Poster Title: Maximum 12 words

Ask Masi: Building perinatal mental healthcare capacity in the Ottawa region

Hospital/Organization

The Ottawa Hospital (TOH), Ottawa Birth and Wellness Centre (OBWC), Champlain Maternal Newborn Regional Program (CMNRP)

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Topic: Brief description of the issue/challenge

Canadian data shows that the frequency of perinatal mental illnesses (PMIs) have increased from 1 in 5 to 1 in 3 since COVID-19. Data from Better Outcomes and Registry Network (BORN) Ontario indicates that distress reported by those in the Ottawa region is higher than provincial averages. TOH has certainly experienced a surge of perinatal mental health referrals over the past years from waitlists of approximately 30-50 referrals (and maximum wait times of 2 months for initial consultation) to >150 referrals (and wait times of 6-8 months). National Institute for Health and Care Excellence (NICE) guidelines advise a maximum of 2 weeks to initial assessment and 4 weeks to be actively connected to treatment.

TOH Perinatal Mental Health has explored various means of offering more efficient, evidence-based care: group psychotherapy, group medical visits, drop-in pregnancy support groups, virtual care coupled with outreach models, collaborative care clinics with diverse and at-risk populations, and hiring more perinatal psychiatrists. While these measures have certainly had a positive impact, the needle has moved minimally. Clearly, what is needed is a paradigm shift in the way we deliver care altogether.

Methodology: How you addressed the issue/challenge

This project seeks to improve access to timely perinatal mental healthcare in the Ottawa region by supporting primary perinatal care providers (PPCPs) such as midwives, nurse practitioners, family physicians, and obstetricians, to independently care for their patients' mild to moderate PMIs.

This will be achieved through the creation of a Perinatal Psychiatry Access Program, known as Masi, which:

- trains frontline PPCPs how to screen for PMIs and treat low-level anxiety or depression when and where it presents;
- provides real-time peer supervision by phone or e-consult to assist PPCPs with practical feedback on more complex cases as well as helpful community resources for their clients;
- offers one-time virtual perinatal psychiatry consultation within one week for the most complex cases to assist PPCP with diagnostic clarification.

Masi is modelled after the University of Massachusetts' MCPAP for Moms developed by Byatt et al. Our goal is to translate this very successful, cost-saving, and clinically-effective American model to the Canadian system starting in our own region with subsequent rollout to partners in Ontario East, Ontario Northeast, and Western Quebec. While we anticipate learning a great deal about the clinical, cultural, financial, and legal differences which influence our own implementation, we will use a developmental evaluation approach. That is, we are just as curious about the lessons which we do not anticipate learning, and how the unanticipated feedback from our regional advisory committee and iterative evaluation metrics inform real-time optimization.

We are currently in the planning and preparation phase. Implementation for TOH PPCPs will begin in 3-6 months. Thus far, the pressing regional questions are how to better integrate child and adult mental health services, and how to capitalize on already-existing regional innovations (such as e-Consults, accessMHA, 1call1click).

Discussion: Maximum 250 words

PMIs are the most common complication of childbearing. They affect 1 in 5 birthing people. Without treatment, PMIs can lead to serious medical and psychological consequences for the affected individual, the non-bearing parent, and their children. With timely recognition, PMIs are easily treated and present a rare opportunity for meaningful prevention of adverse childhood events.

During the pregnancy and post partum period, birthing people will see a healthcare provider around 20-25 times. Despite this high level of contact with the system, over half of those with PMIs will go untreated. PPCPs are not uniformly trained and/or equipped to offer mental healthcare to their clients. Many mildly ill patients, who would be better served by community resources, receive an unneeded psychiatric referral. Meanwhile those with more severe illness requiring subspecialist care get worse on lengthy waitlists. The stakes for negative outcomes are high: hospitalization, psychosis, suicide, infanticide and/or child apprehension.

With this project, we hope to understand and potentially remove many of the barriers that PPCPs face in offering point-of-care mental health evaluation and treatment. In this way, we aim to increase PPCP capacity, facilitate/optimize the uptake of cost-effective, community-based resources (such as peer support), and improve timely access to treatment, all without requiring more perinatal psychiatrists (who a very limited and relatively expensive resource). This represents a potential systemic cost reduction from $150 000 to $4 000 annually per mother-infant dyad. Our American colleagues have

already demonstrated successful scaling across more than 25 other sites that has led to permanent federal and state funding for their access programs.

Outcome/ Summary

Our project directly responds to the Prime Minister's mandate letter (December 16, 2021) to the Honourable Dr. Carolyn Bennett, Minister of Mental Health and Addictions and Associate Minister of Health, with its directive to "ensure timely access to perinatal mental health services". This stepped/shared-care approach will ensure that clients remain in the community, in a more comfortable and convenient environment, in order to support their mental wellness while reducing overall systems costs.

Data from this initiative will inform wider dissemination across other Canadian jurisdictions. Taken together, Ottawa, Eastern Ontario, Northern Ontario, and Western Quebec, encompass many Canadian demographics, i.e. urban/rural, wealth/poverty, BIPOC and francophone, LGBTQ2S+, immigrant/refugee. We will also gather a template for interprovincial implementation.

Such a roadmap is necessary because perinatal psychiatrists are scarce, not every birthing parent needs to be connected to one, but all birthing parents need prompt connection to the proper service in the setting which works best for them. Our blueprint will inform policy-makers, health system leaders, and academic administrators interested in perinatal health nationwide.

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- Subsequent to the Summit we will post the information as a resource on our web site. Therefore please provide the following information in your submission:

Please send your Submission or Questions to aghpsinfo@aghps.com