DC PERINATAL MENTAL HEALTH IMPACT EVALUATION: 2015-2018

Report: Professional Perspective Surveys

Mary's Center Maternal Mental Health Program
Report Written by Masters Public Health/Social Work intern November 2018 and reviewed by Mary's Center staff Spring 2019

Executive Summary: D.C. Perinatal Mental Health Impact Evaluation: 2015-2018

In 2015, a Perinatal Mental Healthcare Needs Assessment was conducted by partners from Mary's Center and the D.C. Collaborative for Mental Health in Pediatric Primary Care, to determine gaps in programming, training, organizational capacity, and advocacy pertaining to perinatal mental health (PMH) in Washington, District of Columbia (D.C.)

Over the past three years, the Mary's Center Maternal Mental Health (MMH) Program and partnering stakeholders have planned and implemented a wide range of activities to meet those needs identified in the 2015 Needs Assessment, including (but not limited to) community-wide perinatal mental health training for medical, mental health and allied professionals, a billing expansion project to expand perinatal mental health screening coverage in medical clinics, and the creation of an interdisciplinary "Perinatal Mental Health Champions" training and working group.

During the course of 2018-2019, an impact evaluation is being conducted by Mary's Center, through the support of the Howard & Geraldine Polinger Family Foundation, to evaluate how the various perinatal mental health-related activities from 2015-2018 have changed the landscape of screening, referral and treatment for perinatal mood and anxiety disorders in D.C., highlighting both successes and remaining gaps in meeting the mental health needs of perinatal women in the District.

Evaluation Design

A cross-sectional impact design is being used for this evaluation. Data collection consists of three separate evaluation activities, including professionals and participants[1], to be completed by June 2019. **This report presents key findings from the professional survey data collection.**

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

Professional Surveys Report

Research Questions

1. What are the beliefs, knowledge and practices of professionals across D.C. related to PMH screening, referral, treatment, and collaboration?
    - What are the biggest barriers to care for participants with PMH concerns?
    - What specific supports are needed to improve care of participants with PMH concerns?
2. What D.C. PMH-related activities have professionals participated in over the past 3 years? How have these activities impacted their screening, referral, and treatment practices?

Methods

Sample

In the 2015 Perinatal Mental Healthcare Needs Assessment, three surveys were used to collect data on attitudes, beliefs and clinical practices regarding perinatal mental health (n=132). The surveys targeted pediatric providers (n=45), non-pediatric "health care providers" (n=44), and mental healthcare providers (n=43) separately, and participants self-selected into the appropriate survey based on profession. In an effort to capture a wider variety of stakeholder perspectives, the survey categories were re-created for this impact evaluation.

Several meetings with key perinatal mental health stakeholders in the DC community were held to identify possible categories, as well as individuals that would fall under those categories. Ultimately, three professional surveys were developed to target the following populations:

- **Medical Professionals:** OB/GYN, Pediatrics, Primary Care, Psychiatry, and any other medical specialties that interact with perinatal women
- **Mental Health Professionals**: Medical Doctor (MD), Doctor of Philosophy (PhD/PsyD), Licensed Clinical Social Worker (LICSW), Licensed Professional Counselor (LPC), Marriage and Family Therapist (MFT), and other any other mental health professionals that interact with perinatal women
- **Allied Professionals:** Doulas, case manager/coordinators, yoga instructors, researchers, policy/programming professionals, educators, and any other professionals that interact with perinatal women

Sample Implications

It is important to note some implications of the 2018 professional survey sample size and reach. The 2015 needs assessment specifically targeted medical and mental health providers. The smaller sample size of 2015 produced data from professionals more closely associated with the Mary's Center MMH Program and key partnering PMH organizations who, as a whole, were more knowledgeable and well-trained in PMH. The 2018 impact evaluation widened the target sample to include non-clinical and other "allied" professionals that do not work directly with perinatal participants, resulting in a more diverse pool of experiences and knowledge which is reflected in the data. When reading this report, particularly in sections that compare impact evaluation data to data from the 2015 needs assessment, it may be helpful to keep these differences in sample size and diversity in mind.

Survey Instruments

The surveys were developed and revised over several successive steps. First, specific questions were identified from the 2015 Perinatal Mental Healthcare Needs Assessment to be adapted for use in the impact evaluation. Additional questions were then drafted to collect information such as involvement in PMH-related activities since 2015. The Allied Professionals survey was created by tailoring the 2018 Mental Health and Medical survey questions to apply to non-clinical professions.

Feedback and input from a range community partners was elicited and incorporated throughout the creation of the survey. Those involved included program staff from the Children's National Health System's Child Health Advocacy Institute (CHAI), the GW 5 Trimesters Clinic, Georgetown Women's Mental Health Clinic, local doulas and programming staff from Mary's Center.

After incorporating stakeholder feedback, the surveys were transferred into a web-based survey format using the Survey Monkey platform. The three surveys were comprised of relevant demographic and work history questions, Likert-scale measurements to assess strength of beliefs and opinions on PMH practices, and open-ended questions to elicit qualitative data on trends in PMH over the past three years.

Dissemination

Through conversations with local PMH stakeholders, key professionals were pinpointed to help with survey dissemination. Specifically, people with access to listservs/email groups containing PMH professionals were targeted. The list of stakeholders who assisted with the 2015 needs assessment dissemination served as valuable source of contacts, as it allowed some of the same participants to be targeted for the impact evaluation. After drafting a comprehensive list of potential disseminators, an email was sent out explaining the impact evaluation and requesting assistance. Ultimately, 18 people from a wide variety of organizations in DC agreed to disseminate the survey through their networks.

The email requesting survey participation included a brief description of the impact evaluation and a prompt instructing respondents to self-select into the appropriate survey based on their profession. Participation was incentivized with the chance to win a $50 gift card. To encourage survey participation, participants were provided reminder emails at several scheduled time points, as indicated on the timeline below.

<u>Timeline:</u>

August 24	Distributed surveys
September 4	Sent first reminder email
September 10	Sent second reminder email
September 13	Sent final reminder email
September 14	Closed surveys; data collection complete

Data Protection

All questions eliciting identifying information (such as name) were optional. All identifying information was separated from the data prior to data analysis to ensure confidentiality.

Results

Participants

The survey yielded a total of 311 responses, including 107 medical, 120 mental health, and 84 allied professional responses. Participants worked in a wide range of professional roles, with the majority of medical respondents working in hospital and community health settings (35.5% and 40.2%, respectively) and mental health respondents working in private practice and community health settings (48.3% and 18.3%, respectively). The Allied Professionals Survey was completed by case managers/coordinators (n=18), doulas (n=11), programming professionals (n=9) educators (n=6), policy professionals (n=2), a yoga instructor, a researcher, and 36 respondents who identified "other" professions including home visitor (n=11), lactation consultant (n=2), peer recovery specialist, chaplain, childbirth education, massage therapist, and nutritionist, among others. Participant credentials/specialties for each survey can be found in Tables 1A-1C.

Of all respondents, medical providers served the highest percentage of perinatal women, with 35.4% reporting a participant load of 75-100% perinatal women. The majority of mental health and allied professionals did not primarily serve the perinatal population, with 56.8% of mental health and 34.7% of allied respondents reporting a caseload of 0-25% perinatal women. 39.4% of all respondents (40.4% of medical, 40.5% of mental health, and 37.3% of allied professionals) reported a caseload of between 25% and 75% perinatal women (see Table 2).

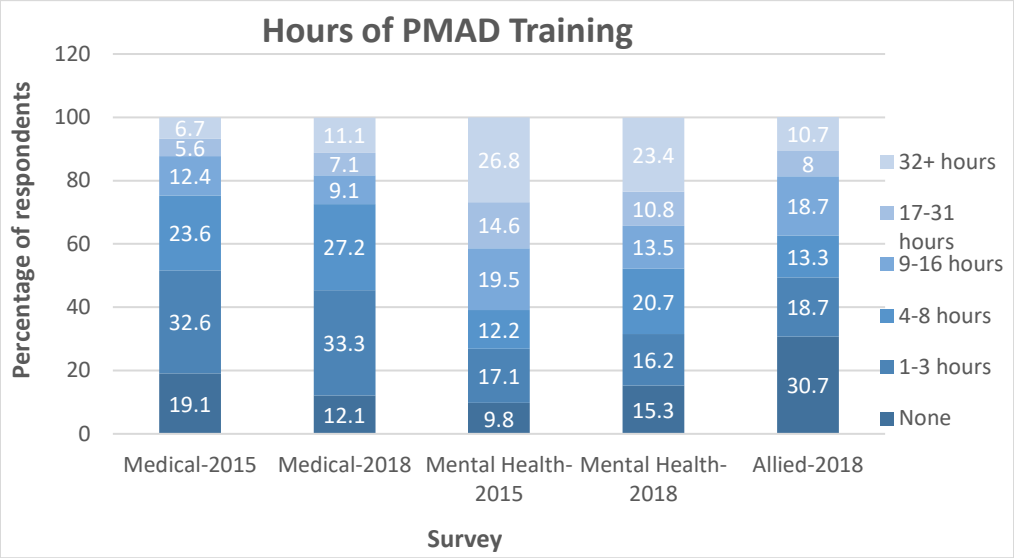
In the beginning of each survey, respondents were asked if they completed the 2015 needs assessment survey. Only 23 participants (7.4%) indicated that they had completed the needs assessment. Ninety one participants could not recall whether or not they had completed it (29.3%), and 197 indicated that they did not complete it (63.3%). Of the 23 that completed the needs assessment survey, 7 were medical providers, 13 were mental health providers, and 3 were allied professionals.

Training

Participants were asked about their level of formal training in perinatal mood and anxiety disorders (PMADs). 12.1% of medical, 15.3% of mental health and 30.7% of allied respondents reported no training. The majority of medical providers reported having between 1 and 8 hours of training (60.1%). Mental health providers had the most training, with 23.4% reporting over 32 hours of training compared to only 11.1% of medical and 10.7% of allied professionals. Allied professionals reported a noteworthy amount of PMAD training. Over one-third (37.3%) of allied professionals reported having 9+ hours of training as compared to only 27.3% of medical providers. See Table 3 for the breakdown of training hours by survey.

In the 2015 needs assessment, 19.1% of medical providers (pediatric and non-pediatric "health care" respondents combined) and 9.8% of mental health respondents had no formal PMAD training. The majority of mental health providers reported at least 9 hours of training (61.0%) compared to only 24.7% of medical providers. When compared to the data from the impact evaluation, these percentages suggest an improvement in PMAD training for medical providers. While mental health providers appear to be less trained in 2018 than in 2015, this may be attributed to the larger sample size and wider breadth of mental health professionals reached in the impact evaluation as compared to the needs assessment. See Figure 1 for an illustrative comparison of PMAD training hours for respondents of the 2015 needs assessment and 2018 impact evaluation.

Figure 1. Hours of PMAD Training, by Survey



Training Types

Respondents were asked to select all types of training/education in which they learned about PMADs. The primary source of PMAD training differed between the professional fields. 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 received their PMAD education primarily from local trainings in D.C. (46.9%) and organizational/"in house" training (46.9%). Local trainings also served as a source of PMAD education for allied professionals (33.3%) and medical providers (26.3%). Respondents from all three surveys indicated online training as an additional source of PMAD education (16.2% medical, 25.2% mental health, and 21.3% allied professionals). "Other" sources of PMAD training indicated by respondents included personal research/work experience (n=9), professional consultation or supervision with a perinatal mental health professional (n=4), Postpartum Support International seminars/conferences (n=4), and medical Residency education (n=4). See Table 4A for a tabulation of training types by survey.

Involvement in PMH Activities

Participants were asked to describe their involvement with PMH-related training, collaboration, advocacy and other programming initiatives since 2015. They were provided the D.C. PMH Activity Timeline for examples (see Appendix A). Across the board, trainings and collaboratives/taskforces were the most reported PMH activities. The most frequently mentioned trainings were Mary's Center PMH trainings and PSI trainings. A large range of collaboratives/taskforces were mentioned, including the DMV Women's Mental Health Consortium, the PMH Champions group, ECIN, Early Childhood and Family Mental Health (ECFMH subcommittee), and DC MAP. The D.C. PMH Champions and DMV Women's Mental Health Consortium groups were most frequently noted, and the DMV Women's Mental Health Consortium was the only group mentioned in all three surveys. Allied respondents reported a wide range of involvement in policy/advocacy initiatives, including an EPDS screening project, the creation of a PMH toolkit for Pediatric Primary Care Providers, the launch of organization-wide MMH screening goals (Children's National Health Center), and advocacy for the creation of a MMH Taskforce. Mental health respondents frequently mentioned collaboration with the Mary's Center MMH Program, and

allied professionals mentioned collaboration with the Zero to Three Healthy Steps program. See Table 4B for a breakdown of D.C. PMH activity involvement, by survey.

Experience and Knowledge

Mental Health Providers

Mental health providers were asked to rate their level of experience providing perinatal mental health care on a scale of "I have no experience" to "I am an expert". 7.2% of respondents reported having no experience, 14.2% had "little" or "some" experience, 36.0% had "sufficient" experience, and 14.4% considered themselves an "expert" in perinatal mental health (see Table 5A). When asked in the 2015 needs assessment about their experience level, 63% of mental health providers considered themselves an "experienced provider of perinatal mental health care". Compared to the 50.5% of the 2018 impact evaluation respondents that reported "sufficient" or "expert" level experience, mental health providers that completed the needs assessment appear to have been either more experienced or more confident in their experience in PMH care. This may also be attributed to the larger sample size and wider breadth of mental health providers included in the impact evaluation sample, as well as the change in language from "experienced provider" to "expert".

Mental health provider experience was stratified by caseload of PMH participants to explore the relationship between experience level of the providers and the number of PMH cases they are seeing (see Table 5B). 50.5% of all survey respondents reported sufficient or expert level experience in PMH (n=56). Out of those respondents, only two reported a weekly caseload of 75-100% PMH participants (3.57%), and only twelve (21.4%) reported a caseload of 50-75% PMH participants. The majority of respondents with sufficient or expert-level experience reported a caseload of 25-50% (39.3%, n=22) or 0-25% (35.7%, n=20) PMH participants. The low percentage of experienced providers seeing PMH participants could be the result of a number of barriers, including lack of referrals, barriers preventing participants from seeking treatment, billing challenges, and others. These barriers will be explored further throughout this report.

Allied Professionals

Allied professionals were asked how strongly they agree with the statement "I have a good understanding of PMADs (prevalence, signs/symptoms)" on a scale from "strongly disagree" to "strongly agree". Over half of respondents agreed (51.5%), and 21.2% strongly agreed that they have a good understanding of PMADs. Only 7.6% disagreed, and even fewer strongly disagreed (3.0%). They were also asked if they would know where to refer someone experiencing PMAD concerns/symptoms. The vast majority either agreed or strongly agreed that they would know where to refer (77.3%). See Table 6 for a breakdown of allied professional PMAD knowledge.

Medical Providers

Medical providers were asked a series of questions assessing their comfort level with addressing PMADs with their patients. 72.9% of respondents either agreed or strongly agreed that they are comfortable assessing the PMH needs of their patients. 70.8% agreed or strongly agreed that they are comfortable starting a conversation about PMH treatment options with patients, and 74.0% agreed or strongly agreed that they are comfortable assisting patients in obtaining care via referrals or patient advocacy (see Table 7).

Compared to the 2015 needs assessment data, these numbers show a notable increase in confidence from medical providers in addressing PMAD concerns with their patients. Only 38.2% of medical

providers either agreed or strongly agreed that they were comfortable assessing the PMH needs of their patients in 2015. A higher percentage felt prepared to support perinatal mental health needs by providing referrals (68.5%), however, that percentage has increased to 74.0% of medical providers in the impact evaluation.

Beliefs

All respondents were asked to rate their current beliefs on PMAD diagnosis and treatment in D.C. The vast majority of respondents either agreed or strongly agreed that there is a high level of undiagnosed/undetected perinatal mental illness (86.5% medical, 90.2% mental health and 84.8% allied professionals), and that many participants who are diagnosed with perinatal mental illness go untreated (86.5% medical, 92.2% mental health, 83.3% allied professionals). There was also 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 agreed or strongly agreed that there are adequate perinatal mental health services available, while 67.0% of medical, 68.8% of mental health, and 54.8% of allied professionals disagreed or strongly disagreed (see Table 8). In the 2015 needs assessment, 89.9% of medical providers and 86.0% of mental health providers either agreed or strongly agreed that there is a high level of unmet need for perinatal mental health treatment. These percentages highlight that, despite advances in PMAD screening, referral and treatment since 2015, professionals across D.C. still see gaps in service availability that need to be addressed.

Referral

Medical and Allied Professionals

Medical and allied professional participants were asked a series of questions about referral of participants with PMAD symptoms. At the time of the survey, 73.5% of medical and 36.0% of allied respondents had identified someone at risk of or experiencing a PMAD in the past month. Of those respondents that identified an at-risk woman, 87.5% of medical and 92.6% of allied professionals referred the participant for mental health support services. Those that responded "yes" to referring a participant to mental health services were then asked if that participant received treatment. 46.0% of medical and 52% of allied professionals indicated "yes", the participant *did* receive treatment, and 6.4% of medical and 16.0% of allied professionals indicated "no", the participant did *not* receive treatment (see Table 9). Respondents that selected "no" had the option of sharing why that participant did not end up receiving mental health services. Of the three medical respondents that answered this question, two indicated that the participant symptoms resolved on their own, and one named the participant's status as an uninsured, undocumented immigrant as the barrier to treatment. The allied professional respondents described mistrust of mental health providers, lack of support group services in Spanish, transportation and lack of childcare as the reasons their participants did not engage in mental health services.

A third response of "unsure" was given as an option to capture those professionals that referred for treatment but either did not follow up with, or, did not receive follow-up communication from the mental health organization/provider referred to. Almost half of medical providers that referred a participant for PMH services indicated that they were unsure of if the participant received the referred services (47.6%). 32% of allied professionals also responded that they were "unsure" if the participant received mental health services (see Table 9). See Appendix B for a visual representation of the proportion of participants who were referred and received mental health treatment.

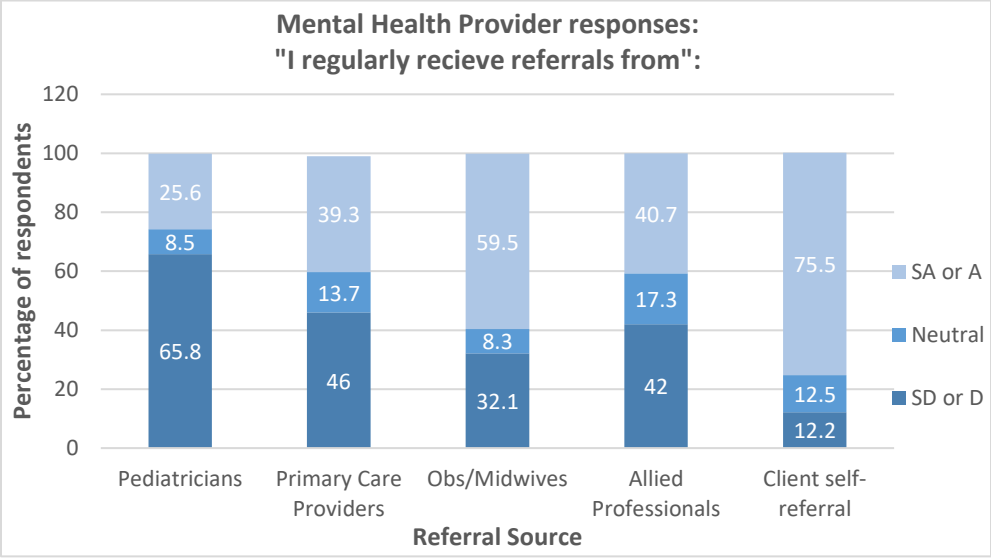
Medical providers were asked which mental health providers they refer their perinatal participants to. The top 3 organizations who were noted as utilizing in house referrals and receiving external referrals are listed below. See Appendix C for a full visual representation of where medical providers refer.

- Top 3 organizations with highest number of in-house referrals- Mary's Center (11), Children's National Health System (8), Unity Healthcare (7)
- Top 3 organizations with highest number of referrals received from external entities- Mary's Center (8), George Washington (GW) 5 Trimesters Clinic (7), Georgetown University Hospital (4)

Mental Health Providers

Mental health providers were given a list of referral sources and asked to indicate on a scale of "strongly disagree" to "strongly agree" whether they regularly receive referrals from each source. The majority of providers agreed or strongly agreed that they receive referrals from participant self-referrals (75.5%) and OBs/midwives (59.5%). 40.7% of mental health providers agreed or strongly agreed that they receive referrals from allied professionals. A majority either disagreed or strongly disagreed that they regularly receive referrals from pediatricians (65.8%), and almost half disagreed or strongly disagreed that receive referrals from primary care providers (46.0%). See Figure 2 for an illustration of PMH referral sources for mental health providers.

Figure 2. **Mental Health Provider PMH Referral Sources**



Collaboration

All participants were asked about their collaboration with other PMH professionals. Medical respondents were asked how strongly they agreed with the statement "I have a collaborative relationship with mental health professionals to whom I can refer my perinatal patients when needed". 66.7% either agreed or strongly agreed. In contrast, only 39.2% of mental health providers agreed or strongly agreed that they have a collaborative relationship with the medical providers of the perinatal women that they serve. 66.7% of allied professionals agreed or strongly agreed that they have a collaborative relationship with other professionals or organizations serving women with PMH concerns (see Table 11).

Obstacles/Barrier to Care

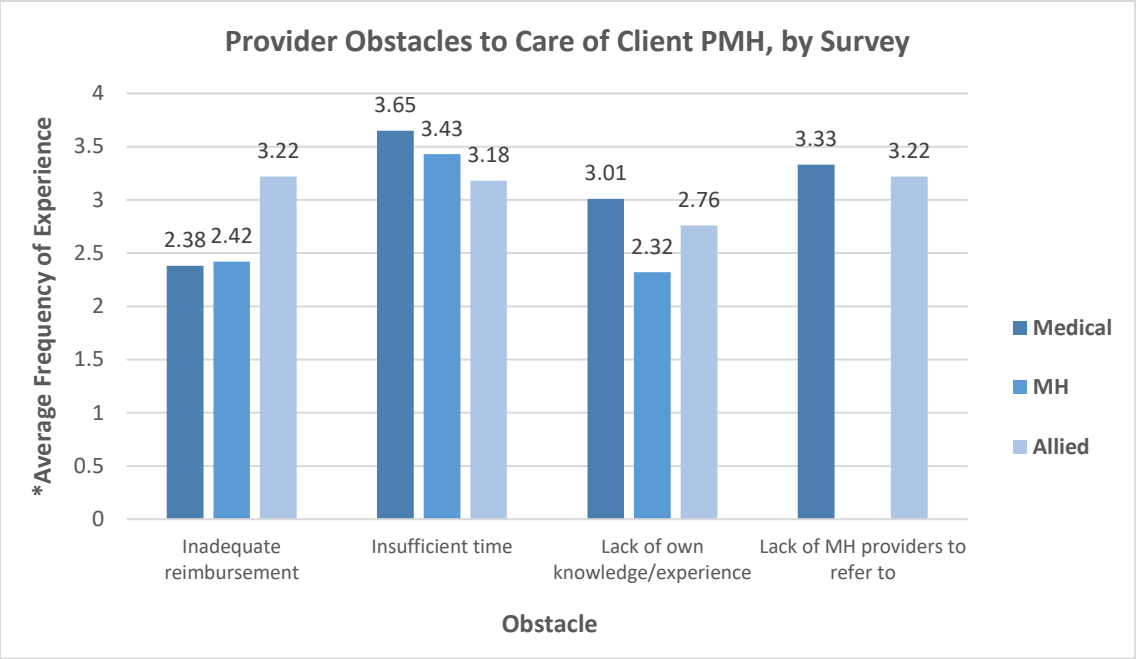
Provider Barriers

Respondents to all three surveys were asked to indicate the frequency in which they encountered obstacles to caring for women with perinatal mental health concerns. Responses ranged from Never (1) to Very Frequently (5). The barrier that was reported as most frequently encountered, on average, was insufficient time (3.46). Medical providers and allied professionals reported lack of mental health providers to refer to as the next most frequently encountered obstacle (3.28). Inadequate reimbursement and lack of own experience, training and/or knowledge were both reported, on average, as an obstacle encountered only occasionally (2.62 and 2.69, respectively). See Table 12 for the frequencies and averages of each variable, by survey.

Respondents were given the option of selecting "other barrier" and providing an explanation. Other barriers expressed by medical providers included lack of follow-up from mental health providers after referring a patient, lack of mental health providers/waitlists for services (n=3), and lack of mental health providers that accept private insurance. Mental health providers listed difficulty connecting with /lack of clear communication with medical providers (n=7), HIPPA (Health Insurance Portability and Accountability Act), participant fear of mistreatment from providers, and lack of role definition for pediatric providers as additional barriers to their care of perinatal participants. No allied professionals offered "other barriers". See Figure 3 for an illustration of the average frequencies of encountering each type of barrier, by survey.

In the 2015 needs assessment, participants were asked to rank obstacles to patient care in order of most (5) to least (1) hindering. Inadequate reimbursement was reported as the most frequently encountered obstacle by both medical providers (3.4) and mental health providers (3.1). The fact that inadequate reimbursement has fallen to a less frequently reported barrier to PMH care by both medical and mental health providers in the 2018 impact evaluation data suggests success in billing/reimbursement expansion for PMH screening and referral since 2015.

Figure 3. Provider Obstacles to Care of Participant PMH, by Survey



**Averages calculated based on the following response scale: N: Never (1), R: Rarely (2), O: Occasionally (3), F: Frequently (4), VF: Very Frequently (5), N/A: Not Applicable; Percentages of "N/A" responses are not included in mean calculations. See Table 12.*

Participant Barriers

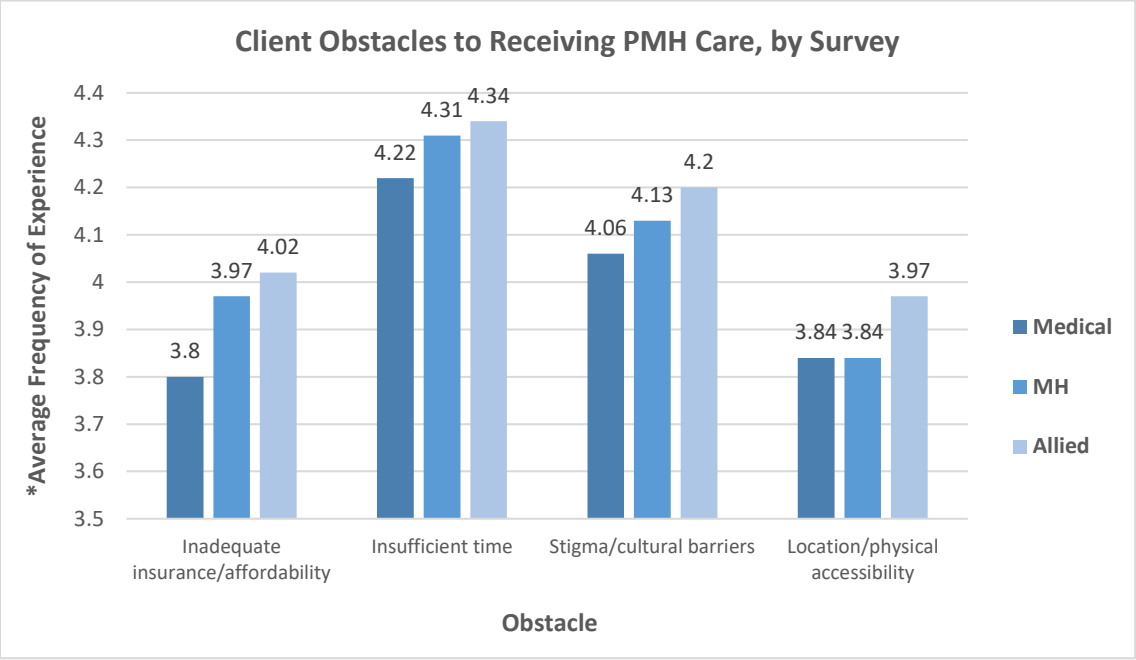
Respondents to all three surveys were asked to indicate the frequency in which they think their participants encounter obstacles that hinder them from accessing PMH treatment. Responses ranged from Never (1) to Very Frequently (5). The barriers that were reported as most frequently encountered by participants, on average, were insufficient time (4.29) and stigma/cultural barriers (4.12). Inadequate insurance coverage/difficulty affording services and location/physical accessibility of treatment were both reported as obstacles experienced frequently by participants (3.92 and 3.87, respectively). See Table 13 for the frequencies and averages of each variable, by survey.

Respondents were given the option of selecting "other barrier" and providing an explanation. Other barriers expressed by medical providers included lack of providers/waitlists for services (n=6), need for assistance in navigating the referral process, language barriers, and lack of motivation. Mental health providers listed fear, competing priorities, lack of childcare, work conflicts, language barriers (n=2), lack of screening/diagnosis, and lack of providers that accept insurance as additional barriers. One obstacle that came up repeatedly by mental health professionals as an "other barrier" is lack of participant knowledge on PMAD signs/symptoms, leading them to believe that their experience is "normal" (n=6). Allied professionals echoed other barriers listed by medical and mental health professionals, including availability of resources/long wait time for services, language barriers, and lack of childcare.

In the 2015 needs assessment, the most commonly cited barrier (70%) was "time/other life demands getting in the way", followed closely by stigma/cultural barriers (68%), and financial issues (62%). Insufficient time and stigma/cultural barriers remain frequently experienced obstacles in the needs

assessment (2.5 and 2.75, respectively, with 1 being frequently experienced and 6 being low) as in the impact evaluation (4.29 and 4.12, respectively, with 5 being frequently experienced and 1 being low). Financial reasons remain an obstacle as well in 2018 (3.92), as well as location/physical accessibility (3.87). See Figure 4 for an illustration of the average frequencies of encountering each type of participant obstacles to care.

Figure 4. Participant Obstacles to Receiving PMH Care, by Survey



**Averages calculated based on the following response scale: N: Never (1), R: Rarely (2), O: Occasionally (3), F: Frequently (4), VF: Very Frequently (5), N/A: Not Applicable; Percentages of "N/A" responses are not included in mean calculations. See Table 13.*

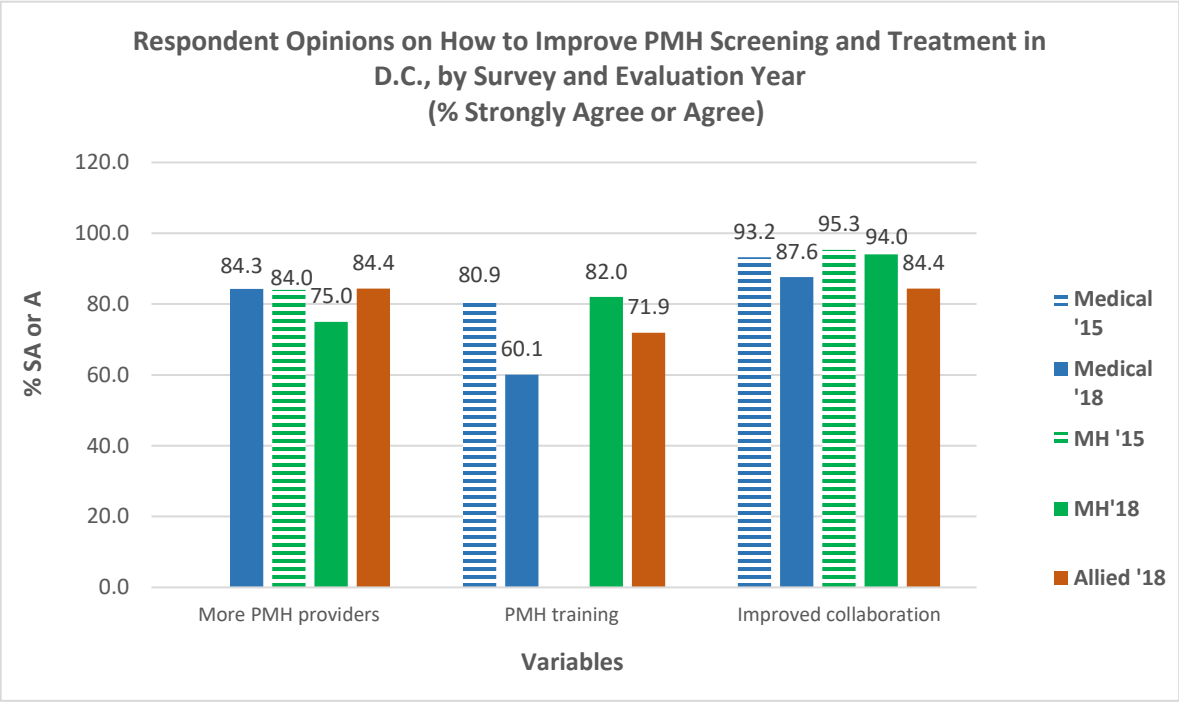
How to Improve

Quantitative Data

All respondents were asked to rate a series of statements on how to improve PMAD screening and treatment in D.C. from "Strongly Disagree" to "Strongly Agree". The majority of respondents from all three surveys agreed or strongly agreed that there is a need for improved collaboration between medical, mental health and allied professionals (89.3%), and that there is a significant need for more PMH providers in the D.C. area (80.6%). There was also strong consensus that receiving PMH training would increase respondent likelihood of screening and providing referrals for perinatal women in need (71.9%). Medical providers were asked to rate two additional statements on how to improve screening and billing. 48.3% agreed or strongly agreed that updated/improved screening protocols are necessary to increase support of PMH, and 40.4% agreed or strongly agreed that expanded coding/billing would greatly increase their likelihood of screening and referring perinatal women in need. See Table 14 for the breakdown of ratings for each statement on how to improve perinatal screening and treatment in D.C., by survey.

Respondents of the 2015 needs assessment were asked to rate similar statements on how to improve perinatal screening and treatment in D.C. In 2015, 84.0% of mental health providers agreed or strongly agreed that there is a significant need for more PMH providers in the D.C. area. In the 2018 impact evaluation, only 75.0% of mental health respondents agreed or strongly agreed to that statement. Percentages of medical and mental health respondents that agreed or strongly agreed to the need for improved collaboration were high in 2015, and remained high in 2018, with 93.2% of medical and 95.3% of mental health providers agreeing or strongly agreeing in 2015, and 87.6% of medical and 94.0% of mental health providers agreeing or strongly agreeing in 2018. In 2015, 80.9% of medical providers from the pediatrics and non-pediatric "health care" needs assessment surveys agreed or strongly agreed that receiving PMH training would increase their likelihood of screening, compared to only 60.1% of medical respondents in the 2018 impact evaluation. This decrease follows a trend seen throughout the impact evaluation data in which medical providers appear to be better trained in PMH in 2018 compared to 2015, and consequently identify less of a need for training to improve their care of perinatal patients. Figure 5 illustrates respondent opinions on how to improve perinatal screening and treatment in D.C., by survey and evaluation year (2015 vs. 2018).

Figure 5. Respondent Opinions on How to Improve PMH Screening and Treatment in D.C., by Survey and Evaluation Year (% Strongly Agree or Agree)



**Respondents of all three 2018 Impact Evaluation surveys (medical, MH and allied) were asked to rate all three statements on improving PMH screening and treatment in D.C., whereas respondents from the 2015 Needs Assessment were asked to respond to select statements based on their survey (i.e. MH respondents weren't asked about PMH training in 2015, medical respondents weren't asked about need for more PMH providers in 2015, etc.)*

Qualitative Data

Respondents were given the option of choosing "other" in response to the question "Please rate the following statements on how to improve perinatal screening and treatment in D.C. area," and to provide additional areas in need of improvement. They were also given two open-ended questions at the end of the survey, "What other specific types of support would enhance your care of PMH concerns?" and "Is there anything else you would like us to know about the mental health needs of women in our area?" to elicit more qualitative information about the state of PMH care in the DC area and how to move forward. The following are themes that arose in the thematic coding of these open-ended questions.

Availability of Accessible, "Culturally Competent" Services

The theme that arose most frequently in the 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 surveys as an area in great need of mental health services. Further, respondents in the medical, mental health and allied professional surveys mentioned lack of "culturally competent" services as an accessibility issue. One mental health provider noted, "Women of color remain considerably undeserved and devalued in

our community. Training and outreach should include clinicians of color, LGBTQ, differently-abled persons; our outreach should mirror the faces of our clients". An allied professional made a similar comment, arguing that, "We need providers of color who are socially and financially supported by the broader community so they can provide services to their community for an extended period of time." Respondent comments on training mirrored the sentiment for more culturally competent services, with the following specific training suggestions made: stigma and values clarification training (medical provider), "culturally appropriate" PMH training (medical provider), training on PMH issues and trans/genderqueer people (mental health provider), and cultural sensitivity training (allied professional).

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. Creative suggestions were given to mediate some of these barriers to access, including in-home PMH services (medical, mental health and allied professionals), peer support groups for women in their own communities (medical, mental health and allied professionals), and "non-traditional" services such as telemedicine, online and texting interventions (mental health).

Specific populations were named as groups in need of more targeted, accessible mental health services. These included families, fathers, teen mothers, uninsured women, and immigrants. Other service needs identified by mental health providers included support for perinatal loss and out of school support for children. Medical providers identified a need for more perinatal substance abuse and smoking cessation services.

Billing/Insurance

Professionals from all three surveys identified some variation of the need for more mental health providers that accept private insurance, Medicaid/Medicare, or serve uninsured women. Mental health providers specifically mentioned the need for reproductive psychiatrists that take insurance. Multiple mental health professionals suggested implementing policy that incentivizes PMH screening in medical settings, and one suggested an "alternative payment model" to support the integration of PMH providers into medical settings.

Training/Education

Training/education needs and suggestions were the second most mentioned theme in the qualitative data. Mental health professionals called for more accessible trainings that provide CEUs and that provide more advanced information on specific interventions. They also noted the opinion that pediatricians and OBs need more PMAD training, and that medical providers need a better understanding of medications during the perinatal period. Medical providers mentioned their own need for training on medication safety in the perinatal period, along with "setting specific" PMH training, training on screening/billing protocol, and training on how to speak to participants about PMH. One medical provider stated that, "We need to begin training early in Medical, Nursing and other allied health schools to change our perception of mental health." Allied professionals spoke to the need for more knowledge on available PMH support resources in the community, and the need for more participant education in the OB setting early in pregnancy.

Collaboration

Both mental health and medical providers noted the need for improved collaboration between the two fields. The need for a comprehensive and accessible list of providers that specialize in PMH was noted from both groups. Additionally, medical providers highlighted a need for easier access to perinatal psychiatrists for consultation, and quicker follow-up after referrals are made. Mental health providers stated a need for more "involvement" from pediatricians and OBs in the care of perinatal mental health concerns.

Screening/Referral Processes

The need for improved and clearer screening protocol was noted from multiple medical and mental health providers. This included standardized screening protocol for pediatricians, primary care providers and OBs (mental health provider), and the need for substance abuse screening protocol (medical provider). One medical provider highlighted the need for "culturally validated screening methods", and improved follow-up from mental health providers to the referring providers after receiving a referral. Mental health providers also mentioned the need for improved referral processes, and specifically, more direct referrals from medical providers (as opposed to instructing participants to call insurance first). One suggestion was made by a medical provider to use computerized screening tools in waiting rooms. Another medical provider called for a task force to be formed to create improved translations of the EPDS in Spanish, Amharic and French.

Discussion

Strengths and Successes

PMAD Training

PMAD training was identified as a great need by perinatal professionals in the 2015 needs assessment. Over the last three years, training initiatives have been implemented across D.C. 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 faced less frequently by medical professionals in 2018 than in 2015, and allied professionals reported it as a barrier experienced only "occasionally" in 2018. Medical professionals indicated notably higher rates of PMAD training in 2018 than in 2015. Now that there is greater general knowledge on PMADs across all three populations, providers are calling for more focused trainings that are specific to their particular work setting and participant populations. For example, one medical provider requested training on PMH care for transgender and queer participants, as they have their own unique set of needs and barriers to care. Future training efforts should focus on deeper content, facilitating a more specialized form of care that providers are eager to provide.

Increase in Medical Provider Confidence and Capacity

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. 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. 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.

While the survey data shows an overall increase in provider confidence and ability to address PMADs with participants, there are still areas for improvement. One-third of mental health professionals disagreed or strongly disagreed that they regularly receive referrals from pediatricians, and almost half disagreed or strongly disagreed that they regularly receive referrals from primary care providers. While many initiatives over the past three years have focused on building capacity to increase referral rates from these providers, the data suggests that there is still work to be done.

An Expanded Network of Professionals

While the larger and more diverse sample size of this evaluation may have skewed some of the data points (such as the mental health provider population appearing less experienced in 2018 despite increased training), it illuminates an important accomplishment. The reach of this evaluation shows an expanded network of professionals that are connected to perinatal mental health work, an observed impact of the incredible PMH initiatives completed across the District since 2015.

The group that best represents this accomplishment is the allied professionals. Throughout this evaluation, they stand out as instrumental gatekeepers to PMH care in our community. The majority of allied survey respondents were well-trained in PMADs, comfortable with referring, and were involved in a wide range of PMH activities across the District over the past three years. Almost half of mental health providers reported regularly receiving PMH referrals from allied professionals, a percentage that is higher than both primary care and pediatrician referrals. This speaks to the success of initiatives such as the PMH Champions project that intentionally targeted allied professionals for training in perinatal mental health, using their networks and expertise to reach more people in need of PMH services. Moving forward, allied professionals should continue to be regarded as key stakeholders in improving perinatal mental health in D.C., and included in policy and programming planning

Barriers and Areas of Improvement

Lack of MH Providers, Communication, and Referrals

Over half of the mental health providers that took the survey reported sufficient or expert-level experience in PMH, but only one-fourth of those respondents had a caseload of over 50% PMH participants. Lack of mental health providers to refer to was identified as the biggest barrier to assisting participants with PMH concerns by both allied and medical professionals. Allied and medical professionals want more mental health providers to refer to, and the majority of mental health providers who are experienced in PMH aren't seeing a high percentage of participants with PMH concerns. Why aren't those mental health providers seeing more PMH participants? There may be a number of answers to this question as identified in the survey data.

For mental health professionals, lack of time and clear communication with medical providers were identified as the two biggest barriers to care for PMH participants. Lack of time could mean a number of things for mental health professionals: overwhelming caseloads, an inability to take on new participants, an inability to take on exclusively PMH participants. Unfortunately, a clearer explanation of "lack of time" as a barrier for mental health providers did not materialize in the survey data, however, some light was shed on the lack of clear communication with medical providers.

Only one-third of mental health providers agreed or strongly agreed that they have a collaborative relationship with the medical providers of the perinatal women that they serve. In contrast, two-thirds

of medical respondents either agreed or strongly agreed that they have a collaborative relationship with mental health professionals. This contrast in perception points to some miscommunication between mental health and medical providers. Another indicator of miscommunication between all three parties is that the majority of allied and medical professionals that referred a participant to PMH services in the month prior to taking the survey were unsure if that participant ended up receiving services. 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.

Improved communication, collaboration and referral processes were identified as a strong need in all three 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.

Participant Barriers

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, and addition to a theme that holds over from 2015 of time/other life demands getting in the way, and financial issues. 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. Without mental health services that are able 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.

Conclusion

This needs assessment provides a broad overview of the state of perinatal mental healthcare in D.C. in 2018, illustrating successes in improving PMH care since 2015. It highlights strengths in training and education, medical provider confidence, and an ever-broadening network of professionals who are involved in a wide range of activities to improve PMH. It also brought forth areas in need of improvement: clearer communication and referral processes, more PMH providers to refer to, culturally-specific and accessible services in areas currently going without. While valuable information was gleaned from these surveys, there are complicated challenges to improving perinatal mental health care that can't be fully understood through this survey data, or through the perspective of one population, in isolation. In order to fully illustrate the context of perinatal mental health in D.C., this report should be reviewed along with the other data collection activities for the 2018 D.C. Perinatal Mental Health Impact Evaluation, which focus on the participant perspective. Combining the experiences of medical and mental health providers, allied professionals and perinatal women will allow for a more complete story to be told, paving the way for more effective steps toward improved perinatal mental health in the District of Colombia.

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Appendices

Appendix A

D.C. Perinatal Mental Health Programming, Capacity Building and Advocacy Activities Timeline: 2015-18

ACTIVITIES	PRIMARY ORGANIZER	2015	2016	2017	2018
Mary's Center engagement w/ PMH stakeholders in DC	Mary's Center MMH Program	X →	→	→	→
Early Childhood Family Mental Health subcommittee (ECFMH) creation & quarterly meetings	DC Learning Collaborative for Mental Health in Pediatric Primary Care	X →	→	→	→
Citywide PMAD training	Mary's Center MMH Program	X →	→		
2015 Perinatal Mental Health Community Needs Assessment	Mary's Center MMH Program & The Early Childhood and Family Mental Health Subcommittee	X			
Launch of DC Mental Health Access in Pediatrics (DC MAP)	Children's National Hospital	X			
Edinburgh Postnatal Depression Screener (EPDS) added to DBH approved Child and Adolescent Screening Tool List and Approved CPT codes for billing	Children's Hospital/Early Childhood Family Mental Health Subcommittee	X			
Creation of PMH Toolkit for Pediatric Primary Care Providers	DC Collaborative for Mental Health in Pediatric Primary Care	X			
Full-time perinatal psychiatrist at Medstar Georgetown University Hospital ** This position started in 2010, with a lapse from 2015-2016*	Medstar Georgetown University Hospital's Women's Mental Health Program		X →	→	→

Perinatal psychiatrist working one-day at Washington Hospital Center OB clinic	Medstar Georgetown University Hospital's Women's Mental Health Program	X →
Reproductive Psychiatrist joins staff at Medstar Georgetown University Hospital's Women's Mental Health Program, becoming the only Reproductive Psychiatrist in DC with specialized training who takes public and provide insurance **2009-present, gap in 2015-16*	Medstar Georgetown University Hospital's Women's Mental Health Program	X →
PMH Champions group-creation and engagement	Mary's Center MMH Program	X →
Maternal Mental Health Lobby Days (annual)	2020 Mom	X →
PMH Champions "train the trainer" project	Mary's Center MMH Program	X →
Perinatal psychiatrist working one-day at Mary's Center	Partnership between Medstar Georgetown University Hospital's Women's Mental Health Program and Mary's Center	X
The Early Childhood Innovation Network (ECIN) includes pilots in pediatric primary care and obstetrics that focus on maternal mental health	Children's National and Medstar Georgetown University Hospital	X
Advocacy for passage of bill that would create MMH Taskforce (and inclusion of PMH provider input/testimony)	Children's Hospital Advocacy Team	X →
Perinatal Stress Support Group launch at Breastfeeding Center for Greater Washington	Breastfeeding Center for Greater Washington	X →

Universal depression screening adopted in MedStar Georgetown University Hospital acute care OB setting (childbirth hospitalization)	Medstar Georgetown University Hospital	X →
SPRING Project started at GWU Hospital to offer psychotherapy treatment for PMADs on a sliding scale	George Washington University Hospital, Elizabeth Fritsch with the SPRING Project	X →
PMH Champions "mini grant" project	Mary's Center MMH Program	X → X
DC Council passed MMH Taskforce (DC Act 22-366)	DC Council (in partnership with a network of community organizations)	X
Children's National Health Center launch of corporate MMH screening goals and creation of PMH Taskforce	Children's National Hospital	X
MMH training on CBT for perinatal population	Ruthie Arbit (via Greater Washington Society for Clinical Social Work)	X
Creation of PMH Toolkit for Obstetric Providers at Medstar Georgetown University Hospital	Medstar Georgetown University Hospital	X
PMH therapist embedded in OB clinic setting	Children's National and Medstar Georgetown University Hospital	X

PROGRAMS THAT PRE-DATE 2015

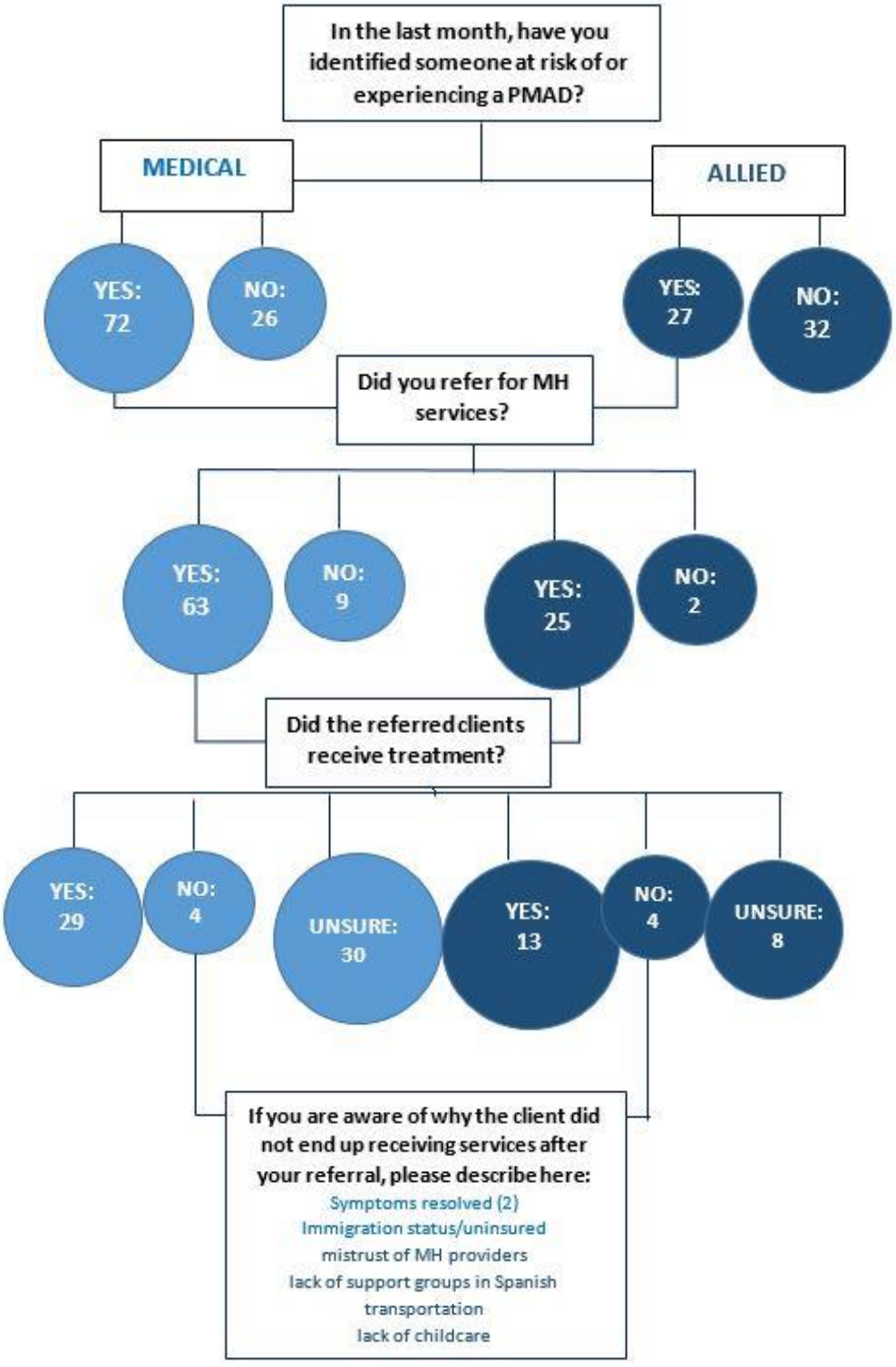
Women's Mental Health Program at MedStar Georgetown University Hospital offers specialized PMH treatment and med management for private and DC Medicaid insurance **started in 2008*	Medstar Georgetown University Hospital's Women's Mental Health Program	X →
Universal Postpartum Depression Screening used at MedStar Georgetown Hospital (outpatient OB)	Medstar Georgetown University Hospital	X →

**adopted 2008*		
Medstar Georgetown University's Women's Mental Health Program sponsored community-wide PMH trainings for medical and mental health providers **began 2008*	Medstar Georgetown University Hospital's Women's Mental Health Program	**X** →
Specialized training in perinatal mental health offered for all Psychiatry and Obstetric Residents **began 2009*	Georgetown University School of Medicine	**X** →
Perinatal Mental Health included in formal medical school curriculum in students 1st and 3rd years Georgetown University School of Medicine **introduced 2010*	Georgetown University School of Medicine	**X** →
Reproductive psychiatry specialty training offered as a formal part of the curriculum for Psychiatry Residents at MGUH **began 2011*	Medstar Georgetown University Hospital	**X** →
The Five Trimesters Clinic opens at GW offering reduced-fee perinatal psychiatric evaluation and brief treatment **opened 2011*	George Washington University Hospital's Five Trimesters Clinic	**X** →
Washington Metro Perinatal Mental Health Collaborative meetings with clinical, academic, and advocacy PMH experts **formed in 2011 as the "DMV Perinatal Mental Health Consortium"*	Collaboration with community partners	**X** →
Mary's Center starts a Maternal Mental Health Program, offers PMH	Mary's Center MMH Program	**X** →

therapy, community education and capacity-building assistance		

Appendix B

Medical and Allied Professional Referrals



Appendix C

Medical Referrals to Mental Health

Question 29 (medical survey): Primary mental health professionals/organizations referred to (list all)				
Health Provider Name	# at entity who refer in house	# externally who refer to entity	# at entity who ONLY refer externally	# at entity who refer internally AND externally
Children's National Health System	8	0	2	2
George Washington University Hospital	1	0	1	1
George Washington MFA working group	1	1	1	1
George Washington (GW) 5 Trimesters Clinic	0	7	0	0
Washington Hospital Center	3	2	0	2
Georgetown University Hospital	4	4	2	2
Howard University	1	1	0	0
Providence	0	1	0	0
Mary's Center	11	8	0	0
Unity Healthcare	7	0	0	3
Community of Hope	0	1	0	0
Mamatoto Village	0	2	0	0
DC Department of Behavioral Health	0	1	0	0
University of MD Health System	1	0	0	0
JOHNS HOPKINS, BAYVIEW	1	0	0	0
Birth Care and Women's Health	0	0	1	0
Paving the Way	0	1	0	0
DC MAP	0	2	0	0
Postpartum Support International (PSI) Support Line/PSI DC	0	2	0	0
Caroline County Health	0	1	0	0

Department mental health/addictions				
Dr. Leah Walker (in VA)	0	1	0	0
Fairfax Inova day M/E evaluation center	0	1	0	0
Unknown	3	0	6	0
TOTALS	41	36	13	11
Total # of providers who responded where refer (includes 9 at "unknown" organization)	52			
KEY				
Top 3 orgs with highest # of in house referrals				
Top 3 orgs with highest # of referrals received from external entities				

Tables

Tables 1A, 1B, 1C. Work Demographics

Table 1A. Medical Survey Work Demographics					
Credentials		**Specialty**		**Work Location**	
Answer Choice	**% (n)**	**Answer Choice**	**% (n)**	**Answer Choice**	**% (n)**
Medical Assistant (MA)	3.74% (4)	OB/GYN	39.3% (42)	Hospital	35.5% (38)
Medical Doctor (MD)	63.6% (68)	Pediatrics	30.8% (33)	Community Health Center/Clinic	40.2% (43)
Midwife (CM)	0.0% (0)	Primary Care/Family Medicine	13.1% (14)	University/Academia	17.8% (19)
Nurse Midwife (CNM)	8.41% (9)	Psychiatry	2.80% (3)	Private Practice	2.80% (3)
Nurse (RN, BSN, MSN, PhD)	8.41% (9)	Other (please specify)	14.0% (15)	Other (please specify)	3.74% (4)
Nurse Practitioner	4.67% (5)				
Physician Assistant	1.87% (2)				
Other (please specify)	9.35% (10)				

Table 1B.: Mental Health Survey Work Demographics			
Credentials		**Work Location**	
Answer Choice	**% (n)**	**Answer Choice**	**% (n)**
Medical Doctor (MD)	3.33% (4)	Hospital	10.0% (12)
Doctor of Philosophy (PhD/PsyD)	15.0% (18)	Community Health Center/Clinic	18.3% (22)
Licensed Clinical Social Worker (LICSW)	52.5% (63)	Other Medical/Health Care Setting	0.0% (0)
Licensed Professional Counselor (LPC)	15.83% (19)	Outpatient Behavioral Health	11.7% (14)
		Inpatient Behavioral Health	0.0% (0)
Marriage and Family Therapist (MFT)	2.50% (3)	University/Academia	0.83% (1)
Other (please specify)	10.8% (13)	Private Practice	48.3% (58)
		Other (please specify)	10.8% (13)

Table 1C. Allied Professional Survey Work Demographics			
Profession		**Work Location**	
Answer Choice	**% (n)**	**Answer Choice**	**% (n)**
Doula	13.1% (11)	Hospital	15.5% (13)
Case management/coordination	21.4% (18)	Community Health Center/Clinic	32.1% (27)
Yoga instructor	1.19% (1)	Private Practice	11.9% (10)
Research	1.19% (1)	University/Academia	1.19% (1)
Policy	2.38% (2)	Non-profit organization	25.0% (21)
Programming	10.7% (9)	Government organization	1.19% (1)
Early childhood/school age education	7.14% (6)	Other (please specify)	11
Higher education	0.0% (0)		
Other (please specify)	42.9% (36)		

Table 2. Percentage of Caseload Comprised of Perinatal Women (pregnant or within first year postpartum)

Percentage of Caseload Comprised of Perinatal Women (pregnant or within first yr. postpartum)				
Answer Choices	**Medical: % (n)**	**Mental Health: % (n)**	**Allied: % (n)**	**Total: % (n)**
0-25%	24.2% (24)	56.8% (63)	34.7% (26)	39.6% (133)
25-50%	19.2% (19)	27.0% (30)	16% (12)	21.4% (61)
50-75%	21.2% (21)	13.5% (15)	21.3% (16)	18.2% (51)
75-100%	35.4% (35)	2.7% (3)	28% (21)	20.7% (59)

n=284

Table 3. Hours of PMAD Training

Hours of PMAD Training				
Answer Choices	**Medical: % (n)**	**Mental Health: % (n)**	**Allied: % (n)**	**Total: % (n)**
None	12.1% (12)	15.3% (17)	30.7% (23)	18.2% (52)
1-3 hours	33.3% (33)	16.2% (18)	18.7% (14)	22.8% (65)
4-8 hours	27.2% (27)	20.7% (23)	13.3% (10)	21.0% (60)
9-16 hours	9.1% (9)	13.5% (15)	18.7% (14)	13.3% (38)
17-31 hours	7.1% (7)	10.8% (12)	8.0% (6)	8.8% (25)
32+ hours	11.1% (11)	23.4% (26)	10.7% (8)	15.8% (45)

n=285

Table 4A. Sources of PMAD Training

Sources of PMAD Training				
Answer Choices	**Medical: % (n)**	**Mental Health: % (n)**	**Allied: % (n)**	**Total: % (n)**
School/academic coursework	63.6% (63)	25.2% (28)	30.7% (23)	40% (114)
Organizational/"in-house" training	------	36.9% (41)	37.3% (28)	24.2% (69)
Local training (D.C.)	26.3% (26)	46.9% (52)	33.3% (25)	36.1% (103)
Training out of State (i.e. PSI, Seleni Institute, etc.)	5.1% (5)	23.4% (26)	8.0% (6)	13.0% (37)
Online Training	16.2% (16)	25.2% (28)	21.3% (16)	21.1% (60)
Grand Rounds	49.5% (49)	12.6% (14)	-------	22.1% (63)
I have no training in PMADs	11.1% (11)	12.6% (14)	20.0% (15)	14.0% (40)
Other	14.1% (14)	12.6% (14)	6.67% (5)	11.6% (33)

n=285

Table 4B. D.C. PMH Activity Involvement, by Survey, Qualitative Data Table

PMH Activity Qualitative Data Table *Response (frequency)*			
Activity Type	**Mental Health**	**Allied**	**Medical**
Trainings, Workshops, Education	PSI training (5) Mary's Center PMAD training (4) Train the trainer project (2) Training at Mt. Sinai (2) Online training (2) -APA online training -JSSA 2020 MOM training Ruthie Arbitt CBT training Washington Hospital Center Grand Rounds	PSI training (2) Mary's Center PMAD training (2) Mental Health First Aid Training Perinatal Training-Carroll County Hospital OSSEE training/education 2020 MOM Other online trainings	PSI training (2) Mary's Center PMAD training (3) CNHS trainings (3) "in house" training (2) AAFP training ACOG courses NA Society for Psychosocial Ob-Gyns University education (Univ. of Maryland) Grand rounds (GW)
Collaboratives, Work Groups, Taskforces	PMH Champions (5) DMV Women's (Reproductive) MH Consortium/Salon Groups (10) DMV PMH Collaborative (2) CNHC MMH Task Force (2) ECFMH "PMH Working Groups"	PMH Champions (4) DMV Women's MH Consortium DC MAP (2) ECIN (2) DMV PMH Collaborative CNHC MMH Task Force ECFMH PMH Taskforce	DMV Women's MH Consortium (4) DC MAP
Advocacy, Policy, Programming	DC MMH Taskforce Bill HRSA PMH funding application	EPDS screening project (to add EPDS to approved DBH screeners) Creation of PMH Toolkit for Pediatric Primary Care Providers MMH Taskforce Bill advocacy CNHC launch of corporate MMH screening goals	Internal QI improvement projects (3) Blue Dot Maternal Mental Health Advocacy projects
Partnered with PMH Organizations	Mary's Center MMH Program (6) Consultation with PMH specialists	Healthy Steps (2)	Partnered with Georgetown Pediatrics for a research study on PMH screening
Informal or Self-Initiated Activities	Created/taught PMH trainings (4) "personal pregnancy"	---	---

Table 5A. Mental Health Provider Experience in Providing PMH Care

Mental Health Provider Experience in Providing PMH Care

Answer Choices	No experience	Little experience	Some experience	Sufficient experience	I am an expert
% (n)	7.21% (8)	15.3% (17)	27.0% (30)	36.0% (40)	14.4% (16)

n=111

Table 5B. Mental Health Provider Experience in Providing PMH Care, by Caseload

Mental Health Provider Experience in Providing PMH Care, by Caseload					
Percentage of Weekly Caseload Comprised of PMH clients	**No experience %(n)**	**Little experience %(n)**	**Some experience %(n)**	**Sufficient experience %(n)**	**I am an expert %(n)**
0-25%	11.8% (8)	22.1% (15)	36.8% (25)	25.0% (17)	4.41% (3)
25-50%	0.0% (0)	3.85% (1)	11.5% (3)	69.2% (18)	15.4% (4)
50-75%	0.0% (0)	6.67% (1)	13.3% (2)	26.7% (4)	53.3% (8)
75-100%	0.0% (0)	0.0% (0)	0.0% (0)	50.0% (1)	50.0% (1)

n=111

Table 6. Allied Professional PMAD Knowledge

Allied Professional PMAD Knowledge					
Question	**SD % (n)**	**D % (n)**	**N % (n)**	**A % (n)**	**SA % (n)**
I have a good understanding of PMAD(s) prevalence, signs/symptoms	3.03% (2)	7.58% (5)	16.7% (11)	51.5% (34)	21.2% (14)
I would know where to refer someone experiencing PMH concerns/PMAD symptoms	1.52% (1)	7.58% (5)	13.6% (9)	56.1% (37)	21.2% (14)

SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree n=66

Table 7. Medical Provider Comfort Level in Addressing PMADs

Medical Provider Comfort Level in Addressing PMADs					
Question: I am comfortable and prepared to:	**SD % (n)**	**D % (n)**	**N % (n)**	**A % (n)**	**SA % (n)**
Assess the PMH needs of my patients	1.04% (1)	8.33% (8)	17.7% (17)	63.5% (61)	9.38% (9)
Start a conversation about PMH treatment options	1.04% (1)	14.6% (14)	13.5% (13)	54.2% (52)	16.7% (16)
Assist my patients in obtaining care via referrals and/or patient advocacy	3.13% (3)	7.29% (7)	15.6% (15)	59.4% (57)	14.6% (14)

SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree n=96

Table 8. Beliefs on PMAD Diagnosis and Treatment in D.C. (all surveys)

Beliefs on PMAD Diagnosis and Treatment in D.C. (all surveys)

Question: Please rate the following statements:	Survey	SD %(n)	D %(n)	N %(n)	A %(n)	SA %(n)	Unsure %(n)	Total n
There is a high level of undiagnosed/undetected perinatal mental illness	**Med**	4.17% (4)	2.08% (2)	5.21% (5)	42.7% (41)	43.8% (42)	2.08% (2)	96
	MH	0.0% (0)	3.92% (4)	4.90% (5)	38.2% (39)	52.0% (53)	0.98% (1)	102
	Allied	6.06% (4)	0.0% (0)	6.06% (4)	28.8% (19)	56.1% (37)	3.03% (2)	66
Many clients who are diagnosed with perinatal mental illness go untreated	**Med**	3.13% (3)	3.13% (3)	6.25% (6)	41.7% (40)	44.8% (43)	1.04% (1)	96
	MH	0.0% (0)	2.94% (3)	2.94% (3)	34.3% (35)	57.8% (59)	1.96% (2)	102
	Allied	3.03% (9)	3.03% (9)	6.06% (4)	42.4% (28)	40.9% (27)	4.55% (66)	66
There are adequate perinatal mental health services available	**Med**	22.9% (22)	40.6% (39)	16.7% (16)	10.42% (10)	4.17% (4)	5.21% (5)	96
	MH	16.7% (17)	46.1% (47)	16.7% (17)	5.88% (6)	5.88% (6)	8.82% (9)	102
	Allied	13.6% (9)	37.9% (25)	25.8% (17)	13.6% (9)	3.03% (2)	6.06% (4)	66

SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree

Table 9. Referrals in the Past Month-Medical Providers and Allied Professionals

Referrals in the Past Month-Medical Providers and Allied Professionals					
Question:	**Survey**	**Yes %(n)**	**No %(n)**	**N/A %(n)**	**Unsure %(n)**
In the last month, have you identified someone at risk of or experiencing a PMAD(s)?	**Med**	73.5% (72)	26.5% (26)	----	----
	Allied	36.0% (27)	42.7% (32)	21.3% (16)	----
	TOTAL	57.2% (99)	33.5% (58)	21.3% (16)	----
In the last month, have you referred someone to mental health treatment/support for a PMAD(s)?	**Med**	87.5% (63)	12.5%	----	----
	Allied	92.6% (25)	7.41% (2)	----	----
	TOTAL	88.9% (88)	11.1% (11)	----	----
Did the client(s) referred to mental health treatment/support for PMAD(s) receive services?	**Med**	46.0% (29)	6.4% (4)	----	47.6% (30)
	Allied	52.0% (13)	16.0% (4)	----	32.0% (8)
	TOTAL	47.7% (42)	9.10% (8)		43.2% (38)

Table 10. Mental Health Provider Referral Sources

Mental Health Provider Referral Sources						
Question: I regularly receive PMH referrals from:	**SD %(n)**	**D %(n)**	**N %(n)**	**A %(n)**	**SA %(n)**	**N/A %(n)**
Pediatricians	16.7% (17)	36.3% (37)	6.86% (7)	15.7% (16)	4.90% (5)	19.6% (2)
Primary Care Providers	10.8% (11)	27.5% (28)	11.8% (12)	24.5% (25)	7.84% (8)	17.7% (18)
OBs/Midwives	8.82% (9)	17.7% (18)	6.68% (7)	34.3% (55)	14.7% (15)	17.7% (18)
Allied Professionals	10.8% (11)	22.6% (23)	13.7% (14)	23.5% (24)	8.82% (9)	20.6% (21)
Client self-referral	1.96% (2)	8.82% (9)	10.8% (11)	41.2% (42)	25.5% (26)	11.8% (12)

SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree n=102

Table 11. Collaboration with other PMH Professionals (all surveys)

Collaboration with other PMH Professionals (all surveys)

Question: I have a collaborative relationship with:	Survey	SD %(n)	D %(n)	N %(n)	A %(n)	SA %(n)	Total n
Mental health providers to whom I can refer my perinatal patients when needed	**Med**	3.33% (3)	14.4% (13)	15.6% (14)	46.7% (42)	20.0% (18)	90
The medical providers of the perinatal women with whom I work	**MH**	2.94% (3)	25.5% (24)	28.4% (29)	25.5% (26)	13.7% (14)	102
Other professionals and/or organizations that are committed to helping women with PMH concerns	**Allied**	1.52% (1)	6.06% (4)	25.8% (17)	39.4% (26)	27.3% (18)	66

SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree

Table 12. Obstacles to Provider Care of Patient PMH Concerns (all surveys)

Obstacles to Provider Care of Patient PMH Concerns (all surveys)									
Question: How often do the following obstacles hinder your support of clients with MH concerns?	**Survey**	**N %(n)**	**R %(n)**	**O %(n)**	**F %(n)**	**VF %(n)**	**N/A %(n)**	**Mean (n)**	**TOTAL MEAN *(n)**
Inadequate reimbursement	**Med**	18.9%(17)	25.6%(23)	13.3%(12)	7.8% (7)	5.6%(5)	28.6%(26)	2.38 (64)	2.62 (185)
	MH	27.0%(27)	13.0%(13)	14.0%(14)	11.0%(11)	7.0%(7)	28.0%(28)	2.42 (72)	
	Allied	9.4%(6)	12.5%(8)	26.6%(17)	23.4%(15)	7.8%(5)	23.4%(15)	3.22 (49)	
Insufficient Time	**Med**	4.4%(4)	7.8%(7)	26.7%(24)	30.0%(27)	23.3%(21)	7.8%(7)	3.65 (83)	3.46 (222)
	MH	11.0%(11)	9.0%(9)	20.0%(20)	30.0%(30)	20.0%(20)	10.0%(10)	3.43 (90)	
	Allied	6.3%(4)	12.5%(8)	26.6%(17)	23.4%(15)	7.8%(5)	23.4%(15)	3.18 (49)	
Lack of own experience, training and/or knowledge	**Med**	4.4%(4)	22.2%(20)	43.3%(39)	16.7%(15)	7.8%(7)	5.6%(5)	3.01 (85)	2.69 (220)
	MH	30.0%(30)	16.0%(16)	25.0%(25)	10.0%(10)	4.0%(4)	15.0%(15)	2.32 (85)	
	Allied	6.3%(4)	26.6%(17)	29.7%(19)	10.9%(7)	4.7%(3)	21.9%(14)	2.76 (50)	
Lack of mental health providers to refer to	**Med**	6.7%(6)	17.8%(16)	28.9%(26)	22.2%(20)	20.0%(18)	4.4%(4)	3.33 (86)	3.28 (141)
	MH	---	---	---	---	---	---	---	
	Allied	3.1%(2)	25.0%(16)	23.4%(15)	18.8%(12)	15.6%(10)	14.1%(9)	3.22 (55)	

N: Never (1), R: Rarely (2), O: Occasionally (3), F: Frequently (4), VF: Very Frequently (5), N/A: Not Applicable;
*Percentages of "N/A" responses are not included in mean calculations

Table 13. Participant Obstacles to Accessing PMH treatment (all surveys)

Participant Obstacles to Accessing PMH treatment (all surveys)

Question: How often do you think the following obstacles hinder clients from accessing PMH treatment?	Survey	N %(n)	R %(n)	O %(n)	F %(n)	VF %(n)	Unsure %(n)	Mean (n)	TOTAL MEAN *(n)
Inadequate insurance coverage/ difficulty affording services	**Med**	0.0% (0)	12.2%(11)	21.1%(19)	30.0%(27)	27.8%(25)	8.9%(8)	3.80 (82)	3.92 (239)
	MH	0.0% (0)	9.0%(9)	22.0%(22)	31.0%(31)	37.0%(37)	1.0%(1)	3.97 (99)	
	Allied	0.0% (0)	6.3%(4)	17.2%(11)	35.9%(23)	31.3%(20)	9.4%(6)	4.02 (58)	
Insufficient time (other life demands get in the way)	**Med**	0.0% (0)	2.2%(2)	11.1%(10)	45.6%(41)	36.7%(33)	4.4%(4)	4.22 (86)	4.29 (245)
	MH	0.0% (0)	3.0%(3)	11.0%(11)	38.0%(38)	48.0%(48)	0.0%(0)	4.31 (100)	
	Allied	0.0% (0)	1.6%(1)	10.9%(7)	34.4%(22)	45.3%(29)	7.8%(5)	4.34 (59)	
Stigma/ cultural barriers	**Med**	1.1%(1)	3.3%(3)	23.3%(21)	30.0%(27)	38.9%(35)	3.3%(3)	4.06 (87)	4.12 (247)
	MH	0.0%(0)	4.0%(4)	15.0%(15)	45.0%(45)	36.0%(36)	0.0%(0)	4.13(100)	
	Allied	0.0% (0)	3.1%(2)	17.2%(11)	31.3%(20)	42.2%(27)	6.3%(4)	4.20 (60)	
Location/ physical accessibility of treatment (transportation difficulties as a barrier)	**Med**	0.0% (0)	4.4%(4)	31.1%(28)	30.0%(27)	25.6%(23)	8.9%(8)	3.84 (82)	3.87 (237)
	MH	3.0%(3)	12.0%(12)	29.0%(29)	31.0%(31)	20.0%(20)	5.0%(5)	3.84 (95)	
	Allied	0.0% (0)	6.3%(4)	25.0%(16)	28.1%(18)	34.1%(22)	6.3%(4)	3.97 (60)	

N: Never (1), R: Rarely (2), O: Occasionally (3), F: Frequently (4), VF: Very Frequently (5)

*Percentages of "Unsure" responses are not included in mean calculations

Table 14. How to Improve Perinatal Screening and Treatment in D.C. (all surveys)

How to Improve Perinatal Screening and Treatment in D.C. (all surveys)							
Question: Please rate the following statements on how to improve perinatal screening and treatment in D.C.	**Survey**	**SD %(n)**	**D %(n)**	**N %(n)**	**A %(n)**	**SA %(n)**	**Total n**
This is a significant need for more PMH providers in the D.C. area	**Med**	0.0% (0)	1.12% (1)	6.74% (6)	41.6% (37)	42.7% (38)	89
	MH	2.0% (2)	4.0% (4)	19.0% (19)	54.0% (54)	21.0% (21)	100
	Allied	0.0% (0)	0.0% (0)	10.9% (7)	37.5% (24)	46.9% (30)	64
Receiving PMH training would greatly increase the number of mental health providers willing to see perinatal clients	**Med**	1.12% (1)	14.6% (13)	21.4% (19)	37.1% (33)	23.6% (21)	89
	MH	0.0% (0)	0.0% (0)	18.0% (18)	53.0% (53)	29.0% (29)	100
	Allied	1.56% (1)	3.13% (2)	15.6% (10)	37.5% (24)	34.4% (22)	64
There needs to be improved collaboration between mental health providers and perinatal health providers **Allied: "between professionals/organizations working to improve PMH in our community"*	**Med**	0.0% (0)	0.0% (0)	7.87% (7)	43.8% (39)	43.8% (39)	89
	MH	0.0% (0)	0.0% (0)	6.0% (6)	51.0% (51)	43.0% (43)	100
	Allied	0.0% (0)	0.0% (0)	12.5% (8)	43.8% (28)	40.6% (26)	64
Updated/improved screening protocols at my place of work are necessary to increase support of PMH	**Med**	0.0% (0)	19.1% (17)	28.1% (25)	35.6% (29)	15.7% (14)	89
	MH	----	----	----	----	----	----
	Allied	----	----	----	----	----	----
Expanded coding/billing opportunities for PMH screening and referral would greatly increase my likelihood of screening and providing referrals to perinatal women in need	**Med**	1.12% (1)	21.4% (19)	23.6% (21)	22.5% (20)	18.0% (16)	89
	MH	----	----	----	----	----	----
	Allied	----	----	----	----	----	----

SD: Strongly Disagree, D: Disagree, N: Neutral, A: Agree, SA: Strongly Agree