Addressing Barriers to Perinatal Mental Health Care in Safety Net Settings: A Feasibility Pilot Study

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Background

- Perinatal mental health is a major public health concern.
- *Timely* access to mental health treatment is crucial during pregnancy and up to 12 months postpartum.[1]
- Black, Latina and low-income women are more likely to develop perinatal psychiatric problems, but less likely to receive treatment.[2,3,4]
- Coordination between safety net community mental health clinics and prenatal care in urban centers is a challenge.
- Long wait times for therapy and/or psychiatric services may miss the critical perinatal time window.
- Though on-site collaborative care models are the gold standard for outpatient psychiatric consultations and referrals, co-location is not always possible.

Study Setting

- **Mission Neighborhood Health Center (MNHC)** provides prenatal care to medically underserved individuals in San Francisco's Mission District, but lacks on-site access to mental health care services for these patients.
- **Mission Mental Health Services (MMHS)** is a neighboring community mental health clinic in the San Francisco Department of Public Health (SFDPH) that provides comprehensive services to patients with a wide variety of psychiatric diagnoses.
- Both **MNHC** and **MMHS** specialize in treating Latinx/monolingual Spanish-speaking patients in the community, some of whom are treated in both clinics.

Objectives

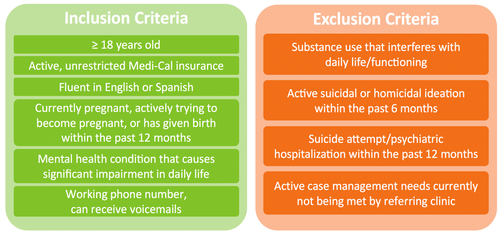
- Demonstrate feasibility of a referral-based community mental healthcare pilot program for pregnant and postpartum patients.
- Examine data from MNHC prenatal and postpartum patient visits to further identify the needs of this patient population.

Methods

Pilot Design

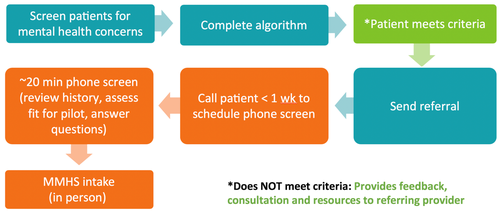
- Established relationship between midwife/perinatal mental health 'champion' at MNHC and psychiatrist at MMHS specializing in perinatal mental health.
- Psychiatrist can accept limited number of patients for expedited evaluation and treatment with short-term individual therapy and/or medication management, if indicated.

Figure 1: Pilot Eligibility



- Developed referral form with criteria to be sent to psychiatrist.

Figure 2: Proposed Pilot Flow



- MMHS treatment options:
  - Therapy
    - Referral (waitlist 1-3 months)
    - Short-term weekly or bi-monthly supportive therapy with psychiatrist during wait period
  - Medication management with psychiatrist indefinitely

Analysis: Aggregate and de-identified patient data from MNHC prenatal/postpartum visits Jan 2021 – Dec 2021. Descriptive analyses of demographics and psychosocial screening measures from these visits. This quality improvement project was deemed not human subjects research by the UCSF IRB.

Results

Figure 3: Pilot Program Clients

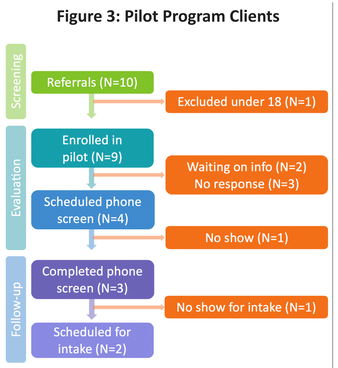


Figure 4: Primary Language Spoken at Home (N=233)

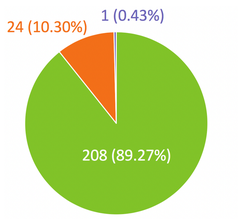
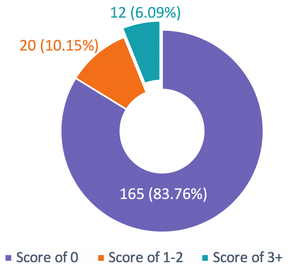
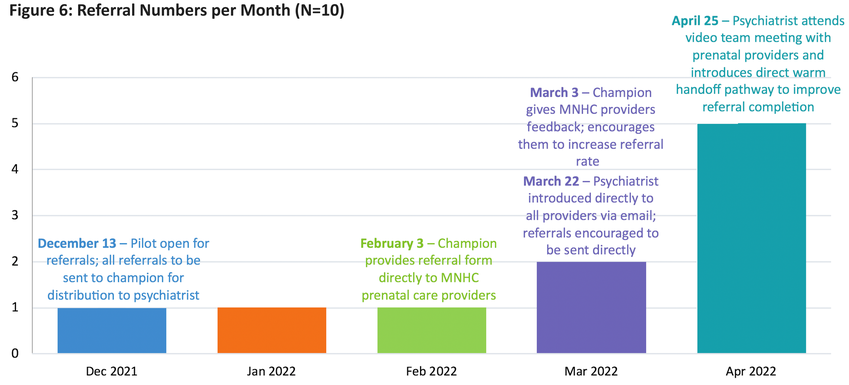


Figure 5: PHQ-2 Depression Scores (*N=197)



*197/233 (84.55%) completed PHQ-2
36/233 (15.45%) did NOT complete PHQ-2

Figure 6: Referral Numbers per Month (N=10)



Discussion

- Building a successful referral model is challenging and must address barriers at all levels of care, as suggested below:
  - *Systems-level:* Multidisciplinary interagency meetings focused on unmet community needs (e.g. perinatal mental health) to facilitate partnerships between local healthcare sites.
  - *Provider-level:* On-site champion is necessary but not sufficient. Initiate face-to-face meetings with referring providers prior to program implementation to improve linkages.
  - *Patient-level:* Warm handoffs: flyer with provider name and photo, schedule screening during prenatal visit.
- Depression screening identified few patients, although staff were aware of many more needing mental health services. This suggests need for broader screening and documentation of mental health needs, although provider time is extremely limited.
- Our pilot may be a feasible model to provide expedited perinatal mental health care services, although full evaluation is not yet completed.

Future Directions

- Further assess barriers to pilot referrals through eliciting formal feedback from both providers and patients.
- Prenatal clinics may improve triage and screening process through e-consults with local partners to facilitate real-time case feedback (feasible with a shared EHR).
- Plan and implement HIPAA-compliant e-mail and/or text messaging to improve patient communication.
- Recruiting more psychiatrists and clinicians into the referral program, as possible, for full-scale implementation.

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Acknowledgements

This work was supported by the SFDPH Behavioral Health Services, in collaboration with Mission Neighborhood Health Center. We acknowledge the UCSF Public Psychiatry Fellowship at Zuckerberg San Francisco General Hospital, Dr. Jim Dilley, Dr. N Kyle Jamison, and Dr. Lisa Fortuna.