



ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Video Transcript: Perinatal Mental Health Conditions in the Outpatient Setting Community of Learning
Session 3: Perinatal Mental Health: Treatments Including Supporting the Mother-Baby Dyad

Vira David-Rivera [00:00:00] Welcome everyone. My name is Vira David-Rivera and I'm a TA Specialist with the AIM TA Center. Thank you for joining us for the Perinatal Mental Health Conditions Bundle in Outpatient Settings Community of Learning. This Community of Learning is jointly produced with the Policy Center for Perinatal Mental Health. As you join, please share your name, state and organization in the chat so we know who's in the room today. Let's get started. The Community of Learning is hosted by the Alliance for Innovation on Maternal Health. Technical Assistance Center, or the AIM TA Center. AIM is a quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes, and save lives. The AIM TA Center is managed by JSI Research and Training Institute, a nonprofit public health consulting agency that works both internationally and across all 50 states. We're dedicated to improving lives through better health and education outcomes for individuals and communities. The AIM TA Center is supported by a cooperative agreement with the Health and Resources Services Administration of the U.S. Department of Health and Human Services. The contents in this webinar today are of the authors and may not reflect the policies of HRSA, HHS, or the U.S. Government. Next, I'd like to introduce my amazing AIM TA Center colleagues who will support the production of this community of learning. Our Program Coordinator is Cora Kakalec and our clinical lead is Meg Sheahan. Meg Sheahan is the TA specialist with the AIM Technical Assistance Center and a practicing full scope certified nurse midwife with nearly two decades of clinical experience. In her role with the AIM TA Center, she provides training and technical assistance to strengthen maternal health systems and support the delivery of high quality evidence-based care. As a practicing midwife in a large academic health system, she provides comprehensive perinatal intrapartum postpartum care, including perinatal mental health services and outpatient settings. Next, I'd like to introduce Joy Burkhard. Joy founded the Policy Center for Maternal Mental Health, a non-profit recognized as a field catalyst by the Bridgespan Group. She spent nearly 25 years leading quality improvement and legislative compliance efforts at Fortune 500 insurance companies. She's known for her expertise in health systems change, including drafting federal and state legislation and facilitating the passage of payment quality levers and working across sector leaders to close gaps in maternal and mental health. Now we'll turn it over to Joy.

Joy Burkhard [00:02:40] Great, well, hello everyone. It's so great to be back together again, for those of you joining us live, which there's about 150 of us on together or watching retrospectively. It's great to be here in community with all of you. We wanted to remind you of what this learning community is covering and what we're not covering in our six sessions together. The two things that we are not covering, although today might feel a bit different, I think. Is that we wanted to remind folks that in this session, we are in our sessions together, we're not going in depth on substance use disorder, though we do acknowledge that it's critically important to address substance use disorder in this period

and that it is ideal to actually implement and screen for both perinatal substance use and perinatal mental health at the same time. It's just that we only have six sessions together and wanted to have enough time to adequately cover maternal mental health disorders and treatment, etc. We also want to remind folks that this is not technically a clinical training. There are deep dive training opportunities available for clinicians. I'm asking my team member to drop a link into chat for at least one of those trainings that are available for clinicians to become certified in perinatal mental health if they wish. There are various trainings that exist. We do luckily have two experts on the clinical side today. So today may be a bit of an exception and at least one of them is a deep expert in substance use disorder. So we'll have a chance to ask some questions and talk about either of these two topics technically in this session as well.

Joy Burkhard [00:04:31] So where have we been together? This is our third session. And you can see our first two sessions, our session one, we provided an overview of what the maternal mental health crisis in America is and why pregnancy and obstetrics is the opportunity to intervene. In our last session together, we talked more about implementing the AIM Perinatal Mental Health Condition Bundle and specifically did a deep dive into screening and diagnosis, including billing codes, using the readiness assessment to make sure that your OB clinics are ready to implement the bundle. There are about 10 steps that we went through. So if you haven't had a chance to review those two sessions yet, we welcome you, invite you to go back so that you don't miss out as this session builds on those two. And today, session three, we're together here to talk in more detail about interventions and treatments. Including supporting the mother-baby dyad.

Joy Burkhard [00:05:41] So I mentioned that we have two guest speakers joining us today. I'm gonna introduce them just briefly that Dr. Sarah Wakefield serves as the Medical Director of Texas PeriPAN and we talked in our last session about telepsychiatry consultation programs or access programs as they're referred to often. She serves as the Chair of Psychiatry at Texas Tech University Health Science Center and she'll have a chance to tell you a little bit more about her work when we turn it over to her in just a moment. And also joining Dr. Wakefield is Dr. Connie Guille, who is also a psychiatrist and serves as the Director and Professor of Women's Reproductive Behavioral Health Division at the Medical University of South Carolina. And both of these colleagues have become very well respected in our field and I'm honored to call them friends and professional colleagues and very much excited to welcome them to our AIM stage today. Before I turn it over to them, I have just a couple of additional slides that I wanted to share with you all as a refresher. Well, and actually not as a refresher today, first to talk a little bit about our learning objectives while we have both of our guest speakers, we're gonna be talking about key components of the AIM, perinatal mental health conditions bundle. We'll hear from Meg in just a moment about the bundle again, and we'll also describe a range of maternal mental health treatments and interventions including talk therapy, drug treatments and new emerging treatments like TMS. We'll also explain the resources available to all of you and your obstetric provider partners, including the telepsychiatry consultation access programs - again, we'll refresh you on those - as well as the range of treatment options and some resources like our menu of treatment options on the Policy Center website. And with that, we are gonna kick us off with a story. And I wanna introduce the story and also invite my team member to drop the full link to Cassie's story in the chat. You can watch this later. Don't click on it now or it'll open up and you'll hear it as this story is playing. But we will start in the middle of Cassie's story. And this is actually a story about what worked well in one person's situation here, Cassie, in her obstetric care clinic. So with that, we're gonna go ahead and hit play.

Video [00:08:13] I was in constant pain from an unplanned c-section and a cluster feeding infant. I hadn't slept more than three hours in a stretch. My anxiety and my obsessive compulsive disorder, dormant since my teen years, had ratcheted up to levels that I did not know were possible. The next few days were some of the darkest of my life. I convinced myself that in that moment I had shaken my baby and brain damaged him. I cried constantly. I begged my mother not to leave, begged my husband not to return to work. I looked at my baby and I did not feel love, only terror. The day before my husband was set to go back to work, I finally called my OB-GYN practice. The practice was made up of eight women, four doctors and four midwives. All but one had children of their own. During my pregnancy, I had attended one of their functions where each doctor and midwife stood up and spoke about her own birth experience - a couple had described postpartum depression. When I called, an available doctor was the only one in the practice that I hadn't had much contact with, and I was really nervous to tell her what was going on. I'm really scared and upset, I told her. I'm scared I'm gonna hurt my baby. I don't want to, but I'm scared something is gonna happen. Are you afraid to be alone with your baby? She asked. Yes. I waited for her response. She sighed. Oh, honey, it's so hard. She said, every one of us wishes we could just set that baby on the porch so we could get a good night's sleep. I chuckled and felt a little bit more at ease. At least she didn't think I was crazy. I see in your chart that you were previously diagnosed with Obsessive Compulsive Disorder. Were you ever put on medication for that? I explained that I had been, but it had made me feel sort of numb, which I didn't like. My dear, numb is gonna be better than what you're feeling now. Numb might be our best case scenario for the time being. She prescribed me that same medication I'd been prescribed as a teen. Within two weeks, I felt an incredible difference. Far from feeling numb, I just felt normal.

Joy Burkhard [00:10:35] All right, so now I want to invite you to pause and reflect. We heard a lot in Cassie's story. We invite you to do this silently or if there was something that you noticed that you wanna share in chat that you thought went well or maybe that you thought you would've done differently or want your OB provider to do differently, we welcome all of that feedback. But why don't you all take a moment? What do you think worked well in Cassie's story? And we invite you to drop it in the chat or just jot it down personally. Thank you Tracy, normalizing. That she felt comfortable enough to contact her provider. Christine, I put some words in your mouth there, but yes, that she actually contacted her provider. Mm-hmm. Thanks, Vanessa and Lisa. She reviewed her medical history. That's a big one, isn't it? I'll add something too. I love this team-based care approach, right? That there are multiple providers in this clinic and that many of them or most of them were mothers themselves so probably have experienced some of the same things that the women that we support experience. Any other comments? Start with what was previously effective. So that medical history. All right, well, thank you all for joining in that reflection with me. But just a couple more slides. Actually, no, I'm sorry. I'm turning it over to you Meg to get to walk us through the bundle and the key components relative to today's session in the bundle. Over to you, Meg.

Meg Sheahan [00:12:56] Yeah, thank you. Thank you, Joy, and thank you for that video from Cassie. So most of you are familiar with the perinatal mental health conditions AIM patient safety bundle, probably all of you at this point. A point that I like to emphasize about these bundles is that they are about strengthening systems. The perinatal mental health conditions patient safety bundle is about building and strengthening systems so that patients with mental health concerns and conditions are identified early. And that they are connected to appropriate care and supported throughout treatment and follow-up. So we're building and strengthening a whole system here, not just relying on an individual clinician, for example, to do all of this work. So today I'm just going to provide a brief

overview about how the AIM perinatal mental health conditions bundle supports that work and quality improvement as well for the mother-baby dyad. And then our other speakers, including our guest speakers, will go into the real nitty gritty about how this can look in practice. So a first step, I think a foundational step in all of this, is to build the response before anyone needs it. Of course, we're already kind of like on this path but the AIM bundle calls for workflows that integrate mental health care across the perinatal period from preconception all the way through postpartum including pharmacotherapy when indicated. And so what that means in part is having a response protocol that is actually feasible in your setting and reflects the reality of your system and of the mental health resources that are available locally. And in practice, that means defining exactly who, and by that I mean a role, not necessarily an individual person, but who responds to a positive screen. What assessment happens next after that positive screen? When treatment or consultation is indicated by what the patient is experiencing? And where the patient goes and how they get there if a higher level of care is needed. So the goal is to move through, we screen for mental health conditions to we have a reliable system for responding when we identify someone who may have one. A next step is making sure that the response is appropriate to the individual patient. AIM calls for an evidence-based patient-centered response that's tailored to that individual and to the severity of the condition and what they're experiencing and is responsive to what they need, what they think will work for them and what the value in how this process and treatment unfolds. So, this might mean that patient will, that, um the response looks different, sorry, from one patient to another, and it could include evolving combinations of talk therapy, pharmacotherapy, or other evidence-based interventions and other community and peer supports. From an implementation perspective, the important thing is having a reliable process for determining what response is appropriate while still allowing for individualized care and shared decision-making. We're not just trying to create a protocol that we follow dogmatically. We're trying to have a process and a pathway that allows for tailoring to what the patient needs. And importantly, that that patient's identified support people can be a part of that process. When the patient wants them involved. So the goal is not simply to identify a condition, it's to connect the patient with the treatment and the support that fits their situation using the resources that are realistically available locally and possibly integrating telehealth where available, where necessary and where the patient might benefit from that. You know, we know there are situations where the response really does need to be immediate. So and AIM specifically covers that and calls for activating an immediate suicide risk assessment and response protocol when indicated for patients who may be experiencing suicidal ideation, who are expressing concern that they may harm themselves or someone else, including their baby, or where there is a concern for psychosis. This immediate response situation is one where we want to minimize variation. You may be aware of the research and the evidence in the aviation field that said minimizing kind of variation, literally using checklists, enhances effectiveness and safety. And it's a similar thought process here. In this immediate response needed situation, staff need to know what triggers this emergency response, this urgent response rather, and who is responsible for what components of it, who's responsible for the assessment, who needs to be notified of the results of the assessment. What emergency and or psychiatric resources are available and how to access them quickly. Training and simulation can be really important and valuable in these urgent response situations. The goal is that when a high-risk situation occurs, the team is not figuring out in real time, who responds to this, how do we respond, who do we pull in, everything is known in advance. There's a defined pathway and everyone knows their role in it. The bundle also emphasizes care pathways that facilitate coordination and follow-up among multiple providers throughout the perinatal period because we work in systems where there are multiple providers involved. So when I am doing this work, when I'm seeing patients who have, say, a positive screen and

someone I have referred for mental health services of some kind, I think beyond the referral itself. It's not just a matter of like me clicking and in our EHR, you know, ambulatory referral to mental health services, because me making that referral doesn't necessarily mean that the patient actually connected with mental health care services or that treatment was initiated or that the treatment is working. So implementation strategies for closing the loop and connecting care can include warm handoffs. I sometimes directly reach out to my mental health teammates. Closed-loop referrals - I want to see in my EHR system that the patient has an appointment coming up or that they had one. Provider-to-provider communication to iron out any wrinkles or gaps, making sure that treatment is effective. And knowing who is clearly has clear responsibility for follow-up to make sure that the patient doesn't fall through any cracks or that their treatment doesn't have gaps in it. So when I see the patient next, and this is what the bundle indicates as well, I need to be asking whether the patient connected to care and how that process went and is going for them, whether it worked and felt comfortable and easy for them and reassessing what their symptoms and their treatment response are. So I don't assume that just because I've made the referral, I'm done. I follow up with all of that to ensure kind of an overlapping safety net for the patient. And because this is the perinatal period, coordination may extend across OB care, mental health, primary care providers and community-based services. So it takes following up throughout all of those different provider services and sources. So the question we want our systems to be able to answer is, did the patient actually connect with the care they needed and what happened next? What's going to happen next? The final systems piece in this is using data to understand whether the systems we've built are actually working. And the perinatal mental health conditions patient safety bundle data collection plan is intentionally focused on the inpatient birth admission because prenatal and postpartum data can be not necessarily universally accessible and we wanna have kind of an apples to apples data plan. The plan includes two state surveillance measures. One is the prevalence of perinatal mental health conditions among people during their birth admission. And the other is severe maternal morbidity among people with a perinatal mental health condition diagnosis. And both of these measures can and should, if you know, whenever possible, be examined by race and ethnicity and payer type. And the data in this bundle also, they extend beyond reporting prevalence and outcomes. We also use process and structure measures to help us understand whether and how the processes that we have in place are working and measures to help our teams understand whether the infrastructure that we've got in place is actually supporting the work that we are doing. So... what we learn from our QI, what the question is, is, you know, what is this data telling us about our system? Are we seeing changes in our system over time? Hopefully positive ones, but if we are seeing changes that are not necessarily indicative of improvement, okay, noted, we know where our opportunity lies. Is there variation across facilities? If so, you, know, what are they and why, and what can we learn, from the people, the facilities rather, who are strong performers. Are there gaps in implementation or differences amongst patient populations that warrant further examination? So what's happening? And then we interrogate that. Why is it happening? Why are we seeing what we've seen? And what are we going to do with that information? The goal is to use that data to identify a specific opportunity and test a change to make improvements, monitor the result of that change and continue the cycle of improvement. When we put these pieces together, the treatment and support becomes more than just an individual clinician's responsibility. The AIM bundle helps teams build systems that can identify perinatal mental health conditions and respond accordingly, according to the severity and the patient's needs and what they're experiencing. It helps us address urgent safety concerns in a very timely way and connect patients with appropriate, effective treatment and support, and then use the data that we've got to continuously improve the system. So ultimately the goal is a coordinated response that supports the health and

wellbeing of both members of the mother-baby dyad. So this is an overview. Please feel free to reach out to us with more questions if you've got them, but for now, I'm gonna pass it back to Joy and to our guest speakers to really get us into the nitty gritty of how this looks.

Joy Burkhard [00:24:44] Thank you so much, Meg. And I also just wanted to comment on, I appreciate you bringing up suicide assessments and we have a chance to talk with our experts today about a range of things during Q&A, including a maternal suicide assessment. We also had a webinar last week on maternal suicide prevention and released a new maternal suicide care pathway, really interesting, I think, insights, including sharing research about how women who are people, general population, who have had an inpatient stay, generally after being referred through the ER, don't actually have a reduction in suicide rates. So some really interesting learnings there that point to important assessment, suicide safety planning, and short interventions that can be taken by obstetric offices rather than referring to the ER automatically. It's really interesting insight. So I wanted to share that as well. And I'm asking Stacey on our team to share the webinar and slide deck from that session as well. All right, I am going to move on to the next slide and just wanted to remind you of some of these slides that we've shared previously about integrating behavioral health into obstetric settings. And this particular continuum that, as I mentioned, we've shared before, and that really the idea here is that every obstetric office can start somewhere. It can often feel daunting for all the reasons and so we like to point out two levels here: one is level one, which is, which is what we consider a light level screening for maternal depression and anxiety using the perinatal or the PHQ-4, two questions about depression, two questions about anxiety and hanging posters about the maternal mental health hotline and the 988 suicide lifeline as a resource. So something that all obstetric providers can do all the way up to what you may have heard about the collaborative care model - this is an official behavioral health integration model, not just having a great team-based approach, but actually collaborative care model where a reproductive psychiatrist in the case of perinatal mental health is aligned to a clinic, they may actually be on staff or they might even be serving in a telepsychiatry consult program or access program and be assigned to a clinic. And so that psychiatrist supports the obstetric provider in all things perinatal mental health. There's also an additional staff member that can wear multiple hats, but is referred to in this collaborative care model as a care coordinator that manages keeping record of referrals and other things. So collaborative care, that's the gold standard for integration. And we'll move on to the next slide. We also just wanted to remind you of the National Maternal Mental Health Hotline here because we are talking about treatment and resources. This is actually a HRSA program developed through federal legislation that our colleagues at the Maternal and Mental Health Leadership Alliance developed and that contract is held by the Postpartum Support International team right now. And the hotline is 833-TLC-MAMA and is available 24/7 via phone for anyone in the United States. It's designed particularly for mothers, but family members, for example, can call. And it's also, there's also a text feature and a chat feature on the website.

Joy Burkhard [00:28:45] And I also wanted to share what we refer to as levels of care, since we're talking about treatment and care pathways. First, we wanted to show sort of level one is the outpatient treatment, behavioral health treatment, so mental health therapy. We recommend that this therapy be provided by perinatal mental health certified providers, PMHC providers. That certification is offered by Postpartum Support International. These visits can be one visit a week all the way up to multiple visits on an outpatient level a week. Generally they're one hour, but they can be shorter visits. Level two is intensive outpatient. It's referred to as IOP. You can read about this. More hours a

day for three to five days a week, partial hospitalization, which is also an intensive level of outpatient therapy. Five to six hours a day, five days a week. Residential treatment, we don't have very many residential treatment programs for maternal mental health. The most of them that exist for the perinatal population exists for substance use disorder, but some of that is changing. And some of those programs are beginning to offer both substance use and maternal mental treatment. Those treatments are provided in home setting. That's why they're referred to as residential treatments. So it's an inpatient level of treatment. Babies and children can stay in these residential treatment programs, which is why we're really starting to show more of a spotlight on these opportunities for residential treatment and see that these programs are built out. And then level of five is inpatient psychiatric hospitalization, focused strictly on immediate crisis stabilization in psychosis - which we've all heard a lot about recently. And so you can see these arrows, I'm not gonna go over all of them, but the blue arrows essentially represent what obstetric providers generally have authority under their scope of practice to refer patients to the ER. And outpatient level one treatment is self-referred. So you can that's in pink, patients self-refer to mental health therapy. So happy to talk more about some of this in the Q&A if it's of interest, just one more slide from me here. Actually, I'm gonna share two more slides. Just as a reminder about the American College of Obstetricians and Gynecologists clinical practice guidelines for treatment and management. We went over the guidelines last week for screening and diagnosis. This is a refresher on treatment and management. There are similar guidelines that have been issued by ACNM, a midwifery organization, and then recommendations made by organizations like the American Psychiatric Association that very much align with these guidelines here. So you'll hear more about these treatment options from our presenters today, but also wanted to point out this box on the section on the bottom left of your screen that emphasizes shared decision-making. So we'll talk a little bit about this. We also heard about from Meg, severity of illness, of course, taking all of these other factors into account.

Joy Burkhard [00:32:17] And then I just wanted to anchor us before I turn it over to our guest presenters today. In this menu of treatment options, I'm asking our team members, Stacey, Kathryn, to drop this into chat and invite you to open it up on your screen now, a menu of Treatment Options. So you're gonna hear about all of these treatments or not all of them necessarily, but many of them today from our guest speakers. But wanted to make sure you had a chance to open this up on your screen. And we will move on to introduce our first speaker. So I already introduced Dr. Wakefield and Dr. Wakefield, we're so glad that you're with us today and Dr. Wakefield has great insights to share on many things, including screening and screening tools which I very much appreciate. So Dr. Wakefield over to you.

Sarah Mallard Wakefield [00:33:12] Great, thank you so much for having me. Really excited to talk with you guys today. And we have a few minutes to cover a lot of different ideas about treatment intervention. But I wanted to start off talking about what was referred to earlier as an access project. And many of you may know what an access project is. And by, you know, what the name says, the goal is to increase access to mental health care into appropriate evidence-based education about healthcare. And the relationship is really between the clinician who is seeing the patient and an expert team so that they can get guidance over time to say, hey, this is how the patient is presenting to me. I'm not certain on next steps, but I feel like something needs to be done. So can you help guide me in those next steps? Some important things that need to be in place for access projects to be the most successful are screenings that are already happening within the clinical settings. Um so that you can deliver that information and say, you know, I screened the patient, their PHQ is a 21. Here is what question nine looks like. And we can have that discussion.

That's really helpful when you're having a clinical discussion about recommendations for next steps in care. And so what happens is the clinician calls and does a brief patient presentation about the symptoms and what their concerns are. And then the clinician on the other side of that phone call is able to give evidence-based recommendations really in a variety of ways or across a variety potential treatment options. So it's atypical to say, do exactly this, start exactly this medicine, go up in exactly this way. But what is typical of these types of programs is to say hey, with the evidence base, it sounds like they are meeting the criteria and that you are concerned about a major depressive disorder, or... Some anxiety, or a postpartum psychosis, and this is what is evidence-based and recommended with those presenting symptoms. And so in that way, it's really each interaction is a teaching experience, and the goal of that teaching experience is to broaden the capacity and the understanding of that frontline clinician so that they feel more equipped to take care of the next patient who might present in that same way. And so it's really an educational process but it's also focused on that direct patient presentation and is there to support that clinician, that frontline clinician, at whatever stage of learning and capacity and confidence that they feel and just helping them expand that a little bit. So many states now have an access project like this and you can click this link to take you to a list about what states have those programs I have been saying 29 states, but I'd have to check the list to make sure that I was correct in that number, but that is you know, so it is widely available across the nation, but there are certain states that do not have those program in place and we are really excited that Postpartum Support International offers a similar type service. It's not a live service so there's not an immediate ability to have that conversation while the patient's in the office or right after the patient called with a specific particular question. But there is an ability to refer a specific clinical question and ask for additional guidance and get that guidance back to help you navigate those next steps in patient care. And then there's a goal to advocate for a national program like this so that we can support our primary care and obstetric providers in states where consult or access programs do not exist. And so the real goal in these access projects is to try to keep care in the obstetrician's office or in the primary care clinician's office so that we're not increasing the number of places that mom is having to go. If any of you have had a baby, you might be aware that it is a very stressful, overwhelming, lots of things to do and take care of. And so we find that if we ask mom to go to lots and lots of different appointments, often the one for herself, or especially the one from her mental health is potentially the one that she will not be able to attend just because of the time crunch and her allegiance to really taking care of baby, adhering to other medical appointments. So we want to make sure we make this as easy as possible and that we only escalate care to additional appointments when it's really important that that additional level of care be implemented for whatever that severity of symptoms are. Um, so let's talk about some of the things that we can do, uh, and an access project, we can recommend lots of different levels of care. Um, the, and so common treatment options, uh are psychotherapy and pharmacotherapy. When you think about, um, so psychotherapy has a wide evidence base, uh in addressing depression and anxiety, um intrusive thoughts, sometimes just helping someone understand how their brain is typically working with the plummet of estrogen right after delivery or with this new, wholly very difficult task of taking care of a human depending on the level of support that they have in their community. Sometimes just understanding that that is a difficult task is half the battle and that normalization. And so we heard that in the story earlier about some of that normalization, like. Many of us want to just put the baby on the front porch that we don't have to hear the baby cry, I think is what was said in the video earlier and kind of normalizing that this is a difficult distressing time or can be, especially when we have less support or maybe a more vocal baby or we are struggling with symptoms as well. So any of those factors can increase the distress in this time period and they're very common. And so how do we normalize that a bit and provide that education to

mom and partners and community around mom so that my mom doesn't feel so alien and different and that something's wrong with her. I always think of the very first goal as empowering mom to feel like she can do this and that what she's experiencing may not be super unique, but it is important and it needs to be addressed and she deserves to have that care. So what we don't have listed here is just some psychoeducation, which sometimes gets lumped into psychotherapy, but I think of it as everyone's task to really help mom understand what is going on right now, how her brain is changing post-delivery due to the pregnancy, all of those different things that help normalize some of these symptoms, but also present the opportunity for intervention. Patients do self-refer for psychotherapy, but sometimes they're not exactly sure what kind of psychotherapy to get or who to go see, or it's difficult to go out of their house. And so those kinds of situations, if they are presenting to their obstetrician or presenting to someone who, a family medicine doctor or other primary clinician, those are important parts of the conversation to have. When we think about the Albundle and those recommendations about considering severity and taking patient preference into account, what are the strengths? What are the supports? Does she have transportation? All of those different things. Can someone watch the baby are really important when we're trying to develop a treatment plan that can meet mom where she is and not be an additional burden to what she's going through at the moment. We want to be helpful. We don't want to additionally burden them to mom. So thinking through these things can be really important and bringing mom into that conversation. How are you ready to talk about some of these things? Often in a difficult birth, some trauma symptoms can either occur secondary to that birth or can reoccur and relapse from prior feelings of being out of control and other traumas. And mom may not feel like she's really ready to do that type of work at the moment, but how do we support her? So really important to bring mom into this conversation and to talk with her about it. If you are not sure what are next steps around psychotherapy and you have access to an access project like we had talked about before, that's a great thing to call and ask about. Here's what's going on with mom. Here are her strengths and supports and resources. She has insurance. She does not have insurance at the moment. All of those different factors can help us guide better about where to meet mom and how to meet mom where she is and provide her the best next steps in care. Obviously, there's also pharmacotherapy. And in the example we heard earlier, that was the next step. And I think that can be a great next step, especially if something has worked well for mom in the past, the symptoms are similar and we expect, and we really think it's very important to get mom as well as possible, as soon as possible. And I guess we always think that for all moms, but that there's not as much time or maybe access to really engaging in therapy and waiting for that response over time may be an additional indication to start a medication. I recommend that we're not ever really thinking only about starting a medicine, that if we start a medicine we're also thinking about additional supports in psychoeducation, group interventions, peer support, and psychotherapy. But medication may be the best first choice to help mom feel less symptomatic and more able to engage in these other interventions. And so there are multiple options for a medication. And that really is dependent on what mom's presenting symptoms are, what has worked in the past. We get a lot of questions about breastfeeding. There are very, very few things that mom can't breastfeed while she's taking. And we want to make sure we support mom and educate her on that. And that is primarily very important to help mom feel better. And then we can think about the rest of things after. The most important thing for a baby is that we have a well mama. So, like I said, there are multiple things that we can prescribe depending on those presenting symptoms. Zuranolone is one of the newer things on the market that has gotten some attention and can work very well for people, and there's an approval process, but we can definitely go through that. You do need some infrastructure to get all of those prior authorizations done, and so we can follow up on guidance for that, if that can be

helpful in the future. And so when to refer or escalate is a really important question. When we talk about our goal is to not over to mom with a million appointments and additional places to go and just this guilt for having to do all of these different things to take care of herself. We want her to feel empowered to take of herself and powerful, like she can do this work and we do trust her. There are some instances where we want to make sure that mom is getting the care that she needs more urgently and those are in these these higher risk higher crisis situations or things that may evolve or devolve into more of a crisis situation have a higher risk of doing that. And I think this is a little bit of a fine line that we walk because we never want to come off as checking mom or not validating or not trusting mom. We do want to help mom understand what her diagnosis is, what the risks associated with her diagnosis is and that is it appropriate and that she deserves to have a support network around her and to bring that support network into the discussion about risk benefits and what to do if things do increase to a higher acuity level. And so that could happen if we have a suspected bipolar diagnosis. Bipolar disorder carries with it the highest risk of postpartum psychosis, which then carries the highest risk of infanticide. And mom is, that's a very scary thing to talk about, but it can be very important to talk about so that you can safety plan and talk about what she would want to happen and how she would wanna be cared for if her symptoms progressed to that much more serious, scary, place. And so I think that's a very important thing to do early to bring mom into that discussion about if these things happened, what would happen first? What would this look like? What partner, you know, what support system does she want activated? Where would she want to get care? All of those different things so that she has some ownership and power in that discussion and in that plan as well. It may result in the need for a more toxic medication. Again, even most of the medications that we use for bipolar disorder, we support breastfeeding. There may be some nuances about how we breastfeed, all of those different things. The thing that I worry most about breastfeeding and bipolar disorder is maintaining a supporting sleep. So that's a different question than the medication, but it is still a really important conversation to have. Um, and then when we think about treatment-resistant depressive disorders, we may need to escalate to a higher level of care if first-line interventions have not been effective. Personality disorders or other kind of developmental work that needs to happen may need a specifically skilled clinician to do that work over time to support mom. And then postpartum psychosis, I already talked about a little bit when we were talking about bipolar disorder. That, and I think Dr. Guille will, I know, we'll talk a little bit more about in just a few minutes. But we don't, one of the most important things for me is to distinguish postpartum psychosis from obsessive compulsive disorder. And those obsessive intrusive thoughts that happen, they're actually maybe fairly common for all women after delivery or for many women after delivery, even if they don't meet the criteria for an obsessive-compulsive disorder, some of these thoughts can be very scary and we want to create an environment where moms can tell us it's okay to say and that it's not scary to us when you say these things we're here to help you and to help you understand how your brain is working and and what we can do to support you in this journey but the well postpartum psychosis is an emergency obsessive compulsive disorder is not and requires a lot more psychoeducation but early presentation can look similar. And so this would be a great time to have a reproductive psychiatrist or someone who feels very skilled in this area to assess mom, to give more clarified diagnosis and next steps in treatment. All right, very excited to pass this torch over to Dr. Guille and hear more about what she has to teach us.

Constance Guille [00:49:09] Thanks so much, Dr. Mallard-Wakefield. I'm so happy to be here, and that was such a great overview of treatment, and I think I'm just going to take a couple next steps with that, so I will go to the next slide. One of the things that we, as Dr. Wakefield talked about, Um, really mainstay of therapy is psychotherapy and medications.

That is sort of the, the initial approaches, you know, psychotherapy basically for everybody. But if you have more moderate, severe symptoms, that's when we're talking about medications, transcranial magnetic stimulation. If we think about where does this fit into, I'll say a little bit more about what this is and how it fits in, but, um, this is someone who is maybe has not done well on antidepressant medications, meaning they haven't had a good treatment response or they can't tolerate these medications. Transcranial magnetic stimulation is a completely different approach. So it's not a medication, it's actually a magnet. It's a coil that creates an electrical field and you put it over an area of the brain for depression and OCD, different areas where we found that if we can provide the stimulation, we can potentially reduce those symptoms associated with depression and OCD. Generally, if you were to do this treatment, you need to go physically to a place that has a TMS machine. You would get an evaluation to see if this was appropriate for you. You would also sort of sign up for treatment, which is really, it's pretty intense. It's once a week for at least six weeks. And those sessions are about 45 minutes. And so it's really important to think about sort of the practicality of this approach as well for individuals to see if that is something that they can do. So when they go in for the treatment, it's actually fairly comfortable. They're sitting in a chair, they're reclined. We've sort of determined where the area of the brain is gonna be stimulated. It feels like a little tap on the forehead. Some people, it irritates more than others. You can put some numbing gel if that is ever needed. The way that I often explain it to patients is that oftentimes, especially with depression, the frontal part of your brain, the frontal lobe, which is really responsible for that reasoning, that sort of... Executive functioning that is sort of going offline and what's beneath that is the amygdala and that is your emotions that is that the raw fear center of your brain. And so if you're taking the frontal lobe offline and depression and you are experiencing intense emotions including fear what TMS is doing is trying to stimulate a pathway between that frontal lobes and the sort of emotion center of brain to sort of dampen down some of those fearful thoughts or some of the sort of really raw emotions that could be coming forward in the context of a depression or an OCD. That's a very lay person way to explain it, but sometimes it can just help people understand what we're trying to do to strengthen the connection between parts of our brain so that we can handle some of the intense emotions that can come in play when you have depression or OCD. This is an FDA approved treatment for depression and OCD for adults. Right now, there is some work to take this treatment, as I mentioned, it's really delivered once a week for four to six weeks, and take all of that sort of dose of the intervention and condense it to a week. And that is much more practical for people, those are sort of intense days of treatment, but we've seen in that particular approach, which is called SAINT, that is FDA approved for depression at this point. There is an ongoing study right now in four centers across the country that are testing that sort of condensed TMS, that SAINT intervention for postpartum depression. We do not use TMS in pregnancy, although the risk of that is likely very low. It's just not a treatment that's normally done, but we are trying to see if that sort of accelerated treatment in the postpartum period could reduce depressive symptoms. So really excited to see that work continuing. Do you want to go to the next slide? Oh, that's me, sorry. So for postpartum psychosis, I'm going to transition to talking about that. And Dr. Wakefield did a really nice job already introducing this topic, which is truly a psychiatric emergency. So when somebody is in the state, you want them to get them to an emergency room, get them a full evaluation and really address the psychotic symptoms that are apparent. It is something that occurs in about one in a thousand deliveries. It is that often we talk about it occurring pretty immediately following delivery, but I have absolutely seen it months out after delivery. It's not something that is just in that short period of time. I think most cases I've treated have been actually five, six, seven months out in the postpartum period. As mentioned, we do think this is part of a postpartum, but this is a part of bipolar disorder and oftentimes. This is the first presentation that somebody

would ever have of this illness or any psychiatric illness. And so sometimes it catches people off guard a little bit because they haven't had prior mental health problems and they're having a really severe and significant one. What this can look like is I think oftentimes in retrospect, people will recognize that their mood was really irritable. Their mood may have been pretty labile. They are not able to sleep despite actually being pretty sleep deprived. There's sort of an agitation restlessness that can be sort of brewing. And then what can happen is, is going into that altered state of psychosis. And what that really looks like is it could be a belief, what we call a delusion. It could be hallucination. It could be paranoia. And it is just it is something that's occurring in this person's life that is really not consistent with their background their education their belief systems before and so they sort of have a different view of the world which is very different than how they normally view the world and that can really be out of touch with reality and delusions oftentimes we talk about paranoid delusions of feeling like someone might be after you it could be a delusion. Um, that, uh, often religious connotations, um, it can center on the baby. Um, it consider on the people around them and on themselves. Um, what's a little bit tricky about identifying this is that there is this waxing and waning of what we call waxing in waning, um of symptoms in this time period. And what that means is that, um you can see somebody, uh in sort of this, uh, a little of confusion, a bit of disorientation. The state where they're really not thinking the way that they normally think with some of those delusions. And then later in the day, they sort of reconstitute and they're sort of back to themselves. And that fluctuation makes it really difficult sometimes for people to say, hey, wait, there is a problem here. Let's get this person to care. And so it can often be missed because we're not always seeing the person in the state. When it gets very severe, that state is pretty consistent. So, just some things to mention. When having sort of on your differential, is this postpartum psychosis or not, it's really important to talk to family members, people that are around this person, so you can get sort of that full history of how they've been doing over time, not just in this moment of time. That can be really helpful. Also knowing that there was a family history of bipolar disorder, that sort of increases your suspicion for this a little bit more. That can be sort of helpful in putting the pieces together to make an accurate diagnosis. It's something, as I mentioned before, you really want a good psychiatric evaluation. The treatment for this is lithium. Lithium is the first line treatment. We will add some other things on to get people to sleep, but that is one of the most important treatments to get started. And I think that's all I had for, yes, there you go, turn over to Joy.

Joy Burkhard [00:57:22] Thank you so much, Dr. Wakefield and Dr. Guille we're excited to have some great Q&A with you in just a moment as well. I wanted to wrap up by sharing a final slide about dyadic care. You will hear it both ways. And this is when the type of treatment that we are serving both parents, generally it's a mother and a child together as the dyad, a pair. And this can be this type it can be preventive and educational, and you'll hear some examples of this type of therapy in just a moment, or a form of treatment that targets family wellbeing as a mechanism to support healthy child development. Generally, we hear about this framework in the context of child development, but we know it can be powerful to teach parents and mothers in particular skills as well and build their confidence. And help support the mother-baby attachment relationship. Examples of dyadic care, breastfeeding support is dyadic, right? We all know that. When it works well, it's a great way to form an attachment, secure attachment, and mother feel confident about her abilities to breastfeed and feed her baby. It works the other way as well. When it doesn't work well, it actually can be. Be harmful, and we need to wrap mother with lots of support for breastfeeding and choosing alternatives, of course, to feeding her baby and letting her know that that's okay. Support groups, so support groups that are for maternal mental health or even educationals, parenting groups are excellent and should be things

that we consider as interventions. And parenting education. Which can happen in those support group settings, but also happen one-on-one with therapists and others, including things like interactive play, how to play and reach your baby and seeing infant massage. And then the last sentence is cut off for me. I don't know if someone else can read it for me, oh, there we go, providing parents with tools, oh, such as tools for soothing infants crying. That is another form of dyadic care. At the end of our slides today is a full range of the types of therapy that are considered evidence-based dyadic therapy. We're not gonna go into those today, but did want to include those for you as a reference. And then just a reminder again, that the menu of treatment options is really your home base as supporting obstetric providers. We suggest that you add it to a tablet, laminate it and provide it to patients and allow them to help work with the prescribing provider or other staff like CHWs that may work in the clinic to develop a treatment plan together. And with that, we're excited to invite you to- and reflect and we'll turn it over for Q&A as well. And you can add what is new or surprising to you in chat and then I'm turning it back over to you, Vira.

Vira David-Rivera [01:00:33] Yeah. So thank you so much to all of our speakers. A recording of the session will be available within the next week, as well as we'll send out the slides and we'll have additional links directly to everything shared today. Please take a moment to complete our survey and feel free to be specific about what you'd like to see in future sessions. Now I'd like to invite you to join us for a half an hour of Q&A and office hour session.