Evolving Systems of Care for Perinatal Mental Health and Substance Use Disorders

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Overview

- Screening and Referral to Treatment
  - Listening to Women & Pregnant & Postpartum People
- Building Workforce and Access to Treatment
  - Moms IMPACTT: Improving Access to Maternal Mental Health & Substance Use Disorder Care Through Telemedicine and Tele-mentoring
- Alternative pathways to family building and mental health considerations
- Questions & Discussion

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Maternal Deaths due to Mental Health Conditions are Preventable


MATERNAL HEALTH

By Susanna L. Trost, Jennifer L. Beauregard, Ashley N. Smoots, Jean Y. Ko, Sarah C. Haight, Tiffany A. Moore Simas, Nancy Byatt, Sabrina A. Madni, and David Goodman

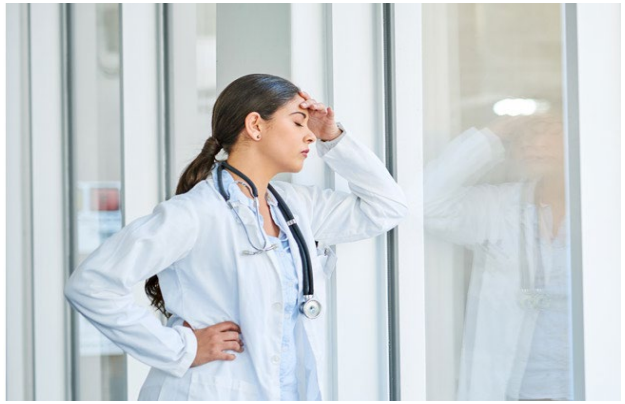
Preventing Pregnancy-Related Mental Health Deaths: Insights From 14 US Maternal Mortality Review Committees, 2008-17

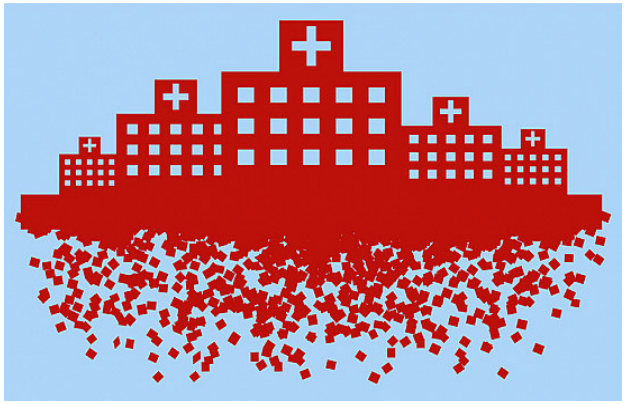
- Effective screening, identification, referral, appropriate treatment and communication and care coordination during pregnancy and postpartum year.

- 1 in 5-8 screened for depression
  - Black individuals < likely to be screened than White individuals

- 1 in 4 attend treatment
  - Black individual < likely to attend treatment than to White individuals
  - Rural residence < likely to attend treatment than urban residence

Barriers to Successful Screening & Effective Referral to Treatment



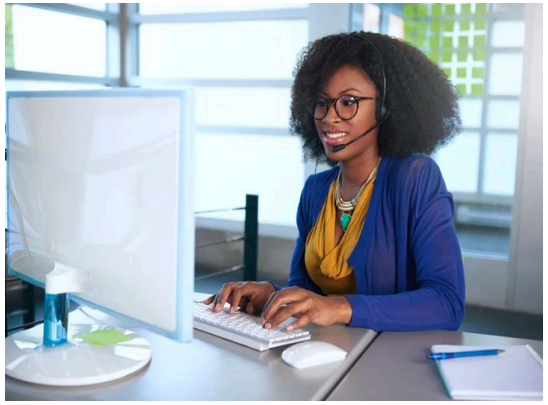


Patient	Provider	Healthcare System
Bias, Discrimination, Stigma, Racism	Bias, Discrimination, Racism	Structural Racism
Social Determinants of Health	Insufficient time	Cost: Time & Re/Training
Fear of social/legal consequences	Lack of MH/SUD knowledge	Separation of MH/SUD care
Lack of available or accessible *MH/SUD treatment providers	Lack of available or accessible *MH/SUD treatment providers	Lack of available or accessible *MH/SUD treatment providers

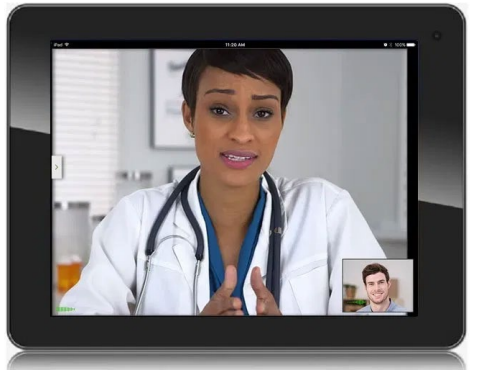
*MH: Mental Health; SUD: Substance Use Disorder

Listening to Women & Pregnant & Postpartum People

Text Message Based Screening



Brief Intervention
Remote Care Coordinator (MSW)



Referral to Treatment
Telemedicine/ Office or Home
Follow up

Communicate with Ob/Peds Team
Screening information
Referral and Tx Progress

Case examples

Patient 1- Perinatal Mood and Anxiety

LTWP Screening

What we knew

- 25 y/o, G1P1: 30 days postpartum
- Symptoms of depression and anxiety
- Rural location

Care Coordinator Intervention

What we learned

- Sx started in pregnancy, increased postpartum
- No psych history, no medications
- Passive SI, no intent or plan
- Mentioned only some symptoms to family
- Shame, guilt and fear of social consequences

Shared Decision Making

Creating a care plan together

- Validation of symptoms
- Home-based telemedicine services
- Linkage to resources

Randomized Clinical Trial

January 2021 to April 2023
Large Healthcare System in Southeast
Electronic Health Record (EHR)

LTWP (Text/Phone)

(n=224)

Screened

- Text validated questionnaires (phone/email)

Screened Positive

- Brief assessment, intervention and referral to treatment, if appropriate (MSW)

Referred to Treatment

- Co-located in Ob/Gyn Practice

Attended Treatment

- Psychiatrist, psychologist, or therapist in Ob/Gyn practice

Usual Care

(n=191)

Screened

- Verbal validated questionnaires (RN)

Screened Positive

- Brief assessment, intervention and referral to treatment, if appropriate (CNM, Ob/Gyn)

Referred to Treatment

- Co-located in Ob/Gyn Practice

Attended Treatment

- Psychiatrist, psychologist, or therapist in Ob/Gyn practice

Demographics (No Group Differences)

Characteristic	Statistics	LTWP (n=224)	UC (n=191)	P-value
Age, years	median [IQR]	31 [27.0 - 34.0]	31 [26.0 - 34.0]	0.55
Annual household income				0.26
< $25,000/year	n (%)	46 (20.5%)	31 (16.2%)	
≥ $25,000/year	n (%)	178 (79.5%)	160 (83.8%)	
Number of living children	median [IQR]	1 [1.0 - 2.0]	1 [0.0 - 2.0]	0.89
Number of pregnancies	median [IQR]	2 [1.0 - 3.0]	2 [1.0 - 3.0]	0.37

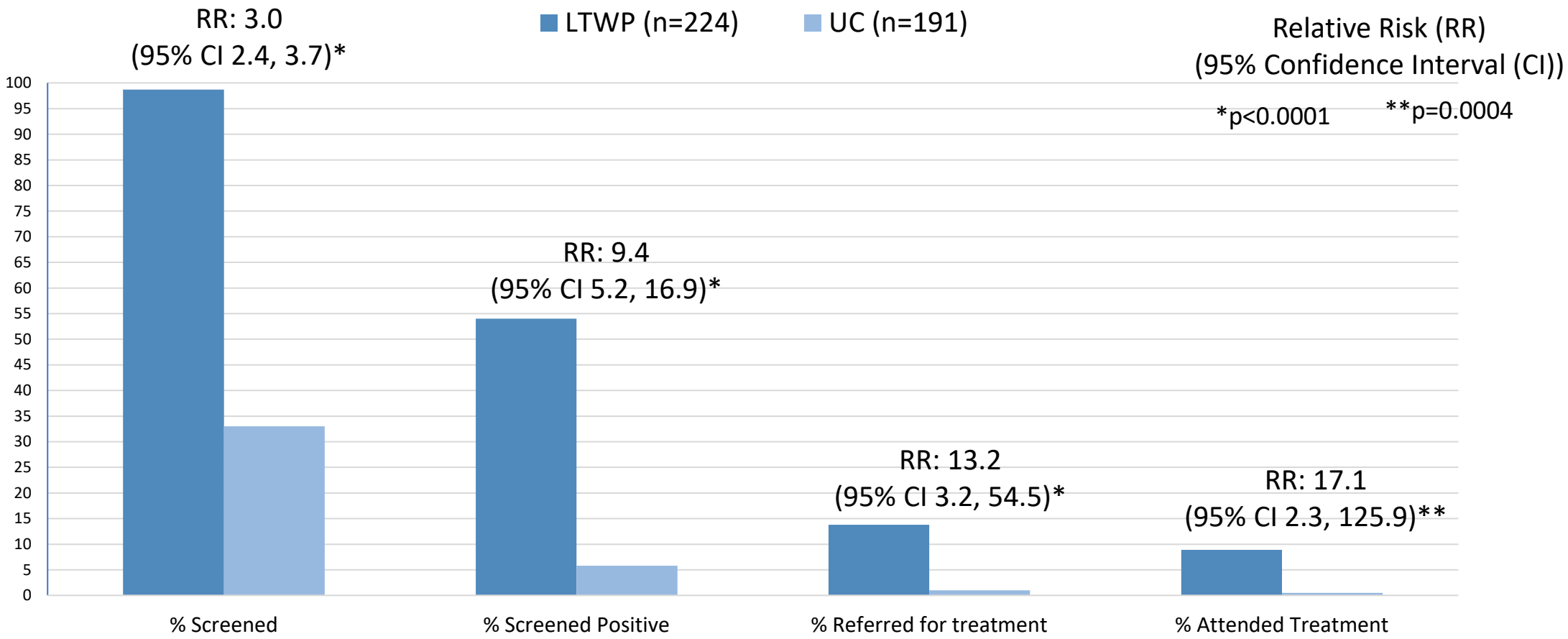
Characteristic	Statistics	LTWP (n=224)	UC (n=191)	P-value
Currently pregnant	n (%)	102 (45.5%)	85 (44.5%)	0.83
Number of week pregnant[†]	median [IQR]	28 [20.0 - 33.0]	28 [23.0 - 32.0]	0.86
Months postpartum[‡]	median [IQR]	2 [1.0 - 4.5]	2 [1.0 - 8.0]	0.99
Depressive Symptoms (EPDS)	median [IQR]	5 [2.0 - 8.0]	6 [3.0 - 9.0]	0.11
Anxiety Symptoms (GAD-7)	median [IQR]	3 [1.0 - 6.0]	3 [1.0 - 7.0]	0.69

Demographics (No Group Differences)

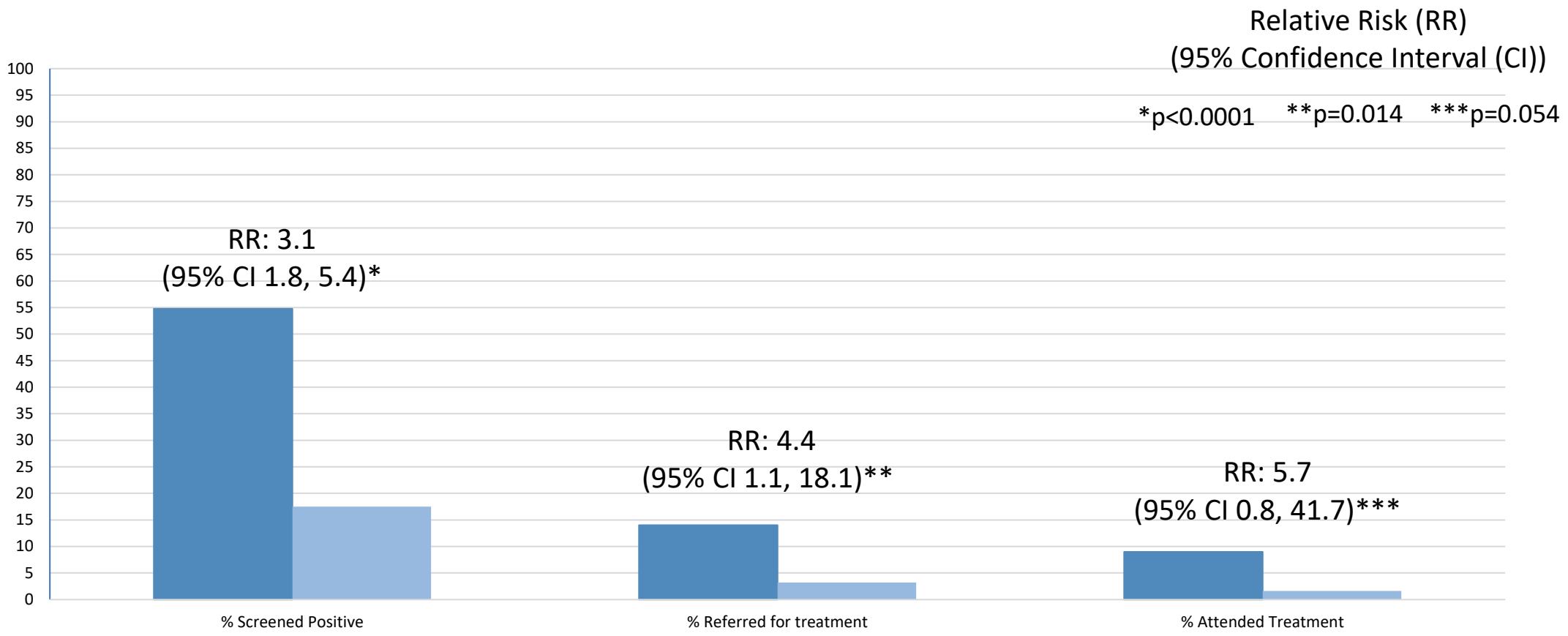
Characteristic	Statistics	LTWP (n=224)	UC (n=191)	P-value
Race/Ethnicity				0.32
Black, non-Hispanic	n (%)	70 (31.3%)	71 (37.2%)	
Hispanic	n (%)	12 (5.4%)	8 (4.2%)	
White, non-Hispanic	n (%)	135 (60.3%)	110 (57.6%)	
Other	n (%)	7 (3.1%)	2 (1.0%)	
Rurality of residence				0.28
Rural	n (%)	14 (6.7%)	18 (9.6%)	
Partially rural	n (%)	154 (73.3%)	141 (75.4%)	
Non-rural	n (%)	42 (20.0%)	28 (15.0%)	

Characteristic	Statistics	LTWP (n=224)	UC (n=191)	P-value
Self-reported psychiatric diagnoses				
Mood disorder	n (%)	35 (15.6%)	27 (14.1%)	0.67
Anxiety disorder	n (%)	67 (29.9%)	52 (27.2%)	0.55
Substance use disorder	n (%)	21 (9.4%)	9 (4.7%)	0.07
Psychotic disorder	n (%)	0 (0.0%)	0 (0.0%)	0.99
None	n (%)	141 (63.0%)	129 (67.5%)	0.33

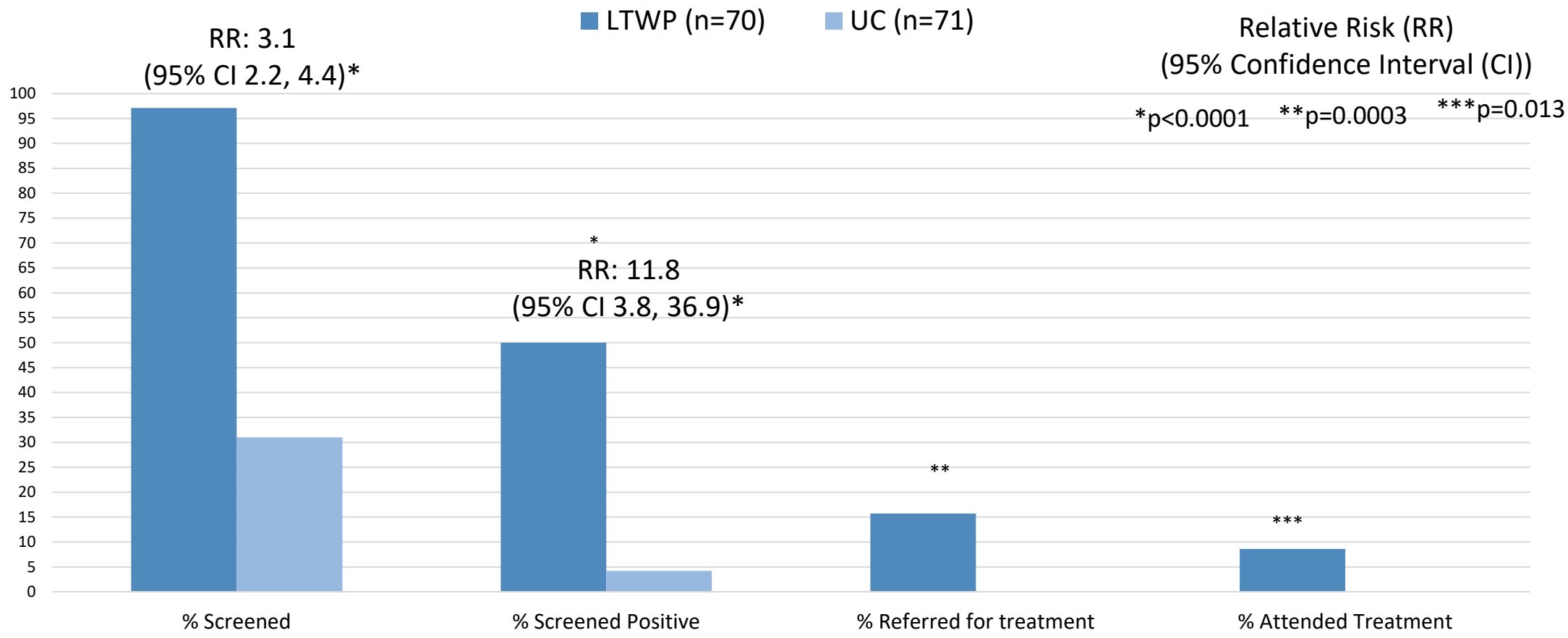
Primary Outcomes:
% of LTWP vs. UC Screened, Screened Positive, Referred to Treatment & Attended Treatment



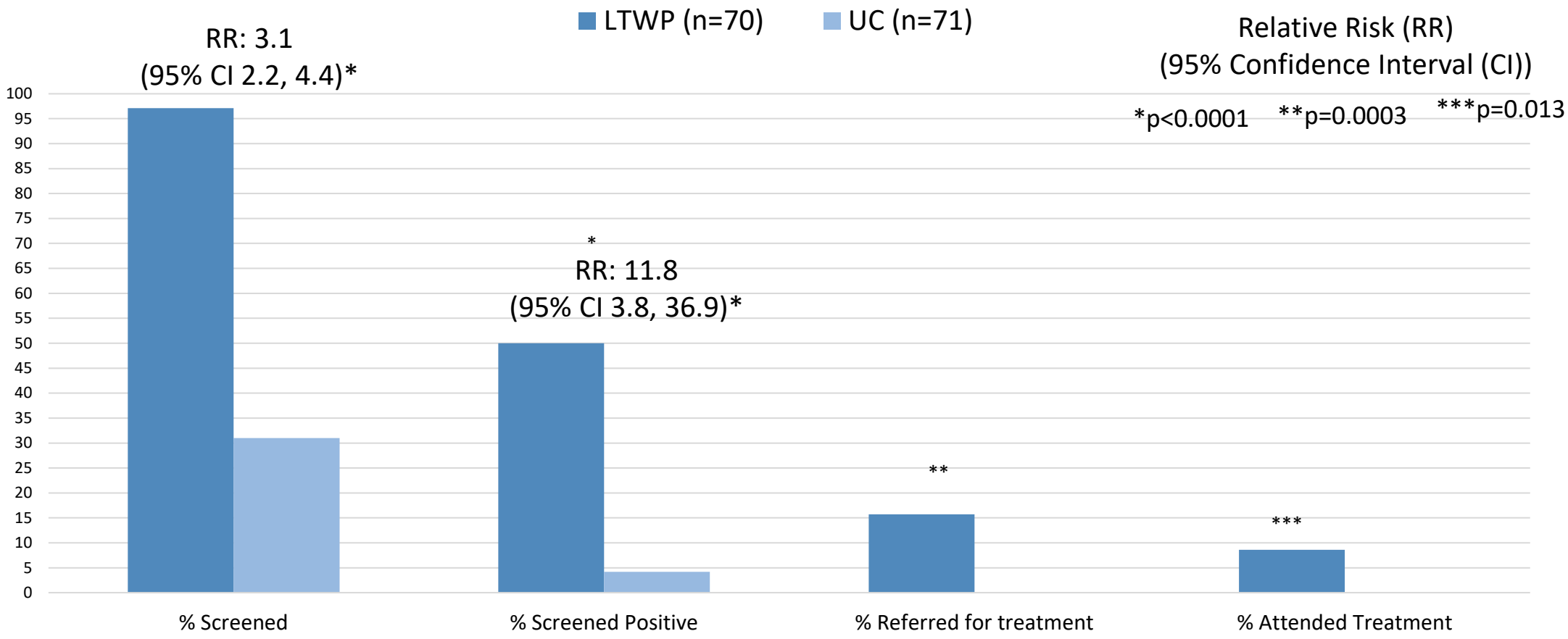
Secondary Outcomes [Participants Completing a Screen]: % of LTWP vs. UC Participants Screened Positive, Referred to Treatment & Attended Treatment



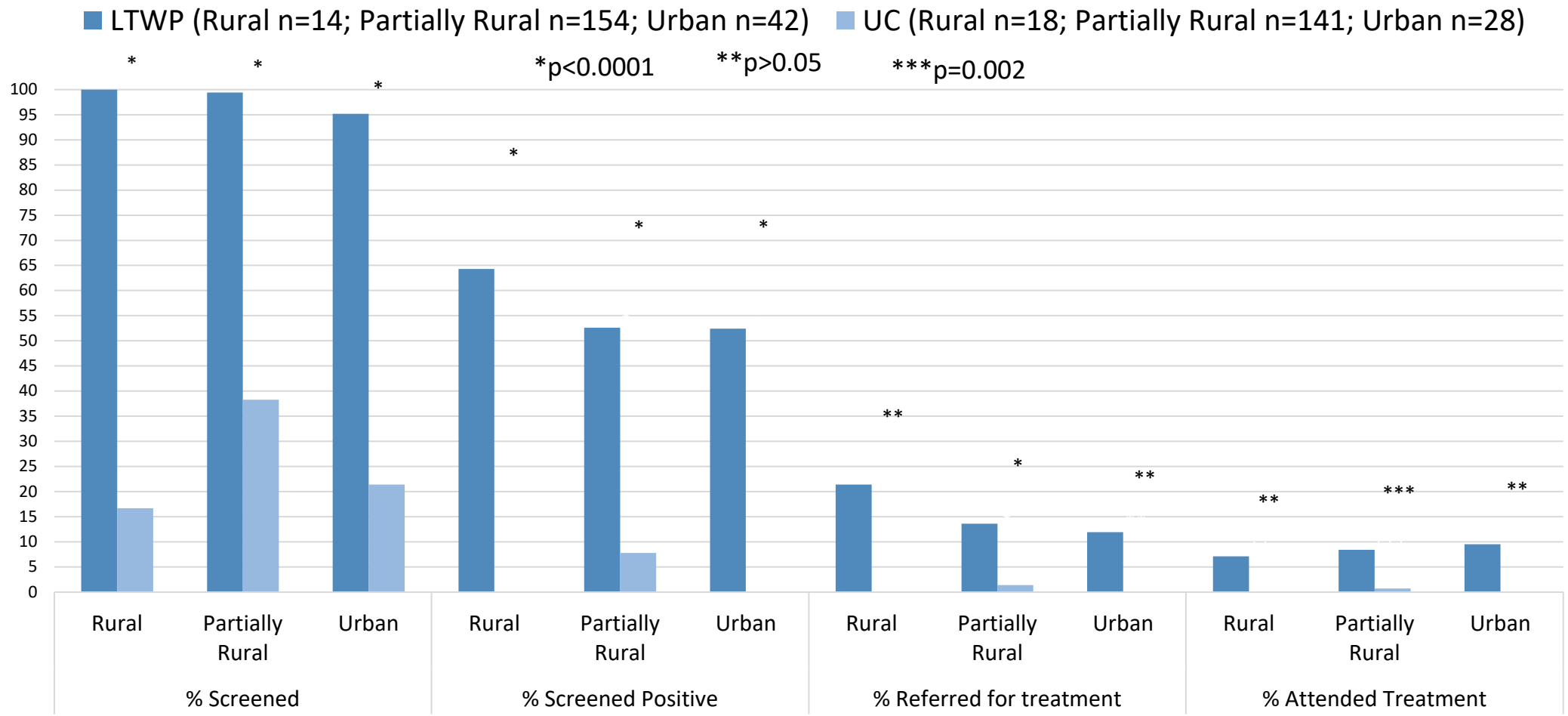
Subgroup Analyses [Black, Non-Hispanic]: % of LTWP vs. UC Participants Screened, Screened Positive, Referred to Treatment & Attended Treatment



Subgroup Analyses [by Rural, Partially Rural and Urban Residence]: % LTWP vs. UC Participants Screened, Screened Positive, Referred to Treatment & Attended Treatment



Subgroup Analyses [by Rural, Partially Rural and Urban Residence]: % LTWP vs. UC Participants Screened, Screened Positive, Referred to Treatment & Attended Treatment



Summary

Compared to UC, LTWP participants were:

- 3 times more likely to be screened

Among those that are screened, compared to UC, LTWP participants were:

- 3 times more likely to screen positive
- 4.4 times more likely to be referred to treatment
- 5.7 times more likely to attend treatment

Findings consistent in Black, Non-Hispanic & Rural and Partially Rural Populations

Findings reinforce call for healthcare system level changes, insurance payments, and policies to support adoption of text/phone screening and referral

Continued efforts to support digital literacy, affordable internet service plans, access to broadband and devices with A/V capabilities

Mom's IMPACTT:

IMProving Access to Maternal Mental Health and Substance Use Disorder Care Through Telemedicine and Tele-Mentoring

Goal 1: Provider
Building Frontline Provider Capacity

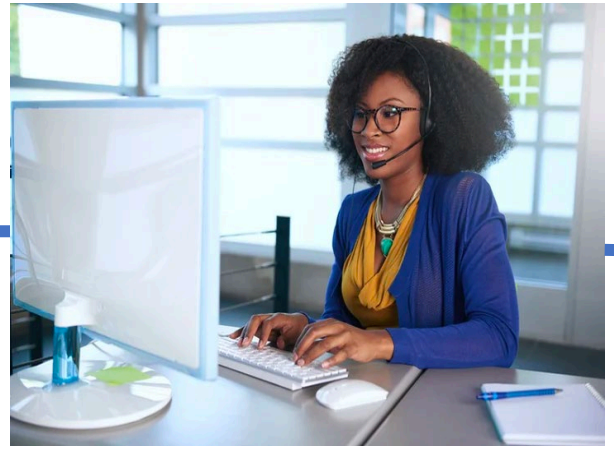
Goal 2: Patient
Access to MH/SUD Care

- **Mom's IMPACTT has 3 components and provides:**
  - **Real-time psychiatric consultation for providers** to support them in effectively managing maternal mental health and substance use disorders.
  - **Mental health and substance use disorder trainings** tailored to the needs of the hospital and/or outpatient practice's providers and staff.
  - **Brief Phone assessment by Care Coordinator** to provide appropriate referral to treatment and community-based resources.

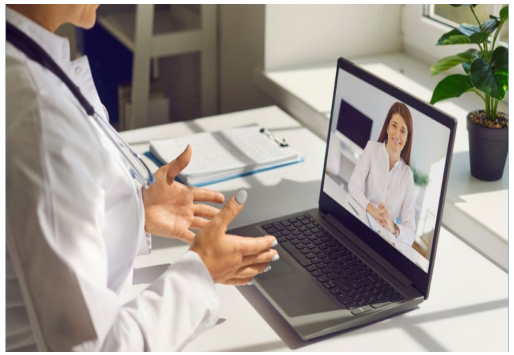
How Mom's IMPACTT Works
[Building Provider Capacity: Training & Consultation]

843-792-MOMS
(843)-792-6667

Doulas
Midwifes
Obstetricians
Pediatricians
Psychiatrists
Community Health Workers
Advance Practice Providers
Primary Care/Family Practice



- Assessment
- Referrals & Resources
- Care Coordination
- Referrals & Resources

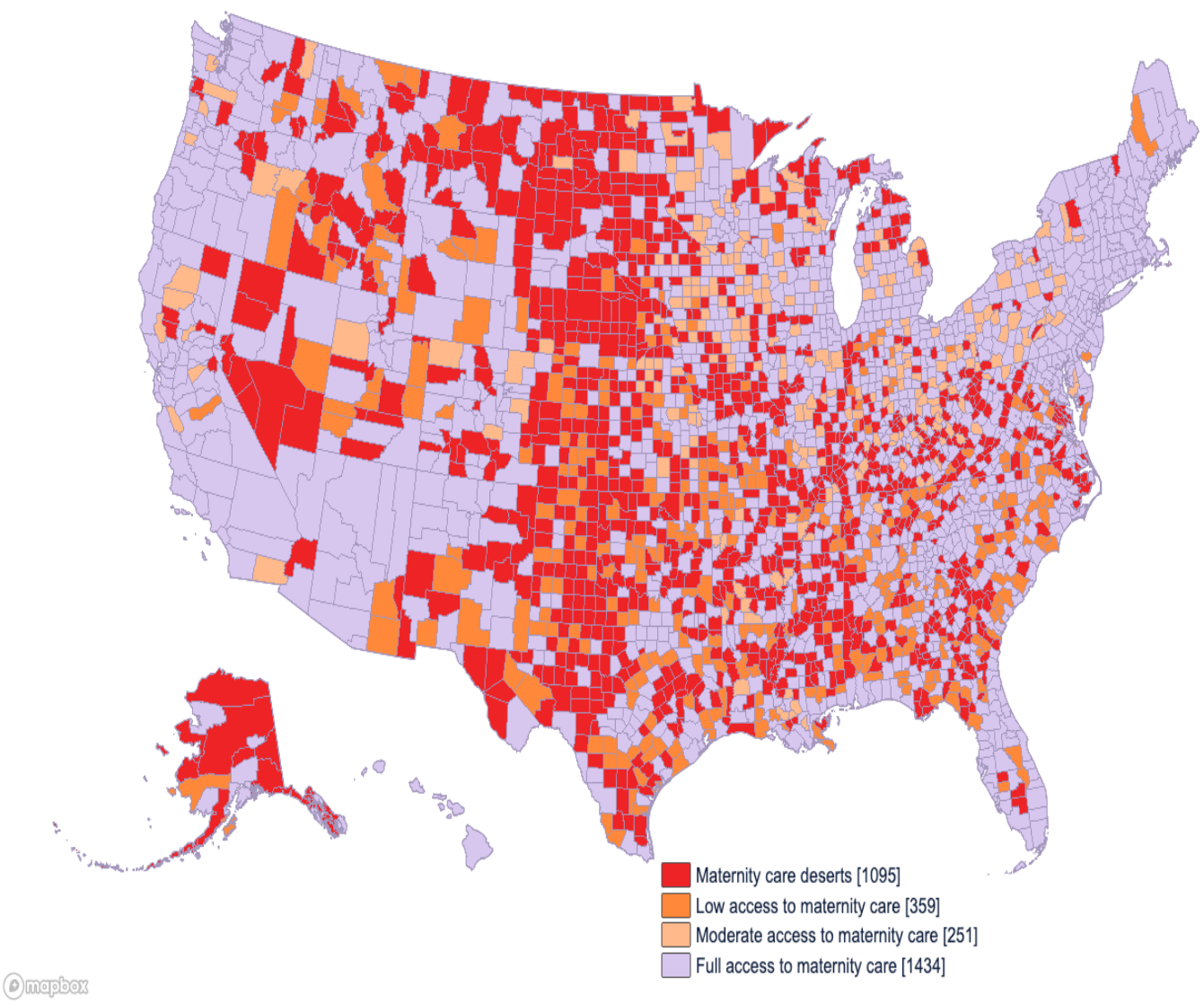


Provider-Provider Consultation

Provider Trainings

47.8% of SC counties are a Maternity Care Desert or Low Maternity Care Access.

Maternity Care Deserts

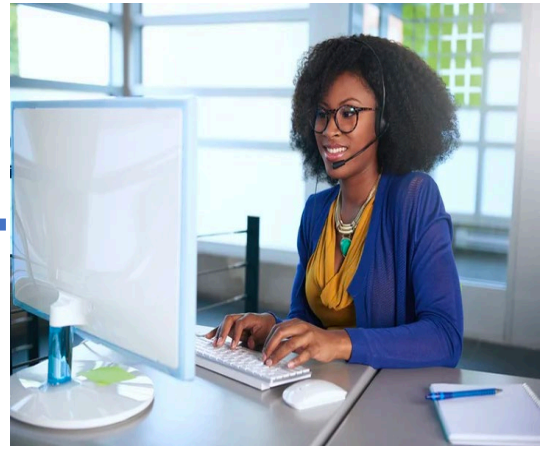


Source: U.S. Health Resources and Services Administration (HRSA), Area Health Resources Files, 2019

How Mom's IMPACTT Works [Patients]

Pregnant

0-12 Months Postpartum



- Assessment
- Referrals to Resources
- Permission to Communicate with Provider for Care Coordination

Patient-Provider Treatment

Moms IMPACTT
Outcomes: May 2022- Present

- MH/SUD trainings for 1,005 front-line providers
- 67 provider-to-provider consultations
- Access to care for 1,970 pregnancy and postpartum people from 100% of Counties in SC

➢ Race/Ethnicity

61.1% White
32.6% Black
2% Native American
8.0% Hispanic

➢ Insurance

55.8% with Medicaid

➢ Location

96.2% Fully Medically Underserved Areas
51.5% Rural Counties

SC Pilot Program for the Treatment of Perinatal Substance Use Disorders

Study Goals: To reduce maternal morbidity and mortality associated with Perinatal Mental Health (PMH) and Perinatal Substance Use Disorder (PSUD), including Perinatal Opioid Use Disorder (POUD) by addressing gaps in the continuum of care throughout pregnancy and the postpartum year for the mother-infant dyad and family unit.

Study Aims:

- Improve outcomes by providing a continuum of evidence-based, integrated SUD/MH treatment, recovery support, and care coordination.

- Improve outcomes for children and families by providing evidence-based parent, child, and family interventions.

- Increase the capacity of health care, child welfare, & criminal justice entities to effectively screen, identify and manage PMADS/PSUDs

Goal 1: Enhance Continuum of Care

- **Targeted Outreach**
  - Rural, Medically Underserved: Chesterfield, Darlington, Dillion, Lancaster, Orangeburg
  - High rates of Overdose & NOWS: Charleston, Horry, Greenville, Lexington

- **Strategic Collaboration**
  - Community-based organizations, detention centers, local law enforcement & EMS, family shelters, harm reduction services

- **Enroll PPW accessing IMPACTT in LTWP**
  - Specialized care coordination team
  - Ongoing screening; depressive symptoms, substance use, SDoH

Goal 2: Improve Outcomes for Families and Children

- **Access to trauma-informed behavioral health services for minor children of caregivers with SUD/OUD**
  - Evaluation, case management and care coordination

- **Peer Recovery Doulas**
  - Workforce training: 36 trainees over 3 years
  - Recruit 3 additional Peer Recovery Doulas to the IMPACTT care team

Case examples

Patient 2- Perinatal Opioid Use Disorder

Self Referral to Moms IMPACTT

Concern: medication questions

- 35 y/o, white woman
- G1PO, 14 weeks
- Birth control failure
- 5 years sustained recovery with MOUD
- Provider stopped prescribing in pregnancy
- Experiencing withdrawal with craving
- No longer connected to recovery community support

Care Coordinator Intervention

Understanding stigma

- Home-based telemedicine services
  - Risk/benefits of options during pregnancy
  - Stabilized on MOUD
- OB Provider with adequate POUD training
- Delivery hospital with NOWS experience
- Coordination across health care systems
  - Training and education
- Linkage to community & recovery support services

Peer Recovery Doulas

Certified Peer Support Specialist:

- Individuals who bring the lived experience of successful recovery, combined with training and supervision, to assistant others in becoming and staying engaged in the recovery process through shared understanding

Community-Based Doula:

- Provide extended, intensive support to families throughout pregnancy, during labor and birth, and up to 12 months postpartum in communities that face high risks of negative birth and developmental outcomes.
- CBDs are of and from the communities being served

Workforce Development

Curriculum:

- 80hrs of didactic information (10 weeks)
- 1:1 mentorship through 3 births
- On-going reflective mentorship
- Peer learning community

GOAL: 36 trained over 3 years

Certified Trainees: Chrysalis Center, SCDC, Courage Center & MUSC

Current Cohort: Newberry, Chapin, LRADAC, Prisma Health

BirthMatters

empower prevent plan

REBIRTHED

Mothers serving mothers in recovery and birth

Acknowledgements

Peripartum Individuals
Taking Part in Research & Clinical Care

Women's Reproductive Behavioral Health Team

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Alternative Pathways to Parenthood and Mental Health Considerations

Infertility: Diagnosis & Prevalence

- Trying to conceive for 12+ months without achieving pregnancy
- 6.7 million women in the USA has trouble getting pregnant or sustaining a pregnancy each year

- Health-related factors
  - Male factor, female factor
  - Childhood or AYA cancer treatments
- Non-traditional family types
  - Single parents by choice
  - LGBTQ+

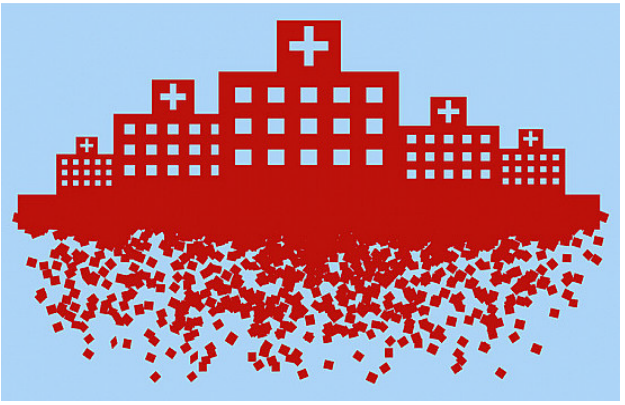
Impacts of infertility

- Financial
  - Without donor gametes, average cost of IVF cycle in the US was $12,400 in 2020
  - **Cost per live birth can exceed $60,000**
  - **271%** more expensive in the US
  - Diagnoses & medicalization may impact insurance coverage
- Mental health
  - Distress similar to newly-diagnosed cancer patients
    - Increases as treatment progresses
  - Intersection of stigma and mental health risk for LGBTQ+ community members seeking parenthood

The American Society for Reproductive Medicine (ASRM) Recommendations

- 2021 ASRM Committee Opinion on minimum standards for practices offering ART states **“a consultant/mental health professional with expertise in reproductive issues” should be standard of care for all patients**
- Recommendations for **psychoeducation consultation and decision making appointment** for recipients of donor gametes

Barriers to Mental Health Care



Patient	Provider	System
Stigma	Poor understanding of role mental health plays in treatment	Hard to access providers trained in fertility-related mental health concerns
Fear of being dismissed from care	Fear of offending or stigmatizing patient	Insurance/payor barriers
Avoidant coping	Referral capacity after screening	Policy and legal implications for marginalized populations

LGBTQ+ Considerations

- Discrimination in healthcare
  - 17 % of fertility clinics reported they would turn away LGBTQ+ folks looking for treatment in early 2000s
  - Required a recommendation letter- fitness to parent
  - 10% of fertility clinics rated unaccepting of LGBTQ+ patients
- Myth of differing outcomes for offspring of LGBTQ+ families
- Decision points- intersecting with identity, stigma, job security
- Postpartum depression: Unclear
  - Less support?
  - Less disclosure of symptoms

Case examples

Patient 3- Non-binary Birth Parent

Self Referral to Moms IMPACTT

History of moderate OCD, baby in NICU

- 33 y/o, partnered, white, non-binary (they/them) birth parent
- Hx of childhood cancer, conceived via fertility treatment
- G2P1- baby in NICU born at 33 weeks
- Intersection of stress, OCD and anxiety symptoms (Intrusive thoughts: danger and germs)
- Fear of gender identity being documented in medical record, delay in disclosing

Intervention

CBT and ACT

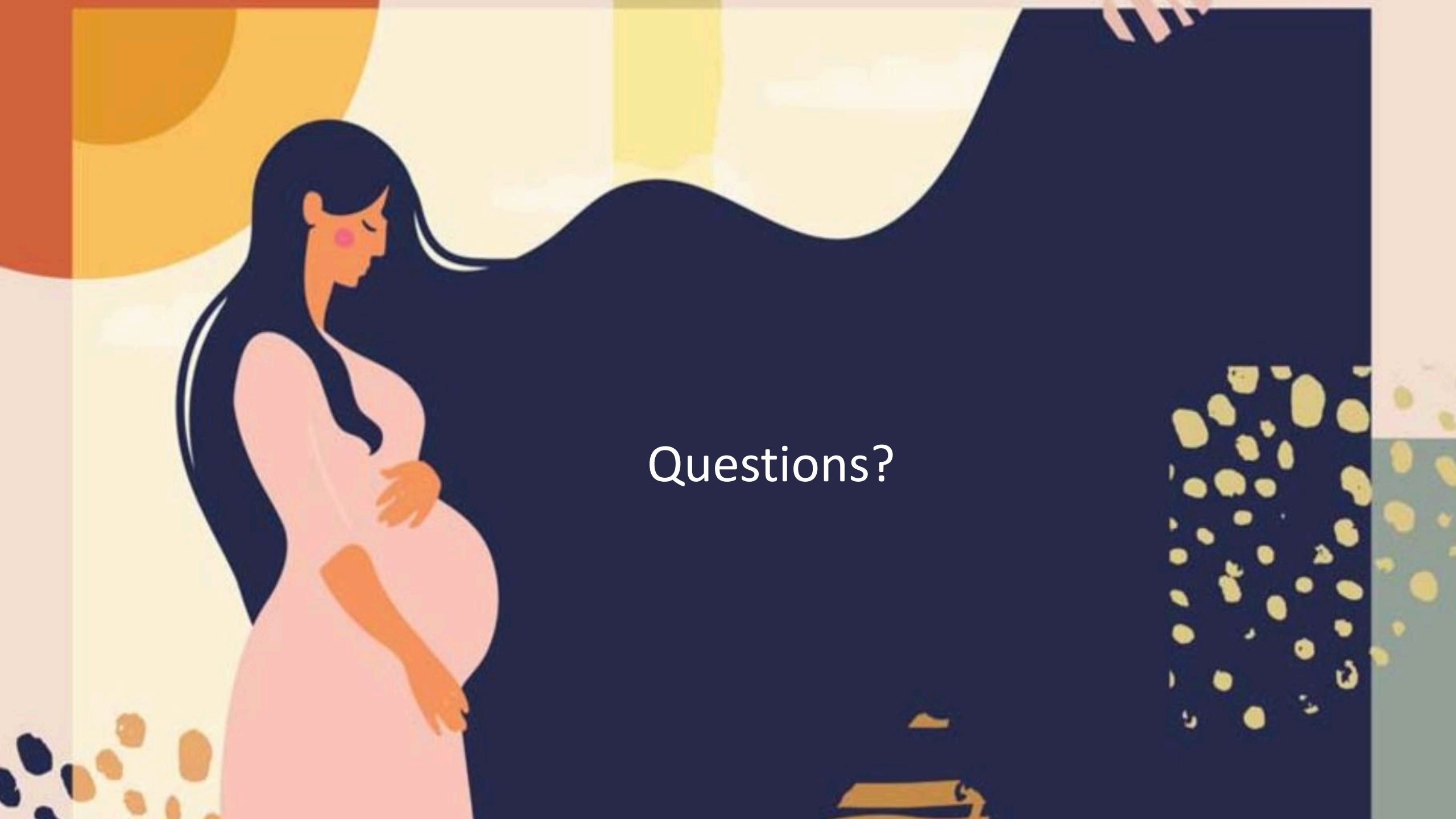
- Radical acceptance, cognitive defusion and increased values-congruent actions in response to intrusive thoughts
- Response prevention, distress tolerance
- Increased self-esteem and confidence
  - Returned to work in new career role
- Use of social support

Recommendations to Providers

- Become familiar with various routes to parenthood for LGBTQ+ patients
- **Seek training** in providing culturally sensitive care to diverse family types
- **Ask:** about sexual orientation and gender identity. Ask about preferred pronouns. Ask about which partner will assume which role
- Approach conversations with openness and curiosity.
- **Screen** for postpartum depression in new LGBTQ+ parents just as should be done for heterosexual parents. **Refer** to treatment as needed

Recommendations for Clinics

- **Inclusive** website, public spaces, forms, diverse imaging
- **Inclusive** pregnancy groups, childbirth, and new parent classes
- To the extent possible, hire a **diverse** staff
- Staff training
- Informed consent- what will be documented in record?
- Distress screening at intake
- Referral to treatment
  - Integrated care model
  - Partnering with local mental health providers


Questions?