Perinatal Behavioral Health Initiative

Maternal, Child & Family Health Coalition
Background

- 2009-Mapping A Course – Maternal Mental Health 1 of 4 Top Priorities

- 2011-MHB and MCFHC Investment Management Partnership

- July 2012 to Present – Phase I

- July 2016 – Phase II Begins
MHB Mission

To improve the lives of the City’s most vulnerable children and adults by investing in the provision of quality services.
Vision

**MHB** is a strategic, visionary leader in the City of St. Louis. We will improve the quality of life for City residents by investing and participating in a coordinated system of behavioral health services aligned with community priorities and guided by the following principles of excellence:

- Highly effective;
- Comprehensive, accessible, and responsive;
- Consumer centered;
- Evidence based;
- Data informed;
- Outcome and results oriented.
2015 Adult Behavioral Health Needs Assessment

- Led by Enola Proctor, Ph.D.
- George Warren Brown School of Social Work
- Washington University in St. Louis
Key Questions

- What are the behavioral health needs of adults in St. Louis City?
- How adequate are current mental health services? What are the gaps in the system, and challenges for meeting the need?
- What recommendations can guide future MHB investment decisions?
Major Needs & Underserved Populations

- Depression
- Bipolar
- Heroin addiction
- Alcohol abuse
- City jail population

- Individuals with co-occurring disorders
- Youth moving into adult service system as they age out of child services
- Individuals with behavioral health disorders who are also homeless
Key Shortages/Barriers

- Psychiatry
- Social work and case managers
- Drug treatment
- Long-term housing for those with behavioral health needs
- Financial
- Access: getting to services

1% of those with depression received treatment
Quality of Care

- Long wait lists
- High staff turnover
- Uneven delivery of evidence-based treatment
- Inability to monitor quality, due to low use of standardized outcome measures
Needs Assessment Recommendations

1. **Invest in better data about needs, service availability, services delivered and outcomes**

2. **Invest in service improvements—support programs that:**
   a. Co-locate behavioral and physical care
   b. Address co-occurring needs
   c. Shorten wait times

3. **Invest in quality improvement**
   a. Support workforce training in EB interventions
   b. Tie grant funding to delivery of EB interventions
   c. Equip primary health care staff to address behavioral health needs
4. **Support quality of life improvements to ensure recovery**
   
   a. Support intervention in early-stage disorders
   b. Continue to support stable housing and transportation resources
   c. Support programs that address exposure to violence and toxic stress
Community Mental Health Fund:

*Investment Framework & Priorities*
Community Mental Health Fund

- State Statute R.S.Mo. 205.975
- St. Louis City residents age 18 and older
- Recipients must be nonprofit organizations
- Services proposed are designated by DMH
- Individuals receiving clinical/therapeutic services must have a diagnosis
Behavioral Health Continuum of Care

Most programs fall into one main area of this continuum, but others may span two or more. Each segment of the continuum necessitates different strategies for successful program design.

- **Prevention**
  - Universal
  - Selective
  - Indicated

- **Treatment**
  - Case/Symptom Identification
  - Early Treatment/Intervention
  - Standard Treatment

- **Continuing Care**
  - Engagement (Long Term)
  - Long Term Care/Aftercare

**Intensity and Duration of Services Provided Increases**

**Cost Increases and Number of Consumers Served Decreases**

3/24/2016
### FY17-19 CMHF Impact Areas

<table>
<thead>
<tr>
<th>IMPACT AREA 1</th>
<th>IMPACT AREA 2</th>
<th>IMPACT AREA 3</th>
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</thead>
<tbody>
<tr>
<td>PREVENTION/EARLY INTERVENTION</td>
<td>TREATMENT/INTERVENTION</td>
<td>CONTINUING CARE</td>
</tr>
<tr>
<td>Behavioral health conditions are prevented or identified and addressed through early intervention</td>
<td>Behavioral health conditions are improved through effective treatment/intervention</td>
<td>Behavioral/physical health, stability and productivity are supported through continuing care</td>
</tr>
</tbody>
</table>
Expectations of MHB-Funded Projects & Partnerships

- Consumer-centered
- Trauma-informed
- Strengths-based
- Utilize evidence-based practices/treatments or practice-based evidence
- Culturally and linguistically appropriate
FY17-19 CMHF Funding Priorities

1. Services for Transition-Age Youth and/or Young Adults
2. Integration and co-location of primary & behavioral health care
3. Services that address racial equity and reduce disparities
4. Services that respond to emerging behavioral health issues
CMHF Standard Outcomes
(Attainment Must Be Documented)

1. Maintain/improve daily functioning
2. Reduce/effectively manage symptoms
3. Develop/strengthen skills that support independent living
4. Secure/maintain safe, stable housing
5. Secure/maintain gainful employment and/or pursue other educational attainment
6. Maintain/improve management of co-occurring condition(s)
7. Maintain/improve management of co-morbid condition(s)
8. Avoid/reduce substance use and other risky behaviors
9. Resolve legal issues and/or requirements
10. Comply with and accept community norms
11. Advocate and access appropriate community resources
12. Adhere to recommended health regimen
13. Develop/maintain positive relationships with family, peers and others

3/24/2016
THANK YOU!

Jama Dodson, Executive Director
March 24, 2016
Phase I MHB Partnership

GOALS

▪ Implement or Expand Screening of Perinatal Women for Behavioral Health Concerns
▪ Provide Brief Intervention Treatment (Counseling, Psychiatry)
▪ Provide Referral To Case Management for Other Support Services
▪ Increase providers proficient with Motivational Interviewing

Four Projects Funded:
▪ Kingdom House - Apoyo y Carino (originally Casa de Salud)
▪ Family Care Health Centers-Supporting Her in Pregnancy
▪ Saint Louis University, Cardinal Glennon Children’s Medical Center, Danis Pediatric Clinic- Healthy Mothers, Happy Babies
▪ Washington University-Perinatal Behavioral Health Service

Motivational Interviewing - St. Louis Center for Family Development
  ◦ 4th Cohort in Progress
  ◦ 56 Providers From 20 organizations Trained and Coached
Phase 1
Understanding and Developing The System

- Patient Protection and Affordable Care Act of 2010
- 2013 Environmental Scan & Focus Groups
- 2014 MCFHC established Perinatal Resource Network committee
  - Professional Development Series
- New framework – Perinatal Mood and Anxiety Disorder (PMAD)
Phase I Lessons

- Screening Results: Need for Greater Attention to Addressing Unmet Behavioral Health Concerns in Perinatal Women

- Screening is Not Universal or Following Professional Guidelines

- Services Don’t Match what Women Want

- Training Individual Providers Changes Their Practices VS. Organizations Adapting Their Approaches to Support Provider Use of Evidence Based Practices

- Lack of Providers Trained in Perinatal Mood & Anxiety Disorders
Phase I
Recommendations

- Broaden To PMAD With Co-Occurring Concerns

- Increase % of Providers Screening For Behavioral Health Concerns

- Increased Screening = Increased Pressure on System Capacity (Increased Demand For Case Management & Basic Needs)

- Comprehensive Data System to Evaluate And Support Coordination
Maternal and Child Family Health Coalition Needs Assessment

Jeff Noel, PhD, Research Assistant Professor
Edward Riedel, MSW, LCSW, Project Director
Megan Finneghan, MSW, Research Specialist
Jessica Oakley, BSW Intern
March 24, 2016
Introduction and Methods

- November 2015 contract for Needs Assessment
- Secondary Data
  - Literature Review
  - Identification of Screening Tools
- Primary Data
  - Web-based Survey of Providers
## Literature Review

<table>
<thead>
<tr>
<th>Category</th>
<th>St. Louis City</th>
<th>St. Louis County</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Birthweight</td>
<td>12.0%</td>
<td>8.8%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Teen Birthrate</td>
<td>64/1000</td>
<td>26/1000</td>
<td>40/1000</td>
</tr>
<tr>
<td>Uninsured</td>
<td>19%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>High School/GED</td>
<td>62%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>9.1%</td>
<td>6.5%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Severe Housing Problems</td>
<td>23%</td>
<td>14%</td>
<td>14%</td>
</tr>
<tr>
<td>Single Parent Household</td>
<td>62%</td>
<td>35%</td>
<td>34%</td>
</tr>
<tr>
<td>Children in Poverty</td>
<td>43%</td>
<td>16%</td>
<td></td>
</tr>
</tbody>
</table>
Additionally in Missouri

- 18.9% of mothers did not receive prenatal care
- 13.2% had symptoms of postpartum depression
Intimate Partner Violence

- 1.5 million women annually, 324,000 while pregnant (2.5%-7%)
- Physical or sexual violence is more common than pre-eclampsia or gestational diabetes
Missouri IPV (Age, Race, Medicaid Status)

- Overall: 0.0%
- 20-29: 2.5%
- Black/African American: 5.0%
- Other Race: 7.5%
- non-Medicaid: 10.0%

3/24/2016
14% reported Post Partum depression symptoms
Also more common in younger women
2010 Study, City of STL and Southeastern MO with MA eligible and enrolled in WIC 30.9% met criteria for a 12-month psychiatric disorder
- Only ¼ were receiving any type of mental health care
Substance Use

- NSDUH 8.5% of pregnant women age 15-44 drank alcohol in the past month
  - 17.9% in the first trimester
  - 4.2% during the second trimester
  - 3.7% during the third trimester

- Marijuana is the most frequently used drug among women of childbearing age, including during pregnancy and post partum
Mental Health and Substance Use

- Frequently co-occur

- 36%-40% of pregnant women with substance use also meet criteria for major depression
Barriers to Screening and Referral

- Lack of staff
- Time
- Caseload size
- Lack of training in IPV, Depression, Substance Use screening practices
- Fear of screening positive
- Knowledge of resources and referrals
- Lack of knowledge about state requirements
- Lack of confidence about their expertise
- Fear of being intrusive or losing trust
- Fear of backlash by a perpetrator
In collaboration with the MCFHC, MIMH conducted a provider survey asking about:
- Organizational characteristics
- Populations served
- Screening practices
- Collaboration with other providers

59 Individuals from 36 Agencies responded to the survey
Web Survey Results

- Organizations provided a variety of services to pregnant and postpartum women (top 5)
  - Case management
  - Resource referral
  - Community education
  - Mental health counseling/medications
  - Social work services

- Ranged in staff size from 0.5 to 500 (avg. 36.4, median 250)

- Served 0-10000 perinatal women (avg. 691, median 100.5)
Challenges

- Percentage of clients with substance use
- Percentage of clients with mental health symptoms/concerns
- Percentage of clients who have problems with both substance use and mental health symptoms/concerns
- Percentage of clients with domestic violence
- Percentage of client with chronic medical conditions
Substance Use

- Marijuana: 0.0%
- Smoking: 10.0%
- Alcohol: 20.0%
- Heroin/Opioids: 30.0%
- Prescription Medication: 3/24/2016
- Benzodiazepines: 40.0%
- Cocaine: 40.0%
Medical Conditions

- Obesity: 40.0%
- Hypertension: 30.0%
- Diabetes: 20.0%
- Asthma: 10.0%
- Prenatal Care/General Health: 0.0%
- Poor Nutrition: -61.0%

3/24/2016
Positive Screens Generate

- Other children in the household are screened
- Spouse/Domestic partner are screened
- Other family members in the household such as grandparents, aunt, uncle, cousin are screened
- Additional Screening Does not Occur

Bar chart showing percentages for Mental Health, Substance Use, Domestic Violence, and Other Traumatic or Stressful Life Experiences.
Barriers to Screening

- HIPAA confidentiality Requirements
- Resource Competition Among Departments
- Different Treatment Philosophy Among Staff
- Managed Care Restrictions
- Organizational Instability (e.g. staff turnover, funding challenges)
- Cultural Competence among staff
- Clients ability to pay out of pocket
- Inadequate insurance reimbursement
- Caseload problems at your organization
- Long waiting lists
- Insufficient staff
- Client Stigma
- Client Transportation
- Other (Please Specify)
- Other (Please Specify)
Where Referrals Go

<table>
<thead>
<tr>
<th>Service</th>
<th>Within my organization</th>
<th>Outside of my organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>60.25</td>
<td>17.50</td>
</tr>
<tr>
<td>Substance use</td>
<td>50.00</td>
<td>25.00</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>45.00</td>
<td>35.00</td>
</tr>
<tr>
<td>Other support Services</td>
<td>52.50</td>
<td>70.00</td>
</tr>
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UMSL MIMH
Missouri Institute of Mental Health

3/24/2016
Referral Follow Up Rates

33% of organizations had a written referral policy.
Barriers to External Referrals

- Resource competition between your organization and the receiving organization
- HIPAA confidentiality requirements
- Organizational instability
- Hours of operation inconsistent
- Mistrust of the agency
- Cultural competence of the receiving agency
- Different clientele between programs
- Different treatment philosophies
- Managed care restrictions
- Insufficient staff at the receiving agency
- Client stigma
- Caseload problems at the receiving agency
- Geographical distance
- Inadequate insurance reimbursement
- Long waiting lists
- Clients' ability to pay out of pocket
- Client transportation barriers
Collaboration

- 16 organizations responded to this question
- 82 partners identified
- Average of 8.3 collaborative partners, rated most collaborations as “Useful” to “Very Useful”
- Average level of collaboration on a 5 point scale was 2.28 meaning they were:
  - Sharing of information and some resources
  - Frequent communication
  - Some shared decision making
Summary

- Mental Health, substance use, intimate partner violence are common and co-occur
- STL City women have a disproportionate amount of compounding factors
- Screening for MH, SU, IPV is inconsistent
  - Summary of screening tools in the report
- Barriers to screening and referral exist
- Knowledge of referral sources is limited
- Collaborative relationships exist, but stronger connections could benefit clients
Thank You

Jeff Noel, PhD, Research Assistant Professor
Edward Riedel, MSW, LCSW, Project Director
Megan Finnegan, MSW, Research Specialist
Jessica Oakley, BSW Intern
All Women Should Be Screened For Depression During Pregnancy And After Giving Birth

Maternal Mental Health Can Affect Children:
- Leading to Behavioral Problems
- Emotional Instability
- Difficulty In School

Increased Screening & Detection Is A Public Health Need
PHASE II
New Approach for Perinatal Behavioral Health Initiative

Goal: Improve the System of Service Delivery to Perinatal Women Experiencing Behavioral Health Concerns

2-Prong Approach:

➢ Fund/Partner a Network of Providers (8-15) to Align Mutually Reinforcing Services (Screening, Case Management For Treatment and Referral) for Perinatal Women And Their Children;

➢ Build The Capacity of Providers And Organizations to Better Serve Perinatal Women And Their Children;
Partner Organizations will serve women at highest risk for behavioral health concerns and includes the following:

- Live in high infant mortality zip codes in St. Louis City
- Have a previous birth that resulted in infant death, low birth weight, prematurity
- Screens of concern for perinatal mood and anxiety disorder
Partner Organizations

- Primary Care
- Behavioral Health
- Social Service
Partner Organizations Will...

- Form a referral network that coordinates care across the network for their patient/client/consumer
- Work within a collaborative and reciprocal framework
- Learn together to identify and solve challenges, celebrate success and
- Create a sustainable network through increasing partnerships to integrate primary and behavioral health and social supports to improve service delivery for perinatal women and families
What Will Be Funded...

Tailored to each organization:

- Identified Gaps
- Enhance Service Delivery
Integrated Model of Support for Perinatal Women with Behavioral Health Concerns

- Ideal Team Model:
  - Starts Prenatally
  - Includes Follow Up And Continuity of Care
  - Includes Professional And Social Support
  - Providers and Supporters Respect Confidentiality of The Family
  - Family Feels That Team is Working Together And is Not in Conflict
  - Accessible/Flexible to Meet Unique Needs
Collaboration Between And Among Partner Organizations

In Screening, Referral, Service Delivery,

And Follow Up

Leads To A More Coordinated System

In Identifying and Supporting Perinatal Women and

Children With Behavioral Health Concerns
Next Steps

➢ Application Release – March 24, 2016  2:00 P.M.

➢ Electronic Application Form – April 1, 2016
  ○ MCFHC Website

➢ Technical Assistance – Mandatory
  ○ April 11 – April 29, 2016
SUBMISSION

COMPLETED APPLICATIONS MUST BE SUBMITTED:

• Electronically to: jmichael@stl-mcfhc.org
• Thursday, May 5, 2016 5:00 P.M.

Applications Received After This Deadline Will NOT Be Accepted

NO EXCEPTIONS WILL BE MADE
What To Expect

- May 9 – May 20, 2016: MCFHC review submitted applications

- May 23 – June 3, 2016: Partner Organization negotiations

- June 10, 2016: Partner Organizations notified and contracts mailed

- June 17, 2016: Partner Organization contracts signed and received at MCFHC

- June 23, 2016: Partner Organizations Pre-Implementation meeting: Mandatory attendance by designated staff to include contracts, financial, data management, service delivery staff, etc.
For more information

Maternal, Child and Family Health Coalition