Behavioral Health Care for Maternal Mental Health in Philadelphia

Barriers to Care

Recommendations for Change

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Background: What Do We Know?

Mothers can experience mood-disorders throughout the spectrum of perinatal depression including mild mood disturbance requiring social support, to psychosis or suicidal ideation, requiring hospitalization. Due to the barriers to behavioral health services experienced by many women in need, our project sought to systematically identify strategies to improve quality of care and access to appropriate behavioral health treatment services for low-income women in Philadelphia County. The fundamental issue which emerged from our work - and served as the framework for our recommendations - is that perinatal depression is a bi-generational phenomenon, which has significant adverse impact on both mothers and children.

We acknowledge the initiatives of City of Philadelphia's *Department of Behavioral Health and Intellectual disAbility--Community Behavioral Health (CBH)*[1] and area providers to address perinatal depression, however our findings indicate that the current behavioral health system does not effectively meet the unique needs of mothers with perinatal depression.

In particular, the current system lacks a formal infrastructure with the capacity to accommodate mothers with young children, or who have significant barriers to attending therapy and psychiatry appointments. In addition, our findings reveal that the current behavioral health system lacks the capacity to optimally serve women throughout the spectrum of perinatal depression. In addition, our findings reveal great disparity in the geographic dispersion of available providers, which results in extremely long travel times for many mothers, who are pregnant, post-partum, or traveling with small children.

[1] Community Behavioral Health is the Medicaid contractor for behavioral health services in Philadelphia and Souteastern PA.

In order to effectively meet the needs of **all mothers** with perinatal depression, our recommendations are both holistic and comprehensiveand include the importance of screening, referrals, and effective treatment for women throughout the spectrum of the disorder.

What Have We Done?

Since March 2011, MCC performed an extensive scan of the current literature on perinatal depression, and interviewed local, state-level, and national key informants with expertise in perinatal depression, behavioral health, and maternal and child health. Synthesized, the categories of barriers and recommendations that emerged were: 1) *individual/client barriers* and recommendations, 2) *agency/provider barriers* and recommendations, 3) *screening/referral and treatment barriers* and recommendations, and 4) *funding barriers* and recommendations. Note, these categories are not presented in terms of "rank" nor "order of importance"; yet demonstrate the point of impact (e.g. client-level, funding-level, etc.)

The following section will illustrate those recommendations that potentially address the most significant barriers and gaps within the current behavioral health delivery system for perinatal depression among low-income mothers.

What are the Barriers and Recommendations?

Barriers and Recommendations: Individual Barriers

Perinatal Depression, which includes the continuum of mood disturbance ranging from mild self-limited moodiness called *"baby-blues"* to more serious mood disturbances present in post-partum depression, post-partum obsessive-compulsive disorder, post partum psychosis, et al.,[2345] significantly impacts the quality of life for mothers and their children[67]. For mothers who

[2] Burt, V.K., & Stein, K. (2002). Epidemiology of depression throughout the female life cycle. *Journal of Clinical Psychiatry,* 63 (7) 9-15.
[3] Chaundron, L.H., & Pies, R.W. (2003). The relationship between postpartum psychosis and biopolar disorder: A review. *Journal of Clinical Psychiatry,* 64 (11), 1284-92.

need help, often there are numerous barriers to care. Depression and associated mood disorders, significantly disrupts cognition, judgment, and insight, which can lead to denial of clinical mental health issues, and diminished decision-making ability[8]. In addition, mothers often are isolated or overwhelmed with the care of their baby and other children, experience significant family and intimate partner stressors, and may be juggling home/career and other responsibilities[9][10]. Moreover, mothers who have an adverse history and/or fear of the mental health system, may not seek care[11]. Individual barriers identified include:

1. Practical Barriers : "Logistical impediments for mothers in attending mental health appointments[12]" (e.g. childcare, transportation, distance to available providers).
2. Personal Barriers: Other priorities/appointments; physical limitations during pregnancy and post-partum; disrupted cognition, insight and judgment; and denial and stigma associated with mental illness.
3. Lack of familiarity with the symptoms of "depression" (low motivation, inability to concentrate, etc.).
4. Interpersonal Barriers: Intimate partner/family stressors.

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[4] Freeman, M. P. (2007) Refining the questions in women's mental health. *Journal of Clinical Psychiatry,* 68 (1), 120-21

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[6] Children's Defense Fund Minnesota.(2011). Zero to three research to policy project: Maternal depression and early childhood full report.

[7] Field, T. (2011). Prenatal depression effects on early development: A review. *Infant Behavior & Development*, 34 (1), 1-14.

[8] Wisner, K.L., Parry, B.L., & Piontek, C.M. (2002). Postpartum depression. The New England Journal of Medicine, 347 (3), 194-99.

[9] Lancaster, C.A., Gold, K.J., Flynn, H.A., Yoo, H., Marcus, S.M., & Davis, M.M. (2010). Risk factors for depressive symptoms during pregnancy: a systemic review. *American Journal of Obstetrics & Gynecology*, 202 (1), 5-14.

[10] Silverstein, M., Reid, S., DePeau, K., Lamberto, J., & Beardslee, W. (2010) Functional interpretations of sadness, stress and demoralization among urban population of low-income mothers. *Maternal and Child Health Journal,* 14, 245-53.

[11] Anderson, C.M., Robins, C.S., Greeno, C.G., Cahalane, H., Copeland, V.C. & Andrews, R.M. (2006) Why lower income mothers do not engage with the formal mental health care system: Perceived barriers to care. *Qualitative Health Research,* 16 (7), 926-43.

[12] Boyd, et al. 2011.

5. Unfamiliarity (or fear) of the behavioral health system.
6. History of adverse experiences with the behavioral health system.

Given the range of individual barriers identified, the following are suggested recommendations:

1. *Patient/Client Navigators "Psychological Doulas"—paraprofessional staff, who would serve as social support for the mother, and work with clinical/therapeutic staff to ensure and support care.*
2. *Home-based "mobile" therapy*—Behavioral health services offered in a mother's home.
3. *Integrated Physical and Behavioral Health Care*—Integration of behavioral health and physical health providers (e.g. family practice, internal medicine, OB/GYN, pediatricians, etc.) to facilitate continuity of care.
4. *Phone Therapy* –The use of technology (telephone or video) to facilitate therapy or psychiatric treatment by a remotely located therapist or psychiatrist.

Barriers and Recommendation: Agency/Provider Level

The agency/provider barriers identified included:

1. Confusing and time consuming referral/intake process for mothers who sought care.
2. Client mistrust and "fear" of providers, usually due to previous experiences.
3. Long agency wait-times for care.
4. Lack of practitioners with expertise in spectrum of perinatal depression.
5. Reimbursement obstacles: Currently unable to bill for all services within the spectrum of perinatal depression.

6. Limited or no programming/treatment options to accommodate the spectrum of perinatal depression ("baby blues to psychosis").

Our recommendations for agency barriers include:

1. Streamline intake for perinatal depression, in order to effectively triage for the appropriate level of care.
2. Create an incentive for agency staff and practitioners to be trained in perinatal depression.
3. Develop pilot projects, which more effectively meet the range of need throughout the spectrum of the disorder.
4. Agencies to develop innovative projects (e.g. Center of Excellence), with the goal to increase capacity to serve mothers with perinatal depression.

Barriers and Recommendations: Detection, Screening Referral and Treatment

In order to optimize services for mothers with perinatal depression and other pregnancy-related mental health issues, there is a need to build the infrastructure for a seamless system for detection, screening, referral and treatment. For many, behavioral health services are not thought of as a place to seek help when a pregnant or post-partum mother is experiencing a mood disturbance. This is especially true for women who have no history of mental health issues, or no history of involvement with a behavioral health system. In our work, we identified non-behavioral health clinical entities, which we refer to as "points of entry" (PoE). The significant of the PoE is that due to their professional interactions with pregnant and parenting mothers, they serve a critical role in detecting, screening and referring mothers with mental health issues to the appropriate behavioral health services.

Points of entry identified in our work included: clinical, non-behavioral health providers (obstetricians/gynecologists, internists /family practitioners, emergency medicine physicians, pediatricians, midwives and nurse practitioners), social service entities (e.g. parenting programs, homeless shelters, etc,), schools (early child education and K-12— to address teen mothers), and child welfare agencies.

The following represents detections, screening, referral, and treatment barriers observed:

1. Lack of professional awareness of perinatal depression detection, screening and referral among clinical, educational, social service agencies and other points of contacts with pregnant and post-partum mothers.
2. Lack of protocols for perinatal depression screening during pregnancy, at birth, or post-partum.
3. Cumbersome or insufficient processes for clinical providers to recognize, screen, and refer for perinatal depression services.
4. Perinatal depression resources or referral process are not widely known by clinical education, and social service professionals.
5. Limited cross-collaboration with other medical and social services regarding perinatal depression awareness, screening and referrals.

Recommendations for detection, screening, referral, and treatment include:

1. "Mental Health First-Aid"—Awareness and specialized training is recommended to increase perinatal depression detection, crisis intervention, and referral among entities that interface with pregnant and post-partum women.

2. All pregnant and post-partum women, should be screened for perinatal depression during prenatal care visits, at birth, OB post-partum appointment, well-baby visits and post-partum internal medicine/family practice visits.
3. Provide opportunities and incentives (e.g. continuing education credits) for provider/practitioner training in perinatal depression to improve detection, screening, and referral among behavioral health, OB/GYN, primary care (internal medicine, pediatrics) early childhood/secondary education and social services.
4. Entry into the behavioral health system should accommodate mothers at each stage within the spectrum of perinatal depression, including those who do not require a psychiatrist.
5. Treatment for perinatal depression services should include programs which adequately address the spectrum of mood disturbance ("baby blues to post-partum psychosis").
6. Improve process for information sharing among referring and treating clinical providers, including the use of emergency medical records.
7. Office of Mental Health, or designee should update and widely distribute resources in multiple formats (e.g. print, interactive webpage, etc.) for diverse audiences, with the focus on ensuring accurate listings for referral agencies and distribution to potential referral sources (e.g. social service agencies, primary care providers, schools, etc.).

Barriers and Recommendation: Funding Barriers

Funding significantly impacts perinatal depression service delivery, especially among mothers who receive behavioral health services from CBH-contracted providers. The following funding-level barriers were identified:

1. Many women who are Medicaid-eligible (CBH) experience longer wait-times to get care, limited time-slots available for “CBH-clients” and are more likely to be seen by psychology interns and psychiatric residents.
2. Limited/no reimbursement from Medicaid for “social support” and non-psychiatric related perinatal depression services.
3. Perinatal depression does not have a billing code; consequently it is not universally recognized by public and commercial insurance providers.
4. Limited number of visits allowed for services from public and commercial insurance providers (including low-income women who do not qualify for Medicaid) which might not adequately treat perinatal depression

Recommendations proposed for addressing funding barriers:

1. Develop and evaluate “pilot” projects, that ensure that the range of available treatment services aligns with the level of need for mothers with perinatal depression.
2. Change billing codes and the use of “waivers” to more adequately serve mothers with perinatal depression; ensure funding from Medicaid.
3. Increase awareness of the importance of perinatal depression coverage through a public education campaign.
4. Advocate for collaborative projects with local behavioral health, physical health, and social services agencies, to share funding or expenses for perinatal depression services.
5. Identify funding to develop and implement a systemic model of comprehensive services for perinatal depression, which meets the range of need throughout the spectrum of the disorder.

6. Modify existing billing structure to allow other licensed therapists (e.g. LCSW, MA, PhD, PsyD.) to lead treatment plans, especially for mothers with mild to moderate depression.

Special Populations: Adolescent Mothers

While it is recognized that most low-income mothers face multiple barriers, our work revealed that *teen mothers* experience *additional barriers* which significantly increases their risk of not receiving services for perinatal depression. The following section represents barriers identified in the literature and by key stakeholders in adolescent and school behavioral health in Philadelphia:

1. Fragmented protocols for screening and referring adolescents with perinatal depression exist between schools, social service agencies, behavioral health system and behavioral health school-based providers.
2. Teen pregnancy programs generally do not include perinatal depression as a health subject.
3. Teen mothers often face limited ability to seek behavioral health services for perinatal depression, without parental involvement.
4. Teens are generally treated by *child behavioral health providers* and the issue of perinatal depression is not prioritized.
5. Symptoms of perinatal depression in adolescents might be masked by situational stress (e.g. relationship discord, familial stress), or diagnosed as "developmental."

Recommendations for adolescent mothers include:

1. Implement policy changes to build upon the existing school-behavioral health infrastructure, to improve systemic detection, screening, referrals, and treatment; provide training for school counselors and contracted social service providers.
2. Increase awareness about perinatal depression among child behavioral health providers, including a training initiative explicitly focused on differentiating the nuances of perinatal depression symptoms from situational stressors or developmental behaviors associated with adolescence.

Other Vulnerable Populations

There were several vulnerable populations identified which we believe require more attention and advocacy than was possible within our scope of work. These mothers represent those with significantly adverse barriers to care: *Mothers detained or incarcerated*

- *Teen mothers in juvenile detention or rehabilitative treatment facilities*
- *Mothers who lack US documentation status*
- *Homeless mothers*
- *Mothers with Developmental Disabilities*

Summary

Perinatal depression significantly impacts both mothers and their children with potentially life threatening and life altering consequences. A strategic effort is needed to address the many barriers to perinatal depression services and to work to improve systemic awareness, detection, screening, referrals and appropriate treatment for mothers. While there is recognition of local, state-wide, national and federal initiatives to address perinatal depression, considerable work remains to be done.

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