Series 6 Evaluation and CME

- Evaluations were sent yesterday
- We appreciate any feedback you have
- Instructions for claiming CME are provided at the end of the evaluation
- Reach out to uwictp@uw.edu for any questions

Integrating Perinatal Mental Health Treatments into Prenatal Care

Amritha Bhat, MD, MPH
Associate Professor
Department of Psychiatry and Behavioral Sciences

Speaker Disclosures

- Perinatal PCL

Learning Objectives

- To describe integrated perinatal mental health models
- To describe modifications to the CoCM model for delivery to perinatal populations

Perinatal mental health disorders are common

- Perinatal depression 10 – 20%
- Perinatal anxiety 15 – 20%
- Perinatal PTSD 6 – 20%
- Postpartum psychosis 0.1%

Any hypertension in pregnancy 8.6%
Gestational diabetes 7%

Impact of untreated perinatal mental health disorders

- Poor prenatal care
- Increased substance use and smoking
- Pregnancy complications
- Gestational weight retention
- Lactational difficulties
- Cost - $14 billion for the 2017 birth cohort
- Leading cause of maternal mortality

Children of mothers with perinatal depression:

- Preterm birth, low birth weight.
- Increased dysregulation, irritability, crying, sleep difficulties
- Malnutrition, stunted growth
- Higher rates of hospitalization and mortality in the first year
- Cognitive, emotional and developmental delays
- Internalizing and externalizing disorders
- Adolescent depression

Taking the care to where they are

Ob, PCP

Doulas

PHN, RN

CM, Peers

Birthing hospitals, NICU

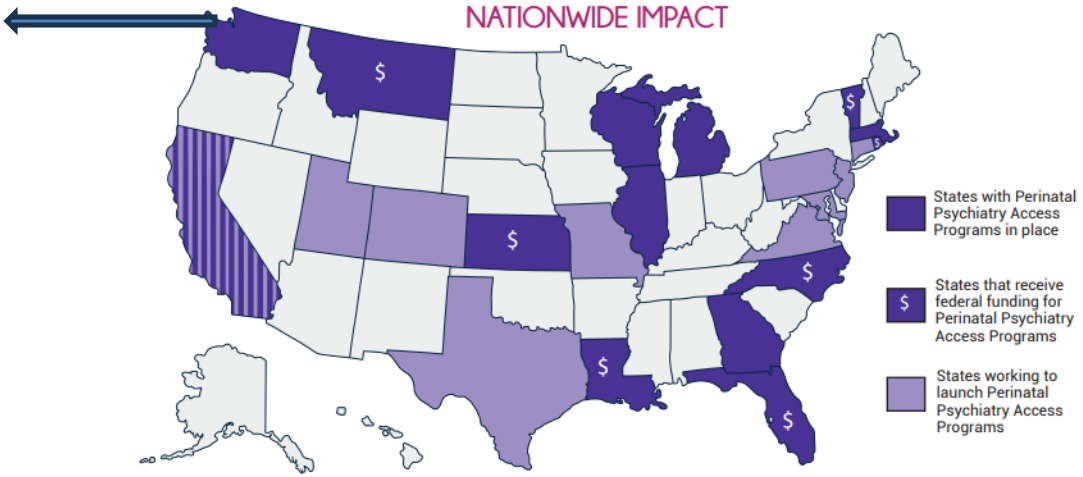
Home Visitors

Pediatric clinicians

ECD experts, Home Visitors

INTEGRATED PERINATAL MENTAL HEALTH CARE – PERINATAL PSYCHIATRY ACCESS PROGRAMS

Perinatal Psychiatry Access Programs



Source: Maternal Mental Health Leadership Alliance

UW Perinatal Psychiatry Consultation Line for Providers

Perinatal PCL / Partnership Access Line (PAL) for Moms

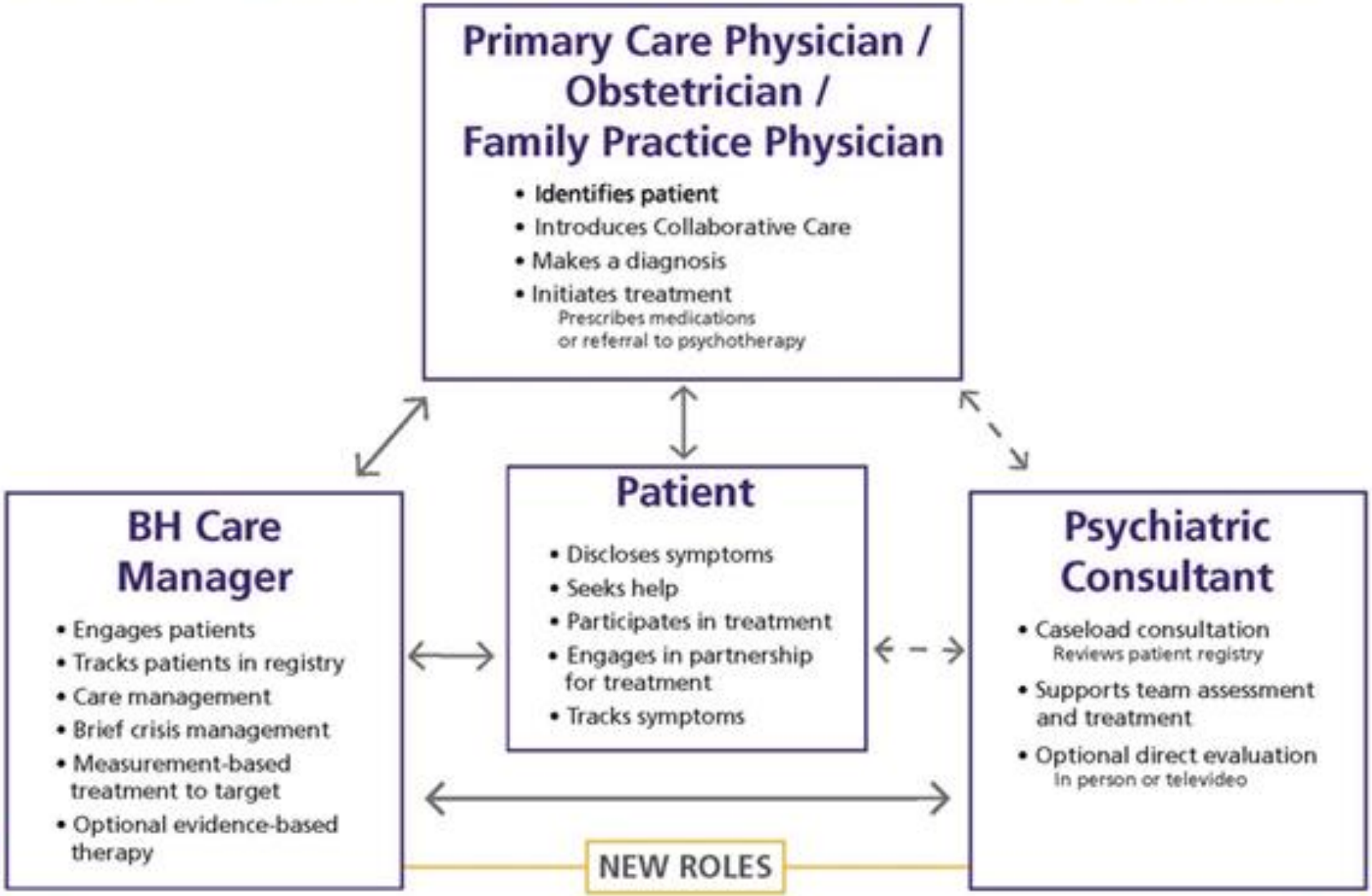
WEEKDAYS 9:00 – 5:00PM | 877-725-4666 (PAL4MOM) | PPCL@UW.EDU

- Who can call? Any provider who cares for pregnant/postpartum patients
- What kind of questions? Any behavioral health-related questions for patients who are pregnant, in the first year postpartum, or who have pregnancy-related complications (e.g. pregnancy loss, infertility). Topics may include:
    - Depression, anxiety, other psychiatric disorders (e.g., bipolar disorder, post-traumatic stress disorder), substance use disorders, or co-occurring disorders
    - Pregnancy loss, complications, or difficult life events
    - Weighing risks and benefits of psychiatric medication, non-medication treatments
    - Local resources & referrals
- Staffed by UW perinatal psychiatrists
- Learn more https://www.mcmh.uw.edu/ppcl

Funded by:
Washington State Health Care Authority

INTEGRATED PERINATAL MENTAL HEALTH CARE – PERINATAL COLLABORATIVE CARE

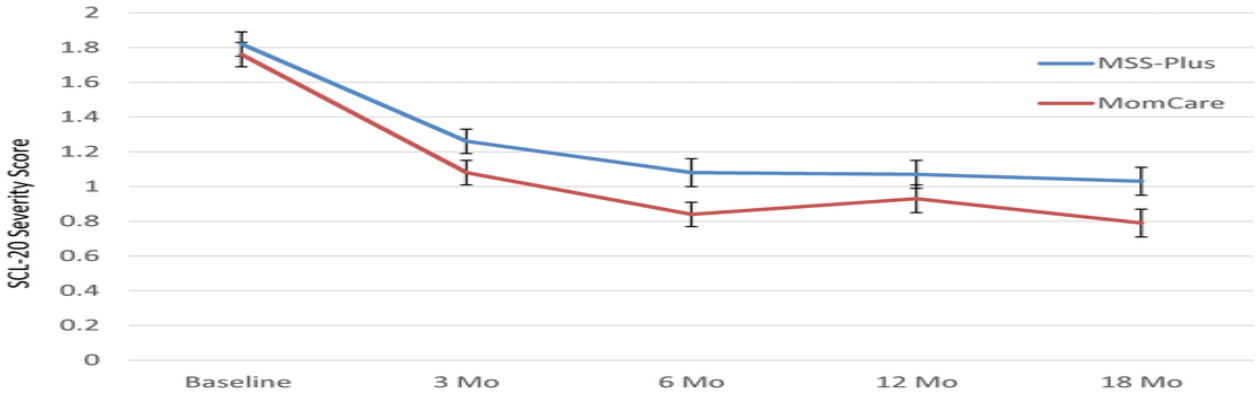
Collaborative Care Team Structure

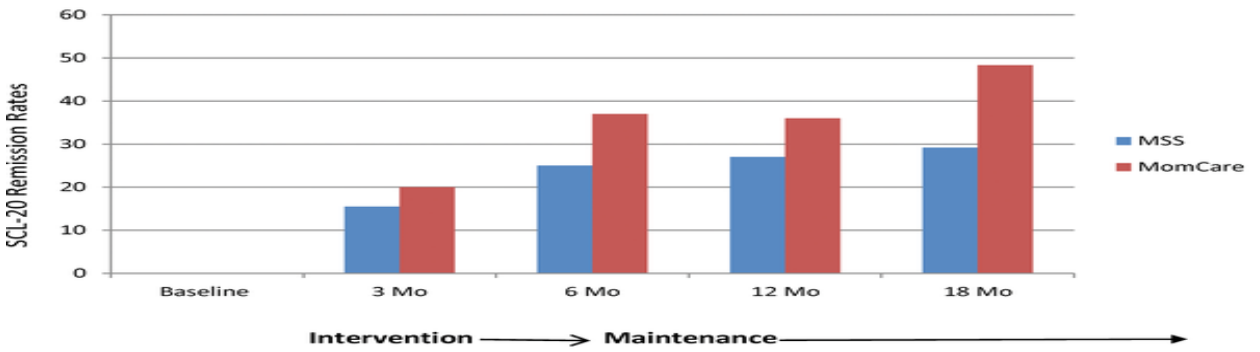


Evidence Base for Perinatal Collaborative Care

- More than *80 randomized controlled trials* have shown Collaborative Care to be more effective than usual care for common mental health conditions such as depression and anxiety.
- Robust evidence base for CoCM in women and in the perinatal period.

Perinatal Collaborative Care – RCT

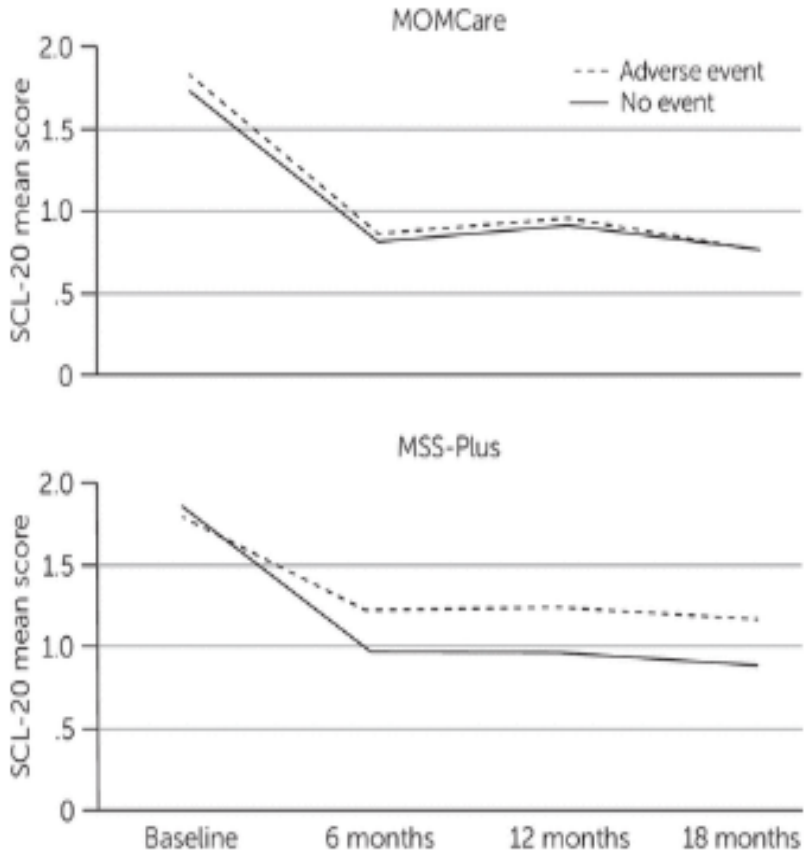




Depression severity (SCL-20) range 0-4. Main effect for group in depression severity p<.05, controlling for baseline.
Remission rates = % N <0.5 on SCL-20. Main effect for group in depression remission rates p=.05, controlling for baseline.
3-month F/U=before birth; 6-month F/U=mean 3 mos. postpartum; 12-months F/U=mean 9 months postpartum; 18-months F/U=mean 15 months postpartum.

Grote et al, 2015

Perinatal Collaborative Care – Perinatal Depression and Adverse Birth Outcomes



Bhat et al, 2017

Perinatal Collaborative Care reduced the risk of depression in mothers who experienced adverse birth events

Qualitative analyses

- Depression treatment should be considered part of regular prenatal care.

  "trying to incorporate different aspects of your healthcare into one program"

  "one stop shop kind of approach"
- Teamwork
- Improved access
- Multiple engagement strategies including text messaging

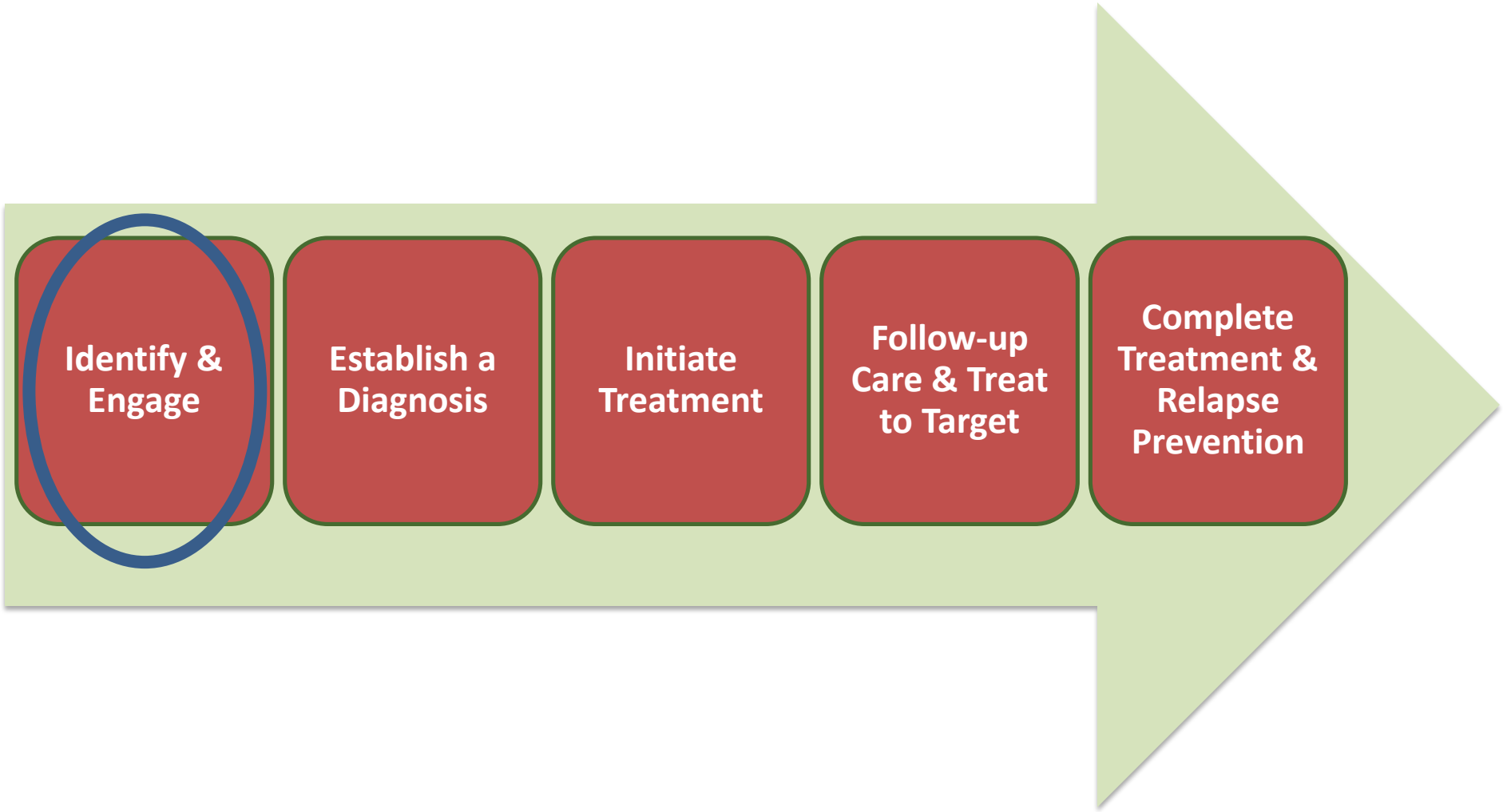
Bhat et al, 2018

COMPASS

- Collaborative Care Model for Perinatal Depression Support Services
- Northwestern University Feinberg School of Medicine, Chicago, IL
- 340 eligible women referred to the perinatal collaborative care program; 64 (75.4%) engaged in the program.
- Women who engaged were more likely to intend breastfeeding and to continue breastfeeding at the postpartum visit
- Implementation of COMPASS reduced disparities in screening for antenatal depression and in treatment recommendations for those who screened positive.

Allen et al,, 2019; Parzysek et al, 2019, Snowber et al. 2022

Modifications



Screening tools and recommendations

- PHQ-9 vs EPDS
- GAD – 7 or EPDS 3A
- NIDA quick screen
- AUDIT
- Screen for bipolar disorder – MDQ / CIDI

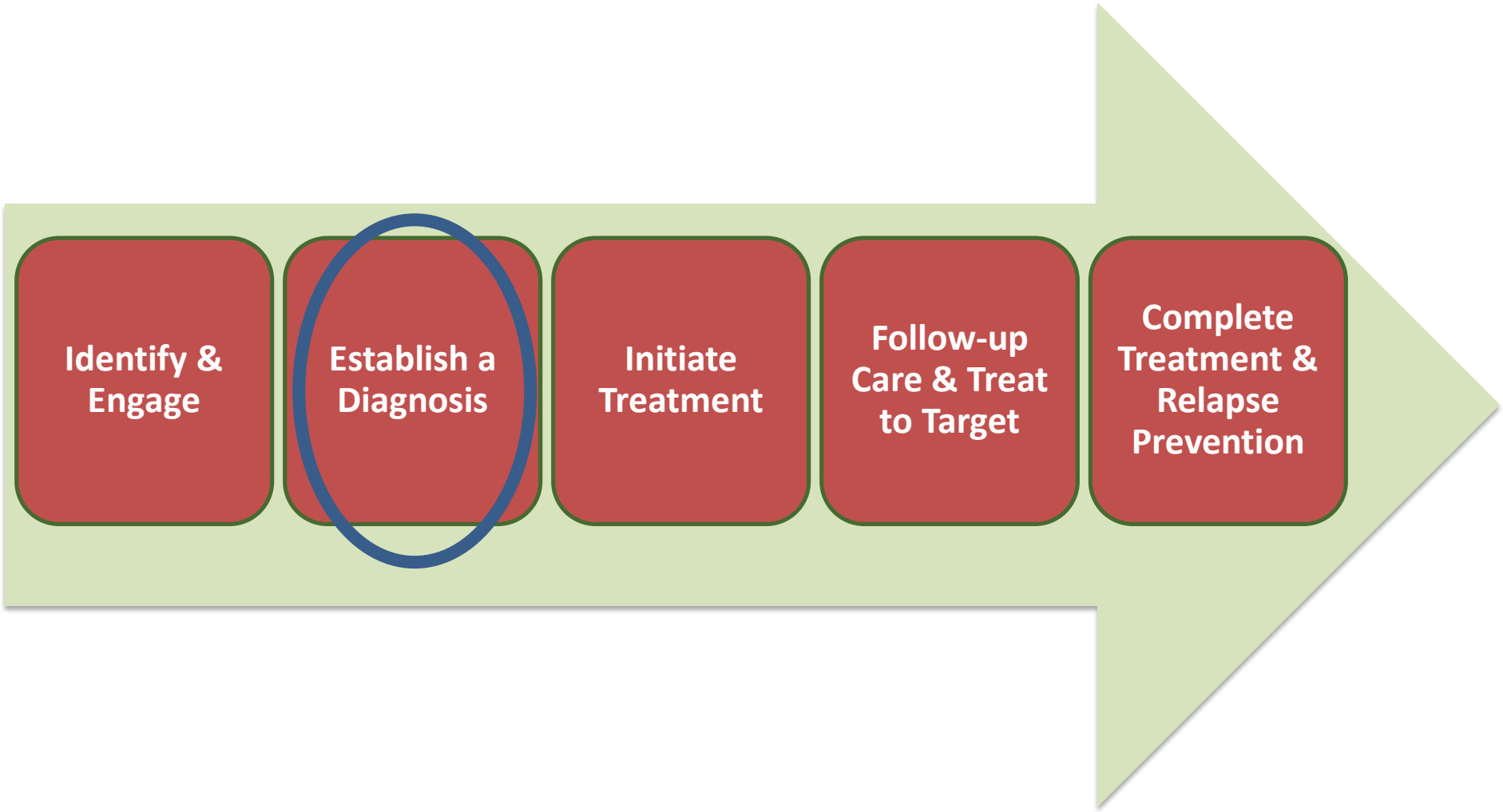
- Considerations for Ob only vs Ob + Primary care
- Perinatal depression screening frequency
  - ACOG: At least once in the perinatal period
  - AAP: 1, 2, 4 and 6 month well child visit
  - APA:
    - (depressive, anxiety, and psychotic disorders) once in early pregnancy and once later in the pregnancy
    - postpartum patients should be screened for depression during pediatric visits as recommended by the AAP.
    - systematic response to screening should be in place to ensure that psychiatric disorders are appropriately assessed, treated, and followed

Modifications - Engagement

- Initial engagement session
  - Aimed at improving patient acceptance of the depression diagnosis and choosing an evidence-based treatment.
  - Reflective statements and non-judgmental listening techniques
  - Explore potential barriers to attending clinic visits and how these barriers might be overcome.
  - Motivational Interviewing techniques
- Many more opportunities to engage!
  - Well child visit
  - Home visiting / Public health services

LaRocco-Cockburn et al, 2013

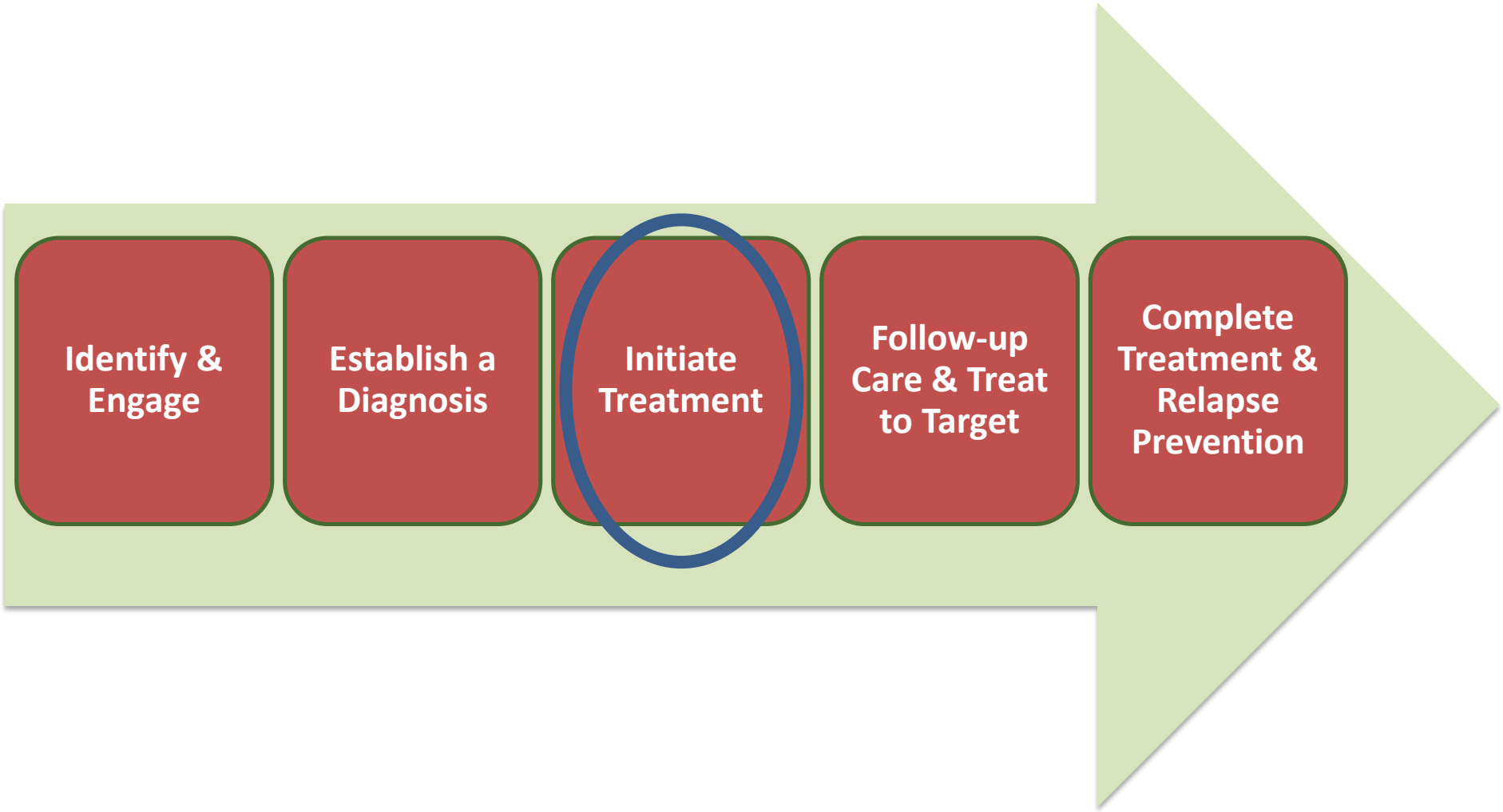
Modifications



Modifications - Diagnosis

- Postpartum blues
- Postpartum psychosis
- Bipolar vs Unipolar depression
- Parenting challenges and Dyadic interaction

Modifications



Modifications – Treatment

Treatment	Considerations in Pregnancy
Behavioral Activation	High risk pregnancy; The busy mother paradox
Cognitive Behavior Therapy	Parenting self-efficacy; Infant related themes
Interpersonal Therapy	Attention to role transitions, grief , loss
Problem Solving Therapy	Obtaining support
Antidepressants	Safety during pregnancy and lactation

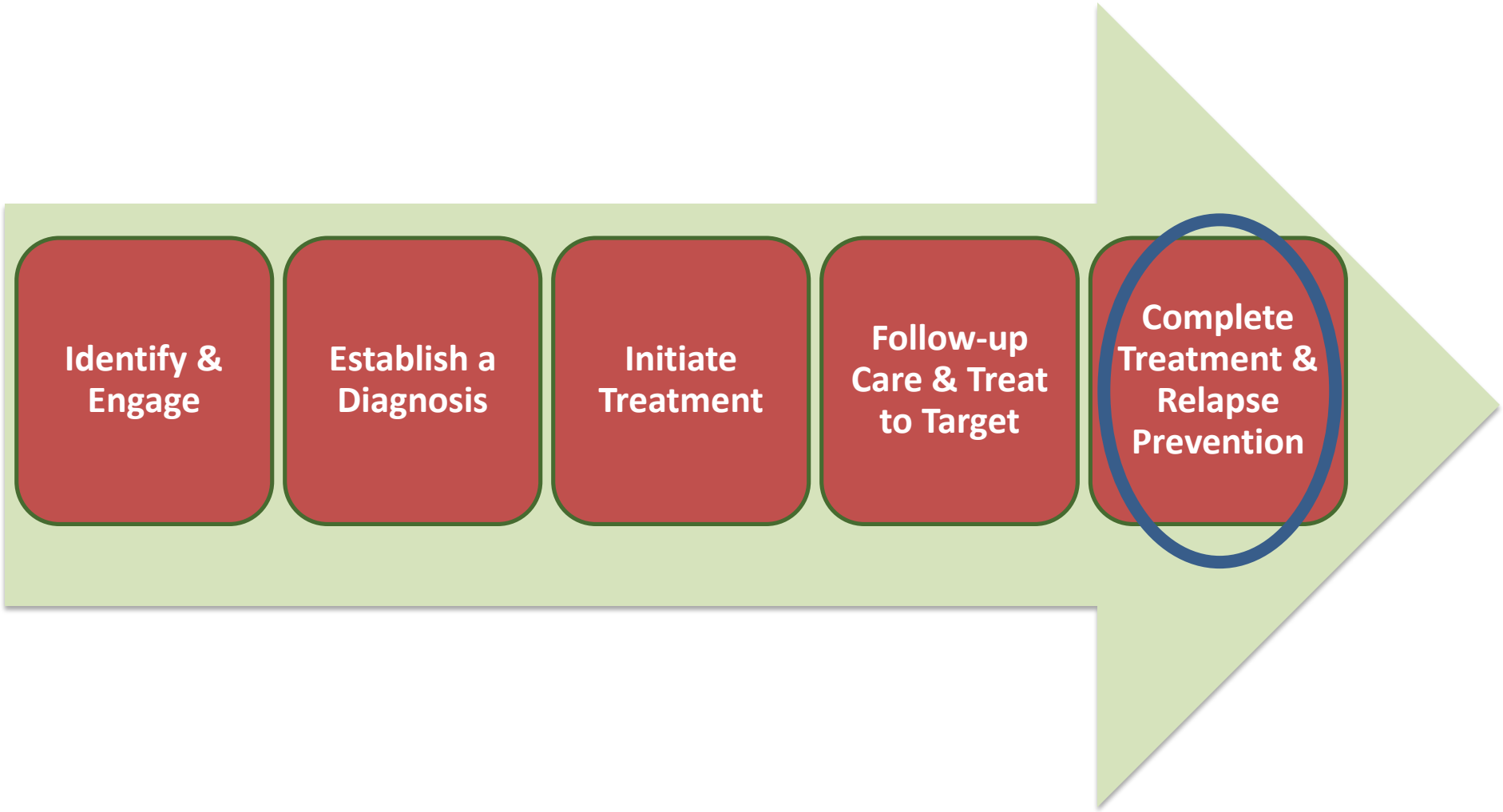
Modifications - Treatment

- Who conducts the informed consent discussion?
- Prerequisites to offering medication
  - Thorough diagnostic evaluation including an understanding of patients' responses to previous treatments
  - Understanding patient's treatment goals, concerns and constraints (financial, time)
  - Prescribe only when clearly indicated and with a strong evidence base.

Modifications – Safety Protocols

- Suicidal Ideation
- Thoughts of harming the infant
  - CM trained in assessing risk
  - Clinic / organization protocol for responding to risk

Modifications



Modifications – Relapse Prevention

- Hold off if close to EDD or 6 week postpartum check
- Connect with pediatrician for continued monitoring and care coordination as needed
- Educate on risk of recurrence of PPD

Challenges and Opportunities

- Continuity of care
- Coordination of care
- Utilization of available resources
- Billing and sustainability

Takeaways

- *Pregnancy and the year postpartum is a period of high risk for common mental disorders and a period of more opportunities for identification and treatment*
- *Various integrated care models can be integrated into perinatal are*
- *Unique considerations for integration of perinatal mental health care include the encounter based natured of prenatal lease include at least 3 takeaways from your didactic*

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- Screening for perinatal depression. ACOG Committee Opinion No. 757. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e208-12.

Resources

- Perinatal Support Washington: http://perinatalsupport.org/
- UW Perinatal Psychiatry Consultation Line https://www.mcmh.uw.edu/ppcl
- UW PAL for Moms Care Guide https://www.mcmh.uw.edu/care-guide
- Reprotox: www.reprotox.org
- Lactmed: https://www.ncbi.nlm.nih.gov/books/NBK501922/
- MGH Center for Women's Mental Health: https://womensmentalhealth.org/
- Ask Suicide Screening Questions https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/adult-outpatient/adult-outpatient-brief-suicide-safety-assessment-worksheet

Additional Free Resources for Washington State Healthcare Providers

*No cost

EDUCATIONAL SERIES:

- AIMS Center office hours
- UW Traumatic Brain Injury – Behavioral Health ECHO
- UW Psychiatry & Addictions Case Conference ECHO UW PACC
- UW TelePain series About TelePain (washington.edu)
- TeleBehavioral Health 101-201-301-401 Telehealth Training & Support - Harborview Behavioral Health Institute (uw.edu) | bhinstitute@uw.edu

PROVIDER CONSULTATION LINES

- UW Pain & Opioid Provider Consultation Hotline Consultation (washington.edu) – 844-520-PAIN 7246)
- Psychiatry Consultation Line - (877) 927-7924
- Partnership Access Line (PAL) (pediatric psychiatry) - (866) 599-7257
- PAL for Moms (perinatal psychiatry) - (877) 725-4666

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- PAL for Moms
  - (877) 725-4666
- UW TBI-BH ECHO

Questions and Discussion

- Ask questions in the chat or unmute yourself

Registration

- If you have not yet registered, please email uwictp@uw.edu and we will send you a link