Behavioral health integration webinar series: Stigma

On Nov. 19, 2020, the Behavioral Health Integration (BHI) Collaborative held the fifth webinar in the Overcoming Obstacles BHI webinar series: "Physicians leading the charge: Dismantling stigma around behavioral health conditions and treatment."

View webinar slides (PDF).

About the event

This BHI Collaborative-hosted interactive webinar shares examples of how physicians, and other non-physician clinicians of the care-team can be leaders in breaking the stigma barrier and normalizing treatment for people with mental health conditions with an emphasis on those who are underserved or are of special populations.

Moderator

- Mary Giliberti, JD, executive vice president of policy, Mental Health America

Speakers

- Sourav Sengupta, MD, MPH, assistant professor of psychiatry & pediatrics; director of training—child and adolescent psychiatry, University at Buffalo School of Medicine and Biomedical Sciences
- Tiffany Moore Simas, MD, MPH, MEd, FACOG, professor of obstetrics & gynecology, pediatrics, psychiatry and population & quantitative health sciences; vice chair, Dept. Ob/Gyn; director, Research Division, Dept. Ob/Gyn; co-director, Maternity Center; medical


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Transcript

**Kwiatkowski:** Good evening, everyone. This is Meghan Kwiatkowski with the AMA. Before we get started, I'd just like to go over a few housekeeping items that we have. Please use the chat box for any questions. We do encourage attendees to interact and share comments or questions in the chat box while our panelists are presenting. Please note that this webinar is being recorded and is informational only. You should consult a professional advisor for specific medical, legal, financial or other advice. Both the recording and the slides will be shared in an email following the event. A survey will also be included. The staff of the Collaborative encourage you to share your feedback as we plan our future events.

**Remick:** Good evening, and welcome to the BHI Collaborative's Overcoming Obstacles series, "Sustaining Behavioral Health Care in Your Practice." I'm Arlene Remick, program director at the American College of Obstetricians and Gynecologists. As a member organization representative of the BHI Collaborative, I am pleased to welcome you to our fifth webinar in this series. This educational series as part of a suite of ongoing activities by the BHI Collaborative dedicated to equipping physicians with the necessary knowledge to sustain a whole-person, integrated and equitable approach to physical, mental and behavioral health care in their practices during the COVID-19 pandemic and beyond. These webinars are a collaborative product of eight of the nation's leading physician organizations, established to catalyze effective and sustainable integration of behavioral and mental health care into physician practices. With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

Today's webinar titled "Physicians Leading the Charge: Dismantling Stigma Around Behavioral Health Conditions and Treatment" will provide examples of how physicians and other non-physician clinicians of the care team can be leaders in breaking the stigma barrier and supporting their patients. At the end of tonight's discussion, we will have a Q&A with our experts to explore common issues or concerns that you may be experiencing.

I am pleased to introduce our speakers. Dr. Sourav Sengupta is an assistant professor of psychiatry and pediatrics and director of training for child and adolescent psychiatry at the University of Buffalo School of Medicine and Biomedical Sciences. Dr. Tiffany Moore Simas is the engagement director for MCPAP for Moms and medical director of Lifeline for Moms. She is the chair of the Department of
Giliberti: Hello, everyone. I'm Mary Giliberti. I am the executive vice president of policy for Mental Health America. And I'm going to get us started this evening. Next slide. That slide shows you the separation between the brain and the body, which is the foundation of stigma. And I've been asked to start us off by talking from the patient and family perspective. I work at Mental Health America, which is a group that really focuses on the individual with a mental health condition. I also previously was the CEO of NAMI, the National Alliance on Mental Illness, which many of you know and works with families. So I'm going to wear that hat today when I talk to you a little bit about that perspective. And I'd like to use some common words for stigma because I think if you went out there and asked people, "What's stigma," a lot of people don't talk about it that way. They talk about discrimination, shame and blame. So those are the three concepts I'm going to talk about today, mostly focusing on the shame and blame because that's how patients and families experience things. Next slide, please.

So talking about discrimination to start us off, but my colleagues are going talk even more about this. We know that you all here, and I want to thank you so much for being here, you want the very best for your patients, or you wouldn't be doing this after a full day of seeing them. But you have a lot of structural discrimination. And that shows up in the education that you receive, where mental health and substance use is not always included, and then certainly in payment. And we know that, mental health specialists, but also the doctors that interact with them do not get compensated for that as a result of that discrimination or stigma. And I know my colleagues are going to talk a lot more about how to address those issues. Next slide, please.

But I want to focus on the shame and the blame, which is how the patients and families feel a little bit. Patients reflect the views of their culture, their society, their families, and they often internalize that mental health conditions are a character flaw or something to be denied or embarrassed or shamed about. And you know and I know that it's a medical condition, but people don't always feel that way. And particularly interacts with culture and race as we as a society really grapple with racial justice issues, we have to think about the fact that people who already experienced discrimination are concerned about aligning themselves with a condition that is further marginalized. And there's lots of intersectionalities between LGBTQ status, race, mental health and other areas of people's lives. And then their social determinants. So you may be saying to the patient, "Hey, you should think about seeing a specialist," and in their mind, they're thinking, oh my goodness, another co-pay, another transportation problem, how am I going to get there, how am I going to take time off of work, all of those issues that play into those considerations. Next slide, please.
And then there's the blame part of it that people worry about. So they worry a lot that you as their physician are going to look at them differently if you know that they have a mental health or substance use condition. Some worry a lot that the practice won't continue seeing them. That's particularly something I've heard from people who have substance use conditions. They're worried about how the health care system is going to treat them because now we have EHRs. And that's great. We always say, "Hey, we're going to treat the whole person." But what happens when someone goes to get treatment for a physical health condition and they're not treated as well because they can see that they have a mental health condition? I've had help line calls. One of the things I used to do a lot of is take help line calls of people who were really upset because they got to the hospital, and when they saw that they were taking medication for schizophrenia, all of a sudden they found themselves treated like a criminal justice situation with someone outside their door and really not treated the same way. So those issues are in the back of people's minds.

And then they're also concerned about what's going to happen with the information outside the health care system. So will this get to criminal justice? Will this get involved in Child Protection? Will somebody else be notified? Immigration issues. So, again, culture, race coming into all of that. So there's a shame piece of it. There is a blame piece of it that people really are concerned about. Next slide, please.

So how does that show up in the clinic? So think about if I'm coming and I have all these questions that I've been talking about, all these concerns swirling around in my head, and then you hand me some sheets and tell me to fill them out, not answering any of those questions, not getting at any of those feelings. Similarly, sometimes people will do this, and then they tell me later that they never heard back. They didn't even get any response to what they had said on their screening. And then if someone's just referred out and no one really has a conversation with them, and I'm going to talk a little bit later about what people want when these conditions are discovered, how does that make someone feel? So getting information from people about how it makes them feel, looking at data, particularly around race and ethnicity, can be helpful ways to address how things are working in the clinic. Next slide, please.

So I thought this slide might be interesting for some of you to see because we at MHA have a screening program. And I'm going to give you the website for that, but you can go on our website and take a screen. They're all validated. So their PHQ-9s, GAD-7s, those kinds of screens. And if you screen that you have some of these symptoms, we will tell you. And you'll see on the next slide maybe you want to get some additional help, and we'll offer some options. But I think this slide is interesting because we broke down. We have demographic data by race and ethnicity who said they were willing to do something as a next step once they got their results. And you'll see there that it does vary quite a bit by race and ethnicity, with black screeners being the most likely to do something. And I think that that's important just to see the data there because sometimes we bring biases into what we're doing, and the data tells us that people are really wanting to know and take action about some of these.
conditions. Next slide, please.

This slide shows you from our screening data what people wanted to do next. And, again, I think this also is not always intuitive to those of us that are in the health care field because the first one on the left says make a phone call or get a referral. And you'll see there that pretty much uniformly, some a little bit more than others, but uniformly people weren't that keen on that one. But the next one is just learn more. And that got a much higher response. Using digital tools came next, and then getting using some worksheets and tools to get help. And I think that, really, if you think back what I talked about, the shame, the blame, all those things that people are thinking about, it makes sense that a patient's on a journey. And when they discover that they have something, these are the kinds of steps that might move them along that journey. And that's just something to be thinking about as we think about stigma and its role. Next slide, please.

So I want to end on, really, a positive note, which is I think that this is a unique time with a tremendous amount of opportunity because the silver lining on COVID is it really has normalized the conversation around mental health. And I think that's very helpful because it's not seen so much as outside or something to be ashamed of. Everybody is experiencing anxiety. Everybody is dealing with this epidemic. And then you have people who are disproportionately feeling the impact, and that's well-known. And so having those conversations about grief and anxiety is more normalized. And then in popular culture, we see lots of celebrities talking about this, and we're seeing lots more conversation in community, whether that's in schools or it's doctor's offices or anywhere, faith communities, just being talked about in community. And then, of course, what the rest of the presentation's about, there's so many opportunities for people to get help and consultation. I think there's never been more. Of course, we always need more than there is today, but there's really some great resources that we're excited to share with you. Next slide.

And there you see some of the celebrities, but I just want to close by saying you really are my heroes because as someone who works with all the patients and families and people who have these conditions, it's folks like you who are willing to take your time again to help. It just makes a tremendous difference. So thank you very much. And next slide, last slide. This is my contact information. And on the bottom there, you see our screening website. And when you go to that website, if you go down a little bit, it has learn more. And there's a lot of Q&A's there that are the way people talk about these things, plain language, very colloquial. And so it's a resource for you as you're talking to patients. If you want to have people be able to look and answer questions that they might have, that's a resource that I urge you to use. Thank you very much. And I'll turn it over now to Dr. Sengupta.

Dr. Sengupta: Thanks so much, Mary, and thanks for your work at Mental Health America and advocating for patients and families and their experiences in helping to live better lives. So, again, my name's Sourav Sengupta. I'm a child and adolescent psychiatrist in Buffalo, New York, and I wear a couple different hats. So I'm the co-chair for the American Academy of Child and Adolescent
Psychiatry's Collaborative and Integrated Care Committee. And I run an integrated care program where we have psychiatrists and therapists and care coordinators embedded into primary care practices. And then I do a fair amount of medical education. I run our child psychiatry fellowship. So a lot of my mental energy is spent thinking about integrated care, behavioral health integration and also how we can help others be able to utilize it as much as we can. And so I wanted to just give a little bit of a sense of how we can navigate stigma from the clinical perspective. Next slide, please.

So I think part of it is we have to acknowledge that it's a little bit challenging to think about the idea of holding stigma against mental health, especially as physicians, as different types of providers in the health care space. Next slide. And I think part of it's helpful is just to take a look at some of the facts around it. We've been able to take a look at challenging aspects of our practice before think about how we're better understanding the role of implicit bias in medicine. And this is another area where if we just look at the facts, some mental health issues are becoming increasingly prevalent in the general population. There are more prevalent presentations in different kinds of care settings. But there's also some things that are different about it. So mental health issues can present as behaviors, and those are things that we have a natural tendency to wonder, how much of this is related to an illness or disorder and how much is in the control of an individual? And I think that's a natural question for us to ask, but when we are wavering within that, if we're wavering towards the side of something being in control of an individual, that's also a place from which we can bring some judgment to that.

And also, mental health issues impact others beyond just the patient. And this is probably true of many different types of conditions. But think about families, caregivers, the staff in your practice or your hospital, your other colleagues in medicine. Sometimes they can have challenging experiences working with some of these individuals, and it can be challenging for us, not necessarily for us, to feel something related to that that can subtly or maybe not so subtly contribute to some issues around stigma. Next slide, please.

And so one of the things I like to try to think about, and I try to think about this with my trainees, is what are the differences in the ways we feel comfortable asking about different types of things? So how comfortable do we feel about asking about physical health conditions compared to mental health conditions? What's the difference in how comfortable we feel about talking about our own challenges, right? I might say, "Oh yeah, I had a left knee replacement a couple of years ago, I'm doing fine now," whereas am I going to say the same about trying to get through a depressive episode from the past? And you can make arguments, "Well, that's more intimate information. That's more private," but at some level, there's some room for stigma to be a part of that.

Another thing I often try to bring up is what are the differences in what we laugh about? And sure, we all I think have a little bit of a space to be able to vent and release some steam when we're in a challenging workplace, but I do challenge folks to ask how much we'll be laughing about someone

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struggling to manage a certain type of physical health condition versus someone struggling to manage a personality disorder, or something along those lines. And I think we would be hard-pressed not to find certain differences in those things. And in those differences, I think we can see some room for stigma to grow. And I think we need to potentially be a little bit more cautious about that. Next slide, please.

So I still find it's often very challenging to have conversations just for myself or with colleagues about the concept of stigma. I think we're all coming to this place with the intent of being helpful to our patients. And so sometimes I think it helps to sort of break it down and take a look at it. So we're talking about behaviors, what is the behavior? And I think one of the primary behaviors associated with stigma is avoidance. And that often, one of the things we find ourselves doing is sort of not addressing these kinds of issues in a similar way that we might other sort of, even challenging clinical issues that we come up against in practice on a daily basis. Next slide.

And so if we think about what are the components of avoidance, one of them is fear, right? The fear of the unknown, the fear of a big, bad thing happening. Next. Part of it is just simply a lack, a lack of knowledge, not really understanding what it is that I need to do, next, and also just simply not having had an opportunity to really practice and do it before, right? So much of our training model is an apprenticeship model. It's focused on learning by doing, and if I haven't done it before, how am I supposed to know how to manage it now? Next.

So let's just take a look at a couple of different aspects of this. So with fear, next, we might be worried about, again, some of those big, bad outcomes, the possibility that one of our patients might be thinking about suicide or commit suicide, next, that they might get violent. This is not necessarily always an accurate concern, but certainly one that can create a lot of fear within us as physicians. Next. And then there's liability concerns. Again, when we're not sure what to do, our sort of fear can take us to this place of, "Well, what if I get sued? I don't know what's going to happen." Next.

And then within lack of knowledge and experience, let's take a look at a couple of different components here, Next. Did we ever actually learn how to do this, right? So in medical school, in residency, did we actually get access to the knowledge of how do I treat this type of condition? How do I work with this type of patient? Next. Okay, so maybe I didn't, how the heck do I learn about it now, right? In the midst of all of the different types of continuing medical education and maintenance and certification, all these things that we have to do, how are we supposed to find the energy and space to learn about new things that obviously are important, but how do I do it? Next.

And then, how do you possibly address these things in the context of a very busy clinical practice? All of you are busy doing the good work, but to do some of this work involving behavioral health integration, working with folks with mental health issues, often it takes a different skillset, more time, more energy. Next.
So let's just take a look at a couple of examples of some of these kind of components. So specifically around the fear around suicide, I want to share with you just a very practical resource that I think a lot of my primary care colleagues have found very useful. Next, please.

So this is the Suicide Prevention Resource Center, also called SPRC, and they have a wonderful suicide prevention toolkit for primary care practices that gives access to just kind of clinical algorithms, logistics and processes. Next, please. So here's an example of a really, a well done sort of algorithm for how to look at high, moderate, and low risk patients in terms of suicidality, right? And in terms of some of the questions you might ask, and just some of the step-by-step processes that we might need to engage in for someone who is at higher risk.

This is the kind of thing that when I'm thinking about how to help my staff better and more commonly manage a patient with an acute medical issue, let's say, [inaudible 00:21:05] chest pain, we can also do exercises to help them figure out how to manage when someone calls in talking about acute suicidality as well, and that's one way to allay that fear. Next, please.

And then how about the lack of knowledge and experience? So in terms of addressing that issue of how do we do this in the context of the busy clinical practices, as many of you know, there's so many different models out there in terms of ways that people have tried to find ways to collaborate and join behavioral health expertise within medical models. Folks have taken a look at patient-centered medical home, so the idea of creating, for instance, registries for folks that have depression, doing certain amounts of screening and outreach for those types of patients.

Behavioral health care managers, these are really wonderful folks that really can help to make sure that the information involved in patient care for folks with behavioral health issues flows, or that they get the referrals and connections to the right resources they

And beyond that, you have behavioral health consultants or integrated care therapists and psychiatrists, and this is where folks are actually engaging in some direct care at the point of service in medical care environments. Next, please.

Super busy slide, I know, but just giving you an example of the huge breadth of ways that folks throughout the entire country are taking a look at creatively addressing this issue of how do we manage to help these patients in the context of busy clinical practice, right? Sometimes it's just coordinating care and really developing closer relationships between behavioral health providers and medical providers. Co-locating, getting into that same physical space, rubbing elbows, making it easier to have some of those quick conversations and handoffs of care, and then true integration where we're really breaking down those silos of information and care where we're working together. Next, please.

And then when it comes to workforce education and training, next, please, a couple of great examples looking at just good resources out there in the community. So in terms of pediatrics, so this is the
Pediatric Access Line, Bob Hilts' program out in Washington out of Seattle Children's where they have some great resources on, for instance, how to manage depressive symptoms in a young patient. Next, please.

And then for the adult world a little bit more so, the AIMS Center, also out of Washington, but available for all to take a look at logistics and processes for how can you actually implement some of these types of programs in your practice. And so it's just a really, a good font of information out there for everybody.

So next, we'll have some folks that are going to really talk about just some success in terms of how they've been able to develop these kinds of programs. I'll turn it over to Dr. Byatt and Dr. Moore Simas.

**Dr. Byatt:** Thank you. So I'm Nancy Byatt. I'm a perinatal psychiatrist, and similar to Sourav, have spent most of my career focused on working to integrate care for mental health and substance use disorders into maternal child health care settings, the majority of that time being obstetric settings. And I'm here with Tiffany Moore Simas, an OB-GYN who I have worked with on a lot of these projects who will be speaking after me.

So I think as you heard, I love the way Sourav put it, I mean, around avoidance, right? And when we think about stigma, a lot of what it can cause is avoidance. And it often leaves peri... And I'm going to focus specifically on perinatal mental health, and it often leaves these conditions unaddressed with far-reaching implications.

So this is actually a picture of my mother and her mother when my mother was a baby. So speaking of avoidance, this was in the 1950s when nobody even knew what postpartum psychiatric illness was, to the extent that my mom was actually sent to go live on a farm with a family she'd never met for six months in her first year of life due to some unknown, still, we don't understand what happened, psychiatric illness that my grandmother had.

So I grew up kind of being really aware of the importance of maternal mental health and also of stigma and how not even acknowledging this can really have these far-reaching implications. Next slide, please.

You fast forward 60 years to when I was a consultation liaison psychiatry fellow at Brigham and Women's, and this woman presented to me who I'm going to call Kai, and she presented in her second pregnancy and described her experience in her first pregnancy, and really described that she began to have depression symptoms in pregnancy. She described that when the baby was born, it hit her like a ton of bricks. She said the baby felt like an alien to her. And she really felt that she wasn't there during that baby's first year of life. And she had absolutely no idea that she had depression, and she also didn't realize until she came out of it about a year and a half later that she wasn't herself and


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that that's not what motherhood is necessarily like all the time and that we can expect to feel better.

And there was a few things that really struck me about this. One, no one ever asked her about whether she had depression. And she saw many providers during that time period that could have asked her about it, could have let her know this was common, and could have also helped refer her for treatment. And if we think about diabetes as a parallel, that would never happen, right? If we think about diabetes and pregnancy. Depression is actually twice as common as diabetes and pregnancy, but diabetes, we screen, we address it, and we make sure we refer.

So if we think about the maternal child health care settings, there's so many opportunities to dismantle stigma against mental health within these health care systems. And we can do that by integrating care in and prioritizing this as much as we do physical. Next slide, please.

So why does this occur? I think, Mary, in the first talk outlined this really well. She talked about how patients are feeling. Patients feel ashamed, they feel discriminated against, and then providers avoid it. As Sourav said, they avoid it. And why do they avoid it? Because they don’t have the knowledge, they don’t have the experience, and they also are afraid. They don't want it.

We actually, when we first started doing research on this, one of the focus groups, one of the providers said, "We ask them, 'Are you suicidal? Are you homicidal?' and we hope they say no to all of it because we don't know what to say." They want to do the right thing, but they're afraid and they don't have the knowledge or the skills to be able to address this, especially obstetric providers who this has not traditionally been a part of their training.

And then the systems, as Mary talked about this earlier, and then their systems aren't integrated. And a lot of this is all driven by stigma. Mental health hasn't been prioritized as part of medical care as much as some of the other specialties have.

So you get this system where women aren't disclosing symptoms or seeking care, and then you have unprepared providers with limited resources and unprepared systems. So of course you're going to get limited or no engagement in treatment, and then you're going to get poor outcomes.

So if we can build front-line provider capacity to get over some of the things Sourav talked about, build their skillset so they're not afraid, build their knowledge, and then give them experience, we can then integrate mental health care in these settings and decrease stigma. And the goal, if we can do that, then we can also shift to a strength-based perinatal care model. Next slide, please.

So I'm going to give an example of ... many wonderful, integrative care models, and I'm going to talk about one specifically, which is MCPAP For Moms, a program I founded and direct, and it stands for the Massachusetts Child Psychiatry Access Program For Moms. There's a child pediatric version of this that we built this off of that was spoken about in an earlier webinar.

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So it really has three core components, education, consultation, and resource and referrals. So we go out and we do trainings and we train providers how do you talk to women so they don't feel like "I hope they so no to all of it because I don't know what to do." So we can help build this up ... how do you have these conversations? And also, what do you do if someone screens positive, and how do you have a strength-based discussion?

We also do consultations. So we do that by telephone and face-to-face. They can call us, we can answer questions. And then we provide resources and referrals to help them navigate through that complicated mental health system. And throughout this whole process, we're engaging providers and patients.

I'm going to give an example. I'm going to go back to Kai and talk about how it could have been different through our program. So what we do is we train providers and we have toolkits and algorithms, and in that, we recommend screening twice in pregnancy, once postpartum. So going back to Kai, for example, her OB could've screened her in the first trimester and let her know, "Depression is twice as common as diabetes. We're here to help you, and this is going to be part of your care and we're going to continue to ask these questions throughout your pregnancy because your mental health is an important part of your obstetric care."

And then if she screened positive, they could have had a conversation with her and offer her treatment. And if they didn't know what to do, they could call MCPAP For Moms and we can help hold their hand and help them figure out how to manage, how to either start a medicine or do a referral. If she needed a therapy referral, one of our resource and referral specialists could have called Kai and referred her to treatment in the community. And if the OB didn't know what to do and felt uncomfortable after a phone consultation, we can see her for a one time consult, and we can usually get people in for that within a couple of weeks.

So that kind of gives a high level overview of how Kai's situation could have been different if the care had been integrated, and throughout that, we were prioritizing her mental health, thus decreasing stigma and making it part of whole health. Next slide, please.

And one of the things that we've seen happen as we've done this is that as we build frontline provider capacity, we have seen, in Massachusetts, the culture shift. Our utilization data of our program shows this, providers are calling about more complicated complex illness. We started with depression and we've moved to now they're calling about bipolar disorder. We had a substance use expansion, and we're also focusing on response to COVID-19 and health equity.

The intersectionality between the discrimination and trauma people experience around trauma in general, and then also discrimination around mental health, and then you get other forms of discrimination, particularly for communities that have been marginalized or underserved, you get this intersectionality that we are working to proactively address to make sure to do the best we can so that
people who experience more barriers to care, that we're working to engage them and dismantle all the barriers there as well. Next slide, please.

And I'm pleased to tell you that we have 15 Access Programs that are modeled off this throughout the country, that all aim to do this. And if any of you are interested and want to learn more about whether you have a program in your state, you can go on our website and we have all those programs listed. Also, Postpartum Support International has a national alliance. And so any of you out of country can call, if you have a pregnant or postpartum woman that you would like to get consultation regarding, you can call PSI and you can speak with a perinatal psychiatrist who can help answer any of your questions. Next slide. And so in summary, if we can integrate mental health care into maternal child health care, it can help us provide whole health so that we're thinking of it like diabetes. That forward screened, it's addressed and we follow her until treat remission, just like we do for other medical illnesses. And if we can do that using a trauma informed strength-based approach, we can also shift it.

So for example, so instead of when we see people we're often asking, and I know I was taught to do this, even at my residency and be like, "What's wrong with you?" And we were problem lists, and we're very often problem focused in medicine, but to change the conversation to what happened to you and how have you managed to cope with it. Instead of, for example, saying, "Why are you late for the appointment?" Saying, "Must've been hard to get here? How did you manage to get here despite all those challenges?" So really doing it in a strength based approach. Now I'm going to transition to Tiffany Moore Simas, the OB-GYN, who I collaborate with on many things, including MACPAC for Moms, who's going to talk more about what you do at the practice level to actually integrate these things into your workflow. Thank you.

**Dr. Simas:** Good evening, everybody. Thank you for the opportunity to talk to you and to be with you here today. Nancy talked a lot about why it's important for us to address mental health in this pregnancy and postpartum time period. And there are a lot of reasons to support why this is an ideal period to do it and why it should be "easy to do it", right? So, women will have 12 to 15 visits in a nine month period of time during pregnancy. They'll have then visits within the postpartum period, and then they'll have visits with their pediatric provider for well-child visits and there is opportunities at all of those points to screen a woman and engage her in care. And then if you look at the literature and you talk to women, they in fact welcome the opportunity to talk to obstetric providers. Obstetric providers have a lot of really intimate conversations with their patients and patients are generally comfortable talking to them.

So there's great patient accessibility around this. And so in that there is an opportunity to decrease stigma. However, next slide. That avoidant behavior ... talked about, that lack of training, the lack of guidance and recommendations until recently, really has made it such that many OB-GYNs don't actually see mental health within their scope of practice. And it hasn't really been a part of our professional identity. And so when you take that in the context of not being comfortable with it, not
being part of your professional identity, not setting up your office in a way to address it, not being reimbursed in a way to set up your office to address it. It just contributes to the stigma, the shame, the blame, and the avoidant behavior. Next slide.

So what has really made a very significant difference in the past five years, and it really has been that recent is that perinatal mental health has been recognized as a public health problem. And by public health problem meaning one of the most common complications of pregnancy and the postpartum period and the complication that is universally identified as being associated with maternal mortality and a preventable cause of maternal mortality. So women should not die of mental health conditions in pregnancy and postpartum, certainly given all this contact with the medical community and many of us on the call would say ever, but yet it happens. So what has happened in the past five years is many of the professional societies and the governmental organizations you see on the slide there have come forward with very clear recommendations for universal screening of pregnant and postpartum women using a standardized tool. So that's great. That is a first step and that universal screening, providing that opportunity to everyone is an opportunity to decrease stigma. Next slide.

Beyond that, many of the recommendations come, not just with the recommendation for screening, but the ability to take it to the next step, the subsequent assessment, the connecting with treatment. The ability to refer and being able to do that, to do it seamlessly is an important step in decreasing stigma. However, what often happens is people would adhere to the recommendation to screen, "Oh, you're not depressed, are you?" So there's that, "Please tell me you're not depressed." I'm going to ask it in a way that's not going to open the door to give you an opportunity to say it. Or if screened positive, then there's those stigmatizing, shaming, blaming conversations around, "But you just had a baby. You should be so happy." Or, "You don't want medication. You're pregnant."

And so it's not just enough to screen and to have systems it's also incredibly important to use that strength-based language to be able to have a conversation that is non-stigmatizing, that is not shaming, that is not blaming and to not avoid it, to be able to address it. Next slide.

So one of the reasons why women find themselves in that situation with OB-GYNs is because of that avoidant behavior. Because of the lack of training. Most OB-GYNs out in practice now have trained pre those guideline recommendations, pre those recommendations and pre the recognition of this as a significant cause of complications and cause of maternal mortality. So you're dealing with avoidant providers who are uneducated in this in some ways, and it wasn't part of their professional identity. So Sarov talked about this. The not having been trained. The not having been educated is a huge component to the why there's stigma here. And so training and tool kits are incredibly important. A one-time module, a one-time maintenance, a certification, a one-time is not enough in and of itself.

So these algorithms, these tool kits are incredibly important. And it's also not enough as we've heard from providers to just give the algorithms, but to also help. And you can see the links in the bottom of the slide here. These are publicly available, you're welcome to download these, but also within them to
help give that language, to help provide some of that strength-based conversational language to help have these conversations between the provider and the patient. Next slide.

Beyond the training of that individual provider or the individual providers within the practice, it is incredibly important to look at the practice itself. The opportunity to de-stigmatize, to create an environment that allows a woman to engage and be comfortable with answering the screener and being enabled to engage in care really starts from the beginning. The person at the front desk is that the person who's administering the screen or how do they do that? Where does she do it? Is she doing it in the waiting room? Is she's doing it in a private exam room. How was that given to her? The person that receives the screen from her, what do they do when they receive it? How do they address it? When they score it, how are they doing that? How do they respond to that score? If it's not the provider that sees the score, how is the provider being made aware of it? And when the provider goes back to the patient, what's the conversation around that? And what is the language that's being used? It's incredibly important.

We have engaged with a lot of practices in the past that the recommendations came out, they instituted screening and as Dr. [Byatt 00:48:03] said, they were like, "Please, please, please let her not screen positive." Because although they implemented the screening, there weren't the downstream steps that were implemented in thought through in the practice. And so incredibly important. Next slide.

So the perinatal psychiatry access programs that we heard Nancy talk about address, fortunately, very thankfully a lot of providers have really appreciated these access programs, address that. Well, once she screens positive, if I am uncomfortable, if I don't know what to do, I can pick up the phone and call that lifeline of the access program and get some guidance from somebody else to help me walk through. Because when I was a provider, I didn't train in this. So I'm not comfortable. So the access programs really help provide support and decreasing the barrier of that avoidant behavior. So support and helping to know how to assess the patient, the support in helping to know how to treat, what treatment options are there, and how do you deliver that information in a way that it is strength-based, shared decision-making. It equally balances the risks of untreated versus treated disease, and really helps support a woman saying she deserves to be better. She deserves to be treated and then following it through from there. Next slide.

So, beyond the toolkits, beyond the access programs, other approaches to helping decrease stigma is really in, as I went through somewhat already, having a step by step approach to implementing how to integrate mental health into obstetric care. And that happens at the screening level, it happens at the assessment and treatment level. It happens at monitoring. And the goal is to really engage, not just the patient in the process, but the entirety of the practice with the aim of improving outcomes. And as the Council on Patient Safety and Women's Health Care notes in their Patient Safety Bundle around this, it's doing this and that nonjudgmental culture of safety, where we really look at mental health as


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holistically part of the care that we provide in pregnancy in the postpartum period.

And so we have implementation protocols to help practices step-by-step walk through this and not just start screening and then hope she doesn't screen positive. But really before you even start screening, walk through the whole thing. And what would it look like if, what would it look like if, what do we need to have in place to set up the practice successfully to support the patient successfully. Next slide.

So, if you look past over the past five years, there's been significant progress made in all of this. There's still a long way to go. Because if we look at the model that Serov talked about, where we talked about coordinated care, co-located care, integrated care, at best we are still in the center of this triangle. Yes, we're focused on the pregnant person and the infant. Yes, in some cases, we wrap her in the care team, the settings and sometimes there's that collaboration integration. But until we go out and broaden the scope and are able to bring in social determinants of health or able to bring in structural inequities and biases, not just bring them in, but be able to address them. We won't really be able to knock down the stigma completely. So we've made a lot of progress and we have a lot of progress to go. Next slide.

And so there is tremendous strength in increasing the frontline providers' capacity to provide mental health care, to integrate that into obstetric care in the case specifically of perinatal mental health and that in and of itself will decrease stigma. And so these are some great initial steps. We still have a way to go. Next slide.

And so thank you. And we're happy to open it up to questions at this point.

Giliberti: All right. So let's start with a couple of questions and please send them into the chat because we want to answer your questions. That's what gets fun about these webinars, but I'm going to start us off with a question about how can physicians deal with potential stigma in the profession? Dr. Byatt?

Dr. Byatt: Mary, are you referring to stigma within the profession as far as addressing our own mental health? Or are you referring to... I think that's part of it, but I'm wondering about stigma around us all, or around, or maybe it's both. Because I actually think they go hand in hand.

Giliberti: Great. Why don't you address it that way?

Dr. Byatt: Okay. All right. So I'll give you an example. I was recently talking with, I can't tell you how many colleagues I have that have told me, "Oh, a psychiatrist who's prescribing themselves antidepressants because they don't want to go see a psychiatrist." Or, people not telling people about their kid's psychiatric illness, because they're embarrassed. If it was your kid had asthma, if your kid had a malignancy, you would just talk about it. You'd be like, "I can't come in because my kid's getting chemotherapy." And you would tell people I got to go and see my dentist. So I think that part of how
we do this is by talking about our own, this touches all of us, whether it's our family members on ourselves. And I think part of it is that we need is us walking the walk.

So I think that's one piece of it. And I think a lot of the other piece is how we talk about this. So I was taught, I think in my residency, people would say, "Oh, he's a 64 year old schizophrenic." No, he's a 64-year-old male who's been diagnosed with schizophrenia. The person is not their illness. The illness does not define them and we need to stop talking about people that way. And Sarov mentioned this earlier with how we write notes in the charts, how we talk to people, how we define ... We use so much pejorative language. And it's really ingrained in our culture. So I think that's one thing that there's a lot to be done around is how we talk about these things, how we address our own mental health openly and how it touches all over our lives.

And I think the other piece is when we talk to patients directly, we can really change the language. So for example, instead of asking someone, "What brings you in? What's wrong?" But like, "What's going well for you? And how did you manage to get through that?" Instead of, "Oh, you're..." There's ways you can use very subtle wording changes to come at it from a strength based approach. And I think that's really, really critical and that's what the patients need. It's what our colleagues need. And we can talk about it with each other that way too.

Giliberti: Great. Does anyone else want to jump in or should we go to the next question?

Dr. Sengupta: Actually, I have one little comment on that, which is that I think often addressing stigma, we shouldn't fool ourselves in saying that it's free. It's easy. It can have a cost, frankly. And I think the question is just, is it a cost worth bearing? And for me, it's the mirror test. Can I look myself in the mirror at the end of the day? And oftentimes sometimes confronting or talking about some of these things, it can have a quick interpersonal cost, but you can work through that. We're physicians, we can heal that little rupture that comes up, but there's a lot of good that comes from making that sort of like, "What did you mean by that," and having that quick interaction. But I think the costs can be worth it.

Giliberti: We've got a couple of specific questions with respect to maternal issues. So, one of them is when dealing with maternal anxiety, depression, is a group model better for patient acceptance or an individual model?

Dr. Simas: I find myself wanting to seek clarification around if we're talking about group prenatal care versus individual prenatal care, or once a diagnosis of anxiety, depression is identified, group therapy versus individual therapy.

Giliberti: I think it's saying when dealing with it, so I think they're talking about once the person's been identified.
Dr. Byatt: I think that really depends. I think it depends on the individual. I think groups can be very powerful and they can be really... People can have an experience that's very empowering. A lot of people, I know at MCPAP For Moms we refer to groups, we refer to individual therapy. The vast majority of people we find prefer individual therapy because it seems like an easier place to start a lot because if you may want to go to one person to tell them how you're doing, but to go in to tell a group, it can feel overwhelming for some people. So I think it really depends on the person's preference. I think the most important thing is to ask people what they prefer and then refer them that way. So I think it's really individualized.

Gilberti: That's definitely been my experience working with individuals and families, asking always makes a lot of sense. One of the questions was, is there a difference in the perinatal results of two evaluations during pregnancy compared to one?

Dr. Simas: I think this is referring to screening, and so if you look at ACOGs guidance, the recommendation is screening in the perinatal period, which of course would be pregnancy or postpartum. The most recent update was if you screen in pregnancy, please make sure to do so again postpartum. U.S. Private Services task force says, "And," so pregnancy and postpartum. And the Council on Patient Safety recommends twice in pregnancy and once postpartum.

I know our group has looked at this pretty thoroughly, and had really recommended screening at the initial OB visit really to pick up the people that are coming into pregnancy with a not yet recognized illness. Screening in the late pregnancy period to identify those that have picked it up, who have onset of disease or exacerbation over the course of pregnancy. And then at postpartum to pick up that late onset pregnancy or early postpartum.

Then of course it continues on into the pediatric area, to the well child visits because often a woman's care with her OBGYN ends somewhere at six to 12 weeks postpartum, but yet their risk of postpartum depression extends well beyond that, so continuing to screen beyond that.

Gilberti: And the next question really talks about those barriers that I think, Dr. Sengupta, you were talking about some of them earlier, but they're asking if HIPAA interferes with mental health professionals communicating with primary care about how to help a patient. So, the role there of these laws that sometimes are designed to protect people, but can also be barriers.

Dr. Sengupta: Absolutely, it can. It can get in the way of useful flow of information that really, frankly, patients and families want that we can't always facilitate due to at least perceptions of what HIPAA says and the way we're supposed to work with it. For us, in our programs, the way we try to really upfront be on top of getting all of our releases of information signed at the beginning of any kind of engagement so that we can really recognize that we've got a free flow of communication between primary care medical providers and behavioral health providers. That's a part of the logistical workflow that you have to work and spend some time and energy on upfront, for sure.
Gilberti: So the next question is sort of saying that we have all framed in our discussions, stigma, as lack of time, lack of knowledge, lack of care plan, those kinds of things. But this question says, "What about unconscious bias or stigma? How do we uncover that around those providers who may not know that they're stigmatizing patients?" And I certainly have seen that with individuals and families going to someone who really doesn't recognize that what they're doing is stigmatizing. So any thoughts about how to uncover and address a bias that you might not recognize as a provider?

Dr. Byatt: I think it's somewhat how we think about all implicit bias because part of it's to be an upstander and it's hard ... I was on call the other day and one of our residents called and one of the internal medicine residents spoke about a psychiatry patient and basically said to the resident, "If this was a different patient than I would basically follow the standard of care, but because this is a psychiatry patient, I'm not going to follow the standard of care." And the resident, we were like, "Okay, well, what are we going to do about this?" It wasn't an implicit bias, but we thought about [this].

And so we talked about, well, this is important and this is really ... So we talked about how to address that and I think that's an extreme example, but stuff like this happens on a continuum all the time, every day in a lot of the medical world. So I think it's talking with our colleagues and having those difficult conversations, just as we are now when we're having conversations about implicit bias as it relates to racism and these other hard conversations, but we need to have them. And I think part of it's doing that and also being role models for our medical colleagues because if we talk about them in a strength-based way, then it will have a trickle effect.

Dr. Simas: The other thing I would say, this is somewhat tangential, but I feel like I really want to say this. We talked a lot about the avoidance behavior, that stigma coming out as avoidant behavior. The opposite of that also is feeling less comfortable can come out as alarmist behavior, too. So the woman that presents and is saying that she's having intrusive thoughts or thoughts to harm the baby or what have you, and is immediately whooshed off to emergency mental health care. She is feared that the baby is going to be taken away or it is minimally, it's separated from her and not able to breastfeed. Avoidance or lack of knowledge or comfort can come in two extremes; one is avoidance and one is this hyper response to it. That hyper response is not just stigmatizing and shaming and blaming in the moment. That can really have significantly long-term effects that can be immersive to her getting care even when it's recognized she might need care. And so I think that it's important to recognize that also.

Gilberti: And this question was burnout, depression and suicide in physicians is very high. How do you address stigma to improve access for this population, recognizing that some states ask about this in license renewal? And, this person wanted to know is that being addressed or how should people be thinking about the issues, the stigma within the profession? Another example of stigma within the profession.
Dr. Sengupta: This is an area I feel very passionately about. I've educated and I've written about my own mental health struggles as well. I think that, just going back to what Nancy was saying earlier, we have to walk the walk here. We have to be open about situations where we've been able to confront this, acknowledge we have this issue, and be able to get help for it.

I think it also means we have to be good to helper colleagues. When we notice a colleague that's struggling, we have to be interested. I think sometimes we tend to duck our heads to that. And we have to be also willing to be helpful and find ways to get support for our colleagues, to pitch in if someone's having a difficult time, to help them get connected with care. It can be very, very challenging for physicians to get access to care because they're so worried about the stigma against that.

I think lastly, I think it also does a disservice to physicians when we talk about just depression and burnout and we don't take a look at the systemic issues that contribute to that. Some of the incredible burdens related to paperwork and bureaucratic aspects of medicine, this is not the reason that people went into medicine and as they're struggling to deal with the existential crisis of being a physician in the 21st century, if we just ignore that aspect and just say, "Okay, deal with your depression and burnout," I think we're missing some big opportunities to improve how physicians are doing, but also frankly, patient care and how the culture is doing as well.

Giliberti: Well, we don't have too much time left, but this question was for Doctors Byatt and Simas. Can you talk more about how to assess disease severity of a patient who screens positive? Are there tools available to help physicians when someone screens positive in figuring out the severity?

Dr. Byatt: We actually just developed a tool to do exactly that. It was one of the tools that Tiffany showed. I think the screenings tools are great. They are screening tools. I think I worry that there's a knee jerk to oh, you have a positive scale, your screen was positive, let's give you an SSRI. They're tools. Some of the tools can help you determine severity. They can also be great for follow-up because, for example, if the score is going down, then it tells you that hopefully they're getting better.

But they need to be accompanied by an assessment. I'm sure our slides will be available, there's a link to one of them and on it, we actually have a toolkit that has screening tools for depression, anxiety, bipolar disorder and PTSD all in together. And then we have an accompanying toolkit, it talks about how do you assess that severity.

I'd say, generally, what you want to be thinking about for when women are pregnant or postpartum is you want to be asking what's going to happen if this woman doesn't get treatment? And that kind of tells you about the severity and then you're asking how is it impacting your functioning? So for example, is she able to take care of her baby? Is she getting through her daily activities? Or is she getting through them but it's taking her a ton of effort and it's hard?
So you really want to be getting at the functioning and a lot of helpful way to do it is look at how she's feeling about herself. Is she feeling hopeless? Is she feeling helpless? Is she feeling bad about herself? And does she feel like that some of the times? Are they fleeting or does she feel like that most of the time or all the time? So those, I think, are just some very high-level things about how to get at severity, but please take a look at our toolkit and hopefully that will be helpful because we tried to summarize that in a way that's that is accessible for all of you...

Giliberti: All right. Well, it looks like we are very close to time. Is there anything that any of you really want to add before we conclude our session tonight?

Dr. Sengupta: Keep the faith. Thanks for having interest in this area.

Dr. Simas: Thank you for the opportunity.

Dr. Byatt: Thank you. And for the AMA for prioritizing this.

Giliberti: Absolutely. Thank you all.

Remick: So we're at the end of our time for today's discussion. Before we adjourn, we at the BHI Collaborative would like to ask if you could provide your valuable feedback in our short event survey, which will be sent around via email. Your feedback will help inform future educational sessions and research development. The BHI Collaborative is currently planning a 2021 programming. The first two webinars will be hosted in January and will cover BHI privacy and security concerns and key BHI implementation strategies. Stay tuned for the email updates.

Also, if you're unable to attend the previous webinars in this series, a link to all previous recordings will be included in the survey email. Thank you again to our speakers for tonight's presentation and to all of you for joining us live. Have a great rest of your evening.

About the BHI Collaborative

The American Medical Association along with seven leading medical associations have established the BHI Collaborative, a group dedicated to catalyzing effective and sustainable integration of behavioral and mental health care into physician practices.

With a focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients’ mental and behavioral health needs.

Disclaimer: The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.

988 Suicide & Crisis Lifeline

With an increased number of people reporting worsening mental health in recent years, it is imperative that people are aware of the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline) telephone program.

People experiencing a suicidal, substance use, and/or mental health crisis, or any other kind of emotional distress can call, chat or text 988, and speak to trained crisis counselors. The national hotline is available 24 hours a day, 7 days a week.

The previous National Suicide Prevention Lifeline phone number (1-800-273-8255) will continue to be operational and route calls to 988 indefinitely.