HRSA-SAMHSA NWHW Women's Mental Health Webinar
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Transcript

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>> STEPHEN HAYES: Hello and welcome to this webinar in the HRSA Women's Health Leadership Series. We're conducting this with the HRSA office of intergovernmental and external affairs, I.E.A. Region 9, and SAMHSA. Today we will feature presentations from 2020 Mom and the maternal mental health leadership alliance. This is also in observation of the 2020 National Women's Health Week. National Women's Health Week is an annual observation to encourage women and girls to reflect on their individual health needs and take steps to improve their overall health. My name is Stephen Hayes with the Office of Women's Health, joined by Ellen Hendrix and Nidhi Jain. We will be collecting questions from the chat after the speaker presentations are completed. It is now my pleasure to introduce Nancy Mautone-Smith. Nancy leads cross agency initiatives and consultations to advance the health, safety and wellbeing of women served by HRSA programs. She currently oversees activities and initiatives that support interventions of violence, care coordination for women with opioid use disorder and advancing cervical health within HRSA settings of care. Nancy was previously Deputy Director of OWH and prior to HRSA served as the HHS office of population affairs headquarters in Rockville, Maryland, where she's led service delivery program activities of the Title X Family Planning program. She also worked at the Region 9 office of the health administrator where she was our title X family planning programs throughout the region. A graduate of the University of Buffalo school for social work, she received an award for noteworthy contributions to the social work provision. She retired from the U.S. Public Health Service in 2020 after a career spanning 20 years. Nancy is also a proud Air Force veteran and served as a clinical social worker within treatment programs at Travis Air Force base and Vandenberg Air Force base in California. Nancy?

>> NANCY MAUTONE-SMITH: Thank you so much, Stephen, for that wonderful introduction. And welcome. Good afternoon and welcome to everyone on today's event for women's mental health. I am Nancy Mautone-Smith, Director of the Office of Women's Health. And this event

was developed in collaboration and made possible by HRSA's Office of Intergovernmental and External Affairs and our colleagues at SAMHSA. And it is part of our Office of Women's Health Leadership Series.

As Stephen mentioned, this event is being held in recognition of National Women's Health Week, which was observed last week from May 8th to the 14th, along with in observation of Mental Health Awareness Month, which runs throughout the month of May.

We all know that the COVID 19 pandemic has taken a disproportionate toll on women's mental health and wellbeing, and I'm really pleased for today's event, which will talk about our federal efforts, national policy, and stakeholder engagement around this extremely important topic of women's mental health. Next slide, please.

During today's event, you will hear from us, the Office of Women's Health, about National Women's Health Week and about HRSA's work in this area. You'll also hear from SAMHSA about their resources and their activities in women's mental health. And then we're going to move into a discussion on national policy and stakeholder engagement around mental health care from the HRSA supported settings of the 2020 Mom and the Maternal Mental Health Leadership Alliance.

We've also set aside a few minutes today for questions at the end, so please use the chat box to raise any questions throughout today's presentation. And the presentation and transcript will be made available on our website after the event today.

A little bit about HRSA, our agency, as you get to know us. Please help us as well get to know you by adding your name, your organization, and where you're joining us from, if you've not already done so, in the chat.

So, the Health Resources and Services Administration, or HRSA, is an operating division of the U.S. Department of Health and Human Services. And we support a broad range of programs to provide health care to people who are geographically isolated, economically or medically challenged. And every year, HRSA programs serve tens of millions of people, including people with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access quality health care. Next slide, please.

The Office of Women's Health at HRSA provides leadership on women's health and sex and gender specific issues, and we're part of a network of women's health offices across the department, and we work within and outside of the Department of Health and Human Services to improve the health, wellness, and safety of women across the life span. Next slide, please.

Again, this event is being held in recognition of several health observations, including National Women's Health Week, where we join with the HHS Office on Women's Health to encourage and remind women and girls to reflect on their individual health needs and take steps to improve their overall health and mental health awareness month, where we work to raise awareness about the importance of mental health in the lives of all Americans. Next slide, please.

Over the last several years, we've been faced with challenges that have highlighted many of the health disparities that existed previously, including those related to the opioid epidemic. And along with those challenges, we've seen enormous innovations in how health care and public health professionals are caring for those in need.

One innovation towards improving the health of women and their families is a toolkit for providers and organizations developed by my office and the HHS Office on Women's Health. And I encourage you to review and share this resource with your networks, and it's available at the link that you see on this slide, on the Office of Women's Health website. And next slide, please.

HRSA's behavioral health work is extensive, ranging from efforts around behavioral health integration into primary care, leveraging telehealth and workforce training, and placement through the National Health Service Corps. And some of the other key innovations and opportunities that you see here on this slide include the newly unveiled National Maternal Mental Health Hotline. And this HRSA supported initiative just launched earlier this month and is available 24 hours a day, seven days a week, 365 days a year, and it provides services in both English and Spanish, via voice, text, and web chat.

HRSA's Maternal and Child Health Bureau's partnership with the American College of Obstetricians and Gynecologists, or ACOG, includes the work being done around women's preventive health services, or WPHS, a set of health services recommendations, which among many other things includes anxiety among their topics. And these help define the range of services that are covered by health plans without cost sharing.

HRSA also hosted the integrated behavioral health resource library, which provides a hub for a range of resources to assist health care providers with integrating mental health services into their practices. Next slide, please.

It is now my great pleasure to introduce Emily Hassey. Emily Hassey currently works at the Substance Abuse and Mental Health Services Administration, SAMHSA, as a Public Health Advisor and Government Project Officer. She oversees the National Family Support Technical Assistance Center Grant, Grants for Expansion and Sustainability of the comprehensive community mental health services for children with serious emotional disturbances and the

mental health awareness training grants. She also assists with the Child Crisis portion of the 988 rollout across the country. And before working at SAMHSA, she gained experience working in direct care with children in the Texas foster care system who were abused and neglected, and also has worked with public health agencies and LGBTQ+ health equity work. Over to you, Emily. Thank you for joining us today.

>> EMILY HASSEY: Thank you so much for the introduction! Well, everyone, I am Emily Hassey. I'm from SAMHSA. I work in the Center of Mental Health Services, and specifically, I am in the Child, Adolescent, and Family branch. We can go to the next slide.

So, the learning objectives we're going to go over during my portion of this presentation: Understanding the National Family Support Technical Assistance Center; serious mental illness advisor, SMI Advisor, SAMHSA resources for women throughout the life span.

And I just want to give a little bit of background before this. At SAMHSA, we do not have any women specific grants. And today I'll share the role of women in a different in a couple different grants as well as resources SAMHSA provides. And you can go to the next slide.

The National Family Support Technical Assistance Center is committed to providing training and technical assistance using a lifespan approach that focuses on mental health and substance use/addiction challenges. Our approach is anchored by the underlying principles that families play a vital role in supporting their loved ones and are experts regarding their family support needs.

The technical assistance piece of this grant is mainly for the Statewide Family Network grant that enhances the capacity of statewide mental health, family controlled organizations to engage with family members and primary caregivers who are raising children, youth, and young adults with serious emotional disturbances SED. You can go to the next slide.

The National Family Support Technical Assistance Center serves families whose children of any age experience mental health and substance use challenges across the lifespan and the workforce. Organizations and communities that support them by providing resources, technical assistance, and training. This includes, but is not limited to, mental health and substance use information, training for families and the family support workforce, including family peer specialists, providers, clinicians, and educators; mental health and substance use lifespan resources; connections to family support services; technical assistance for organizations.

The National Family Support Technical Assistance Center is led by the National Federation of Families, a family run organization, with the Partnership to End Addiction, C4 Innovations, SAFE Project, and Boston University. The Center's approach is anchored by the underlying principle

that families play a vital role in supporting their children and are the experts regarding their family's support needs. You can go to the next slide.

The recipient of the National Family Support Technical Assistance Center grant is the National Federation of Families, in which their mission is to: The National Federation of Families, a national family run organization, serves as the national voice for families of children who experience emotional, behavioral, and mental health and/or substance use challenges across the lifespan. We advocate at the national level for the inclusion of family voice in all aspects of services and supports across clinical, educational, and community settings; promote effective partnerships among families, professionals, and policymakers at the local, state, and national level; advance the value of lived experience and the family peer workforce to support families; collaborate with family run and mission aligned organizations to transform family serving systems and health care in America.

And you can go to the next slide. The women's roles within the National Family Support Technical Assistance Center it's a women run organization. Majority of caregivers and guardians are women. Even when women struggle with their own mental or physical health, they are still the main caregiver. Women are the largest group of mental health providers. There is no specific role women have in this organization, but they do make up a large part of the individuals who run services and guardians of children. This TA Center looks to help connect and assist guardians, but the large percentage are women. You can go to the next slide.

Serious Mental Illness Advisor SMI Advisor. You can go to the next slide. To advance the use of person centered approach to care that ensures people who have SMI find the treatment and support they need. For clinicians, we offer access to education, data, and consultations so you can make evidence based treatment decisions. For individuals, families, friends, people who have questions, or people who care for someone with SMI, we offer access to resources and answers from a national network of experts. This is the mission for SMI Advisor. And we can go to the next slide.

So, in July of 2018, the American Psychiatric Association was awarded a five year, $14.2 million grant from SAMHSA to establish a Clinical Support System for Serious Mental Illness. This is how SMI Advisor began and its purpose to support clinical care. The SMI Advisor team leads a broad team of experts and organizations who work on the project. This team includes experts in clinical treatment; peer support; recovery; patient and family engagement; instructional design; technology; and marketing. You can go to the next slide.

This is a little video about SMI Advisor. Is it able to play? Great. Oh, no, we can't hear it.

>> EMILY HASSEY: There's no sound. Well, I can share it in the chat. I don't want to take up too much time trying to get this video. It's only about a minute and a half. But the great part about this video is it's really showing how SMI Advisor works and what kinds of resources are within what SMI Advisor has. So, I'll share it in the chat afterwards. It's really a quick look/overview of the services and resources that are available. So, we can go to the next slide. That's all right.

So, when we're looking at SMI Advisor, like I said in the beginning of this presentation, at SAMHSA, we don't have anything that is women specific, but SMI Advisor, the only thing that is women specific is pregnancy. So, mental illness and pregnancy and anything that might come around that.

So, whenever you search I'm showing you a screen shot of exactly searching "pregnancy." And so, if you have any questions on pregnancy and maybe working with a client who suffers from severe mental illness, this might help.

And within SMI Advisor, you can search many different co-occurring issues that might come up for a client. And you can go to the next slide.

So, like before, when I was showing so, if you type in "pregnancy" and you saw one of those boxes I just clicked on one and took a screen shot of it. And this is an example of something you can see within SMI Advisor. So, this one was what treatments are available for postpartum depression or depression after childbirth. It gives you some information as well as some programs that are available and other resources that you can access. And this is a very easy search and everything is quite condensed in SMI Advisor. It's really there for the clinician to be able to find information quickly, without doing an extensive amount of research, because your time is valuable. So, SMI Advisor is taking all of that work out so you can quickly look and see what is available to you. And you can go to the next slide.

Some SAMHSA resources. This is the SAMHSA home page. This is full of so many resources, I'm giddy thinking about it. Many of you are practitioners in this event today. There are trainings in there, there are places to find treatment, there is data, there are different grants that you can apply to. There's just news about mental health, publications. This really has everything. It even is talking about the 988 rollout, and maybe on here it says the National Suicide Prevention Lifeline, you know, just a lot of things that are happening, and this is a great resource just to bookmark, to look up any mental health information that might be coming up. You can go to the next slide.

So, in this slide, someone is going to put this into the chat, but these are just all the links that I talked about, including a couple area. So, I have the SAMHSA resource and the National Family Support Technical Assistance Center, National Federation of Families. I included a resource on certified clinical behavioral health clinics. It didn't fit into my presentation, but it's a good

resource to see what's available there. And then something a little bit more specific for women and mental health, clinical guidance for perinatal addiction. That's not my area of expertise, so I wanted to provide that information and you can disseminate the information from there. It's a great document. And as well as SMI Advisor. And the next slide.

Well, that is all I have for you today. Thank you so much for your time. And I hope you get a lot out of the presentations today. Thank you.

>> STEPHEN HAYES: Thank you very much, Emily. Now it is my pleasure to introduce our speakers from 2020 Mom. Joy Burkhard is the founder and Executive Director And was inspired to start the organization after several worlds collided, including losing her little brother to suicide, learning about the complexities of the mental health system working with a health insurer and then experiencing the realities of birth and postpartum with her first born.

She realized she was in a unique position to learn why mothers and others were not being treated for mental health disorders in the same way they were for medical conditions. The most gratifying projects at 2020 Mom have included hosting the organization's annual forums which bring together hundreds of change agents, pushing the envelope in the fields of maternal and mental health as well as the National Coalition for Maternal Mental health, which addresses gaps in maternal mental health. She is recognized with several awards, including receiving the American public health association's maternal child health leadership and advocacy award, California's American mother of achievement award, the emerging leader award in women's health from the U.S. Department of Health and Human Services Office of Women's Health, and the volunteer of the year award. She lives with her husband and two junior high school aged children in Los Angeles, California.

Also presenting with Joy today is Cindy Herrick. She is 2020 Mom's strategic partnerships and national campaigns lead and runs the maternal suicide awareness campaign as well as the maternal health week awareness campaign under the Blue Dot Project. Her experience with maternal mental health experiences in 2012 sparked her to bring change to the health care system as well as work toward mainstreaming the discussion about maternal mental health. She is a subject matter expert for the Arizona Department of Health services, ADHS, Maternal Mortality Board and is also on the maternal mental health task force where she chairs the awareness work group. Cindy is also a patient merit reviewer.

Prior to joining 2020 Mom, she was a graduate instructor and researcher at Arizona state university, specializing in autism spectrum disorders and she founded her piano music studio in 2007, created to meet the individual needs of both neurotypical students and students on the autism spectrum. She currently resides in Phoenix, Arizona, with her husband and son. Thank you to both of our speakers from 2020 Mom.

>> JOY BURKHARD: Excellent. Thanks so much. We're glad to be here, and we can advance to the next slide, Stephen. As Stephen mentioned, I'm Joy Burkhard. I'm the founder. We can advance to the next slide. So, a little bit about 2020 Mom before we jump in. Our mission is to close gaps in maternal mental health care, and we do this work through policy and health care systems change.

We were recently named a field catalyst for the field of maternal mental health by a trusted consulting firm in the nonprofit space, and we've been around for ten years. At heart of our work, we really believe this statement here on the bottom of the slide, that families, employers, and society, all of us who are paying for health care benefits, including mental health benefits, are entitled to receive screening diagnosis and treatment within the health care system. We also believe that services like Doula support, certified peer support, et cetera, should be part of the health care delivery system. So, next slide.

I always like to start with these statements when we're talking about maternal mental health, and notice I'm talking about depression here. And the field of maternal mental health is not limited to depression, but most of the research started in this space. So, let's get started.

Did you know that women in their childbearing years account for the largest group of Americans with depression? Did you know that the American Academy of Pediatrics has noted that prevalence of depression and anxiety in teen girls is skyrocketing? We know that, of course, now with the COVID crisis, and that was the case before the crisis.

Also, did you know maternal depression is the most common complication of childbirth? Did you know that there are more new cases of mothers suffering from maternal depression each year than women diagnosed with new cases of breast cancer? And despite all of this, did you know that maternal mental health disorders largely go undiagnosed and untreated here in the U.S.? Next slide.

So, you hear about various terms when you hear about maternal mental health. Some in the field still might say postpartum depression, as you heard me mention earlier. This was the disorder that was researched first. So, there's a lot of research, and often it's used to talk about the umbrella. We actually believe it's important not to use the term postpartum depression as the umbrella term because we can do harm when we use that term. And onset of these disorders are almost as frequent in pregnancy as in the postpartum period, so another reason to avoid the term postpartum depression, if we're talking about that umbrella set of disorders.

Another term you might hear about, it's all the same thing, are PMADs, perinatal mood and anxiety disorders. It's sometimes still used by clinicians. In the field, though, it's become a no-no, and that's because of the acronym MAD. Unless people spell it out, which often isn't the case, folks have found that maternal mental health has been an easier term to use for that

reason. So, again, why use maternal mental health? It's easy for non-clinicians and clinicians to understand. It leaves no disorder out or time period out, and it also offers hope maternal mental health. Next slide.

I'm going to turn it over to Cindy for a brief overview of what these range of disorders are before we get back to some of the meat around why women aren't being screened and diagnosed. Cindy.

>> CINDY HERRICK: Thank you so much, Joy. Next slide. As Joy previously said, postpartum depression has been incorrectly used as an umbrella term for all maternal mental health disorders, so now it's important to understand what spectrum of disorders and conditions fall under the range of maternal mental health disorders. So I'm going to give you a brief overview so you understand the range of disorders we're actually talking about when we say "maternal mental health disorders."

So, first two, we have maternal depression and persistent depressive disorder, dysthymia. One in five women experience maternal depression. However, I'd like to note that a lot of these prevalence rates were done before the pandemic, and research has shown that this number has more than doubled since the pandemic. Dysthymia is also another form of depression that is more persistent, whereas maternal depression is a major depressive disorder. It's more intense, usually two weeks of symptoms. Dysthymia doesn't happen until at least two years. Next, please.

Anxiety is almost as prevalent as depression. And as Joy said, a lot of these disorders can happen during pregnancy or during the postpartum period, or both. Anxiety happens to up to 15% of women and again, because of the pandemic, this has greatly possibly shifted. These numbers were conducted before the pandemic and research has shown that the pandemic has raised the level of anxiety and depression symptoms among pregnant and postpartum women.

Next we have birth related PTSD. The prevalence of PTSD is 3.1%, and as a leading researcher in this field has said, you know, trauma is in the eye of the beholder. So, if there is trauma that is experienced by the mother at some point during pregnancy or the postpartum period, they're at risk for PTSD.

And an interesting fact 34% of new mothers report experiencing a traumatic childbirth experience. So, while this doesn't mean that they will directly have PTSD, it definitely increases their risk. Next, please.

Maternal OCD. So, this is definitely an area that has been consistently misunderstood and definitely needs more research in the maternal mental area space. In fact, this has been such a

gap that 2020 Mom has been focused on closing this gap through our partnership with the International OCD Foundation to create a Maternal OCD Resource Center.

More studies are needed to identify a consistent rate of prevalence for maternal OCD. One study found that maternal OCD affects about two in ten women during pregnancy and two to three women in every 100 women in the year after giving birth, but definitely more studies are needed, and we think that the actual numbers may be higher.

It is really important to better understand maternal OCD because lack of proper training and diagnosis and understanding the symptoms, which include things like intrusive thoughts, can contribute to a wrongful diagnosis of postpartum psychosis, which I'm going to hit on next, and this can really further traumatize moms who go and ask for help for maternal OCD and get misdiagnosed for something like postpartum psychosis.

So, going on to postpartum psychosis, it's an extremely rare condition, and it only happens in approximately one to two out of 1,000 deliveries. And this is usually these are usually the cases when they go untreated, where we hear some of the tragic stories we hear in the news, but it is definitely treatable, but it is a definite medical emergency risk. So, this is an emergency, and we ask people to go for help immediately. Next slide, please.

Now, here are some other features and factors. I think most of them are pretty self-explanatory birth loss and grief, mania. Mania can be a precursor to psychosis, so it's really important that mothers receive clinical support. A lot of times, we see the onset of bipolar disorder, either during pregnancy or in the postpartum period for the first time.

The baby blues, which up to 80% of women will experience. The difference between that and it morphing into depression is if it persists beyond two weeks, it is likely that the mother may be experiencing depression.

And the last one, intrusive thoughts, which is associated with maternal OCD. These are the scary thoughts, unwanted, scary thoughts that people get. And I think this statistic is very important to highlight that 70% to 100% of women and their partners have these scary, unwanted scary thoughts surrounding childbirth and the postpartum period.

Now, if these intrusive thoughts aren't well managed or addressed, they can sometimes be tied to OCD, if they get more severe. So, now I'm going to turn it back to Joy, who's going to continue to tell you more about our work.

>> JOY BURKHARD: Thank you so much, Cindy. Just wanted to share with folks that 2020 Mom's work from uncovering the root cause of why women aren't being routinely screened, diagnosed, and treated are well documented in the reports that you'll find on our website. We

will make sure that link is dropped in the chat. Here's a couple screen shots of those reports. We have several issue briefs on important topics like screening for maternal mental health disorders; what are the barriers and opportunities; as well as the use of certified peer support specialists. Next slide.

All right. So, what we believe. You've already heard me touch on some of this work. But the first bullet is that we think the health care system should work for all of those suffering from mental health disorders, and especially and including the maternal population.

We also believe that treatment shortages must be addressed with urgency. Our friends at the American Medical Association talk about how OB/GYNs and primary care providers, if they don't have a line of sight and don't have providers they can refer to, they're not going to screen for these disorders. It makes sense, because they don't have capacity to treat or knowledge in some cases to treat in the range of treatments that are available.

We also know that reproductive psychiatrists, therapists, and certified peer support specialists and Doulas should be addressed with urgency. And obstetricians, in particular the medical home for mothers during the perinatal period, should have built capacity to address mild to moderate depression and anxiety, leaving the psychiatrist to practice at the top of their licensure, and that they need more support in doing that.

We also believe providers need to be educated and tested to do no harm. There are great efforts under way through ABOG and ACOG, and of course, the American Psychiatric Association and our partners at the Marseille Society of North America to ensure that OBs and psychiatrists are receiving the training and support that they need, and training is also available with Postpartum Support International for therapists and others.

So, the other thing that 2020 Mom has really focused on is the role of health insurers and hospitals. We believe that payers and insurers, including Medicaid agencies, employers, and private insurers, commercial insurers, play a critical role in closing gaps in mental health and in maternal mental health. We also recognize that hospitals, as the hub of birth here in the U.S. still it's 98% of births happen in a hospital setting really can play a vital role in scaling change. Next slide.

We also want to acknowledge that it's really important not just to focus on that right side of the screen here, the health delivery system, also focusing upstream, identifying root causes. What are the stressors mothers are facing, and how do we prevent them? Our colleagues at Maternal Mental Health Leadership Alliance are diving into this in a deeper way, which we're excited about. You'll hear more from Adrienne in just a moment. Next slide.

So, we also like to think about the levers for change with what we call the seven solutions or the seven Ss. Practical support. So, how do women get support? Again, on that left hand side of the tree. Practical support with things that you can imagine are important when you have a new baby at home. Social support is critically important. That's the support that peers and neighbors and family members may provide with emotional support.

Self care. We know what that is, taking care of one's self physically, emotionally, and through efforts like eating appropriately, for example. That's hard for some folks, particularly women that are facing multiple stressors and socioeconomic stressors, for example. Screening to identify these disorders. We've already touched on that just a bit. There's more information on our website. I know Adrienne also has some information to share about screening as well. What are the validative tools? You can find all of those tools on our website.

Systems integration. So, again, if we know that the obstetric office is the primary medical home for mothers during this time, how can we integrate mental health screening, detection, and treatment within an OB setting?

What about stepped care? Some of you may know about the stepped care approach, right? What level of care does a mother need? And we have gaps here in the maternal mental health space. OBs might prescribe an antidepressant, for example, or hope that if they prescribe talk therapy, a mother actually doesn't have to wait for eight weeks or have struggles finding someone in that work to get that therapy. And really, right now it's those options or the ER. We have very few inpatient programs and very few outpatient treatment programs like IOP programs in the United States, so more work to do there around stepped care options.

And then, people ask about, what about smartphone enabled services? And of course, there's a role there. We also believe it's really important to think about integrating those options through the obstetric primary home, to ensure that's well integrated and that our OBs and medical systems are not let off the hook for providing the medical services that we are all paying for. Next slide.

So, what do the professional clinical associations say? The American Academy of Pediatrics needs to be applauded as the first association to recommend screening in pediatric settings through their Bright Futures Task Force in 2010. One of the challenges with pediatric screening is that the mother is not the pediatrician's patient. So, when this is happening, it's largely a piece of paper with the questions, the screening questionnaire, and resources on the back of the page. It's still better than nothing, but we believe there should be much more integration and that obstetricians should be screening starting in pregnancy.

ACOG first recommended screening for this population in 2017. Thank you, ACOG, for that work. That triggered some additional updates, including overturning recommendations by the

U.S. preventive services task force, who previously did not recommend screening. Once ACOG issued their position, the U.S. Preventive Services Task Force issued theirs.

What does that mean? We heard previously, it means that payers need to cover screening, cannot deny screening to patients. What we have found, though, is that screening still doesn't happen routinely, even though it's covered. It doesn't mean that providers are conducting screening and know how to bill for screening. So, implementation is still very much a problem. And then, finally wanted to share that AHRQ, not specific to maternal mental health, but has indicated that only 35% of adults were screened for depression. That was the latest report in 2019, using 2015 data. So, we, again, mental health sort of sits in this larger problematic situation that is not unique to mothers, but mental health providers in general are PCPs in general are still struggling with mental health screening. Next slide.

So, what about, then, Medicaid coverage and insurance? So, you already heard me talk about how insurers need to cover screening and detection. We also know that health care coverage, of course, is foundational, and many of you, especially on this call, know that there's a great effort under way to expand and extend pregnancy Medicaid through the full year postpartum, which we're excited about. But coverage doesn't mean the system will work. It hasn't been working for those with coverage for quite some time. There's no universal system of care in the U.S., right, no tracking around clinical practice guidelines being adopted widely. And we say it's not like a Starbucks infrastructure, right, where you get the same thing everywhere every time, that it's not predictable. One provider might screen and another may not. And we're really dependent on the practices of individual providers to put these systems in place and for payers to incentivize these practices. Next slide.

What about screening and measurement? So, I did just want to quickly highlight that there is now I'm going to skip to the last point there is now a measure for maternal health, HEDIS. We know there are a range of disorders that providers should be screening for, but this is a start. We should be seeing those rates reported nationally in September of this year. Really excited about the availability of that new HEDIS measure, which 2020 Mom helped to advocate for. Next slide.

And then, one of my final slides is just to share what's happening in the state. So, 2020 Mom has been involved in championing state policy and supporting our fellows involved in state policy, both in state agencies, like public health departments, and in nonprofits, leading legislative change. I'm not going to go over all of this here. You'll have access to the slides later, but wanted to give you a snapshot of what's happening, and it's quite possible that this map does not capture all of the activity happening. So, if you're in a state and know that your public health department, for example, is doing something, or just heard about a new bill, we would love to hear about that from you. So, next slide.

Finally, just want to share that there are awareness materials that we have on our website, like palm cards that can be customized. We also have whole mom hospital and insurer best practice checklists. So, what can insurers and hospitals do to start to move the needle? We have a resource center on maternal suicide and a resource center around the use of state certified peer support specialists. And with that, I have one last slide, I think, the forum? Yep, we host it, convene it every year with multiple stakeholders. We invite you to check it out. Materials are available on their website from this year's forum and on our YouTube channel. And with that, I am happy to turn it back to Adrienne and Stephen. Thank you.

>> STEPHEN HAYES: Thank you, Joy and Cindy. Now it is my pleasure to introduce Adrienne Griffen, a subject matter expert in maternal mental health. Former to MMHLA, she was with postpartum support Virginia with peer led support groups and created educational programs for mental health providers and maternal child health care professionals and helped pass legislation requiring information about postpartum depression and anxiety be provided to new mothers.

Adrienne graduated from the United States naval academy and has a master's in public policy from Harvard's Kennedy School of Government. Adrienne and her family live in Arlington, Virginia. Over to you.

>> ADRIENNE GRIFFEN: Great. Thank you so much. And thank you, everybody, for taking time from your very busy days to be here and learn about maternal mental health. I have the honor and privilege of leading maternal mental health leadership alliance, and I'm going to focus on what's next. So, policies, programs, and novel approaches. So, next slide.

So, a little bit about my background. As Stephen said, I graduated from the Naval Academy. I worked at the Pentagon, the White House, I worked for the United Nations. I was large and in charge. I was on track to, like, living my best life, and then I had my son, John, and I had significant postpartum depression after he was born. I had a very scary emergency C-section. He didn't sleep very much. And between having a toddler and a newborn, I was slowly losing my mind, and it took me about six months to get the help that I needed, despite having every privilege possible. I live outside of Washington, D.C.

I had insurance. I had a husband. I have Internet. And I kept thinking during this dark time in my life, I need to do something so that other women don't suffer as I did. So, I started volunteering with Postpartum Support International and then Postpartum Support Virginia for ten years and now I'm with MMHLA to focus on national policy. Next slide, please.

So, just a quick recap of what Joy and Cindy have been talking about. Maternal mental health conditions are actually the most common complication of pregnancy in childbirth, affecting at least one in five pregnant or postpartum people and close to one in three in high-risk

populations. These untreated conditions can have long-term negative impact on mother, baby, family, and society, and we know that there is a significant financial cost of not treating these conditions. It's also really important to note that the majority of people who experience maternal mental health disorders or Perri mental health issues go untreated. Next slide, please.

We can't talk about maternal health without talking about maternal mortality. So, the slide on the left should not be a surprise to anybody. This has been in the news for the last five years or so. The U.S. maternal mortality rate continues to rise. It is the only we are the only industrialized nation where the maternal mortality rate is actually rising. And this information comes from Maternal Mortality Review Committees, which published a report in I think 2017 or 2019, showing that 700 women died each year during pregnancy or the first year following pregnancy, and that women of color died at three to four times the rate of white women. So, we really have been focusing on these racial disparities over the last several years.

But also what was included in that report is that suicide and overdose combined are the leading cause of death in the first year postpartum. Women during this timeframe use the most lethal means. They want to end their lives. They are so desperate.

Fewer than half actually attend their postpartum obstetric visit, but the majority of women who commit suicide in the postpartum period visit their emergency department within a month of committing suicide. And we know that the peak incidence of suicide is six to nine months postpartum. So you heard Joy talk about extending medical coverage for the first year postpartum and the need for pediatricians to be screening. So, two important ways that we can help make sure that moms are being cared for. Next slide, please.

I don't even need to say anything else. The additional anxiety that moms are feeling with the COVID 19 pandemic, and now the formula shortage. Can we just add insult to injury? Next slide, please.

So, why should we care? I'm just going to let you think about this for a moment. How is it possible that in the country that spends the most per capita on health care, we have a system that allows mental health complications to be the most common complication of becoming a new parent and that suicide and overdose are the leading cause of death for new mothers. We ought to be ashamed. We ought to be galvanized. We ought to do something now to make sure that women, pregnant and postpartum people, are educated about and screened for mental health conditions and get the care that they need. Next slide, please.

So, what are we doing to address this? Next slide. Fortunately, we're starting at the top. The President's FY '23 budget actually included this exact phrasing, which was a formal document that puts the whole Federal budgeting process into motion. "Recognizing that maternal mental

health conditions are the most common complications of pregnancy and childbirth, the Budget funds two specific programs a dedicated maternal mental health hotline and grants to states. Next slide, please.

There are also three pieces of legislation currently being considered by Congress that would address maternal mental health issues at the national, state and local levels. The first is Into the Light, which would fund the programs mentioned in the President's budget. That's the dedicated maternal mental health hotline and grants to states programs.

The triumph for New Moms Act would establish a national task force and create a national strategy. Both have been included in the house mental health bill that's moving forward.

Then the third piece of legislation is the Moms Matter Act, addressing inequities in perinatal or maternal mental health, creating grants for community-based programs and growing and diversifying the workforce. Next slide, please.

Just a word or two about the maternal mental health hotline. You heard it mentioned earlier. It was launched on Mother's Day. It's a HRSA service with a contract to postpartum support international, the world's leading organization in providing support information, encourage, and help to parents affected by maternal mental health conditions. It's 24/7/365, voice and text, English and Spanish, staffed by licensed and credentialed health care and certified peer specialists.

If you call the hotline, you will get education, information, support, and brief intervention, as well as resources and referrals. And the hotline does have reciprocal agreements with other hotlines like the new 988 suicide prevention line and the domestic violence. Next slide, please.

So, you heard Joy talk quite a bit about screening. We have recognized that screening is inadequate, insufficient, not happening as well as it should, so we, along with the March of Dimes, have launched a yearlong effort to synthesize existing screening recommendations from a variety of organizations to create a draft framework for maternal mental health screening and education.

Whenever we say screening, we also mean patient education. It's not just simply handing a mom a piece of paper. It's talking to her, explaining that these issues are very common, asking her how she's doing, making sure she knows that this is the most common complication of pregnancy and childbirth.

So, women will actually see a health care provider about 25 times during the routine screening period from conception through a full year following pregnancy. So, what the draft framework is recommending or suggesting that screening happen at least each trimester, prior to

discharge from the hospital, within three weeks postpartum, and then during all regularly scheduled obstetric and pediatric visits in the first year following pregnancy. Next slide, please.

There are other key players when we think about maternal mortality. Of course, the maternal mortality review committees, which are state organizations that identify, review, and analyze maternal deaths. And then they disseminate findings, which then the perinatal quality collaboratives typically pick up these findings and figure out ways to address them, often working with hospital systems, often working with the Alliance for Innovation on Maternal Health, which is a national partnership that provides evidence based patient safety and quality improvement resources, what they call safety bundles, on specific topics so that hospitals, obstetric providers, primary care providers, can actually take action that kind of dials all the way back to address issues uncovered by the MMRs. Next slide, please.

Of course, one of the key players is ACOG, the American College of Obstetricians and Gynecologists. As Joy mentioned, they have some screening recommendations, also a new document Committee Opinion 736 talking about Optimizing Postpartum Care, talking about the fourth trimester or the first three months of baby's life and the first three months of the new mother's life, and they'll be issuing new guidance on screening assessment and managing mental health issues through psycho pharmacology. And ACOG chose this year as two of their pieces of legislation to support mental health issues. Next slide, please.

Psychiatry access programs are fabulous programs at the state level that basically provide three specific things: Trainings and toolkits to frontline providers, such as obstetricians and their staff, so that they can treat sort of the milder cases of anxiety and depression; realtime psychiatric consultation for more complex cases; and then resources and referrals for those affected by maternal mental health conditions. This program, actually, is modeled after a program in Massachusetts called McPAP for Moms and it is where all the states on the right were implementing psychiatry access programs through Lifeline for moms. They meet quarterly for professional development and networking and helping each other out.

And on the right, as I said, are all the states that are implementing psychiatry access programs, and those highlighted in yellow are ones that have received federal funding from legislation that was introduced five years ago that were authorized to increase the number of states. Next slide, please.

And wouldn't it be better if we could prevent, rather than treat these programs? So, there are three evidence based prevention programs listed here mothers and babies, roses, and PREPP. Each one takes a slightly different approach, but primarily focused on low income women during the final stages of pregnancy and the early days of the postpartum period. In fact, we're so excited about these programs that we are working with the White House and the

Department of Health and Human Services to host a summit on these three prevention programs on Monday, May 23rd. And information about that will be shared with all of you afterwards as well. We'd love for you to join that summit. Next slide, please.

And again, thank you for being with us today, taking time from your busy lives. I know that we have a few minutes left for Q&A, so I'll just turn that back over to Stephen. Thanks again.

>> STEPHEN HAYES: Thank you, Adrienne. And thank you to all of our speakers today. I would encourage our participants to continue to put questions into the chat as we have the remaining period here within the hour to hear from our fabulous speakers today. One question that's come through to us today and this is open to everyone, of course, is about how what we've learned during the impacts of the current pandemic, we can build upon the lessons of leveraging telehealth during the perinatal period. And I think we have a lot of examples. We've heard of opportunities there, but we would love to hear more from our speakers about some of those.

>> JOY BURKHARD: Sure. Well, Adrienne, jump in here if you'd like to as well.

>> ADRIENNE GRIFFEN: Go ahead.

>> JOY BURKHARD: We've found that the pandemic has done a lot of great things for mothers, including increasing ease of access to behavioral health services during the pandemic, working from home, if possible, et cetera. And so, we are absolutely in support of continuing the policies that were put in place to allow for telehealth to be extended during the pandemic and want to encourage those policies to continue as long as possible and indefinitely. And Adrienne, I'll turn it over to you to talk a little bit about the work around McPAP again, teleentry consultation, and how the pandemic may have influenced that work.

>> ADRIENNE GRIFFEN: Absolutely. So, telehealth has really removed many barriers to care that new mothers face transportation, child care, time away from family or work. I mean, telehealth is not perfect, but it really has removed some of those barriers to care. And so, we're working hard to make sure that the provisions that were rolled back around telehealth during the pandemic remain rolled back.

We want to make sure that moms are able to access everybody's able to access care in the easiest way as possible. And we know that ACOG is actually looking at lining up more telehealth visits in the future and fewer in person visits. So, I think telehealth is really here to stay.

>> STEPHEN HAYES: Thank you all for that. Another question, we're hearing a number of questions sort of around screening overall, and a couple of presentations we heard about the

challenges regarding both willingness to screen, around providers potentially not knowing how to refer out or what to refer to, but also knowing about organizational capacity to refer to those services. If you speakers want to touch upon some opportunities there or potential promising practices you've heard from your stakeholders?

>> ADRIENNE GRIFFEN: Sure. I'll go first and then Joy can chime in. I mean, we hear over and over again from providers, you know, that they're not trained about these issues, they're not reimbursed for screening, and they don't know where to send moms for help. Well, I wouldn't screen either if I didn't know those three things. So, now with the dedicated Maternal Mental Health Hotline, anybody can be referred to that hotline. And Postpartum Support International, which is staffing the hotline, has volunteer coordinators, volunteers in every single state. They have specialized coordinators for unique group like parents who have a baby in the NICU or military parents or parents who have suffered miscarriage. Similarly, they have over 20 online support groups a week. So, I always say that while there are not enough resources, there are resources, and I always start with Postpartum Support International.

>> JOY BURKHARD: That's great. I'll just add. With our interest in supporting the health delivery system, we are really looking at screening and integration with sort of two levers for change to support obstetricians, in addition to the telepsychiatry consultation program. We're looking at things like care coordination and case management. So, once a mother is identified with a positive screen, who can support linkage to care, monitor whether or not mother went in to care, needs more support? And we think there's two options to support those levers. One is the use of insurer developed care coordination programs. Many of you may know that insurers offer case management care coordination programs for things like diabetes care, low back pain, even eating disorders, and we think that insurers should be developing such programs for maternal mental health. Ideally, all of them would, and OBs wouldn't have to figure out what insurance is doing you know, what for each patient. This would be available across the board.

The other lever we see, and we're quite excited about, looking to pilot in a third pilot around the use of state certified peer support specialists is embedding certified peers within OB care settings, whether it's virtually or on site to provide screening, actually, to deliver screening and provide it in a way that reduces stigma, also provide brief intervention for those at risk or suffering as they get into care and that care coordination support on an ongoing basis.

>> ADRIENNE GRIFFEN: I just want to add in here that we're putting a lot on the clinical system and the medical system, but we all also have to shoulder the burden. We all know mothers. We all have mothers. We all need to ask new mothers, "How are you doing? What can I do to help? Can I fold the laundry? Can I take the baby so you can take a shower?" Right? We need a better social support system around our mothers as well. So, I'd just leave that with

everybody. This is my challenge to you. When you know somebody who is a new mother, reach out and offer to help.

>> STEPHEN HAYES: Thank you, Adrienne, for what I think is an excellent closing point there. And thank you for all of our speakers being part of today's Women's Health Leadership Series webinar in observance of National Women's Health Week with a particular focus on women's mental health. I just want to encourage all of our participants to sign up for HRSA e News as well to stay up on HRSA activities, NOFO and other programmatic activities. We will be circulating a recording link available to everybody who registered today in the next week or so. And once again, thank you all for your time and participation.

(Session concluded at 3:00 p.m. CT)