Making Systems Work for Women with Perinatal Depression:

Resources for Perinatal Depression
DECEMBER 2011

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Maternity Care Coalition, December 2011.

FINDINGS: RESOURCES FOR PERINATAL DEPRESSION

EXECUTIVE SUMMARY:

The purpose of the study is to determine the capacity of Community Behavioral Health (CBH) contracted providers to meet the needs of Medicaid-eligible mothers with perinatal depression, in Philadelphia County. We sought to determine the average time that a mother with perinatal depression would wait to receive care from the point of first contact with a behavioral health agency in Philadelphia; and the overall capacity of the current behavioral health system to meet that need.

MAJOR FINDINGS:

- The longest wait-time for an intake was 8 weeks; and 10 weeks for a therapist and psychiatrist, after intake.
- Several agencies required a psychiatrist to see a client *before* therapy can begin.
- The spectrum of perinatal depression ("baby-blues" to psychosis) is not well served by the current behavioral health system.
- Some provider agencies have limited hours to see Medicaid (CBH) clients.
- Many mothers with Medicaid receive their care from medical residents, psychology interns and psychiatric nurses, many of whom have no formal training in perinatal mental health care.
- Federally Qualified Health Centers (FQHC) are the only "integrated care" model [integrated physical and behavioral health care], yet do not offer the full range of psychiatric and therapy services; and only serve current patients in their medical clinic.
- There are areas in Philadelphia County underserved by out-patient psychiatric providers.
- Some provider agencies are linked to substance abuse programs, and as a result, only provide therapy to women enrolled in substance abuse treatment.
- Only 18% of provider agencies in our study have staff and practitioners who attended the CBH/MCFH/Drexel Perinatal Depression Training.
- Intake and front-line staff have limited knowledge of Perinatal Depression and the CBH/MCFH/Drexel Perinatal Depression Training.
- The current resource directory distributed to clients and referral agencies contains inaccurate contact data.

METHODS

Using a descriptive, cross-sectional design, MCC collected information from CBH-funded provider agencies and solo practitioners, regarding their wait-time, availability and geographic location. Information was obtained from 79 CBH provider agencies currently listed in the *2009 Community Behavioral Health Member Handbook* and the *2011 CBH Updated Providers Listings.* In addition, we contacted CBH directly to obtain information on CBH-provider agencies not listed in the current Member Handbook at the time of print, or if questions emerged about member agencies during the process.

Information from CBH-providers was collected by master-level student interns who called provider agencies. When CBH-provider agencies requested, we submitted questions via email or fax. Providers and practitioners included in this study met the following criteria:

1. Currently listed as an adult "psychiatric out-patient clinic" (community mental centers, hospital/university affiliated centers, and solo/group practices); and
2. Located in Philadelphia County.

Furthermore, interns asked representatives from CBH-provider agencies about their language capacity and participation in, and knowledge of the CBH/MCFH/Drexel Perinatal Depression Training.

When contacted, interns usually spoke with one or more of the following: an intake staff, office manager, behavioral health director/coordinator, or practitioner (usually, if calling a solo/group provider agency).

RESULTS, FINDINGS AND DISCUSSION

Out-patient Psychiatric Clinics

There were 3 major quantitative outcomes recorded in our study: 1) average wait-time for intake, first therapist and first psychiatrist appointment, 2) provider location, and 3) number of full-time therapists and psychiatrists.

In addition, we also captured information regarding whether mothers needed to see a psychiatrist before beginning therapy, other languages spoken, the knowledge of perinatal depression among front-line staff, service delivery based on insurance (Medicaid vs. commercial), agency policies regarding "no-shows", accuracy of listings in the resource directory and knowledge of the CBH/MCFH/Drexel Perinatal Depression Training.

There were 134 out-patient psychiatric clinics identified as *"CBH-Providers"* in the *CBH Member Services Handbook, 2010 CBH Member Handbook Service Providers Guide--Updates, Perinatal Depression Resource Guide,* and collected from CBH Member Services, directly. Of

the 79 contacted, 70 met the inclusion criteria (located in Philadelphia and psychiatric outpatient mental health agencies), and 69 responded to our study.

The breakdown of the 70 was as follows:

Description of Eligible Psychiatric Out-Patient Clinics Contacted

Community Mental Health Centers	**36**
Hospital/University Affiliated Centers	**9**
Solo/Group Practices	**7**
Federally Qualified Health Centers	**11**
Substance Abuse Provider Agencies	**7**
TOTAL	**70**

Description of Psychiatric Out-Patient Clinics <u>Included</u> in the Study

Community Mental Health Centers	**35**
Hospital/University Affiliated Centers	**9**
Solo/Group Practices	**7**
Federally Qualified Health Centers	**11**
Substance Abuse Provider Agencies	**7**
TOTAL	**69**

Data in this section represents the *location* of CBH-provider agencies throughout Philadelphia County. This information was based on the current listing in the *Community Behavioral Health Member Services Handbook (2009)* and *2010 CBH Member Handbook Service Providers Guide—Updates.* The table indicates the geographic distribution of *all contacted* CBH (Non-FQHC) provider agencies throughout Philadelphia County (n=58). CBH-provider agencies were categorized, based on zip code. This data does not include FQHCs.

Location (Geographic):

	# of Provider Agencies **(Excluding FQHCs)**
Center City	**8**
Northeast	**11**
North	**21**
Northwest	**6**
South	**2**
Southwest	**1**
West	**9**
TOTAL	**58**

The wait-time information includes the average, and range (shortest to longest time), in weeks, that a mother would wait to seek care at an out-patient psychiatric clinic. In addition, wait-time for *therapists* and *psychiatrists* were calculated from the time ***after an intake appointment.*** This distinction was made, to differentiate an *intake* conducted by a therapist or psychiatrist, from a therapy or psychiatric *appointment.* All providers required an intake appointment before treatment could begin. In addition, FQHCs were not included in this list.

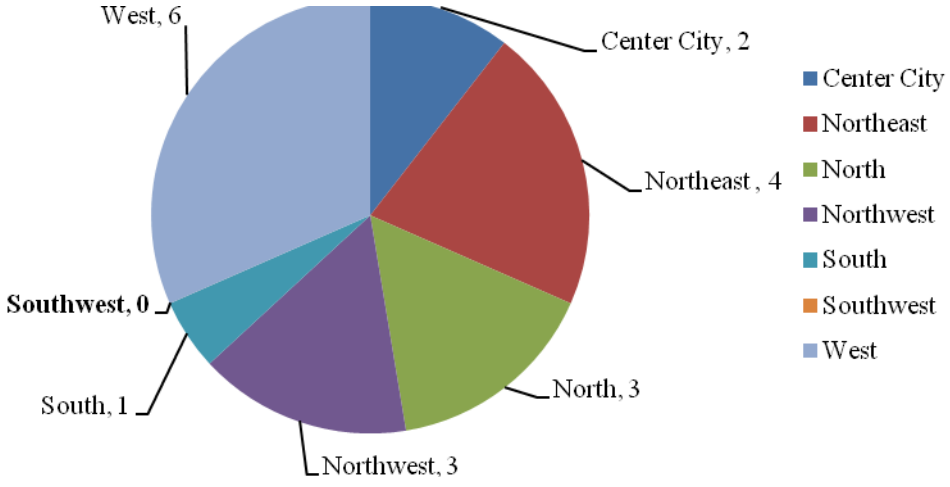
Wait-time (average and range, in weeks):

	Average	Range (weeks)
Intake	**2**	**1 to 8**
Therapist (after intake)	**2**	**1 to 10**
Psychiatrist (after intake)	**3**	**1 to 10**

In addition, several provider agencies required that all clients be seen by a psychiatrist ***prior*** to receiving therapy. This policy ***increased*** wait-time for a therapist up to 22 weeks.

Our findings indicated that of the agencies included in the study, **16** out of 58 out-patient psychiatric providers required that a psychiatrist appointment precedes therapy. Problematic with these agencies' practice is that mothers who seek services for perinatal depression are forced to wait *longer* for services; increasing the risk that their depression will worsen.

Number and Location of Agencies That Require a Psychiatrist *Prior* to Beginning Therapy(n=16)



The following two sections present data for *practitioner availability* based on *geographic location.* These tables represent full-time and part-time therapists and psychiatrists.

Availability and Number of Full-Time Therapists (non-FQHCs) (37.5 or more hours per week)

	Daytime	Evenings (after 5)	Weekend	**TOTAL**
Center City	**64**	**1**	**1**	**66**
Northeast	**73**	**2**	**2**	**77**
North	**187**	**10**	**0**	**197**
Northwest	**33**	**0**	**0**	**33**
South	**40**	**0**	**0**	**40**
Southwest	**7**	**0**	**0**	**7**
West	**47**	**2**	**1**	**50**
TOTAL	**451**	**15**	**4**	**470**

Availability and Number of Full-Time Psychiatrists (non-FQHCs) (37.5 or more hours per week—Day-time weekday hours, only.)

	TOTAL
Center City	**5**
Northeast	**17**
North	**19**
Northwest	**4**
South	**2**
Southwest	**0**
West	**8**

Our study findings revealed that there were very few full-time psychiatrists available during non-daytime weekday hours; hence the only meaningful data were for those psychiatrists available during the day.

Language Proficiency

Our study indicated that of the 69 provider agencies included in the study, 49 (71%) indicated that there were practitioners who spoke a language other than English. The predominate language spoken by participants in our study was *Spanish;* followed by *Mandarin, Cantonese, Vietnamese, and Russian.* Many providers indicated that they were aware of, and have used, translation services provided by CBH.

Additional Findings:

Federally Qualified Health Centers

There were 11 Federally Qualified Health Centers (FQHC) included in our findings. While these agencies met the initial criteria for this capacity study, we found that given their unique programming—integrated physical and behavioral health care via "Behavioral Health Consultants"—that they were best analyzed separately. In addition, the BHCs used in Philadelphia FQHCs provided services to *established patients in the physical health services*; and were not a referral source for general behavioral health services. Therefore, including them in our wait-time data yielded inconclusive information. Yet, the services provided by the BHCs appeared to meet the needs of those clients with mild psychiatric issues and could potentially serve as a model for mothers with *mild mood disturbance* (*"baby blues"*) who are current clients in the physical health program. As of the time of this report, FQHCs represented the majority of provider agencies in Southwest Philadelphia.

Closed Waiting Lists/Closed to CBH Clients

During our data collection, several agencies indicated that they were closed to new clients, due to excessive wait-times for intake appointments. In addition, a few provider agencies mentioned that they were no longer accepting CBH clients. The concern is that closed waiting lists potentially forces clients to travel longer distances to seek care; and lists closed to CBH clients results in low-income mothers not receiving care.

Appointment Times Based on Insurance

A few agencies indicated limited appointment slots for CBH clients. For example, one provider agency only had slots open on Mondays for CBH-clients, and another Wednesday afternoon. This is important to note, as the primary insurer for low-income women in Philadelphia is Medicaid, through CBH. Clearly, limiting appointment times based on insurance significantly impacts capacity and unfairly burdens poor women with perinatal depression.

Care of CBH-Clients is Often Provided by Medical Residents and Psychology Interns.

Several agencies—especially those affiliated with medical schools or teaching hospitals—often assigned the care of CBH clients to medical residents and psychology interns. This potentially results in CBH-clients receiving care from practitioners who are transient, have limited experience in psychotherapy and/or psychiatry, and lack training in perinatal depression.

Integrated with Substance Abuse Recovery Programs

In our study several provider agencies indicated that behavioral health services are only available to clients actively enrolled in their substance abuse recovery program. As a result, these providers are not available for women who do not meet program criteria.

Limitations to Data Collection and Analysis:

While collecting information for this study, there were limitations. Limitations to data collection included: 1) *discrepancies in resource directory, 2) contact issues, 3) communication issues with front-line staff, and 4) lack/limited knowledge of CBH/MFCH/Drexel Perinatal Depression Training.*

Discrepancies in Provider Listing

While attempting to contact provider agencies using the most recent *2009 CBH Member Handbook* and the *2010 CBH Service Providers' Guide Updates*, we encountered several inaccurate listings. The inaccuracies included: 1) incorrect or disconnected phone numbers; 2) fax numbers; and 3) phone numbers to administrative offices—which did not handle intake. The discrepancies created extra work in searching for contact numbers, including internet searching, and frequent "transfers" from departments within an agency. Although this was challenging for our interns and staff to navigate, the concern intensifies when mothers who wish to contact agencies for help encounter the same difficulties.

Contact Issues

During the 3 months of data collection, our interns and staff contacted eligible CBH psychiatric out-patient provider agencies. In attempts to reach a staff person to collect information, several of the numbers were not direct extensions to intake, and required a series of "transfers" to connect with an intake staff. In addition, there was extensive hold time (up to 5 minutes) without being connected. Within hospital based agencies, several calls were misdirected to non-psychiatric departments (eg. neurosurgery, billing, etc.). Moreover, several agencies were left messages and no calls were returned for many days; and some messages were never returned. The concern with misdirected calls and no return calls is that for mothers who seek care for perinatal depression, the process is extremely overwhelming and often results in a mother simply "giving up" and never getting the care she needs. It must also be noted that the intern did not always indentify as a "staff person conducting a study."

Limited Knowledge of Perinatal Depression Among Front-line Staff

Many agencies' front line staff were unaware of programs for perinatal depression within their agency (even in agencies that had programs or intake procedures specifically for perinatal depression). Furthermore, we found that many agency staff we spoke with had limited or no knowledge of the *CBH/MCFH/Drexel Perinatal Depression Training.*

Provider Feedback on CBH/MCFH/Drexel Perinatal Depression Training

In 2009, *Community Behavioral Health, Philadelphia Department of Health, Division of Maternal Child and Family Health* and *Drexel University College of Medicine Behavioral Healthcare Education* (CBH/MCFH/Drexel) collaborated to develop and implement the *Perinatal Depression Training* initiative. The purpose of the initiative was to provide awareness of perinatal depression to better meet the unique mental health treatment needs of mothers with perinatal depression in Philadelphia. As of the time of this report, there are 19 agencies with staff who received the training. Of these agencies, 16 were psychiatric out-patient clinics and only 14 were in Philadelphia County. Despite the efforts of CBH to recruit providers for this training, *less than one-quarter of provider agencies* (14 out of 79 or 18%) have staff trained in the CBH/MCFH/Drexel Perinatal Depression Training, at the time of this report.

The structure of the CBH/MCFH/Drexel Perinatal Depression Training requires participants to meet once monthly, for 10 months to receive instruction on various training modules, including understanding the "spectrum of disorder," trauma-informed therapy, cultural competency, and medication management during pregnancy and lactation. General feedback among those who attended the training was mixed—some felt the training was helpful in increasing their knowledge of perinatal depression, and others felt the training, while important, was too time consuming. Solo practitioners were more likely to report that the training was difficult to attend due to the time commitment required.

Given the importance of increasing practitioners comfort with and knowledge of treatment throughout the spectrum of perinatal depression, is it important that trainings which purport to educate practitioners take into consideration the barriers practitioners face with continuing education.

SUMMARY

Perinatal depression significantly impacts the quality of life of both mother and child. Currently, mothers can wait up to 8 weeks for an intake appointment, and up to 10 weeks *after intake* to see a therapist or psychiatrist. In some cases, agency policy requires that a psychiatrist is seen before therapy can begin, further extending the waiting period for treatment. In addition, given the nuanced nature of the disorder, not all women require a psychiatrist to receive help, yet are forced to endure long wait-times in order to get care, which could have been met by a social support program or psycho-educational intervention. Conversely, those mothers who have more severe psychiatric needs (e.g. psychosis) are forced to wait, are at risk for crisis intervention and hospitalization. Unfortunately the current behavioral health system is ineffective in addressing the spectrum of disorder.

Our findings also indicated that although there are provider agencies throughout Philadelphia County, there are geographic areas, which are underserved. While there is acknowledgement

from CBH that this remains an issue, at present some mothers are forced to travel long distances, usually on public transportation, while pregnant, or post-partum. Also, most agencies only offered "weekday, daytime hours", which creates a significant barrier to women who work or have small children in day care and school. In addition, only 18% of psychiatric out-patient clinics indicated having attended the CBH/MCFH/Drexel University training for perinatal depression. This is problematic, given the potential unmet need of perinatal depression among low-income women in Philadelphia.

At some agencies, there was strict "no-show" policies, which often mandated that women who had missed appointments would have their chart closed, or had to submit to another intake procedure. While it is understood that no-show rates are problematic for agencies, there is substantial data on client barriers to care[1] , which indicate significant issues with transportation, childcare, fear and previous adverse experiences with behavioral health agencies, which supports the need for more flexibility for clients who miss appointments.

Eleven of the provider agencies were *Federally Qualified Health Centers* (FQHC); and facilitated behavioral health care through an "integrated model"—linking physical health with behavioral health. While optimal in structure, the limitations of the current FQHC behavioral health model is that it offered limited behavioral health services (only provided "short-term" social support counseling, via "behavioral specialists"), and referred clients who required more intensive services to other psychiatric out-patient clinics. Moreover, the FQHC model only served established patients in their medical practices. For mothers who required more intensive services, or were not an established patient, the model was inefficient for the predominate number of women. Furthermore, in certain geographic areas (primarily Southwest Philadelphia) FQHCs were the only behavioral health provider agency. Several agencies only offered care for mothers who were currently seeking substance abuse services, which significantly limited services for a broad scope or mothers.

In closing, this study sought to serve as a preliminary analysis to examine the current behavioral health system and determine the capacity to meet the needs of low-income mothers with perinatal depression in Philadelphia County. Clearly, our findings should serve as a catalyst for more policy and systemic modifications to more effectively meet the needs of low-income women with perinatal depression.

[1] Boyd, et al., 2011.

Acknowledgements:

Maternity Care Coalition would like to acknowledge and thank Community Behavioral Health and the City of Philadelphia Department of Behavioral Health/Intellectual disAbility Services (DBHIDS) for their cooperation and interest in this project.

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