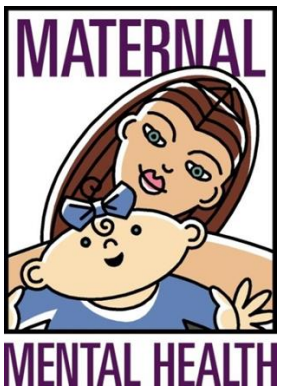
Oregon Project LAUNCH- Deschutes County

Maternal Mental Health Initiative

Early Childhood Wellness
LASTS A LIFETIME

Background - Addressing Maternal Mental Health



In 2011, a lack of screening and treatment services in Central Oregon prompted development of the Maternal Mental Health (MMH) initiative.

Led by LAUNCH and the Children and Families Commission, the initiative used SAMHSA's *Maternal Depression Making a Difference Through Community Action Planning Guide* to inform its strategic plan.

Goal. To improve the MMH system in four key ways: 1). Train primary care providers to provide MMH screenings; 2). Create a tightly linked screening, referral, and support system; 3). Improve the capacity of mental health services; and 4). Build community awareness about the importance of MMH.

Activities to meet goals included:

- Formation of a tri-county MMH steering committee
- Community survey in partnership with the state
- Grand Rounds for area physicians, 50 attended
- Two broad community trainings about prenatal and postpartum depression (>200 participants)
- Development of English and Spanish client education materials
- Establishment of Postpartum Support International Warm Line in Central Oregon – a resource that can connect women to services in the area
- Development of a screening/referral process
- Training about screening and referring for 9 physician practices in partnership with the Oregon Pediatric Society START initiative
- Development of a 30-second MMH PSA in English and Spanish and aired on network television
- Piloting an embedded behavioral health therapist in Women, Infants, and Children (WIC) clinic

Evaluation – Measuring the Maternal Mental Health Initiative

Qualitative Methods were used to explore perceptions about the maternal mental health system created through the Initiative. Questions addressed whether the MMH Initiative had made a difference to the women and families served, which components of the system had been most helpful, and what gaps still remain.

- *Key Informant Interviews* with 15 behavioral health therapists, primary care providers and staff, and home visiting nurses (response rate of 83%). The semi-structured interviews lasted between 15 and 30 minutes. Those involved in screening for prenatal and postpartum depression were asked specifically about this process.
- *A Focus Group* was held with 15 staff members from Deschutes County Women, Infants, and Children (WIC) Clinic. The 30 minute focus group addressed the questions above but specifically asked about the embedded Behavioral Health therapist located in the WIC clinic.

Quantitative data from a local OB/GYN clinic administering the Edinburgh Postnatal Depression Screen, referral information from Postpartum Support International, and screening and referral information from Deschutes County WIC have been used to better understand the prevalence of prenatal and postpartum depression in the tri-county region. This descriptive information was not included in a formal evaluation, but the findings are discussed below.

Findings - What We Learned

Screening is valuable

Providers and public health staff indicate that the screening has been easy to administer and valuable. Many express that the screening results highlight concerns that they might not have noticed otherwise.

Preliminary Data from OB/GYN clinic (Jan-Mar 2014) –Screens are administered prenatally (intake and 32 weeks) and postpartum

- 96% (N=806) of mothers receiving maternity care were screened for depression (rate was 99% prenatal period, 87% postpartum)
- 10% (N = 85) positive for moderate-severe depression (rates were 14% Oregon Health Plan vs. 7% private insurance)

Referral options and feedback are essential

A common theme among providers and staff was the need to have greater referral to treatment options. One of the strategies was to establish Postpartum Support International (PSI) Warm Line in 2012, providing a referral link for women and providers. Since that time, 172 women have called directly and 232 referrals have been made from a local pediatric clinic (172) and OB/GYN clinic (59). Results are not available about services received or outcomes.

"There's a lot of stigma that comes with that [mental health] and I think that having somebody down here with us, they trust us, and so they trust who we are handing them off to – kind of erases that barrier" ***- WIC Certifier***

Timing and location are important

Warm hand-offs make a difference whether it is from a clinic provider or a public health staff. The introduction to a mental health therapist from a trusted professional can help moms take that next step.

Walk-in availability makes a difference

Having the option to see someone immediately is important for those women who might otherwise not seek help. LAUNCH worked with behavioral health and public health to pilot having a LAUNCH-funded therapist in WIC. The bilingual therapist reports that mothers are now much more willing to come back to see her because they met through a warm hand off during a WIC visit. Findings show that the women also value the walk-in availability.

Implications for Policy and Practice

When developing a community MMH system, the following should be considered:

- Community awareness about maternal depression is important and requires local data
- Stakeholders must be involved and educated from the beginning – including health care providers
  - Identify early adopters and champions
- It's important to have the referral and treatment capacity before initiating screening. Providers are hesitant to screen without adequate capacity to meet the mother's needs.
- Resources should be available for ongoing education, technical assistance and system monitoring.

Nationwide, Project LAUNCH demonstration sites are pioneering new ways to promote young child wellness (prenatal - age 8). In 2009, Deschutes County was selected as the LAUNCH demonstration site for Oregon.
For information visit: Deschutes.org/ecwellness

This initiative was developed in part under grant # IH79SM058339-01 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

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