Access to Mental Health Care in the Perinatal Population: Identifying Barriers and Exploring the Role of Integrated Care

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Background:

- Depression during pregnancy or the first 12 months postpartum affects 10-20% of child-bearing women in the United States. Risks of untreated perinatal depression include preterm delivery, preeclampsia, low birth weight, and poor attachment. Suicide is one of the leading causes of postpartum maternal deaths.[5]
- Only 22% of perinatal women who screen positive for depression engage in mental health care with screening alone; rates are even lower for women of color.[1,4]
- Mental health care utilization increases with more robust engagement strategies or alternative models of care.[1,3]
- Previously identified barriers to care for perinatal women include stigma, lack of community resources, and limited number of perinatal mental health providers.[2]
- This project identifies barriers specific to an urban, publicly insured perinatal population in order to develop and implement interventions to reduce those barriers within a traditional referral model.

Methods:

- Study Population:
  - From OBGYN and psychiatry clinics in downtown Baltimore, Maryland
  - Peripartum patients scoring moderate to severe on the Edinburgh Postnatal Depression Scale (>10)
- Baseline: Initial appointment show rate for all women's mental health referrals from July-December 2022 was 38.5% versus overall clinic show rate of 51.4%
- Study Design:
  - Aim: To improve the initial appointment show rate of women's mental health referrals to equal that of general clinic referrals by June 2024
- Measures: Provider/staff compliance with interventions, ease of implementation, and percentage of patients presenting to psychiatric intake appointment
- Selecting Interventions:
  - Conducted a series of meetings with providers and staff in both clinics to ascertain their perspectives on barriers specific to our traditional referral model
  - Divided barriers into provider-level, patient-level, community-level, and health care system/structural barriers (see Table 1)
- Based on these identified barriers, designed three interventions to reduce or eliminate those barriers (see Table 2)

Results:

Providers/Staff Interviewed	Provider-Level Barriers	Patient-Level Barriers	Community-Level Barriers	Health Care System/Structural Barriers
-OBGYN Clinic: RNs, SWs, referral coordinator, nurse midwives **-Psychiatric Clinic: Psychiatrists, SWs, clinic coordinator, intake coordinator**	-Varying levels of comfort managing psychiatric disorders in pregnancy -Misidentifying signs/symptoms of mental illness as normal to pregnancy/postpartum -Lack of communication between clinic staff, especially psychiatric and obstetric providers	-Low health literacy (especially mental health literacy) -Discomfort/lack of familiarity with healthcare system -Decreased motivation to seek care due to mental and/or physical illness	-Lack of resources such as childcare, transportation, case management -Mental health stigma, negative attitudes about treatment, and mistrust of the medical system within the community	-Limited number of psychiatric intake appointments, long wait times -Staffing shortages in community clinics, lack of support/admin staff to answer phones, conduct patient outreach, etc. -Question of funding and physical clinic space for co-located providers

Table 1: Provider/staff identified barriers from qualitative interviews conducted in the OBGYN and community psychiatry clinics

Intervention	Barriers Targeted
Clinic-Specific Brochure	- Improve mental health literacy, combat stigma, familiarize patients with clinic, providers, and services offered - Anticipate challenges in getting to intake appointment
Pre-Intake Patient Outreach via Phone	
Offering Telehealth Visits	- Childcare, transportation, and other logistical or psychosocial issues that hinder a patient's ability to attend in-person appointments

Table 2. Interventions designed to target specific barriers identified during qualitative interviews

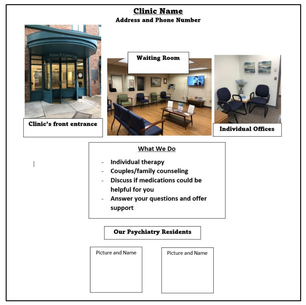

Image 1: Sample brochure, specific to clinic and providers

Pre-intake appointment outreach phone call
Psychiatrist introduction
Psychoeducation on role of psychiatry
Address concerns of seeing a psychiatrist or anticipated barriers to attending appointment
Contact information

Table 3. Topics covered in pre-intake patient outreach phone call

Discussion:

- Barriers identified in this clinic population were similar to previously identified barriers
- Feedback from staff demonstrated high awareness that barriers to care existed, but there were limited efforts to reduce those barriers in a systematic way
- Resource-related barriers to care (childcare, transportation) are barriers to engaging in any outpatient appointment, but show rates to psychiatric appointments are particularly low. This suggests that there are additional barriers to accessing psychiatric care, such as stigma and perceived dangers of psychiatric medications

Future Directions:

- Ongoing data collection from all women's mental health referral intake appointments between July 2023- June 2024
- Collecting provider/staff feedback on interventions and challenges to implementation
- If show rates improve, will implement clinic-specific brochures, pre-intake phone calls, and telehealth appointments permanently
- If show rates do not improve, may consider more robust interventions in the future such as implementing alternative care models instead of traditional referral (such as co-located psychiatrist embedded in OBGYN clinic, collaborative care model, etc.)

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