Perinatal Mental Health Learning Community
Group Office Hours July 15, 2021  12 – 1 p.m.

Staff & Patient Education About PMH
Substance Use Disorders & Perinatal Mental Health

Guest Speaker: Margaret Lynn Yonekura, MD, FACOG
Perinatal Behavioral Health Physician Champion,
CommonSpirit Health
Housekeeping

- Everyone is automatically muted upon entry. You can unmute yourself when you wish to speak.
- We’d like to see you on video!
- Use “Chat” to make comments or ask questions.

Speaker View: large view of the person currently speaking.
Gallery View: images of all attendees in smaller individual squares.
Our Team

Anna King
Clinical Training Specialist, Maternal Mental Health NOW

Gabrielle Kaufman
Clinical Director, Maternal Mental Health NOW

Kelly O’Connor-Kay
Executive Director, Maternal Mental Health NOW

Barbara Sheehy
System Director, Perinatal Behavioral Health CommonSpirit Health

Julia Slininger
Program Manager, PMH Learning Community Hospital Quality Institute

Boris Kalanj
Director of Programs, Hospital Quality Institute
Timeline – *Perinatal Mental Health Learning Community*

**2020**
- Jan
- Apr
- Jul
- Dec

**2021**
- Jan
- Jul
- Dec

### Education and Technical Assistance (Feb ’20 - Dec ‘21)
- **Group Office Hours** (2020: Mar, May, Jul, Sept, Nov; 2021: Jan, Mar, May, Jul, Sept, Nov)
  - 1:1 Technical Assistance (on demand)
  - In-Person Regional Events (Nov ‘20)

### Training Tools and Resources (Apr ‘20 – Dec ‘21)
- E-learning module and quick reference guide for staff
- E-learning module for patients
- Brochure template

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**Case Studies Developed**

**Case Studies Available**
Past Topic Recordings Available

- Staff education on perinatal mental health
- Patient and family information & education
- Resource and referral development
- The Impact of Covid 19 on Hospitals and Birthing Families
- Disparities in Perinatal Mental Health Care
- Supporting Patients with Perinatal Loss
- Supporting NICU Families
- Birth Trauma and Perinatal Mental Health
- Substance Use Disorders and Perinatal Mental Health

Recordings and slides available on program website:
https://www.hqinstitute.org/pmh-learning-community
## Remaining Topics in 2021

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Presenter</th>
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</thead>
<tbody>
<tr>
<td>August 19</td>
<td>Child Abuse Reporting and PMH Webinar</td>
<td>Patricia Taylor Anna King</td>
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<tr>
<td>September 16</td>
<td>Child Abuse Reporting and PMH Office Hour</td>
<td>Patricia Taylor Anna King</td>
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<tr>
<td>October 21</td>
<td>Breastfeeding and PMH Webinar</td>
<td>Nakeisha Robinson</td>
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<td>November 18</td>
<td>Breastfeeding and PMH Office Hour</td>
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<tr>
<td>December 16</td>
<td>Fathers and Partners and PMH Webinar</td>
<td>Kevin Gruenberg</td>
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Register on program website:  
[https://www.hqinstitute.org/pmh-learning-community](https://www.hqinstitute.org/pmh-learning-community)
Save the Dates: Capstone Events!

Northern California: **Dec 8, 2021**
Mercy San Juan Medical Center (Sacramento)

Southern California: **Dec 10, 2021**
San Antonio Regional Hospital (Upland)
**Goal:** Prevent severe post-partum depression

*Here are the "Asks":*

1) Do all your perinatal staff members have a good understanding of how they can be helpful?

2) Does your hospital have a systematic way to provide information and resources to every patient?
Levels of MMH Programming

**Level 1:** Deployment of training – online or other- and patient information + resources.

**Level 2:** Documented protocol regarding patient and provider education, and maintaining a list of current referral resources

**Level 3:** Implementation of comprehensive education, screening and referral program for maternal mental health disorders, including data collection
In Focus for June and July: Substance Use Disorders

Learning Objectives:

- Learn about substance use disorders and their potential co-occurrence with perinatal mental health disorders.
- Learn how staff in perinatal care units can screen and help patients suffering from substance use disorders in the perinatal period.
Guest Speaker: Margaret Lynn Yonekura, MD, FACOG

Specialist in Maternal Fetal Medicine
Perinatal Behavioral Health Physician
Champion, CommonSpirit Health
Executive Director, Los Angeles Best Babies Network
Prevalence of Substance Use Disorders and PMADs

Perinatal Mood and Anxiety Disorders

- Depression
- Anxiety
- Panic Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Bipolar Disorder
- Postpartum Psychosis

Dignity Health
California Hospital Medical Center

MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families

Hospital Quality Institute
- Use person-first language
- The change shows that a person “has” a problem, rather than “is” a problem.
- The terms avoid eliciting negative associations, punitive attitudes, and individual blame
- It’s a misconception that pharmacotherapy merely “substitutes” one drug or “one addiction” for another.
• **Why?**: Identification of substance use during pregnancy allows for interventions aimed at improving maternal and fetal health, by linking to appropriate **services and supports**
  – A **golden opportunity** to change the lifecourse of 2 generations

• **When?**: First prenatal visit and each trimester, including PP; admission to hospital

• **Who?**: All patients

• **How?**: Using a validated screening tool
The 5 P’s

- Parents: Did any of your parents have a problem with alcohol or other drug use?
- Partner: Does your partner have a problem with alcohol or drug use?
- Peers: Do any of your peers have a problem with alcohol or drug use?
- Past: In the past, have you had difficulties in your life because of alcohol or drug use, including prescription medications?
- Pregnancy: Since becoming pregnant, have you used alcohol or other drugs?

Scoring: Any “yes” should trigger further questions
Pregnancy and Co-Occurring Disorders

Margaret Lynn Yonekura, M.D., FACOG
July 15, 2021
MMH Now and IHI
Case Study

• Katie is a 26 yo. G4P4 who is 2 mo. PP. She was referred to treatment by her DCFS worker because of her alcohol abuse; her infant is in foster care. Her other 3 children were also removed from her custody 2 years ago.

• During her intake, you discover the following:
  – Katie is currently homeless because she finally left her abusive husband.
  – She has been considered suicide lately because of her overwhelming guilt about being a failure as a mother and wife.
  – She remembers drinking since she was about 12 years old. She drinks to lessen the “feelings of sadness and feeling down”. She also reports that she feels “just as bad, if not worse” if she stops the drinking.
Next Steps: Discussion
• To evaluate her “alcohol abuse”:
  – 5 Ps
    • Parents: both parents drank excessively
    • Partner: drank excessively; occasionally used weed or meth
    • Peers: binge drank on week-ends with friends; occasionally used weed
    • Past: been drinking since age 12; has tried to quit in the past but was too busy with her children to stay in treatment and husband disapproved
    • Present: tried to cut back during pregnancy but resumed drinking in third trimester

– NIDA Quick Screen
Since becoming pregnant, how often have you used the following*:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost daily</th>
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</thead>
<tbody>
<tr>
<td>1. Alcohol (&gt;3 drinks/day)</td>
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<td>X</td>
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<td>2. Tobacco products</td>
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<td>3. Prescription drugs for nonmedical reasons</td>
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<td>4. Illegal drugs including marijuana</td>
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If the patient says “NO” for all drugs in the Quick Screen, reinforce abstinence. Screening is complete.

If the patient says “Yes” to one or more days of heavy drinking, she is an *at risk drinker*.

If the patient says “Yes” to any tobacco use, advise to quit.

If the patient says “Yes” to use of illegal drugs or prescription drugs for non-medical reasons, proceed to **Question 1 of the NIDA-Modified ASSIST**
2. **In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc)?**

<table>
<thead>
<tr>
<th>Substance Description</th>
<th>Never</th>
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<th>Monthly</th>
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<tr>
<td>b. Cocaine (coke, crack, etc.)</td>
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3. **During the past 3 months**, how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?

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4. **During the past 3 months**, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?

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<td>5. Has a friend or relative or anyone else <strong>ever</strong> expressed concern about your use of (first drug, second drug, etc)?</td>
<td>No, never</td>
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<td>Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc.)?</td>
<td>No, never</td>
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<td>j</td>
<td>Other – Specify:</td>
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</table>
Instructions: Ask Question 7 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

7. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?
   [ ] Yes
   [ ] No, never

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
  - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussion of the risks associated with injecting.
  - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.
For Katie: score of 10 for cannabis plus High Risk for drinking alcohol
Katie’s Scores

#1 3  
#2 3  
#3 3  
#4 3  
#5 2  
#6 3  
#7 3  
#8 3  
#9 2  
#10 3  
Total = 28
Columbia Suicide Severity Rating Scale

<table>
<thead>
<tr>
<th>Ask questions 1 and 2</th>
<th>Past month</th>
<th>Katie</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>YES</td>
<td>Yes</td>
</tr>
<tr>
<td>2) Have you had any actual thoughts of killing yourself?</td>
<td>NO</td>
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</table>

If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

<table>
<thead>
<tr>
<th>3) Have you been thinking about how you might do this?</th>
<th>Lifetime</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>e.g. &quot;I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.&quot;</td>
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<thead>
<tr>
<th>4) Have you had these thoughts and had some intention of acting on them?</th>
<th>Lifetime</th>
<th>No</th>
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<tbody>
<tr>
<td>as opposed to &quot;I have the thoughts but I definitely will not do anything about them.&quot;</td>
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<thead>
<tr>
<th>5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</th>
<th>Past 3 Months</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills; but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</td>
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If YES, ask: Was this within the past 3 months?
Adverse Childhood Experience (ACE) Questionnaire

Name: ___________________________ Date: ___________________________

This Questionnaire will be asking you some questions about events that happened during your childhood; specifically the first 18 years of your life. The information you provide by answering these questions will allow us to better understand problems that may have occurred early in your life and allow us to explore how those problems may be impacting the challenges you are experiencing today. This can be very helpful in the success of your treatment.

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often:
   - Swear at you, insult you, put you down, or humiliate you?
     - Yes ☐ No ☐ If Yes, enter __________
   - Act in a way that made you afraid that you might be physically hurt?
     - Yes ☐ No ☐ If Yes, enter __________

2. Did a parent or other adult in the household often:
   - Push, grab, slap, or throw something at you?
     - Yes ☐ No ☐
   - Ever hit you so hard that you had marks or were injured?
     - Yes ☐ No ☐ If Yes, enter __________

3. Did an adult or person at least 5 years older than you ever:
   - Touch or fondle you or have you touch their body in a sexual way?
     - Yes ☐ No ☐
   - Attempt or actually have oral, anal, or vaginal intercourse with you?
     - Yes ☐ No ☐ If Yes, enter __________

4. Did you often feel that:
   - No one in your family loved you or thought you were important or special?
     - Yes ☐ No ☐

5. Did you often feel that:
   - You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you?
     - Yes ☐ No ☐ If Yes, enter __________
   - Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
     - Yes ☐ No ☐ If Yes, enter __________

6. Were your parents ever separated or divorced?
   - Yes ☐ No ☐ If Yes, enter __________

7. Were any of your parents or other adult caregivers:
   - Often pushed, grabbed, slapped, or had something thrown at them?
     - Yes ☐ No ☐
   - Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
     - Yes ☐ No ☐
   - Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
     - Yes ☐ No ☐ If Yes, enter __________

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   - Yes ☐ No ☐ If Yes, enter __________

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   - Yes ☐ No ☐ If Yes, enter __________

10. Did a household member go to prison?
    - Yes ☐ No ☐ If Yes, enter __________

ACE SCORE (Total “Yes” Answers): ________
# The HITS Screening Tool for Domestic Violence

<table>
<thead>
<tr>
<th>How Often Does Your Partner</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Fairly Often</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically hurt you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Insult or talk down to you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Threaten you with harm</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scream or curse at you</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

* A total score of more than 10 is suggestive of intimate partner violence. This information, called R3, is available as a free Android or iPhone app. From Sherin et al.\(^5\)

Katie’s score: 20
Assessment Based on Screening Tests

- Parents, partner, and peers drank excessively and occasionally used weed
- She’s been drinking excessively since age 12
- Tried to cut back in pregnancy but resumed drinking in third trimester
- NIDA Modified ASSIST revealed: Severe AUD and moderate cannabis use disorder
- EPDS = 28
- Columbia Suicide Severity Rating Scale = needs Behavioral Health referral
- ACEs Score = 10
- HITS Score = 20
- Currently homeless
- Has an open DCFS case
- Children need evaluation by Regional Center to r/o FASD
• **PTSD** is an exaggerated fear response that occurs following exposure to one or more extremely upsetting events. Such events can include, war, terrorist attack, threatened or actual physical or sexual violence, being kidnapped, natural and man-made disasters, and serious MVA. **People with PTSD report the most distressing trauma to be sexual abuse before age 18 years.**

• Symptoms are grouped into 4 categories:
  – **Intrusive, persistent re-experiences of the trauma**, including recurrent dreams or nightmares, flashbacks, and distressing memories
  – **Persistent avoidance** of people places, objects, and events that remind the person of the trauma or otherwise trigger distressing memories, thoughts, feelings, and physiological reactions
  – **Negative alterations in cognition and mood**, such as memory loss (particularly re details surrounding the event), self-blame, guilt, hopelessness, social withdrawal, and an inability to experience positive emotions
  – **Marked alterations in arousal and reactivity**, such as experiencing sleeplessness or feeling “jumpy”, “on edge”, easily startled, irritable, angry, or unable to concentrate
There is a strong association between PTSD and substance misuse including lifetime SUDs and lifetime AUD.

The presence of 12-month or lifetime PTSD is associated with a 1.3 to 1.5 increased odds of having a past-year or lifetime SUD.

Comorbid PTSD and addiction are highly complex and associated with worse treatment outcomes (including lower rates of remission and faster relapse), poorer treatment response, more cognitive difficulties, worse social functioning, greater risk of suicide attempt, and heightened mortality.

Compared to people with PTSD or AUD alone, those with both report more traumatic childhoods, more psychiatric comorbidities, an increased risk of suicide, more severe symptoms, and greater disability.

People with PTSD tend to misuse the most serious substances (stimulants, opioids); however, misuse of prescriptions medications, cannabis and alcohol also are common.
Treatment of PTSD and SUDs

- Historically, there has been a debate about whether to treat PTSD and addiction concurrently or sequentially, with most providers falling on the side of treating the SUD separately and first.
- **Integrated, concurrent treatment that addresses both conditions simultaneously** is preferable to clients and is increasingly considered the current standard of care, particularly when combining psychosocial and pharmacologic approaches.
- Do not try to provide trauma exploration treatment in view of the potential for highly destabilizing effects.
- Provide present-focused psychoeducation about PTSD, such as teaching the client to recognize symptoms of the disorder and how to cope with them.
- People with PTSD and substance misuse are more likely to experience further trauma than people with substance misuse alone.
- Repeated trauma is common in domestic violence, child abuse, and some substance-using lifestyles (e.g., drug trade), so **helping the client protect against future trauma** is an important part of treatment.
- Given the **high prevalence of self-harm** in this population, you should **screen for suicide risk early on and throughout the course of care.** Risk of suicide in people with PTSD is correlated with a history of childhood maltreatment and more severe PTSD symptoms – especially ones concerning negative mood and cognition.
• SAMHSA Treatment Improvement Protocol #42. Substance Use Disorder Treatment for People with Co-Occurring Disorders. Updated 2020.
• Trust for America’s Health & Well Being Trust. Pain in the Nation: Alcohol, Drug and Suicide Epidemics. Special Feature: COVID-19 and Trauma. May 2021
• Massachusetts Child Psychiatry Access Program (MCPAP) for Moms. Obstetric Provider Toolkit. www.mcpapformoms.org
Provider Toolkit Table of Contents

Assessment and Management of Perinatal Mood and Anxiety Disorders

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- Edinburgh Postnatal Depression Scale (EPDS)
- Assessment of Depression Severity and Treatment Options
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- Summary of Emotional Complications During Pregnancy and the Postpartum Period
- Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women
- Recommended Steps before Beginning Antidepressant Medication Algorithm
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Assessment and Management of Perinatal Substance Use Disorders (SUDs)

- Screening and Brief Intervention for Substance Use in Pregnancy (SUD1)
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- Treatment Options for Perinatal Substance Use Disorders (SUD3)
- Choosing a Medication for the Treatment of Opioid Use Disorder (OUD) (SUD4)
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- Summary of Impact and Management of Substance Use during the Perinatal Period (SUD 7/8)
### Assessment of Depression Severity and Treatment Options

<table>
<thead>
<tr>
<th>EPDS Score</th>
<th>Limited to No Symptoms</th>
<th>Mild Symptoms</th>
<th>Moderate Symptoms</th>
<th>Severe Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-8</td>
<td>Reports occasional sadness</td>
<td>Mild apparent sadness but brightens up easily</td>
<td>Reports pervasive feelings of sadness or gloominess</td>
<td>Reports continuous sadness and misery</td>
</tr>
<tr>
<td>9-13</td>
<td>Placid - only reflecting inner tension</td>
<td>Occasional feelings of edginess and inner tension</td>
<td>Continuous feelings of inner tension/intermittent panic</td>
<td>Unrelenting dread or anguish, overwhelming panic</td>
</tr>
<tr>
<td>14-18</td>
<td>Sleeps as usual</td>
<td>Slight difficulty dropping off to sleep</td>
<td>Sleep reduced or broken by at least two hours</td>
<td>Less than two or three hours sleep</td>
</tr>
<tr>
<td>19-29</td>
<td>Normal or increased appetite</td>
<td>Slightly reduced appetite</td>
<td>No appetite - food is tasteless</td>
<td>Needs persuasion to eat</td>
</tr>
<tr>
<td>30-39</td>
<td>No difficulties in concentrating</td>
<td>Occasional difficulty in concentrating</td>
<td>Difficulty concentrating and sustaining thoughts</td>
<td>Unable to read or converse without great initiative</td>
</tr>
<tr>
<td>40-49</td>
<td>No difficulty starting everyday activities</td>
<td>Mild difficulties starting everyday activities</td>
<td>Difficulty starting simple, everyday activities</td>
<td>Unable to do anything without help</td>
</tr>
<tr>
<td>50-59</td>
<td>Normal interest in surroundings &amp; friends</td>
<td>Reduced interest in surroundings &amp; friends</td>
<td>Loss of interest in surroundings and friends</td>
<td>Emotionally paralyzed, inability to feel anger, grief or pleasure</td>
</tr>
<tr>
<td>60-69</td>
<td>No thoughts of self-reproach, inferiority</td>
<td>Mild thoughts of self-reproach, inferiority</td>
<td>Persistent self-accusations, self-reproach</td>
<td>Delusions of ruin, remorse or unredeemable sin</td>
</tr>
<tr>
<td>70-79</td>
<td>No suicidal ideation</td>
<td>Fleeting suicidal thoughts</td>
<td>Suicidal thoughts are common</td>
<td>History of severe depression and/or active preparations for suicide</td>
</tr>
</tbody>
</table>

### Signs and Symptoms of Depression

- *Signs and symptoms in each column may overlap*

### Treatment Options

- *Treatment options in each column may overlap*

**Limited or no symptoms of depression**

- **Mild Symptoms**
  - Consider medication
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)
- **Moderate Symptoms**
  - Consider inpatient hospitalization when safety or ability to care for self is a concern
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)
- **Severe Symptoms**
  - Consider inpatient hospitalization when safety or ability to care for self is a concern
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)

**Limited to no symptoms**

- **Mild Symptoms**
  - Consider medication
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)
- **Moderate Symptoms**
  - Consider inpatient hospitalization when safety or ability to care for self is a concern
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)
- **Severe Symptoms**
  - Consider inpatient hospitalization when safety or ability to care for self is a concern
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)

**Severe symptoms of depression**

- **Limited or no symptoms**
  - Consider medication
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)
- **Moderate Symptoms**
  - Consider inpatient hospitalization when safety or ability to care for self is a concern
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)
- **Severe Symptoms**
  - Consider inpatient hospitalization when safety or ability to care for self is a concern
  - Therapy for mother
  - Dyadic therapy for mother/baby
  - Community/social support (including support groups)
Screening and Brief Intervention for Substance Use in Pregnancy

All women should be screened for substance use at the first prenatal visit using a screening tool; e.g., the Modified NIDA Quick Screen (Modified NIDA) (see SUD).

If positive screen on Modified NIDA, had abstinence urine test, or clinical suspicion (see SUD), woman is at risk

Brief Assessment
1. “What substances have you been using in the past 3 months? During this pregnancy?”
2. “How much of each substance have you been using at a time?”
3. “How frequently are you using them?”
4. “How does this affect your life (job, home, life, self-care, health, emotions)?”
5. “Are you being treated for an SUD? Have you had prior treatment?”

If negative screen, then woman is lower risk

Educate
1. Provide brief education about recommendations to not use alcohol, tobacco, cannabis, Illicit opioids, or other drugs.
2. Encourage the patient to ask for help in the future, as needed.

Stratify into risk groups

High Risk
Current: Opioid use or binge pattern/ heavy use of any substance(s) or release of any SUD

Moderate Risk
Current: Low level use of non-opioid substances, engaged in MAT, or other SUD treatment
History: High use in past and/or past treatment for SUD

Low Risk
Current: No use
History: Low-level use prior to learning of pregnancy

Brief Intervention
1. “How ready are you to quit now?” Ask the patient to rate this motivation on a scale from 1-10.
2. “How confident are you that you can stop?” Ask the patient to rate their confidence on a scale from 1-10.
3. “Why did you rate that way?”
4. “How can we increase this score?”

Create Treatment and Monitoring Plan
1. Refer to or provide medication treatment for opioid/alcohol use (see SUD)
2. Recommend non-pharmacological treatment (see SUD)
3. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester
   - Urine testing at least once per trimester
   - Check MassPAT at each visit
4. Identify who will coordinate Plan of Safe Care (see SUD)
5. Call MCPAP for Moms with questions

MAT: medication for addiction treatment
SUD: substance use disorder
OUD: opioid use disorder
MassPAT: Massachusetts Prescription Awareness Tool

Is there an active need for a referral to treatment?

Yes

Monitor and Refer to Treatment
1. Counseling on MAT in pregnancy (see SUD) and non-pharmacological treatment (see SUD)
2. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester
   - Urine testing at least once per trimester
   - Check MassPAT at each visit
3. If already in treatment, contact SUD provider
4. Identify who will coordinate Plan of Safe Care (see SUD)
5. Call MCPAP for Moms with questions

No

For all women with any opioid use or on MAT for OUD, discuss:

- Opioidcece on (see SUD)
- MAT during pregnancy/postpartum (see SUD)
- Neonatal Opioid Withdrawal Syndrome (NOWS) - a.k.a. Neonatal Abstinence Syndrome (NAS)
- Pain management (see SUD)
- Plan of Safe Care and DCF reporting (see SUD)

Call MCPAP for Moms at: 855-MOM-MCPAP (855-666-6272)  www.mcpapformoms.org

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Q&A, Discussion, Sharing
Coming Up

**August 19:** Webinar (Noon – 1 pm)

   Child Abuse Reporting and Perinatal Mental Health

**September 16:** Group Office Hours (Noon – 1 pm)

   ✓ Staff & Patient Education About PMH
   ✓ Child Abuse Reporting and Perinatal Mental Health

Register on HQI website: [https://www.hqinstitute.org/pmh-learning-community](https://www.hqinstitute.org/pmh-learning-community)
Meeting Evaluation

Polling question: “Attending today's Group Office Hours was a good use of my time.”

- Agree
- Disagree
- Unsure

Open Text feedback – type into Chat: “What could we have done better or differently?”