Hospital Quality Institute
Leadership in quality and patient safety

Perinatal Mental Health Learning Community

Webinar June 17 , 2021 12 – 1 p.m.

Substance Use Disorders & Perinatal Mental Health

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

CHCF

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

CommonSpirit

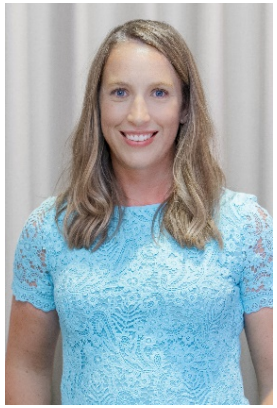
Housekeeping

- Everyone is automatically muted upon entry.
- Raise your hand if you'd like to be unmuted.
- Use "Chat" to interact with everyone ("all panelists and attendees.")
- Use "Q&A" to ask questions of panelists and organizers.
- Download slides from Chat.

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

Hospital Quality Institute

Program Website

https://www.hqinstitute.org/post/perinatal-mental-health-learning-community

Timeline – *Perinatal Mental Health Learning Community*

Education and Technical Assistance (Feb '20 - Dec '21)

- Webinars (2020: Feb, Apr, Jun, Aug, Oct, Dec; 2021: Feb, Apr, Jun, Aug, Oct, Dec)
- 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)

TODAY

Training Tools and Resources (Apr '20 – Dec '21)

- E-learning module and quick reference guide for staff
- E-learning module for patients
- Brochure template

Case Studies Developed	Case Studies Available

Hospital Quality Institute

AB-3032: Hospitals Maternal Mental Health Act

- It requires all birthing hospitals in California to provide education and information to postpartum people and their families about maternal mental health conditions, post-hospital treatment options, and community resources.
- All regular staff in labor and delivery departments (e.g. registered nurses and social workers) must receive education and information about maternal mental health disorders.
- Hospitals can offer additional services to ensure optimal care.

Law became effective on January 1, 2020.

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

Recordings and slides available on program website:
https://www.hqinstitute.org/pmh-learning-community

Hospital Quality Institute

Remaining Topics in 2021

Date	Topic
January 21	Perinatal Loss Office Hour
February 18	NICU and PMH Webinar
March 18	NICU and PMH Office Hour
April 15	Birth Trauma and PMH Webinar
May 20	Birth Trauma and PMH Office Hour
June 17	Substance Use Disorders Webinar
July 15	Substance Use Disorders Office Hour
August 19	Child Abuse Reporting and PMH Webinar
September 16	Child Abuse Reporting and PMH Office Hour
October 21	Breastfeeding and PMH Webinar
November 18	Breastfeeding and PMH Office Hour
December 16	Fathers and Partners and PMH Webinar

Register on the program website:

https://www.hqinstitute.org/pmh-learning-community

Hospital Quality Institute

Save the Dates: Capstone Events!

Hospital Quality Institute

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

Substance Use Disorders and Perinatal Mental Health

Margaret Lynn Yonekura, M.D., FACOG
June 17, 2021
Hospital Quality Institute

Dignity Health™
California Hospital
Medical Center

Disclosures

- I have nothing to disclose

PSI MEMORIAL QUILT

Postpartum Support International (PSI) has **two** memorial quilts that commemorate women who died by suicide during pregnancy or postpartum. The quilts are accompanied by a collection of loving descriptions from survivor families. As PSI says about the quilt collections: "Reading about the women behind the embroidered names is difficult. They are our sisters, daughters, our friends and, for many, they are us - but for whatever it was that put us on a road toward survival. We have hope that fewer women in the future will die, thanks to the great efforts of PSI, its sister organizations, and all those who devote so much time to make certain we know we are not alone, and that we survive."

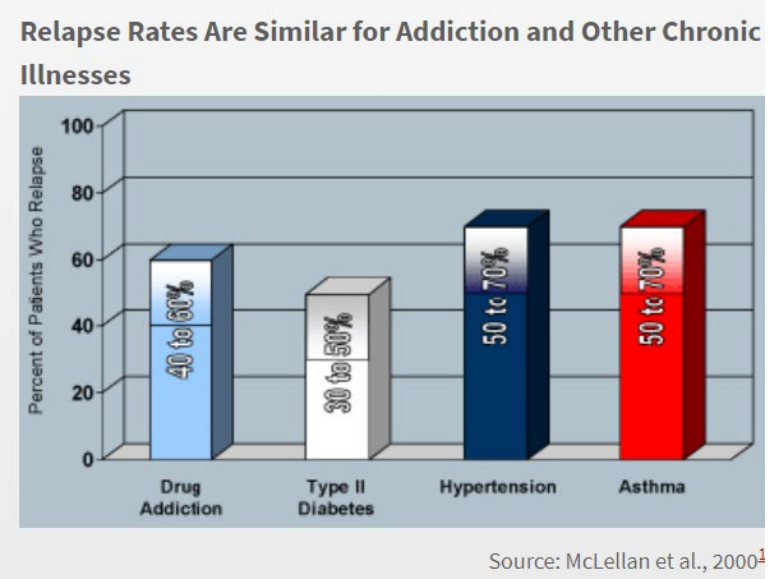
PSI POSTPARTUM SUPPORT INTERNATIONAL

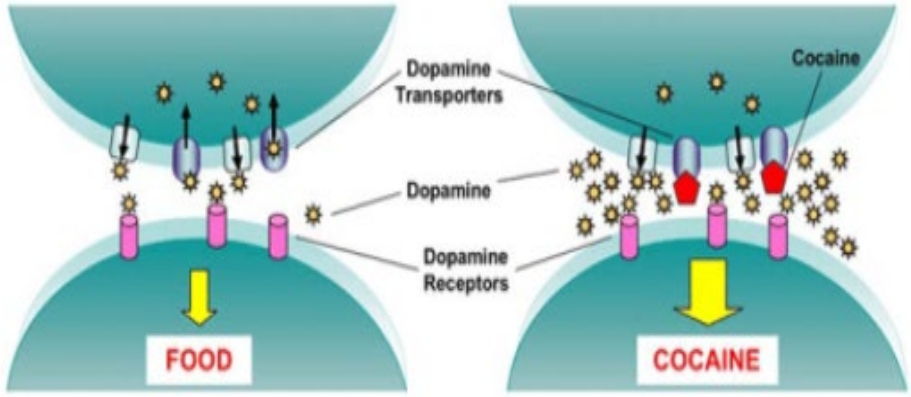
Learning Objectives

- Describe the impact of the COVID-19 pandemic on mental health, substance use, and suicides
- Use non-stigmatizing language that reflects an accurate, science-based understanding of substance use disorder (SUD) and is consistent with your professional role
- Screen and identify pregnant women with SUD
- Recognize the impact of the COVID-19 pandemic on perinatal mental health and substance use
- Recognize the prevalence of the co-occurrence between SUDS and mood and anxiety disorders, including PMADs

Addiction

- Defined as a **chronic, relapsing** brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences and long-lasting changes in the brain
- Nearly all addictive drugs directly or indirectly target the brain's reward system by flooding the circuit with dopamine
- Dopamine is a neurotransmitter present in regions of the brain that regulate movement, emotion, cognition, motivation, and reinforcement of rewarding behaviors





Dignity Health.
California Hospital Medical Center

Substance Use Disorder

Loss of control
- more than intended
  - amount used
  - time spent
- unable to cut down
- giving up activities
- craving

Physiology
- tolerance
- withdrawal

formerly "dependence"

Consequences
- unfulfilled obligations
  - work
  - school
  - home
- interpersonal problems
- dangerous situations
- medical problems

formerly "abuse"

- A ***substance use disorder*** is defined by having 2 or more • in the past year resulting in distress or impairment.
- **Tolerance** and **withdrawal** alone don't necessarily imply a disorder.
- Severity is rated by the number of symptoms present:
  - 2-3 = mild
  - 4-5 = moderate
  - 6+ = severe

Diagnostic and Statistical Manual V

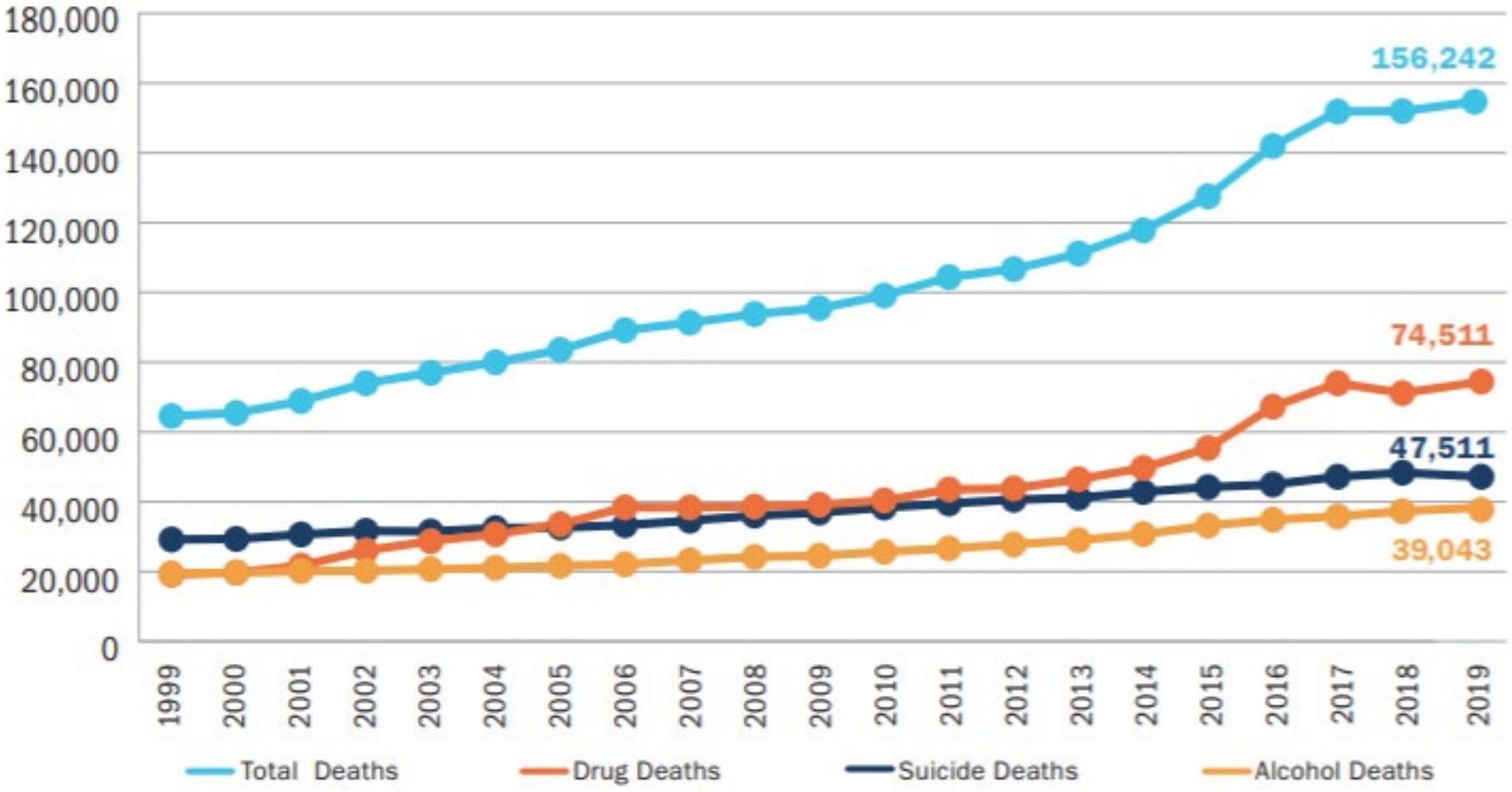
Words Matter

- Stigma is discrimination against an identifiable group of people
- Stigma about people with SUD might include inaccurate or unfounded thoughts or beliefs
- FACT: Addiction is a chronic, treatable brain disease from which patients can recover and continue to lead healthy, productive lives.
- Impact of stigma on person with SUD: decreased willingness to seek treatment or trust provider

Terms to Use, Terms to Avoid, and Why

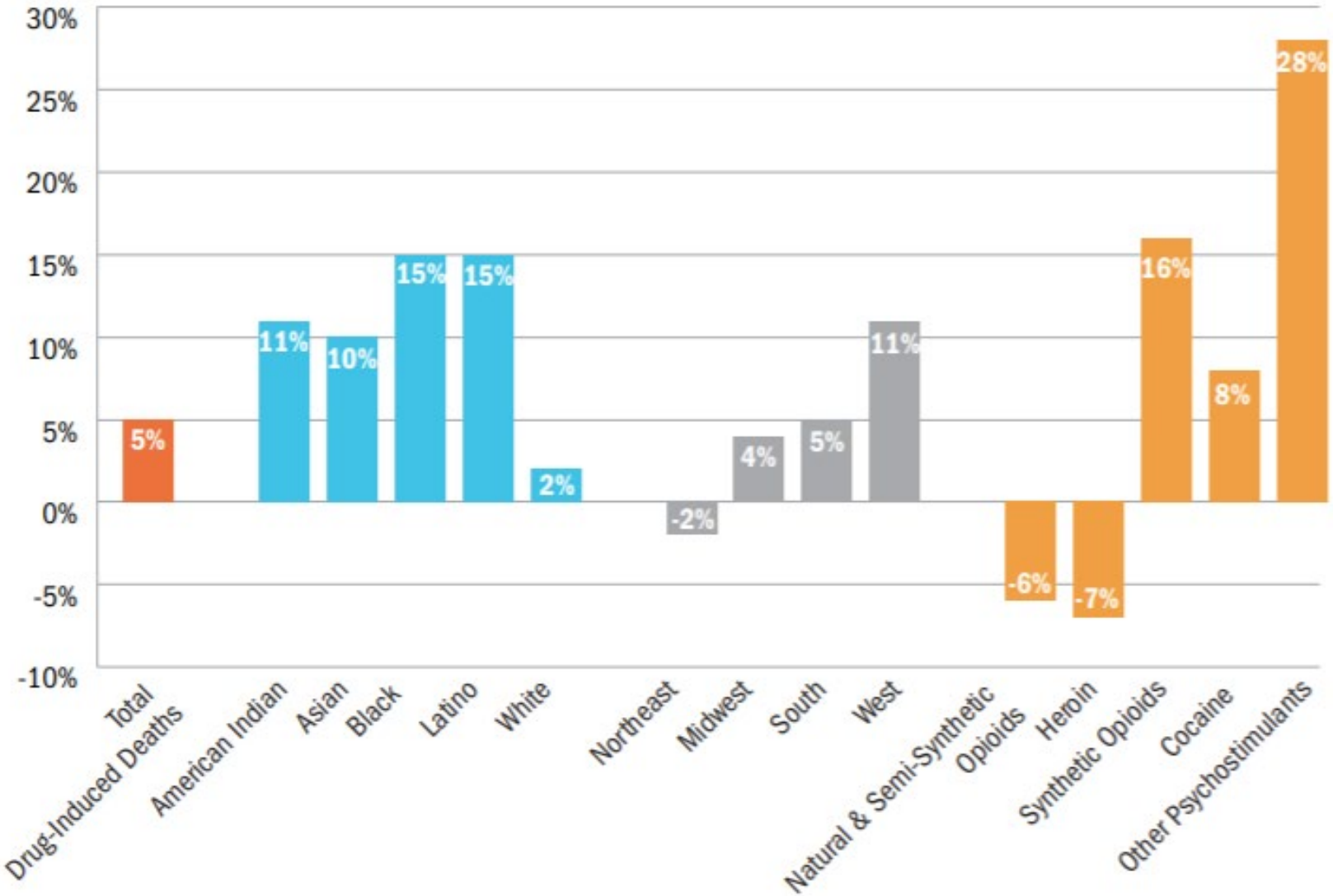
- Use person-first language
- The change shows that a person “has” a problem, rather than “is” a problem.
- The terms avoid eliciting negative associations, punitive attitudes, and individual blame
- It’s a misconception that pharmacotherapy merely “substitutes” one drug or “one addiction” for another.

Annual Deaths from Alcohol, Drugs, and Suicide in the United States, 1999–2019

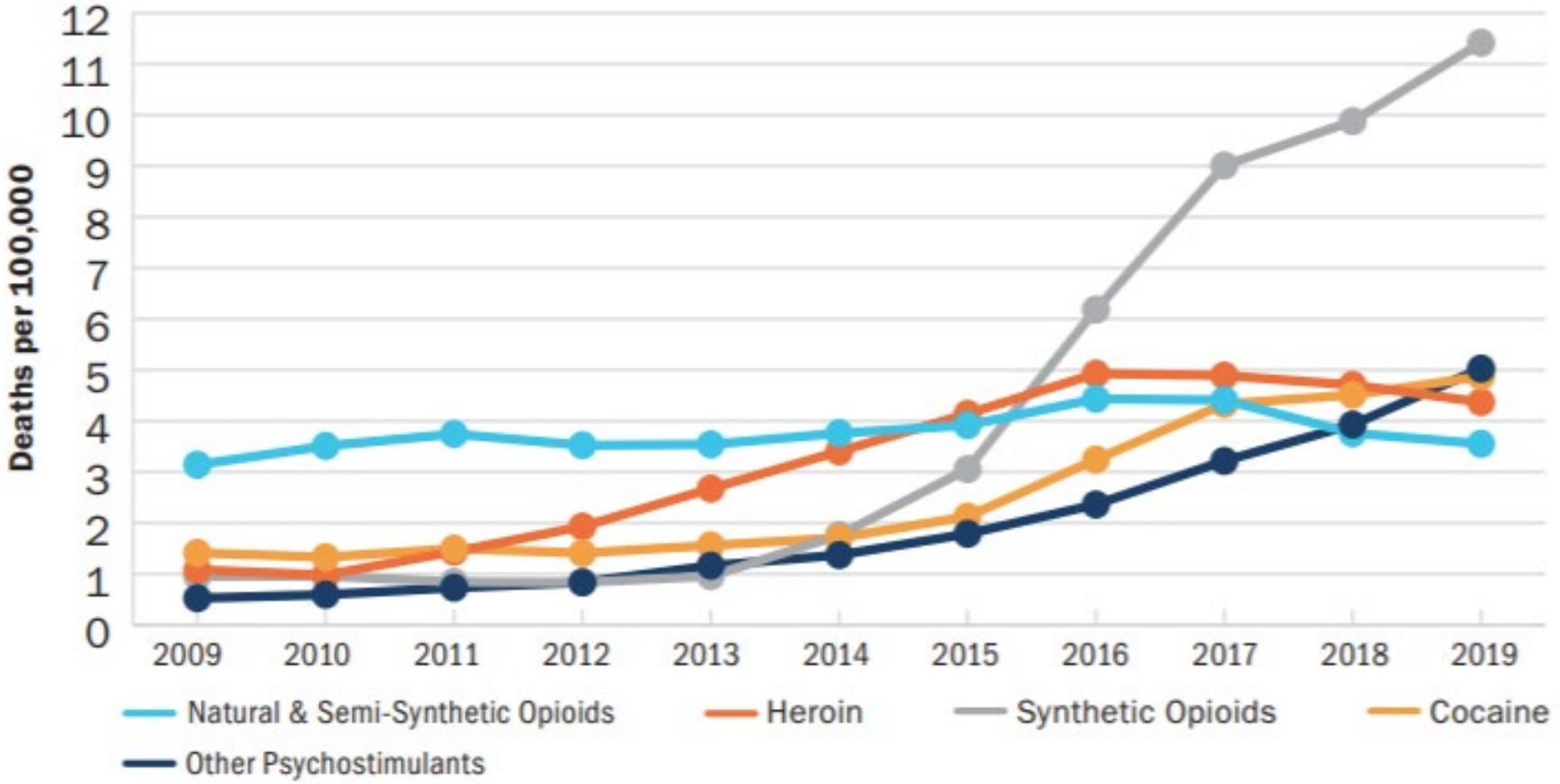


Source: TFAH and WBT analysis of National Center for Health Statistics data

Percent Change in Age-Adjusted Rates of Drug-Induced and Drug-Specific Overdose Mortality, 2018-2019

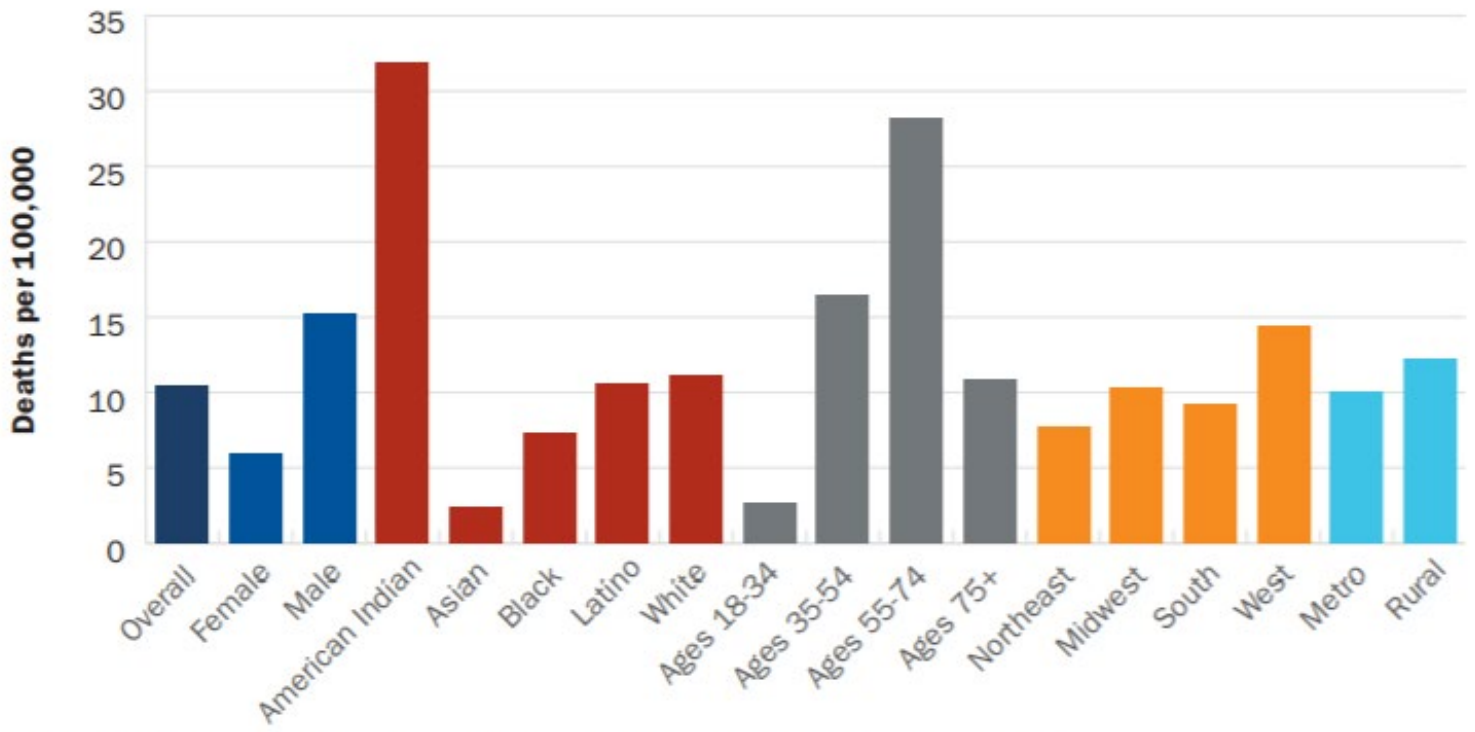


Annual Age-Adjusted Mortality Rate (Deaths per 100,000) from Overdoses by Drug Type, 2009–2019



Source: TFAH and WBT analysis of National Center for Health Statistics data

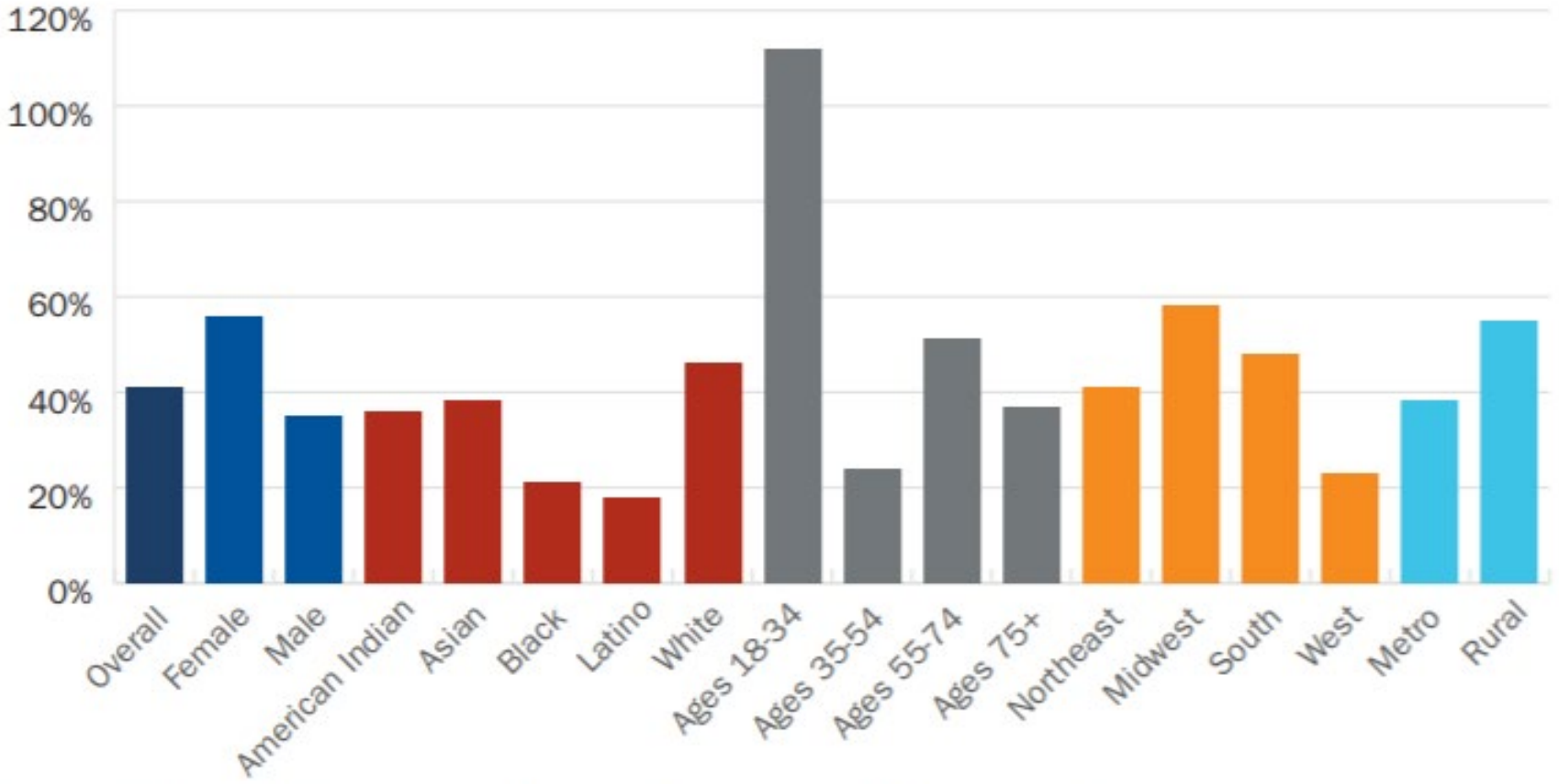
Age-Adjusted Alcohol-Induced Mortality Rate (Deaths per 100,000) Overall and by Select Demographics and Region, 2019



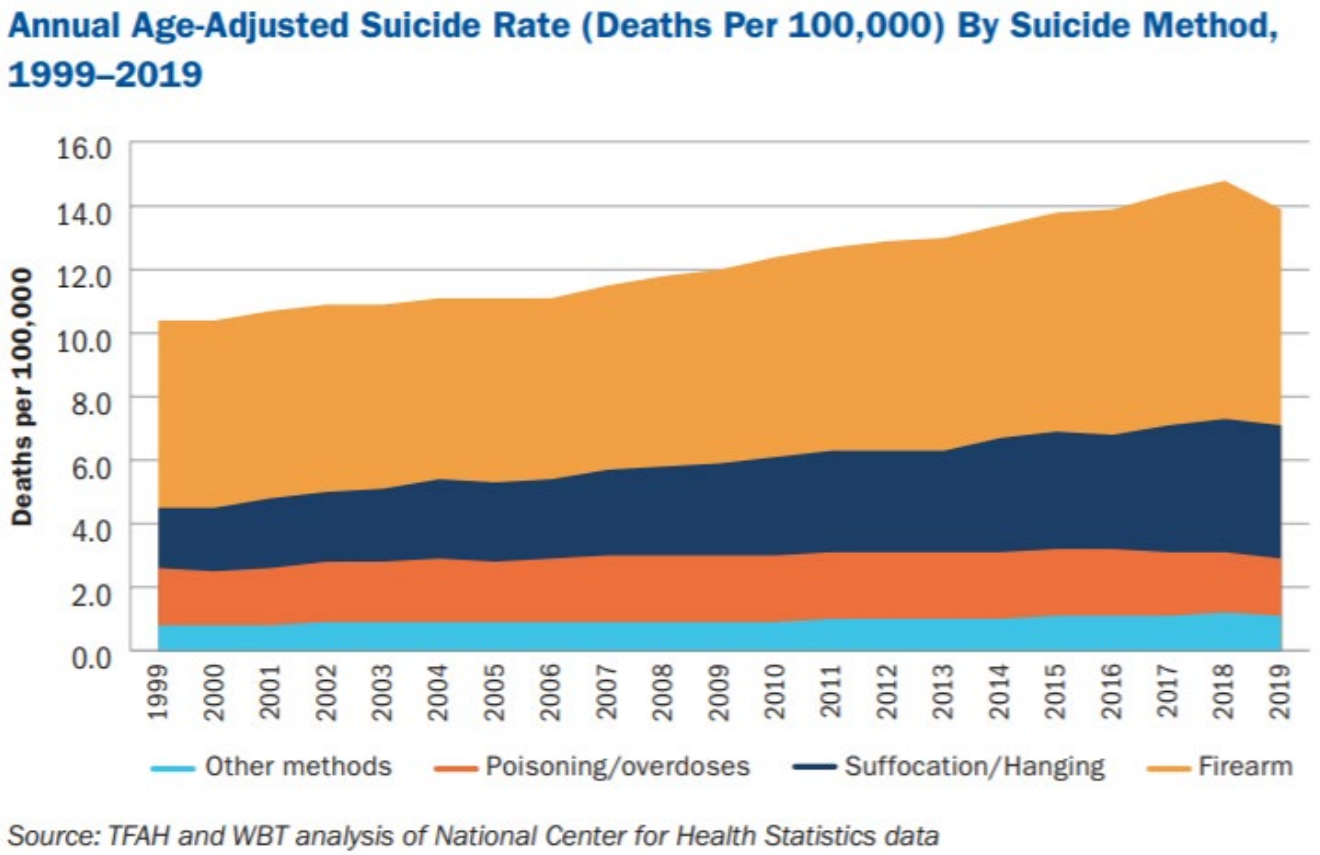
Source: TFAH and WBT analysis of National Center for Health Statistics Data

- **Alcohol-induced deaths** include alcohol poisoning, liver diseases, and other diseases; it does not include alcohol-attributable deaths, such as alcohol-related violence, accidental, or vehicle fatalities
- The rate of American deaths from alcohol-induced causes was 4% higher in 2019 compared with 2018, increasing from 9.9 to 10.4 deaths per 100,000 (age-adjusted rates). It was the 10th year of growth

Percent Change in Alcohol-Induced Mortality Rates by Select Demographics and Region, 2009–2019

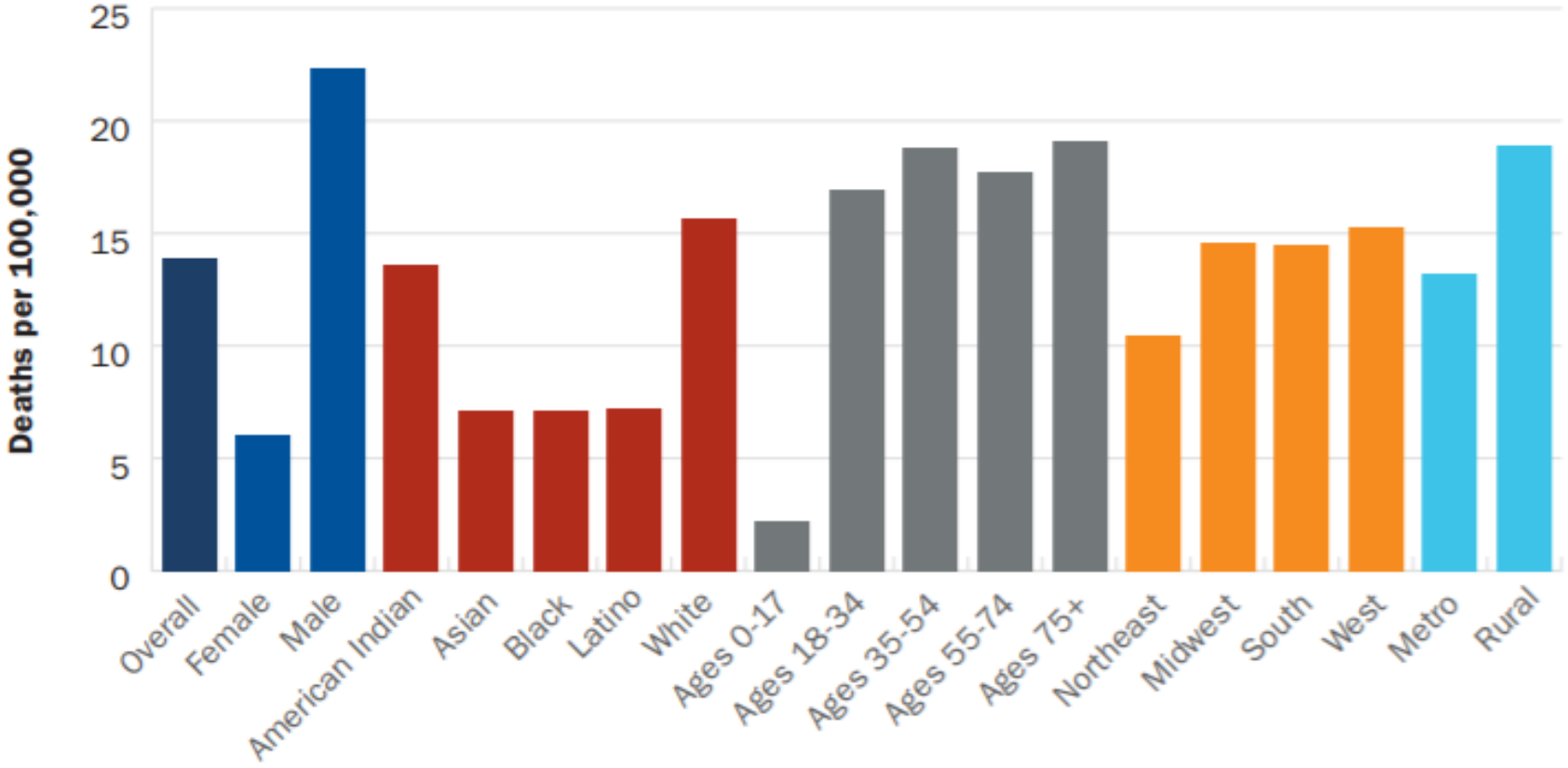


Source: TFAH and WBT analysis of National Center for Health Statistics Data



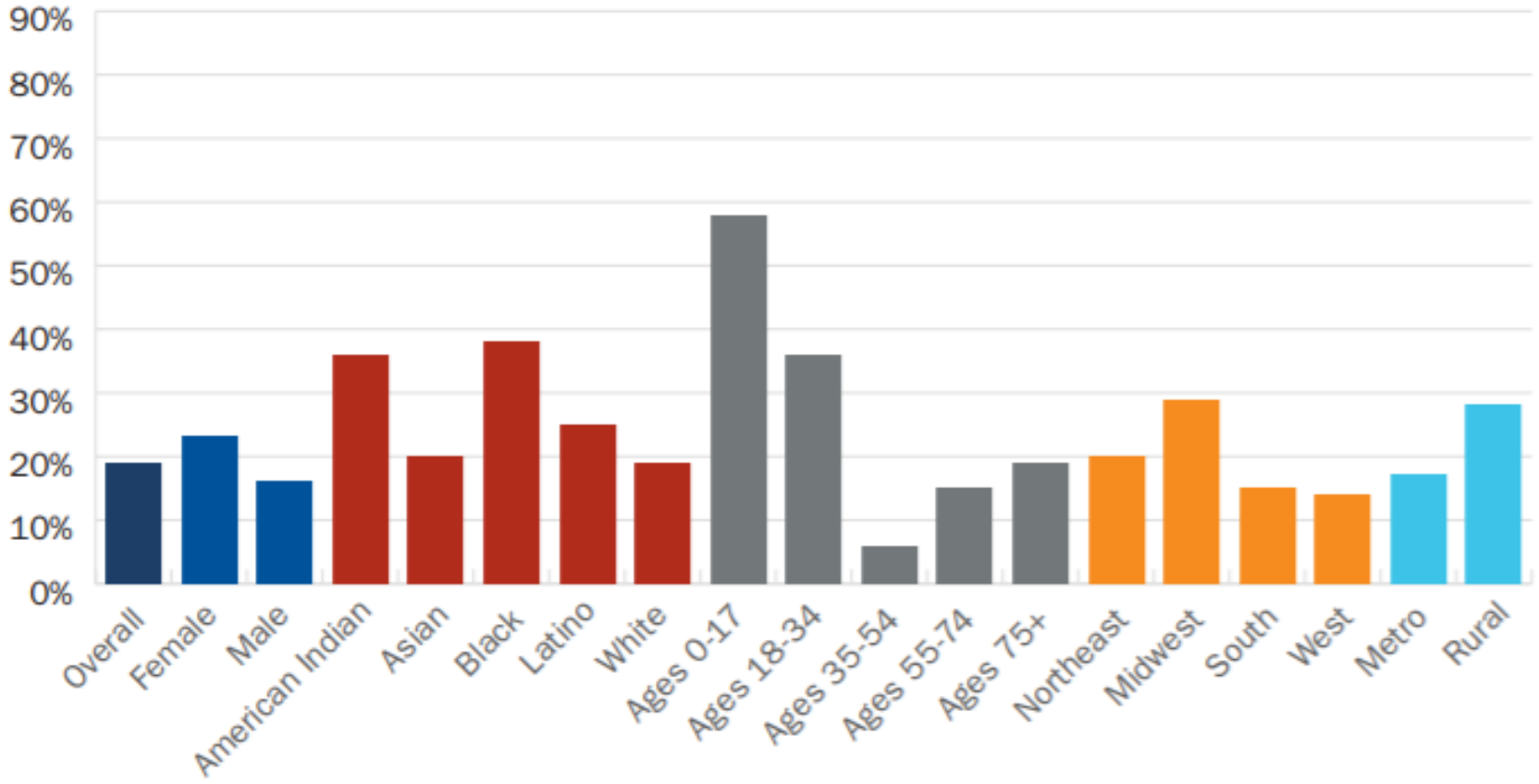
- In 2019, 47,511 Americans died from suicide
- Suicide rates decreased by 2% in 2019 compared with 2018
- In 2019, half of suicides were by firearm, 29 % were by suffocation/hanging, 13% were by poisoning/overdose, and 8% were by other methods

Age-Adjusted Suicide Mortality Rate (Deaths per 100,000) Overall and by Select Demographics and Region, 2019



TFAH and WBT analysis of National Center for Health Statistics data

Percent Change in Suicide Mortality Rates by Select Demographics and Region, 2009–2019



TFAH and WBT analysis of National Center for Health Statistics data

Pain in the Nation:

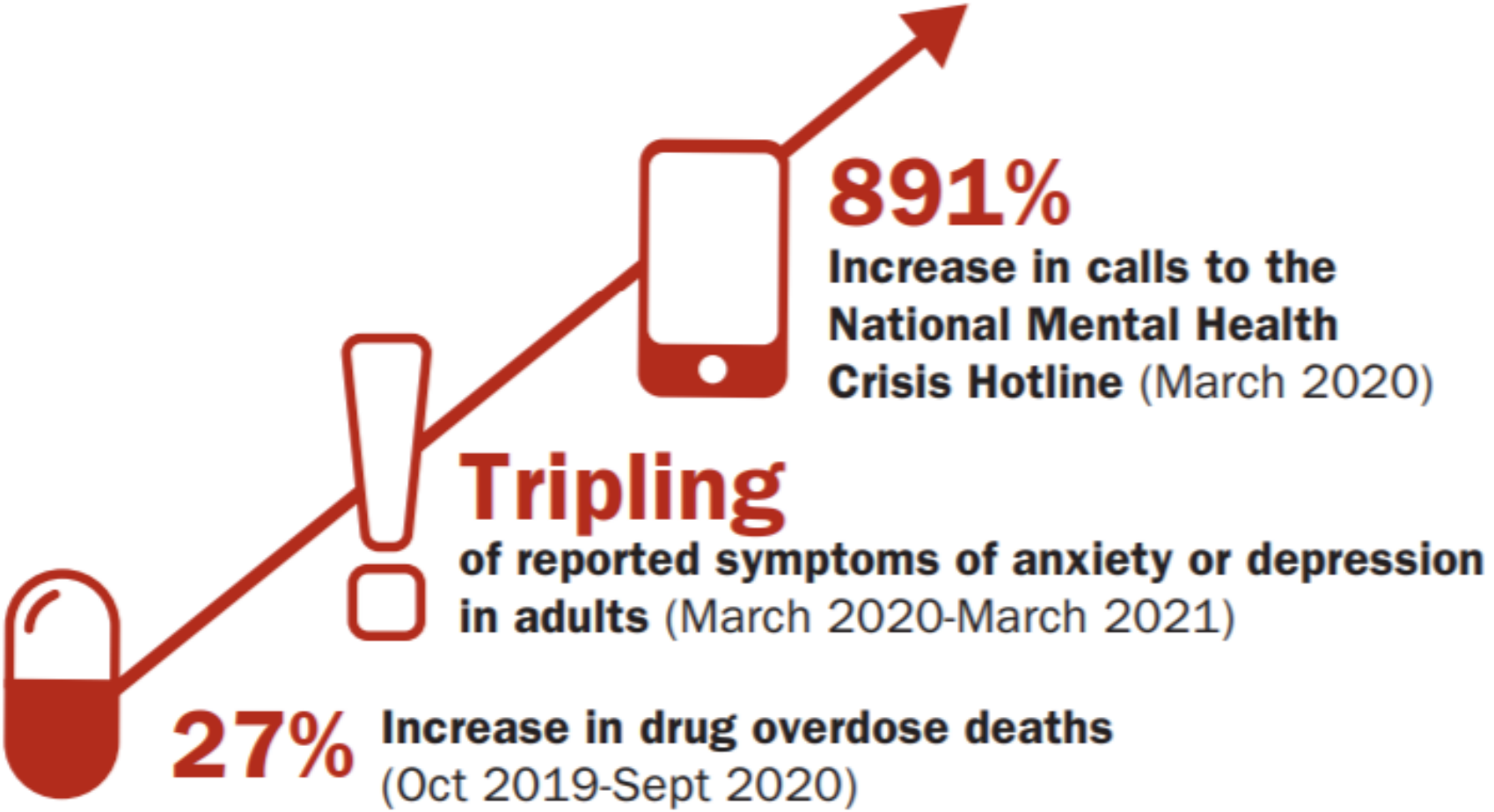
Alcohol, Drug, and Suicide Epidemics

SPECIAL FEATURE: COVID-19 AND TRAUMA

MAY 2021

- In 2020, the COVID-19 pandemic created new, almost inconceivable heights of trauma, grief, stress, and isolation for many Americans
  - Cases, hospitalizations, and deaths disproportionately affected racial/ethnic minorities
  - Many Americans unable to maintain healthy coping strategies

During the COVID-19 Pandemic, there has been...



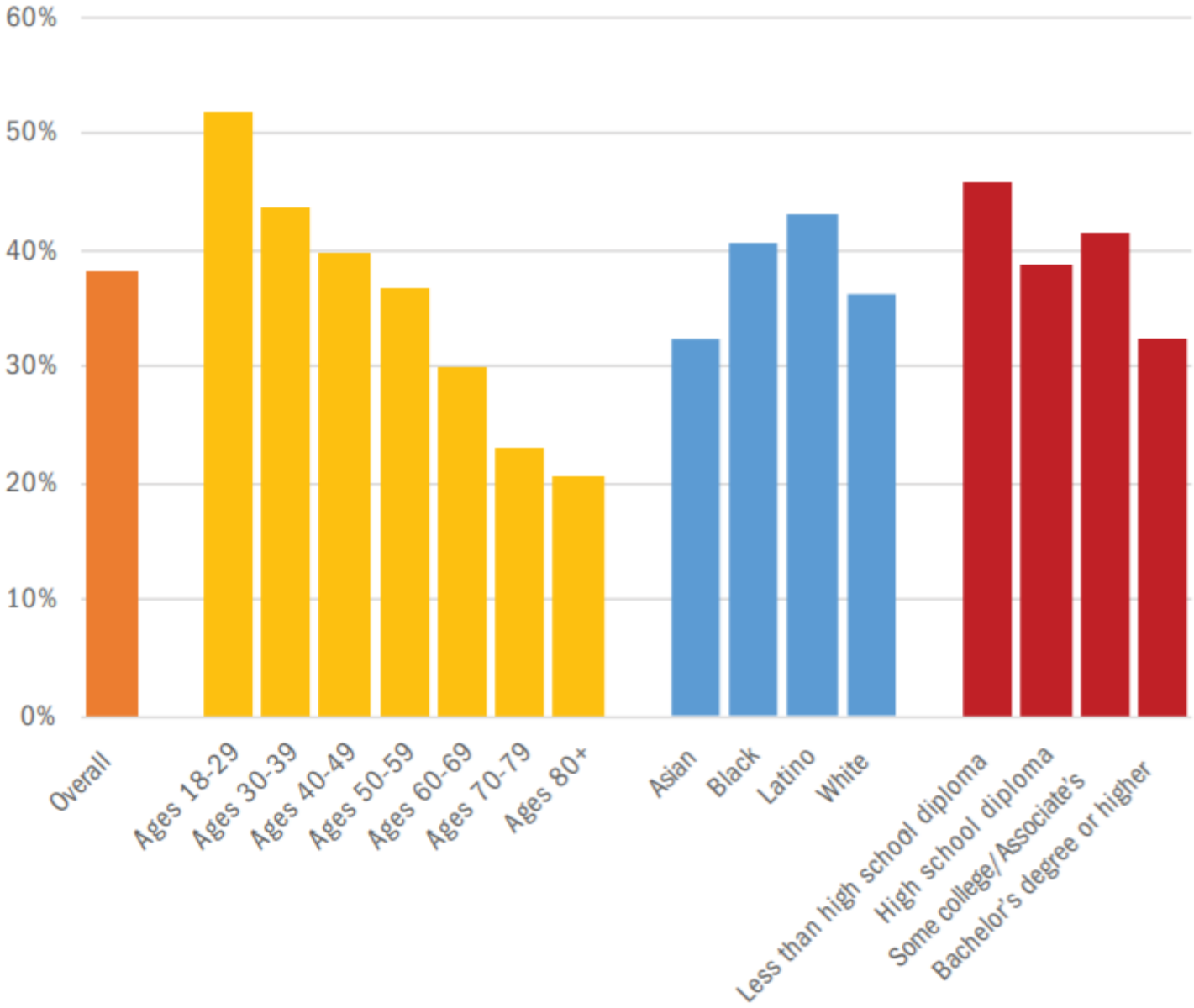
891%
Increase in calls to the National Mental Health Crisis Hotline (March 2020)

Tripling
of reported symptoms of anxiety or depression in adults (March 2020-March 2021)

27% **Increase in drug overdose deaths** (Oct 2019-Sept 2020)

Source: ABC News; Household Pulse Survey, National Center for Health Statistics

Average Percent of Adults Reporting Anxiety or Depression Symptoms in Prior Week, by Demographic, April 2020–March 2021



Deteriorating Mental Health

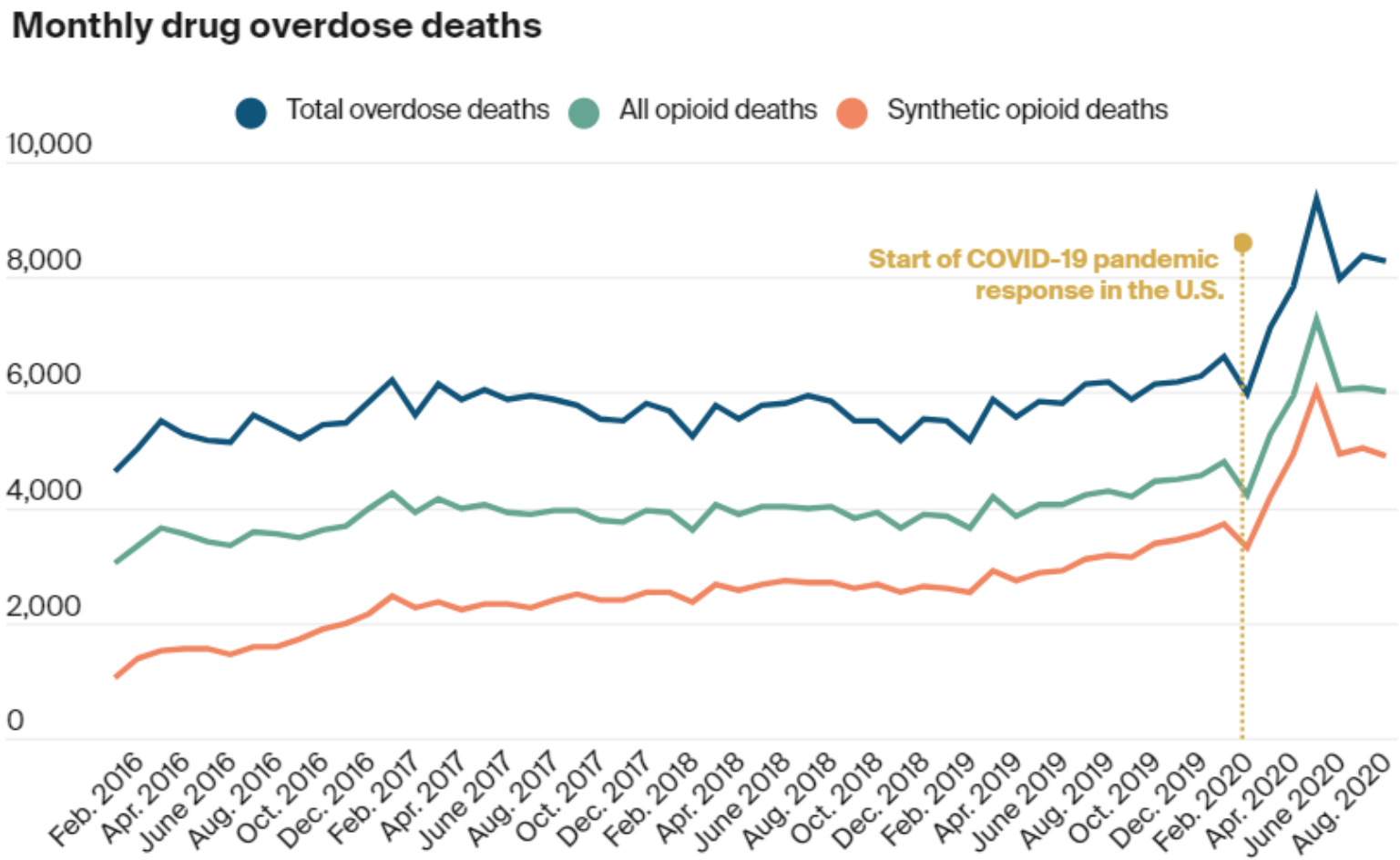
- Mental Health America reported dramatic increases in number of people seeking online screening and resources for anxiety and depression on their website in the first 9 months of 2020 (January-September) compared with all of 2019
  - 93% more anxiety screens
  - 62% more depression screens
- More people also reported moderate to severe symptoms for anxiety and depression, suicidal thoughts, and self-harm.
  - Loneliness or isolation were top contributors

Increasing Substance Use

- One CDC study found during a June 24-30, 2020 survey, that overall **13% of adults "started or increased substance use** [including drugs and alcohol**] to cope with pandemic-related stress or emotions"**
- A number of groups increased substance use disproportionately:
  - Ages 18-24 25%
  - Ages 25-44 20%
  - Blacks 18%
  - Latinx 22%
  - Individuals without HS education 22%
  - Essential workers 25%
  - Unpaid adult caregivers 33%
  - Pre-existing anxiety disorder 27%
  - Pre-existing depressive disorder 25%
  - Pre-existing PTSD 44%

MMWR 2020; 69: 1049-1057

Overdose Deaths Increased in Almost Every State During the First Eight Months of 2020



Dignity Health. California Hospital Medical Center

24 states and the District of Columbia had an estimated increase of at least 30%, and the overall U.S. total increased by 33%

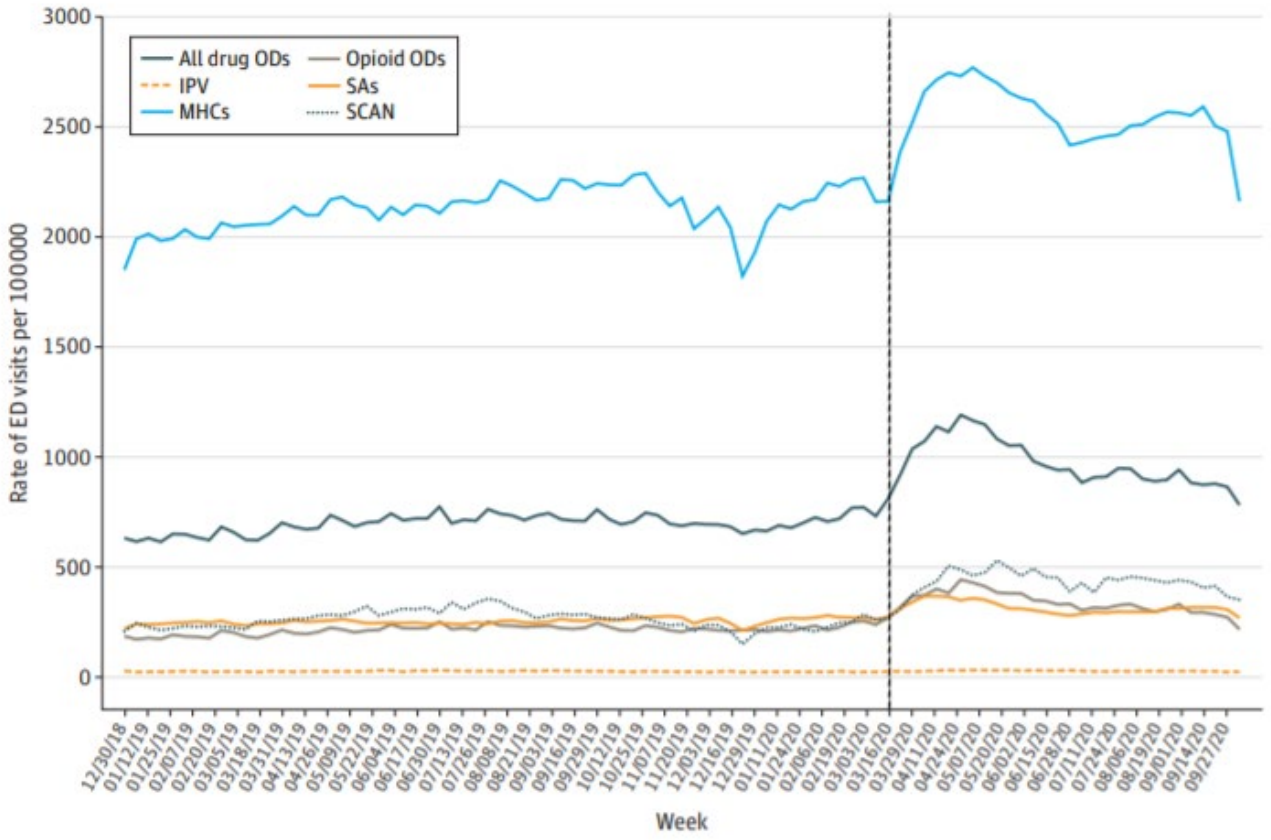
Skyrocketing Overdose Deaths

- Total overdose deaths spiked to record levels in March 2020 after the pandemic hit
- Monthly deaths grew by more than 50% between February and May to more than 9,000; remained around 8,000 in August. Prior to 2020, U.S. monthly overdose deaths had never risen above 6,300
- Opioids accounted for around 75% of all overdose deaths during the early months of the pandemic; around 80% of those included synthetic opioids.

Fatal Dose

Emergency Department Visits

Figure 2. Rate of Emergency Department (ED) Visits for All Drug and Opioid Overdoses (ODs), Intimate Partner Violence (IPV), Suicide Attempts (SAs), Mental Health Conditions (MHCs), and Suspected Child Abuse and Neglect (SCAN) per 100 000 ED Visits in the US, December 30, 2018, to October 10, 2020



ED visit counts consistently decreased near the beginning of the pandemic after the declaration of a national emergency on March 13 and the “15 Days to Slow the Spread” national proclamation on March 16

When the median ED visit counts between March 15 and October 10, 2020, were compared with the same period in 2019, the 2020 counts were **significantly higher for SAs, all ODs, & opioid ODs and significantly lower for IPV & SCAN ED visits**

Dignity Health. California Hospital Medical Center

JAMA Psychiatry 2021; 78: 372-379

Emergency department visits for suspected suicide attempts among U.S. girls ages 12–17 have increased during the COVID-19 pandemic*

February–March 2021

51% ↑

From the same period in 2019

* After an initial drop

CDC.GOV

Suicide can be prevented

- Increase social connections for youth
- Teach youth coping skills
- Learn the signs of suicide risk and how to respond
- Reduce access to lethal means (like medications and firearms)

Help is available 24/7 at suicidepreventionlifeline.org

bit.ly/MMWR61121

MMWR

American Has a Drinking Problem

(Photograph by Chelsea Kyle; Prop Stylist: Amy Elise Wilson; Food Stylist: Sue Li)

When the pandemic forced Americans to stay home, many turned to alcohol to cope, slurping down the apocalyptic news cycle with a hearty glass of red wine.

Increasing Alcohol Consumption

- Comparing surveys from April 29-June 9, 2019 and May 28-June 16, 2020, researchers found an increase in overall alcohol consumption for adults, with **higher increases among women**, adults ages 30-59 years, and whites. JAMA Open Network 2020; 3(9): e2022942
- Another study revealed that from April-June 2020, alcohol sales increased 34% and tobacco sales 13% compared to previous year
  - Relative increases in both alcohol & tobacco sales were higher among higher-income households, younger adults, larger households, households with children younger than 18 years, and ethnic minorities
  - Relative increases in sales were higher for liquor (+49.2%) than for wine (+29.1%) or beer, malt beverages, and cider (+30.2%)

Annals Int Med 2021. doi:10.7326/M20-7271

Alcohol Use Disorders and Comorbid Mental Health Disorders

Prevalence of Comorbid Mood and Anxiety Disorders in Individuals with Alcohol Abuse and Alcohol Dependence

Comorbid Disorder	Alcohol Abuse		Alcohol Dependence	
	1-yr rate (%)	OR	1-yr rate (%)	OR
National Comorbidity Survey (1997)				
Any mood disorder	12.3	1.1	29.2	3.6*
MDD	11.3	1.1	27.9	3.9*
Any anxiety disorder	29.1	1.7	36.9	2.6*
PTSD	5.6	1.5	7.7	2.2*
NESARC (2004)				
Any mood disorder	11.7	1.3	27.5	4.1*
MDD	8.2	1.2	20.5	3.7*
Any anxiety disorder	11.8	1.1	23.4	2.6*

* $p < .05$

Prevalence of Psychiatric Disorders in People with Alcohol Abuse and Alcohol Dependence

Comorbid Disorder	Alcohol abuse		Alcohol dependence	
National Comorbidity Survey[1]	**1–year rate (%)**	**Odds ratio**	**1–year rate (%)**	**Odds ratio**
Mood disorders	12.3	1.1	29.2	3.6*
Major depressive disorder	11.3	1.1	27.9	3.9*
Bipolar disorder	0.3	0.7	1.9	6.3*
Anxiety disorders	29.1	1.7	36.9	2.6*
GAD	1.4	0.4	11.6	4.6*
Panic disorder	1.3	0.5	3.9	1.7
PTSD	5.6	1.5	7.7	2.2*
Epidemiologic Catchment Area[2] study	**Lifetime rate (%)**	**Odds ratio**	**Lifetime rate (%)**	**Odds ratio**
Schizophrenia	9.7	1.9	24	3.8

NOTES: *Odds ratio was significantly different from 1 at 0.05 level. The odds ratio represents the increased chance that someone with alcohol abuse or dependence will have the comorbid psychiatric disorder (e.g., a person with alcohol dependence is 3.6 times more likely to also have a mood disorder compared to a person without alcohol dependence).
The 1–year rate of a disorder reflects the percentage of people who met the criteria for the disorder during the year prior to the survey. The lifetime rate reflects the percentage of people who met the criteria for the disorder at any time in their lifetime.
SOURCES: [1]Kessler et al. 1996. [2]Regier et al. 1990.

- For each of the psychiatric disorders examined, prevalence rates were higher among people diagnosed as alcohol dependent than among alcohol abusers
- In the NCS study, 7.2% of the survey respondents were diagnosed as alcohol dependent during the 12 months before the survey, and in the ECA study, 7.9% of respondents were diagnosed as having been alcohol–dependent at some point in their lifetime

Alcohol Research & Health Vol. 26, 2002

Gender Differences on the Risk for Comorbid Disorders

- Stress is known to contribute to the development of alcoholism in at-risk individuals and to the maintenance of the disease through stress-induced relapse
- Stress is also a well-known precipitant of stress-related psychiatric disorders such as major depressive disorder (MDD) and PTSD
- Symptoms of depression co-occur with alcohol dependence in ~80% of patients; 30-40% of alcohol-dependent men and women suffer from an independent MDD during their lifetime
  - Men are twice as likely as women to develop AUD
  - In **women with AUD**, the disorder is more likely to follow an **accelerated course** and to **emerge after** the onset of the stress-related mood or anxiety disorder
  - Women with AUD are **more susceptible to alcohol's neurotoxic effects** compared to men

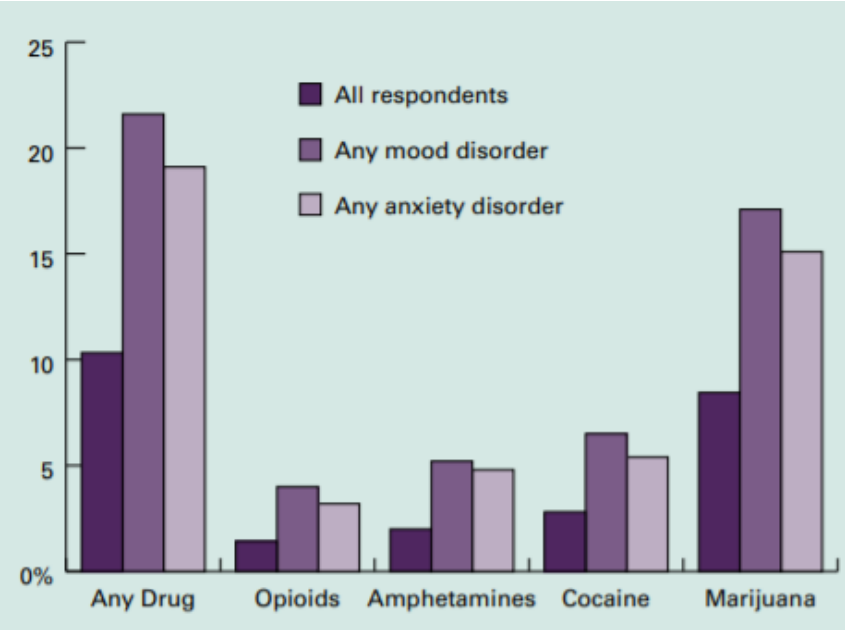
Gender Differences on the Risk for Comorbid Disorders

- **Women are twice as likely as men to suffer from MDD & to have an earlier age-at-onset than men**
  - Men with MDD are more likely to have comorbid alcohol and other drug use disorders, along with ADHD
  - **Women with MDD are likely to suffer from comorbid PTSD and bulimia nervosa**
- **Women have higher rates of PTSD than men** and the onset of PTSD antedates the onset of AUD in adolescent girls compared with boys

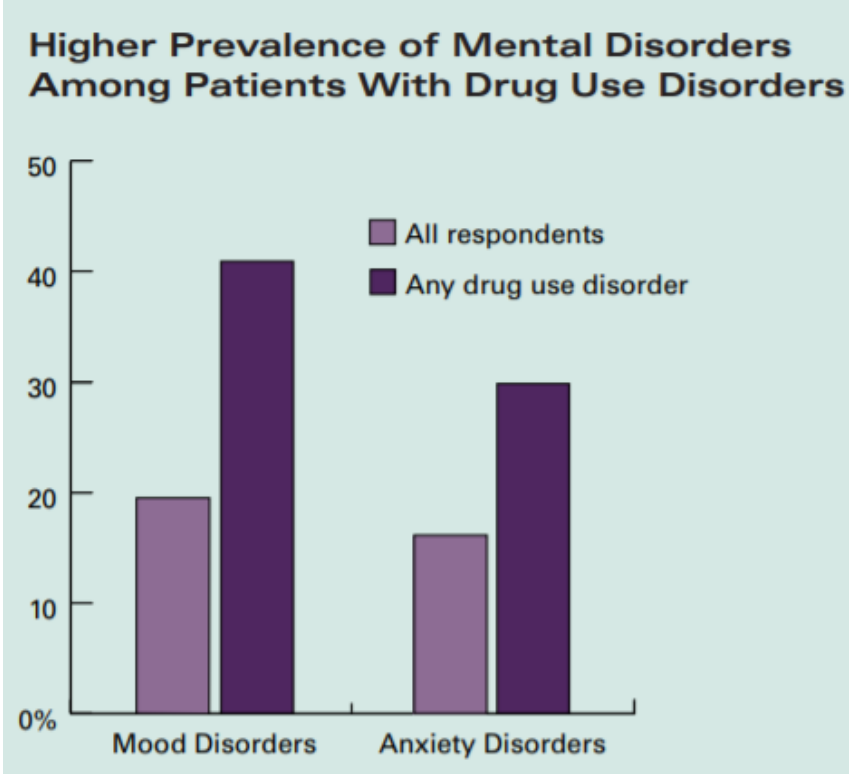
- The increased risk for stress-related MDD and/or PTSD in women with AUD is a function of biological sex differences in HPA and eCRH stress systems and environmental gender effects (e.g., ACEs including traumatic life events)

Drug Use Disorders and Comorbid Mood & Anxiety Disorders

High Prevalence of Drug Abuse and Dependence Among Individuals With Mood and Anxiety Disorders



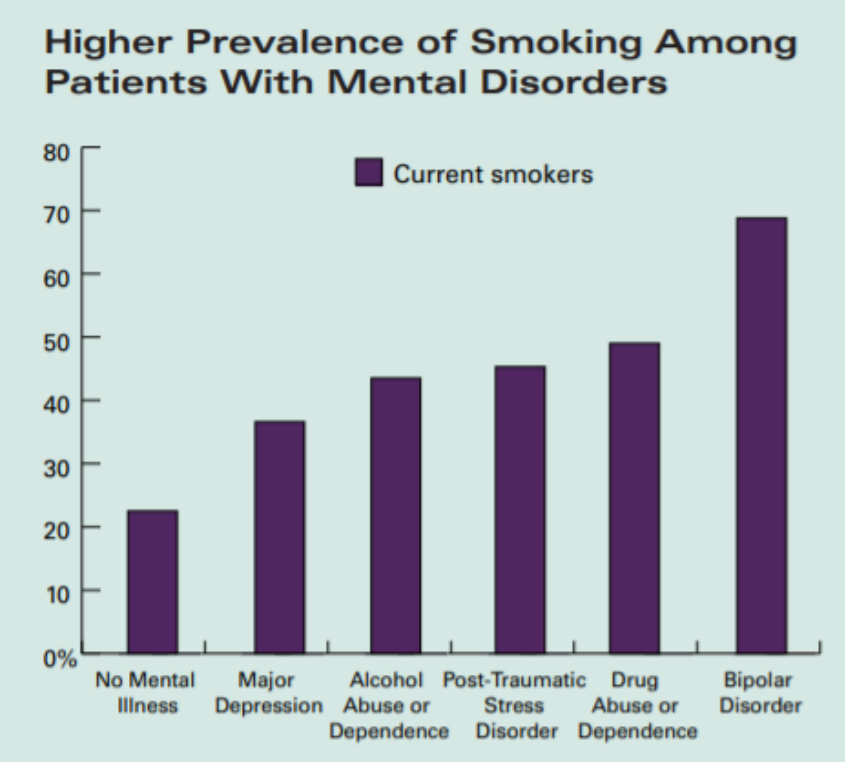
Because mood disorders increase vulnerability to drug abuse and addiction, the diagnosis and treatment of the mood disorder can reduce the risk of subsequent drug use and vice versa.



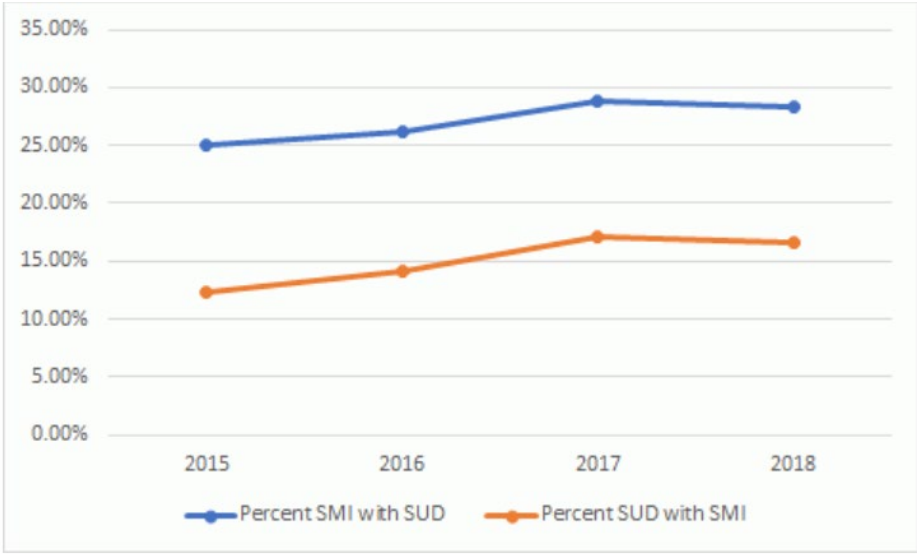
Both drug use disorders and other mental illnesses are caused by overlapping factors such as underlying brain deficits, genetic vulnerabilities, and/or early exposure to stress or trauma

NIH Publication Number 10-5771

Drug Use Disorders and Comorbid Mood & Anxiety Disorders



Mental illnesses can lead to drug abuse. Individuals with overt, mild, or even subclinical mental disorders may abuse drugs as a form of self-medication



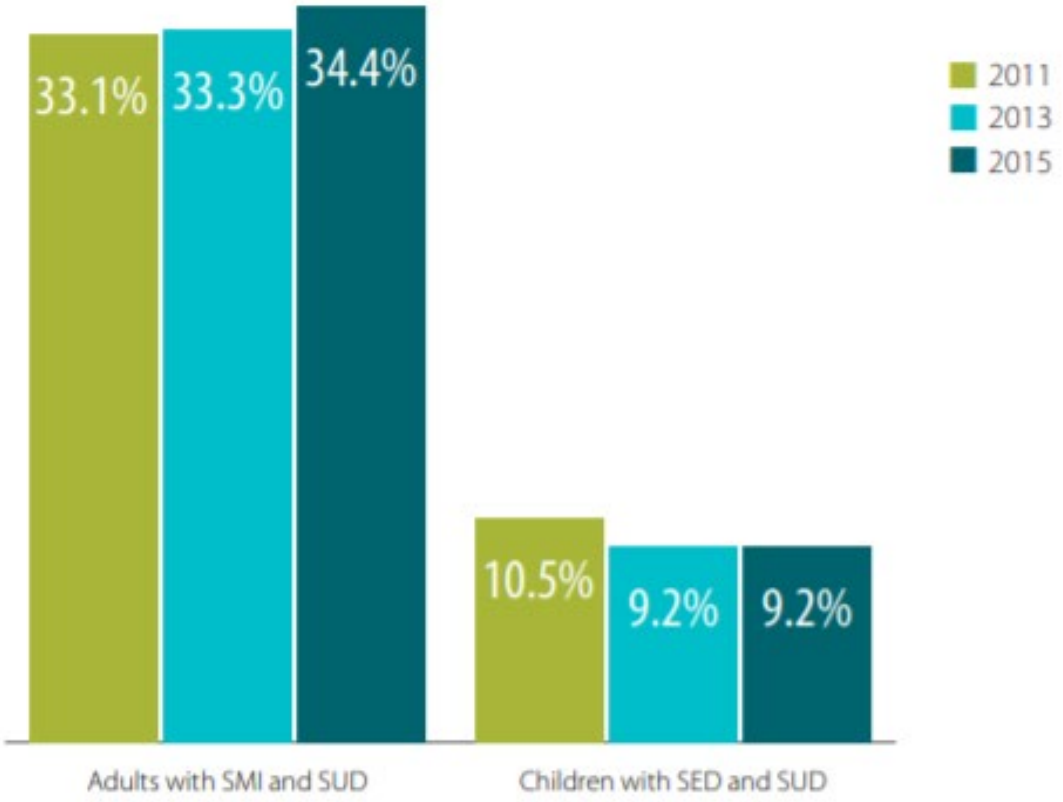
Source: SAMHSA, Center for Behavioral Health Statistics and Quality,

Serious mental illness among people ages 18 and older is defined at the federal level as having, at any time during the past year, a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities

Adults with SMI and SUD and Children with SED and SUD

California, 2011 to 2015, Selected Years

PERCENTAGE USING COUNTY MENTAL HEALTH SERVICES



Notes: *Serious emotional disturbance (SED)* is a categorization for children age 17 and under. *Serious mental illness (SMI)* is a categorization for adults age 18 and older. See page 3 for full definitions. *Substance use disorder (SUD)* is a problematic pattern of substance use leading to clinically significant impairment or distress as manifested by two or more diagnostic symptoms occurring in a 12-month period. County health services are provided for people with SED or SMI who have Medi-Cal or are uninsured, among others.

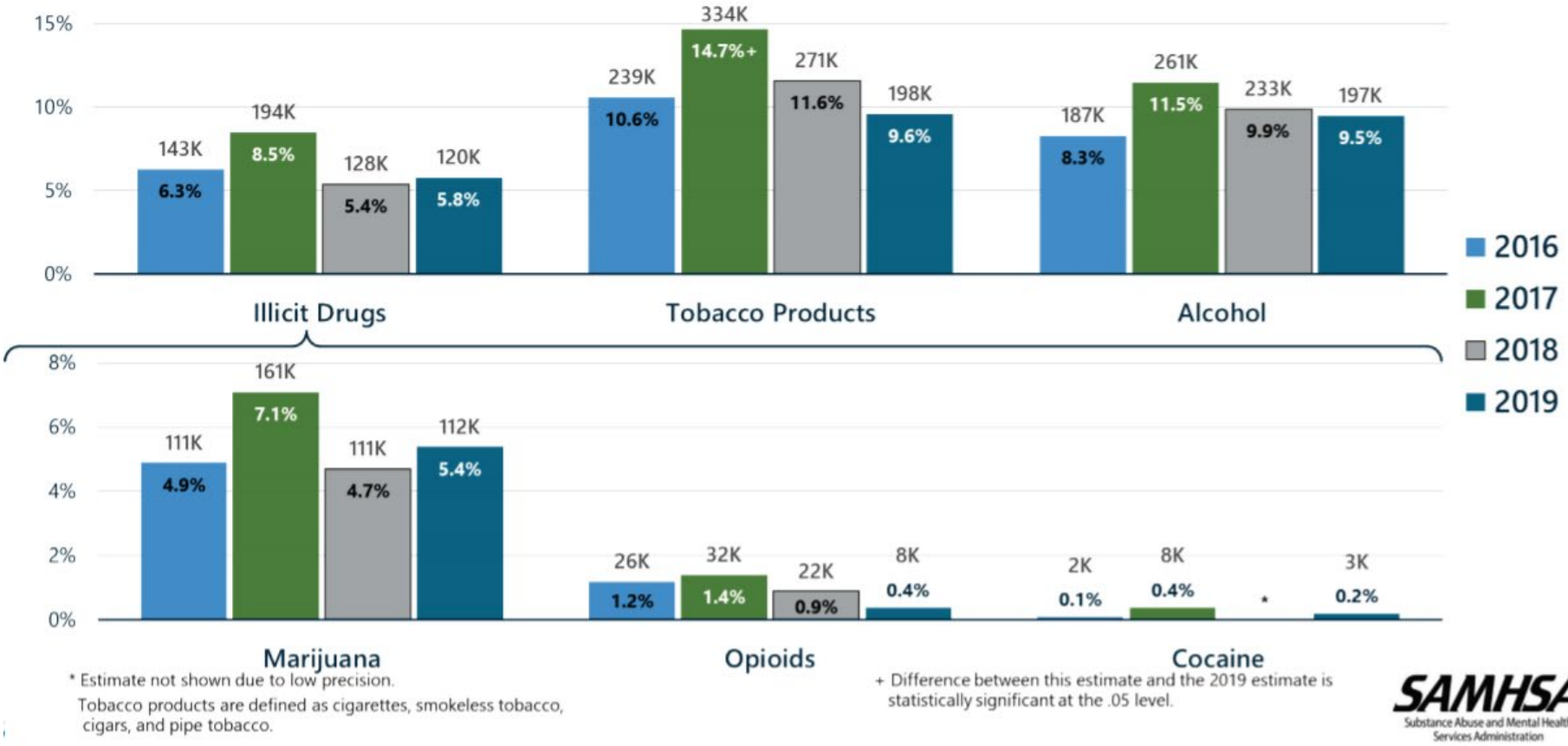
Sources: *California Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System*, 2011–2015, www.samhsa.gov; Sarra Hedden et al., *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, Substance Abuse and Mental Health Services Administration, 2015, www.samhsa.gov (PDF).

Mental Health
Prevalence

The rate at which people with mental health disorders experience a co-occurring alcohol or substance use disorder was high compared to those with no mental health disorder (not shown). For those using county mental health services in California, a third of adults with serious mental illness, and nearly 10% of children with serious emotional disturbance, had a co-occurring substance use disorder.

Past Month Substance Use among Pregnant Women

PAST MONTH, 2016-2019 NSDUH, 15-44



* Estimate not shown due to low precision.

Tobacco products are defined as cigarettes, smokeless tobacco, cigars, and pipe tobacco.

\+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

SAMHSA
Substance Abuse and Mental Health Services Administration

Pregnancy and Substance Use

- **Vast majority (83%)** of pregnant women will achieve abstinence from at least one substance by the end of second trimester
- Mostly no medical intervention
- More likely to achieve abstinence from alcohol, marijuana, and cocaine, than cigarettes
- Only 32% of smokers achieved abstinence
- Women with OCD and GAD were more likely to achieve abstinence whereas those with PTSD less likely to abstain

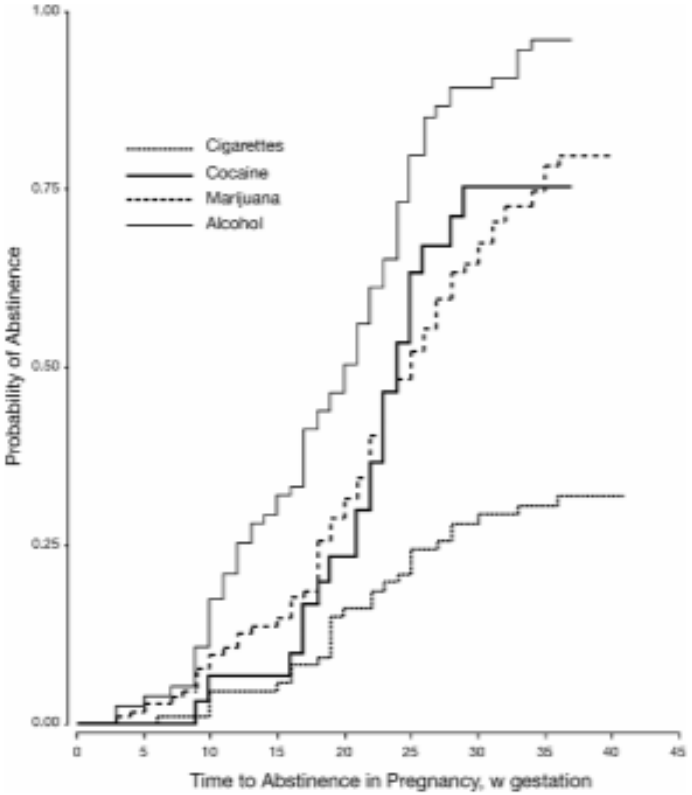


Figure 2. Time to Abstinence in Pregnancy by Drug
Kaplan-Meier estimates of the time interval in pregnancy (weeks in pregnancy) to abstinence from cigarettes, alcohol, marijuana or cocaine.

Drug Alcohol Depend. 2015; 150:147-155

Postpartum and Substance Use

- **80% of women** who were abstinent in the last month of pregnancy returned to using at least one substance within 2 years of delivery
- More likely to relapse to cigarettes, alcohol, and marijuana than cocaine
- Relapse to cocaine was only 34% that of cigarettes
- Women with MDD were more likely to relapse than women without a diagnosis of depression

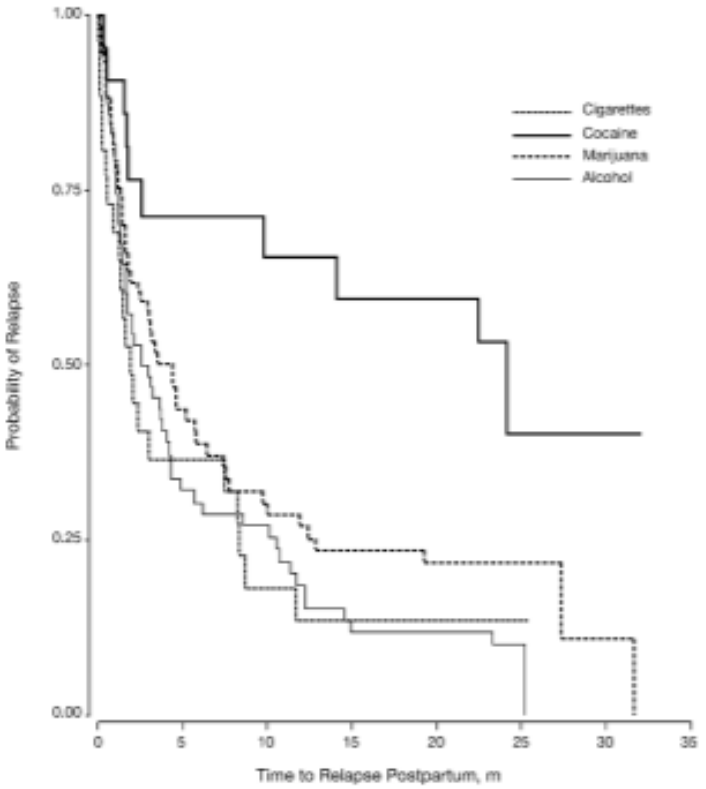
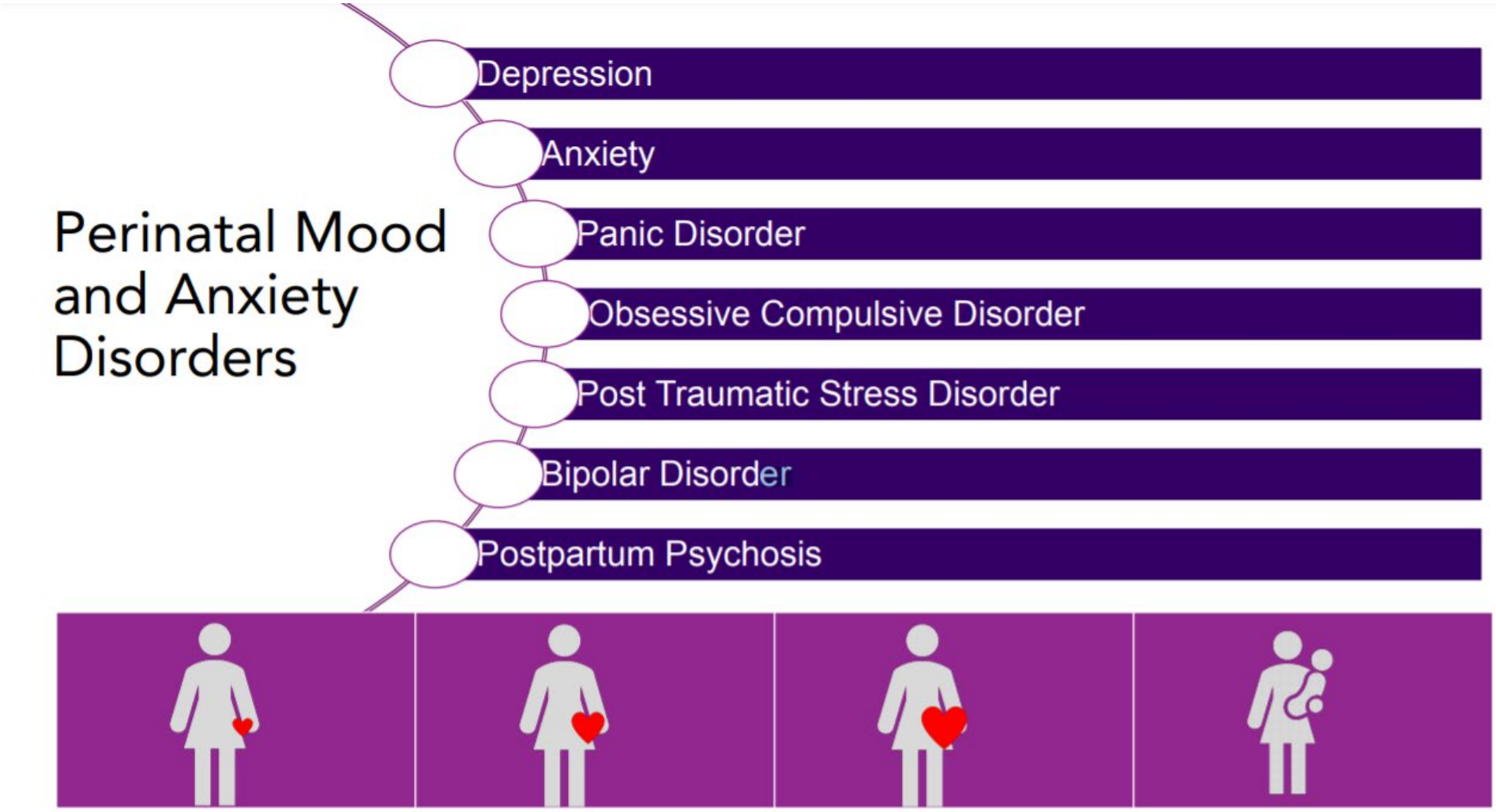


Figure 3. Time to Relapse After Delivery by Drug
Kaplan-Meier estimates of the time from delivery until relapse to cigarettes, alcohol, marijuana or cocaine in the 24 months postpartum.

Drug Alcohol Depend. 2015; 150:147-155

What is the Prevalence of PMADs and SUDs?



Postpartum Substance Use and Depressive Symptoms: A Review

- Postpartum alcohol (prevalence range 30.1% −49%) and drug use (4.5%–8.5%) were lower than use among not pregnant, not postpartum women (41.5%–57.5%; 7.6%–10.6%, respectively) but higher than use among pregnant women (5.4%–11.6%; 3.7%–4.3%, respectively)
  - Correlates of postpartum problem drinking were being unemployed, unmarried, and a cigarette smoker
  - Prevalence of drug use was highest among white new mothers, followed by Blacks and Hispanics
- Overall, findings from this review suggest that women with PPD are more likely to use substances than new mothers without PPD
  - Postpartum substance users and women with a history of substance use had higher PPD prevalence (19.7%–46%) compared to women not using or without such a history

Women Health. 2013 July ; 53(5): 479–503

ACOG Monograph on Mood and Anxiety Disorders,

Volume XVI, Number 5, September 2017

- Approximately 15% of all pregnant women have a pre-existing psychiatric illness and as many as 10% of pregnant women take a psychotropic medication
- For these women, pregnancy and the postpartum period are periods when psychiatric illness may worsen or relapse
  - The risk of relapse during pregnancy increases in the setting of medication discontinuation
- A 2002 study found that the risk for major depressive disorder and bipolar disorder during pregnancy was approximately equivalent to the risk for women who were not pregnant; however, the risk in the immediate postpartum period was clearly increased in patients with major depressive disorder, with an adjusted OR of 1.52 (CI; 1.07–2.15)
- Perinatal screening for PMADs often focuses on perinatal depression; however, the burden of anxiety disorders, experienced by 14% of perinatal women, may be more important as it relates to co-occurring SUDs

Postpartum mental illness during the COVID-19 pandemic: a population-based, repeated cross-sectional study

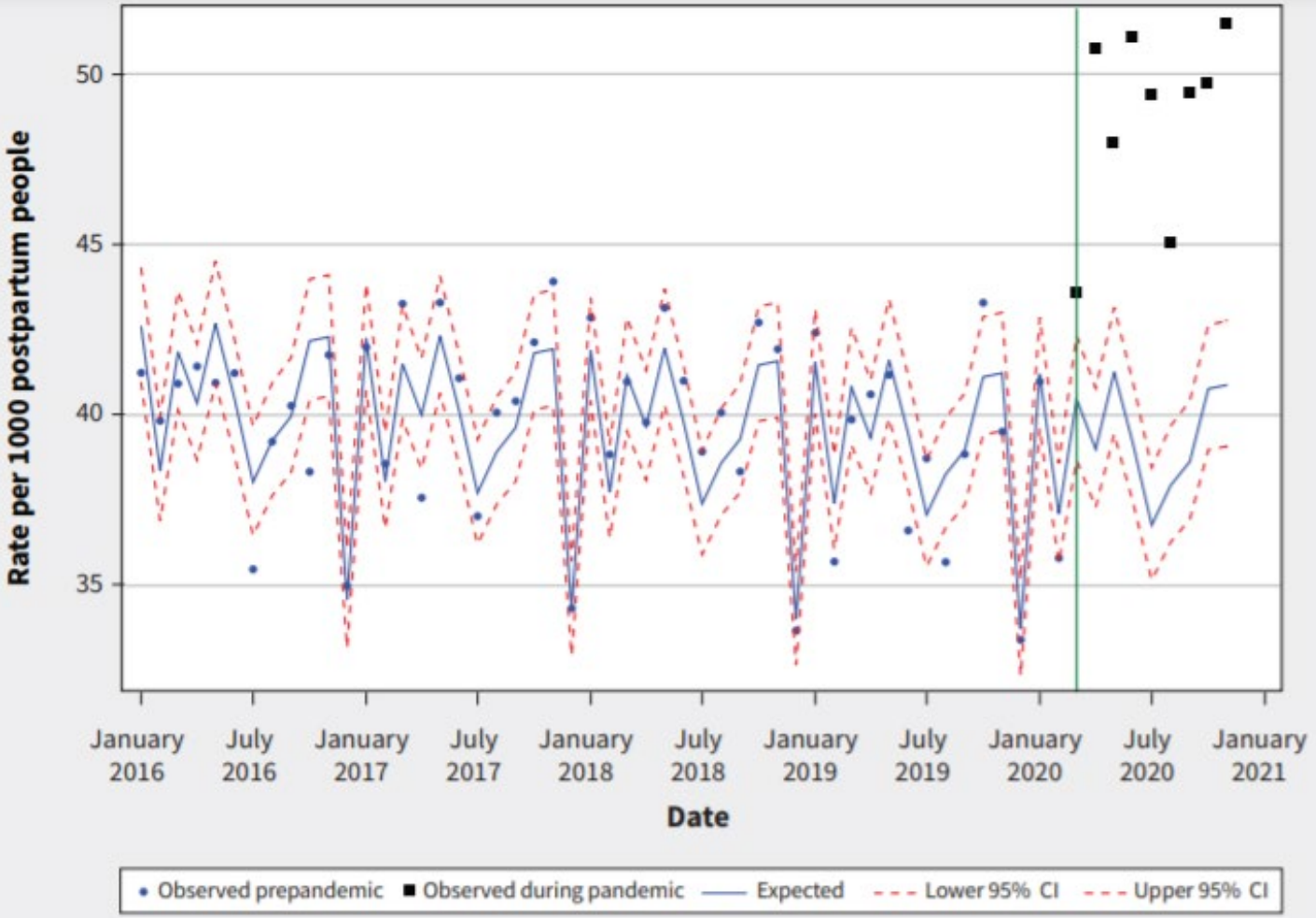


Figure 1: Observed and expected rates of postpartum mental illness visits to primary care physicians or psychiatrists per 1000 postpartum people from January 2016 to November 2020, with 95% confidence intervals (CIs).

CMAJ 2021; 193:E835-E843

Timing	Month	No. of people contributing at-risk time to monthly sample	Rate/1000 postpartum people		Absolute rate difference (95% CI)	Incidence rate ratio (95% CI)
			Observed	Expected		
0–90 d postpartum	March	39 996	41.1	35.8	5.2 (3.3 to 7.0)	1.15 (1.09 to 1.21)
	April	39 990	55.1	35.1	20.0 (18.1 to 21.8)	1.57 (1.49 to 1.65)
	May	40 888	51.6	36.4	15.2 (13.3 to 17.1)	1.42 (1.35 to 1.49)
	June	41 276	55.8	35.3	20.5 (18.7 to 22.3)	1.58 (1.50 to 1.67)
	July	42 655	51.5	33.0	18.6 (16. to 20.2)	1.56 (1.48 to 1.65)
	August	43 272	43.7	34.2	9.5 (7.7 to 11.3)	1.28 (1.21 to 1.35)
	September	43 026	44.5	34.8	9.7 (7.9 to 11.5)	1.28 (1.21 to 1.35)
	October	42 095	46.2	36.5	9.8 (7.8 to 11.6)	1.27 (1.20 to 1.33)
	November	39 656	45.5	35.6	9.9 (8.0 to 11.7)	1.28 (1.21 to 1.35)
91–365 d postpartum	March	107 609	40.5	38.5	2.0 (0.1 to 3.9)	1.05 (1.00 to 1.11)
	April	107 207	44.5	36.9	7.6 (5.7 to 9.3)	1.20 (1.15 to 1.27)
	May	106 881	42.1	39.2	3.0 (1.0 to 4.9)	1.08 (1.02 to 1.13)
	June	106 186	44.5	37.0	7.6 (5.7 to 9.3)	1.20 (1.15 to 1.27)
	July	105 787	43.7	34.7	9.1 (7.3 to 10.7)	1.26 (1.20 to 1.33)
	August	104 965	41.0	35.6	5.4 (3.6 to 7.1)	1.15 (1.10 to 1.21)
	September	104 052	46.6	36.4	10.2 (8.4 to 12.0)	1.28 (1.22 to 1.35)
	October	104 308	45.9	38.2	7.7 (5.8 to 9.5)	1.20 (1.14 to 1.26)
	November	104 076	48.5	38.9	9.7 (7.7 to 11.5)	1.25 (1.19 to 1.31)

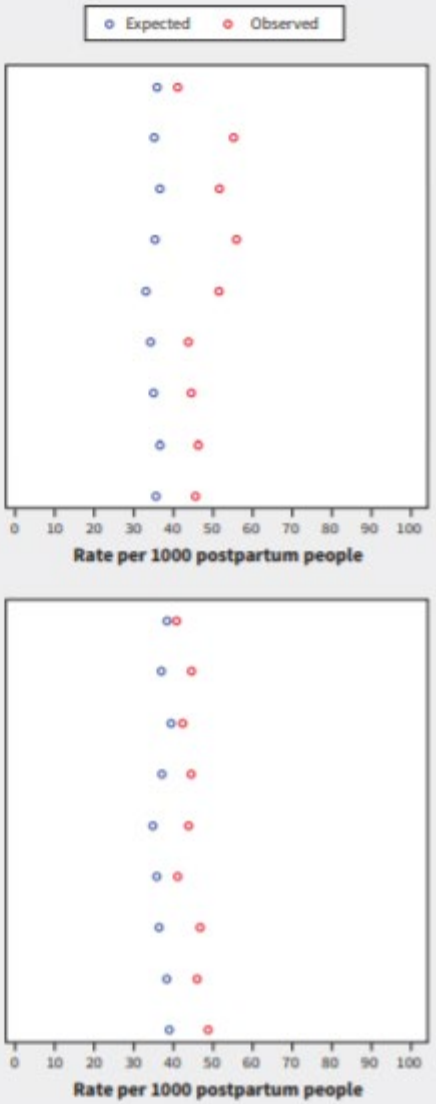


Figure 4: Rates, absolute rate differences and incidence rate ratios of visits to primary care physicians or psychiatrists for postpartum mental illness per 1000 postpartum people from March to November 2020, comparing observed rates with expected rates as predicted by modelling from the prepandemic period (January 2016 to February 2020), stratified by time since delivery (0–90 days postpartum and 91–365 days postpartum). Note: CI = confidence interval.

Clinical diagnosis	Month	Rate/1000 postpartum people: Observed	Rate/1000 postpartum people: Expected	Absolute rate difference (95% CI)	Incidence rate ratio (95% CI)
Anxiety and related disorders	March	30.8	27.6	3.2 (1.8 to 4.5)	1.12 (1.06 to 1.17)
	April	35.7	26.7	9.0 (7.7 to 10.3)	1.34 (1.27 to 1.40)
	May	33.8	28.0	5.8 (4.4 to 7.1)	1.21 (1.15 to 1.27)
	June	35.2	26.4	8.7 (7.4 to 10.0)	1.33 (1.27 to 1.40)
	July	34.5	24.7	9.7 (8.5 to 10.9)	1.39 (1.33 to 1.46)
	August	31.0	25.7	5.4 (4.1 to 6.6)	1.21 (1.15 to 1.27)
	September	33.7	26.7	7.0 (5.7 to 8.3)	1.26 (1.20 to 1.33)
	October	34.7	27.9	6.8 (5.4 to 8.1)	1.24 (1.18 to 1.31)
	November	35.9	28.3	7.7 (6.2 to 9.0)	1.27 (1.21 to 1.33)
Depressive disorders or other nonpsychotic disorders not elsewhere classified	March	5.7	5.6	0.1 (-0.4 to 0.5)	1.01 (0.94 to 1.09)
	April	6.4	5.4	1.0 (0.6 to 1.4)	1.19 (1.10 to 1.28)
	May	6.6	5.8	0.8 (0.3 to 1.2)	1.13 (1.05 to 1.22)
	June	7.3	5.6	1.8 (1.3 to 2.2)	1.32 (1.22 to 1.42)
	July	6.8	5.3	1.5 (1.1 to 1.9)	1.28 (1.19 to 1.38)
	August	6.6	5.4	1.3 (0.9 to 1.7)	1.24 (1.15 to 1.33)
	September	7.4	5.3	2.1 (1.7 to 2.4)	1.39 (1.29 to 1.50)
	October	7.0	5.7	1.3 (0.9 to 1.7)	1.23 (1.14 to 1.32)
	November	7.4	5.6	1.8 (1.4 to 2.2)	1.32 (1.23 to 1.42)
Bipolar disorders	March	1.7	1.7	0.0 (-0.2 to 0.1)	0.98 (0.88 to 1.09)
	April	1.8	1.8	0.0 (-0.2 to 0.2)	1.02 (0.92 to 1.13)
	May	1.9	1.8	0.1 (-0.1 to 0.3)	1.05 (0.94 to 1.17)
	June	2.0	1.8	0.2 (-0.1 to 0.4)	1.13 (1.02 to 1.26)
	July	1.9	1.5	0.5 (0.3 to 0.6)	1.31 (1.18 to 1.46)
	August	1.6	1.7	-0.1 (-0.2 to 0.1)	0.96 (0.87 to 1.07)
	September	2.0	1.7	0.3 (0.1 to 0.5)	1.17 (1.05 to 1.30)
	October	1.8	2.0	-0.1 (-0.3 to 0.1)	0.94 (0.84 to 1.04)
	November	1.9	1.9	0.0 (-0.2 to 0.2)	0.99 (0.89 to 1.10)
Psychotic disorders	March	0.4	0.4	0.0 (-0.1 to 0.0)	0.92 (0.78 to 1.09)
	April	0.6	0.5	0.1 (0.0 to 0.2)	1.24 (1.04 to 1.47)
	May	0.5	0.5	0.0 (-0.1 to 0.1)	1.07 (0.90 to 1.27)
	June	0.6	0.5	0.1 (0.0 to 0.2)	1.18 (0.99 to 1.40)
	July	0.6	0.5	0.1 (0.0 to 0.2)	1.22 (1.03 to 1.45)
	August	0.4	0.5	0.0 (-0.1 to 0.0)	0.95 (0.80 to 1.13)
	September	0.7	0.5	0.2 (0.1 to 0.3)	1.41 (1.19 to 1.67)
	October	0.5	0.4	0.1 (0.0 to 0.2)	1.25 (1.05 to 1.48)
	November	0.5	0.4	0.0 (-0.1 to 0.1)	1.06 (0.90 to 1.26)
Alcohol and substance use disorders	March	2.3	2.1	0.3 (-0.1 to 0.6)	1.13 (0.96 to 1.32)
	April	3.5	1.9	1.6 (1.2 to 1.9)	1.82 (1.53 to 2.15)
	May	2.7	2.1	0.6 (0.2 to 0.9)	1.28 (1.07 to 1.52)
	June	2.9	1.9	1.0 (0.7 to 1.3)	1.54 (1.29 to 1.84)
	July	2.7	2.0	0.8 (0.4 to 1.1)	1.39 (1.17 to 1.67)
	August	2.5	2.0	0.6 (0.2 to 0.9)	1.29 (1.08 to 1.55)
	September	2.6	1.8	0.8 (0.4 to 1.1)	1.43 (1.19 to 1.72)
	October	2.5	1.9	0.7 (0.3 to 1.0)	1.35 (1.12 to 1.63)
	November	2.4	1.8	0.6 (0.2 to 0.9)	1.33 (1.10 to 1.61)
Other disorders	March	3.0	2.7	-0.3 (-0.6 to -0.1)	0.89 (0.82 to 0.96)
	April	2.8	2.9	-0.1 (-0.3 to 0.1)	0.97 (0.90 to 1.05)
	May	2.6	3.2	-0.6 (-0.9 to -0.3)	0.81 (0.75 to 0.88)
	June	3.0	3.0	0.0 (-0.3 to 0.2)	1.00 (0.92 to 1.08)
	July	2.9	2.9	0.1 (-0.2 to 0.3)	1.03 (0.95 to 1.11)
	August	2.8	2.9	-0.1 (-0.3 to 0.1)	0.97 (0.89 to 1.05)
	September	3.2	2.9	0.2 (0.0 to 0.5)	1.08 (1.00 to 1.17)
	October	3.1	3.1	0.0 (-0.2 to 0.3)	1.01 (0.94 to 1.10)
	November	3.3	3.0	0.3 (0.0 to 0.5)	1.08 (1.00 to 1.17)

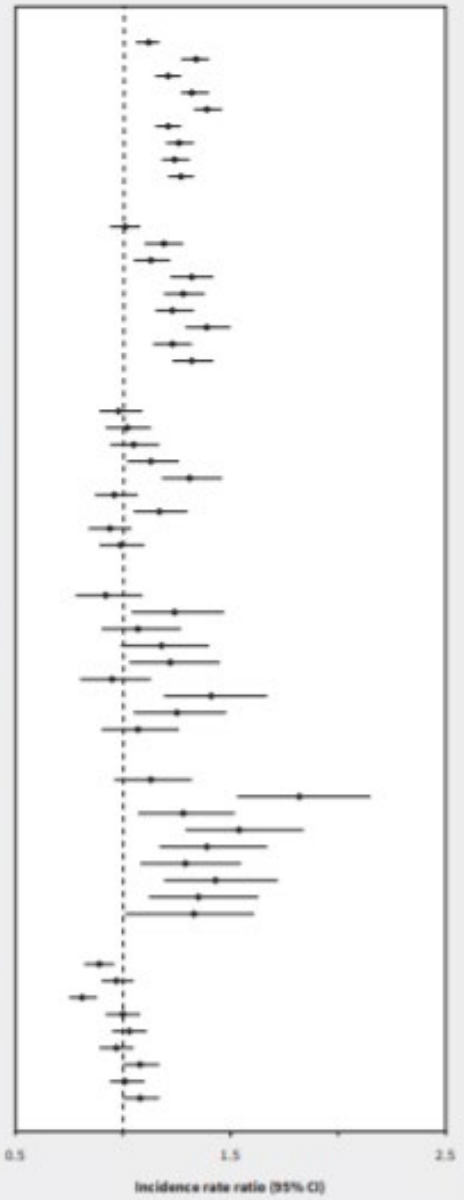


Figure 3: Rates, absolute rate differences and incidence rate ratios of postpartum mental illness visits to primary care physicians and psychiatrists per 1000 postpartum people from March to November 2020, comparing observed rates with expected rates as predicted by modelling from the prepandemic period (January 2016 to February 2020), by clinical diagnosis. Note: CI = confidence interval.

Screening for Perinatal Substance Use

- **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

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

NIDA Quick Screen

Since becoming pregnant, how often have you used the following*:	Never	Once or Twice	Monthly	Weekly	Daily or Almost daily
1. Alcohol (≥ 3 drinks/day)					
2. Tobacco products					
3. Prescription drugs for nonmedical reasons					
4. Illegal drugs including marijuana					

If the patient says “NO” for all drugs in the Quick Screen, reinforce abstinence. Screening is complete.

If the patients 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**

Laboratory Testing

- Universal laboratory testing for evidence of drug use is NOT recommended for screening purposes because of its limitations
- Patients should be informed of potential ramifications of a positive test result and should give **informed consent prior to testing**
- Medically indicated drug testing without written informed consent is acceptable if patient is unconscious or showing obvious signs of intoxication and needs to be tested in order to render appropriate medical care.

Possible Clinical Indications for Lab Testing in Pregnancy

- Previous positive drug test
- Monitoring compliance with methadone or buprenorphine
- Abruptio placentae
- Idiopathic preterm labor
- Idiopathic fetal growth restriction
- Frequent requests for prescription drugs that are commonly misused
- Noncompliance with prenatal care
- Unexplained fetal demise

Identify Comorbid Conditions

- **Psychiatric illness** including PMADs
  - Pre-existing co-occurring mental health conditions, especially stress-related mood and anxiety disorders
  - Co-occurring perinatal mental health conditions are common (50-65%) especially depression, anxiety, and PTSD
- **Adverse Childhood Experiences (ACEs)**
  - In one large study, people with a history of ≥4 adverse childhood events were 7-10 x more likely to report illicit drug use and addiction
- **Intimate partner violence**
  - IPV is common is this patient population (60%)

Discussion with Your Patient

- In the SBIRT model, patients who **screen positive** are provided with nonjudgmental information about risks of continued use for both the mother and fetus/child and then referred for appropriate treatment.
- Additional discussion points that can be helpful to determine degree of use and guide treatment selection include:
  - **Pattern of use**: frequency, length of most recent pattern of use, time of last use; where, when and with whom?
  - **Route of administration**: oral, intranasal, "skin popping" (SQ), IV
  - **Quantity used**: amount spent on daily, weekly or monthly basis
  - **Additional symptoms**: tolerance or withdrawal symptoms for each substance used
  - **Prior substance use treatmen**t: longest period of abstinence; use of 12-step groups

SBIRT=screening, brief intervention & referral to treatment

Substance Use Navigator (SUN) in EDs of Hospitals Participating in CA Bridge Program

- Contact your SUN who can facilitate referral of your patient to appropriate Alcohol/Drug Treatment Program
  - In Los Angeles County: Substance Abuse Service Hotline (SASH) 1-844-804-7500
  - In Sacramento County: 1-916-874-9754
- Simple telephone assessment will be completed and the client will be triaged to the appropriate level of care
- There are specialized programs for pregnant/postpartum women where infants/toddlers can accompany mothers
  - Options for Recovery, Torrance, CA: (310) 222-5410
- There are limited specialized programs for clients with SMI and co-occurring SUD

Free Perinatal Psychiatry Consultation Service

Real-time telephone consultation

For provider support with diagnosis, treatment planning, and medication management of pregnant and postpartum women with depression and anxiety.

Free service for all providers in Arizona, Arkansas, California, Iowa, Kentucky, Minnesota, Nebraska, Nevada, North Dakota, Ohio, Oregon, Texas, and Washington.

Perinatal Psychiatrist: Miriam Schultz, MD
Phone: 1.833.205.7141

Hours: Monday to Friday
Noon - 4:30 PM (PT) • 1 - 5:30 PM (MT) • 2 - 6:30 PM (CT) • 3 – 7:30 PM (ET)
(Except national holidays and consultant vacation days)
Calls will be answered immediately or returned within the hour

Questions? Contact:
Barbara Sheehy, MS
System Director, Perinatal Behavioral Health
415.544.2395 | Barbara.Sheehy@DignityHealth.org

CommonSpirit

Questions?

Thank you.

Questions

Hospital Quality Institute

Coming Up

July 15: Group Office Hours (Noon – 1 pm)

Substance Use Disorders and Perinatal Mental Health, continued

Staff and patient education about PMH, revisited

August 19: Webinar (Noon – 1 pm)

Child Abuse Reporting and Perinatal Mental Health

Register on HQI website: https://www.hqinstitute.org/pmh-learning-community

Webinar Evaluation

Polling questions:

1) Today's webinar was a good use of my time

   (agree-disagree-unsure)

2) Today's webinar increased my understanding of substance use disorders in the context of perinatal care

   (agree-disagree-unsure)

Open Text feedback – type into "Chat":

What could have been done better or differently?