Maternal-Child (and Family) Mental Health MATTERS

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NC IOM Perinatal Task Force
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Maternal Fetal Triage Index (MFTI)

Is the woman presenting for a scheduled procedure and has no complaint?

- NO
  - Does the woman or fetus have STAT/PRIORITY 1 vital signs?
    - OR
    - Does the woman or fetus require immediate lifesaving intervention?
      - OR
      - Is birth imminent?

- YES
  - STAT/PRIORITY 1

Abnormal Vital Signs
Maternal HR <40 or >180, apnea, SpO₂ <98%, SBP ≤80 or DBP ≤10, systolic, no FHRR detected by doppler
(unless previously diagnosed fetal demise), FHR <110 bpm for >60 seconds

Immediate lifesaving intervention required, such as:

Maternal
- Cardiac compromise
- Severe respiratory distress
- Seizuring
- Hemorrhaging

Fetal
- Prolapsed cord
- Birth imminent
  - Fetal parts visible on the perineum
  - Active maternal bearing-down efforts

Abnormal Vital Signs
Maternal HR >120 or <50,
Temperature ≥101°F, 38.3°C, RR >26 or <12, SpO₂ <95%, SBP >140 or DBP >90 symptomatic or <80/40, repeated FHR >160 bpm for >60 seconds; decelerations

Severe Pain: (unrelated to cdx) ≥7 on a 0-10 pain scale
Examples of High-Risk Situations
- Unstable, high risk medical conditions
- Difficulty breathing
- Altered mental status
- Suicidal or homicidal
- <34 wks c/o of, or detectable, uterine cdx
- 34 wks with regular contractions or SROM/leaking with any of the following
  - HIV+
  - Planned, medically-indicated cesarean (maternal or fetal indications)
  - Breach or other malpresentation

Transfer of Care Needed
- Clinical needs of woman and/or newborn indicate transfer of care, per hospital policy

Abnormal Vital Signs
Temperature >100.4°F, 38.9°C, SBP ≥140 or DBP ≥90, asymptomatic

Prompt Attention, such as:
- Signs of active labor ≥34 weeks
- C/o early labor signs and/or c/o SROM/leaking 34-36 6/7 weeks
- ≥34 weeks with regular contractions and HSV lesion
- ≥34 weeks with regular contractions and HSV lesion
WACHENHEIM
Cindy
Beloved Wife, Mother, Sister, Daughter and Aunt
May 18, 1968 - Mar. 13, 2013
אידה בת קרמי אוסער
oo ניידת אמה, אחות, בת, בת אשת
נובמבר 18, 1968 - מרץ 13, 2013
Objectives

• Overview of Perinatal Mood and Anxiety Disorders (PMAD)
  » Prevalence
  » What is known in NC

• NC Maternal Mental Health MATTERS
  » Screening
  » Assessment
  » Treatment

• Future Directions
• Recommendations
Overview of Perinatal Mood and Anxiety Disorders
Antenatal and Postpartum Depression

PREVALENCE

- Pregnancy is not protective against depression and anxiety
- Between 10-20% of women will experience AND and PPD

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- Suicide is one of the largest contributors to maternal mortality

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• Delayed cognitive and socioemotional development

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- Preeclampsia, Preterm Birth
- Delayed cognitive and socioemotional development
- ADHD, Depression, and Psychosis in Offspring

Perinatal Mood and Anxiety Disorders and Families

- Partners are affected by PPD by supporting and coping with their partner’s symptoms but also by experiencing depression (Paulson and Bazemore, 2010)
  - 24% to 50% of partners experience depression along with their partner (Goodman 2004), 1/10 fathers experience depression in the first year (Kessler et al 2003)
  - Non-gestational carrier parents are balancing all the changes of having a baby too!
Perinatal Mood and Anxiety Disorders

- **Depression**
  - No more episodes
- **Anxiety**
  - e.g. GAD, OCD, Panic
  - Only during times of hormonal change
- **Mania**
  - Waxing and Waning Anxiety Disorder
- **Psychosis**
  - Incl. disorganization, catatonia, paranoia
  - Recurrent Major Depression w/o and w/ psychotic features

**Bipolar Disorder**
Perinatal Mood and Anxiety Disorders

**Depression**

- No more episodes

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- Only during times of hormonal change
- e.g. GAD, OCD, Panic

**Mania**

- Waxing and Waning Anxiety Disorder
- Recurrent Major Depression w/o and w/ psychotic features

**Psychosis**

- Incl. disorganization, catatonia, paranoia

**Substance Abuse**

**Eating Disordered Behavior**

**Attachment Problems**

**Attention and Cognition**

**Non Affective Psychosis**

**Trauma**

**Bipolar Disorder**
NC Maternal Mental Health MATTERS
(Making Access to Treatment, Evaluation, Resources & Screening Better)

Aims

• Enhance systems for screening, assessment and treatment of behavioral health disorders in pregnant and postpartum women

• Support local providers through training and in the integration of maternal mental health into primary care practice
The MATTERS Team

Program:
Dr. Mary Kimmel, Hannah Rackers, Dr. Gary Maslow, Kendra Rosa, Dr. Naomi Davis

Perinatal Mental Health Specialists:
Liz Cox, Edith Gettes, Samantha Meltzer-Brody, Susan Michos, Chris Raines, Erin Richardson, Marla Wald

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NC DHHS Partners:
Belinda Pettiford
Becky Moore-Patterson
Tara Owens Shuler

OB Champion:
Dr. Alison Stuebe

Substance Use Expert:
Dr. Hendree Jones
Program Components: Tiers of Patient and Provider Support

- Primary Care Provider Education and Training
- Consultation Line (NC-PAL)
- Telepsychiatry Assessments
- Telepsychiatry Clinic

Program Components:
- Screening
- Assessment
- Treatment
**Program Conceptual Model**

**Societal Factors:**
- Separation of behavioral health from physical health
- Stigma

**Individual Factors:**
- Provider knowledge, comfortability, & specialty

**Environmental Factors:**
- Practice structure & staffing
- Screening
- Reimbursement
- Local referral resources

**Program Factors**
- Education and recommendations on screening tools
- Education and training on assessment and treatment
- Psychiatric case consultation support
- Increased connection to local resources
- Improved referral pathways for specialty care

**Increased provider self-efficacy**

**Increased screening rates**

**Increased rate of those who screen positive being treated or referred for treatment**
Provider Education and Training

SCREENING

• Screening toolkit designed for medical home
• Provided in partnership with Postpartum Support International (PSI) on components of care for perinatal mental health
• Provider specific support via consultation line
• Practice specific support during enrollment visit and ongoing through lunch and learns
• Webinar series and case discussions
Consultation Line

ASSESSMENT & TREATMENT

- For primary care providers to treating mental health concerns
- Staffed by UNC and Duke perinatal mental health specialists
- Case specific consultation and support
- Care coordination services to ensure connections to appropriate local resources
Mental Health Assessments

ASSESSMENT & TREATMENT

• For higher-need patients who may be treated locally but need further evaluation

• Psychiatric assessments completed by a Perinatal Mental Health Specialist (PMHS) in-person or via Telehealth

• Care coordination services to ensure connections to appropriate local resources
TREATMENT

- For patients that need specialized care and do not have local resources
- Treatment in UNC’s Women’s Mood Disorder Clinic in-person or via Telehealth by PMHS
- Care coordination services to ensure connections to other needed services
Perinatal Psychiatry Inpatient Unit

5 bed inpatient psychiatric unit for pregnant and postpartum women

MISSION: To provide specialized multidisciplinary care to assist in the recovery of perinatal (pregnant and postpartum) women from psychiatric illness requiring inpatient care

VISION: A world that understands and provides for the unique mental health needs of women and their families during the critical perinatal period

PPIU Admissions Coordinator
Laurie Gardner    984-975-3834
5-Year Target Counties
5-Year Target Counties

Challenges
- 35 of our 100 counties are classified as Mental Health Professional Shortage Areas
- Diverse demographics and geography mean that needs, resources, and access vary greatly across the state
<table>
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<tr>
<th>2019</th>
<th>Fall</th>
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<td>Summer</td>
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<td>◆ PSI Training Kick-Off</td>
<td>◆ Enroll practices and identify their current practices and telepsychiatry capabilities: • Warren • Granville • Vance • Halifax • Person • Franklin</td>
<td>◆ Refine policies and procedures from lessons learned</td>
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<td>◆ Launch Screening Tool Kit</td>
<td>◆ Enroll practices and identify their current practices and telepsychiatry capabilities: • Orange • Wake • Alamance</td>
<td>◆ Enroll practices and identify their current practices and telepsychiatry capabilities: • Edgecombe • Nash • Pitt</td>
<td>◆ Enroll practices and identify their current practices and telepsychiatry capabilities: • Robeson • Forsyth • Guilford</td>
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<td>◆ Launch Website</td>
<td>◆ Convene Stakeholder Group for Sustainability</td>
<td>◆ Case Discussions (Similar to ECHO model)</td>
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<td>◆ Consultation Phone Line and Telepsychiatry Clinic Launch (July)</td>
<td>◆ Reach out to NC ACOG, Midwives of NC, NC Pediatric Society, NC Academy of Family Physicians</td>
<td>◆ Seminars on Perinatal Mood and Anxiety Disorders, Interventions for PMAD</td>
<td>◆ Seminars on Substance Abuse, Mother-Baby Attachment, PTSD and trauma, Psychosis</td>
<td>◆ Seminars on ADHD/Eating Disorders/Personality Disorders</td>
<td>◆ Seminars on Resources</td>
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| ◆ Develop monitoring and evaluation plan | ◆ Set baseline for evaluation indicators | }
Future Directions
Other Evidence-Based Practices

• Data systems for population level monitoring
• Collaborative care
• Peer support
• Expansion of home visiting

“Never underestimate the power of a woman, the love of a mother for her baby or the ability of a woman who has suffered to support other women.” Diane Flores
Recommendations?
Thank you!

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www.womensmooddisorders.org

UNC PPIU Inpatient Admissions:
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UNC Outpatient Clinic:
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New Patient Line:  984-974-3989