BUILDING CAPACITY OF RURAL HEALTH PROVIDERS TO PROMOTE MATERNAL MENTAL HEALTH: LAUNCH OF A STATEWIDE PROGRAM

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OBJECTIVES

1. Review the burden of disease in the State of Arizona

2.Discuss the barriers that rural health providers face in providing effective care for birthing persons experiencing maternal mental health and substance use concerns, and understand how the new statewide program can help to address these barriers.

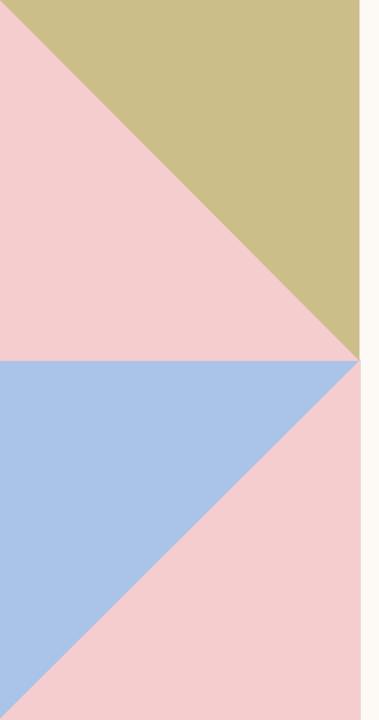
3. Develop skills and strategies for effectively preventing, identifying, and managing maternal mental health and substance use concerns, using the resources and consultation services provided by the new statewide program.

DEFINITIONS:

Maternal/Perinatal Mental Health Conditions- refers to conditions that affect a pregnant person's mental health during pregnancy and the post-partum period.

Perinatal – Covers the time period of pregnancy and up to one year postpartum

PMADs- Perinatal mood and anxiety disorders. This includes perinatal AND post partum depression, anxiety, OCD, PTSD, bipolar disorder and does include post-partum psychosis.

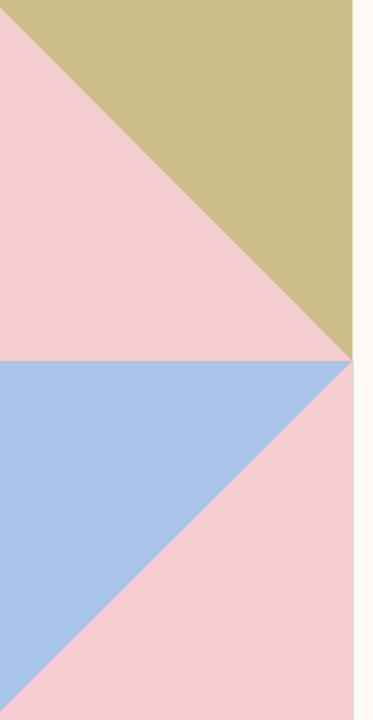


MORE ABOUT PMADS

- The most common complication of pregnancy
 - Occurs in 1:5 people (And this does NOT include substance use disorders or ADHD!)
 - Comparison- preeclampsia which pregnant people are screened for frequently occurs in 1:25
 - They are treatable and preventable causes of maternal morbidity and mortality
- Frequently untreated
 - Up to 80% of people with PMADs do not receive treatment
 - For depression alone, 60% of women nationally are never diagnosed and 50% never receive any treatment after diagnosis

THE HIGH COST OF PMADS

- To mother:
 - Increased risk of miscarriage, antepartum and post-partum hemorrhage, gestational hypertension, **suicide**, preeclampsia, poor attachment, placental abnormalities, poor maternal nutrition, breastfeeding difficulties, have poor nutrition, struggle to manage their own health
 - Maternal suicidality is one of the leading causes of maternal mortality in the first 12 months post-partum
- To Baby:
 - Increased risk of preterm birth, NICU admission, low birth weight, neonatal hypoglycemia, microcephaly, increased risk of psychiatric illness in childhood and adolescence, poor attachment, cognitive and motor delays, emotional and behavioral problems in child
- To community:
 - average cost per affected mother-child dyad is \$31,800
 - Loss of economic productivity, cost of pre-term birth, cost of other maternal health expenditures



MATERNAL MENTAL HEALTH AND SUICIDE

Mental health conditions are the MOST COMMON complication of pregnancy and childbirth, affecting 1 in 5 women and childbearing people (800,000 new parents each year in the United States).

Suicide and overdose combined are the LEADING CAUSE of death for women in the first year following pregnancy.

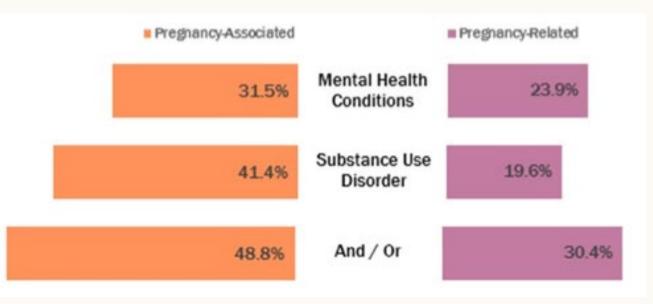
The peak incidence of suicide is 6-9 months postpartum. New mothers who die by suicide

- Are mostly white and older
- Use the most violent forms of suicide (hanging, jumping, shooting)
- Die in the late postpartum period
- Do not attend a postpartum obstetric visit (<50%)

ALMOST HALF OF ALL PREGNANCY-ASSOCIATED DEATHS IN ARIZONA WERE RELATED TO MENTAL HEALTH CONDITIONS OR SUBSTANCE USE DISORDERS

2016-2018 DEATHS IN ARIZONA OF WOMEN 15-49 YEARS OLD WITH A PREGNANCY IN THE PREVIOUS 365 DAYS

There were 203 total Pregnancy-Associated Deaths between 2016-2018. Of these, 99 were related to Mental Health and/or Substance Use.

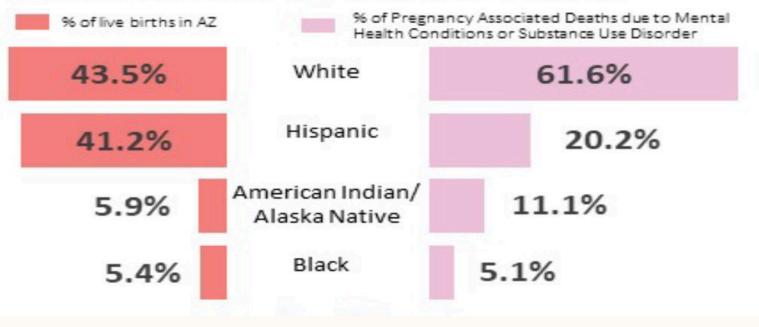


AZDHS DATA 2016-2018

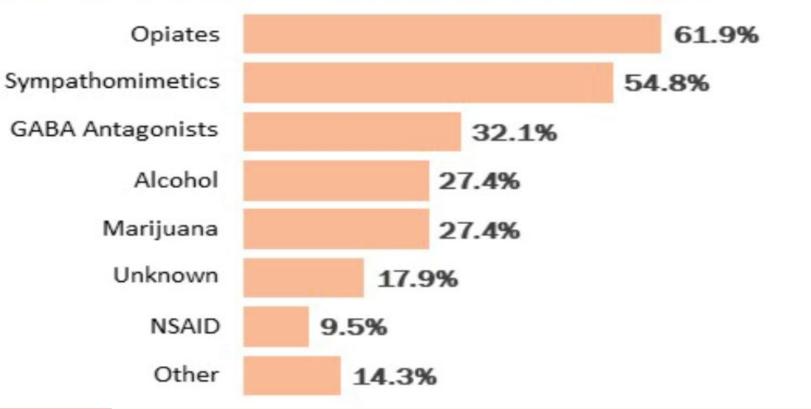
Almost Two Thirds of Pregnancy Associated Deaths Related to Mental Health Conditions or Substance Use Disorder Occurred between 42 and 365 Days Postpartum



American Indian/Alaska Native Women Experience the Greatest Disparity in Pregnancy Associated Deaths Related to Mental Health Conditions or Substance Use Disorder



Almost Two Thirds of Pregnancy Associated Deaths Related to Mental Health Conditions or Substance Use Disorder Involved Opiates



AZDHS DATA 2016-2018

STATE LAWS AROUND SUD AND PREGNANCY

24 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes, and 3 consider it grounds for civil commitment.

25 states and the District of Columbia require health care professionals to report suspected prenatal drug use, and 8 states require them to test for prenatal drug exposure if they suspect drug use.

19 states have either created or funded drug treatment programs specifically targeted to those who are pregnant, and 17 states and the District of Columbia provide pregnant people with priority access to state-funded drug treatment programs.

10 states prohibit publicly funded drug treatment programs from discriminating against pregnant people

Source : Guttmacher Institute

ARIZONA POLICIES ON SUD DURING PREGNANCY

Arizona Considers Substance Use During Pregnancy as Child Abuse however, it is not grounds for Civil Commitment

When Drug Use is Diagnosed, Suspected, AZ requires reporting

In AZ Pregnant People are given priority access in General Programs

STATE OF PSYCHIATRY IN AZ

The Need:

- Births in 2020: 76,947
- People likely impacted by PMADs: 15,389
- Cost to Arizona: \$477 million if none treated

Access to care:

- Total number of Psychiatrists in Arizona in 2023: 915
- Ratio: 1: 8000
- Some counties have no psychiatrists, very few trained in perinatal psychiatry



PERINATAL PSYCHIATRY ACCESS PROGRAMS

PERINATAL PSYCHIATRY ACCESS PROGRAMS:

Perinatal individuals interact with a healthcare provider 20-25 times during routine prenatal/postpartum care, and well-child visits for the infant until one year of life.

Frontline providers can play a critical role in addressing PMH conditions, but face significant challenges including low comfort treating perinatal mental health conditions, evolving guidelines for treatment, limited access to resources for patients.

- Access programs are designed to address gaps in care of perinatal population by increasing capacity of frontline care workers to screen, treat and provide resources for perinatal psychiatric illness.

PERINATAL PSYCHIATRY ACCESS PROGRAMS

- First access program launched in 2014 with MCPAP for Moms out of Massachusetts
- Generally, multiple components including education, consultation and resources



on evidence-based guidelines for screening, triage, and referral; risks and benefits of treatment; and discussion of screening results and treatment options.

2 CONSULTATION

Real-time psychiatric consultation for frontline providers caring for individuals during the perinatal time frame. 3 RESOURCE & REFERRAL Linkages with communitybased mental health resources including individual and group therapy, support groups, and other

resources to support perinatal health and wellness.

Perinatal Psychiatry Access Programs are being implemented and funded in various ways





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Arizona Perinatal Psychiatry Access Line



When you call, you are connected with a perinatal psychiatrist who can help evaluate patients, provide consultation on treatment, and provide a framework for discussing psychiatric treatment in pregnancy and lactation.

888-290-1336

Patient consultations are available Monday-Friday, from 12:30 p.m. to 4:30 p.m.

APAL.arizona.edu

WHAT APAL OFFERS

PHONE LINE 888-290-1336

When you call, you are connected with a perinatal psychiatrist who can help evaluate patients, provide consultation on treatment, and provide a framework for discussing psychiatric treatment in pregnancy and lactation.

Available Monday – Friday 1230pm-430pm



For Moms & Families

RESOURCES

Explore excellent resources across Arizona for you, your family, and newborn.

You are not alone. These resources are here to help you navigate the challenges that come with parenting during the perinatal period. If you are in a mental health crisis, call the **Suicide & Crisis Lifeline** at 988. If you are experiencing a medical emergency, call 911.



TRAININGS

Request APAL Trainings

Type of Training Requested (All trainings are 1.5 hours unless otherwise noted)

Psychotropic medication management in the perinatal time period

Addressing substance use disorders in pregnancy

The perinatal time period and its associated physiological and psychological considerations

Approach to assessment of psychiatric concerns in the perinatal time period

ADHD management in pregnancy and postpartum

] Other

GENERAL TREATMENT PRINCIPLES: EXPECT PREGNANCY

By age 44, 85% of US women will be mothers. Unexpected pregnancy makeup 50% of all pregnancies in the United States.

It is essential to discuss pregnancy safety when a medication is prescribed.

GENERAL PRINCIPLES

- Revisit diagnosis and verify it yourself
- Classify severity of illness
- Maximize use of Behavioral and Somatic Treatments and Interventions
 - Bright light therapy is an underutilized tool and has evidence of benefit alone or in combo
- Minimize the number of adverse exposures
 - Don't expose to both illness and meds treat to remission
- Use Medications with Data when possible
- Assess other risks (Smoking, Marijuana Use) when making a plan
- Educate Everyone

INFORMED CONSENT IN PREGNANCY

- Risk Risk discussion
- Collaborative, patient-centered approach required
- No one drug is "the one"
- No one study covers everything
- Use medications when the risk of disorder outweighs the risk of treatment
- Patients with similar presentations can make very different decisions regarding treatment

PERSPECTIVE ON RISK

Rate of major malformations: 3-4%

Rate of premature delivery: 11-12%

Rate of gestational diabetes: 2-7%

Untreated psychiatric disorders carry risks for woman and baby

PROVIDER CONSIDERATIONS

Education

- MGH Center for Women's Mental Health
 - Website
 - Weekly Virtual Grand rounds
- National Curriculum for Reproductive Psychiatry
- Marce Society MONA (Marce of North America)
- NASPOG (North American Society for Psychological Obstetrics and Gynecology)
- BUMPS(Best use of Medicines in Pregnancy) Leaflets produce by UK Teratology Information Services
- Perinatal Mental Health Toolkit by the RCGP (Royal College of General Practitioners)
- NAMS North American Menopause Society

Consult

Bio ethics committees

Risk management

PROVIDER RESOURCES

MothertoBaby: (866) 626-6847 / www.mothertobaby.org Motherisk.org: (877) 439-2744 / www.motherisk.org Infantrisk.com: (806) 352-2519 / www.infantrisk.com Reprotox: www.reprotox.org LactMed: www.lactmed.nlm.nih.gov E-Lactania: www.e-lactancia.org/ingles/inicio.asp Toxicology Data Network: www.toxnet.nlm.nih.gov

THANK YOU

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Visit our Website

To request an APAL training, download the toolkits, and access other resources, scan the QR code to visit our website.

CITATIONS

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