POSTPARTUM SUPPORT INTERNATIONAL

Unique Challenges of Maternal Mental Healthcare in Rural Settings

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Overview for Today

- What are Perinatal Mood Disorders?
- What are predictors of maternal mortality?
- How is Arizona doing in comparison to other states?
- Resources to improve referral networks, access to care, and strategize for working with diverse populations with cultural humility
- Case Study

Perinatal Mood and Anxiety Disorders (PMADs)

PMADs stands for Perinatal Mood and Anxiety Disorders, a group of mental health conditions that can affect individuals during pregnancy and up to one year postpartum.

These disorders include postpartum depression, anxiety disorders, postpartum psychosis, and other mood and anxiety-related conditions.

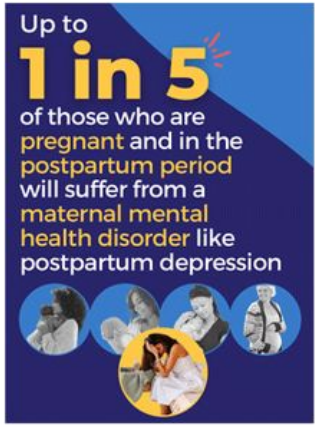
Quick Quiz

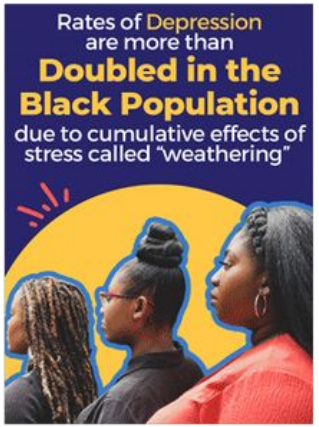
A. How prevalent are perinatal mood disorders in the population *(e.g.,1 in **"X"** people will experience it)*?

B. If report cards were given for Maternal Mental Healthcare, what grade **(A - F)** would you give Arizona?

C. In your care area, what **ONE thing** is needed to adequately care for people experiencing perinatal mood challenges?

What are Perinatal Mood Disorders?





POLICY CENTER FOR Maternal Mental Health™

PolicyCenterMMH.org

To view references search: MMH infographic citations

Symptoms

Symptoms can start anytime during pregnancy through first year postpartum

Depression

- Anger or irritability
- Lack of interest in the baby
- Appetite and sleep disturbance
- Crying and sadness
- Feelings of guilt, shame or hopelessness
- Loss of interest/pleasure in things used to enjoy
- Thoughts of harming baby/self
- **~15% have significant depression postpartum.**

Not the **"baby blues"** - feelings of sadness in few days after delivery. Up to 4/5 new parents (80 percent) effected. Start 2d and last 2w postpartum; usually go away without treatment.

Postpartum depression is similar, but more severe and last longer.

Anxiety

- Constant worry or feeling something bad is going to happen
- Racing thoughts
- Disturbances of sleep and appetite
- Inability to sit still
- Physical symptoms: dizziness, hot flashes, and nausea

- ***Postpartum Panic Disorder*:** anxiety w/panic attacks
- ***Obsessive Compulsive Disorder***
  - Obsessions or intrusive/repetitive thoughts, mental images related to baby; upsetting
  - Compulsions: repetitive behaviors done to reduce stress; cleaning, checking, counting
  - Fear of being left alone with infant and/or hypervigilance in protecting
  - Know thoughts are abnormal, unlikely to act on them (vs postpartum psychosis)

Symptoms

Post-Traumatic Stress Disorder

- 9% following childbirth, partners too;
  - Real or perceived trauma during delivery or postpartum.
  - Feelings of powerlessness, poor communication and/or lack of support and reassurance during the delivery
- Previous trauma = higher risk
- Intrusive re-experiencing of a real or perceived traumatic event or nightmares
- Avoidance of stimuli associated with event, including thoughts, feelings, people, places
- Persistent arousal (irritability, difficulty sleeping, hypervigilance, startle response)
- Anxiety and panic attacks
- Feeling a sense of unreality and detachment

Symptoms

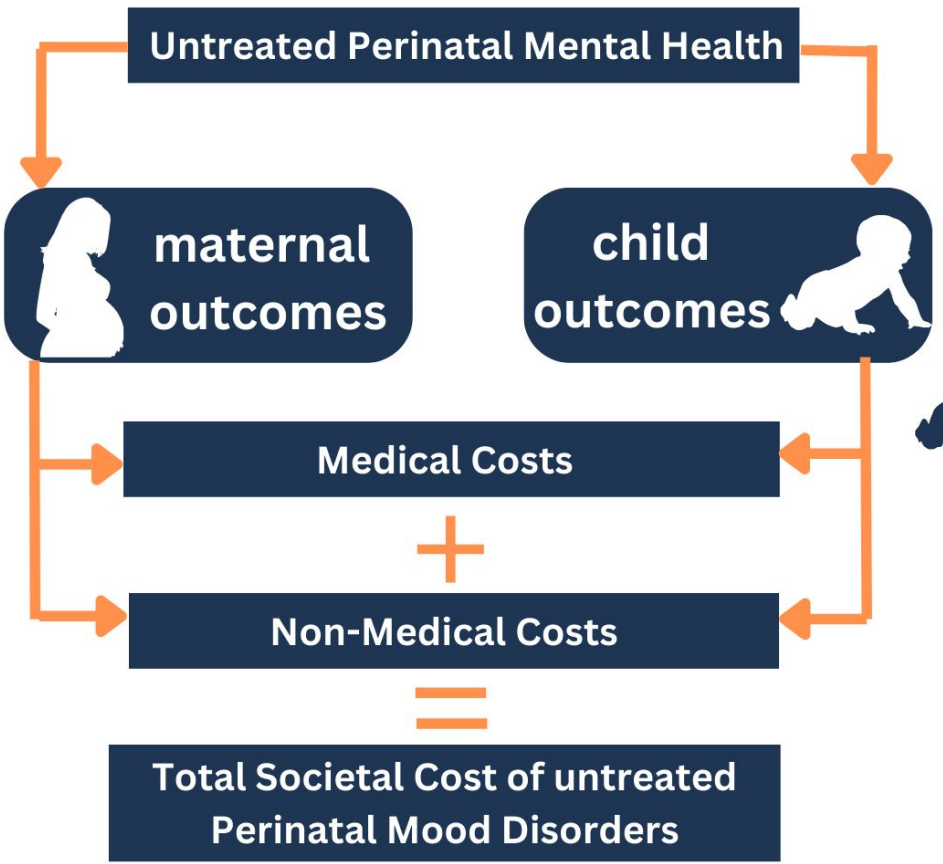
Bipolar Disorder

- **50% of birthing people with bipolar disorder are first dx in postpartum period**
- + Family history & high risk relapse
- Periods of severely depressed mood and irritability
- Mood much better than normal
- Rapid speech/thoughts, trouble concentrating, decreased need for sleep, high energy,overconfidence, impulsive, poor judgement
- Delusions (grandiosity paranoia)

Psychosis

- ~1 to 2 out of every 1,000 deliveries, or 0.1 -0.2% of births.
- Onset is usually sudden, often within 2 weeks postpartum
- **Delusions or strange beliefs/paranoia**
- **Hallucinations (seeing or hearing things that aren't there)**
- Irritability, hyperactivity, decreased need for or inability to sleep
- Psychosis is an emergency

Multigenerational Societal Costs of Untreated Perinatal Mood Disorders



- Increased risk of **worse maternal health**,
- Increased likelihood of **suicide**,
- Higher **work absenteeism**,
- Lower **labor force** participation

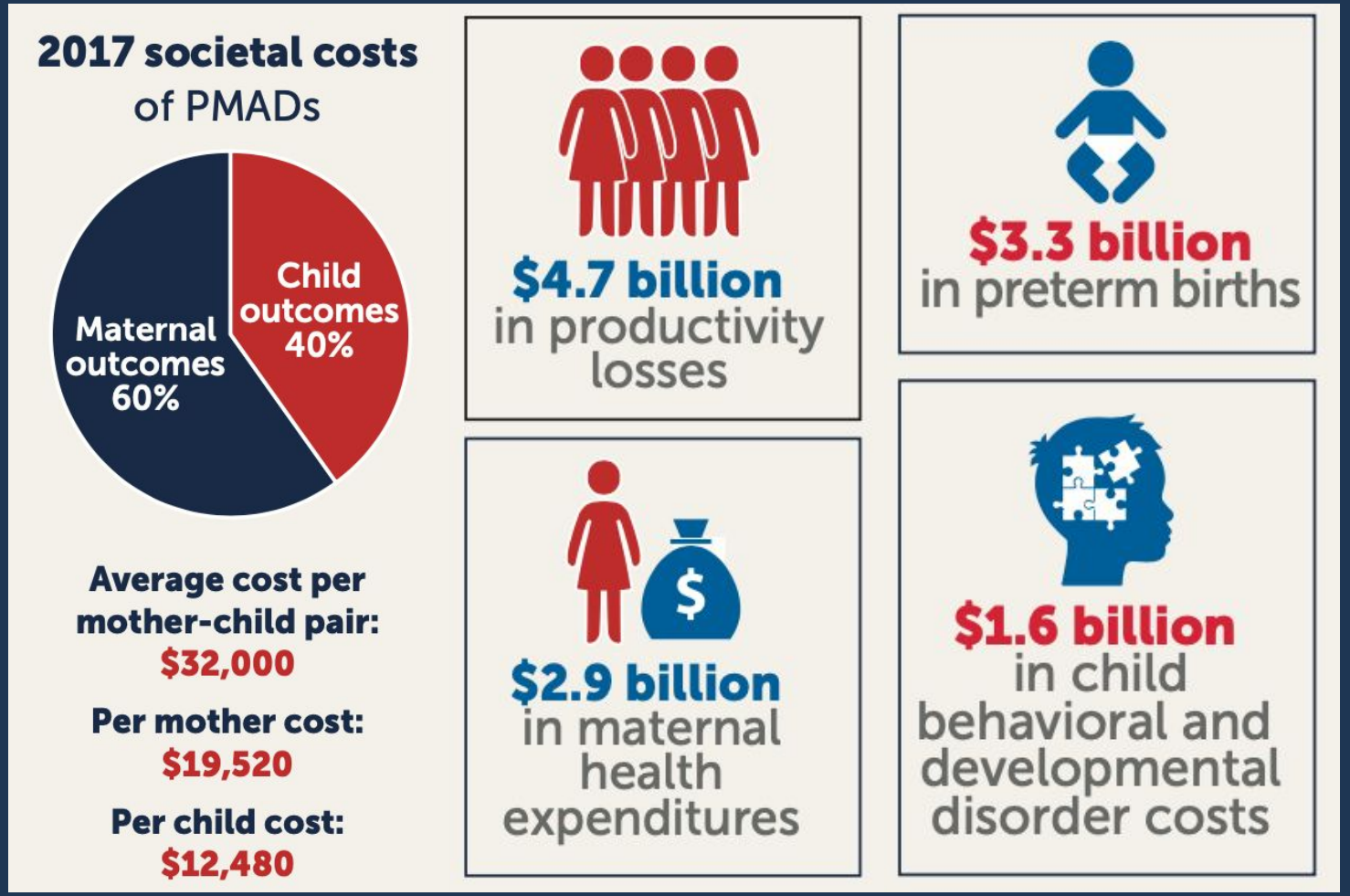
- Increased risk of **low birth weight** or **pre-term birth**,
- Increased risk of **SIDS**,
- Increased risk of **behavior and developmental disorders**,
- Increased likelihood of **worse child health**,
- Lower likelihood of being **breastfed**

Adapted from *Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States, Mathematica Policy Research. Apr, 2019*

“Untreated Perinatal Mood Disorders are among the most costly conditions during pregnancy and postpartum.”

“Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States”

April 2019



Untreated Perinatal Mental Health Conditions

cost ~5x's more

than the other common perinatal complications

gestational diabetes
up to $3,300 per mother

postpartum hemmorrhage
up to $3,300 per mother

Untreated Perintatal Mood Disorders
$17,100 per mother-child pair over a six-year time frame.

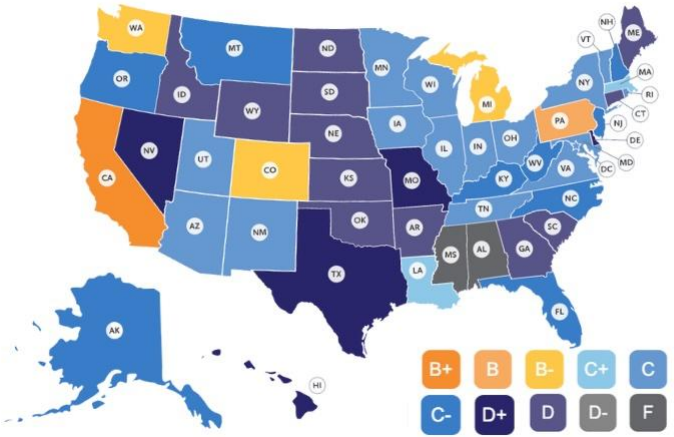
Source: Cambridge, MA: Mathematica Policy Research. Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States. Apr 29, 2019
https://www.mathematica.org/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-the-united-states

National Maternal Mental Health Data

The U.S. has made incremental progress, with an overall grade of a **C-,** improving slightly from a **D+** in 2024. One state obtained a score of B+ (California), and 6 states obtained scores of B or better.

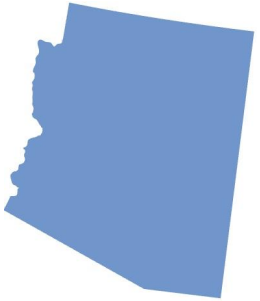
The report card grades states in three domains:

1. **Providers and Programs**
2. **Screening and Screening Reimbursement**
3. **Insurance Coverage and Treatment**



Up to four points are provided for each of the 20 measures within these domains. See how your state ranks in this year's Report Card.

Arizona's Report Card



- Improved from an overall score of C- (2024) to a C (2025)

Providers and Programs C

- Meets ratio of non-prescriber MMH providers to perinatal population (5 per 1,000 births)
- Meets ratio of MMH prescribers to perinatal population (1 per 5,000 births)
- Has at least one inpatient or residential MMH treatment program
- Has at least one MMH intensive outpatient program (IOP) or partial hospitalization program (PHP)
- Has or has had a state-sanctioned MMH Task Force or Commission
- Meets ratio of community-based organizations (CBOs) providing direct service for MMH (at least 1 per 50,000 births)
- State Perinatal Quality Collaborative (PQC) has prioritized MMH

Screening and Reimbursement F

- Top performer on the HEDIS "prenatal depression screening" measure (among commercial insurance and/or Medicaid)
- Top performer on the HEDIS "postpartum depression screening" measure (among commercial insurance and/or Medicaid)
- Medicaid requires MCOs to report "prenatal depression screening" HEDIS measure
- Medicaid requires MCOs to report "postpartum depression screening" HEDIS measure
- Maternity providers submit claims to private insurers for prenatal MMH screening (among at least 1% of prenatal patients)
- Maternity providers submit claims to private insurers for postpartum MMH screening (among at least 1% of postpartum patients)

Insurance Coverage and Treatment C

- Expanded Medicaid
- Extended Medicaid coverage to one year postpartum
- Requires health plans to develop an MMH quality management program
- Maternity providers submit claims to private insurers for prenatal MMH treatment
- Maternity providers submit claims to private insurers for perinatal MMH treatment
- Maternity providers submit claims to private insurers for postpartum MMH treatment
- State provides enhanced Medicaid reimbursement or state investment in group prenatal care (New in 2025)
- Medicaid coverage of group parenting programs (New in 2025)

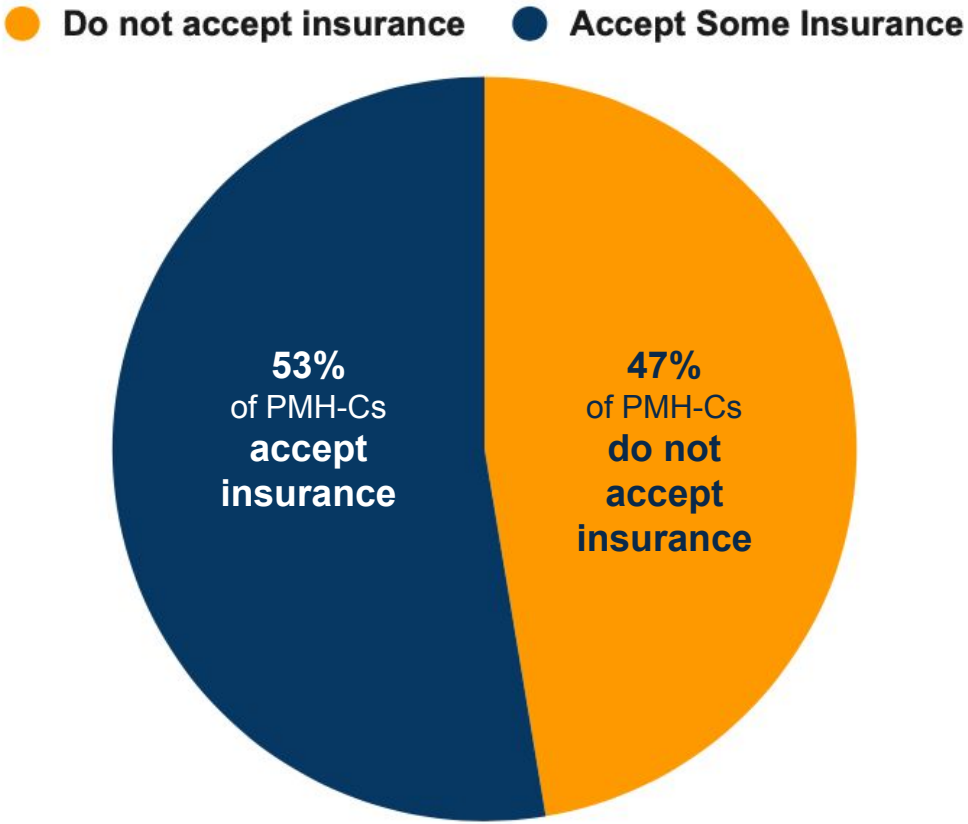
Social/Environmental Risk Factors for Maternal Mortality

- **Socioeconomic status:** Lower socioeconomic status is associated with increased risk, potentially due to limited access to healthcare and resources.
- **Lack of antenatal care:** Inadequate or inefficient prenatal care is a risk factor.
- **Racial and ethnic disparities:** Research shows disparities in maternal death rates, with Black women and American Indian/Alaska Native women at highest risk in the United States.
- **Discontinuity of care:** Discontinuities in hospital care can contribute to increased risk.
- **Interpregnancy interval:** Shorter intervals between pregnancies may increase risk.
- **Violence and trauma:** Exposure to violence and trauma can have significant impacts on maternal health.

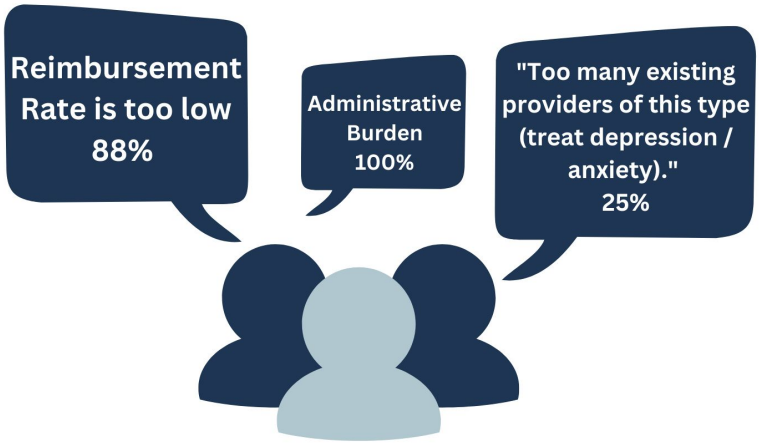
CDC Maternal Mortality Review Committee

- Pregnancy related deaths occur during pregnancy, delivery, and up to 1 year postpartum
- Over 80% of pregnancy related deaths were determined to be preventable
- Two-thirds of U.S. pregnancy-related deaths occur during the postpartum period
- Mental health conditions and substance use disorders together are the leading cause of maternal mortality (accounting for 22.7% of all deaths, 8.4% of deaths occurred from suicide)
- The U.S. stands alone as the only high-income country where there is no federally mandated paid leave policy.

Barriers to Accessing Treatment for Perinatal Mood Disorders



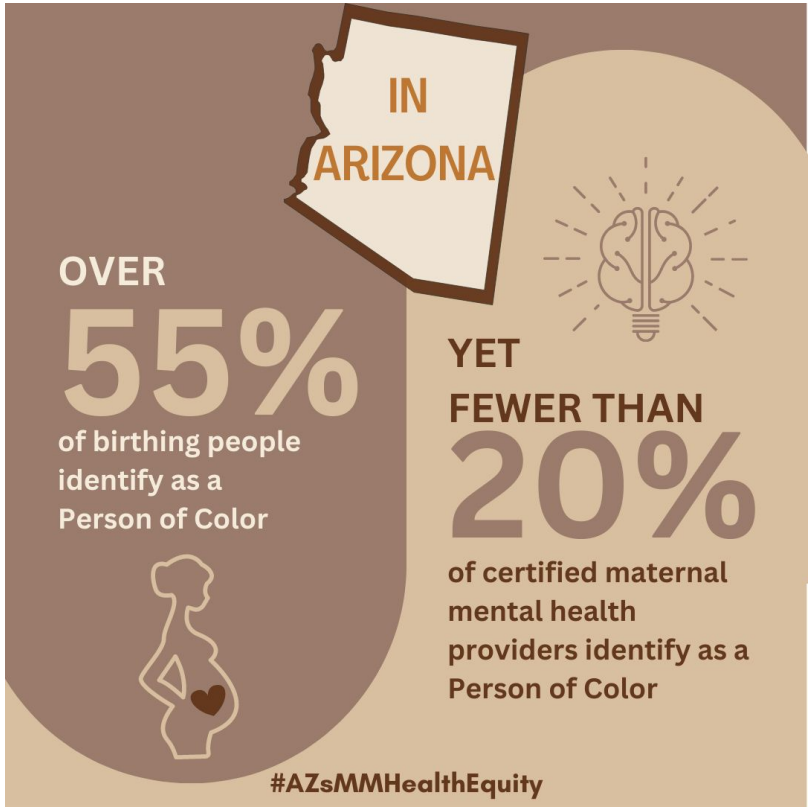
Based on March 2023 PMH-C Questionnaire with 30% Response Rate

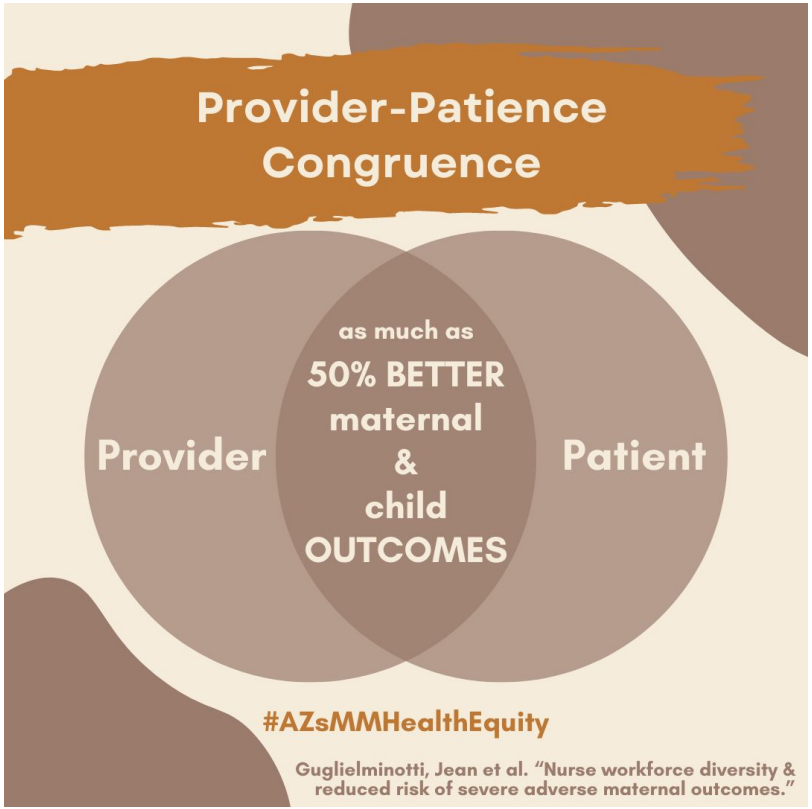


67% of these providers operate as independently owned private practices

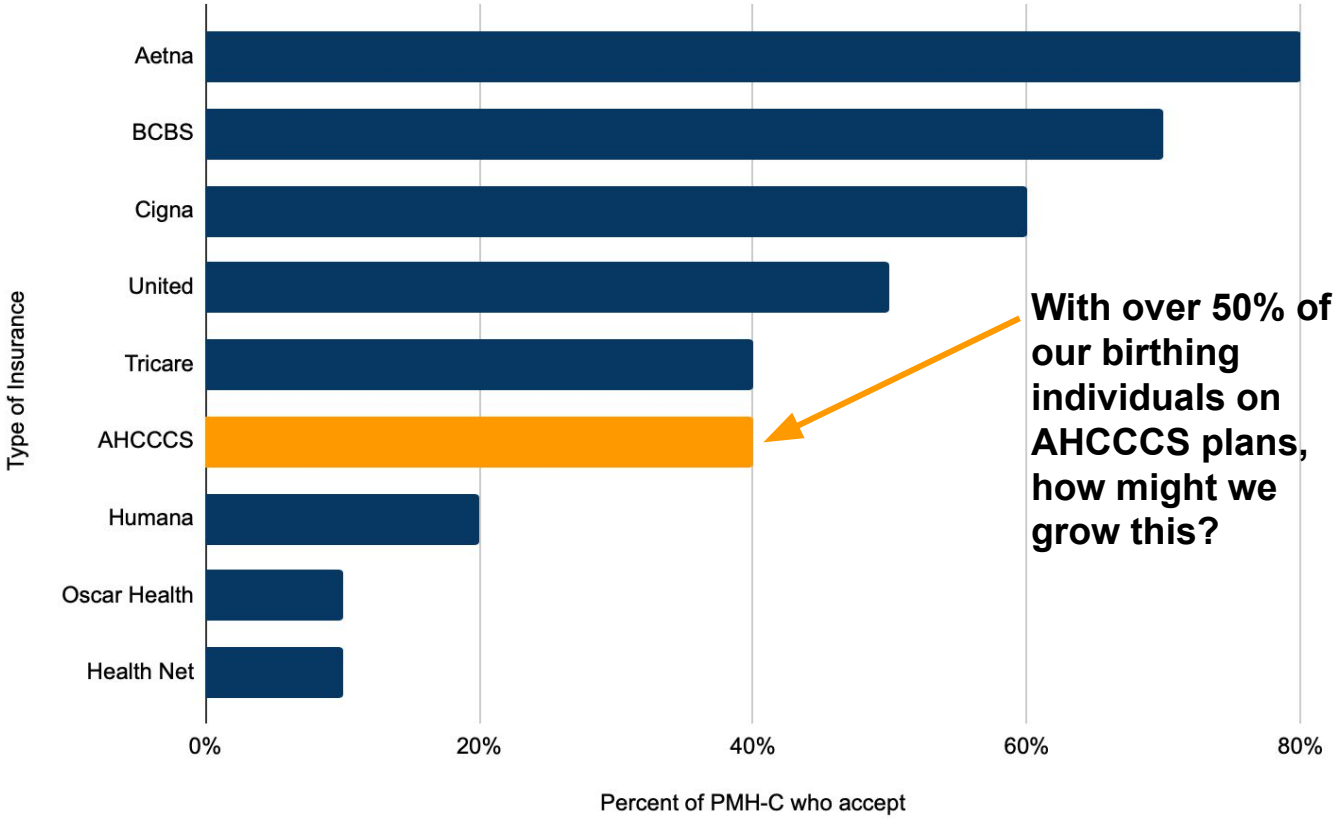
Typical Cash Pay Rate
$100 - $150 per hour

State of the State: PMH-C Provider-Patience Incongruence





% of Certified Perinatal Mental Health (PMH-C) Accepting Each Type of Insurance



With over 50% of our birthing individuals on AHCCCS plans, how might we grow this?

Resources Available
Postpartum Support International (PSI)

FREE Resources for Help-seekers

National Maternal Mental Health Hotline

Support Groups

Find Your Peer Mentor

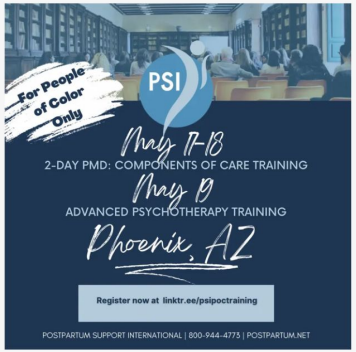
Connect with a Local Specialist

Connect with a Specialized Coordinator

Chat with an Expert

For Providers

Phoenix, AZ



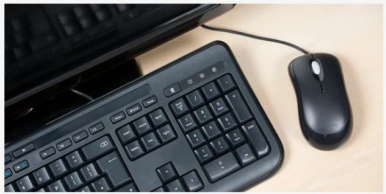
Virtual Certification Training

Tucson, AZ

Frontline Provider Training

Let us bring training to you

On-Demand Webinars



FREE Educational Webinars

FREE MMH 101

Maternal Mental Health 101

PSI Perinatal Psychiatric Consult Line

Medical professionals: Get a free consult about mental health care related to childbearing and pre-conception planning.

LEARN MORE

AZ Perinatal Access Line (APAL)

Real-Time Consultation, Education and Care Coordination

OB/Gyn,
Family Medicine,
Pediatrician,
Mental Health,
Midwife,
Lactation specialist

5 perinatal psychiatrists on faculty

Soft Launch in May 2023, Official Launch in June 2023

Trainings, Toolkits,
Website

Case Study

Tamara identifies as a 36 year old married female who is 37 weeks pregnant with her first child. She lives with her husband and mother in law in Camp Verde, Arizona. She reports having a positive relationship with her mother in law and believes she will be helpful and supportive when the baby comes. There have been no physical health complications during her pregnancy. She has paid parental leave through her employer, however, her husband does not have a parental leave policy. He currently has 80 hours of annual leave which he plans on using during the immediate postpartum period. Tamara indicates both her and her husband have stable housing and employment, and are middle class socioeconomic status.

What risk factors are present for PMADs/Maternal mortality?
What resources may be beneficial for Tamara and her family?
How can you assist in finding appropriate referrals and supports?
What other questions do you have that could inform resource sharing?