Building Mental Health Support into Family Planning Services
July 27, 2022
Transcript

Slide 1

- [Naima] Hello everyone. This is Naima Cozier with the Reproductive Health National Training Center and I'm delighted to welcome you all to today's webinar about Building Mental Health Support into Family Planning Services. I have a few announcements before we begin. Everyone on the webinar today is muted, given the large number of participants. We plan to have some time for questions at the end of the webinar today. You can ask your questions using the chat at any time during the webinar. A recording of today's webinar, the slide deck, and a transcript will be available on RHNTC.org within the next few days. Closed Captioning has been enabled for this webinar. To view, click on the CC icon at the bottom of your screen. Your feedback is extremely important to us and has enabled the RHNTC to make quality improvements in our work based on your comments. Please take a moment to open the evaluation link in the chat and consider completing the evaluation real-time. In order to obtain a certificate of completion for attending this webinar, you must be logged into rhntc.org when you complete the evaluation. This presentation was supported by the Office of Population Affairs (OPA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of OPA, OWH or HHS.

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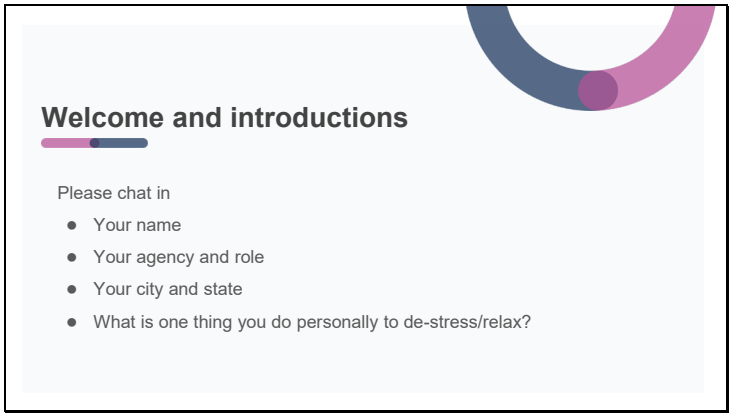

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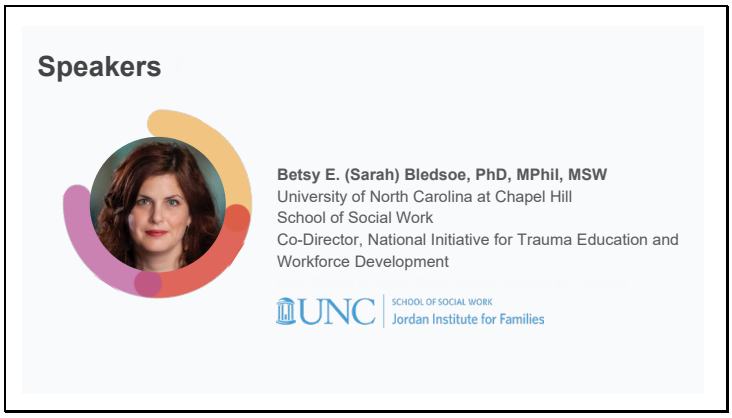

I'm pleased to introduce Dr. Betsy Bledsoe. Betsy is an associate professor at the University of North Carolina at Chapel Hill School of Social Work. She is Co-Director of the National Initiative for Trauma Education and Workforce Development, co-investigator at the Family Informed Trauma Treatment Center and a consultant with the Center for Adjustment, Resilience & Recovery – all part of the National Child Traumatic Stress Network funded by the Substance Abuse and Mental Health Services Administration. She has expertise in mental health services and intervention and implementation research with a focus on mood, anxiety, and trauma related disorders during the perinatal period and beyond. Her research has examined the implementation and dissemination of evidence-based practice and empirically supported interventions with attention to the cultural adaptation of these practices to increase access to historically marginalized communities and populations including Black Indigenous and People of Color, individuals living in rural areas, and individuals surviving poverty.

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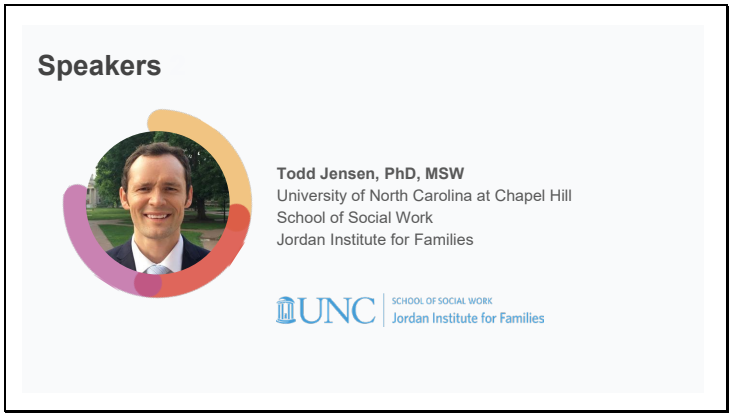

Next, I'm pleased to introduce Todd Jensen. Todd is a Research Assistant Professor in the School of Social Work and a Family Research and Engagement Specialist in the Jordan Institute for Families at UNC. His scholarship focuses on promoting family well-being in diverse contexts; strengthening family-serving systems; and prioritizing equity in family research, practice, and policy. His work attends to families experiencing shifts in parental structure, family violence prevention among military-connected families, promoting the use of evidence and relationship-focused implementation strategies in family-serving systems, advocating for inclusive definitions of family, and centering equity in the theory and methods used to study and support families.

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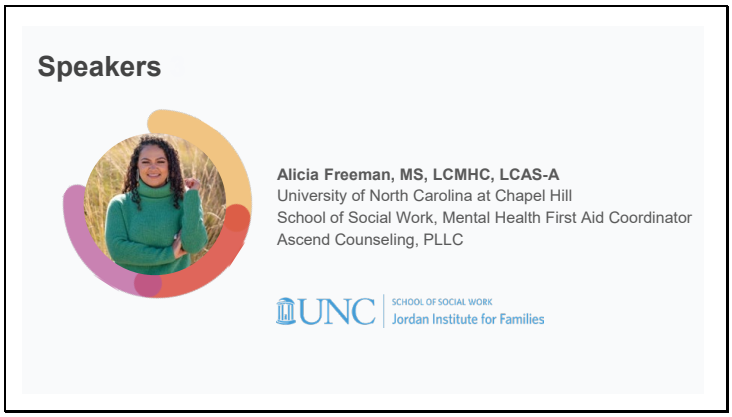

Finally, I'm pleased to introduce Alicia Freeman. Alicia has been in the mental health field for over 12 years and is the Mental Health First Aid Coordinator at the Behavioral Health Springboard within the School of Social Work at UNC-CH. She is a Licensed Clinical Mental Health Counselor and Licensed Clinical Addictions Specialist Associate and has a private practice at Ascend Counseling. Her background includes holistic wellness modalities. Alicia was raised in a rural Native American community called Buckhead and is a member of the Waccamaw Siouan Tribe.

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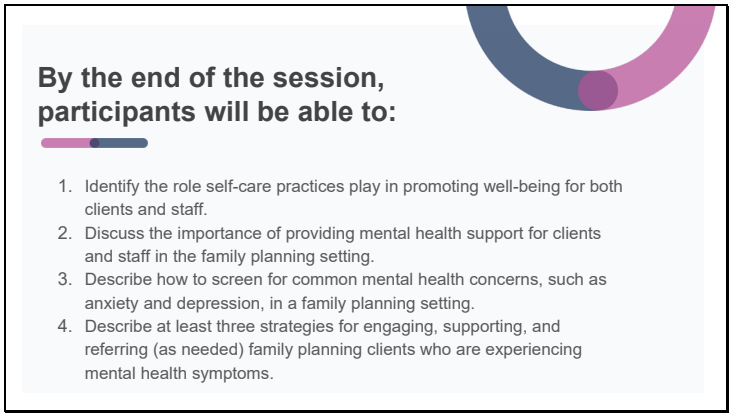

Next, I just want to review our session, our learning objectives for the webinar today. So we all hope that you will be able to identify the role self-care practices play in promoting wellbeing for both clients and staff, discuss the importance of providing mental health support for clients and staff in the family planning setting, describe how to screen for common mental health concerns, such as anxiety and depression, and finally describe at least three strategies for engaging, supporting, and referring family planning clients who are experiencing mental health systems. So with that, I'd like to turn it over to Todd to get us started.

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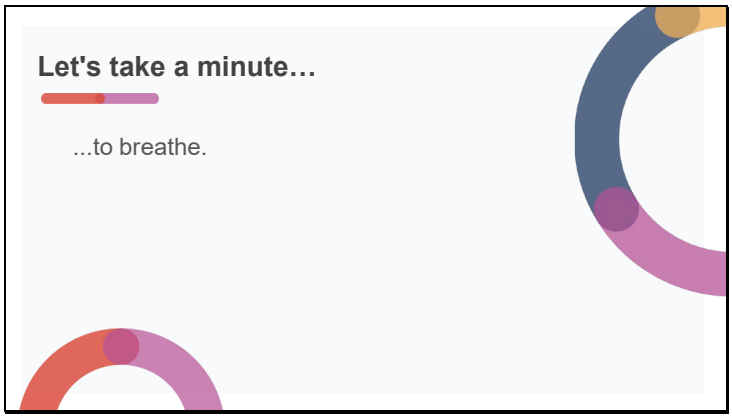

- [Todd] Great. Thanks so much. I'm so happy to join you all this afternoon. A big thanks to all of you who are introducing yourselves in the chat. We're glad to have you with us. As we really begin our time together here, I just want to take a brief moment and help us get relaxed. Help us get a little centered here. So just to start, let's take a moment to relax. Let's bring your attention to your breathing. Feel the air enter and fill your lungs. Feel the air exit your lungs and nostril. Breathe at whatever pace works well for you.

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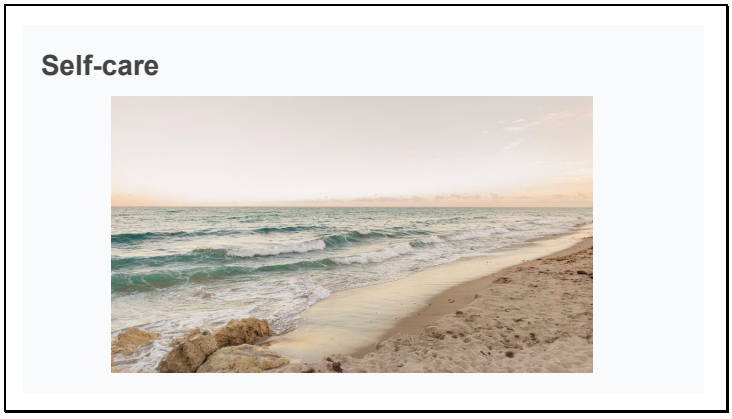

And as you continue breathing, let's take a brief moment to reflect. All of you are engaged in incredibly important work. Your work matters a great deal. You matter a great deal. Your work is making an incredible impact. And that impact is not always something you get to see directly. The benefits you offer patients can reverberate across time and across your patient's social network. Now, continue noticing your breathing and try to relax your body. Now, remind yourself of why you went into this profession. Remind yourself of your passions, your goals, your ambitions. Try not to lose sight of what motivates you and never forget that you are important and your wellness is critical. Now, exercises like this can be viewed as a self-care tool, which can be done anytime you have a brief moment throughout even the busiest of work days or at home. And as we continue this webinar together, please feel free to practice self-care in any way that makes sense for you. Consider any of the following. Listen in while you stretch or stand. Grab a cup of coffee, or tea, or water, or healthy snack while listening. Remove the various demanding distractions around us, like email or your cell phone. Breathe deeply. Feel where you're holding tension and release it. So now, that we've taken a moment to breathe and reflect, please feel free to share in the chat if you'd like how you're feeling. Consider sharing what you're doing or plan to do to feel relaxed, and to feel well during this webinar. And we want to quickly acknowledge that it can be difficult to practice self-care in a work environment that is not supportive of or conducive to self-care practices for a variety of different reasons. As a result, efforts to promote individual wellness should be multi-pronged, involving both individual and system level changes. And please know that in any case, self-care isn't selfish. Instead, it's essential for your wellbeing and that of the people you serve. If we aren't rested and centered, it's hard to hold space for patient needs in responsive care. There are also powerful connections between mental health and our overall health that support the centering of mental health in all these healthcare contexts in which we might do our work. And thank you all very much. I'd like to now turn it over to Alicia.

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- [Alicia] Thank you so much, Todd, for getting us started. I always love to get started with some self-care because it's so important. We're going to be discussing mental health today, especially as it relates to preconception health. It's an essential dimension of wellness, as it encompasses emotional, psychological, and social wellbeing. Our mental health affects how we think, how we feel and behave, including the choices we make and how we relate to others. Taking care of our mental health, even in the absence of a mental illness, is self-care. And we all want to continue to improve and engage in different self-care modalities. It's essential to our overall health and quality of life. Mental health is the core component of preconception healthcare and visits in family planning clinics. Even if at times, our patients may not understand the intersections of mental health with these visits, we can help in that education. And I believe the times when our mental health is most impacted is during periods of change and transition. So, addressing mental health during the preconception period is so pivotal because it provides the opportunity for patients to engage in preventative care in preparation for a time when their life will undergo significant change and will require adjustments both mentally and physically. Next slide, please.

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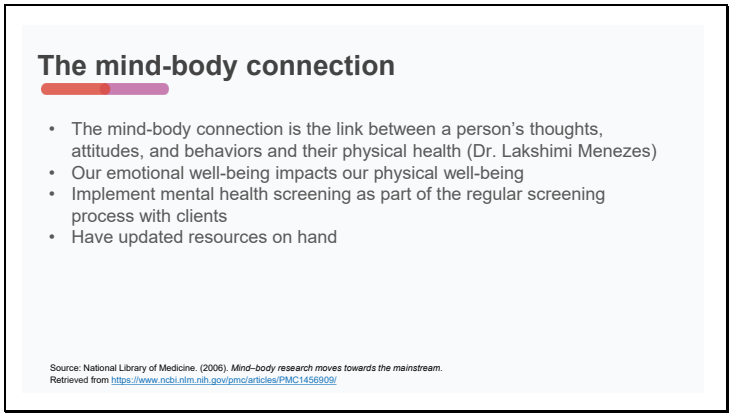


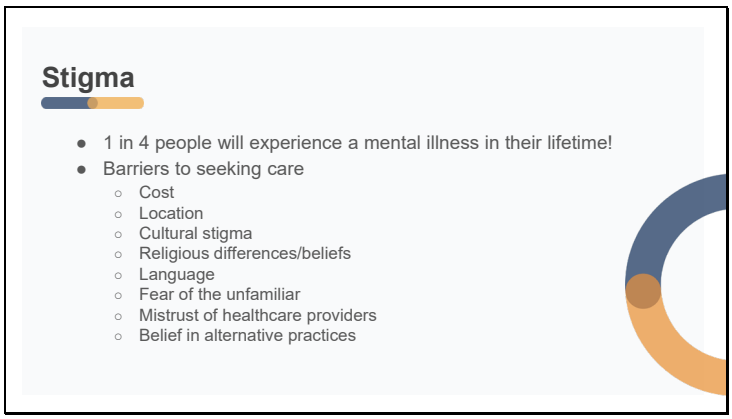
So, the mind body connection here. This is the link between a person's thoughts, attitudes, and behaviors, and their physical health. So, let's consider how this might show up for our patients. We know that prolonged stress is a risk for heart disease and even short-term stress is associated with weaken immune system, slow digestion, and even delayed healing processes. So, we can infer that physical changes will inevitably impact our mental state. However, due to the stigma associated with mental health treatment, we're more likely to see patients present with physical health concerns. So, it's important for us to recognize that sometimes these

physical health concerns that patients are bringing to us may actually be rooted in untreated mental health challenges or the initiation of the onset of those mental health challenges. So, even if it's not your role or your expertise to diagnose or treat mental health conditions, we can still play a role in this by implementing a standard screening process during those regular preconception and family planning appointments. This can help us identify additional concerns beyond the scope of your practice or appointments and help us play a pivotal role in connecting patients to appropriate professional resources.

Source:

- National Library of Medicine. (2006). Mind–body research moves towards the mainstream. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1456909/)

Slide 11



And so, we'll discuss more about the screening process later, but first let's talk a little more about stigma. So, stigma is definitely a real thing when it comes to mental health. Many patients have difficulty sharing their feelings with clinical and nonclinical staff for various reasons, such as lack of understanding about what they're feeling, previous negative experiences with healthcare providers, or other social systems, even mistrust of medical professionals, fear of being misunderstood, being labeled or shamed, among other reasons. Almost half of adults, so about 46.5%, will experience a mental illness in their lifetime. And about one in four, that's about one in four. So, it's important that we continue to destigmatize these conversations and encourage help seeking behaviors. So that we can begin to reduce some of those impacts folks are experiencing to their lives. Some individuals may have misconceptions about mental health, like it isn't a real thing or we can just tough it out. But we wouldn't expect someone with cancer to just tough it out. So if we think about those physical health concerns, like if someone had cancer, we would expect them to see a medical provider for standard evaluations and be provided with treatment options, so they could choose the best route for them. And the same is true with mental disorders. But due to stigma, we tend to shy away from these challenging conversations. And unfortunately, that results in less access to care and that continued stigma. So, we can play a role in shifting that. Folks experience various barriers, which we see here on the screen. And so, it's important to ask questions. And even though it may increase the time of our appointments, it can help us identify the onset of those mental health challenges and help our patients receive proper care. As with any medical concern, typically the sooner and individual gets help, the better the outcome is going to be. So for example, if someone had a broken ankle, their recovery might include a cast, rest, and physical therapy. But if they didn't seek medical treatment immediately, it could result in more permanent damage. And so, the same is true with mental disorders. Next slide. Thank you.

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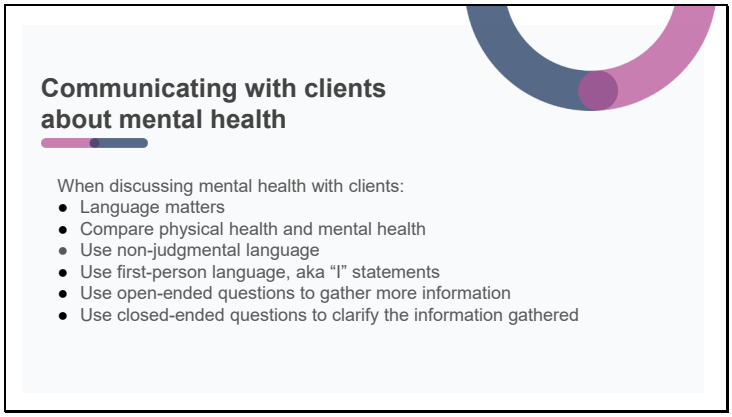

So, now let's think about when we're communicating with clients about mental health and how we can destigmatize our language. We can help reduce that stigma by shifting those conversations and the language related to mental health. I find it helpful to make comparisons between physical health and mental health, as I just did previously, even if you won't be using examples, such as diabetes. If someone had diabetes, we wouldn't expect them to just pull their self up by their bootstraps. Because we know that there's medical professionals and treatment protocols that can support individuals with managing their illness and improving their quality of life, even though that's a chronic condition. And the same is true with mental health. There's trained professionals and treatment that can help and recovery is possible. So, we want to be sure to instill that hope and have conversations about positive outcomes and recovery, as it relates to mental health, the same way we do with physical health. So, a few ways we can do that is by using person first language. So for example, a person with a disability. I'm sure this isn't new information. But we would say a person with a disability rather than handicap or rather than the name of the condition. For example, a person with substance use disorder. We wouldn't say an addict, even if the person refers to themself that way as a part of their 12 step recovery process, we still want to use first-person language, unless the individual has made it known to us that they prefer otherwise.

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It can also be helpful to try to shift our language to be a little non-judgmental. I know a lot of times it's our job to make observations. And we can do so by using I statements like I've noticed, or I've observed, or I'm concerned. And so, that helps us be a little more factual about our observation and own the observations that we're making without it sounding so judgmental

to the patient. And I recognize that many of the screening instruments tend to use closed ended questions, because they're usually given in a brief time period. But I would encourage you when having conversations about mental health to use more open-ended questions to gather additional information and really understand the scope of the concern so that you can make appropriate referrals. And we'll offer some language for conversation starters later. But first, I just want to touch on a little more about communication as it relates to suicide. So if we're concerned about risk of suicide when seeing patients, it's important that we ask direct questions here. Let's just think like why would we not want to say, are you thinking of harming yourself or hurting yourself? We would want to say, are you considering suicide? Or are you thinking of killing yourself? Rather than using words like harming or hurting, because that can be vague and the individual may not be clear on what we mean. And there's also situations where individuals may engage in self-harm or non-suicidal self injury, which is not, in that their intent is not to die by suicide. It's more of a coping mechanism they've developed. So, we want to be very clear with the situation so that we can definitely get immediate professional help in these situations. And for example, when we, you probably heard me say died by suicide rather than committed suicide. Because when we use words like committed, it implies judgment or moral value. That's commonly associated with things like crime or sin with religion. And so, when we're asking family questions, like has anyone in your ever died by suicide? We would want to continue to use die by suicide rather than committed or successfully completed.

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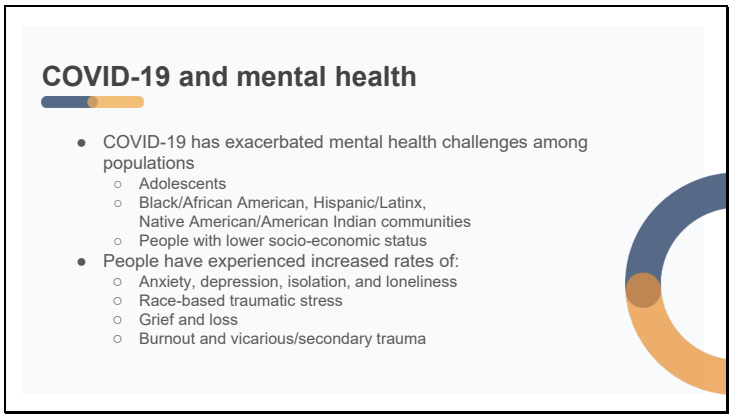

And so, we're all familiar with COVID-19 as we continue to battle through this never ending pandemic, which has exacerbated mental health challenges. I would say primarily due to the uncertainty, the isolation, the loneliness, and even the physical illnesses associated with COVID-19. And although we've all been impacted, some groups continue to experience more significant effects than others. And these groups consist of adolescents. People of color are navigating racism and higher rates of loss during COVID-19, which can feel like multiple pandemics simultaneously. So with family planning, we want to take these things into consideration and use screening tools and conversation to generate understanding, support, and connection with diverse populations. There's generally even more stigma in communities of color. So taking that into account and really listening to the barriers that folks have with accessing care can be helpful. One thing we can do when encountering folks, especially those who have been disproportionately impacted by COVID-19 is giving reassurance and information. And I like to call this giving hope with facts. We don't want to make promises we can't keep, like, oh, you'll feel brand new tomorrow or this will all be over soon. But instead we might say things like, many options of professionals and there are many options of professionals and treatments to support you. And I can offer you those resources if you're interested to

choose what's best for you. So, some things that we actually can do in those situations. And as providers, we also face unique challenges due to COVID-19, such as increased risk of burnout and vicarious trauma. Because we got to think about who's helping the helping professionals. It's challenging to navigate your own personal experiences with mental health and COVID, while supporting others through your profession. And so that's why self-care is so vital and why we're asking you about those self-care options and why we instilled a brief moment of that to start with. But I am going to pass it over to Betsy to give us a little more insight into different conditions you all might see in your clinics.

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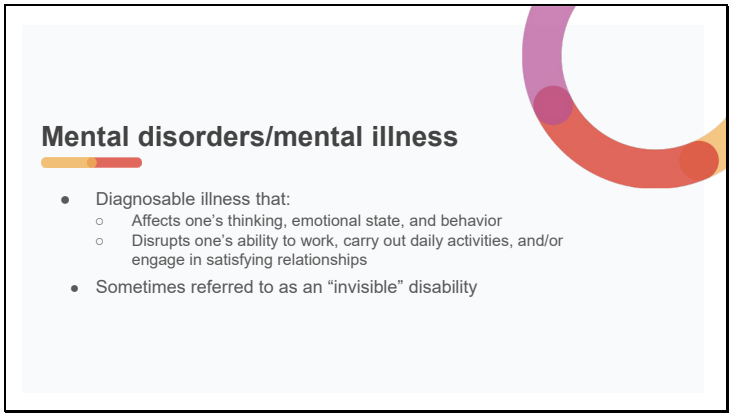

- [Betsy] Thank you, Alicia. So, I'm just giving a brief overview of the next few slides that will allow us to talk a little bit more about differences between anxiety, depression. We'll provide the PDF of the slides after the webinar, if you'd like more information on this. And one of the things we want to start with is really talking about the difference between mental disorders and mental illness. So, mental illness is really a diagnosable illness, similar to any other illness that affects someone's life. And with mental illness, we see an impact particularly on emotional state and behavior. These illnesses often disrupt an individual's ability to work, to carry out daily activities or what we refer to as functioning, as well as their functioning and ability to engage in satisfying relationships. Sometimes, this is referred to as an invisible disability. What we know is that family planning patients are experiencing higher rates of depression and anxiety. More than 20% of women in the US experienced a mental health condition in the past year, such as depression or anxiety. In 2020, the prevalence of any mental health or psychiatric illness was higher among women compared to men (womenshealth.gov – Mental Health) (https://www.womenshealth.gov/mental-health). We see that 26% of women versus 16% of men were had a diagnosable mental illness. And we know that these are also higher among younger people among those of reproductive age. Between the years of 18 and 25 in particular, 31% of individuals in the US experienced a mental health condition. Between the ages of 26 to 49, 25% compared to other age groups experienced a mental health or mental illness (NIMH Mental Illness Statistics) (https://www.nimh.nih.gov/health/statistics/mental-illness). Currently, 18% of adolescents and 23% of young adults report the pandemic has had a serious negative impact on their mental health (National Alliance on Mental Health - Mental Health Statistics 2022) (https://www.nami.org/mhstats).

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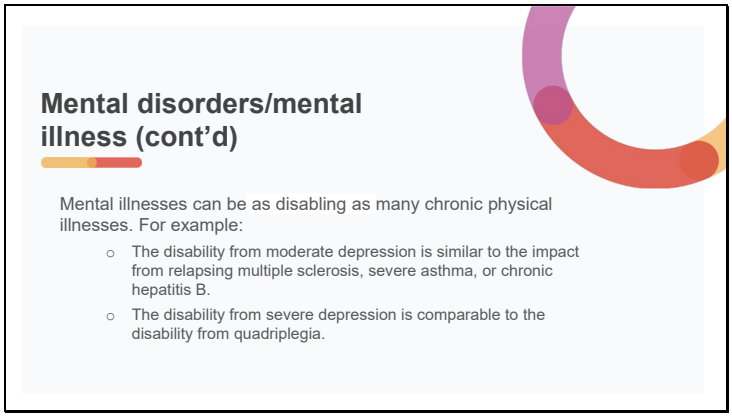

As Alicia stated, COVID-19 has exacerbated conditions of mental illness and mental health challenges for many individuals. Mental health illness was stigmatized before COVID-19. And because of the stigma and other barriers, we sometimes don't realize the disabling effect of mental illness on people has been even further exacerbated. We would never let asthma or a sexually transmitted infection, diabetes, go untreated, but we often let mental health go untreated. It can be helpful to use this metaphor when talking about mental health and the importance of holistic health with your family planning clients. There's a high level of comparison between mental health. It can be so disabling that it can be comparable to quadriplegia for some folks.

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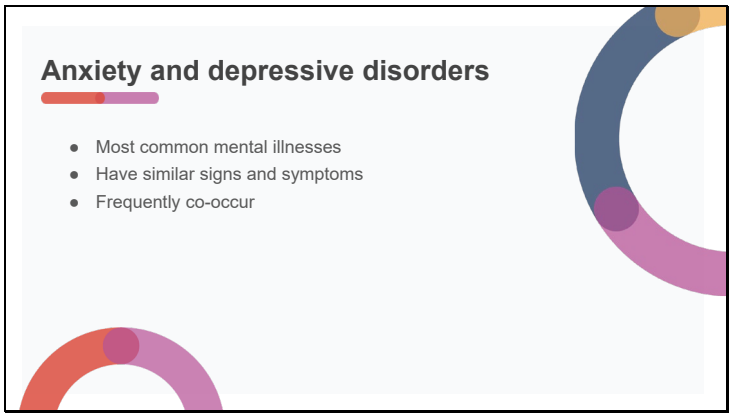

So, let's talk about the different types of common mental illnesses that you're likely to see in your family planning patients. Due to time, we're focusing on what we believe you'll see most in the patients and clients that you serve. We're going to focus on depression, anxiety, and stress today, knowing that there are so many more illnesses we need to learn about to take care of our patients. Stress anxiety and depression are both common and treatable. We know that family planning patients are experiencing higher rates of depression and anxiety.

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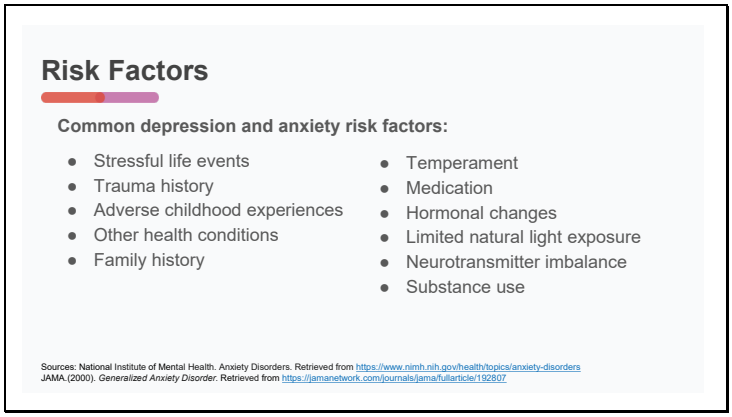

We talked earlier about the more than 20% of women who've experienced these conditions, as well as the fact that they're more current in younger folks. What we didn't talk about is the fact that oftentimes these conditions co-occur and they have similar symptoms and signs. So, it's important also to know that individuals, as well as those of us who are providers who may experience some of these health challenges, tend to self blame when it comes to mental health. Among the patients you see, please chat in some of the most common types of mental health illnesses you see when you screen a patient. And I'll give folks just a minute to do that. I see depression, anxiety coming up in the chat. Depression. Bipolar disorder, which is a mood disorder. Anxiety, depression, stressful events, substance use disorder, post-traumatic stress disorder. Absolutely, yes, you're all spot on. These are the common illnesses that we see. ADHD, absolutely. So while there are many different illnesses that we see, as I mentioned previously, today we're going to be focusing on depression and anxiety. And I want to talk a little bit about some of the common risk factors related to depression and anxiety. The first is stressful life events, distressing and uncontrollable events. Many people have experienced the COVID-19 pandemic and the dual pandemics of racism and other forms of discrimination as stressful life events. We often think of post traumatic stress disorder or acute stress disorder, perhaps even adjustment disorders, when thinking about stressful life events. However, these are often common risk factors for other mental health conditions, such as depression and anxiety. People have been talking a lot about the adverse childhood events or the ACEs study. We know that having a history of trauma, a difficult childhood, a history of childhood anxiety, also can place people at greater risk for having a mental illness or a mental health condition. Ongoing stress and anxiety also contribute to risk, as well as having a previous episode of depression or anxiety or another mental illness, even if it's well managed. Family history can also be a risk factor. We know that this is not a prescription or a certainty. But that some illnesses, including depression and anxiety, tend to run in families. We also see individuals who are more sensitive and emotional in nature being at greater risk. Those who have a chronic illness, particularly an illness that is life threatening or those who have chronic pain, are at greater risk of developing depression or anxiety. It's critical to know the medications and other illnesses that are being treated as symptoms of depression and anxiety can be side effects of some medication. Recent childbirth can also be a risk factor. We also know that premenstrual changes in hormone levels can increase risk, as well of lack of exposure to bright light, particularly in the winter. Sometimes, depression and anxiety is more related to chemical or neurotransmitter imbalances. Or also individuals who are using substances, have intoxication or withdrawal, may show signs or symptoms of depression or anxiety. They may be experiencing a comorbid episode of anxiety or depression or they may be trying to self medicate when they have anxiety or depression. So anytime there's substance misuse, intoxication, or withdrawal,

we want to be mindful that depression and anxiety may be associated with that in some way. At times, the emotional and mental challenges that are being faced are related to chemical and hormone changes related to fertility and childbirth. Even birth control can affect our mental health and changes in hormones.

Sources:

- National Institute of Mental Health. *Anxiety Disorders*. (https://www.nimh.nih.gov/health/topics/anxiety-disorders)
- JAMA. (2000). *Generalized Anxiety Disorder*. (https://jamanetwork.com/journals/jama/fullarticle/192807)

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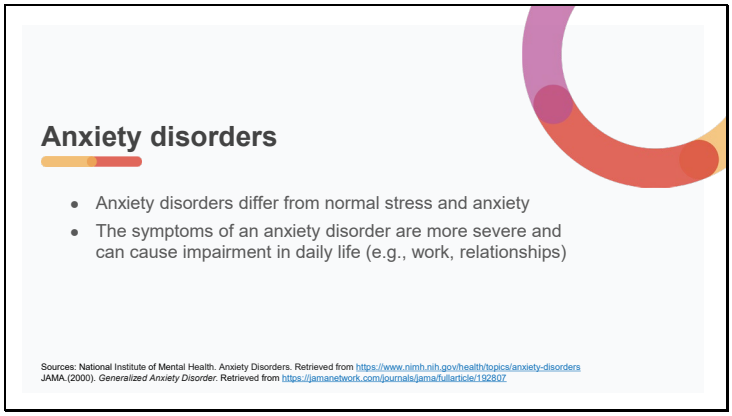
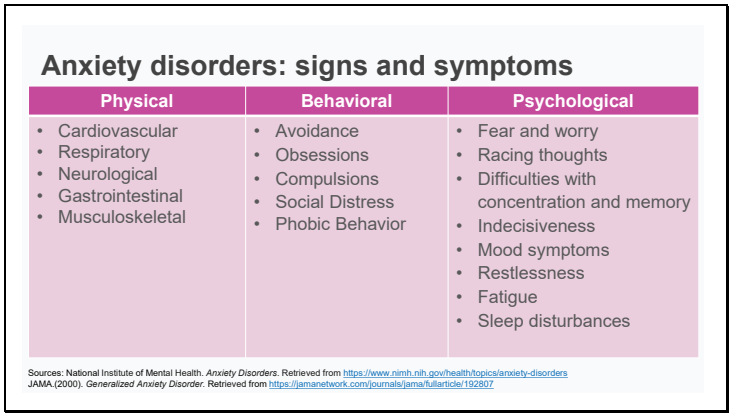


I want to move on to anxiety and focus just a bit on anxiety in particular for a moment. Anxiety disorders are the most common mental illnesses. They affect 18% of the US population every year. If you think about that, that's almost one out of every five individuals. Feelings of anxiety can be a natural or normal response to a stressful or uncomfortable situation. However, when an anxiety response is present in a situation where it's not needed or is out of proportion to the situation where it lasts longer than usual, where it isn't serving the individual, this may be due to an anxiety disorder.

Sources:

- Anxiety and Depression Association of America. *Anxiety Disorders - Facts & Statistics*. (https://adaa.org/understanding-anxiety/facts-statistics)
- National Institute of Mental Health. *Anxiety Disorders*. (https://www.nimh.nih.gov/health/topics/anxiety-disorders)
- JAMA.(2000). *Generalized Anxiety Disorder*. (https://jamanetwork.com/journals/jama/fullarticle/192807)

Slide 20

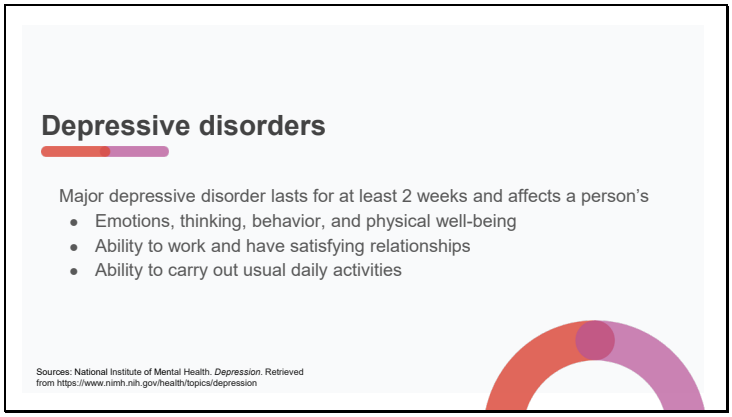


You can see here some of the physical, behavioral, and psychological signs and symptoms of anxiety disorders. Physical symptoms can include cardiovascular symptoms, such as pounding heart, chest pain, rapid heartbeat, and flushing. Fast breathing and shortness of breath are common respiratory symptoms that we see with folks who have anxiety disorders. They're also neurological symptoms. Dizziness, headache, sweating, tingling, and numbness can be part of anxiety disorder symptoms, as well as gastrointestinal, feelings of choking, having a dry mouth, stomach pains, nausea, vomiting, or diarrhea. We also see that there are musculoskeletal symptoms that go along with anxiety disorders. Muscle aches and pains, especially those in the neck, shoulders, and back, feelings of restlessness, tremoring or shaking, and a general inability to relax. This is one of the reasons that it's important to make sure that we rule out other health conditions that may be causing these. But also important to realize that oftentimes, individuals with anxiety will present to medical clinics or emergency rooms believing that there's a physical underlying cause for the symptoms they're experiencing. In order to help determine if these symptoms are related to an anxiety disorder, it's important to also know the behavioral and psychological symptoms. Behavioral symptoms include avoidance of situation, obsession, or compulsive behavior, distress in social situations, as well as phobic behavior. While psychological symptoms include unrealistic or excessive fear and worry, either about past, current, or future events. The mind racing or going blank, decreased concentration and memory, indecisiveness, irritability, impatience, anger, confusion, restlessness or feeling on edge or nervous, as well as fatigue, sleep disturbances, or even vivid dreams. These can co-occur and be happening simultaneously.

Sources:

- National Institute of Mental Health. *Anxiety Disorders*. (https://www.nimh.nih.gov/health/topics/anxiety-disorders)
- JAMA. (2000). *Generalized Anxiety Disorder*. (https://jamanetwork.com/journals/jama/fullarticle/192807)

Slide 21



Finally, I'd like to talk a little bit about depression and depressive disorder. Major depressive disorder lasts for at least two weeks and affects a person's emotions, thinking, behavior, and physical wellbeing. Their ability to work and have satisfying relationships, as well as their ability to carry out their usual daily activities. It's also known as depression and it's the leading cause of disability in the US for individuals ages 15 to 44. This is your population. Depression symptoms affect about 70, I'm sorry, not 70, thank goodness, 7% of the US population every year and are more prevalent in women compared to men. Depression can cause pervasive feelings of sadness, but can also present as irritability and loss that may be difficult to explain. Symptoms have to be present for at least two weeks in order to receive a diagnosis. I'll give a quick example of some of the folks who've presented with reproductive age, who have signs of depression. Oftentimes, we see that they may worry that this is due to another condition. That sometimes they may think that the irritability or the sadness are related to changes in menstrual cycles or even individuals who may be, have had a previous pregnancy and are looking for interception care, maybe presenting the signs of postpartum depression.

Source:

- National Institute of Mental Health. *Depression*. (https://www.nimh.nih.gov/health/topics/depression)

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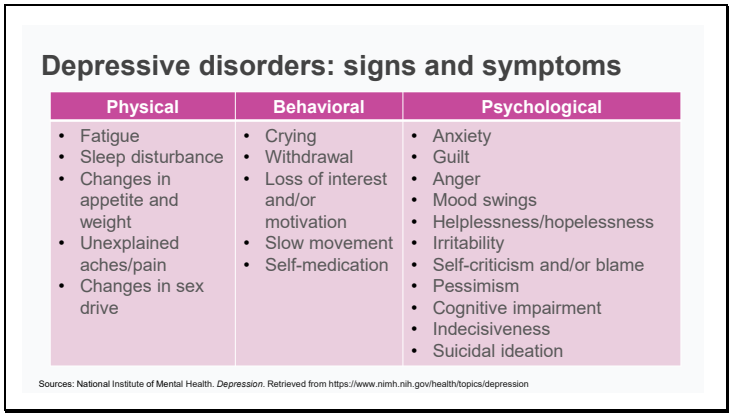

You can see here some of the physical, behavioral, and psychological signs and symptoms of depressive disorders. These can co-occur with anxiety and be happening simultaneously. As well as different people present differently with depression. So, it's important to understand the

spectrum of mood changes that individuals may experience. It's also important to know that many patients present with physical symptoms rather than psychological symptoms. Physical symptoms of depression may include fatigue, lack of energy, sleep disturbances, which can present as sleeping too much or too little, or not being able to sleep at different times in the night and then needing to sleep during the day or when they would normally be waking and taking care of their daily routine or work expectations. It can also include changes in appetite, either overeating or loss of appetite, changes in digestion, including constipation, weight loss or weight gain, headaches, irregular menstrual cycles, loss of sexual desire. And as well, we see oftentimes unexplained aches and pains. That's one of the reasons it's important to also know some of the behavioral symptoms, such as crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation, slow movement, use of drugs and alcohol to self medicate. In addition to some of the more common psychological symptoms that we are, we may be more familiar with such as anxiety, guilt, anger, mood swings, feeling helpless or focused, being more self critical, having more pessimistic outlook, cognitive impairment, indecisiveness, and suicidal ideation. Now, I'd like to turn it back over to Todd.

Source:

- National Institute of Mental Health. *Depression*. (https://www.nimh.nih.gov/health/topics/depression)

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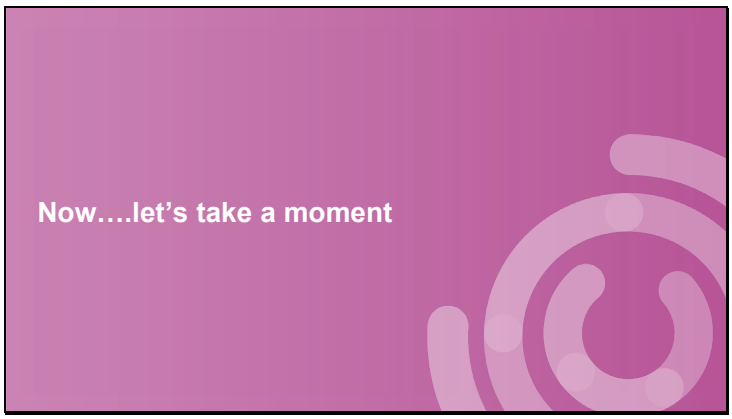

- [Todd] Thanks so much, Betsy. Well now, we just like to take a brief moment, summarize some of the key takeaways up to this point. And while I highlight some of those key summary points, please feel free to enter any questions you have up to this point in the chat. And we'll be sure to monitor that and maybe be able to respond to a question or two before we proceed. But up to this point, we've highlighted connections between mental health and preconception health more broadly. We've discussed the power of language and communication in reducing mental health stigma and inviting meaningful conversation between provider and patient. And we've provided a brief overview of some common mental health concerns and risk factors and symptoms associated with specific psychological disorders, such as depression and anxiety, which can be commonly presented in a lot of different age groups. So, I'm just kind of keeping an eye on chat here, seeing if any questions are coming up for you at this point. We still have time at the end, closer to the end of our time together to have more questions and answers as well. So if no questions are coming up for any of you at this point, please be sure to enter any into chat if they do come up for you. So without seeing any more questions coming into the chat here, I'll go ahead and pass things back over to Alicia.

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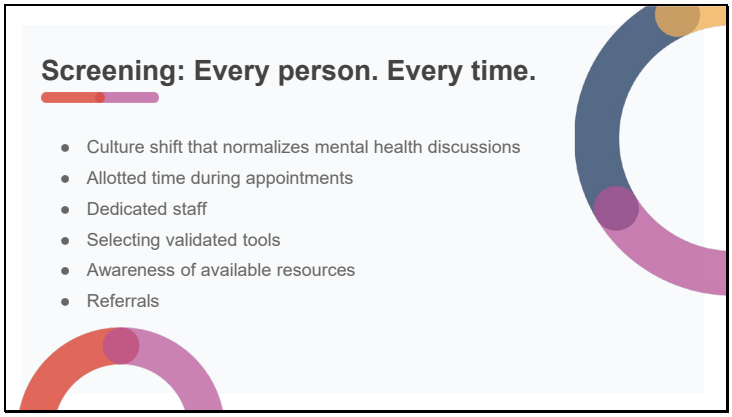

- [Alicia] Thank you, Todd. We're going to get back into it and start diving into the screening process here. It's important for us to help patients understand that mental health issues are medical issues. And so, having a standard screening process where you screen every patient every time can be helpful with folks to help understand the intersection there with medical and mental health. And to understand why we're asking questions about mental health at medical appointments, preconception appointments, family planning appointments. And here's some ways we can start to do that. Your relationship with your patients matters. And so, how can we start to shift to a culture that normalizes these discussions of mental health? Make sure we have allotted time during the appointments to screen each patient each time they are arriving for an appointment. And who is your staff person that's going to do these screenings? Is it administrative staff? Is it medical assistant? Is it nurses? So having a dedicated staff person or process there can be helpful. Selecting validated tools and I'll get into some recommendations we have for some of those tools. And of course, we want to also have resources and referrals available. We don't want to ask these questions and find out about these concerns, and then not be able to support the patients through that. So having list, having resource lists available and regular referrals that can be made is such an important part of this process. And so, each clinic can develop and implement protocols that works for your patients and works for your process.

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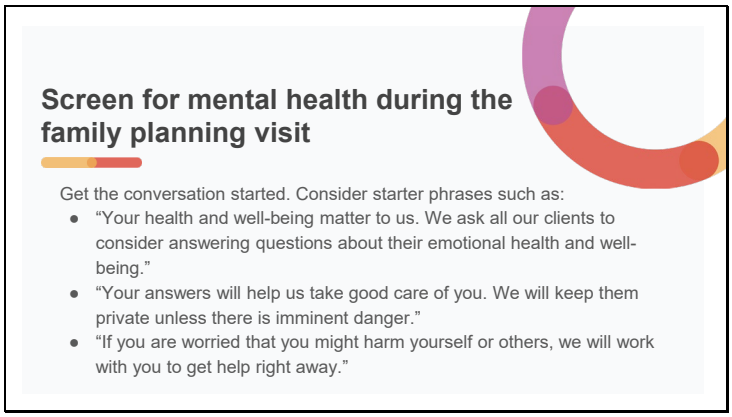

So, let's touch on some aspects of assessment or screening patients during those family planning visits. So here, we have some tips for getting the conversation started. So when you have a screening instrument, you would simply just ask the questions, but how do we get into that? It can be a little awkward and it can be uncomfortable. So, it's helpful to build trust and

build rapport with the patients during the screening process. So, they are provided with a safe place to share. So, some language we could use for this. "Your health and well-being matters to us. We ask all our clients to consider answering questions about their emotional health and well-being." "Your answers will help us to take good care of you. We will keep them private unless there is any imminent danger or safety concerns." "If you're worried that you might harm yourself or others, we will work with you to get help right away." So really showing folks that you care and thinking about the tone and the pace of your conversation with your patients can also be supportive of building that trust and that rapport. As I mentioned, these discussions can be uncomfortable. So, having this standard language available can be helpful. And we also want to make sure that we're mindful of the barriers to these conversations that reside with us. So, that might be fear and discomfort. It might be bias or something else. So really thinking through that and even with your staff on site. Having those conversations with each other about those barriers so you all can start to break those down. But definitely, use an open-ended questions and techniques such as motivational interviewing can also be helpful strategies. And I really encourage all medical staff to explore additional training in motivational interviewing if you're looking to build skills in this area.

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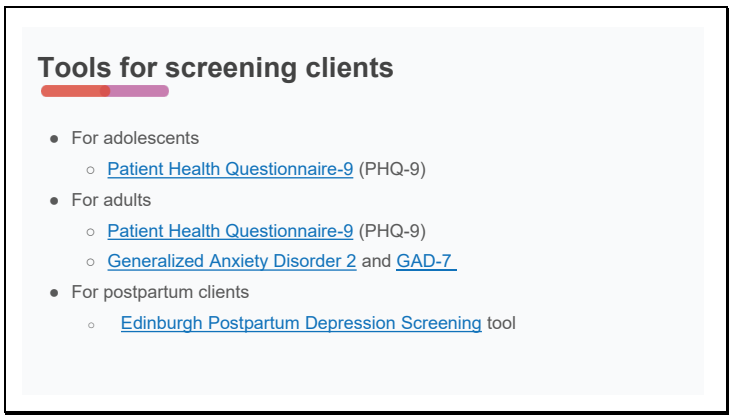

So, let's talk about some tools for screening your clients. So, here's a couple recommendations we have. The PHQ-9 and the GAD-7, so the Patient Health Questionnaire-9 and the Generalized Anxiety Disorder-7 are both, they pair well together. So, the PHQ-9 is a nine question instrument that screens for depressive symptoms. And then, the GAD-7 is a seven question instrument that screens for anxiety. You can also use the GAD-2, which chooses two of those questions from the GAD-7. And then, if you get high indicators on that two, you might choose to move into that GAD-7 to get a little more information. And then, we also have provided the Edinburgh Postpartum Depression Screening tool. And so, it's a 10 question instrument. We like that these instruments are brief, but they get directly at those top indicators that we were seeing earlier with anxiety and depression. And they also are standardized tools and they provide rubrics for next steps. So, that's super important. It is really critical that we are using these appropriately and it's given, the instructions and the rubrics, for moving forward with next steps with your patient based on the responses. It's all provided for you as a part of these screening instruments, which makes them very user friendly.

Sources:

- For adolescents
    - Patient Health Questionnaire-9 (PHQ-9)
- For adults

    - Patient Health Questionnaire-9 (PHQ-9)
    - Generalized Anxiety Disorder 2 and GAD-7
- For postpartum clients
    - Edinburgh Postpartum Depression Screening tool

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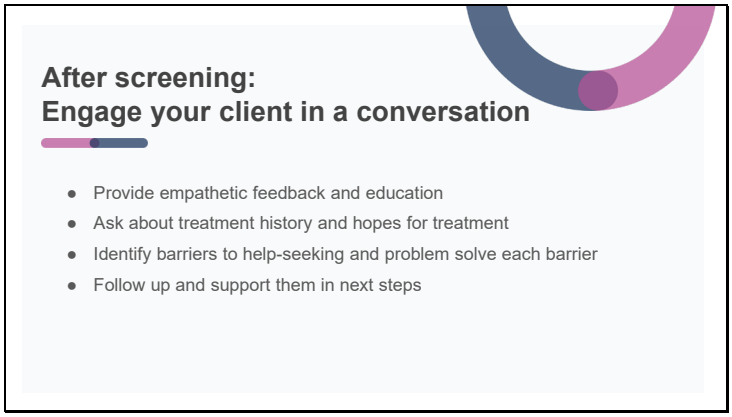

So now that you've screened your patient, you know where they've landed on some of these instruments, what's next? We've got to continue that conversation. We want to provide empathetic feedback and education. So, providing information about next steps and even asking about their treatment history or their hopes for treatment and recovery, including those potential barriers, can help us support those next steps for the patients. When we think about barriers, we also want to think about our own bias. Because if we have folks of color who have mistrust of medical providers or they have community members who just don't really see mental health as a real thing, how can we support them through that? You know, not force them to make any choices, even though we might think something is best for them. We want to look at them as the expert on their own lives. And that is really at the core of that motivational interviewing technique. It's we have information we can provide, but they have their life experience and they are the ones who will have to figure out how to apply that information and education to their lives. So we want to provide, continue to provide that follow up and next steps and not, we never want to minimize the power of planting that seed. Because even if someone is not ready just yet, that information could make a difference in the future after they've had time to think about the education you've provided. And when you follow up, they may have a different or a change of mind. Planting that seed is also an important part of this process.

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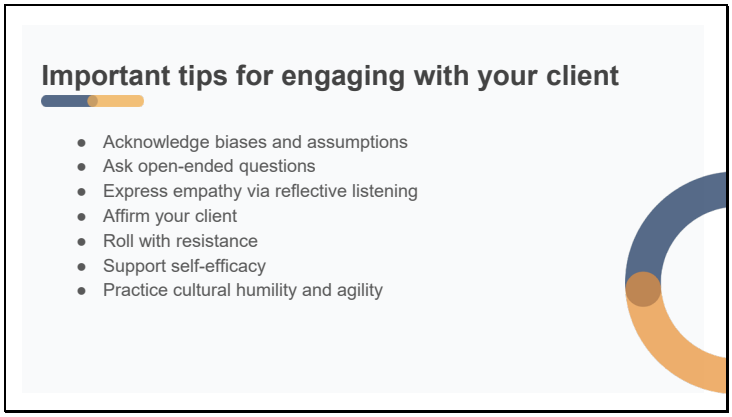

Yes, so let's think about some more tips for engaging with those patients, clients, not sure which term you all prefer. We have a wide variety of folks here. But acknowledging your biases and those assumptions, we can accept what people share whether we agree or not. Folks may have different beliefs. They may make different decisions. They may have different behaviors from us. But we can accept that they are choosing what is best for them. And if it's not best, that they will figure that out quickly and adjust, right? As long as you know, we don't have to necessarily agree with the choices they're making. We can always get more information and show that curiosity and build rapport with those open-ended questions. We really want to continue to express empathy throughout, like think about putting yourself in their shoes. And engage in that reflective listening to make sure we're understanding, like so what I heard was and am I right in. And then rephrasing kind of what we've heard from those folks. We really want to validate their concerns when it comes to mental health and when they're sharing emotion, 'cause that can be really challenging. And roll with that resistance. That's also another one of those core components of motivational interviewing. Anytime there's a change, there's automatically going to be resistance. So, whether it is, whether it's, what word am I trying to use? I'm trying to say whether it's intentional or not, that resistance is likely going to be there. And so, how we roll with that can sometimes be just information and let me know if your mind changes and moving on there. So, supporting that self-efficacy and always practicing that cultural humility and agility there with that curiosity, and really understanding those different cultural backgrounds.

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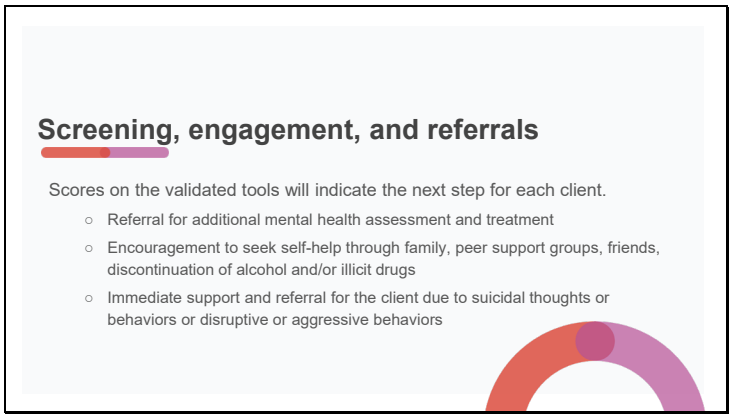

And so, as I mentioned earlier, validated tools tend to provide us rubrics for next steps based on the score received. And this really makes it simpler for providers or whoever is providing that screening to identify the level of care needed and make those appropriate referrals. So, it's also important to consider how we can help, and encourage, and facilitate, that behavior change with our patients, even if resistance is present. And so, this may be an encouraging, empathetic, nonjudgmental conversation or it may require an immediate referral depending on the level of need and where the patient is in terms of that stage of change that they're ready for. The clinics will need to have follow up protocols. So, if we're making the referrals, want to make sure that that's going smoothly and that on the other end, folks are receiving the care that they are looking for, that they had hope for in their recovery. And it's important with that we ensure these holistic approaches to healthcare and that patients are receiving services beyond preconception health and family planning as that is needed.

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So we thought this quote, we know we've had a short time here and that time with your patients can be short. And sometimes, as staff, we're burn out especially with everything that's going on lately, over extended staff from being short staffed. However, relationships matter and communications matters. And that patient centered care is really critical to supporting our patients. So here we have what Zuckoff states, "By understanding patients' individual and culturally-embedded needs and perspectives, and by communicating this understanding to them, a clinician can increase the likelihood that the patient will accept the information and treatment recommendations they offer, especially if the clinician is able to align potential treatment benefits with priorities expressed by or elicited from the patient." So, we feel like that really summed up our point here is how we can support our patients going forward. And I'm going to pass it back off to Todd.

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- [Todd] Thanks so much, Alicia. We're cognizant of the time and we definitely want to be respectful of everyone's time. And so, we did want to hop briefly into a Q&A session here and we have seen some questions coming into the chat. And there's one here that I think would be really helpful to lift up. And here's this question, "What if someone screens high in suicidality and the clinic doesn't have a mental health expert on staff?" And so, I'll let Sarah and or Alicia share their thoughts on that one.
- [Betsy] So, I can lead off and then pass to Alicia for any additional thoughts. One of the things that we we talk about frequently is safety planning. And safety planning involves asking about intent, asking about what the individual would need to, what would keep them from harming themselves. But I think first and foremost, we want to make sure that we are focused on safety

and keeping people safe. What we know is that people who have attempted suicide or self-harm during depression and anxiety and have not died by suicide are always report that they are glad they did not. And one thing we know is that if there is imminent evidence of harm, or intent, or plan that they say they will put into action and can't guarantee safety, that it's always better to err on the side of a commitment in order to keep that individual safe. There are also resources that we'll share that may be helpful in making some of those decisions. Alicia, what would you like to add?
- [Alicia] I think you covered it. Your spot on. I was going to say the same thing related to planning questions and intent there, and really just making sure you make that an immediate connection to the appropriate resources there.
- [Todd] Great. Thank you both. We have maybe time for this, with this one additional question before we provide a brief overview on some available resources. So one attendee asked the following, "Can you talk more about workflows for conducting the screening during a family planning visit? Adding on another screen to the visit will be a challenge, fitting all that into a 15 to 20 minute visit with everything else that needs to be done." Any thoughts on that front, Betsy and Alicia?
- [Betsy] Yeah, so one thing I would say is that it is critical to screen. And I understand that you work in very short time periods and are often very overworked and have so many questions to fit in. There is a two question version that we may look into, but I think oftentimes, what we can really gather information from is just learning to recognize the signs and symptoms. Knowing that if we ask someone, "What brings you in today?" Even if it's question as simple as, "How are you doing, otherwise? How is your stress level? Have you had any feelings of anxiety or depression?" That can be a good way to get at things. Many of the clinics where I have partnered or done some co-located behavioral healthcare include this in a pre-screening that they may have the patients fill out beforehand. But what we know is that oftentimes, it's your connection with the client that may actually help you to or help them really to feel comfortable sharing these things with you. Alicia, what would you add?
- [Alicia] Yeah, I would think about some things. I totally agree. This is a major challenge. But is it possible to extend the appointments, standard time from, for about five to 10 additional minutes? Is it possible to combine or find a questionnaire or screening that combines some of the screenings that you're using or use the shorter versions, like the GAD-2 instead of the GAD-7. And definitely, what Betsy stated, it is just paying attention during your total visit and that conversation, we can get a lot from that body language and the verbal and nonverbal language we're getting from in those visits, even beyond the standardized screening.

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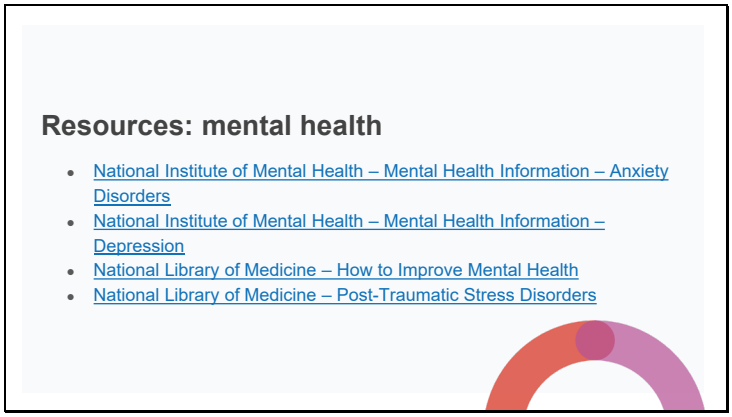

- [Todd] Excellent. Thanks so much. We just want to briefly highlight a few resources. These will be made available following the event. There's some here that are worth looking at and digging into. Some here from the National Institute of Mental Health. We have some resources that might be especially useful for teens and young adults, as well as for the kind of Title X workforce context specifically. And then, a couple resources here with respect to mental health first aid.

Sources:

- National Institute of Mental Health – Mental Health Information – Anxiety Disorders
- National Institute of Mental Health – Mental Health Information – Depression
- National Library of Medicine – How to Improve Mental Health
- National Library of Medicine – Post-Traumatic Stress Disorders
- The Impact of the Covid-19 Pandemic: Rising Stress and Burnout in Public Health - Results of a National Survey of the Public Health Workforce, 2021

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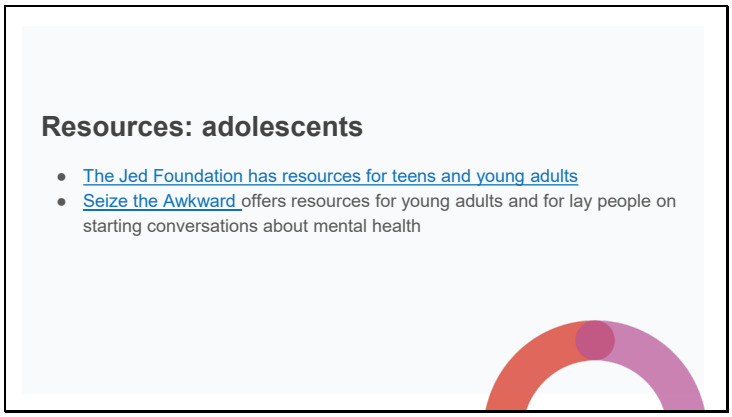

Sources:

- The Jed Foundation has resources for teens and young adults
- Seize the Awkward

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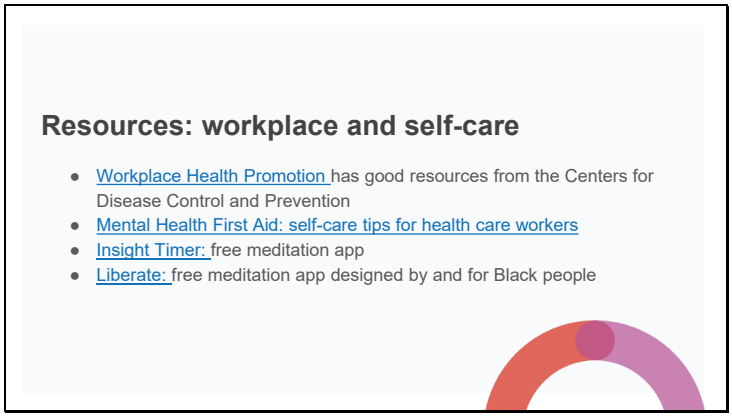

Sources:

- Workplace Health Promotion
- Mental Health First Aid: self-care tips for health care workers
- Insight Timer
- Liberate

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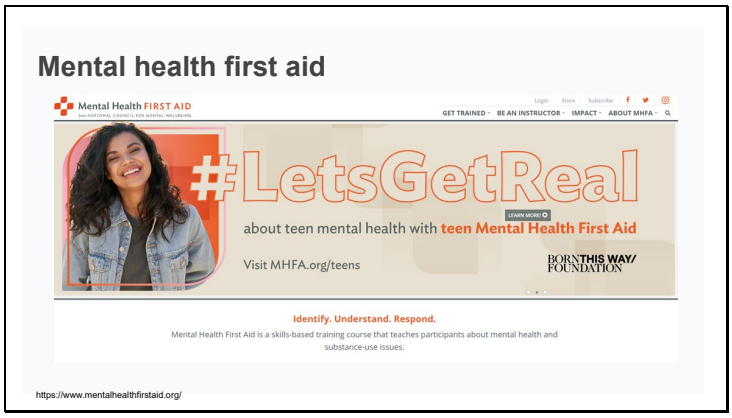

Source:

- Let's Get Real

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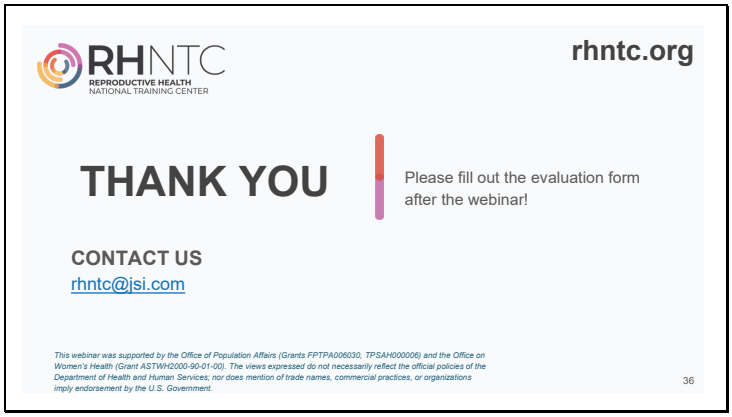

- [Naima] Thank you for joining us today. Please do take a minute to complete the workshop evaluation. Your input matters to us. And a final thank you to Alicia, Betsy and Todd. I hope you'll join me in thanking our speaker(s). As a reminder, we will have the materials from today's session available within the next few days. If you have additional questions for the RHNTC on this topic, please don't hesitate to email us at rhntc@jsi.com. Our final ask is that you please complete the evaluation today. The link to the evaluation is in the chat and will appear when you leave the webinar. The evaluation link will also be emailed to you after the webinar. We really love getting your feedback and we use it to inform future sessions. In order to obtain a certificate of completion for attending this webinar, you must be logged into rhntc.org when you complete the evaluation.

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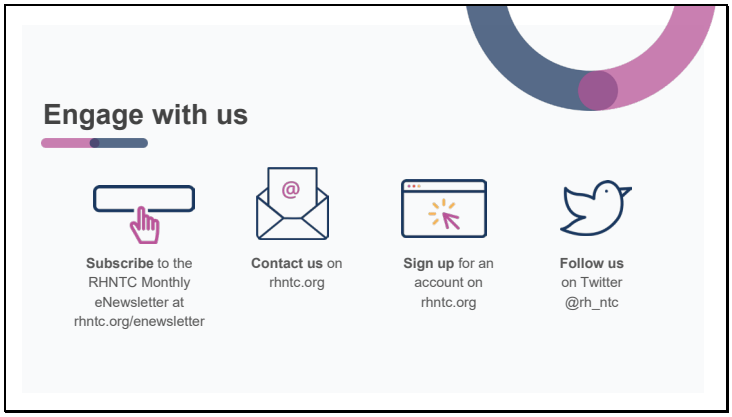

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