2018 DC Perinatal Mental Health Impact Evaluation Brief

Summary of Findings

Purpose: The purpose of this project is to gain insight into the impact of various perinatal mental health (PMH) activities in Washington, District of Columbia (D.C.) that have occurred over the past three years, since a Perinatal Mental Health Needs Assessment[1] was completed in 2015, by looking at the attitudes, beliefs and practices of primary care, mental health, and other, related healthcare service providers and participants/clients/patients[2] regarding perinatal (pregnancy and the first year postpartum) mental health in DC.

Process & procedure: The impact survey project and reports was conducted by a team of staff and graduate-level public health and social work interns in the Maternal Mental Health (MMH) Program at Mary's Center (MC), and in collaboration with a variety of perinatal mental health community partners and stakeholders.

Caveats: As noted above, in 2015, an initial PMH needs assessment was conducted with local providers. When comparing data from the 2015 assessment to the current study, note that there is a much larger provider sample size in the current study, with people less closely affiliated with Mary's Center's MMH program. Also of note, participant data is solely from Mary's Center.

Sample:

2015 Provider Online Survey	2018 Provider Online Survey	2018 MC Participant Survey	2018 MC Participant Focus Groups (3)
132 respondents self-selected into 3 provider groupings • Pediatric providers (n=45) • Non-pediatric healthcare providers (n=44) • Mental healthcare providers (n=43)	**311 respondents** self-selected into 3 provider groupings • Medical providers (n=107) • Allied providers (n=84) • Mental Health providers (n=120)	66 surveys (English/Spanish) completed Only **50 surveys** could be used, given 16 did not have signed consent Distributed at 2 and 6 month Well Child Check (WCC), when	**13 postpartum (less than a year) women** participated in 3 focus groups sessions Session 1: Spanish-speaking (n=4) Session 2 Amharic-speaking (n=6) Session 3: English-

[1] The purpose of *The Integration of Mental Health in Pediatric Primary Care: A Mixed Methods Needs Assessment of DC Providers*, otherwise referred to as the "Perinatal Mental Healthcare Needs Assessment", conducted in partnership between the DC Collaborative for Mental Health in Pediatric Primary Care and Mary's Center, was to determine the attitudes, beliefs and practices of primary care, mental health, and other, related healthcare service providers and to determine gaps in programming, training, organizational capacity, and advocacy pertaining to PMH in DC. For this project, three separate assessments were created: one for pediatric primary care providers, one for perinatal healthcare and related providers (e.g. lactation consultants, home visitors), and one for mental health providers.

[2] Going forward in this report, the term "participant" will be used in reference to "patients" or "clients".

		moms routinely complete Edinburgh Postnatal Depression Screen (EPDS) 20 expressed interest in the focus group 49% (n=23) of participants identified that this was their first pregnancy 51% (n=25) identified that they had experienced more than one pregnancy	speaking (n=3) 34 total women expressed interest in the focus group, 13 ultimately participated 54% (n=7) of participants identified that this was their first pregnancy 46% (n=6) identified that they had experienced more than one pregnancy

Impact Survey Full Reports

- This document serves as a summary of the following supporting documents, available up on request at mmh@maryscenter.org
    - Professionals Survey Report
    - Participant Focus Group Report
    - Participant Survey Report
    - Professional and Participant Screening Tool Data Summary Document

SUMMARY OF RESULTS

Work Setting

- 75% of healthcare/medical respondents reported working in hospitals and community health settings. This was consistent between 2015 and 2018. When comparing where mental health (MH) respondents work, the percent working in hospital/community health clinics decreased from 32% in 2015 to 18.3% in 2018, whereas the percent working in private practice remained ~50%.

Experience and Knowledge

*Mental Health Providers***:** In 2018, 50.5% of the MH respondents reported "sufficient" or "expert" level experience compared to 63% in 2015.

Allied providers: In 2018, 72.7% of Allied providers agreed/strongly agreed (A/SA) that they have a good understanding of Perinatal Mood & Anxiety Disorders (PMADs). 77.3% of Allied providers either A/SA that they would know where to refer a participant.

Medical Providers: In 2018, ~72% of medical providers A/SA that they are comfortable assessing the PMH needs of their participants, compared to 38% in 2015. When looking at data from the participant

survey, 67% of participants report feeling comfortable speaking with a medical provider about their emotional health.

Training

Lack of training/PMH knowledge was cited less as a barrier in 2018 than in 2015. See detailed report for breakdown of numbers of hours of training providers had.

In 2018, the following provider groups report having no formal PMAD training:

- 12.1% of medical (compared to 19.1% in 2015)
- 15.3% of mental health (compared to 9.8% in 2015)
- 30.7% of allied (no comparison from 2015)

In 2015, 80.9% of medical providers (pediatric and non-pediatric healthcare respondents) A/SA that receiving PMH training would increase their likelihood of screening, compared to only 60.1% of medical respondents (or average of 70% when combined with allied providers) in the 2018 impact evaluation.

Training Setting Types

- **Medical providers** indicated **academic work and Grand Rounds** as the primary sources of PMAD education (63.6% and 49.5%, respectively), whereas **mental health providers** obtained their PMAD education primarily from **local trainings in D.C. (46.9%) and organizational/"in house" training (46.9%)**.
- **Local trainings** were also a source of training for **allied providers (33.3%) and medical providers** (26.3%).

Involvement in PMH Activities

- **Trainings and collaborative/taskforces** were the most commonly reported PMH activities by all groups.
    - Of the trainings, the most frequently mentioned were **Mary's Center PMH trainings** and **Postpartum Support International (PSI) trainings**.
    - A large range of collaborative/taskforces were mentioned, including the DC/MD/VA (DMV) Women's Mental Health Consortium, the PMH Champions Trained Trainers group, Early Childhood Innovation Network (ECIN), Early Childhood and Family Mental Health (ECFMH) subcommittee, and DC MAP (Mental Health Access in Pediatric Care). **The D.C. PMH Champions and DMV Women's Mental Health Consortium groups were most frequently noted**, and the **Women's Mental Health Consortium was the only group mentioned in all three surveys (medical, mental, and allied health).**

Screening & Referral

Results from provider surveys:

- One third to one half of medical and allied providers report being **unsure if their PMH referral was successful**.

- One-third of mental health providers disagreed or strongly disagreed (D/SD) that they regularly receive referrals from **pediatrician**s, and almost half D/SD that they regularly receive referrals from adult **primary care providers**.
- 40.7% of **mental health providers A/SA that they receive referrals from allied providers**
- Mental health providers A/SA that their referrals come from the following:
    - 75.5% from participant self-referrals
    - 59.5% from OBs/midwives
    - 40.7 from allied providers
- Mental health providers D/SD their referrals come from the following:
    - 65.8% from pediatricians
    - 46.0% from primary care providers
- Medical providers were asked **which mental health providers they refer their perinatal participants to**. The top 3 organizations who were noted as utilizing in house referrals and the top 3 organizations receiving external referrals are listed below. See Appendix C in full provider's survey report for a visual representation of where medical providers refer.

    - Top 3 orgs with **highest # of in-house referrals**- Mary's Center (11), Children's National Health System (8), Unity Healthcare (7)

    - Top 3 orgs with **highest # of referrals received from external entities**- Mary's Center (8), George Washington (GW) 5 Trimesters Clinic (7), Georgetown University Hospital (4)

- 48.3% of medical providers A/SA that updated/improved screening protocols are necessary to increase support of PMH
- **40.4% of medical providers A/SA that expanded coding/billing** would greatly increase their likelihood of screening and referring perinatal women in need of mental health services.
- 71.9% of allied and medical providers agreed that **receiving PMH training would increase their likelihood of screening and providing referrals for perinatal women** in need.

Screening & Referral perspectives from Mary's Center participant focus group and survey:

- **Comparison of screening experience, past and present**
    - Women who experienced more than one pregnancy were asked to compare their most recent and past pregnancies regarding being asked about their emotional health. **Women report a vast array of different experiences that influence the way in which they feel emotional health was addressed across their pregnancies, making a comparison of past and present PMH landscapes difficult to assess.**
    - *Memory* of which tool and how/if they were asked was also noted repeatedly as a challenge to a true comparison.
- **Perspective on discussing emotional health**
    - Seventy one percent **of survey respondents reported that they were comfortable/very comfortable discussing emotional health with a variety of primary care providers, highlighting the importance of these providers as a gateway for women to get help for mental health issues since lack of comfort can act as a huge barrier to receiving mental health referrals/services.**

- Focus group participants **report mixed feelings about their general comfort with discussing emotional health either indirectly through screening tools or directly through discussions with providers. Women also reported mixed responses about their honesty in answering questions about their emotional health with either method, and some noted challenges with conducting a self-assessment through a screening tool**.

- **When in perinatal period asked about emotional health**
  - Of the 13 women that participated in the focus groups, most reported being asked about their emotional health at pediatric appointments (n=8) followed by prenatal appointments (n=4). **All participants were asked at least once during the perinatal period, but there was little consistency as to which appointment/provider types they were asked/or recall being asked at.**
    - Overall, individuals report being asked about their emotional health at a variety of different appointments (pediatric, prenatal, postpartum, physical therapy, and genetic appointments were all mentioned). Women report being asked both indirectly using screening tools, directly by the provider, or both.
  - Per participant survey data, a **large majority of women reported being asked about their emotional health by more than one provider (42%) at more than one appointment type (64%).**
- **Linkage with care**
  - 80% of participant survey respondents who were referred to services reported that they were never scheduled for their appointment (See Section F in the 2018 Participant Survey Report for more details).
  - Participant Survey Data from 2018 indicates that even when scheduled, most women (60%) did not go to their scheduled appointment. Provider beliefs about barriers to treatment/care and participant behaviors regarding attendance at mental health appointments align with one another
- **Perspective on EPDS screening tool**
  - When asked if "the EPDS does a good job of asking you questions about your emotional health"
    - 90% of survey respondents indicated yes, and only 11% responded no.
      - Of those who responded no, they indicated issues with the questions that made it difficult to answer them honestly. One respondent said, "it is easy to lie and be in denial of symptoms on a hand written screening," another indicated that "the questions articulated the extreme feelings that are way more difficult to acknowledge, and might be a deterrent to answering honestly," and the last respondent reported that "answering honestly might mean [her] baby will be taken away."
      - The important takeaway from this is that, while the majority of women reported that the EPDS does a good job of assessing their emotional health, providers must also take into consideration the limitations of hand written screening tools

and make sure to also engage women in discussions regarding their emotional health to ensure that women continue to have opportunities to be connected to mental health services beyond their answers on the screening tools.

- Focus group participants **generally (9 out of 13 participants) report positive attitudes towards the EPDS as an assessment instrument for emotional health and believe it is a useful tool in facilitating conversations with their providers about emotional health.**

- **Perspectives on EPDS compared to Patient Health Questionnaire (PHQ) screening tool**
  - When focus group participants compared the EPDS and Patient Health Questionairre-9 (PHQ9) side by side, and with probing (note: when asked generally about how one feels about the EPDS, participants responded favorably- see above), the EPDS is viewed in a less positive light, and the following preferences for the PHQ9 are noted:
    - Women indicated that they felt the questions and the answer options on the PHQ-9 were more inclusive and less limiting compared to the EPDS. Women noted that the PHQ-9 questions had more options/language they could identify with and were more objective/required less contextualizing to answer appropriately.
    - Preference for PHQ-9 because it provided a question at the end that enabled them to add a level of context to their answers that the EPDS did not have.
    - Preference for Likert scale of the PHQ-9 over the multiple-choice format of the EPDS because it either made the screener feel shorter/reduced the reading burden or because it provided them with what felt like less limiting answer choices.
    - Preference for 2-week timeframe on the PHQ-9 compared to the 7-day timeframe on the EPDS. Felt that a 2-week time was a more realistic time-period to adequately assess their emotional health
- **Challenges with screening and referral**
  - Focus group participants share experiences that may indicate they are feeling/seeing a provider identified barrier to providing care, lack of time, and offer ideas for improvement:
    - Participants in the focus groups noted feeling that they **lack awareness of resources available to them**, highlighting their belief in a **responsibility that providers have/that they need their providers to more actively link them/facilitate linkage and share information/resources** with them to ensure women are aware of emotional health services available to them.
    - Women in the focus groups noted the perceived **importance of the role of pediatricians** in identifying and helping new mom's access support services, as highlighted more generally above. Women shared that pediatricians were generally the only provider they saw regularly in the postpartum period.

        - Participants recommend providers **focus attention on the mom, vs computer screen, when asking** about emotional health.
        - Women also noted the need for providers to **ask them about what their emotional health was like prior to pregnancy** and to address with participants how these concerns may have changed or been aggravated during their pregnancy.
        - The **Amharic language group** particularly noted that women don't answer the questions **honestly** because they don't expect to get **"solutions"** from the provider, which is what they want.
    - **Barriers to accessing mental health/other perinatal support:** lack of awareness about available support services and difficulties scheduling the initial appointment
    - **Summary of general challenges to screening, per participants: Self-assessment, logistical challenges, desire to provide more context**

Provider Perception of Participant Barriers to care

- Providers perceptions of participants barriers to care remain largely the same in 2018 as in 2015, and in the same order of severity, including **1) insufficient time/other demands getting in the way, 2) stigma/cultural issues, 3) financial issues/inadequate insurance coverage**, and more prominent in the 2018 needs assessment was the identification of **location/physical accessibility** of treatment options, which was only a minor theme in the 2015 survey.

Collaboration *the collaborative relationship is highlighted as it relates to referral to treatment, coordination/follow up to ensure care

- Improved communication, collaboration and referral processes were identified as strong needs in all three survey populations, signifying an awareness of the problem across the board.
- Percentages of medical and mental health respondents that A/SA with the need for improved collaboration were high in 2015 and remained high in 2018.
    - 93.2% of medical and 95.3% of mental health providers A/SA in 2015, and 87.6% of medical and 94.0% of mental health providers A/SA in 2018
- For mental health providers, lack of time and **clear communication with medical providers** were identified as the two biggest barriers to care of PMH participants.
    - Only one-third of mental health providers A/SA that they have a collaborative relationship with the medical providers of the perinatal women that they serve.
    - In contrast, two-thirds of medical respondents A/SA that they have a collaborative relationship with mental health providers.

DISCUSSION AND IMPACT ATTRIBUTION

Successes and Strengths

- *Expanded Network of Providers* (increased # of respondents, addition of allied providers group and large # of respondents, allied providers are well trained and confident in referring women for PMH treatment)

    - IMPACT OF PMH CHAMPION TRAIN THE TRAINER: PMH Champions Train the Trainer project intentionally targeted interdisciplinary providers, including allied providers, for training in perinatal mental health
    - IMPACT OF INTERDISCIPLINARY TRAINING: Teaching take-home- "anyone who touches the life of a perinatal woman is responsible" [to ask/educate/support perinatal women and families]
- *Increase in Medical Provider Confidence and Capacity:* In the 2018 impact evaluation survey, medical providers responded that they are better trained, more comfortable starting conversations around perinatal mental health, and more comfortable referring participants to PMH treatment than they were in 2015
    - IMPACT OF MEDICAL SETTING TRAINING: Since 2015, a significant portion of PMH initiatives have been housed in medical centers and hospitals, focused on increasing knowledge and capacity for medical providers in addressing the PMH needs of their participants.
- *Multidisciplinary screening/initiation of conversations about emotional wellness*: Survey data from participants indicates that women are given multiple opportunities to engage in emotional health discussions with multiple providers at multiple appointment types, increasing their chances of being connected to mental health services and decreasing their risk of going undetected if they have unmet emotional health need.
- *General PMAD Training:* PMAD training was identified as a great need by perinatal providers in the 2015 needs assessment. Over the last three years, training initiatives have been implemented across DC to respond to that need, and results from this assessment indicate that those trainings were a success. **Lack of training/PMAD knowledge was reported as an obstacle/barrier faced less frequently by medical providers in 2018 than in 2015**, and allied providers reported it as a barrier experienced only "occasionally" in 2018. **Medical providers indicated significantly higher rates of PMAD training in 2018 than in 2015**.
    - IMPACT OF GENERAL, INTERDISCIPLINARY TRAINING
- *Mary's Center trainings*:
- *Mary's Center trainings and collaborative (PMH Champion group), Postpartum Support International (PSI) training and DMV Women's Mental Health Consortium*- For the PMH activity categories of training and collaborative/taskforce, **Mary's Center was in the top 2 (with PSI for training and DMV Women's Mental Health Consortium for collaborative involvement) most commonly mentioned entities in the categories of training and collaborative activities. Given that training and collaboration were 2 identified needs from the 2015 needs assessment, it can be noted that Mary's Center opportunities were highlighted in 2018 as 1 of the top 2 entities participated in for training and collaboration, and that PSI and DMV Women's Mental Health Consortium were in the top two as well.**

  Mary's Center served as an important source of perinatal mental health training for providers over the last 3 years. Per the PMH activity timeline, there are few local PMH trainings for mental health providers beyond what was offered through Mary's Center, thus, it is **safe to conclude that the majority of the 46.9% of mental health providers who received their PMAD education "primarily from local trainings in DC" received it at a Mary's Center hosted training**.

    - IMPACT OF PMH CHAMPION TRAIN THE TRAINER

    - IMPACT OF INTERDISCIPLINARY TRAINING
    - IMPACT OF DMV WOMEN'S MENTAL HEALTH CONSORTIUM
    - IMPACT OF NATIONAL TRAINING/RESOURCE ENTITY PSI
- Inadequate **reimbursement for PMH screening** was identified as a frequently encountered barrier to participant care in 2015, and is now experienced only occasionally by providers, a testament to the success of billing/reimbursement expansion efforts over the past three years.
    - IMPACT OF SCREENING REIMBURSEMENT ADVOCACY/CHANGE LED BY CHILDREN'S HOSPITAL/ECIN

<u>Gaps/Needs</u>

- Much like in 2015, providers from all three surveys (~80%) identified some variation of the **need for more mental health providers and particularly those that accept private insurance, Medicaid/Medicare, or serve uninsured women (INSURANCE/MORE MH PROVIDERS)**
    - Only one-fourth of MH respondents with "sufficient" or "expert level" PMH knowledge had a caseload of over 50% PMH participants
    - Only ~18% of mental health respondents work in the hospital/community health setting, and 50% work in private practice
    - **Lack of mental health providers to refer to was identified as the biggest provider barrier to assisting** participants **with PMH concerns by both allied and medical providers**
        - Strong consensus on **lack of availability of perinatal mental health resources.**
        - Only 14.6% of medical, 11.8% of mental health and 16.7% of allied professionals A/SA that there are adequate perinatal mental health services available, while 67.0% of medical, 68.8% of mental health, and 54.8% of allied providers D/SD.
- The theme that arose most frequently in the 2018 provider's qualitative data was the **lack of availability of accessible, "culturally competent" services**. Under this umbrella, specific gaps/needs were identified, including lack of mental health providers to refer to, long waitlists for services, and a need for mental health services in "underserved areas".
    - **Wards 7 and 8 were identified consistently throughout all three provider surveys as an area in great need of mental health services.**
    - Further, respondents in the medical, mental health and allied provider surveys mentioned lack of **"culturally competent" services** as an accessibility issue.
    - **language** was identified in all three surveys as a barrier to care, and Spanish, French and Amharic-speaking women were mentioned as populations specifically in need of accessible mental health services. Other barriers to access of PMH care that were mentioned included **stigma, lack of transportation, and lack of childcare**.
- Training/education needs were the second most mentioned theme in the 2018 providers qualitative data. **Mental health providers called for more accessible trainings that provide CEUs, and medical and mental health providers,** who have more of a baseline knowledge of PMH now than in 2015, are calling for **more advanced training and information on specific interventions/protocols for work with the PMH population**.
    - **Mental health providers that completed the 2015 needs assessment appear to have been either more experienced or more confident in their experience with PMH care than those in 2018**. This may be attributed to the larger survey sample size, wider

breadth of MH providers, and more educated MH providers across the board so that now in contrast to other their peers, providers who once identified as being "highly experienced" no longer feel particularly so compared to their peers.

- Opportunity to strengthen **provider to participant psychoeducation and support with linkage to care, including sharing information/resources and support of linking participants with care** (from Focus Group data)
    - Participant data generally identified two areas of need that if improved would be most helpful to them and make them feel more comfortable discussing their emotional health with providers:
        - (1) the **need for more information surrounding emotional health** during pregnancy and available support services and
        - (2) the **need for improvements in the participant-provider interaction regarding emotional health.**
    - Comparing the type of support women suggested in an open-ended question with the support services women reported they engaged in (See Section C in the 2018 Participant Survey Report), women **indicate a potential need to increase access to and awareness about existing emotional health support and support group services, since only 5% of respondents indicated they used this type of support resource and it was one of the top 3 suggestions from women for programs that might be helpful to new moms.**
    - **The needs noted by providers in 2015 continued to be echoed by perinatal** participants **in 2018, who indicate the need for more materials and resources regarding perinatal emotional health and increased collaboration among providers to increase opportunities to connect women to therapy/counseling or support groups to meet their emotional health needs.**
- In 2018, 1/3-½ of medical and allied providers report not being sure if their referral was successful. This continues to highlight **need for collaboration and challenge with lack of time to follow up (more on collaboration/communication below)**.
    - From the participant experience data as well, there are existing gaps in linkage with care/getting scheduled for the appointment, which suggests there are multiple places where the system can be improved to address this, both on the participant and provider end.
        - Participant data indicates that while provider's may be providing women with referrals to mental health services, there is a large amount of drop off in terms of women who get an appointment **scheduled for these services. This also indicates that referring providers may need to play a more active role in assisting women in obtaining care through referral services by facilitating appointment scheduling** either before the participant leaves or through follow up calls to make sure participant connect with referral services and initiate scheduling.
    - **Women seem to face major barriers when it comes to scheduling referral appointments, which could be a specific area in need of an intervention to ensure that women are at least connected to a referral appointment through the scheduling of an initial visit.** Participant **reports appear to mirror what providers believed to be their major barriers to access to PMH services, indicating that the barrier landscape has**

changed very little for women over the last 3 years, and that many of the barriers are more participant related than provider related, but that providers use of screening tools and directly asking women about their emotional health is an important responsibility that providers care.

- Given there continue to be barriers for women in (1) scheduling and (2) attending their emotional health appointments, research regarding the specific barriers to both activities is warranted based off the current data.

- **Improved communication, collaboration and referral processes** were identified as strong areas of need for improvement in all three provider survey populations, signifying an awareness of the problem across the board. Moving forward, these needs should continue to be prioritized in order to ensure that participants in need receive PMH treatment by experienced mental health providers.
    - The contrast in perception about communication between mental health and medical providers points to a possible miscommunication, lack thereof, or difference of expectations around communication.
    - Another indicator of miscommunication between all three parties is that the majority of allied and medical providers that referred a participant to PMH services in the month prior to taking the survey were unsure if that participant ended up receiving services.
- **While many initiatives over the past three years have focused on building capacity to increase referral rates from primary care and pediatric providers**, the data suggest that there is still work to be done.
    - Despite improvements in the PMH landscape in DC since 2015, a "responsibility" gap still persists. While providers have more screening protocols in place, and more knowledgeable about PMADS and comfortable referring, the increase in provider knowledge/protocol is not widely felt by perinatal families, who identify many inconsistencies with PMH care and gaps in the system. From the participant perspective, there are both provider level and systems level changes that can improve care and how the improvements may be felt by participants (see above).
- **Barriers and Areas for Improvement per Providers -** *Participant Barriers*
    - With more providers screening city wide, more women across the city are identified as needing care, highlighting the challenges in the current landscape which include **limited perinatal mental health care options**.
    - Additionally, while the past three years saw successes in training and education for providers, education for the community may have been overlooked. A reoccurring theme throughout the survey data was lack of knowledge of PMAD signs/symptoms as a barrier for participants. There is concern that perinatal women do not know that what they are experiencing is abnormal, preventing them from seeking treatment. Stigma was also mentioned repeatedly as a barrier preventing participants from seeking the help they need. Tied into the need for **community education and anti-stigma efforts is the need for accessible, culturally competent services, especially in Wards 7 and 8**.
- **Brief Summary of Needs/Gaps:** Ongoing desire for more collaboration, more mental health providers, more provider time, and more training. Some want continued expanded coded/ billing.

Moving Forward

- Moving forward, **allied providers should continue to be regarded as key stakeholders**
- Targeted **training of mental health providers who accept insurance**, as well as **general PMH training of MH providers**, to increase capacity
    - Roughly 90% of respondents in 2015 as well as in 2018 agree that there is a high level of unmet need for PMH treatment, including many participants who are diagnosed but go untreated, or are not diagnosed/detected as experiencing a PMAD at all. The persistently high percentages highlight that, despite advances in PMAD screening, referral and treatment since 2015, providers across D.C. still see large gaps in service treatment of women with perinatal mental health concerns and availability of treatment resources.
- **Access to/availability of culturally appropriate PMH resources**: Without mental health services that are equipped to serve the language, cultural, transportation, and other unique needs of the community they are serving, campaigns to increase awareness and decrease stigma are null.
- **Strengthen the behavioral health system of care in the hospital/community health setting** (only ~18% of mental health respondents work in those settings, and 50% work in private practice)
- Now that there is greater general knowledge on PMADs across all three populations, providers are calling for **more advanced and focused trainings that are specific to their particular work setting and participant populations, specific interventions, and which provide CEU's**. Future training efforts should focus on deeper content, facilitating a more specialized form of care that providers are eager to provide.
- Continue **in house organizational training**, **Mary's Center (or comparable) sponsored trainings, grand rounds, and offering opportunities for medical students to engage in perinatal mental health as part of their academic work**, as these are primary sources of perinatal mental health education/training for a variety of profession types.
- The D.C. **PMH Champions and DMV Women's Mental Health Consortium** groups were the most frequently noted collaborative/taskforce opportunities respondents participated in, so maintaining these opportunities is crucial to continued cross-city collaboration to strengthen the perinatal mental health system of care. It is also crucial to note that if Mary's Center is not offering the dedicated trainings that it did in 2015-2016, training roughly 1,400 people, there is a large void for training this large of a number of interdisciplinary providers, so developing an ongoing and sustainable mechanism for training city providers is essential.
- Opportunities to **strengthen interdisciplinary collaboration/communication and provider lack of time, to support linkage with care** (referral and follow up), addressing the latter could include **updated/improved screening protocols**, **expanded coding/billing, and further PMH training.**
    - Without clear communication between the referring provider and the mental health provider receiving the referral, it is impossible to pinpoint at which point in the referral-to-treatment pipeline participants are falling through the cracks, and why experienced mental health providers are not seeing more PMH participants.
- Providers can most successfully engage with perinatal women around their emotional health through **use of a screening tool AND direct conversation/dialogue to include psychoeducation**

and information about supports/services, and support with scheduling a first mental health appointment

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