A Strategic Framework for Perinatal Mental Health in Montana

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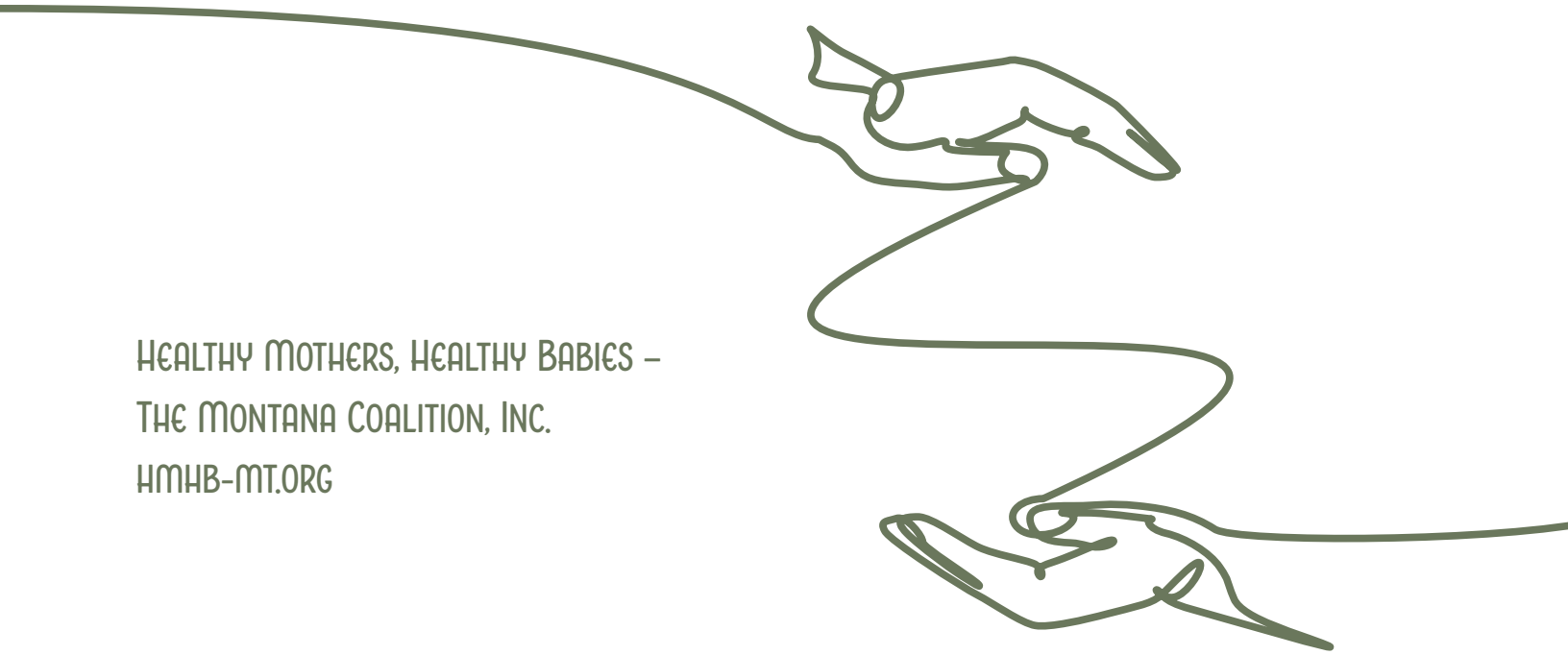

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Healthy Mothers, Healthy Babies
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YARROW

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Introduction

This Framework was designed to guide the work of organizations and government agencies across Montana who are working to improve the lives of Montana families by addressing the landscape of care and social services that affect perinatal mental health (PMH).

The PMH field in Montana has experienced significant growth in recent years. This increase was spurred by tragic sentinel events, such as an incident in 2016 in which an entire family was lost due to postpartum depression. These events have raised awareness and sparked conversation and action across the state. Similarly, awareness has increased nationally, creating a surge in funding for initiatives addressing perinatal mental health.

Numerous Montana organizations as well as local PMH coalitions are now working diligently to make a larger impact. These organizations are working to raise awareness of PMH, improve screening and treatment, and provide support to those who are struggling. They are also working to advocate for policies that will improve the mental health of Montana families.

The work of these organizations is essential to ensuring that all birthing people have access to the care they need to thrive.

Timeline of Selected Perinatal Mental Health Initiatives in Montana

2016
- Healthy Mothers Healthy Babies begins annual Perinatal Mental Health (PMH) conference

2017 – 2019
- Community-based Perinatal Mental Health Coalitions began in Missoula, Flathead, Helena

2018
- Meadowlark Initiative is launched by Montana Healthcare Foundation, with later support by Montana Medicaid

2019
- Montana Obstetrics and Maternal Support (MOMS) Initiative is launched by Montana Department of Health and Human Services (DPHHS), Billings Clinic, and the University of Montana Rural Institute for Inclusive Communities (UM RIIC)
- Montana Medicaid begins reimbursement for Peer Support

2021
- OneHealth launches the Peer Support Doula training and program
- The Linking Infants and Families to Supports (LIFTS) Online Statewide Resource Guide is launched by Healthy Mothers Healthy Babies (HMHB) of Montana to improve resource referrals for providers and access to resources for families

2022
- Rural Maternity Obstetrics Management Strategies (RMOMS) launches Maternal Health Connection under the guidance of Intermountain Health in southwest Montana
- Postpartum Support International (PSI) Chapter launches in Montana
- Maternal Mortality Review Committee (MMRC) is formed in Montana for the first time
- Perinatal Mental Health Collaborative group begins to form
- Roots Family Collaborative & Tree of Life Doula Care Planning Grant from Montana Healthcare Foundation to create a Postpartum Doula care for mental health

2023
- HMHB launches the Native American Initiatives Program to address maternal mental health in Tribal Communities
- Montana Medicaid expands postpartum coverage for up to 12 months postpartum

To add to the Timeline or to see an updated version of the Timeline, go to HMHB's website.

Background

The impact of perinatal mental health conditions on women, babies, and families across the United States (US) and Montana can be seen through many lenses including health outcomes, economic security, and family stability.

Prevalence and Impact

- Maternal mental health conditions, such as anxiety, perinatal and postpartum depression, birth-related PTSD, are the most common complications of pregnancy and childbirth, affecting 1 in 5 women.[1,2]
- With nearly 1 in 5 women affected by maternal depression, it is the most common obstetric complication in the US.[3]
- **In Montana, 1 in 6 women experience depression during pregnancy.**[4]
- In the US, 13.4% of women report symptoms of depression after giving birth. **In Montana, this number increased to nearly 15% in 2020.**[5]
- When a mother has a perinatal mood of anxiety disorder, 10% of fathers will also experience a mood disorder.[4]
- Children born to mothers with untreated mental health conditions are at higher risk for low birth weight or small head size, preterm birth, longer stay in the NICU, excessive crying, impaired parent-child interactions, and behavioral, cognitive, or emotional delays.[6]
- Maternal depression and other perinatal mood disorders are linked to risk factors for maternal mortality and morbidity, including hypertension, preeclampsia, and gestational diabetes.[7]

Maternal Mortality

- The leading cause of death for women in the first year of pregnancy is suicide and overdose combined.[8]
- Over the past decade, suicide attempts during and after pregnancy have nearly tripled in the US.[9]
- From 2016-2020, maternal mortality in the US was 19.3 deaths per 100,000 live births. **In Montana, this number reached 22.6 deaths related to or aggravated by pregnancy per 100,000 live births.**[10]
- In 2020, the US experienced an increased rate of 23.8 maternal deaths per 100,000 live births, being one of the worst in the developed world.[11] In 2021, this number further increased to 32.9 deaths per 100,000 live births.[12]
- Deaths due to drug use, suicide, and homicide accounted for over 1 in 5 pregnancy-associated deaths in the US from 2010 through 2019.[13]

Substance Use Disorders (SUD) and Child Removals

- Women are at their highest risk of developing a substance use disorder between the reproductive ages 18 to 29 years old.[2,14]
- Women with PMADs may experience co-occurring substance use disorders. **In Montana, 1 in 8 births insured by Medicaid have perinatal drug exposure.**[4]
- Substance Use Disorders (SUDs) affected 7% of mothers who gave birth in hospitals in the US from 2007-2016.[15]
- In 2020, approximately 1 baby was diagnosed with Neonatal Abstinence Syndrome (NAS) every 24 minutes in the US.[16]
- Fetal Alcohol Spectrum Disorders (FASD) are estimated to affect as many as 11-50 per 1,000 children in the US, with an estimated total lifetime cost of $2 million per affected individual.[2,17]
- Approximately 2% of women of childbearing age (15-44) were pregnant at treatment admission in the US in 2020.[18]
- In 2020, parental alcohol or drug misuse was identified as the condition in 39% of child removal cases in the US, increasing to 51.4% of cases in children under 1 year.[18]
- **In Montana, parental alcohol or drug misuse was identified as the condition for removal in children under 1 year in 51-60% of cases in 2020.**[18]
- In 2021, 203,770 children under 18 entered foster care in the US, a rate of 3 per 1,000, with 21% of those children being less than 1 year old. **In Montana, 18% were under 1 year old when placed in foster care.**[19]

Workforce

- **According to the Postpartum Support International provider directory, there are currently 55 providers in Montana with various specialties in perinatal mental health, 37 of whom are accepting new clients.**[22]
- Data show that in 2021, 12 percent of all births were attended by a midwife, and the number of births attended by midwives have increased. **In Montana, 14.8% of births were attended by a midwife.**[23]
- **There are currently 60 Certified Nurse Midwives and 37 Licensed Direct-Entry Midwives in Montana.**[24]
- **In 2021, Montana's Maternal, Infant, and Early Childhood Home Visiting Program provided 12,127 home visits to 2,186 participants.**[25]
- **From 2022-2023 the MOMS Program sponsored three Indigenous Doula Trainings in Montana with a total of 47 participants.**

Screening and Treatment

- Nationally, about 1 in 5 women (20%) are not asked about depression during a prenatal visit.[20]
- 75% of women who experience maternal mental health symptoms go untreated across the US.[21]
- Over 50% of pregnant women in the US with depression are not treated.20

Economic Costs

- An estimated total societal cost of untreated PMADs in the US is $14.2 billion for all births in 2017, with 60% pertaining to maternal outcomes and 40% pertaining to child outcomes.[26] The cost of not treating these conditions results in approximately $32,000 per mother-infant pair.[27]
- **In Montana, untreated perinatal or postpartum mood and anxiety disorders (PMADs) cost the state approximately $42.6 million annually.**[4]

Disparities and Inequities from across the United States

- Women who are disabled get pregnant and give birth at the same rate as women identifying as nondisabled, and those with physical disabilities are at significantly increased risk for postpartum depression.[28]
- In 2022, people who gave birth within the last 5 years who identified as lesbian, gay, bisexual, transgender, queer, asexual, and other (LGBTQ+) (31%), reported having a worse birthing experience (fair, poor, or very poor) than their cisgender, heterosexual counterparts (18%) in the US.[29]
- 51% of LGBTQ+ birthing people in the US reported that the quality of their experience with pregnancy, birth, and postpartum care was impacted by bias or discrimination, compared to 35% of cisgender, heterosexual people in 2022.[29]
- Additionally, *half* of LGBTQ+ birthing people (51%) reported numerous complications, including mental health, following childbirth in the US in 2022.[29]
- Groups considered to be at higher-risk for maternal mental health conditions include Black, Indigenous, and People of Color (BIPOC), those impacted by poverty, military service members, and military spouses.[7,30,31]
- BIPOC women are also least likely to have access to mental health care during pregnancy and in the postpartum period.[7]
- In 2021, the maternal mortality rate for Black women was 2.6 times the rate for White women.[12]
- Black women are twice as likely as white women to experience maternal mental health conditions but half as likely to receive mental health treatment and counseling as white women.[32,7]
- American Indian/Alaska Native (AI/AN) women are two times more likely to die of pregnancy-related causes than white women.[33]
- Up to 30% of AI/AN suffer from maternal depression.[34]
- **93% of AI/AN pregnancy-related deaths are preventable.**[34]
- Pregnant and postpartum AI/AN people are at the highest risk of drug-related and suicide death than any other racial or ethnic group.[13]

A Strategic Framework for the Perinatal Mental Health System of Care in Montana

This Framework is a culmination of more than 100 conversations had with people across Montana who are invested in perinatal mental health (PMH) in Montana. The interviews included a wide range of perspectives, from health and public health professionals to people with lived experiences of PMH. The culmination of those conversations resulted in the report called *A Qualitative Understanding of the Perinatal Mental Health Landscape in Montana* and can be found at the **Healthy Mothers, Healthy Babies – The Montana Coalition, Inc.** website or available upon request at hmhb@hmhb-mt.org.

While conducting the conversations, people were asked if they would be interested in participating in developing a strategic Framework in the summer and fall of 2023. After the report was published, these 13 people came together twice in a virtual setting to provide direction and feedback on the Framework. In addition to the qualitative information gathered in *A Qualitative Understanding of the Perinatal Mental Health Landscape in Montana,* data from additional secondary sources was also consulted to inform the priority areas of this Framework.

Vision

To create a Montana where all birthing people and families have access to the support they need throughout the perinatal period to prevent and address perinatal mental health conditions and allow families to thrive.

Mission

To improve perinatal mental health outcomes in Montana by advocating for and implementing policies that support perinatal mental health, reducing stigma and discrimination, and increasing access to quality care.

Values

- Equity: We believe that everyone deserves access to quality perinatal mental health care, regardless of their race, ethnicity, socioeconomic status, or location.
- Collaboration: We believe that we can achieve our goals more effectively by working together with other organizations and individuals.
- Evidence-based: We believe that our work should be informed by the best available evidence.
- Innovation: We are committed to finding new and innovative ways to improve perinatal mental health outcomes.
- Systems of support: We believe that perinatal mental health is best supported by a strong network of systems and we are committed to working with these systems.

Priority Areas and Strategies

Public Awareness

Increase awareness of the following aspects of PMH: risk factors, symptoms, prevalence, community impacts, accurate portrayals of the ability to parent, limiting adverse childhood events (ACEs), and available resources for support.

- Develop and implement public education campaigns to raise awareness of PMH issues.
- Partner with community organizations to reduce stigma around PMH among staff and programming.
- Create messaging that is targeted not only to birthing people, but also materials that are specific to partners, grandparents, workplaces, etc.

Peer-Focused Programming

Implement and sustain evidence-informed programming that provides group or individual support to people in the perinatal period and builds community for new families.

- Increase the use of peer support recovery SUD doulas as part of prenatal and postpartum care.
- Increase those trained in Montana Group Peer Support (GPS) around Mental Health and SUD.
- Advocate for access to and use of doulas, childbirth educators, and lactation professionals.
- Create sustainable sources of revenue for peer and supportive programming such as doulas, peer support, and peer group programming.
- Support and refer families to peer lead programming (ex. Group Peer Support, Baby Bistros, parenting groups, etc.)
- Update and maintain LIFTS Online Resource Guide with up-to-date peer programming options at the community level.

Engage Medical Professionals & Program Staff

It is imperative that people working with the perinatal population are provided a comprehensive education that covers all aspects of PMH including: screening and assessment to intervention and treatment, awareness of the importance of early identification and intervention for mental health and substance use challenges, stigma reduction and trust-building, and accurate and timely referrals in PMH care. Medical professionals should understand mental health conditions, their symptoms, treatments, and referral options to the same extent that physical health conditions such as obstetric hemorrhage or hypertension, are understood.

- Scale up the implementation of universal SBIRT (Screening, Brief Intervention, and Referral to Treatment) in obstetric offices to identify and address prenatal and postpartum mental health and substance use challenges.
- Provide training to more providers on perinatal mental health SBIRT in a way that is stigma-reducing and trust-building.
- Promote universal SBIRT among parents in pediatric and family practice care settings.
- Implement a comprehensive PMH education program for all medical healthcare providers, including prenatal and postpartum care staff, as well as all labor and delivery employees.
- Create a formal training program for therapists who want to specialize in PMH.
- Establish and maintain a statewide listing of PMH providers to improve referral to these experts.

Care Coordination

A myriad of support types is necessary to support people with PMH conditions and SUDs. Creating this support network requires timely connection of birthing people to the resources they need, as they need them, and investment in care coordinators, peer supporters, and others who intimately understand the resources available and are skilled at building relationships with patients, providers, and program staff.

- Establish centralized care coordination centers to serve as a single point of contact for birthing people and their families in every community, and to ensure that people are connected to the right resources in a timely manner. This might be accomplished through support of Certified Community Behavioral Health Clinics (CCBHC) or other organizations focused on perinatal health.
- Enhance the referral system between organizations by creating clear and concise bi-directional referral pathways and by ensuring that all providers, including primary care, obstetric, pediatric, and mental healthcare providers are aware of the resources that are available.
- Build systems that make communication and collaboration between providers easier by using electronic health records (EHRs) and other technologies that allow providers to share information quickly and easily.

Culturally Informed Programming

Culturally informed programming is essential to providing quality PMH care. This means ensuring that programs are designed and delivered in a way that is sensitive to the needs and experiences of the people they serve.

- Provide ongoing cultural safety training[35] to providers and programming staff covering the importance of being respectful and responsive to the cultural needs of others.
- Increase diversity among providers and programming staff so that people have access to care providers who understand their culture and experience.
- Update policies so that policies are inclusive of and supportive to all cultures. (ex. Allow smudging or larger numbers of family members in waiting rooms)

Social Determinants of Perinatal Mental Health

Address social determinants of health that impact PMH. This includes policies that support affordable housing, accessible transportation, food security, and affordable childcare.

- Work with Medicaid, private insurance and others to advocate for policies that support PMH access and fair reimbursement for people working in this field.
- Work with statewide housing groups such as the Montana Housing Coalition to advocate for policies that make housing more affordable and accessible for pregnant people and families.
- Work with statewide transportation groups such as the Montana Transit Association and the Montana Department of Transportation's TranPlanMT to advocate for policies that make transportation more affordable and accessible for pregnant people and families.
- Work with statewide food security groups such as Montana's Food Security Council, Montana's No Kid Hungry, Montana Breastfeeding Coalition, WIC, SNAP, and others to advocate for policies that make healthy food more affordable and accessible for pregnant people and families.
- Work with statewide childcare groups such as Raise Montana, Montana Association for the Education of Young Children (MTAEYC), The Montana Family Childcare Network, Zero to Five Coalitions, and others to advocate for policies that make childcare more affordable and accessible for pregnant people and families.

Potential Metrics

- Increase in the number of people who are aware of PMH issues.
- Decrease in the stigma associated with PMH.
- Increase in the number of people who are screened for PMH conditions.
- Increase in the number of people who are referred to treatment for PMH conditions.
- Increase in the number of people who have access to quality PMH care.
- Decrease in the number of people who experience negative social determinants of health that impact PMH.

Potential Collaborators

The potential collaborators listed here are not exhaustive and new partners will be welcomed to any table that is created.

- Doula Services and Training Programs
- Healthy Mothers, Healthy Babies - The Montana Coalition
- Health Systems and Independent Clinics providing Perinatal Care
- Labor & Delivery Hospitals in Montana
- Local Health Departments
- Local Head Start Programs
- Local HRDCs (Human Resource Development Council)
- Local Perinatal Health Coalitions
- Local School Districts
- Montana Chapter of the American Academy of Pediatrics
- Montana Chapter of Postpartum Support International
- Montana Healthcare Foundation, Meadowlark Initiative
- Montana Midwifery Association
- Mother's Milk Bank of Montana
- Montana Public Health Institute
- Montana State University, Mark and Robyn Jones College of Nursing, Midwifery Program
- MT DPHHS, Child and Family Services Division
- MT DPHHS, Healthy Montana Families - Home Visiting
- MT DPHHS, Family and Community Health Bureau
- MT DPHHS, Montana Medicaid
- MT DPHHS, Special Supplemental Food Program for Women, Infants and Children (WIC)
- Roots Family Collaborative
- University of Montana, Center For Children, Families And Workforce Development
- University of Montana, Rural Institute for Inclusive Communities

This Framework provides a roadmap for continuing to improve PMH outcomes in the next several years. The specific strategies and metrics will need to be tailored to the various organizations and partners who collaborate to improve PMH in Montana.

Acronyms and Definitions

Birth-related Post-Traumatic Stress Disorder (PTSD): PTSD resulting from a traumatic childbirth experience

Certified Nurse Midwife (CNM): A registered nurse with additional training in midwifery, providing care to women during pregnancy, childbirth, and postpartum

Doula: A trained professional who provides emotional, physical, and informational support to a mother before, during, and after childbirth

Fetal Alcohol Spectrum Disorders (FASD): A range of conditions caused by prenatal exposure to alcohol, leading to physical, behavioral, and cognitive abnormalities

Home Visiting Program: A support service where professionals visit families at home to provide assistance, guidance, and resources, often focusing on maternal and child health

Licensed Direct-Entry Midwives: Midwives who are trained through non-nursing routes and are licensed to provide care to women during pregnancy, childbirth, and postpartum

Maternal Anxiety: Excessive worry, fear, or unease experienced by a mother, often related to pregnancy, childbirth, or the postpartum period

Maternal Depression: Depressive symptoms experienced by a mother during pregnancy or the postpartum period

Maternal Mental Health (MMH): The overall psychological well-being of a mother, encompassing emotional and mental aspects related to pregnancy, childbirth, and postpartum

Maternal Mortality: The death of a woman during pregnancy, childbirth, or within a specified period after the end of pregnancy

Neonatal Abstinence Syndrome (NAS): Withdrawal symptoms experienced by a newborn exposed to addictive substances, usually opioids, during pregnancy

Neonatal Intensive Care Unit (NICU): Specialized medical care unit for premature or ill newborns

Perinatal: Pertaining to the period before and after birth, typically covering the stages of pregnancy and the postpartum period

Perinatal Mental Health (PMH): Mental health issues during the perinatal period, including depression, anxiety, and other mood disorders

Perinatal or Postpartum Mood and Anxiety Disorders (PMADs): A group of mental health conditions that can affect women during pregnancy or in the postpartum period, including depression and anxiety

Postpartum: Relating to the period following childbirth

Substance Use Disorder (SUD): A condition characterized by the harmful or hazardous use of substances, including alcohol or drugs, leading to addiction or dependence

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