Rethinking Maternal Mental Health Screening: Is There a Better Approach?

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Overview

- SBIRT Screening in Primary Care, Pediatrics, & OB-GYN
- Beyond SBIRT - other screening
- Screening in the perinatal period
- Importance of maternal mental health screening
- Should we be doing it differently?
Historical Overview

- Began as a partnership between SCF and CITC in 2004
- 1 of 7 grants in the nation
- CITC and SCF were only Tribal organizations
- Goal of providing access and links to treatment services
S-BIRT Approach

- Proactive approach/Early Intervention
- Customer-Owner driven and voluntary
- Part of ROUTINE care
S-BIRT Integration into Primary Care

Integrated Care Team Setting

Team includes:
- Physician
- Case Manager
- Certified Medical Assistant (CMA)
- Case Management Support
- AND……

Behavioral Health Consultants
- All Masters Level Therapists.
- Currently 13 BHCs spread throughout in Primary Care, 4 in Pediatrics, 1 in OBGYN, and 2 in Valley Native PCC
Behavioral Health Consultant (BHC)

- Consultation and education to providers and case managers on behavioral health issues
- Provide psycho-educational materials and workbooks to aid in treatment and understanding
- Screening, assessment, brief intervention, education and follow-up/monitoring for patients experiencing mental/medical health issues and life stresses
- Joint visits and care conferences with provider teams for complex cases
- Consultation with specialists, referral for longer term therapeutic interventions
Who is screened? How often?

- Every customer 11 years or older who visits the clinic is screened for alcohol and drug use.
- Ages 11-17 receive CRAFFT, 18+ years receive SBIRT
- Annually, if screened negative
- Every six months, if screened positive
Screening Process

- C/O first contact: CMA administers AUDIT (CRAFFFT is self-administered)

- Scores are calculated and need for further screening is determined.

- C/O second contact: PCP introduces BHC to come in and complete screening

- C/O third contact: BHC discusses results

- At risk behaviors identified
### Please complete questions 1-4 only

1. How often do you drink anything containing alcohol?
   - 0 □ Never
   - 1 □ Less than monthly
   - 2 □ Monthly
   - 3 □ Weekly
   - 4 □ 2-3 times/week
   - 5 □ 4-6 times/week
   - 6 □ Daily

2. How many drinks do you have on a typical day when you are drinking?
   - 0 □ 0-1 drink
   - 1 □ 2 drinks
   - 2 □ 3 drinks
   - 3 □ 4 drinks
   - 4 □ 5-6 drinks
   - 5 □ 7-9 drinks
   - 6 □ 10 or more

3. How often do you have four or more drinks on one occasion?
   - 0 □ Never
   - 1 □ Less than monthly
   - 2 □ Monthly
   - 3 □ Weekly
   - 4 □ 2-3 times a week
   - 5 □ 4-6 times a week
   - 6 □ Daily

4. Do you use non-prescription drugs (such as marijuana, cocaine, or heroin), or overuse any prescriptions such as Oxycontin?
   - 0 □ No
   - 1 □ Yes

**SCORE Q1-Q3:** __________ **SCORE Q4:** __________

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### BHC completes questions remaining questions.

5. How often during the last year have you found that you were not able to stop drinking once you had started?
   - 0 □ Never
   - 1 □ Less than monthly
   - 2 □ Monthly
   - 3 □ Weekly
   - 4 □ Daily or almost Daily

6. How often during the past year have you failed to do what was expected of you because of drinking?
   - 0 □ Never
   - 1 □ Less than monthly
   - 2 □ Monthly
   - 3 □ Weekly
   - 4 □ Daily or almost Daily

7. How often during the past year have you needed a drink first thing in the morning to get yourself going after a heavy drinking session?
   - 0 □ Never
   - 1 □ Less than monthly
   - 2 □ Monthly
   - 3 □ Weekly
   - 4 □ Daily or almost Daily

8. How often during the past year have you had a feeling of guilt or remorse after drinking?
   - 0 □ Never
   - 1 □ Less than monthly
   - 2 □ Monthly
   - 3 □ Weekly
   - 4 □ Daily or almost Daily

9. How often during the past year have you been unable to remember what happened the night before because of your drinking?
   - 0 □ Never
   - 1 □ Less than monthly
   - 2 □ Monthly
   - 3 □ Weekly
   - 4 □ Daily or almost Daily

10. Have you or someone else been injured because of your drinking?
    - 0 □ No
    - 1 □ Yes, but not in the past year
    - 2 □ Yes, during the past year

11. Has a relative, friend, doctor, or other health care worker been concerned about your drinking and suggested you cut down?
    - 0 □ No
    - 1 □ Yes, but not in the past year
    - 2 □ Yes, during the past year

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### AUDIT Score (total Q1-3 & Q5-11): ______

**Question 4 Score:** ______

### Positive Score:
- For women or men age 65 years or older, a score of 7 or higher on Questions 1-3
- For men under age 65, a score of 8 or higher on Questions 1-3
- For everyone, a score of 1 on Question 4

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**Southcentral Foundation**
Breakdown of Adult Positive Score

Service breakdown according to score:

- Brief Intervention (7/8* -15)
- Brief Therapy (16-19)
- Assessment/Referral to Tx (20+)
In Primary Care & OBGYN:

*Since 2006 have completed 96,452 screenings (10% of total visits)

*January-June 2012 screened 10,163 customers (39% of unique customers)
When SBIRT screening is complete...

- The BHC briefly discusses with the client their results and gives brief psychoeducation as related to their mental and physical health.

- Brief intervention is considered 1-5 sessions

- Examples of a brief intervention…
Standard Drinks & Standard Drinking Limits

- **For men:**
  No more than 4 drinks on any single day AND no more than 14 drinks per week

- **For women:**
  No more than 3 drinks on any single day AND no more than 7 drinks per week
Goals of Brief Intervention

- Harm Reduction
Stages of Change Model

- Pre-Contemplation
- Contemplation
- Preparation
- Action
- Maintenance

Assess readiness to change

Prochaska & DiClemente, 1986
Motivational Interviewing

- Respect for autonomy of patients and their choices
- Readiness to change must be taken into account
- Ambivalence is common
- Targets selected by the patient, not the expert
- Expert is the provider of the information
- Patient is the active decision-maker

Rollnick, 1994
Can Do

- The person must believe they be successful in behavior change
- Help strengthen “can do” attitude
- It is always the customer’s choice whether & how to change
When Brief Intervention Isn’t Enough

Utilize other parts of the SCF medical home

- Health Education
- Nutaqsiivik
- Family Health Resources
- Behavioral Health (Behavioral Urgent Response, Access to Recovery, Dena a Coy, Alaska Women’s Recovery Project, Naltrexone, Suboxone, etc)
Beyond SBIRT... Other Screening
The CRAFFT Screening Questions
Please answer all questions honestly; your answers will be kept confidential.

Part A
During the PAST 12 MONTHS, did you:

1. Drink any alcohol (more than a few sips)?
   - No
   - Yes

2. Smoke any marijuana or hashish?
   - No
   - Yes

3. Use anything else to get high?
   - No
   - Yes

   “anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”

Part B

1. Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
   - No
   - Yes

2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
   - No
   - Yes

3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?
   - No
   - Yes

4. Do you ever FORGET things you did while using alcohol or drugs?
   - No
   - Yes

5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
   - No
   - Yes

6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?
   - No
   - Yes
SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each "yes" response in Part B scores 1 point. A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score

DSM-IV Diagnostic Criteria (Abbreviated)

Substance Abuse (1 or more of the following):
- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):
- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

© Children’s Hospital Boston, 2009. This form may be reproduced in its exact form for use in clinical settings, courtesy of the Center for Adolescent Substance Abuse Research, Children’s Hospital Boston, 300 Longwood Ave, Boston, MA 02115, U.S.A., (617) 355-5433, www.ceasar.org.
Brief Interventions and referrals are based upon clinical judgment.
Impact from Screening Youth

- Emergency Department services at the Alaska Native Medical Center (ANMC) for alcohol related conditions or injuries in youth (ages 11-21) were reduced by more than 53%.
Questions:

Over the last 2 weeks, how often have you had any of the following?

1. How often have you felt down, have a depressed mood, or feel hopeless?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

2. How often do you have difficulty enjoying activities that you used to find pleasurable?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

If 2 or greater on 1 and/or 2 continue below:

3. Do you have trouble sleeping? Do you find yourself having trouble falling asleep, or staying asleep? Are you sleeping too much, or not enough?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

4. Do you feel your energy has decreased, that you are tired more than you used to be?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

5. Have you had a decrease - or an increase in your appetite? Have you lost or gained weight recently?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

6. Do you feel like a failure? Do you feel guilty about things?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

7. Do you have trouble concentrating on things? Do you find yourself jumping from one thing to another? Can’t stay focused on reading or a TV show?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

8. Do you feel you have slowed down, that you don’t get as much done in a day? Or are you just the opposite. Do you feel nervous, restless, just can’t seem to sit still?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

9. Have you ever thought of hurting yourself – or that you would be better off dead?
   - Less than 2 days (Not at all)
   - 3 to 6 days (Several Days)
   - 7 to 11 days (More than ½ the days)
   - Greater than 12 days (Almost Every Day)

Total score

Can you tell me, using the scale, how difficult have these problems been for you? (at work, getting along with other people, family, and children)?

Not at all    Somewhat    Very    Extremely
## Strengths and Difficulties Questionnaire

<table>
<thead>
<tr>
<th>Male/Female (circle)</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
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<tbody>
<tr>
<td>Considerate of other people’s feelings.</td>
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<tr>
<td>Restless, overactive, cannot stay still for long.</td>
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<tr>
<td>Often complains of headaches, stomach-aches or sickness.</td>
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<tr>
<td>Shares readily with other children, for example toys, treats, pencils.</td>
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<td>Often loses temper.</td>
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<td>Rather solitary, prefers to play alone.</td>
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<tr>
<td>Generally well behaved. Usually does what adults request.</td>
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<td>Many worries or often seems worried.</td>
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<td>Helpful if someone is hurt, upset or feeling ill.</td>
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<td>Constantly fidgeting or squirming.</td>
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<tr>
<td>Has at least one good friend.</td>
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<td>Often fights with other children or bullies them.</td>
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<td>Often unhappy, depressed or tearful.</td>
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<td>Generally liked by other children.</td>
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<td>Easily distracted, concentration wanders.</td>
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<tr>
<td>Nervous or clingy in new situations, easily loses confidence.</td>
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<tr>
<td>Kind to younger children.</td>
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<td>Often lies or cheats.</td>
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<td>Picked on or bullied by other children.</td>
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<tr>
<td>Often offers to help others (parents, teachers, other children).</td>
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<tr>
<td>Thinks things out before acting.</td>
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<td>Steals from home, school or elsewhere.</td>
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<tr>
<td>Gets along better with adults than with other children.</td>
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<tr>
<td>Many fears, easily scared.</td>
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<tr>
<td>Good attention span. Sees work through to the end.</td>
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Do you have any other comments or concerns?
Screening in the Perinatal Period: Preconception, Pregnancy, Postpartum/Parenting
Preconception Screening/Planning

- Opportunities at:
  - STD checks
  - +SBIRT in women
  - Plan B
  - negative pregnancy tests
  - SDQ
Positive Pregnancy Process

- Reason it began?
  - No structured intervention/assessment first trimester
- Missing important time to make changes-
  Alcohol/drugs
  Relationships
  Making decisions about pregnancy
  Start preparing for parenting
- No prenatal care in OBGYN until 10 weeks
BHC Interview

- Focus on feelings about pregnancy, pregnancy/birth history, DV, mental health

Opportunities:
- To identify hx of mood disorder, trauma history
- To use Motivational Interviewing for behavior change (especially nicotine, marijuana, even caffeine)
- To set goals for self/relationship/or parenting
- To bring up breastfeeding
Postpartum/Parenting

- All mom’s universally screened at six-week postpartum visit
Opportunities to expand/enhance screening and assessment

- When should be screening during pregnancy?
- In what settings?
- At 2 wk well baby visits?
Rethinking Maternal Mental Health Screening

Why screening during pregnancy / post partum is especially important.
- At least two – and possibly three - generations are impacted.
- Parental mental health has much larger impact on life-long health and mental health of child than we have realized.

What to screen?
- Evidence suggests current screening practices are too narrowly focused.
- Need screen that better captures range of common maternal mental health problems.

How - a screen that is both brief and adequately comprehensive.
- Ultra-brief screens now exist for most common mental health disorders.
- Combining ultra-brief screens into a brief and more comprehensive MMH screen worth considering.
Why mental health screening during pregnancy / post partum is especially important.

An intergenerational window of opportunity:

For the child parental mental illness is associated with:
- 70% increased risk of smoking by age 14.
- 230% increased risk of attempted suicide.
- 100% increased risk of alcohol use problems
- 130% increased risk of illicit drug use by age 14.
- 150% increased risk of depression
- 40% increased risk of heart disease decades later in life.
- And many other risks (See CDC-Adverse Childhood Experiences study results)
- Possible epigenetic programming risks (three generation impact)

What to screen?

**Depression:**

- Impacts 10-20% of new mothers.
- 40-50% of mothers in high risk pregnancies.

What to screen?

Maternal Depression linked to:

- Elevated risk of suicide (20% of post partum deaths are due to suicide)
- Increased risk of preterm delivery
- Low birth weight baby
- Decreased maternal sensitivity
- Impaired parenting (lower rates of use of car seats, childproofing)
- Decreased reading and game playing with child.
- **Higher cortisol levels in infant (potential link to lifelong health problems)

What to screen?

Post Traumatic Stress Disorder (PTSD)

- **PTSD is more prevalent in perinatal women than among women overall in the general population (6-8% vs 4-5%).**
- Among American Indian (AI) population the lifetime rates of PTSD have been estimated at 15% with the rate for women at 19%. This is more than double that of Caucasians. It is also higher than risk for depression among AI population
- No formal data exists on life time prevalence of PTSD among Alaska Native mothers but clinical experience suggest it is high.

What to screen?

PTSD associated with:

Maternal PTSD is a risk factor for:
- Substance use during pregnancy
- Generalized anxiety disorder – 3x greater risk
- Major depression – 5x greater risk
- Panic disorder.
- Ectopic pregnancy, hyperemesis, excessive fetal growth, spontaneous abortion

PTSD amplifies the effects of maternal depression.
- Mothers with PTSD and depression have more severe depression
- Experience greater social isolation and lower overall functioning and greater parenting deficits

What to screen?

**Generalized anxiety disorder (GAD):**

- The prevalence of GAD during pregnancy is ~8.5%.
- With comorbid PTSD – generalized anxiety is 3x more likely.

What to screen?

Panic Disorder:

- High co-morbidity of Panic Disorder with PTSD, depression and sexual abuse.
- Panic disorder associated with considerable impairment of function
- Often easily treated.

What to screen?

PTSD during pregnancy – impact of comorbid trauma:

- Exposure only to non-abuse trauma 4%
- Abuse in adulthood only 11%
- Abuse in childhood only 16%
- Abuse in childhood and adulthood 39%

What to screen?

Depression during pregnancy – impact of comorbid trauma:

- No abuse history: 9%
- Abuse in adulthood only: 14%
- Abuse in childhood only: 17%
- Abuse in both childhood and adulthood: 32%

What to screen?

Alcohol use during pregnancy – impact of comorbid trauma:

- No abuse history: 13%
- Abuse in adulthood only: 24%
- Abuse in childhood only: 21%
- Abuse as both an adult and child: 29%

J S Seng et al. (2008) J Midwifery and Women’s Health
What to screen?

Tobacco use during pregnancy – impact of comorbid trauma:

- No abuse: 12%
- Abuse in adulthood only: 29%
- Abuse in childhood only: 28%
- Abuse as both an adult and child: 35%

What to screen?

Illicit drug use during pregnancy – impact of comorbid trauma:

- No abuse: 7%
- Abuse in adulthood only: 16%
- Abuse in childhood only: 22%
- Abuse as both an adult and child: 27%

J S Seng et al. (2008) J Midwifery and Women’s Health
What to screen?

Good reasons to screen for:
- Depression
- PTSD
- Generalized Anxiety Disorder
- Panic disorder
- Alcohol, drug and tobacco use
- Trauma – both current and past
  - Domestic violence
  - Consider adverse childhood experiences screen.
Designing a MMH screen that is brief, highly sensitive and adequately comprehensive – possible?

Design:

- Combine evidence-based ultra-brief screens (1-4 questions) for depression, anxiety disorders, substance use disorders and DV into single screening tool.
- It is possible to create a 15 question evidence-based screen that assesses with high sensitivity (1) Depression (2) PTSD (3) GAD (4) Panic disorder (5) alcohol (6) drug and (7) tobacco use and (8) DV.
- Positive screen followed by interview with mental health professional.
- Consider, carefully, adding questions on adverse childhood experiences.
- Untested design but reviewed with K. Kroenke, MD, who thought reasonable.

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