOMS offers various training programs for provider teams, including:
  - Eat Sleep Console
  - Simulation in Motion – Montana (SIM-MT)
  - NRP and S.T.A.B.L.E.
  - Perinatal mood and anxiety disorders training
  - Peer support and paraprofessional family support certification opportunities
    - Recovery Doula courses

Questions?

MOMS
Montana Obstetrics & Maternal Support

www.mtmoms.org

Contact Information

- Stephanie Fitch, MHA, MS, LAC
- MOMS Grant Manager
- sfitch@billingsclinic.org

- Sarah Reese, PhD, LCSW
- Empaths Principal Investigator
- sarah.reese@mso.umt.edu

- Valerie Lofgren, BS, ACLC
- MOMS Regional Engagement Coordinator
- vlofgren@billingsclinic.org

References

- Glover et al. (2020) Maternal Health in Montana.
- ASAM (2019). Definition of Addiction. *The American Society of Addiction Medicine.* Retrieved from: https://www.asam.org/Quality-Science/definition-of-addiction
- Chasek, C. (2019). Implementing SBIRT in Rural Clinics: A How to Guide. *NAADAC.* Retrieved from: https://www.naadac.org/assets/2416/implementing_sbirt_in_rural_cllinics-a_how_to_guide_webinarslides.pdf
- Day, R. (2020). About Screening, Brief Intervention, and Referral to Treatment (SBIRT). Retrieved from: https://www.samhsa.gov/sbirt/about
- Henry-Edwards, S., Humeniuk, R., Ali, R., Monteiro, M., and Pznyak, V. (2003). Brief Intervention for Substance Use: A Manual for Use in Primary Care (draft). *World Health Organization.* Retrieved from: https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf
- LaFave, L., Bradley, M., Lessels, H., Murray, A., Pepin, A., Hodder, L., and Goodman, D. (2019). NH S·BI·RT Implementation Playbook for Perinatal Providers. *New Hampshire Charitable Foundation.* Retrieved from: https://sbirtnh.org/wp-content/uploads/2019/02/perinatal-playbookFINALdig-2.pdf
- Mee-Lee, D. (2013). *The ASAM Criteria: treatment for addictive, substance-related, and co-occurring conditions*. Carson City, NV: The Change Companies.
- Shapiro, B., Coffa, D., & McCance-Katz, E. F. (2013). A primary care approach to substance misuse. *American family physician*, *88*(2), 113–121.
- ACOG. (2017). Committee opinion no. 711: Opioid use and opioid use disorder in pregnancy. *Obstetrics & Gynecology*, *130*(2), e81–e94.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Author.
- Burke, K. D. (2007). Substance-exposed newborns: Hospital and child protection responses. *Children and Youth Services Review*, *29*, 1503–1519.
- Chakrabarti, S. (2015). Usefulness of tele-psychiatry: A critical evaluation of videoconferencing-based approaches. *World Journal of Psychiatry*, *5*(3), 286–304.
- Eibl, J. K., Gauthier, G., Pellegrini, D., Daiter, J., Varenbut, M., & Hogenbirk, J. C. (2017). The effectiveness of telemedicine-delivered opioit agonist therapy in a supervided clinical setting. *Drug and Alcohol Dependence*, *176*, 133–138.
- Forray, A., Merry, B., Lin, H., Prah Ruger, J., & Yonkers, K. A. (2015). Perinatal substance use: A prospective evaluation of abstinence and relapse. *Drug & Alcohol Dependence*, *150*, 147–155.
- Fortney, J. C., Pyne, J. M., Mouden, S. B., Mittal, D., Hudsen, T. J., & Schroeder, G. W. (2013). Practice-based versus telemedicine-based collaborative care for depression in rural federally-qualified health centers: A pragmatic randomized comparative effectiveness trial. *American Journal of Psychiatry*, *170*(4), 414–425.

References

- Hafekost, K., Lawrence, D., O'Leary, C., Bower, C., O'Donnell, M., Semmens, J., & Zubrick, S. R. (2017). Maternal alcohol use disorder and subsequent child protection contact: A record-linkage population cohort study. *Child Abuse & Neglect*, *72*, 206–214. https://doi.org/10.1016/j.chiabu.2017.08.010
- Haight, S. C., Ko, J. Y., Tong, V. T., Bohm, M. K., & Callaghan, W. M. (2018). Opioid use disorder documented at delivery hospitalization—United States, 1999-2014. *Morbidity and Mortality Weekly Report*, *67*, 845–849.
- Hargraves, D., White, C., Frederick, R., Cinibulk, M., Peters, M., Young, A., & Elder, N. (2017). Implementing SBIRT (Screening, Brief Intervention and Referral to Treatment) in primary care: Lessons learned from a multi-practice evaluation portfolio. *Public Health Reviews*, *38*(1), 31. https://doi.org/10.1186/s40985-017-0077-0
- Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). *Telemedicine and E-Health*, *19*(6), 444–454.
- Hostage, j. C., Brock, J., Craig, W., & Sepulveda, D. (2020). Integrating Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use into Prenatal Care. *Maternal and Child Health Journal*, *24*, 412–418.
- Jumah, N. A. (2016). Rural, Pregnant, and Opioid Dependent: A Systematic Review. *Substance Abuse: Research and Treatment*, *10*(Suppl. 1), 35–41.
- Montana Healthcare Foundation. (2017). *Medicaid's role in the delivery and payment of susbtance use disorder services in Montana.* https://mthcf.org/wp-content/uploads/2018/01/Medicaids-Role-in-the-Delivery-and-Payment-of-SUD.pdf
- Patrick, S. W., Davis, M. M., Lehman, C. U., & Cooper, W. O. (2015). Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2000-2009. *Journal of Perinatology*, *35*(8), 667.
- Prindle, J. J., Hammond, I., & Putnam-Hornstein, E. (2018). Prenatal substance exposure diagnosed at birth and infant involvement with child protective services. *Child Abuse & Neglect*, *76*, 75–83.
- Schiff, D. M., Nielsen, T., Terplan, M., Hood, M., Bernson, D., Diop, H., Bharel, M., Wilens, T. E., LaRochelle, M., Walley, A. Y., & Land, T. (2018). Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. *Obstetrics & Gynecology*, *132*(2). https://journals.lww.com/greenjournal/Fulltext/2018/08000/Fatal_and_Nonfatal_Overdose_Among_Pregnant_and.26.aspx
- Smid, M. C., Stone, N. M., Baksh, L., Debbink, M. P., Einerson, B. D., Varner, M. W., Gordon, A. J., & Clark, E. A. S. (2019). Pregnancy-Associated Death in Utah: Contribution of Drug-Induced Deaths. *Obstetrics & Gynecology*, *133*(6). https://journals.lww.com/greenjournal/Fulltext/2019/06000/Pregnancy_Associated_Death_in_Utah__Contribution.9.aspx
- Strahan, A. E., Guy, G. P., Jr, Bohm, M., Frey, M., & Ko, J. Y. (2020). Neonatal Abstinence Syndrome Incidence and Health Care Costs in the United States, 2016. *JAMA Pediatrics*, *174*(2), 200–202. https://doi.org/10.1001/jamapediatrics.2019.4791

Thank you for joining us!

By attending today's event you are strengthening the ability of your mission driven, community based, patient-directed health center deliver comprehensive, culturally competent, high quality primary care services.

To learn about other upcoming CHAMPS events, visit: http://champsonline.org/events-trainings/distance-learning/upcoming-live-distance-learning-events

CHAMPS

Community Health Association of Mountain/ Plains States

Please complete the evaluation, including the CME section if you wish to receive CME credit, by Thursday, February 24, 2022: https://www.surveymonkey.com/r/MHLC2022