Kansas Perinatal Community Collaboratives
Mental Health Integration Plan Overview

Introduction

This Mental Health Integration Plan and associated toolkit has been created through the work of many state and local partners with a shared interest in providing coordinated and comprehensive services to women before, during and after pregnancy. It has been endorsed by the Kansas Maternal and Child Health Council (KMCHC). Information contained in the toolkit is based on sound research and recommendations from the US Preventive Services Task Force* (USPSTF) and the Substance Abuse and Mental Health Services Administration* (SAMHSA). Screening and crisis intervention algorithms have been adapted from those developed by the Minnesota Department of Health. The plan and toolkit have been developed for use by the Kansas Perinatal Community Collaboratives utilizing the March of Dimes Becoming a Mom® (BaM) curriculum in a group setting.

Plan Steps

1. All BaM group facilitators and support staff (including case management staff) are strongly encouraged to participate in a Mental Health First Aid course. Go to https://www.mentalhealthfirstaid.org/take-a-course/find-a-course/ for training dates and locations near you.
2. Prepare for implementation by utilizing the accompanying "Information on Implementing Screening for Perinatal Mood and Anxiety Disorders for Kansas Community Collaboratives Utilizing the March of Dimes Becoming a Mom® Curriculum" document.
3. All sites will develop a local perinatal mental health committee of partnering providers/agencies focused on perinatal mental health and the development of screening, referral, and follow-up procedures within the community to support and sustain a comprehensive approach. A template for creating local policy on *Screening for Perinatal Mood and Anxiety Disorders* (PMAD) is provided in this toolkit for use if not already developed. Policy must assure an *adequate system of care* is in place to best meet client needs. Priority should be given to establishing protocol related to perinatal depression screening during BaM sessions.
4. Standardized mental health curriculum content is integrated into sessions two and six of the BaM curriculum. Curriculum for session two includes the handout "Relieving stress and being active". For session six it includes the handout "Stress, baby blues, and postpartum depression". Along with the Edinburgh Postnatal Depression Scale (EPDS) (or other evidence-based screening tool strongly supported by research and recommended by local perinatal mental health committee) administered as noted in number 5 below, the following handouts will be provided and reviewed during session six: "Action Plan for Depression and Anxiety Around Pregnancy" and "Depression or Anxiety During and After Pregnancy" to the pregnant woman, and "Moms' Mental Health Matters: Talk About Depression and Anxiety Around Pregnancy" to the support persons in the group (from the National Institutes of Health - *Moms' Mental Health Matters* campaign). Additionally, the "My Maternal Wellbeing Plan" should be provided and worked through during the discussion, so that mom and her support person leave class with a plan in place. All handouts can be accessed under "Patient Education Resources" in the accompanying online toolkit.
5. Resources from the Postpartum Resource Center of Kansas, Postpartum Support International, local mental health providers, and those chosen from the accompanying "Mental Health Integration - Resource/Reference Guide for Providers", or as selected by the local perinatal mental health committee, will be integrated as a part of the curriculum resource component. Sites are encouraged to invite a community partner providing mental health services (such as the community's mental health clinic), to present as a guest speaker, further supporting messaging around the importance of mental health care and accessing such services in the community.

6. The babybuffer.org website and Rx card (sponsored by the Kansas Chapter of the American Academy of Pediatrics) should be integrated into session two, to support the messaging around the effects of stress in pregnancy and the wiring of the infant's brain. Sites will choose either the Brain Builders video from the Alberta Family Wellness Initiative or the video on the babybuffer.org website home page, to show during the group session as another way of communicating this message to participants. Sites are encouraged to invite a community partner providing early childhood services (such as Early Head Start, Tiny K, child care partners, etc.), to present as a guest speaker, further supporting this consistent messaging.
7. Mental health screening is standardized with the implementation of the EPDS (or other evidence-based screening tool strongly supported by research and recommended by local perinatal mental health committee) during sessions two and six (following recommended screening guidelines of ideally once per trimester, or at least once prenatally). Additionally, during session two, all group participants, including support people, may complete the "Stress Quiz" or similar type screening tool (may use "Stress Quiz" provided in accompanying online toolkit or may incorporate locally recommended screening tool identified by perinatal mental health committee) to create a self-awareness of stress level and associated risks.
8. A local Mental Health Resources directory will be developed by the perinatal mental health committee, to include the resource name and location, contact information (including 24-hour hotline numbers if available), hours of service, level of services provided, and payment source options (i.e. what insurance is accepted by each provider/agency, or if there is a sliding-fee scale, etc.). This directory should be included in the resource section of session two and reviewed with participants during the session, and referenced again during session six. A template is provided in the accompanying online toolkit for local adaption.
9. The EPDS (or other evidence-based screening tool strongly supported by research and recommended by local perinatal mental health committee) will be scored by support staff during the BaM sessions, using the scoring instructions on the back side of the EPDS tool (or accompanying selected screening tool), and participants will be approached and referred as determined by local procedures that are included in the accompanying "Ideal Work Flow: Screening for Perinatal Mood and Anxiety Disorders in the Becoming a Mom® Group Setting" and "Ideal Work Flow: Crisis Intervention following Screening for Perinatal Mood and Anxiety Disorders in the Becoming a Mom® Group Setting". Sites should utilize the accompanying "Edinburgh Postnatal Depression Scale Tip Sheet" as part of staff training on EPDS implementation.
10. Sites are encouraged to use their local perinatal mental health committee to develop and integrate a postpartum screening and follow-up process, utilizing local home visitation programs/services, WIC, Title X Family Planning appts., postpartum check-up with OB Provider, and well-child visits as designated screening opportunities (following recommended screening guidelines between 2-4 weeks postpartum, 8-12 weeks postpartum, and 9-12 months postpartum).

*The USPSTF makes recommendations about the effectiveness of specific preventive care services, based on the evidence of both the benefits and harms of the service and an assessment of the balance. "The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up." (Siu, 2016) All evidence demonstrates that "depression is common in postpartum and pregnant women and affects not only the woman, but her child as well". "Almost one in five women get depressed at some time in their lifetime. This percentage goes up in stressful situations, like being a mother with young children. Among young women in home visiting, WIC, and Early Head Start and Head Start programs, nearly half may be depressed." (Depression in Mothers: More than the Blues, 2014, p.2) "The USPSTF found adequate evidence that programs combining depression screening with adequate support systems in place improve clinical outcomes in adults, including pregnant and postpartum women. (Siu, 2016) It is hoped that this plan and toolkit will assist your program and its partnering providers and community agencies to establish that "adequate system of care", each serving a unique role to assure the most comprehensive and coordinated services and support system available to the perinatal population in your community.

Albert L. Siu, MD, MSPH and the US Preventive Services Task Force (USPSTF) Author Affiliations. *Screening for Depression in Adults US Preventive Services Task Force Recommendation Statement. JAMA*. 2016; 315 (4):380-387. Doi:10.1001/jama.2015.18392.

Substance Abuse and Mental Health Services Administration. Depression in Mothers: *More Than the Blues – A Toolkit for Family Service Providers*. HHS Publication No. (SMA) 14-4878. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Ideal Work Flow: Screening for Perinatal Mood and Anxiety Disorders (PMAD) in the Becoming a Mom® Group Setting

BaM facilitator or guest mental health specialist explains relationship between depression and health of pregnant/postpartum woman and her infant

Within the context of session 2 and 6 curriculum and mental health discussion, EPDS is administered

- Normalize the screening process with the group, by discussing it as a part of routine prenatal care
- Emphasize it is only a *screening* tool
- Give directions on EPDS completion
- Ensure privacy and confidentiality within the group setting; have participant turn EPDS over at her place when finished.
- Explain scoring and follow-up process
  Assist participants with completion as needed

BaM support staff collects the tool, scores the tool, and makes notation of any positive answer to #10 or total screen score of 10 or more

Is there a risk of self-harm or harm to others OR positive on #10?

YES

Risk of self-harm or harm to others:

Implement program crisis plan (**go to Crisis Intervention algorithm included in toolkit*)

- BaM facilitator/coordinator and support staff approach participant and her support person following the session, but prior to leaving, in a caring and confidential manner.
- Discuss concern related to risk of harm to self or others and assess if currently having active thoughts or has a plan
- Follow crisis plan according to level of response needed based on current thoughts/plans

NO

EPDS Score

9 or less

Participant is at lower risk PMAD

- Assess for sx's not reflected in score
- Through BaM sessions, participant has been provided with education regarding signs and symptoms to monitor for, stress-reducing techniques, and available resources. Continue with education
- Administer EPDS at next designated contact (session 2 or 6 of BaM or during PP follow-up, depending upon participant's EDD)

Result negative: Routine Care

10 or more

Participant is at higher risk PMAD
(10-12 moderate; 13-30 high)
Needs further evaluation

Implement program referral plan (as developed by your local perinatal mental health committee; may include the following, but should be adapted to a plan/procedure that fits your community and ensures an adequate system of care; please edit below to reflect local plan)

- Contact participant via designated contact mode (day of or day after screening, depending on time of day of session) to discuss score, and refer to OB/GYN and mental health provider (if applic.) – for appt. within next 2 weeks (fax EPDS that day or following day)
- If no existing provider, make referral to a new OB/GYN, primary care, and /or mental health provider
- Make warm referral to home visiting program in the community
  Document score and intervention

Follow up with participant to make sure she has received care within two weeks.

- Help problem solve with accessing care, if needed
- Get signed consent from client for follow-up communication with OB/Primary Care Provider and/or Mental Health Provider
- Give participant "Depression During and After Pregnancy" booklet by HRSA
- Document response and follow up

Adapted for Kansas Perinatal Community Collaboratives by the Kansas Department of Health and Environment, Bureau of Family Health, with review, recommendations, and endorsement by the Kansas Maternal Child Health Council, April 2016. Credit is given to the Minnesota Department of Health for their work to create the *Ideal Work Flow: Screening for Postpartum Depression/Anxiety in Well-Child Visits using EPDS*, Oct. 2015 http://www.health.state.mn.us/divs/cfh/topic/pmad/content/document/pdf/workflowepds.pdf Revised 10/2018

Ideal Work Flow: Crisis Intervention following Screening for Perinatal Mood and Anxiety Disorders (PMAD) in the Becoming a Mom® Group Setting

Further assess positive response to #10
- Is participant having <u>active</u> thoughts of harming self or others?
- Does participant have a plan for causing harm to self or others?

Active thoughts or plan of self-harm or harm to others

NO

YES

Arrange for same day or next day appointment (per plan as developed by local agency; may include the following, but should be adapted to a plan/procedure that fits your community and ensures an adequate system of care; edit below to reflect local plan)
- Ask participant to verbally contract for safety
- Discuss need for immediate appointment and follow-through
- Assess if participant is currently seeing a mental health provider or if requires a new referral
- Provide participant with local *Mental Health Resources Directory* and identify available services/providers
- Schedule same day or next day appointment with mental health provider
- Refer to OB/GYN or primary care provider for follow-up
- Assure participant has support person available to her and emergency plan in place in the event feelings/thoughts worsen
- Document event/intervention (including client's denial of current thoughts or plan)
- Fax EPDS and documentation to providers

Arrange for emergency services
(per plan as developed by local agency; may include the following, but should be adapted to a plan/procedure that fits your community and ensures an adequate system of care; edit below to reflect local plan)
- Discuss need for emergency services
- Identify emergency service options per local *Mental Health Resources directory* and local policy and procedure
- Assess if participant is willing to accept services

Willing to accept emergency services?

YES

NO

If participant accepts emergency services/ treatment:
- Assess if participant has support person available to transport to emergency service location
- Verbally contract for safety
- Arrange for transportation

If participant refuses emergency services/treatment:
- Have participant sign *Refusal of Transport for Evaluation* form
- Call for transport to facility i.e. hospital ER by law enforcement officer as per local protocol for mental health evaluation non-compliance

- Stay with participant until arrangements are made for client safety
- Collaborate with participant for care of child/ren (if applicable)
  - Consider friends, relatives, neighbors
  - Local emergency shelter or law enforcement if no other options
- Document to complete the intervention, including:
  - Participant condition
  - Contacts made
  - Arrangements made
  - Time of events

  *Send copy of documentation to applicable providers
- Contact care provider (primary care, OB, and or mental health provider) to inform of situation

***Contact supervisor at any point in this process (per agency policy)**

Follow-up
Debrief with supervisor

Contact participant next business day:
- Provide support
- Obtain updated status
- Plan for ongoing follow-up visits (by self or partnering program staff, as applicable based on available resources - Make warm referral if necessary to refer)

On follow-up visit with participant:
- Continue to evaluate mental health status
- Discuss experience
- Determine plan for mental health follow-up
- Help problem solve issues with accessing appropriate care
- Get signed consent from participant for follow-up communication with OB/Primary Care Provider and Mental Health Provider
- Stay focused on purpose of keeping baby and mom safe

Keep in touch with assigned therapist/provider:
- Minimum of monthly contact until participant is stable as determined by therapist/mental health provider

Adapted for use by Kansas Maternal and Child Health programs by the Kansas Department of Health and Environment, Bureau of Family Health, with review, recommendations, and endorsement by the Maternal Depression Screening Workgroup. Credit is given to the Minnesota Department of Health for their work to create the Crisis Intervention Algorithm. www.health.state.mn.us/divs/cfh/topic/pmad/content/document/pdf/crisisalg.pdf

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