WOMEN &INFANTS

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Alpert Medical School

Listening to the Living:
Innovative Approaches to Perinatal Mental Health Care

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No conflicts of interest

Objectives

Lessons learned

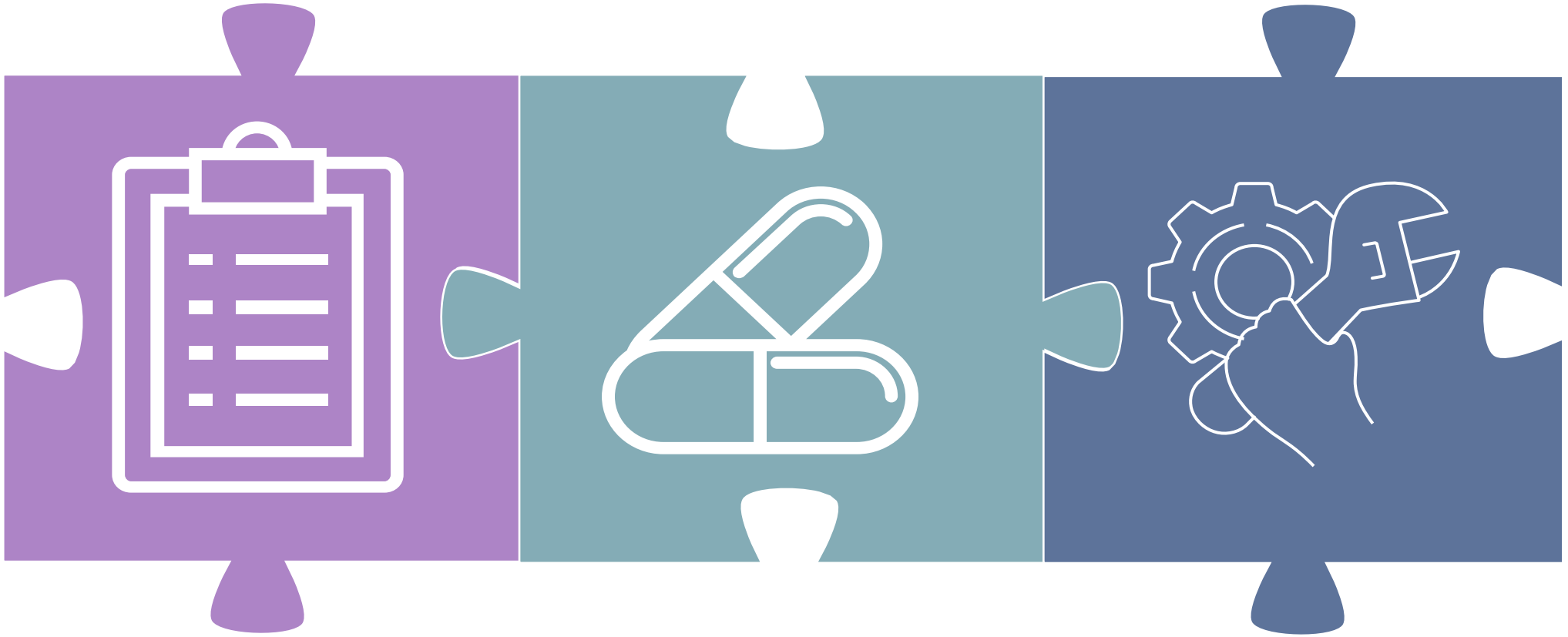
1. Apply best practices toward perinatal mental health screening
2. Discuss and manage psychopharmacotherapy in pregnancy and postpartum
3. Identify health services approaches to support implementation of mental health care in perinatal settings


Reflect and
adapt

Why does someone have to die for us to sit together and learn? We need to be able to listen to the living.

-Kimberly Seals Allers

https://kimberlysealsallers.com/



Screen

Treat

Build a System

ACOG
The American College of Obstetricians and Gynecologists

CLINICAL PRACTICE GUIDELINE

NUMBER 4

JUNE 2023

REPLACES COMMITTEE OPINION 757, NOVEMBER 2018

Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum

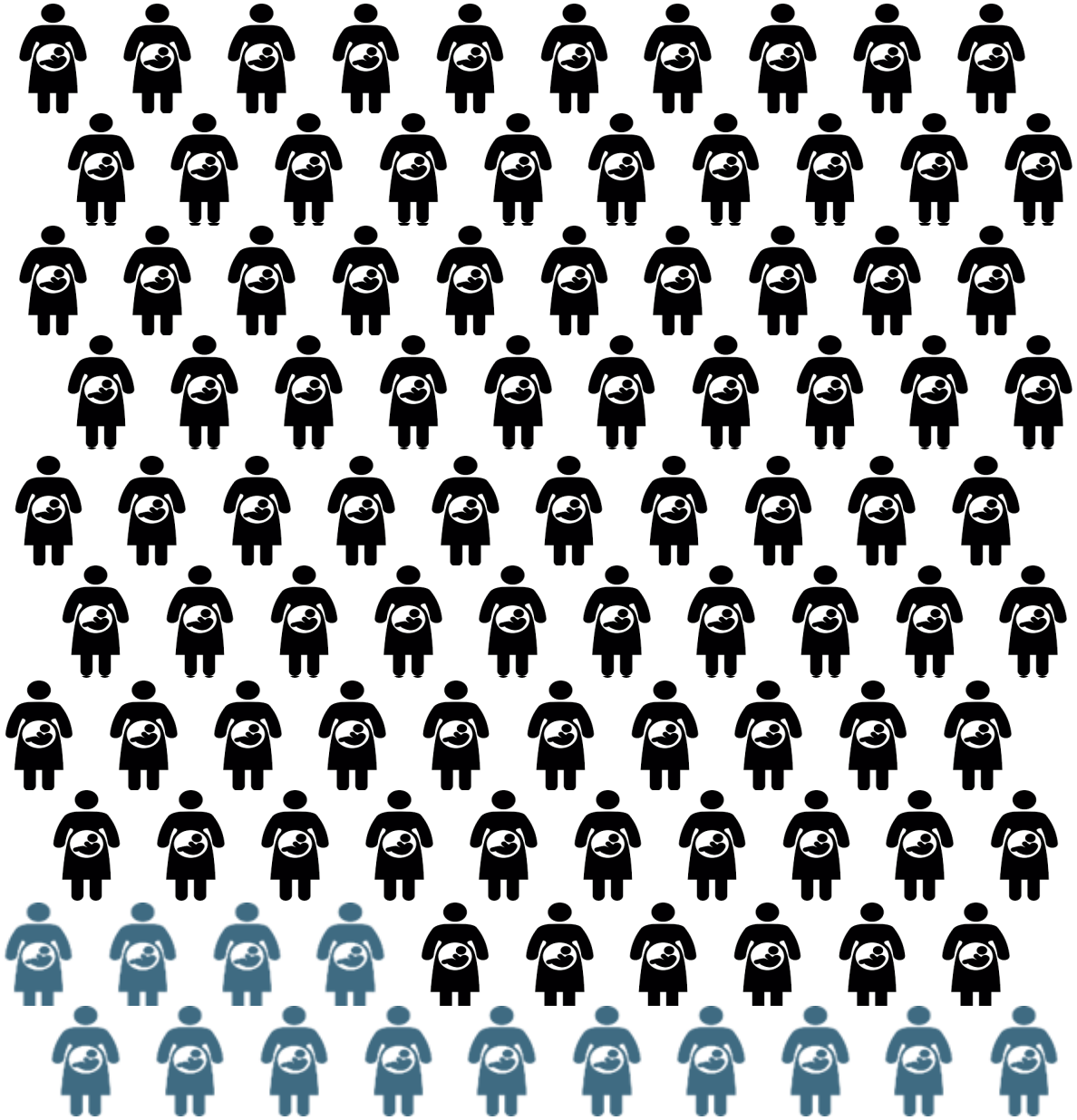
Committee on Clinical Practice Guidelines—Obstetrics. This Clinical Practice Guideline was developed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics in collaboration with Tiffany A. Moore Simas, MD, MPH, MEd; M. Camille Hoffman, MD, MSc; Emily S. Miller, MD, MPH; and Torri Metz, MD, MS, with consultation from Nancy Byatt, DO, MS, MBA; and Kay Roussos-Ross, MD.

The Society for Maternal-Fetal Medicine endorses this document.

The Committee on Women's Mental Health of the American Psychiatric Association reviewed and provided feedback on this document.

I was in a really dark and scary place. I felt very alone. As odd as it is, you're growing a human but you feel so isolated at the same time. It almost doesn't make sense...

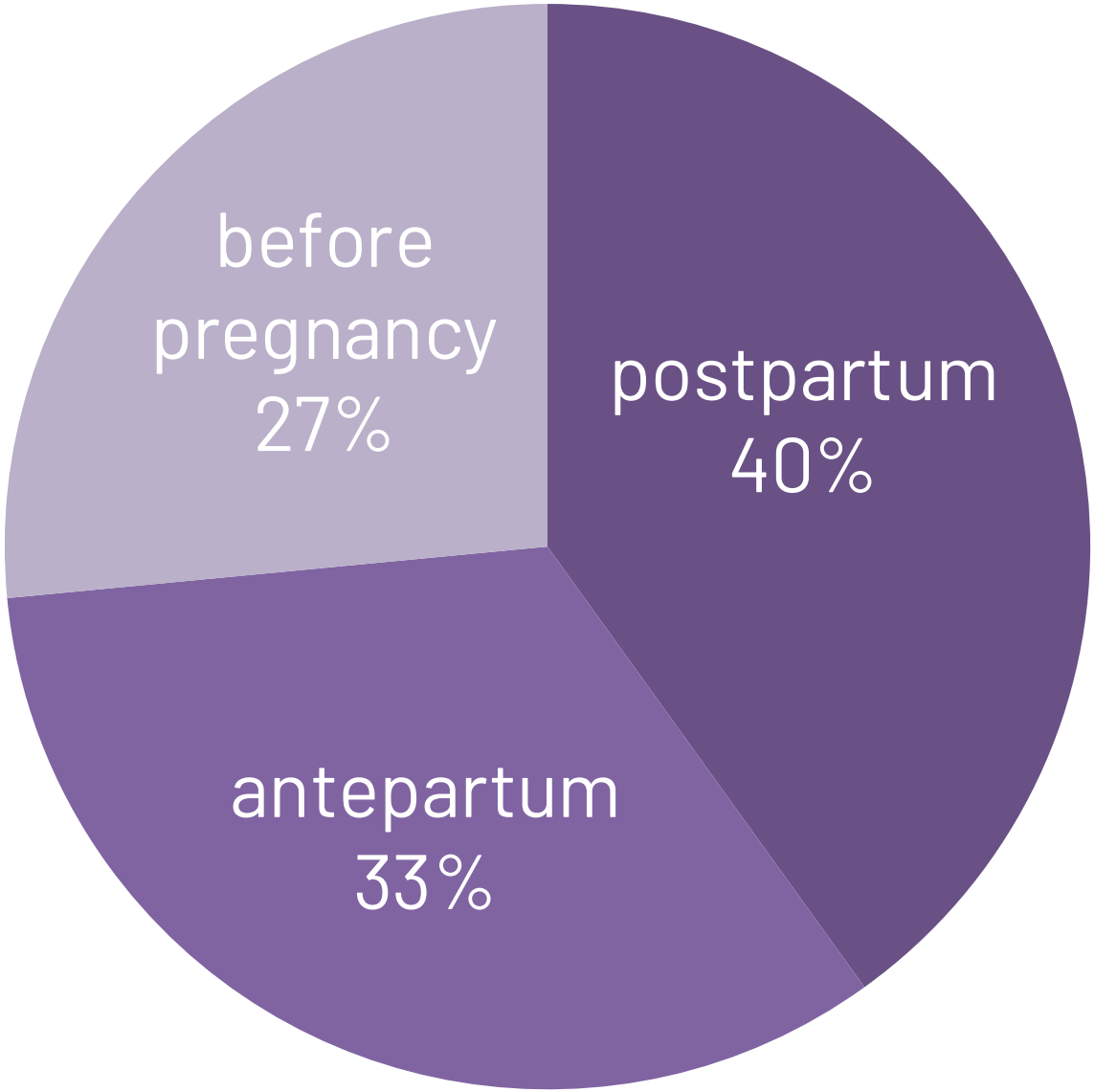
And I think at that time I didn't know what I needed. So, I think when my [obstetrician] mentioned my mental health, that's probably the only way I would've known or found out or even cared to listen about it. (P10)



N=10,000

Mentorship: Send the damn email

Wisner KL et al. JAMA Psych 2013


before pregnancy 27%
postpartum 40%
antepartum 33%

AGOG recommends thiat screening for perinatal depres-
s1on and [anxiety 0ccur at the initial prenatal visit liater in
pregnanc·y, andl at postpart1um visits. (STRONGRECOMMEN
DAT10N, MODERATE- [DEPRESS10N] ANDLOW[ANXIETY] QUAL-
ITVEVIDENCE)

DSM-IV disorders

	Primary Diagnosis
Unipolar depression	70%

ACOG recommends screening for bipolar disorder before initiating pharmacotherapy for anxiety or depression, if not previously done. **(STRONG RECOMMENDATION, MODERATE-QUALITY EVIDENCE)**

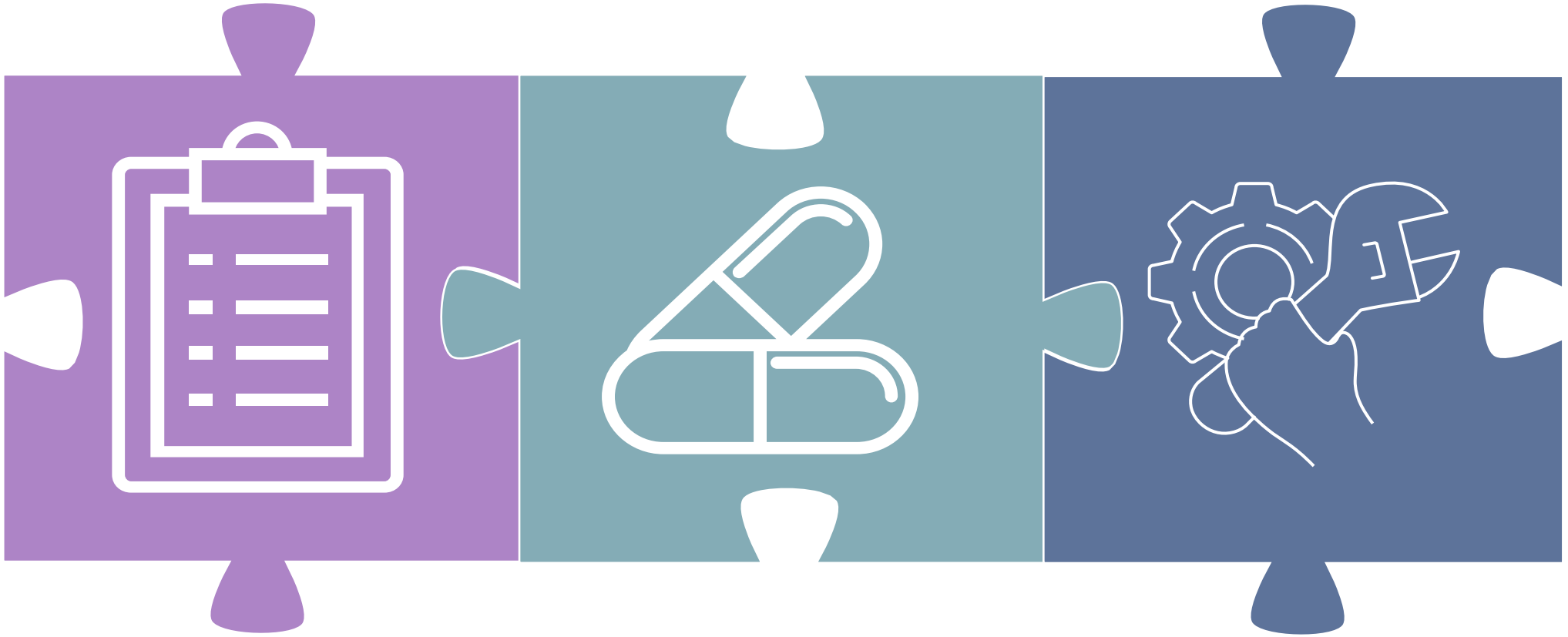
Screening for bipolar disorder

MDQ

http://www.dbsalliance.org/pdfs/MDQ.pdf

THE MOOD DISORDER QUESTIONNAIRE

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○



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Build a System

ACOG
The American College of Obstetricians and Gynecologists

CLINICAL PRACTICE GUIDELINE

NUMBER 5

JUNE 2023

REPLACES PRACTICE BULLETIN NUMBER 92, APRIL 2008

Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum

Committee on Clinical Practice Guidelines—Obstetrics. This Clinical Practice Guideline was developed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics in collaboration with Emily S. Miller, MD, MPH; Torri Metz, MD, MS; Tiffany A. Moore Simas, MD, MPH, MEd; and M. Camille Hoffman, MD, MSc; with consultation from Nancy Byatt, DO, MS, MBA; and Kay Roussos-Ross, MD.

The Society for Maternal-Fetal Medicine endorses this document.

The Committee on Women's Mental Health of the American Psychiatric Association reviewed and provided feedback on this document.

Discussing and initiating pharmacotherapy for depression or anxiety disorders is an important component of comprehensive reproductive health care and, as such, is **within the clinical scope of ob-gyns**.

Treatment 101

- Counseling framework
- Adequate dosing

Table 1. General Approach to Risk Counseling for Depression Psychopharmacotherapy

Risks of under-treatment or no treatment for depression during pregnancy include…	Risks of antidepressant use during pregnancy include…*
Limited engagement in medical care and self-care	PPHN
Substance use	Transient neonatal adaptation syndrome
Preterm birth	Preeclampsia (SNRIs)
Low birth weight	Spontaneous abortion (SNRIs)
Preeclampsia	
Postpartum depression	
Impaired infant attachment (which carries long-term developmental effects)	
Disrupted relationship with partner	
Suicide[†]	

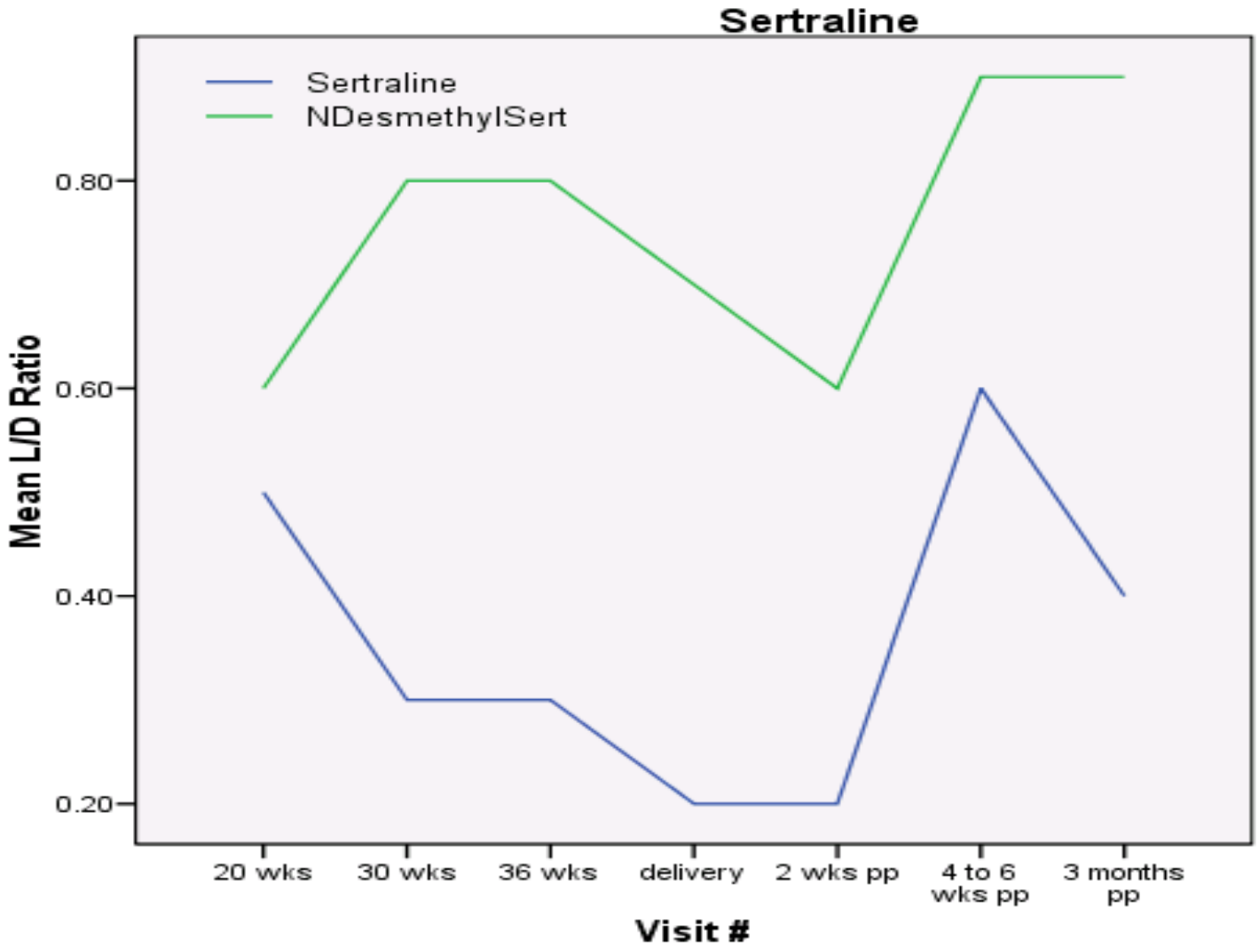
PPHN, persistent pulmonary hypertension of the newborn; SNRI, serotonin-norepinephrine reuptake inhibitor.

*Data derived from literature that accounts for the underlying indication for antidepressant use.

[†]Suicide is a leading preventable contributor to maternal mortality in the United States, exceeding hemorrhage and hypertensive disorders.

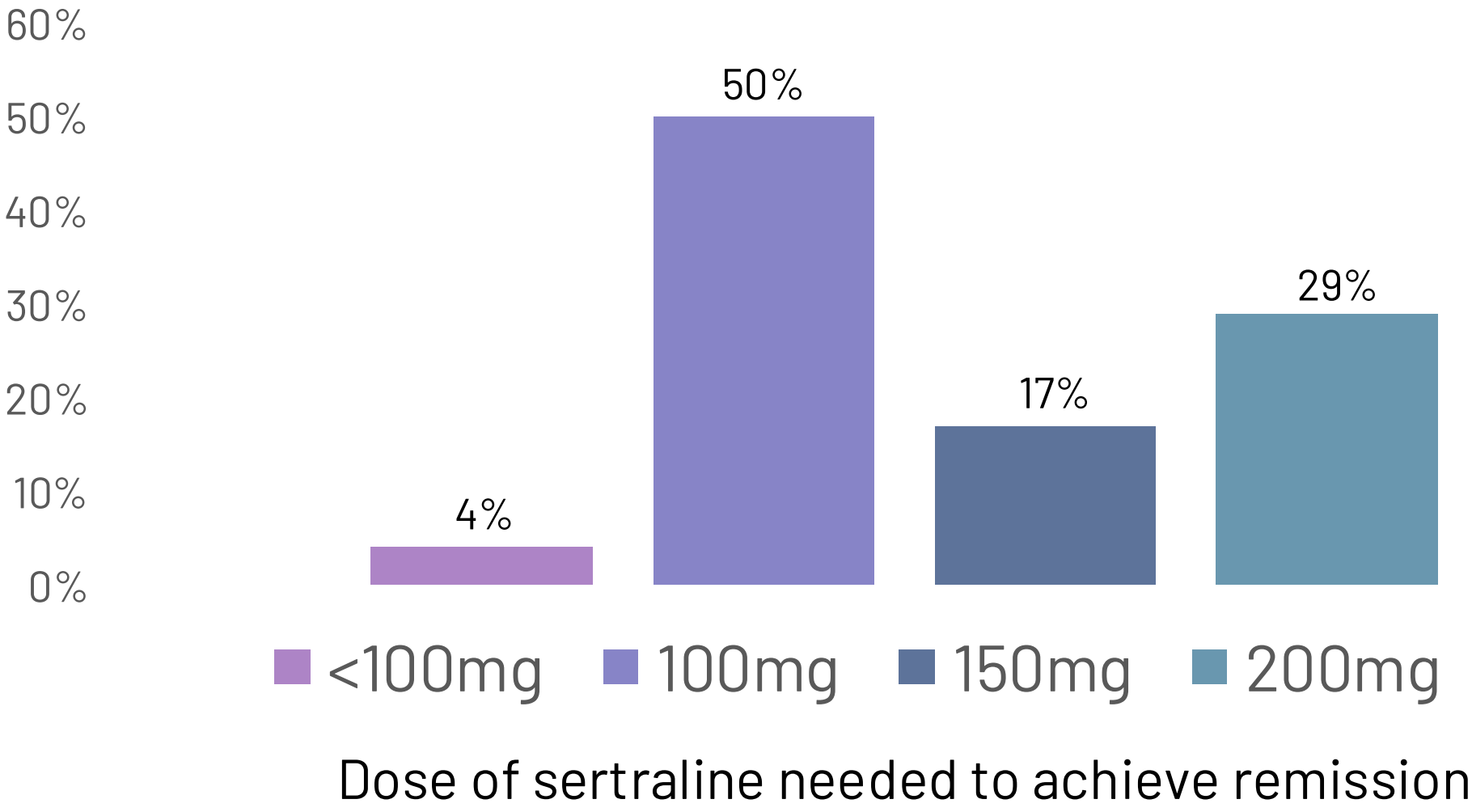
Data from Trost SL, Beauregard J, Nijie F. Pregnancy-related deaths: data from maternal mortality review committees in 36 US states, 2017–2019. Centers for Disease Control and Prevention; 2022. Accessed December 7, 2022. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html *and* Viswanathan M, Middleton JC, Stuebe A, Berkman N, Goulding AN, McLaurin-Jiang S, et al. Maternal, fetal, and child outcomes of mental health treatments in women: a systematic review of perinatal pharmacologic interventions. Comparative Effectiveness Review, No. 236. Agency for Healthcare Research and Quality; 2021. Accessed February 8, 2023. https://www.ncbi.nlm.nih.gov/books/NBK570101/

Adequate Dosing



Sit DK et al, J Clin Psych 2008
Sit DK et al, J Clin Psychopharmacol 2010

Adequate Trial of Treatment



Wisner KL et al, J Clin Psychopharm 2006

Use **half** the lowest recommended dose for 4-10 **days**, then increase in specified increments **every 2-4 weeks** until birthing person achieves remission or has side effects*

Sertraline (Zoloft) *50-250 mg*	**Fluoxetine (Prozac)** *20-80 mg*	**Citalopram (Celexa)** *10-40 mg*	**Escitalopram (Lexapro)** *5-20 mg*
○ Increase in 50 mg increments	○ Increase in 10 mg increments	○ Increase in 10 mg increments	○ Increase in 5 mg increments

Reevaluate depression treatment every **2 weeks** via PHQ-9 or EPDS and clinical assessment

If PHQ-9 remains ≥ 5 or EPDS ≥ 10...

- If no minimal side effects, increase dose and/or add psychotherapy
- If side effects*, consider switching to different medication
- If on max dose, contact Care Manager to facilitate psychiatry consultation

If PHQ-9 is < 5 or EPDS < 10 and no/minimal side effects...

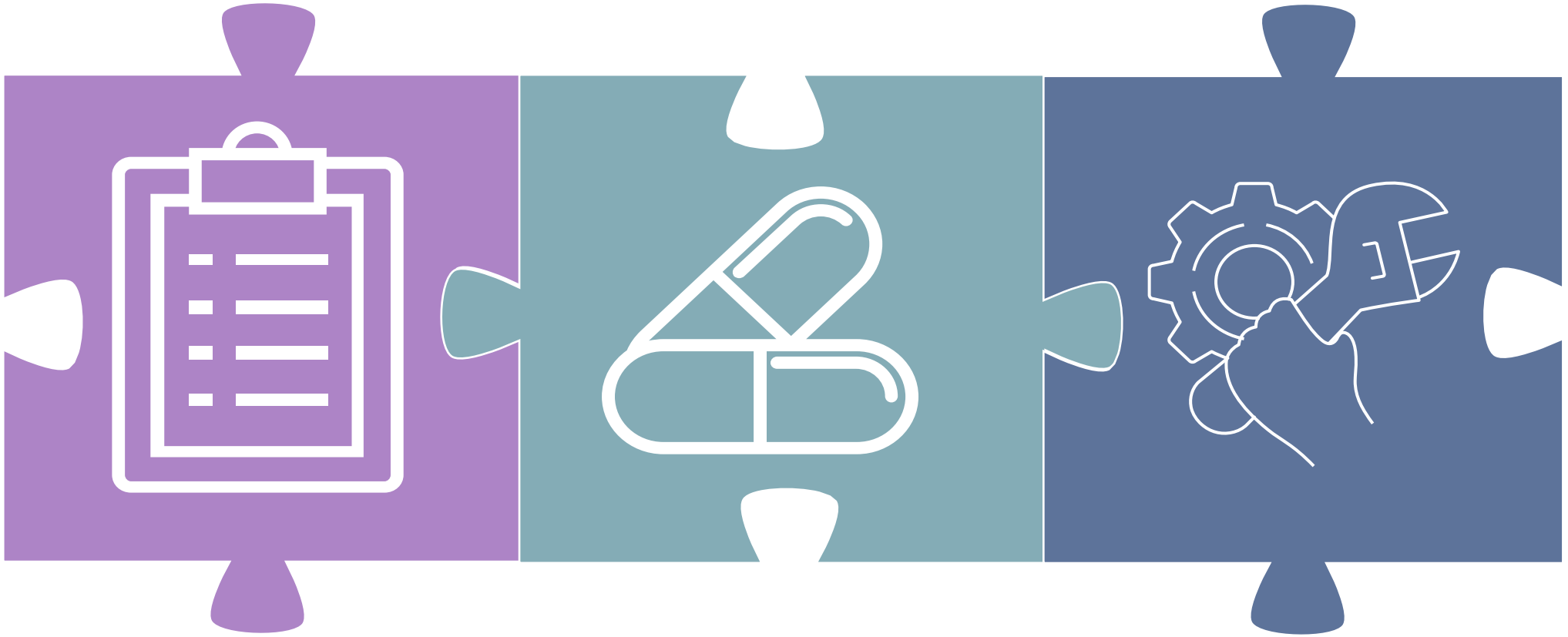
- Reevaluate monthly

Educate: Within first few doses, if the patient experiences an increase in anxiety/agitation or feels energized, stop the medication and contact the Care Manager for an evaluation.

+Remember to administer MDQ prior to any pharmacotherapy for suspected depression
*Common side effects of SSRIs include: nausea, dry mouth, insomnia, diarrhea, headache, dizziness, agitation, sexual problems, and drowsiness

ACOG recommends that selective serotonin reuptake inhibitors be used as first-line pharmacotherapy for perinatal depression. Serotonin-norepinephrine reuptake inhibitors are reasonable alternatives. Pharmacotherapy should be individualized based on prior response to therapy (if applicable). If there is no pharmacotherapy history, sertraline or escitalopram are reasonable first-line medications. **(STRONG RECOMMENDATION, LOW-QUALITY EVIDENCE)**

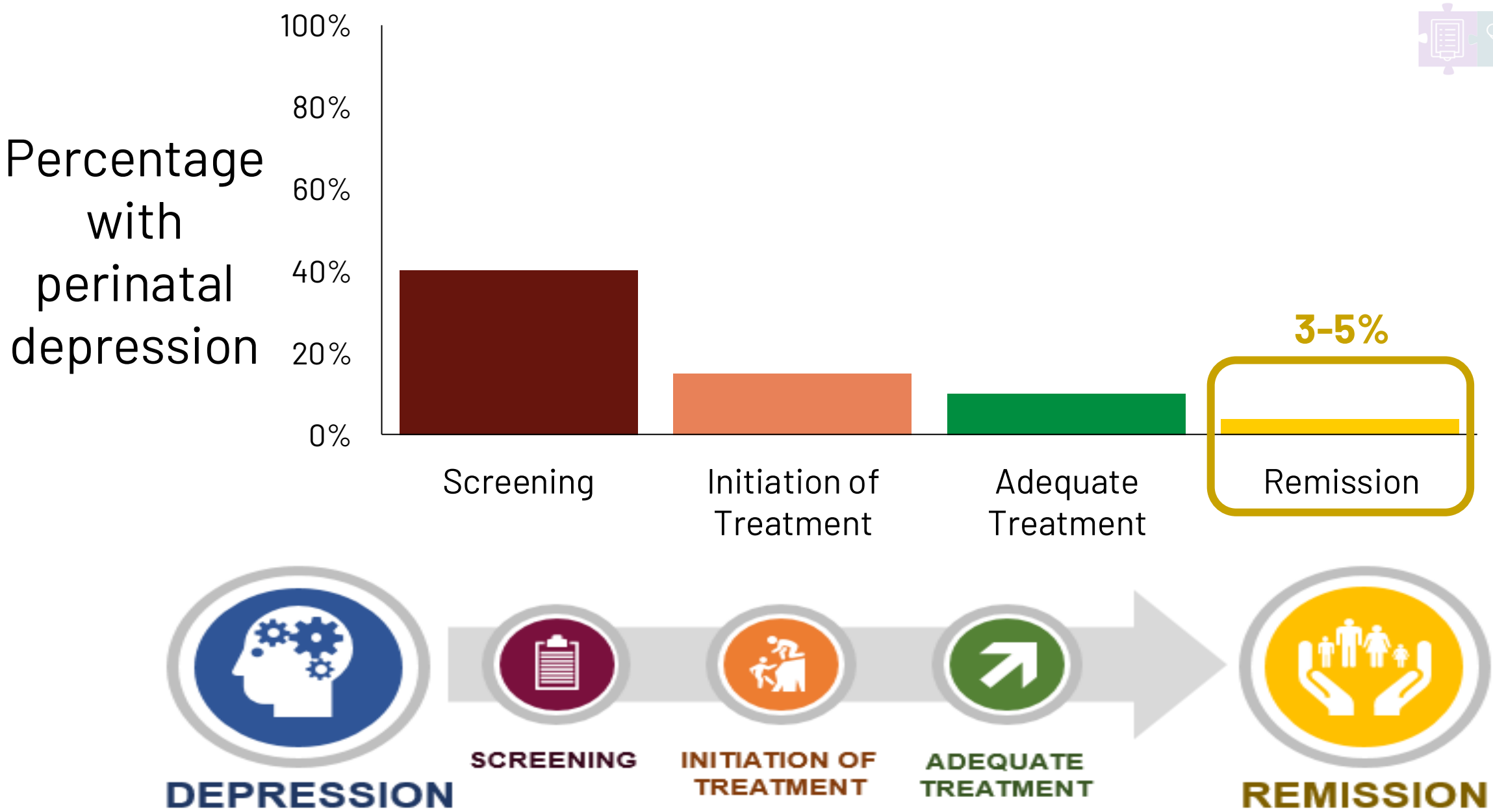
ACOG recommends that a validated screening tool be used to monitor for response to treatment or remission of depression or anxiety symptoms. If clinically indicated, the pharmacotherapy dosage should be up-titrated, with the goal of remission of depressive and anxiety symptoms. **(STRONG RECOMMENDATION, HIGH-QUALITY EVIDENCE)**



Screen

Treat

Build a System



Cox EQ, Sowa NA, Meltzer-Brody SE, Gaynes BN. J Clin Psych 2016

ACOG recommends that mental health screening be implemented with systems in place to ensure timely access to assessment and diagnosis, effective treatment, and appropriate monitoring and follow-up based on severity.

(STRONG RECOMMENDATION, MODERATE-QUALITY EVIDENCE)

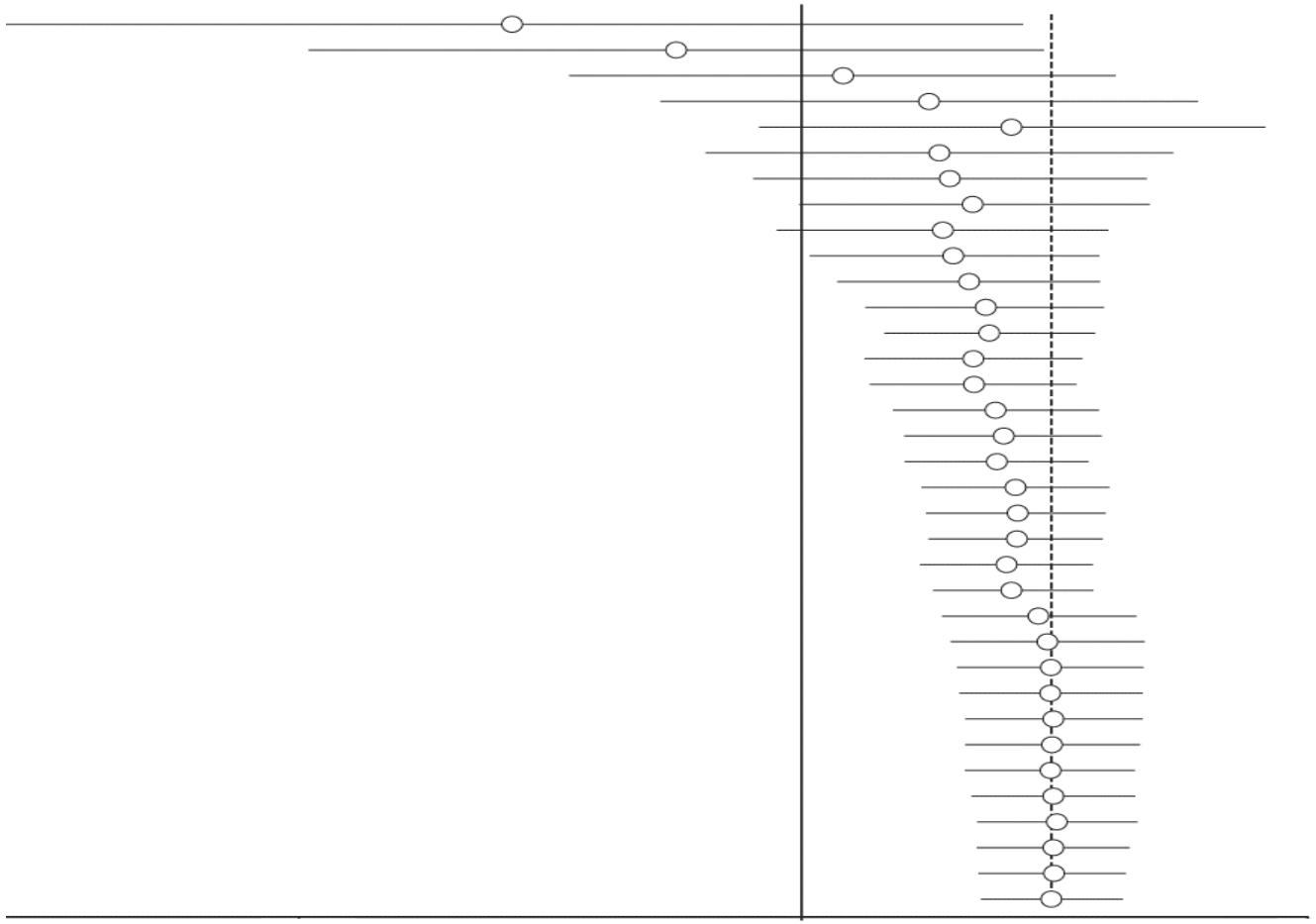
Perinatal Collaborative Care Model (CCM)

Obstetric Clinician

Perinatal Person

Psychiatrist

Collaborative Care Efficacy in Primary Care



Gilbody S et al, JAMA Internal Medicine 2006
Archer J et al, Cochrane Database Syst Rev 2012

	Primary Care	Perinatal Care
Patient-level differences	Stigma of mental illness can be present	Stigma of mental illness also overlaid with stigma of being labeled a "bad" parent
Clinician-level differences	Longitudinal relationship with clinician	Multiple care transitions (obstetrician/midwife to pediatrician to primary care physician)
	Depression more often seen within the scope of the clinician	Obstetrician feel inadequately trained to manage perinatal depression
	Clinical care focused on the individual patient	Competing demands of patient and fetus/neonatal health care
Systems-level differences	Multiple clinical visits	Postpartum care limited to one clinical visit
	Payment model	Bundled payment for pregnancy services without clear guidance pertaining to CC billing codes
	Lower prevalence rates of depression	Higher prevalence rates of depression that can overwhelm infrastructures

Collaborative Care for Perinatal Depression in Socio-economically Disadvantaged Women: A Randomized Trial

Nancy K. Grote, Ph.D.[1], **Wayne J. Katon, MD**[2], **Joan E. Russo, Ph.D.**[2], **Mary Jane Lohr, MS**[1], **Mary Curran, MSW**[1], **Erin Galvin, MSW**[1], and **Kathy Carson, B.S.N**[3]

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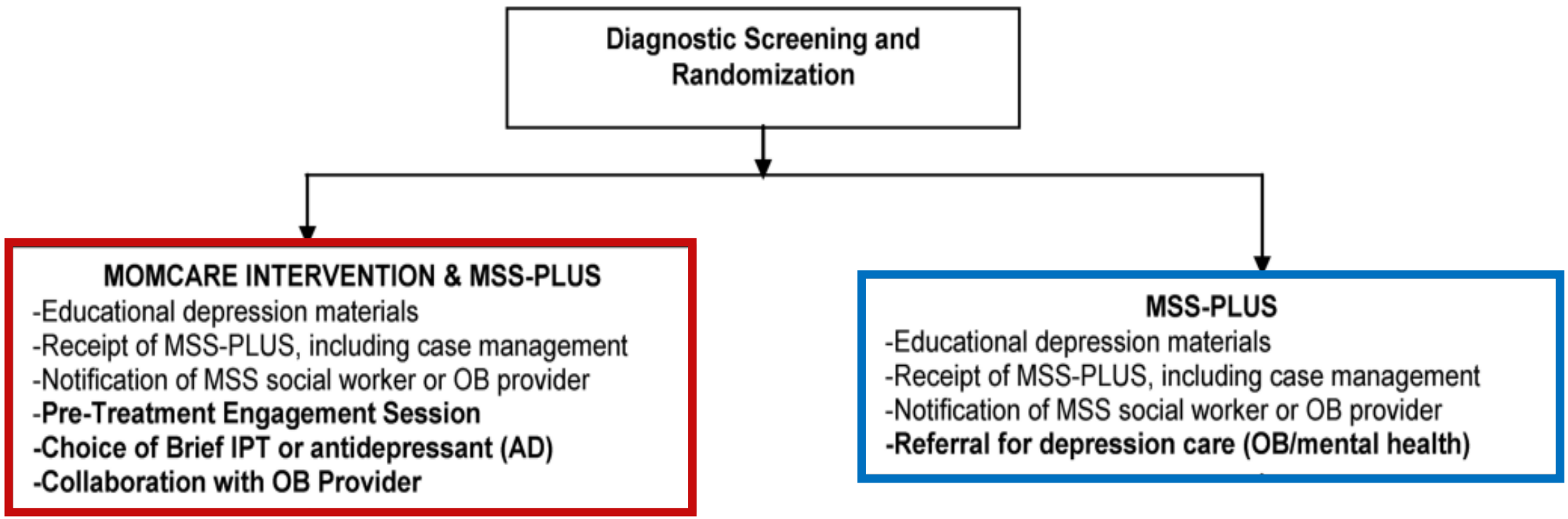
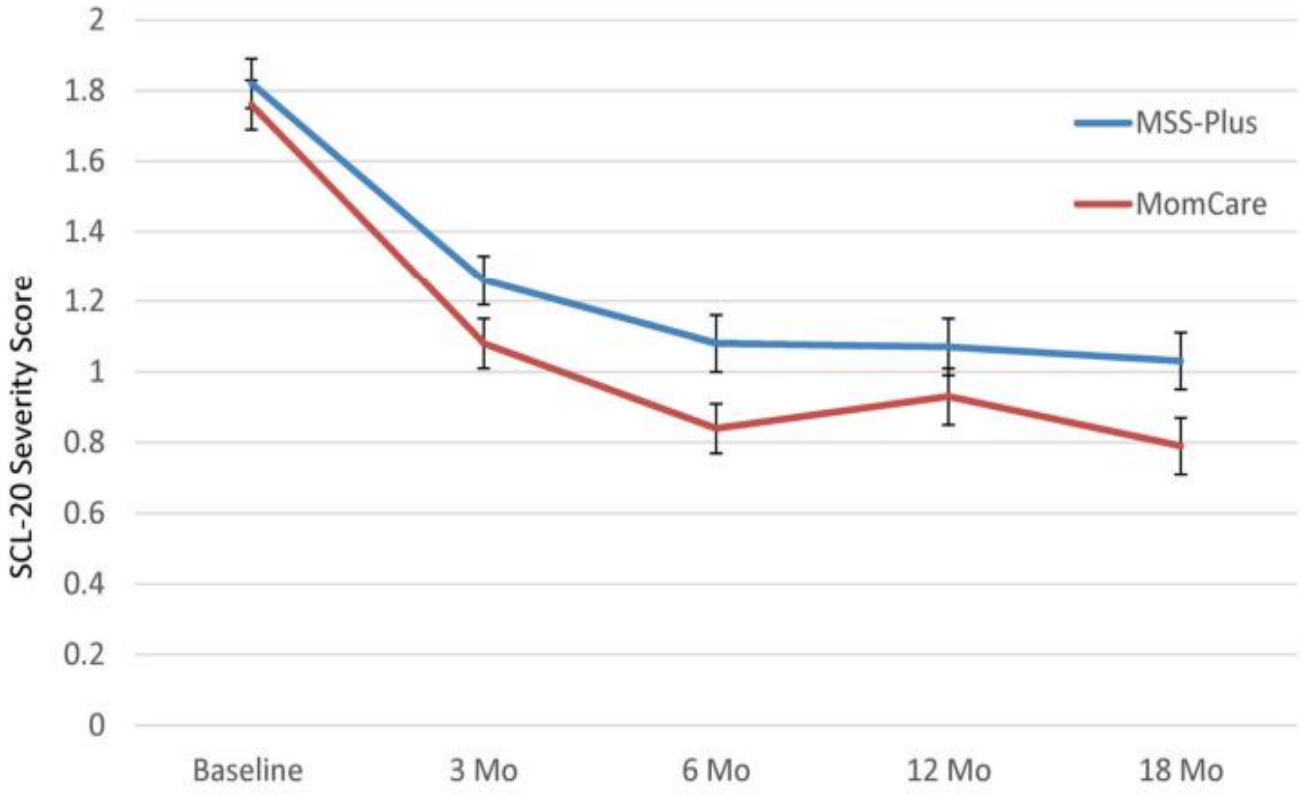
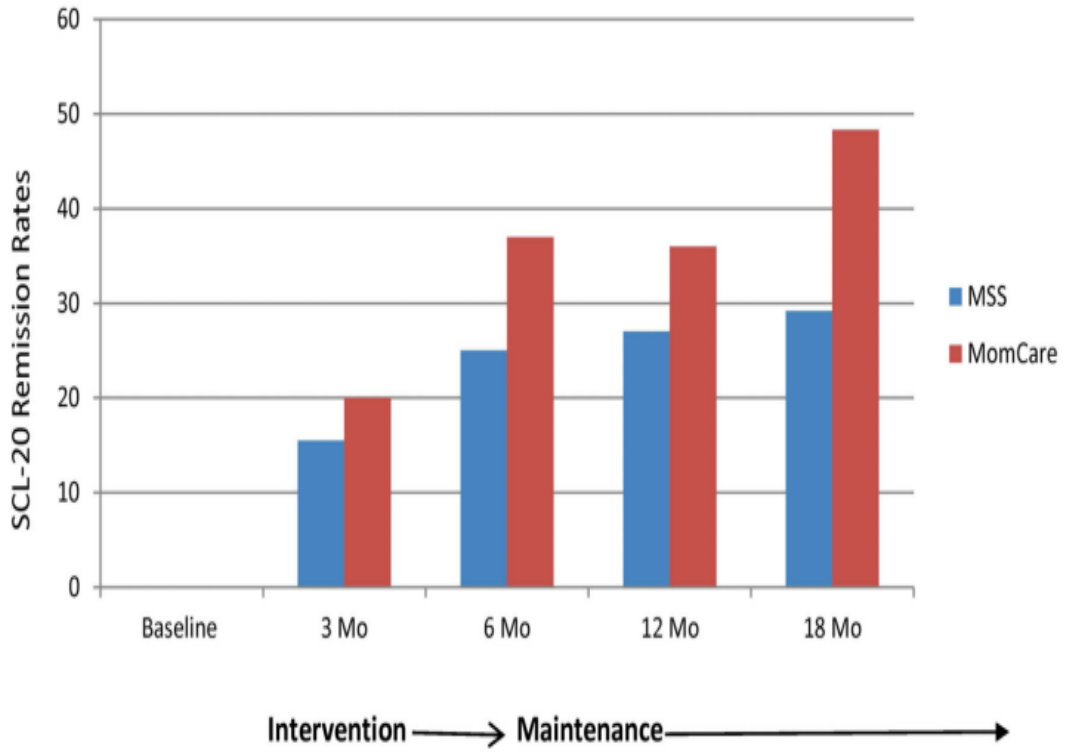






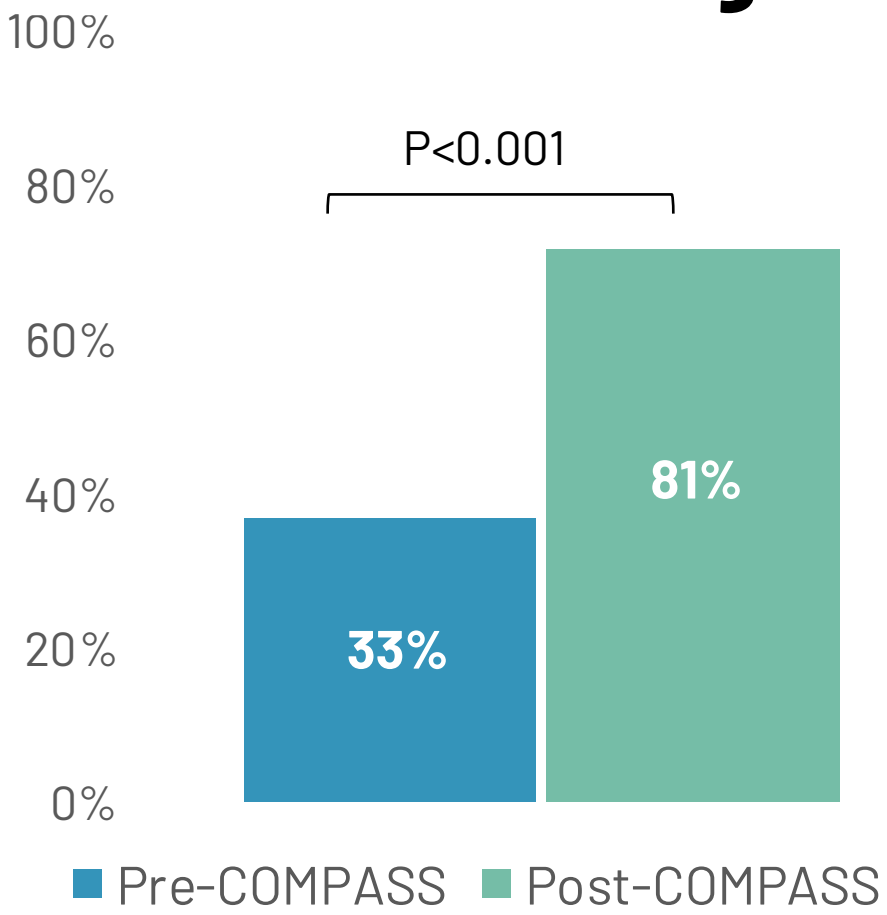
Established **efficacy** of *perinatal* Collaborative Care Model

Grote N et al. Depress Anxiety 2015

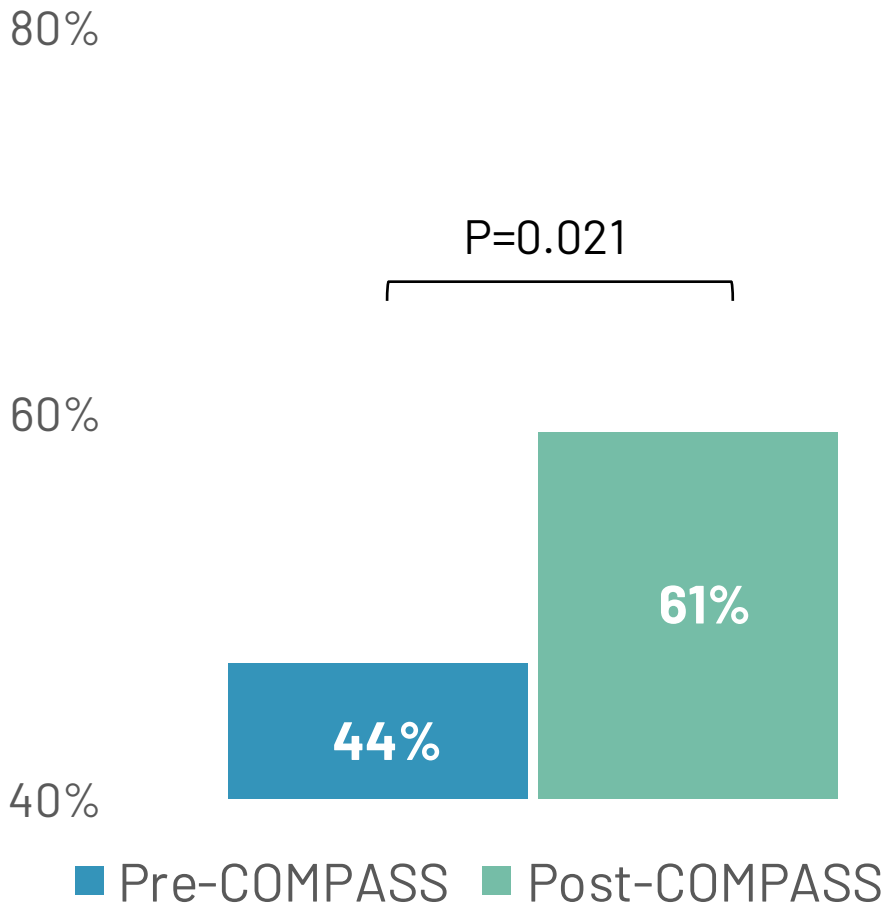
COMPASS

- Collaborative Care Model for Perinatal Depression Support Services
- Implemented January 2017
- Serves ~5000 pregnant and postpartum people annually
  - 5 diversly structured obstetric care offices
- People eligible during pregnancy or postpartum
  - Followed for 12 months postpartum

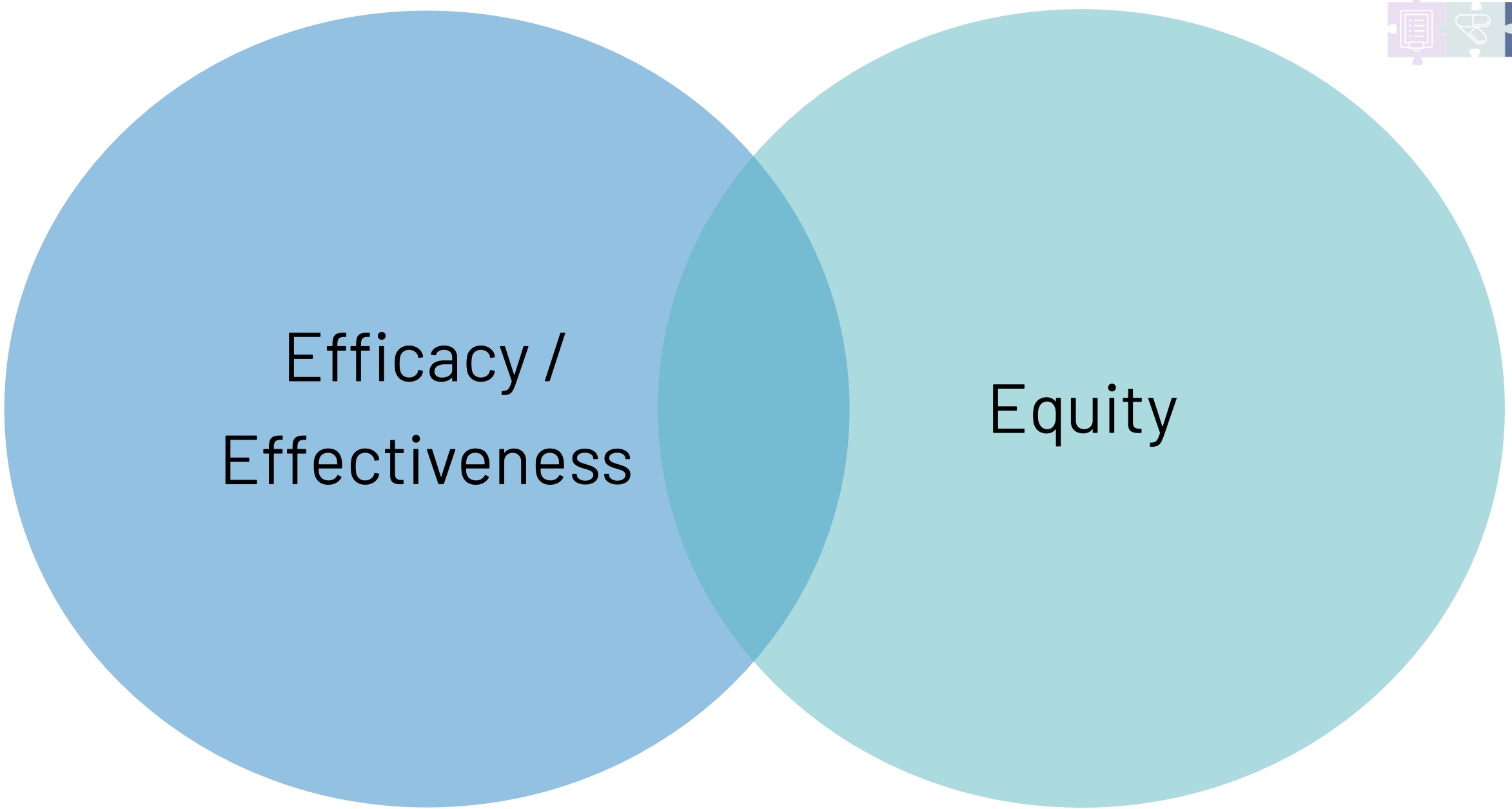
Screening



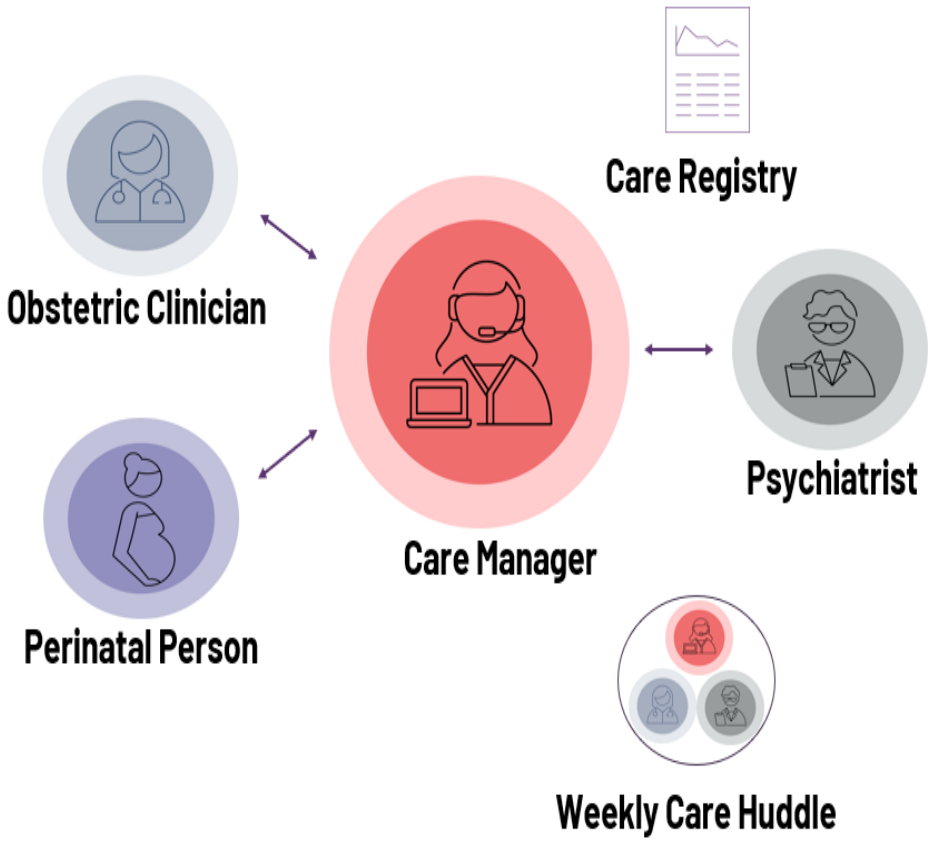
Treatment



Miller ES et al. Psychiatric Services 2021


Efficacy /
Effectiveness
Equity

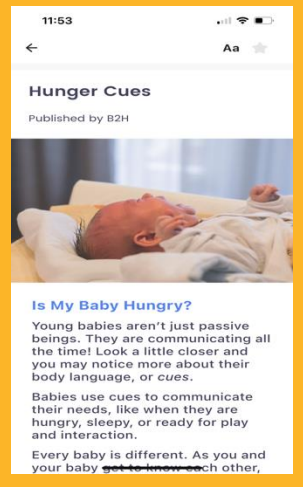
CCM Gaps



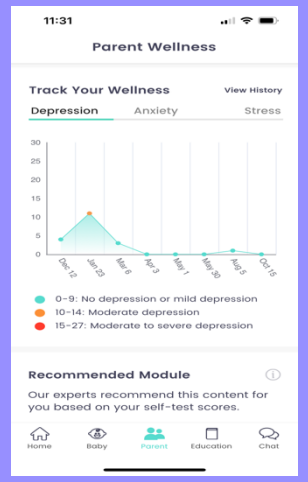
Gaps with the CCM

- Routine obstetric care ends after postpartum visit
- Costs limit scale
- Models overlook non-birthing parents and broader family wellbeing

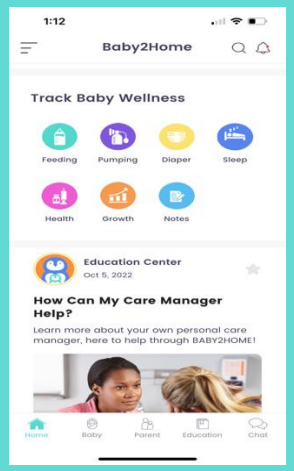
Baby2Home



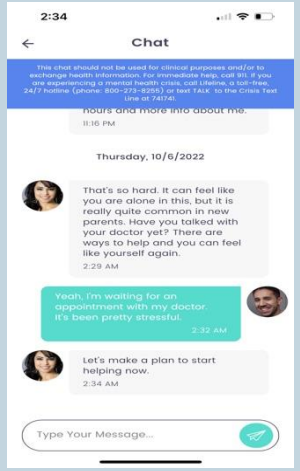
Individualized anticipatory **education** to guide and support new parents



Ability to **track mental health** and create a care plan with support from the care manager and app resources



Infant care trackers to help boost parenting confidence and communication



Live care manager chat for on-demand support, early mental health intervention, and problem-solving around care obstacles


Cick here to watch the
YouTube video about
Baby2Home app.

Signals of Promise (Results Under Embargo)

- Baby2Home was evaluated in a multicenter randomized trial
  - N=642 families
    - 642 birthing parents, 324 non-birthing parents
- B2H was feasible, safe, and implemented as designed
- Findings suggest meaningful potential for family-centered postpartum mental health support

Duckworth M, Miller ES. Contemp Clin Trials 2024

CCM Gaps

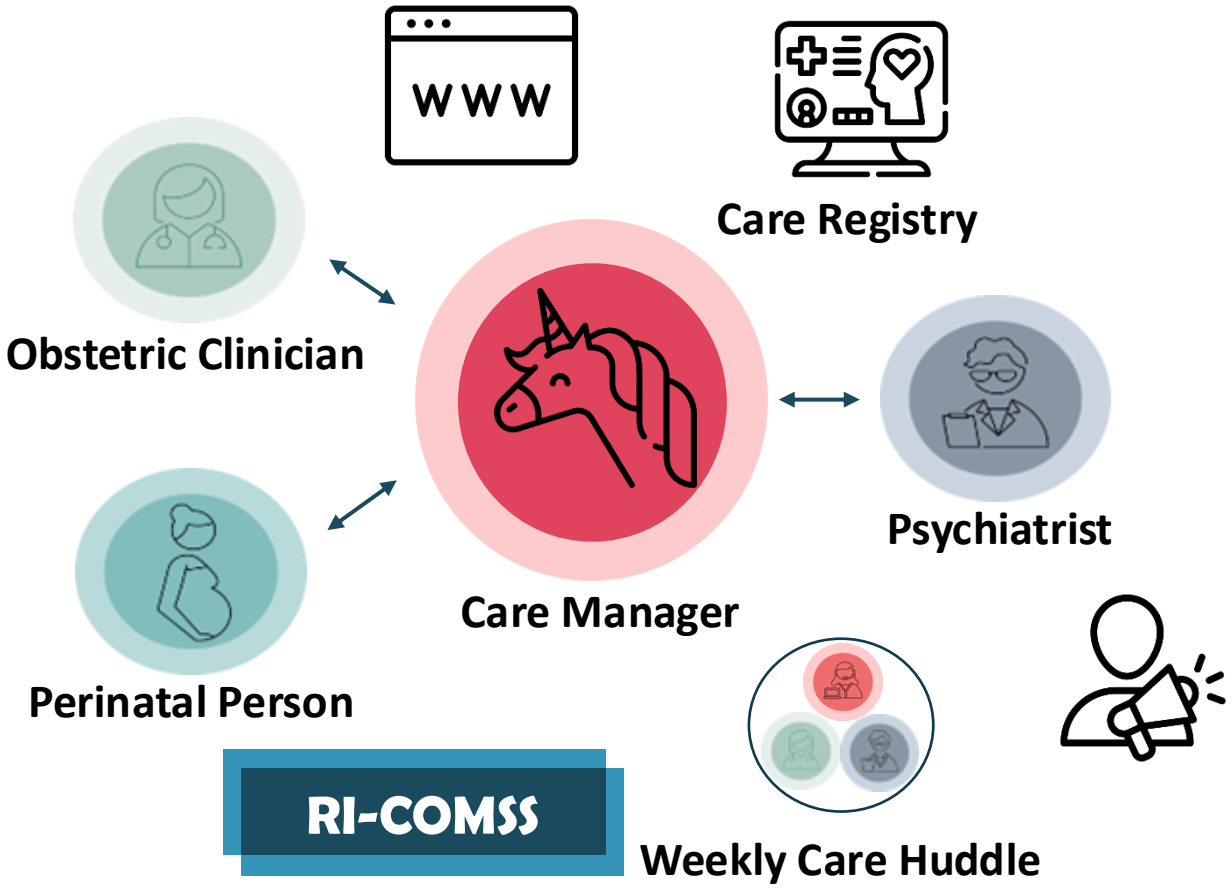
Perinatal Mental Health Outcomes

- Lack of focused attention to HRSN
- Insufficient approach to health equity / anti-racism
- Mental health support limited to those who disclose symptoms

Need for community co-designed solutions for intervention optimization

compass+

COMPASS – **P**opulation-**L**evel Eq**u**ity-Centered **S**olutions



- Care Manager Job Description
- Integration of HRSN
- Health Equity Workshops
- Patient Registry Adaptations
- Website Design

PERINATAL COLLABORATIVE CARE COLLECTIVE

About the Collective | Perinatal CCM | Initiatives | Care Team Training | Patient Resources

Transforming perinatal healthcare with a team-based, holistic, and integrated approach to mental wellness.

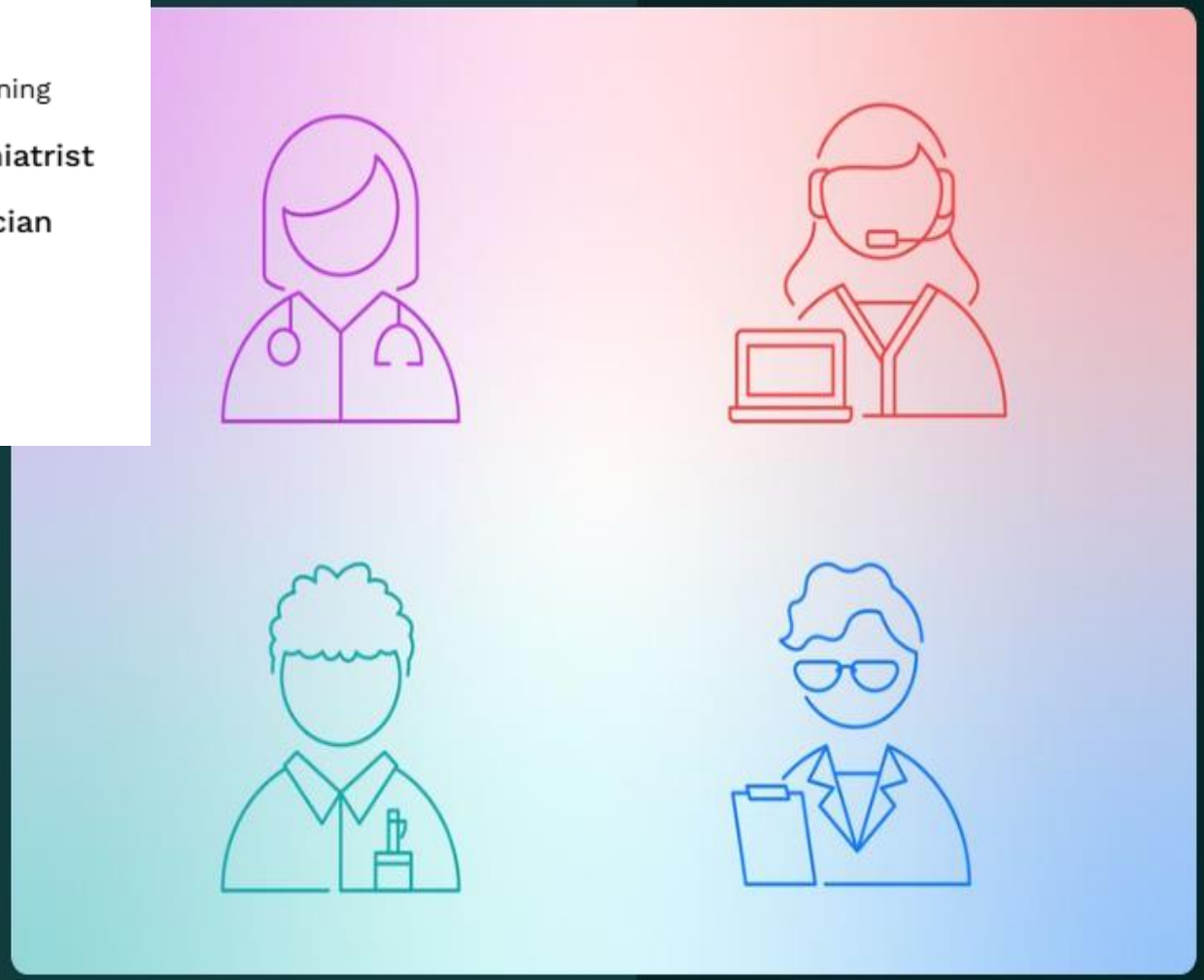
Learn about Perinatal Collaborative Care

PERINATAL COLLABORATIVE CARE COLLECTIVE

About the Collective | Perinatal CCM | Initiatives | Care Team Training | Patient Resources

- Practice Culture
- Care Manager
  - Basic Training
  - Advanced Training
- Perinatal Psychiatrist
- Obstetric Clinician
- Healthcare Administrator
- FAQ

Care Team Training



Summary

1. Obstetric clinicians can be partners in mental health care
2. Programs must be designed to allow us all to listen
3. Community-informed innovation is required

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Questions?