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SMFM Special Statement

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Executive summary: Workshop on maternal mental health, February 11–12, 2024, co-sponsored by the American College of Obstetricians and Gynecologists

Society for Maternal-Fetal Medicine

Key words: anxiety, depression, health disparities, health insurance, medical education, perinatal mental health, perinatal mood and anxiety disorders, pregnancy, prevention, screening

Introduction

Up to 1 in 5 childbearing people experience mental health conditions as a complication of pregnancy.[1,2] Mental health conditions, including suicide and overdose, are the leading causes of death in the first postpartum year and are 100% preventable.[3] Most people who experience perinatal mental health conditions do not get the care they need, which negatively affects their own health and the wellness of their partner, fetus, child, and family.[4] In the United States, the cost of not treating these conditions is $14.2 billion.[5] Gaps in mental health screening and treatment access disproportionately affect historically marginalized people, those who live in low-income neighborhoods, and those who lack access to maternity care.[6,7]

In response to this crisis, the Society for Maternal-Fetal Medicine (SMFM) President's Workshop on maternal mental health was held in conjunction with the 44th annual Pregnancy Meeting in National Harbor, MD, on February 11 and 12, 2024. The American College of Obstetricians and Gynecologists (ACOG) co-sponsored the workshop. Workshop leaders and speakers represented the fields of obstetrics and gynecology (OBGYN), maternal-fetal medicine (MFM), complex family planning, psychology, psychiatry, and pediatric neuroscience. In addition to clinical expertise, participants had experience in research, policy and advocacy, workforce development, medical education, and community-based programming. Invited participants included representatives from medical societies, government agencies, nonprofit organizations, and philanthropic foundations. The goals of the workshop were:

- To expand OBGYN and MFM mental health screening and treatment capacity through discussion of perinatal mental health disorders and identification of pertinent educational resources.
- To leverage the 2-generation perspective and brain plasticity science for clinical and research opportunities.
- To promote access to mental health treatment and prevention during pregnancy and the postpartum period through the identification of effective, scalable health services, interventions, and community-based programs.

Background

Presentations on the first day of the workshop included the following themes:

- Maternal brain plasticity increases during the perinatal period.[8] High levels of stress (including stress associated with poverty)[9] during this period are associated with dampened brain response to infant cries and reduced maternal sensitivity.[10]
- Prenatal brain plasticity is a time of vulnerability and opportunity. Prenatal maternal distress forecasts an adverse postnatal environment, and fetal brain changes in response to this forecast can contribute to the risk for future mental health problems. Consequently, maternal mental health matters for at least 2 generations, namely the parent and the offspring.[11]
- The ACOG recommends screening for perinatal depression and anxiety using standardized, validated instruments at the initial prenatal visit, later in pregnancy, and at postpartum visits.[12] Screening should be implemented with systems in place to ensure timely access to treatment. Discussing and initiating psychopharmacotherapy is within the scope of OBGYNs.[13]
- Black and Hispanic mothers who experience depression are less likely to receive services and more likely to experience poverty, separation or divorce, unemployment, and financial difficulties than White mothers with depression.[14] Efforts to improve maternal mental health

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must prioritize racial equity and center the experiences of members of the communities affected.

- Administering mental health screening, reviewing screening results, and discussing social determinants of health (SDOH) with patients require additional time and effort from physicians and office staff. The International Classification of Diseases, 10th Revision, codes for SDOH and mental health screening[15] should be used for documentation and reimbursement purposes.
- More than 50% of birthing parents with antenatal or postpartum depression go undiagnosed, approximately 85% do not receive treatment, and 95% to 97% are not treated to remission.[16] Increasing OBGYN preparedness to recognize and treat perinatal mental health conditions requires systems-level interventions.
- Depression during pregnancy is the strongest predictor of postpartum depression, and discontinuation of antidepressant treatment is associated with relapse of major depression.[17] Data consistently show that, when adjusted for the underlying mental health condition, selective serotonin reuptake inhibitor exposure in pregnancy is not associated with congenital anomalies, fetal growth problems, or long-term developmental abnormalities.[18,19]
- The Elevating Voices, Addressing Depression, Toxic Stress and Equity (EleVATE) program demonstrates principles of effective community-centered interventions, including engaging program stakeholders for co-creation, collaborating with patients as partners, designating a program staff member to serve as a trusted broker, adopting shared governance structures, establishing protocols to present communal work, and practicing budget transparency.[20,21]
- Counseling interventions can prevent perinatal depression but rely on effective screening to identify those at risk.[22] The United States Preventive Services Task Force (USPSTF) recommends the Mothers and Babies Program and the Reach Out, Stay Strong, Essentials intervention for primary prevention of perinatal depression.[23] Practical Resources for Effective Postpartum Parenting is an emerging intervention.[24] Sizable gaps remain in the implementation of counseling interventions aimed at prevention.
- Resources to enhance clinicians' knowledge of screening and treatment for perinatal mental health conditions include ACOG Clinical Practice Guidelines,[12,13,25] the Alliance for Innovation on Maternal Health Perinatal Mental Health Conditions Patient Safety Bundle,[26] the National Curriculum in Reproductive Psychiatry (NCRP),[27] the National Maternal Mental Health Hotline,[28] Postpartum Support International,[29] and Perinatal Psychiatry Access Programs.[30]
- Collaborative care models are associated with meaningful improvement in depression and anxiety.[31,32] Perinatal collaborative care is associated with increased perinatal depression screening and recommendation for treatment and it reduces racial disparities in these components of the mental healthcare cascade.[33]
- Stillbirth increases the risks for depression, anxiety, substance use disorders, posttraumatic stress disorder, and suicide.[34–37] Stigma and misconceptions about grief worsen outcomes for parents experiencing stillbirth.
- The specific impact of the Dobbs vs Jackson Women's Health decision on maternal mental health remains to be seen, but research has established that being denied an abortion is associated with elevated anxiety and that abortion restrictions disproportionately affect historically marginalized populations.[38,39]

Key findings and preliminary recommendations

Workshop participants were invited to join 1 of 3 breakout groups to discuss the following key issues in greater depth: (1) perinatal psychiatric disorders and educational resources for OBGYNs and MFMs; (2) 2-generation brain plasticity science for clinical and research opportunities; and (3) health services interventions and community-based programs for equitable mental health treatment and prevention during pregnancy and the postpartum period. Summaries of each breakout group's discussion are presented below.

Breakout group 1: perinatal psychiatric disorders and educational resources for obstetricians and maternal-fetal medicine subspecialists

The group grounded their discussion in an acknowledgment that the United States healthcare system does not prioritize mental healthcare and that many of their proposed solutions would require major changes in policy and funding. Discussants agreed that reforms to reimbursement are needed, arguing that fair reimbursement rates would increase access to care by raising the proportion of mental health clinicians who accept insurance. Similarly, if OBGYNs were reimbursed at a fair rate for time spent on mental health issues, they would be more incentivized to seek out the necessary education to provide this care. Participants also reflected that many obstetrical providers were largely unaware of the existing resources shared during the background presentations, pointing to a need for better dissemination of tools such as the NCRP.[27]

The group then discussed strategies to improve trainee education in maternal mental health, including the principles of psychopharmacology. Participants recommended additional emphasis on mental health conditions in the Council on Resident Education in Obstetrics and Gynecology educational objectives,[40] the Society for Academic Specialists in General Obstetrics and Gynecology Pearls of Exxcellence,[41] and the American Board of Obstetrics & Gynecology qualifying and certifying examinations. Participants assessed the idea of required psychiatry rotations in

OBGYN residencies, particularly rotations within perinatal access programs.

The group then delineated strategies to improve mental health education for practicing OBGYNs. A central clearinghouse of resources from various sources and professional organizations would be helpful to clinicians. The group also emphasized the importance of including mental health education in the requirements for licensure and quality measures. They discussed strategies to deliver education and resources at practice locations, including physical materials (eg, magnets or stickers for the National Maternal Mental Health Hotline[28]) and on-site training sessions from experts in reproductive psychiatry. The group noted that efforts to increase patient access to psychotherapy should accompany efforts to increase the provision of psychopharmacologic treatment by OBGYNs. Finally, the group encouraged clinicians to prioritize team-based care and make use of local resources relevant to their patient populations.

Breakout group 2: two-generation brain plasticity science for clinical and research opportunities

The group began by discussing the implications of population heterogeneity in the United States (eg, race, socioeconomic status, gender identity, religion) on 2-generation brain plasticity research. Participants also noted that the inherent challenges of engaging participants with depression in research may skew study populations toward milder depression. A robust study must consider these limitations and take an intersectional and interdisciplinary approach to understanding participants in their personal contexts. Engaging community partners, integrating qualitative methods, and learning from lived experiences also enhance study rigor.

Participants then shared ideas for future research. Discussants encouraged rethinking the setting of studies on maternal mental health. The group brainstormed an accessible screening and intervention project located in a big box retail setting. Participants also noted that researchers should leverage data collected during the COVID-19 pandemic to better understand maternal mental health and consider using allostatic load to better measure stress. The group agreed on the importance of thoughtful messaging when communicating about brain study findings. Research in the field is often characterized by investigating the damage done by stress, but positive framing and messaging about wellness could be more helpful to the public. Finally, the group noted that studies of perinatal depression treatment should include child outcomes, although this may require changes to the existing framework of federal grant funding to support longitudinal follow-up. These additional data would allow for testing of the 2-generation scientific model and provide evidence that treating maternal depression benefits child health and maternal health.

Breakout group 3: health services interventions and community-based programs for equitable mental health treatment and prevention during pregnancy and the postpartum period

The group first discussed ideas for disseminating existing resources to clinicians and patients. One promising strategy would be to embed mental health resources in smartphone applications already used in clinical settings. Discussants agreed that dissemination efforts should seek to destigmatize mental health conditions and that engagement with public figures and influencers would be helpful in achieving this goal. The group discussed challenges in preventing mental health conditions, including a lack of clinician knowledge of the evidence-based interventions for prevention, an inability to accurately predict patient risk, and difficulty obtaining reimbursement for these services. Participants agreed that hotlines and telehealth have the potential to improve access to mental health services. Expanding the care team through advanced practice professionals, doulas, and community health providers will also be crucial to meeting the needs of patients at risk for and experiencing perinatal mental health conditions. The group agreed that integrated behavioral health models and collaborative care can ease physician burden and improve outcomes, but implementation support is critical for broad dissemination. While discussing these solutions, the group acknowledged that a purely medical model approach is unlikely to be effective, and meaningful community partnerships are crucial to support pregnant and birthing people.

The group then discussed opportunities and challenges in delivering digital mental health services. Participants noted that patients vary in their preferences for and comfort with telehealth services. In addition, the heterogeneity in electronic medical records limits how digital interventions can be implemented and what evaluation data can be collected. The group also expressed concerns about existing mental health applications with unclear profit models, a lack of data to support efficacy or effectiveness, and inadequate human components. The group closed with a discussion of health equity issues, including the importance of universal screening to mitigate potential bias and culturally responsive resources for patients identified with screening.

Conclusion and next steps

On the second day of the event, workshop leaders presented summaries of the breakout group sessions and guided attendees in discussion. The large group agreed on several policy priorities to support access to maternal mental health care, including (1) enforcing parity mandates for mental health conditions with insurance companies; (2) requiring equal reimbursement for in-person and telehealth mental healthcare; and (3) mandating reimbursement for

evidence-based models of care (ie, collaborative care) and digital interventions. Additional policy priorities to support birthing people include implementation of paid family and medical leave and decriminalization of perinatal substance use disorders.

Attendees then discussed strategies to improve clinician and patient education in perinatal mental health, including broader marketing and dissemination of the USPSTF recommendations and the NCRP.[27] The group agreed that train the trainer events for residency program educators and practicing OBGYNs will be crucial to help meet demand and noted that NCRP trainers stand ready to provide this training if funding is available. Discussants also recommended that a clearinghouse website should be created to serve as the centralized home for educational resources about clinical and logistical (eg, billing, care models) topics in maternal mental health. The group agreed that public messaging campaigns (including those featuring celebrities and influencers) would improve patient education. Attendees noted that these clinician and patient education efforts would require new funding to implement.

The large group recommended that funding for mental health research should support partnerships with community groups, pilot studies, and the collection of long-term outcomes. Attendees also noted that researchers would benefit from better coordination and bridging among different funding sources (ie, government, philanthropic). In addition, funders can convene diverse groups working on maternal mental health for coordination and collaboration.

Workshop participants acknowledged that changes to clinical practice must be realistic and sustainable and recognize the limits of the traditional medical model. Rebuilding trust between OBGYNs and historically marginalized patient groups will be crucial to efforts to address maternal mental health. Participants agreed that providers should avoid language that connotes judgment, such as "passing" or "failing," when discussing depression screening results with patients. Clinical practices should be responsive to current gaps in the care cascade (ie, build linkage to care into screening tools), have systems in place to address SDOH (eg, provide transportation), and incorporate community groups. Attendees also stressed the importance of integrating mental healthcare across settings (obstetrics, pediatrics, etc.) and partnering across disciplines to break down silos.

Workshop leaders closed the event by delineating perinatal mental health topics for future research, including:

- Optimal methods of medical education in maternal mental health, including the timing (eg, during residency) and format (eg, clinical rotations) of effective training.
- The impacts of the Dobbs decision and abortion bans on maternal and infant brain behavior and well-being.
- Perinatal mental health conditions in nonbirthing partners.
- Protective and strengthening factors in maternal mental health.
- Effective mental health screening tools and approaches to screening for diverse populations.
- The effectiveness of maternal mental health applications currently on the marketplace and in development.
- Perinatal mental health disparities in historically marginalized populations, including people of color and sexual and gender minorities.

This workshop was intended to serve as a catalyst for continued improvements in maternal mental health. Future efforts emanating from this workshop will contribute to workforce development, clinician and patient education, and the establishment of best practices to promote optimal and equitable outcomes for all people who desire or experience pregnancy.

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