A Qualitative Understanding of the Perinatal Mental Health Landscape in Montana

2022-2023

Healthy Mothers, Healthy Babies
The Montana Coalition

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EXECUTIVE SUMMARY

Perinatal mental health (PMH) is essential to the health and wellbeing of birthing people, infants, children, and families. In Montana, a variety of local, statewide, and tribal groups are implementing programs to address this critical issue. However, there is currently no single organization that brings together these groups to advocate for and coordinate PMH services across the state.

This project is the first step towards creating such an organization. Using the Collective Impact framework, Healthy Mothers, Healthy Babies - The Montana Coalition (HMHB) conducted approximately 100 interviews with people who are invested in PMH in Montana. The interviews included a wide range of perspectives, from health and public health professionals to people with lived experiences of PMH. The notes from these interviews were then analyzed thematically and presented in this report.

Priorities for collaborative work identified by the interviewees include the following:

1. Among all perinatal providers and programs, increase awareness of and training for screening, referring, and treating perinatal mood and anxiety disorders (PMADs).
2. Increase public awareness around PMADs and the resources available to support people and families in the perinatal period.
3. Offer care coordination for individuals experiencing PMADs that connects people to right supports at the right times and provides continuity of care between programs and providers.
4. Address social determinants of health that impact perinatal mental health including, but not limited to: Transportation, Housing, Childcare, Food.
5. Increase peer-focused programming that provides group or individual support to people in the perinatal period.
6. Increase access to perinatal-specific mental health providers who are available to provide timely assessment and treatment, including psychiatrists when necessary.
7. Support culturally informed programs that serve the perinatal population through the provision and operationalization of cultural safety training, and increase diversity among providers and programming staff.

INTRODUCTION

Perinatal mental health (PMH) challenges affect not only the health and wellbeing of the birthing person, but also the wide, interconnected network of their infants, children, and family. These PMH issues commonly present as perinatal mood and anxiety disorders (PMADs). PMADs include depression, anxiety, bipolar, PTSD, obsessive compulsive disorders, and psychosis. Challenges around mental health are even further complicated by Montanans' limited access to mental health care and appropriate screening, rurality, elevated incidence of low socioeconomic status, elevated suicide rates, and a lack of provider awareness and education about PMADS. If untreated, symptoms of PMADs can persist for months or even years, and may compromise the mother and children's safety and cause developmental delays for the children. Untreated PMADs impact the safety and optimal development of children. Infant brain development is most impacted during gestation, followed by the first few months of life. Maternal depression is the leading cause of toxic stress in childhood, followed by caregiver substance use and child maltreatment. Outcomes for children are better when women in the perinatal period have routine screenings, access to high quality treatment, and access to medication to manage their mental illness. Yet, many Montana medical providers do not utilize best practices to inform their screening protocols, treatment, and medication decisions.

To address this concern, Healthy Mothers, Healthy Babies (HMHB) aims to improve perinatal mental health outcomes by creating a collaborative group of local, state, and Tribal representatives who, together, can explore and improve behavioral health systems in Montana to better support the perinatal population. According to the Collective Impact Forum, collective impact is "a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population and systems level change." Collective impact is generally used when addressing complex public health issues that require aligned work across sectors, disciplines, and stakeholders. In the spirit of the collective impact through which this initiative is being built, HMHB hosted a series of informal interviews with people who work with the state's perinatal population or any individuals with lived experience of PMH.

Many of the people who participated in the interviews disclosed their own lived experience of PMADs even though they were providing their views in their professional roles. The goal of these interviews included the following: (1) to garner a deeper understanding of current issues and trends around PMH in Montana, and (2) to begin building a network of involved individuals who can support this initiative. These discussions, referred to as the "100 Cups of Coffee," were used to (1) collect qualitative data that will inform a future strategic plan to address perinatal mental health in the state, and (2) gather recommendations on the best way to form and house this collective group. This report contains the results of the 100 Cups of Coffee conversations.

DEFINITIONS

Provider: This term generally refers to anyone within the system of perinatal support. It includes both healthcare and public health professionals and staff who support perinatal people.

Perinatal: This term refers to the time including pregnancy through one year after birth. In many contexts throughout the report the perinatal period can extend to three years and more beyond delivery.

ACKNOWLEDGEMENT

HMHB would like to extend our enthusiastic gratitude to everyone who generously volunteered their time and energy to share their ideas and experiences with us for this project. Perinatal mental health efforts are not new in Montana. Many of the people who were interviewed have been working tirelessly to improve the system of care for families from pregnancy through early childhood. This work is complex, difficult, and at times it feels slow to progress. Nevertheless, HMHB and many of the individuals interviewed remain committed to moving this work forward to create an impactful collective to address PMH in Montana.

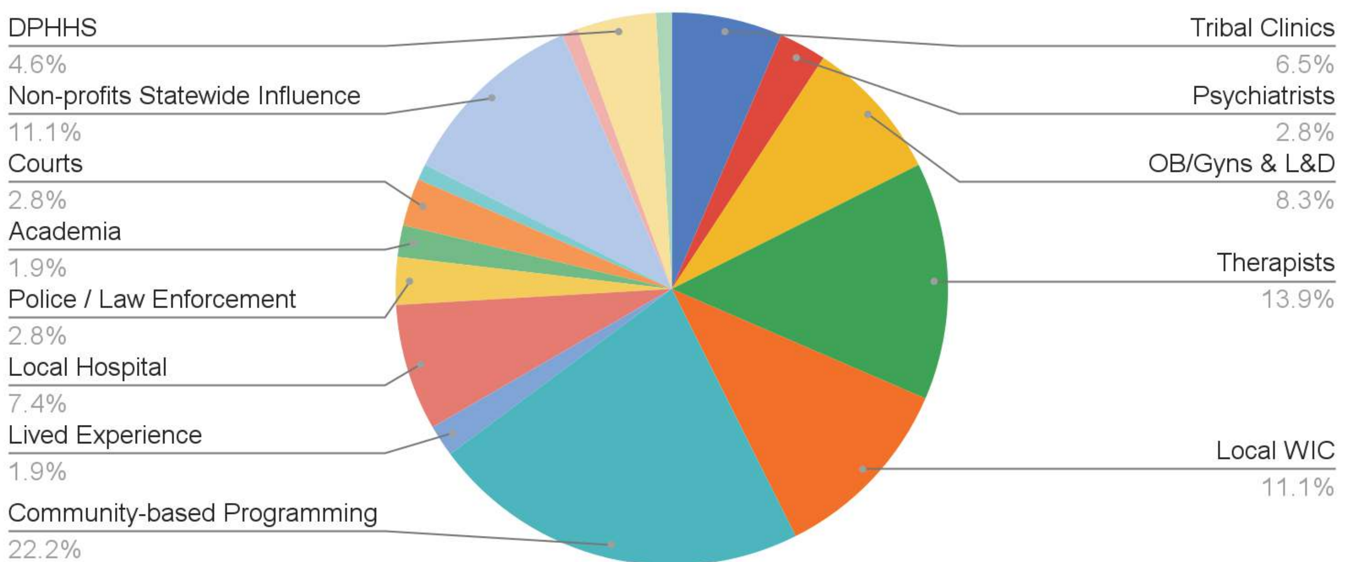
We would also like to thank public health consulting firm Yarrow, LLC for their commitment to this work and assistance in this endeavor.

This project was funded in whole or in part under a contract with the Montana Department of Public Health and Human Services. **The statements herein do not necessarily reflect the opinion of the Department.** Specifically, the project was funded by Substance Abuse and Mental Health Services Administration SAMHSA – Pregnant and Postpartum Women's Pilot Project #H79TI083171.

It has been our organization's longtime dream to begin building a network of passionate people from across the state who can support a healthier ecosystem for perinatal mental health.

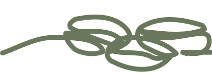
METHODS

Between November 2022 and March 2023, emails and phone calls were made to more than 400 people who were invited to participate in an interview, leading to 111 people who ultimately participated in the 100 Cups of Coffee interviews conducted by HMHB and Yarrow, LLC. Thirty-four different individual and group interviews took place. Ten of the 100 Cups of Coffee chats were held with groups of people in specific geographic areas or communities throughout Montana (Billings, Great Falls, Kalispell, Polson, Missoula, Dillon, Butte, Bozeman, Browning, Helena). Thirteen tribally affiliated interviews were conducted, with representation from 7 Tribal Nations, 2 urban Tribal clinics, and 2 state-level representatives to include perspectives unique to Native American populations. Nine people within the state government were interviewed, as well as individuals from major statewide nonprofits and foundations who work in the areas of perinatal mental health and/or behavioral health. Recruitment for interviews took place through "snowball" methodology (asking those we interviewed who would be a leader in a particular area or have something important to contribute).



Interviews were held either through Zoom or via phone call if Zoom was not a feasible option. On March 28, 2023, a group of interested people from across the state attended a meeting in Fairmont to review the preliminary findings of these 100 Cups of Coffee interviews and to contribute additional information. Their input has also been included in this report.

Notes taken during interviews were analyzed using thematic analysis based on grounded theory. Analyses were conducted by three coders between January and March 2023 using the Dedoose qualitative data analysis application. Findings from the analyzed interviews were separated into several primary themes with exploration of sub-themes in each area. These findings are detailed below, organized by major themes.



RESULTS

Included here are the major themes identified in these interviews, as well as quotes from participants.

Increased Awareness of Perinatal Mental Health

One of the most prominent themes from interviews involved increased awareness of PMH. Interviewees noted an increased awareness of the condition postpartum depression (PPD) as opposed to what's colloquially called "baby blues," which indicates a growing awareness. People noted that they are seeing an increase among all sectors who work with the perinatal population around the importance of recognizing and treating PMH conditions.

Specifically, people noted the following sectors taking notice of PMH:

- **Generalized Mental Health Therapists:** This group of people is noticing an increase in PMH-specific cases and recognizing the need for additional training and specialization in this area.
- **Perinatal Providers:** OB-Gyns, Midwives, Family Practice doctors, and NPs providing perinatal care services are becoming more aware of the presence of PMH conditions as a specific set of conditions that should be screened for and that require additional supportive therapies and treatment modalities.
- **Supportive Perinatal Programs:** Programs that serve the perinatal population such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Child and Family Services, home visiting programs, local breastfeeding and parenting groups, and others are increasingly recognizing the importance of screening, identifying, and talking with participants about PMH conditions and the need to refer these people to appropriate mental health resources.
- **Labor and Delivery Units:** Many delivering hospitals cited the work of the Meadowlark Initiative to ensure that a counselor or coordinator specializing in PMH is available to their patients. Many L&D units noted that they are taking on quality improvement projects around perinatal mental health and offering training to their staff on signs and symptoms of PMH conditions and screening at the time of delivery.
- **Public Health Departments and Behavioral Health Coalitions:** Many larger public health departments and crisis coalitions across the state brought up the growing importance of ensuring that PMH is specifically addressed in programming that supports the perinatal population and the way that crisis systems within their communities respond to crises involving people with very young children.
- **General Public:** Participants noted a growing understanding of mental health in general, indicating that this is helping people recognize mental health conditions as they affect the perinatal population.

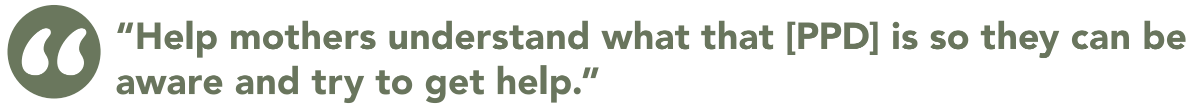
It was noted that in many rural and Tribal communities, there were only one or two "champions" for PMH, indicating that building widespread awareness of the issue is still in the early stages.

Openly discussing PMH and encouraging conversations about women's diverse experiences with PMH-related conditions is paramount to increasing awareness about this issue.

"If we talked about PMH even a quarter as much as we do about substance use, then everyone would know about PMH."

Greater awareness of PMH is not only important for the public, but also for friends and families.

Even with the incredible strides made to help make PMH widely understood and to increase awareness, there is still a long way to go to ensure that every provider in the perinatal arena has the knowledge, skills, and resources to fully support all perinatal women.

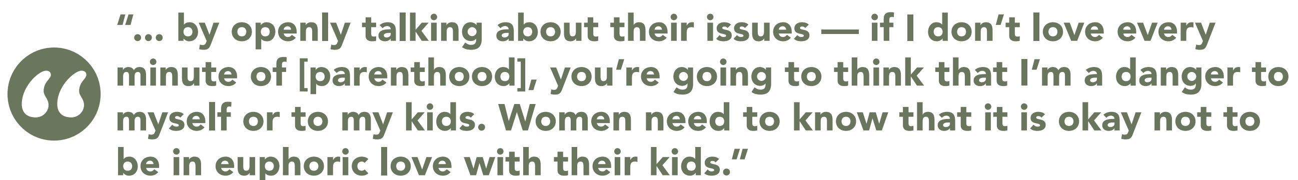


> **"Help mothers understand what that [PPD] is so they can be aware and try to get help."**

Stakeholders noted that increasing awareness was leading to the creation or adaptation of numerous community resources that are currently available to pregnant and postpartum women who may desire perinatal mental health support. Support was available in many different forms, including PMH-specialized mental health therapists, community programs hosted by nonprofit organizations, and peer-directed programs led by women with lived experience. Similarly, interviewees mentioned multiple coalitions that focus not only on PMH, but also on various factors that may impact the severity of PMH illnesses, such as food security, substance use, and parenting self-efficacy.

Reducing Stigma around Perinatal Mental Health

While there is widespread agreement that PMH awareness is growing rapidly, the stigma associated with PMH still needs to be reduced. Many stakeholders called for the normalization of PMH and wished women felt more freedom to talk about their emotions and experiences.



> **"... by openly talking about their issues — if I don't love every minute of [parenthood], you're going to think that I'm a danger to myself or to my kids. Women need to know that it is okay not to be in euphoric love with their kids."**

For some mothers, their only exposure to PMH is through stories of women with severe cases who unfortunately harm themselves or others when they are unable to get the help they need. As a result, many pregnant and postpartum women may dismiss their own experiences and emotions because they "aren't that bad." This internal narrative may be dangerous, or at the very least it delays these women from seeking supportive services.

Due to fear of losing their child/children, fear of being judged as a failure, or fear of their experiences being dismissed as simply "baby blues," many women decide to keep their feelings to themselves instead of reaching out for help. The stigma surrounding PMH may even cause women to be in denial about their experiences. All of these scenarios can culminate in women not receiving the care they need, which can have dangerous consequences.

For women with PMH conditions to feel heard and to succeed, they need a supportive environment of individuals who understand and can empathize with their experiences.

Creating Supportive Environments

While it is important to find outside services and resources that can benefit pregnant and postpartum women, it is equally important that these women have access to communities and families that also extend support and assistance.

"Need a community of people who will teach [mothers] how to take care of themselves and their families. When you are a mother to yourself, you can be a parent to your children."

In order to foster this community and family support, family members and partners must receive education about PMH conditions and what causes them. Many interviewees noted that partners are often left out of the equation because they are not the ones who delivered the baby, even though they are an integral part of the mother's supportive network. Partners can be cheerleaders, offer encouragement, or even just provide a listening ear for pregnant and postpartum women navigating the complexities of PMH conditions.

For those who are not able to lean on family or partners, peer-focused programming may be an effective alternative resource for reassurance and confidence-boosting. Stakeholders suggested that peer support should be present in a variety of settings that cater to those with PMH conditions, including recovery centers, health departments, drop-in centers, and CPS. The benefits of participating in a peer program are plentiful: prenatal and postpartum mothers can build healthy coping skills, grow their social network, and participate in group activities while bonding with other women in similar situations. Solutions that increase participation in peer support efforts must be explored and the positive benefits communicated.

Screening for Perinatal Mental Health Conditions

Interviewees noted wide inconsistencies in who was providing screening, how often women were screened, types of screenings used, and what next steps were taken when a woman screened positive.

They noted a massive increase in the variety of settings in which universal PMH screening is more commonly taking place, including prenatal appointments, labor and delivery units, postpartum appointments, well child exams, WIC appointments, home visiting sessions, and parental peer support groups. The people responsible for screening for PMH symptoms play the important role of opening the doors of assistance for those who may be unaware they have a PMH condition. Early evaluation of PMH symptoms is ideal, but stakeholders observed that, even though screening has increased significantly over the past 1–2 years, many providers and programs are still failing to screen. The lack of appropriate or very limited/saturated referral resources results in inconsistent and inadequate screening.

"Don't want to ask people when you can't help."

Many stated that it is important to identify mothers with subclinical PMH conditions early to prevent the escalation of symptoms, but noted that only some prenatal clinics were screening consistently. Anytime this early window is missed, screening in other locations—such as labor and delivery units, pediatric well child exams, WIC, home visiting, and peer support settings—becomes even more important in engaging the perinatal population. When suggesting that screening of the mother be

conducted in well child exams, it was noted that the structure of our medical system can make this difficult, since mothers are not usually patients in the clinic where the child is being seen; this then raises a question of how to document and who is responsible for making and following up on positive screening results. Challenging this medical process to treat the "dyad of mom and baby" would encompass mom into the periodicity schedule of well child appointments. Many people interviewed spoke to the necessity of extending support and screening beyond the traditional six-week postpartum visit. Mental health concerns can and do arise outside of this period.

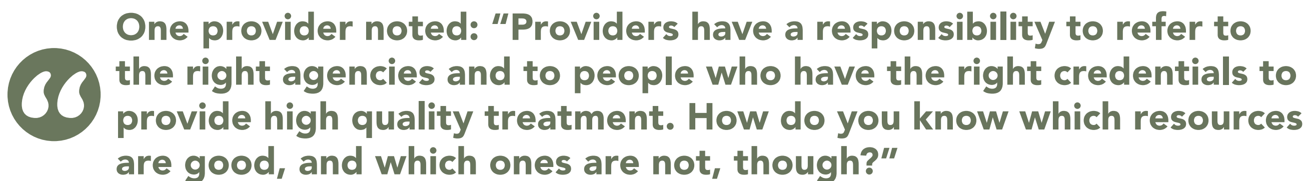
Interviewees felt that maintaining consistent screening methods and increasing the variety of settings in which women are screened for PMH conditions is an imperative first step in ensuring women receive the care and treatment they need. The Edinburgh and the PHQ-2 and PHQ-9 were the most common screening tools cited as currently in use.

It is not enough for screeners to consistently screen women, but providers and those administering screeners must appropriately follow through with referrals to appropriate levels and types of care and support, based on assessment results.

Improving the Referral System

A major recurrent theme within interviews was the need for a high-functioning referral system to link patients/clients with appropriate, individualized care as quickly as possible. For this to occur, providers not only need to know about the different counselors, hospitals, and programming in the client's community, but they also need to know which resources best match the client's needs and then have a way to connect the client with these resources.

Some noted that it is hard for both providers and patients to know and navigate all of the resources available, especially when they change consistently. Programs are often grant funded, and this field sees high rates of staff burnout and turnover. The rapidly changing landscape of resources means that providers and program staff don't always feel comfortable making referrals because they aren't sure what services other programs offer, the best ways to get in touch with the programs, or if they are high quality.



One provider noted: "Providers have a responsibility to refer to the right agencies and to people who have the right credentials to provide high quality treatment. How do you know which resources are good, and which ones are not, though?"

Stakeholders frequently commented that referrals are often "lost in space" when programs stop functioning or there is turnover in key positions. In many of these cases, providers and patients are not given any feedback or follow-through about their request for assistance. Closing referral loops and/or case management would ensure client safety and improve collaborative efforts. In one community conversation for this project, there was a situation in which a provider said that they send referrals for mental health care to a specific program and someone else on the call noted that the program had been closed for some time.

"We don't know who those referrals are going to and if they're being addressed."

Sometimes mothers are given a long list of resources and told to choose or to call all of them, but they don't have the emotional bandwidth to actually make those decisions and thus end up doing nothing. Quite frequently, stakeholders commented that women who experience PMH-related symptoms are unfamiliar with the many different community and governmental resources at their disposal.

> **"There is an expectation that once you become pregnant, you have all the resources and knowledge to do what you need to do. Most people [who are getting pregnant] are under 26, so they don't have their stuff together."**

Several interviewees noted that case managers, if available, are a vital piece of the referral system puzzle. Referral systems can be complex, and case managers are trained to guide clients through the plethora of available services. These professionals can even provide warm handoffs between a general provider and one who specializes in what that client needs. A prevalent suggestion from stakeholders was to develop a common hub or center where referrals are sent, and where a case manager, or someone similar, could communicate seamlessly between providers or services.

> **"Systems are too complex. We have to simplify how people move through healthcare, legal, social services so that we can all keep it straight and guide people through the systems."**

> **"Rather than adding new services, make sure that everyone knows exactly what exists."**

Especially among stakeholders in rural and Tribal communities, it was noted that it is hard for providers in the more urban areas where their clients' babies were delivered to know what, if any, resources exist in their clients' smaller communities and to be able to make and maintain those connections.

Interviewees also identified how certain populations, such as families moving into an area, women who are navigating mental health and substance use illnesses, and those who are not housed, are special groups who may require a more individualized and targeted approach to familiarize them with available resources.

Warm and Hot Lines

Warm lines and hot lines are resources that provide support for those going through a rough period—or for more emergent cases, such as a mental health crisis in which someone or the people near them are in danger and require immediate help. Stakeholders noted that despite the existence of several national warm or hot lines, prenatal and postpartum women with PMH-related conditions may not have many options that are specific to their needs. Some communities have local lines, while many across Montana rely on state and federal lines.

> **"There are lots of different lines to call — but we don't always know about them or when to call which."**

Interviewees frequently demonstrated confusion about the available lines, stating that they weren't sure which were the right ones to recommend. In one group interview, the interviewees started building a list of the available hot and warm lines and realized they all had different resources and different understandings about when to call each.

Increased Training for Workforce in Perinatal Mental Health

People acknowledged an increase in the number of therapists who are specifically trained in PMH, but still cited major shortages. Though a region may have several available mental health providers, these providers may not have adequate training specific to PMH-related conditions. Interviewees noted that even non-mental health and mental health professionals alike could benefit from learning how to identify the signs of PMH conditions and how to talk about these important issues with their clients.

> **One person described the experience of their family member: "Even though she was seeing a counselor she wasn't diagnosed [with postpartum depression]. She was seeing a family counselor that she had gone to previously. With more training, that counselor might have noticed the signs."**

Likewise, stakeholders identified a need for both mental health and non-mental health providers to know how to start the conversation and how to use understanding language, rather than using accusatory tones and verbiage. More importantly, some of those interviewed also noticed that when untrained professionals treat women in need of PMH services, there is a risk of misdiagnosis, which may lead to administering inappropriate therapy, thereby worsening existing symptoms or creating additional ones.

> **"... could see moms being misdiagnosed — going to see a therapist that isn't specialized in perinatal mental health could easily misdiagnose. Different types of medications, treatment could be based on an [incorrect] diagnosis, [because they] won't ask the right questions."**

Interviewees noted that it is important to provide PMH training for everyone across the continuum of providers who may come in contact with clients, in both inpatient and outpatient settings. Doulas, midwives, and home visitors were providers mentioned frequently who work closely with pregnant and postpartum women and would greatly benefit from being cross-trained in PMH.

The Healthy Mothers Healthy Babies annual conference was commonly cited as a primary training resource around PMH in Montana.

> **"HMHB Conference!! Learning about new resources and growing a network of people who can provide these resources. This is a great resource for the state and for local communities."**

Major Barriers to Access for PMH Care

Interviewees were quick to list several major reasons why access to specialized PMH care is so difficult in Montana, including: lack of insurance coverage, high level of effort necessary to obtain insurance, limited service hours and emergency room resources, lack of higher levels of care, and access to specialized and diverse providers.

Many insurance plans do not cover mental healthcare. These are plans that were "grandfathered" in when the Affordable Care Act took effect. Some plans cover mental healthcare to a limited and insufficient degree, and not for the appropriate levels of care. Some plans don't include the right providers or programs in their network. Montana Medicaid reimbursement for therapists is so low that many private practice providers and those centers that don't receive supplemental grant funding cannot afford to provide treatment to people with Medicaid coverage.

There is a lack of integration of behavioral health directly into Ob-Gyn clinics and other settings where people receive prenatal and postpartum care. The Meadowlark and Empaths programs have made strides in this area, but there is still significant silo-ing of behavioral health out of regular perinatal care. The gap in mental health care in our rural communities grows exponentially.

Among outpatient therapy practices, many have limited service hours for either routine care or emergencies. They are generally not open in the evenings or on weekends or holidays. In these cases, the emergency room is the only option available. Emergency rooms are often not well equipped to treat any kind of mental health crisis, let alone a PMH crisis. Even with insurance, emergency room admissions for mental healthcare can be expensive if the hospital is out of network.

In Montana, there is a lack of diversity among providers, specifically women and Native providers. Additionally, there is an insufficient number of psychiatrists or therapists specifically trained in PMH, or organizations that can offer higher levels of care. People in need of assistance are often placed on waitlists and wait weeks and months to establish care. The strain is palpable in inpatient facilities as well, with some providers needing to transfer their patients to different states because of an inadequate number of beds for the volume of individuals who need care.

"We are full — we try to move things around to get [clients] in quickly, but we are just full."

This reality is increasingly exacerbated in rural and Tribal communities where provider shortages are a significant issue and transportation to larger urban settings remains a primary barrier to accessing healthcare in general. Some rural and Tribal communities try to fill this gap with telehealth, but several interviewees noted that there are still significant drawbacks to using telehealth. These include a higher bar to building rapport and the therapist's lack of specialized knowledge of the patient's community, making it difficult to make the best referrals or understand the full scope of available services. Often, inadequate phone and internet service in rural communities remains a barrier to consistently accessing telehealth services. Nevertheless, some rural and Tribal communities noted several benefits of telehealth services, including access (when available) and a greater ease in sharing information about oneself because the therapist is not a community member.

Consequences of Seeking or Needing Perinatal Mental Health Support

Many stakeholders mentioned that a fear of Child Protective Services (CPS) looms over many mothers who wish to seek mental health assistance. Interviewees noted how the dread of being "turned in" and separated from their children can prevent mothers from sharing their thoughts and feelings. And while appointments with healthcare professionals should be safe spaces to discuss difficulties with managing mental health illnesses, many mothers are hesitant to share mental health concerns with health providers for fear of being reported to CPS. Substance misuse and Substance Use Disorders (SUD) further complicates this relationship. Many mothers prefer to live under the radar rather than draw unwanted attention to their families.

> **"I don't want CPS to know that I exist."**

Because of its longstanding reputation for separating families, many people are unaware that CPS now pursues a goal of keeping families together and can be used as an information resource.

> **"Parents have the ability to call into Child Abuse Hotline to ask about resources, but no one wants to make that call because they don't want to open the CPS door. A parent needs to be able to call in themselves because CPS actually provides a lot of resources to parents who call and ask for resources. It's a completely different label than when someone calls in to report a parent."**

CPS has been engaged in training staff around PMH, but interviewees noted that each community still seems to handle situations differently. One interviewee observed that how you are treated and whether you maintain custody of your child(ren) might depend on what county you live in in Montana.

Some labor and delivery facilities routinely test for substances in the infant at the time of delivery. In some cases, families are not aware that this happens and are not prepared to cope with the possible legal and custodial ramifications if an infant tests positive for substances.

> **"Mothers don't even know that their baby is being drug tested and then CPS is all of a sudden in your room taking your baby away — really breaks trust and reinforces to women that the system can't be trusted and not a place that you would turn for help."**

Other legal issues like divorce and custody can be colored by a PMH diagnosis. One interviewee shared an instance in which her family member's diagnosis of severe postpartum depression was used against her by her husband in a custody case. Knowing that these diagnoses can influence a person's ability to maintain custody discourages people from seeking help and being formally diagnosed and treated.

Recognition of Social Determinants Affecting Perinatal Mental Health

Many people identified social determinants of health as a major contributor to PMH conditions that are difficult to control. Interviewees cited the skyrocketing cost of living in many Montana communities. High rent and housing prices were creating financial stress and housing instability, they noted, while the rising cost of food exacerbated food insecurity. In addition, transportation costs and a lack of childcare availability were making it nearly impossible for families to make it to additional appointments. These social determinants of health can magnify PMH symptoms, making coping with symptoms seem impossible. Factors such as inadequate housing and lacking sufficient nourishment for mothers or their families is not only a physical stress, but a mental health one as well.

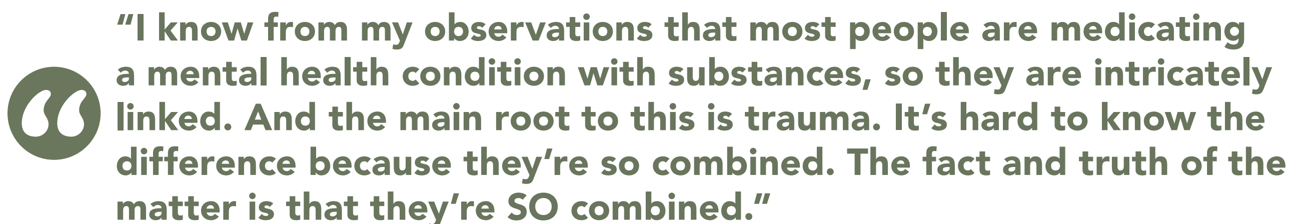
> **"Dare I mention the issue of affordable housing as a systemic issue? So many folks that I talk to ... it is hard to even dive into any potential mental health issues when they are struggling to meet more immediate needs like making their rent...."**

One Tribal community shared that because they believe that social determinants of health have a critical impact on mental health in their community, they have dedicated a significant grant toward improving mental health by funding things like education (HISET, associate's degrees), medical care (pre- and postpartum visits, birth control), and transportation.

Stakeholders expressed a commitment to ensuring that these issues were addressed as part of a comprehensive plan to support PMH in Montana.

Interconnectedness of Mental Health and Substance Use

More and more research is revealing that mental health and substance use are intertwined. Many times, individuals attempting to navigate mental health illnesses may turn to different substances to help them cope with the symptoms. In turn, the use and misuse of illicit and/or non-illicit substances may then exacerbate PMH symptoms, which starts a vicious cycle of using substances to cope with symptoms and worsening symptoms from using substances. When available, Medication Assisted Treatment (MAT) programs prioritize prenatal and postpartum mothers and collaborate with prenatal/obstetric clinics.



> **"I know from my observations that most people are medicating a mental health condition with substances, so they are intricately linked. And the main root to this is trauma. It's hard to know the difference because they're so combined. The fact and truth of the matter is that they're SO combined."**

> **"Trauma = Mental Health = SUD"**

Stakeholders noted a few ways to address this complex issue. Incorporating substance use questions on PMH screening questionnaires, and increasing awareness of the interconnectedness of mental health and substance use to reduce the stigma surrounding it are just two ways to help identify pregnant and postpartum women who may be struggling to develop constructive coping strategies. And just as there are a variety of PMH conditions, a mother could be using any of a number of

substances to manage symptoms. As a result, providers need to treat every case individually, and meet clients where they are.

"We need to cultivate happiness, recovery, joy, hope — addiction is isolation and recovery is connection. Connection to self and to others. We lose that in our SUD and mental health conditions."

Importance of Systems

Interviewees consistently acknowledged the role that high-quality systems play in helping to identify and treat PMADs. They noted that women who suffer from PMADs are often stereotyped and stigmatized as individuals who are "lazy," or "don't care about themselves or their children." They agreed that this is especially hurtful because, in their view, the system is the point where improvement needs to occur, though it is often the individuals who absorb the blame. Interviewees were well-versed in their understanding of the interconnectedness of PMH, Adverse Childhood Events (ACEs), general trauma, substance use, and social determinants of health. The systems in which all of these issues have to be addressed underlies the complexity of PMH in Montana.

PRIORITIES

Listed here are some of the priorities around perinatal mental health that interviewees brought up consistently throughout the interviews. Additional considerations and specific strategies will be considered when creating a strategic plan to accompany this work.

1. Among all perinatal providers and programs, increase awareness of and training for screening, referring, and treating PMADs.
2. Increase public awareness around PMADs and the resources available to support people and families in the perinatal period.
3. Offer care coordination for individuals experiencing PMADs that connects people to the right supports at the right times and provides continuity of care between programs and providers.
4. Address social determinants of health that impact perinatal mental health including, but not limited to: Transportation, Housing, Childcare, Food.
5. Increase peer-focused programming that provides group or individual support to people in the perinatal period.
6. Increase access to PMH-specific mental health providers who are available to provide timely assessment and treatment, as well as psychiatrists when necessary
7. Support culturally informed programs that serve the perinatal population through the provision and operationalization of cultural safety training, and increase diversity among providers and programming staff.

It is the hope of HMHB that a collective group of dedicated people across Montana will be able to work together through a concerted effort to accomplish some of the work noted in the priorities of the interviewees. These priorities will be used to guide a strategic plan to coordinate and drive improvements in the perinatal mental health landscape of Montana.

CONCLUSION AND NEXT STEPS

Numerous prevailing themes emerged from the 100 Cups of Coffee interviews, including the strengths, resources, gaps, and trends across the Montana PMH landscape.

Discussions with state-level stakeholders revealed strategies that could be used to address these concerns, while also ensuring that efforts are not duplicative. Many expressed the need to identify clear objectives and transparent goals or endpoints, and to collaborate with other known coalitions to reach program milestones and meet program objectives. Interviewees frequently mentioned Incorporating the perspectives of lived experts, whose experiences will be instrumental in guiding the PMH Collaborative's work. Similarly, including ambassadors or representatives from different geographies and diverse backgrounds such as indigenous, disability, or LGBTQ populations would also bolster the Collaborative's efforts.

In incorporating the perspectives of diverse populations, many state-level stakeholders mentioned that the voices and needs of Native American populations also need to be raised when developing programs or applying for funding. It is imperative to consider perspectives and feedback from Tribes and Tribal representatives and make measured efforts to improve established processes for reaching out to and collaborating with these communities and populations.

Overall, state- and community-level stakeholders seem hopeful that the PMH Collaborative will be able to address many of the community's concerns, and look forward to working together to tackle many of the issues surrounding PMH in Montana.

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