

Barriers to mental health treatment among obstetric patients at risk for depression

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OBJECTIVE: The objective of the study was to examine mental health referrals outcomes among obstetric patients at risk for depression.

STUDY DESIGN: Fifty-one perinatal women who were offered mental health referrals were queried about their behaviors at 4 steps in the treatment engagement process and factors facilitating or impeding each step.

RESULTS: Although 59% of at-risk women accepted mental health referrals, only 27% ultimately engaged in treatment. Women who proactively sought help via a hotline were more likely to accept referrals ($P < .001$), contact a referred provider ($P < .001$), and engage in treatment

($P < .05$) than those who received unsolicited referrals after screening at-risk for depression. Barriers to successful treatment linkage were identified at the patient, provider, and system levels.

CONCLUSION: Only a minority of women who are at risk for perinatal depression and receive mental health referrals ultimately engage in treatment. Successful linkage may be enhanced via interventions targeting identified barriers; such interventions require prospective evaluation.

Key words: mental health, perinatal depression, treatment engagement

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Depression is among the most common of perinatal complications, occurring in up to 19% of pregnant or postpartum women.¹ Antepartum depression can compromise pregnancy outcome,^{2,3} and postpartum depression can disrupt the parent-infant relationship and have a negative impact on child-

hood development.⁴⁻⁶ Perinatal depression screening is recognized as an effective means of identifying women at risk for depression during and after pregnancy.¹ The American College of Obstetricians and Gynecologists recommends screening pregnant and postpartum women for depression,⁷ and at least 3 state governments have enacted legislation to encourage screening.⁸⁻¹⁰

Despite the collective momentum favoring perinatal depression screening, its effectiveness can be compromised if appropriate evaluation and treatment of at-risk patients does not follow.¹¹ Obstetricians often rely on referral to mental health providers to evaluate and treat their patients who screen positive (at-risk) for perinatal depression. Unfortunately, research suggests that primary care-based mental health referral results in a low rate of successful linkage to treatment for depressed patients.

Based on a review of multiple controlled trials of care management and on data from their own practice, Solberg et al^{12,13} identified limited uptake of referral by patients and low follow-through from referring physicians. Mojtabi¹⁴ found that more than 30% of survey respondents in a nationally representative adult sample reported an unmet need for treatment of depressive symptoms, even

if subjects actively sought treatment. Utilizing data from a telephone survey of primary care physicians, Trude and Stoddard¹⁵ characterized the failure to connect patients to mental health services as a supply side flaw of the health care system wherein inadequate referral systems between medical and mental health services hamper access.

To date, no studies have tracked depression treatment uptake among perinatal women and gathered qualitative data on the help-seeking experience from the patient's perspective,¹⁶ and only 1 study tracked a cohort of perinatal women to observe their mental health treatment outcomes after receiving referrals.¹⁷

To gauge the impact of clinician behavior on treatment follow-through, Flynn et al¹⁷ conducted a longitudinal study tracking depression screening scores, diagnosis for major depressive disorder, impact of inclusion of high Edinburgh Postnatal Depression Scale (EPDS) score in chart on physician discussion of depression treatment, and depression treatment usage from 3 months prior to first prenatal appointment through 6 weeks postpartum. They concluded that physician discussion of depression treatment doubled treatment uptake in the short term for patients with

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TABLE 1
Selected characteristics of study participants (n = 51)

Characteristic	%
Privately insured	88
Publicly insured or uninsured	12
Partnered	88
Unpartnered	13
Antepartum	47
Postpartum	53
High-risk pregnancy ^a	12
Multiple gestation	4
History of mental illness	43
On psychotropic medication	10

^a Defined as receiving obstetric care from a maternal-fetal medicine specialist.

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scores 10 or greater on the EPDS. In contrast to the research presented here, Flynn et al did not seek qualitative information from study subjects explaining behaviors or barriers at each step of the referral uptake process.

In the current study, we conducted extended interviews in a group of women at risk for depression as identified via positive screening or after calling a perinatal mental health hotline. In both instances, standardized telephone assessment¹⁸ and referrals were made by trained mental health staff. The subsequent survey and interviews of consenting women were designed to discern barriers (and facilitators) of referral acceptance and treatment engagement for these at-risk women.^{18,19}

MATERIALS AND METHODS

To understand patient behaviors and barriers at each step of the referral process, this study examined outcomes among a sample of 51 perinatal women who were offered mental health referrals during the course of their obstetric care and agreed to participate in a program evaluation study. Eligible subjects were derived from a preexisting department-based universal depression screening program; the program also sponsors a perinatal depression hotline that is avail-

able throughout the state of Illinois via a partnership with the Department of Public Health. Both the screening program and the hotline service were components of CHAPERONE (Creating Healthy Antepartum and Postpartum Expectations, Realities and Outcomes for New and Expectant mothers), a department-based program that utilizes centralized processing of depression screening coupled to referral of at-risk women to an established network of community-based mental health providers. The details of this program have been described elsewhere.^{18,19}

During the study period (June 2006 to November 2007), 958 patients met eligibility criteria; 379 of these (40%) provided consent to be contacted for research, and 51 subjects were recruited to participate in the study (screen positive, n = 28; hotline call, n = 23). This sample size was targeted based on recommended sample sizes for qualitative research.²⁰⁻²² With approval from the institutional review board, women were contacted an average of 9 weeks (range, 2-24 weeks) after being offered mental health referrals and invited to participate in this study and provide informed consent.

Study invitation was intentionally delayed to afford women adequate time to follow through on any mental health referrals they had received unencumbered by the study inquiry; women who had declined mental health referrals were able to be interviewed, on average, earlier than those who indicated their acceptance of referrals during phone evaluation and triage. Among the screened group who were approached for participation, 59% consented to the study as compared with 26% of eligible women who were invited from the hotline group.

Participants completed a mixed-methods telephone interview at a time of their convenience to examine their behaviors at several key steps in the referral uptake process and to determine what factors in their experience facilitated or impeded each step. Our assessment of the treatment engagement process focused on 4 distinct ordinal steps that were selected to best explore patient,

provider, and systems barriers: (1) verbally accepting a mental health referral during the phone evaluation; (2) contacting a mental health provider after receiving the referral information; (3) seeing a mental health provider for an initial session; and (4) returning for additional mental health treatment thereafter.

All interviews were conducted by mental health professionals with expertise in perinatal care. The interview consisted of fixed-response survey data regarding specific behaviors (eg, did you contact the counselor to whom you were referred?) and semistructured qualitative follow-up (eg, why did you not contact the counselor?). The interviews ranged from 15 to 45 minutes in length.

Interview data were audio recorded, transcribed verbatim (with identifiers removed), and imported into NVivo version 7 data management software (QSR International, Doncaster, Victoria, Australia).²³ Qualitative data were independently coded by 3 trained raters using a comparative case study design to identify barriers and facilitators to mental health treatment.²⁴ Coding was reconciled across raters to ensure accuracy and consistency. NVivo software was used to facilitate qualitative data analysis and retrieval. Demographic and fixed-response survey data were assigned numeric values, coded as participant attributes, and analyzed via 2-tailed Fisher's exact test using GraphPad QuickCalcs software (GraphPad Inc, San Diego, CA).

RESULTS

The demographic and obstetric characteristics of the study sample are reported in Table 1. As compared with the overall group of eligible participants, study subjects were more likely to be privately insured (86.4% of participants vs 59.4% of overall eligible sample; $P = .009$). There was no difference between the participant group and the overall eligible group in marital status (partnered vs unpartnered) or gestational time (antepartum vs postpartum).

Mental health treatment data were initially partitioned between screen-positive subjects vs hotline callers and then subsequently compared. Table 2 illus-

trates the stepwise treatment engagement outcomes for each of these groups. The hotline group was more likely than the screened group to accept a referral (87% vs 36%; $P < .001$), contact a provider (70% vs 18%; $P < .001$), see a provider for an initial session (52% vs 14%; $P < .01$), and continue treatment beyond the initial session (43% vs 14%; $P < .05$). However, similar proportions (50% of hotline callers and 60% of screened women) who initially accepted referral in both groups did not follow through with at least 2 mental health visits.

Beyond the initial barrier of accepting referral information, it appears that both groups had similar rates of retention through steps 2-4 as described in previous text (expressed as percentages in Table 1). For the overall study cohort, the stepwise referral outcomes were not associated with number of other children in the household, time frame in which the referral was provided (antepartum vs postpartum), or prior mental health history (presence or absence of preexisting psychiatric diagnosis).

A variety of barriers and facilitators to successful mental health treatment linkage were identified at the patient, provider, patient/provider interaction, and system levels. The most commonly described barriers at each level are listed in Table 3 accompanied by illustrative quotes from individual subjects. Among patient-level barriers, lack of time was the most commonly cited (noted by 4 of 16, or 25%, of women who accepted referrals but did not ultimately engage in treatment) and recognition of one's own need for treatment the most common facilitator (noted by 14% of the 14 women who ultimately engaged in treatment).

At the provider level, availability (or lack thereof) was the key factor having an impact on treatment linkage (described as a barrier by 56% non-treatment-engaging group and as a facilitator by 21% of the treatment-engaging group). At the system level, cost and insurance match were the most frequently cited variables both hindering (as cited by 56% of non-engagers) and facilitating (as cited by 21% of engagers) mental health treatment engagement. Additional com-

TABLE 2

Degree of mental health referral engagement among perinatal women identified by screening vs hotline

Steps in mental health referral engagement process	Screened at risk, n (%)	Called hotline, n (%)	Total, n (%)
n	28	23	51
Accepted referral	10 (36)	20 (87) ^a	30 (59)
Contacted mental health provider	5 (18)	16 (70) ^a	22 (41)
Saw mental health provider	4 (14)	12 (52) ^b	16 (31)
Returned to mental health provider	4 (14)	10 (43) ^c	14 (27)

Each (percent) represents a proportion of the respective column total.

^a $P < .001$, comparing screened vs hotline-based patient identification; ^b $P < .01$, comparing screened vs hotline-based patient identification; ^c $P < .05$, comparing screened vs hotline-based patient identification.

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monly described barriers included poor match of referral to need, poor patient-provider fit, provider unresponsiveness, and geographic mismatch (cited by 31%, 31%, 25%, and 19% of nonengagers, respectively). Additional factors cited as facilitators included referrals tailored to patient needs, specific encouragement to engage in treatment, geographic match, and active facilitation of the referral process (such as making calls on a patient's behalf, cited by 29%, 21%, 21%, and 14% of treatment engagers, respectively).

Barriers and facilitators differed at each step of the mental health referral process, with patient-level factors (use of other social support, lack of time, recognition of own need for treatment) playing a greater role in determining whether women initially contacted a mental health referral and provider-level factors (specifically, availability) most commonly cited in determining whether a mental health professional was seen. Patient/provider match and cost/insurance issues had the greatest impact on whether women engaged in treatment beyond the initial session.

COMMENT

Our finding that only a minority of women who receive mental health referrals because they are at risk for perinatal depression actually engage in treatment is troublesome and suggests that families remain at significant risk, even when clinical follow-up to positive screening is uniformly applied. To gain insight into this low rate of uptake, our study was

able to examine, from patients' perspectives, barriers at several discrete steps in the treatment engagement process.

We acknowledge that the relatively low study acceptance rate for the hotline group may have influenced our findings as related to the comparison with screened subjects. Our study also may overestimate rates of successful mental health treatment engagement in general because of care facilitation that occurred for all subjects via the initial phone evaluation.

In most centers, perinatal depression screening is not actively linked to a chaproned process of phone evaluation for all at-risk women. Patients inclined toward study participation may also represent those more likely to have had a favorable mental health experience related to the program and thus not be as representative of all at-risk women. It is also noteworthy that women participating in this study were more likely vs the overall patient population to have private insurance, and therefore, barriers to care experienced among publicly insured or uninsured women may be underrepresented. Despite these potential limitations, and despite a relatively small study cohort, however, many barriers to care were identified that warrant further analysis and create opportunities to design interventions to address these barriers.

Women in our study who proactively sought help or advice via a hotline were more likely to accept, contact, and engage the mental health provider to which

TABLE 3

Most common barriers to mental health treatment engagement as cited by perinatal women

Barrier type	Barrier description	Example	Subjects citing, % ^a
Patient level			
	Lack of time	"Mainly it was just time. Who needs 1 more person to call and 1 more thing to do?"	25
	Used other support	"It was a quick period of time before I had that baby and before circumstances were changing and I was getting support in other places."	25
	Spontaneous improvement of symptoms	"I do have the name of someone who takes my insurance. I did not go see them though. By the time that I got all that straightened out . . . I was feeling much better."	13
Provider level			
	Provider unavailability	"[The] hotline gave me the name of 3 psychiatrists and I called all 3. One said they were on vacation . . . and 1 of the doctors called me back and said, 'Well I'm not taking any new patients so I can't see you.' And the third doctor called me back and said, 'I can't see you for 2 weeks.'"	56
	Unresponsive provider	"The first [psychiatrist], who was supposedly the most renowned of the 3, never did call back."	25
Patient/provider interaction			
	Poor match to need	"I just wasn't looking for something long term like [counseling]. I just needed a quick fix."	31
	Poor patient/provider fit	"We just didn't click."	31
	"Phone tag"	"We played phone tag for about a week and half let's put it that way, between the 2 of us."	31
System level			
	Cost/insurance mismatch	"Well, the doctor was very, very easy to talk to. Like I said, she gave me a lot of her time on the phone. And that was great. I wish that we had more money and I could have seen her, I could afford see her and talk to her . . . It was annoying that they didn't take my insurance."	56
	Geographic mismatch/inconvenient location	"I didn't follow up afterward because there wasn't a convenient location that was offered to me."	19

^a Expressed as percentage of subjects who accepted referrals but did not engage in treatment. Percentages do not total 100 because of multiple barriers cited by some participants and omission of barriers cited by single participants only.

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they were referred. This finding could be interpreted as a consequence of higher patient acuity among hotline callers and/or greater motivation to seek care when compared with a screen-positive patient who has not initiated contact on her own.

Our data also suggest, however, that once referrals are accepted by either of these 2 groups, further uptake of treatment (initial and subsequent consultations) appears similar as do the types of patient, provider, and systems barriers perceived by these women. Overcoming barriers for women who screen positive may be just as important when com-

pared with hotline callers because intrinsic motivation to engage in mental health services may be lower in the former group, yet this population represents a substantial proportion of at-risk women for whom treatment may be beneficial. This is illustrated by the relative distribution of at-risk women observed in our center over a 6 year epoch (mid-2003 to mid-2009); 1798 hotline calls were received, compared with 1885 at-risk women identified via antepartum and postpartum screening.

It is noteworthy that some of the barriers to mental health treatment among perinatal women identified by previous

studies were not cited by women in our study. Some of the most common patient-level barriers denoted in the existing literature include patients' perceived stigma preventing acceptance of a postpartum depression diagnosis or treatment,^{16,25-35} misconceptions or lack of knowledge about postpartum depression,^{16,27-30,32,36-38} and aversion to mental health care^{13,16, 25,29-32,35} or pharmacotherapy.^{29,30,35,36,39} Yet none of these barriers were cited by the women who participated in our study in response to direct questioning. This difference may be a consequence of the provider and patient education inherent in the CHAP-

ERONE program and the universal, normalized nature of perinatal depression screening promoted by the program.

Despite the reduction of the specific barriers noted in previous text, universal screening followed by care facilitation as currently implemented under CHAPERONE is clearly not sufficient to ensure that the majority of at-risk women receive the mental health care they need. Further research focused on testing variations in the phone evaluation and triage methodology is required.

Possible strategies to be tested include altering the script used by care facilitators to specifically encourage referral follow-through, direct facilitation of the referral process (making the appointment for the patient), or implementation of follow-up care facilitator contact at specified intervals to identify and help ameliorate barriers to care. Strategies to address provider-level barriers might include conducting focus groups of mental health providers to determine relative awareness of these barriers followed by education sessions of the greater community mental health provider network regarding potential solutions. Systems-level barriers should be addressed via advocating for better mental health coverage for pregnant women and proposing better training models for perinatal mental health to increase the supply of properly prepared providers in the community. Such strategies should be deployed sequentially and tested prospectively. ■

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