WELCOME!

HIGHLIGHTING INNOVATIVE PROGRAMS TO PREVENT PERINATAL MENTAL HEALTH DISORDERS

ADRIENNE GRIFFEN

EXECUTIVE DIRECTOR

MATERNAL MENTAL HEALTH LEADERSHIP ALLIANCE

HIGHLIGHTING INNOVATIVE PROGRAMS TO PREVENT PERINATAL MOOD DISORDERS

GOALS FOR TODAY'S EVENT

Highlight three innovative programs that prevent and mitigate symptoms of perinatal mental health disorders

Educate individuals and organizations at the national, state, and local levels about how to learn more and/or implement

FIRST HOUR
(12 – 1 PM ET)

PLENARY SESSION

Speakers, Program Overviews
Presentation

SECOND HOUR
(1 – 2 PM ET)

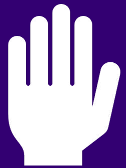
CONCURRENT SESSIONS

"Deep Dive" Into Programs
Q&A Sessions

SESSION GUIDELINES

Only featured speakers and presenters can speak or be seen.

All participants are on mute and have cameras turned off.



Questions will be handled in the breakout rooms.

For technical support, private message "Tech Support" in the chat feature.

Recordings and slides will be posted to MMHLA's website.
Look for a follow up email from MMHLA when they are available.

REPRESENTATIVE NANETTE DÍAZ BARRAGÁN (D-CA-44)

UNITED STATES CONGRESS

RACHEL PRYOR

OFFICE OF THE SECRETARY

COUNSELOR FOR HEALTH POLICY

U.S.Department of
Heath and Human
Services

CAROLE JOHNSON

ADMINISTRATOR

U.S.Department of
Heath and Human
Services

REPRESENTATIVE JAMIE ZAHLAWAY BELSITO

D-4TH ESSEX DISTRICT

MASSACHUSETTS HOUSE OF REPRESENTATIVES

PERINATAL MENTAL HEALTH DISORDERS

It's not just postpartum. It's not just depression.

Pregnancy through one full year following pregnancy

Approximately 25 interactions with healthcare providers

Depression
Bipolar illness
Anxiety disorders
Obsessive-compulsive disorder
Post-traumatic stress disorder
Substance use disorders
Psychosis, especially postpartum

Postpartum Support International, 2021
Uguz et al., 2019

PERINATAL MENTAL HEALTH DISORDERS

PMH disorders are the #1 complication of pregnancy and childbirth

These illnesses affect up to
1 in 5 pregnant or postpartum people
(and up to 1 in 3 in high-risk populations)

Untreated PMH conditions can have long-term negative impact on mother, baby, family, society

The cost of NOT treating PMH conditions is $14 billion ($32,000 per mother/infant dyad)

75%

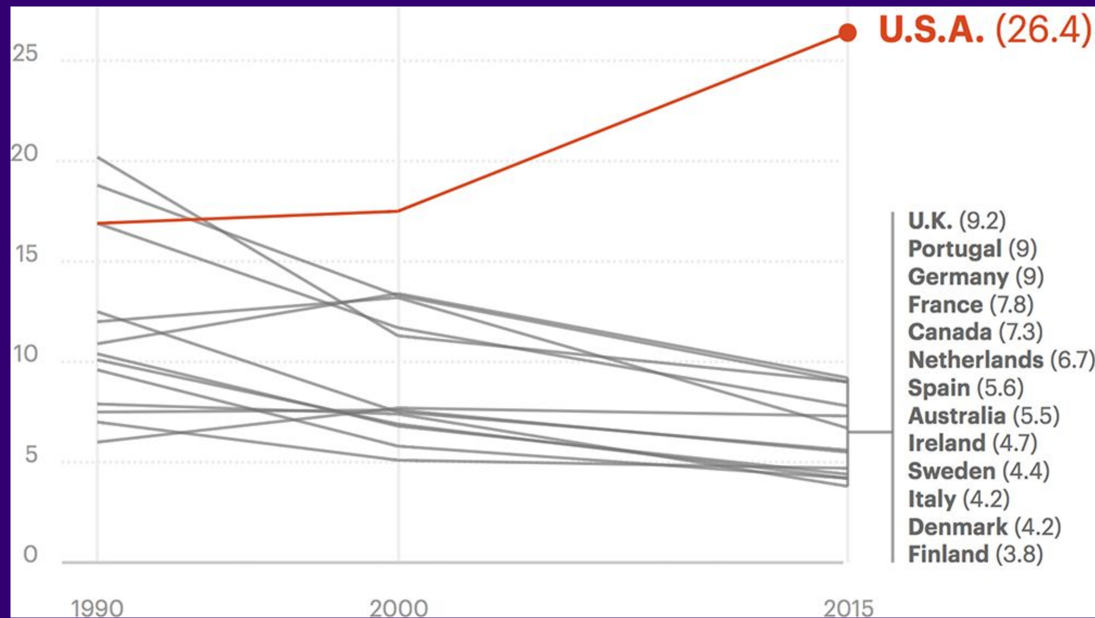
of those who experience PMH symptoms go untreated

Byatt et al, 2015
Ko et al., 2017
Luca et al., 2020
Zivin et al, 2020
Centers for Disease Control, 2020
National Institute of Mental Health, 2013

U.S. MATERNAL MORTALITY RATES

700 women die each year during pregnancy or first year following pregnancy

U.S. ranks last among industrialized nations in maternal mortality

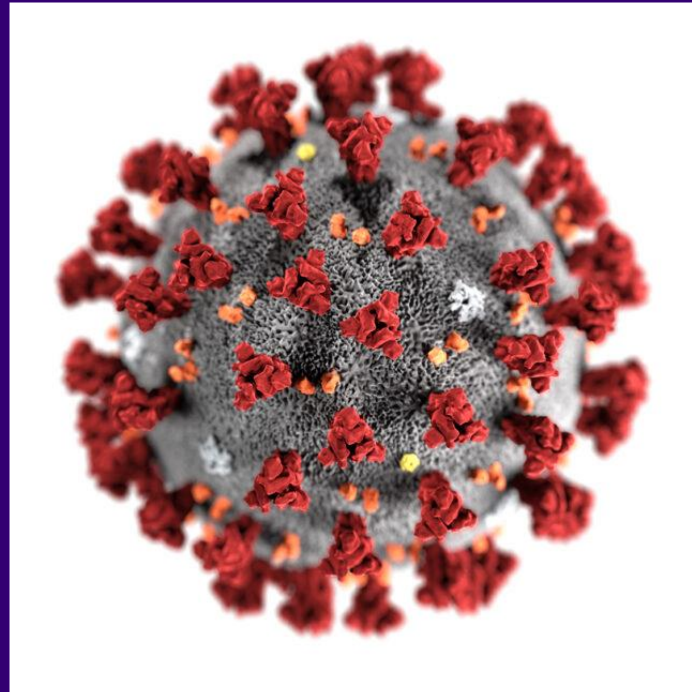


SUICIDE

- Suicide and overdose combined are the leading cause of death in first year postpartum
- Use more lethal means (hanging, gunshot, jumping)
- < 50% do not attend postpartum OB visit
- > 50% visit the ED within a month of suicide
- Peak incidence is 6-9 months postpartum

Trost et al, 2021; Davis et al, 2019
Campbell et al, 2021
Goldman-Mellor et al, 2019
California Dept of Public Health, 2019

ADDITIONAL ANXIETY



WHY SHOULD WE CARE?

Mental health conditions are the
MOST COMMON COMPLICATION
of becoming a new parent

Suicide and overdose are the
LEADING CAUSE OF DEATH
for new mothers

DAWN LEVINSON

DEPUTY DIRECTOR

DIVISION OF HEALTHY START AND PERINATAL SERVICES

MATERNAL AND CHILD HEALTH BUREAU

U.S.Department of
Heath and Human
Services

HRSA
Health Resources & Services Administration

How the Maternal and Child Health Bureau Addresses Maternal Behavioral Health

May 23, 2022

Dawn Levinson, MSW
Deputy Director
Division of Healthy Start and Perinatal Services
Maternal and Child Health Bureau (MCHB)

Vision: Healthy Communities, Healthy People

Maternal & Child Health Bureau Strategic Plan

Mission

To improve the health and well-being of America's mothers, children, and families.

Vision

Our vision is an America where all mothers, children, and families thrive and reach their full potential.

MCHB Goals

ACCESS

Assure access to high-quality and equitable health services to optimize health and well-being for all MCH populations.

EQUITY

Achieve health equity for MCH populations.

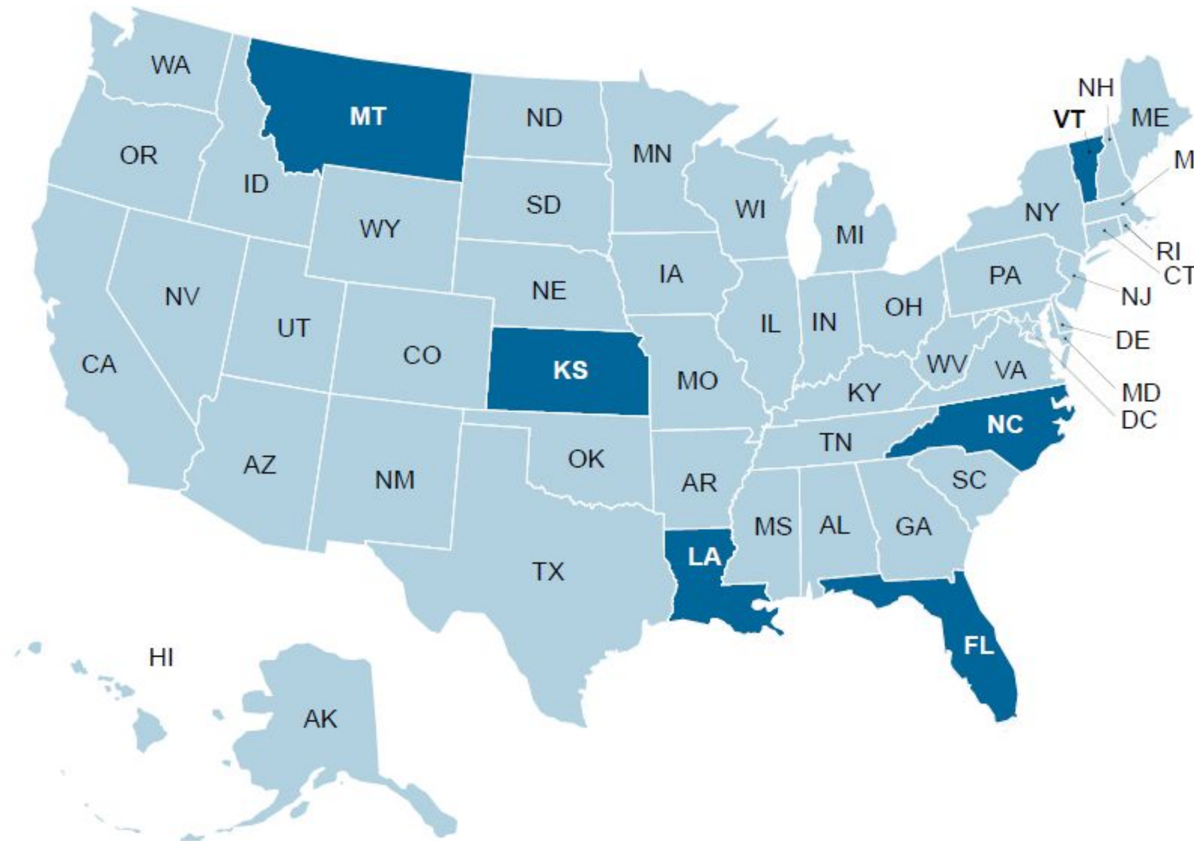
CAPACITY

Strengthen public health capacity and workforce for MCH.

IMPACT

Maximize impact through leadership, partnership, and stewardship.

Screening & Treatment for Maternal Depression and Related Behavioral Disorders



Program Provides: Through new or expanded telehealth access programs, state awardees offer **real-time psychiatric consultation**, **care coordination support**, and **training** to front-line maternity care providers in a state's specified regions, including in rural and underserved areas.

Alliance for Innovation on Maternal Health (AIM)

Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle

Readiness — Every Unit

Provide education to pregnant and postpartum people related to substance use disorder (SUD), naloxone use, harm reduction strategies, and care of infants with in-utero substance exposure.*

Develop trauma-informed protocols and anti-racist training to address health care team member biases and stigma related to SUDs.

Provide clinical and non-clinical staff education on optimal care for pregnant and postpartum people with SUD, including federal, state, and local notification guidelines for infants with in-utero substance exposure and comprehensive family care plan requirements.*

Engage appropriate partners to assist pregnant and postpartum people and families in the development of family care plans, starting in the prenatal setting.*

Establish a multidisciplinary care team to provide coordinated clinical pathways for people experiencing SUDs.*

Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to enhance services and supports for pregnant and postpartum families for social determinants of health needs, behavioral health supports, and SUD treatment.*

Recognition & Prevention — Every Patient

Screen all pregnant and postpartum people for SUDs using validated self-reported screening tools and methodologies during prenatal care and during the delivery admission.*

Screen each pregnant and postpartum person for medical and behavioral health needs and provide linkage to community services and resources.*

Screen for structural and social drivers of health that might impact clinical recommendations or treatment plans and provide linkage to resources.

Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

Engage in open, transparent, and empathetic communication with the pregnant and postpartum people and their identified support person(s) to understand diagnosis, options, and treatment plans.*

Integrate pregnant and postpartum persons as part of the multidisciplinary care team to establish trust and ensure informed, shared decision-making that incorporates the pregnant and postpartum person's values and goals.*

Respect the pregnant and postpartum person's right of refusal in accordance with their values and goals.*

Readiness — Every Unit
Recognition & Prevention — Every Patient
Response — Every Event
Reporting and Systems Learning — Every Unit
Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

National Maternal Mental Health Hotline

For Support, Understanding, and Resources,

CALL OR TEXT 1-833-9-HELP4MOMS

1-833-943-5746

Free - Confidential - Available 24/7

TTY users can use a preferred relay service or dial 711 and then 1-833-943-5746.

Contact Information

Dawn Levinson, MSW

Deputy Director

Division of Healthy Start and Perinatal Services (DHSPS)

Maternal and Child Health Bureau (MCHB)

Health Resources and Services Administration (HRSA)

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Phone: 301-945-0879

Web: **https://mchb.hrsa.gov/**

MCHB's Webpage on Behavioral Health:

https://mchb.hrsa.gov/programs-impact/focus-areas/mental-behavioral-health

Connect with HRSA

Learn more about our agency at:

www.HRSA.gov

Sign up for the HRSA eNews

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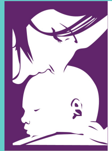
HRSA Maternal & Child Health

PREVENTION PROGRAMS



MOTHERS & BABIES

- Focus on low-income women
- Valid during pregnancy and postpartum
- English and Spanish
- Cognitive Behavioral Therapy
- Group (8 sessions) or individual (9 sessions) via home visiting programs

PREPP

PRACTICAL RESOURCES FOR EFFECTIVE POSTPARTUM PARENTING

- Focus on mother-baby dyad
- Incorporates reflect skills, mindfulness, stress tolerance
- English and Spanish
- One-on-one; 5 sessions
- Starts in third trimester, ends 6 weeks postpartum

ROSE

- Focus on low-income women during pregnancy
- Group or one-on-one
- 4 sessions during pregnancy, 1 booster session postpartum
- Integrated Interpersonal Therapy

MOTHERS & BABIES

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Feinberg School of Medicine
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Northwestern Medicine
Feinberg School of Medicine

The Mothers and Babies Program

Huynh-Nhu (Mimi) Le
Darius Tandon

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

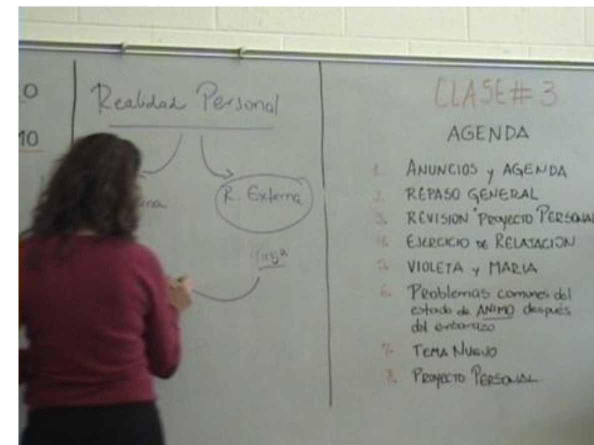
History and Development

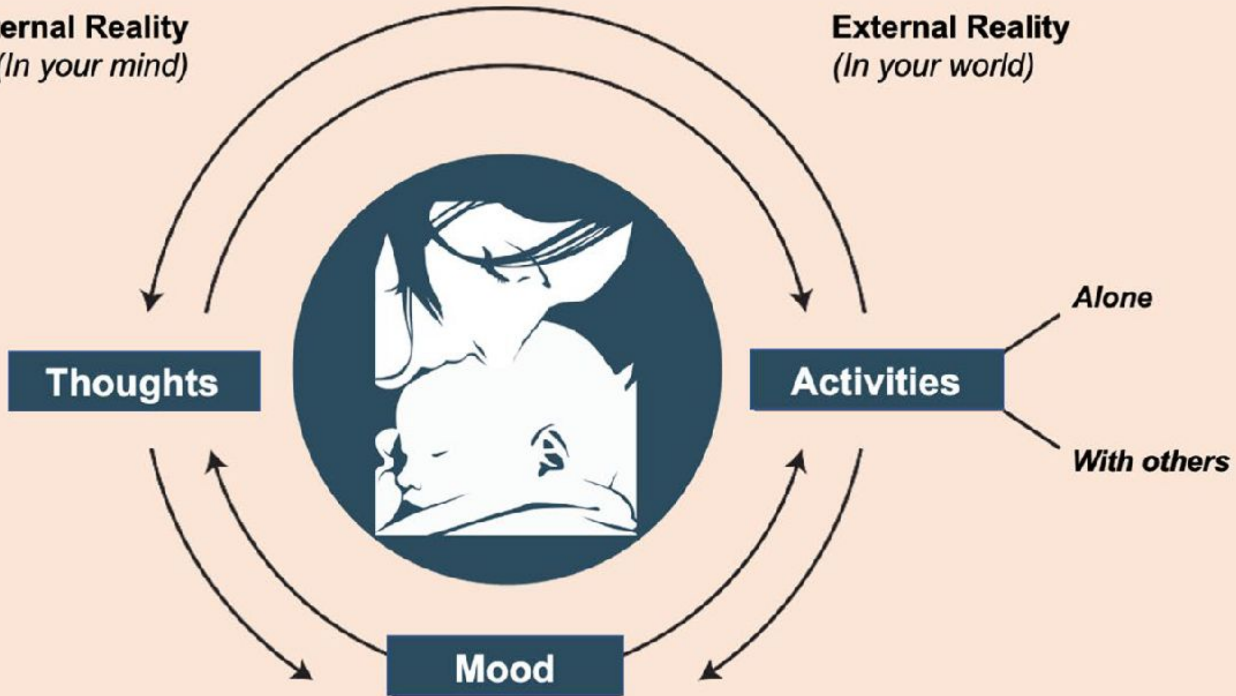
Ricardo F. Muñoz

- 1997: The Latino Mental Health Research Program at San Francisco General Hospital
- Prevention of depression for primary care patients
- Adapted for low-income perinatal Latinas in OB setting

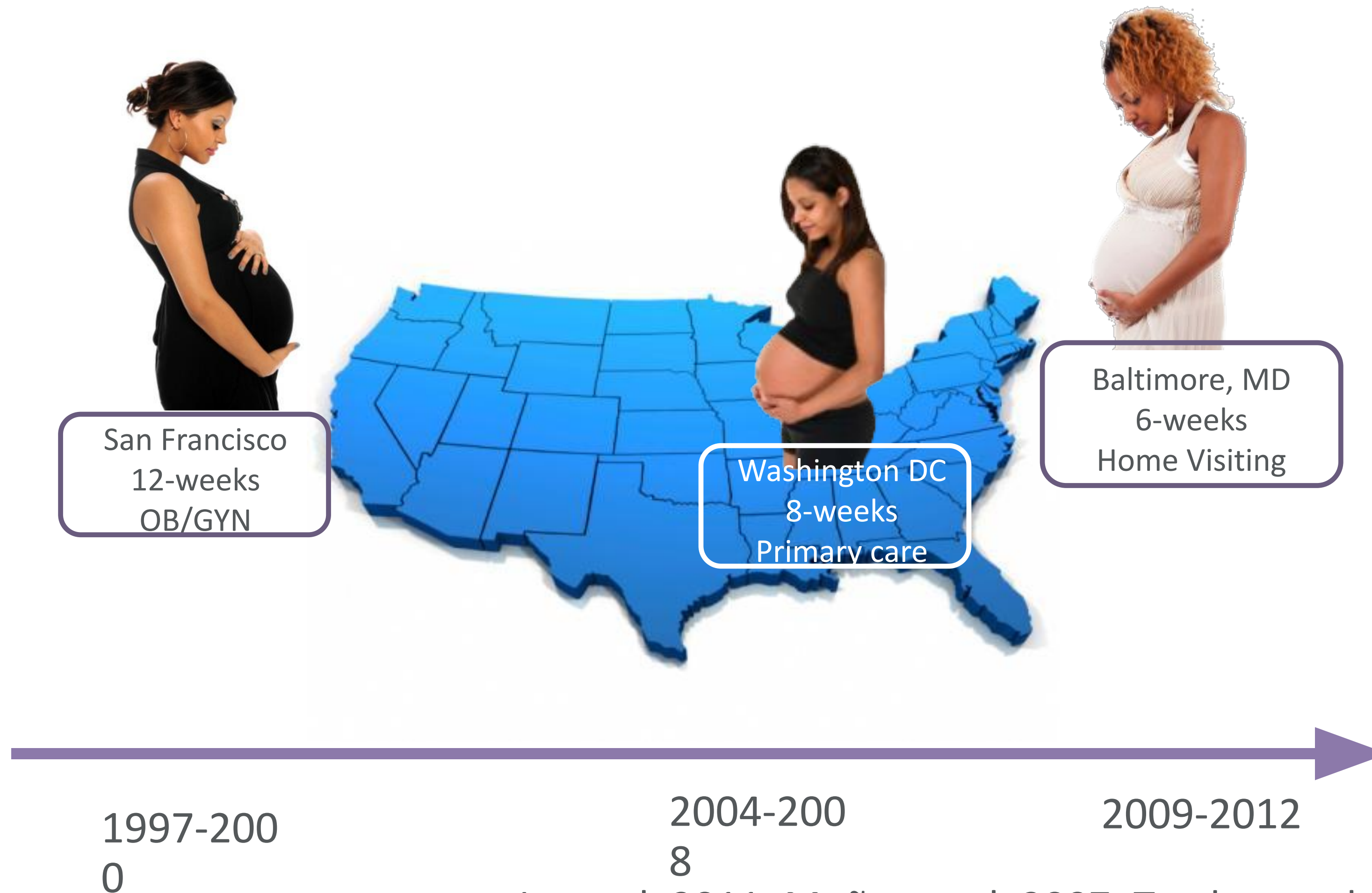
Mothers and Babies

- <u>Goal</u>: Reduce the onset of major depressive episodes by teaching perinatal people mood regulation skills and education regarding parenting and child development
- Individuals at risk for developing clinical depression




My Personal Reality
Internal Reality
(In your mind)
External Reality
(In your world)
Thoughts
Activities
Alone
With others
Mood
Promote parent-infant bonding using cognitive-behavioral strategies

Mamás y Bebés / Mothers and Babies



San Francisco
12-weeks
OB/GYN

Washington DC
8-weeks
Primary care

Baltimore, MD
6-weeks
Home Visiting

1997-200
0

2004-200
8

2009-2012

Le et al. 2011; Muñoz et al. 2007; Tandon et al. 2011,
2014

Northwestern Medicine®
Feinberg School of Medicine

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

MB Current Work and Future Directions

What is the **impact** of MB beyond trials highlighted in the USPSTF report?

- Robert Wood Johnson Foundation (Grant #73664) examining effectiveness of 1-on-1 modality
- NICHD R01 (R01HD097215) examining responsive parenting, parent-child attachment, young child self-regulation

What are ways to expand the **reach** of MB and **engagement** of providers and families with the intervention?

- *Adaptations* for tribal/indigenous families, low-literacy individuals, and sexual and gender minorities
- New *modalities* for delivering MB including "eMB" and virtual MB groups
- *Task shifting* delivery of MB from mental health clini
  health professionals (PCORI Contract #AD-1507-314

MB Current Work and Future Directions

What are ways in which MB is used in **connection with other health areas**?

- NHLBI UG3/UH3 (UG3HL163121)) using MB as part of intervention package to improve cardiovascular health of pregnant individuals and their offspring
- Integration of MB as part of Early Childhood Development and Prevention of Mother-to-Child Transmission for HIV+ rural populations in Africa (Catholic Relief Services)

What are additional **innovations and enhancements**?

- NIMHD R21 (R21MD0011320-01) to develop "Fathers and Babies" to be delivered concurrently with MB, or as a free-standing intervention

Contact Information and Additional Details & Resources

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PREPP
PRACTICAL RESOURCES FOR EFFECTIVE POSTPARTUM PARENTING

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PREPP Co-Developer
Columbia University

Elizabeth Werner, PhD
Assistant Professor of Behavioral Medicine,
Ob/Gyn & Psychiatry
PREPP Co-Developer and Lead Supervising Clinician
Columbia University

PREPP

PRACTICAL RESOURCES FOR EFFECTIVE POSTPARTUM PARENTING

A Mother-Infant Dyadic Treatment to Prevent Postpartum Depression

PREPP Treatment Protocol

Brief (5 sessions)

- 28-32 gestational weeks – 6 week postpartum

For those at risk of PPD

- Stress, depressive symptoms; experiencing poverty

PREPP Conceptual Model

Two unique features

- Begins in pregnancy
- Dyadic approach

An intervention based on the conceptualization of postpartum depression as a potential disorder of the dyad, and one that can be approached through preventative psychological and behavioral changes in the mother that affect her and the child — even before birth

Rationale for Dyadic Approach

- Identification with the parenting role, and a 'primary preoccupation' with the baby begins in pregnancy —leverage this relationship for PPD prevention efficacy (Monk et al., in submission)

- Mother and infant affect each other
  - Lack of sleep is a risk factor for PPD (Leistikow, N et al., 2022)
  - Greater infant fuss/cry/sleep behavior is associated with PPD (Cutrona et al., 1986, Murray et al., 1996, Miller et al., 1993)
  - Behavioral techniques are effective in improving infant fuss/cry and sleep behavior (Hiscock et al, 2008, 2014)

PREPP: Three Treatment Components

- Three components
  - Mindfulness, sleep hygiene and self-reflection
  - Psychoeducation and cognitive support managing expectations
  - Behavioral techniques

- Combine established mindfulness and psycho-education/CBT tools with a dyadic approach, specifically behavioral techniques *for parenting newborns before the baby is born*

Optimize infant's behavioral regulation

Behavioral skills *Component 3*

Aid newborn sleep
- Day/night cues
- Focal feed

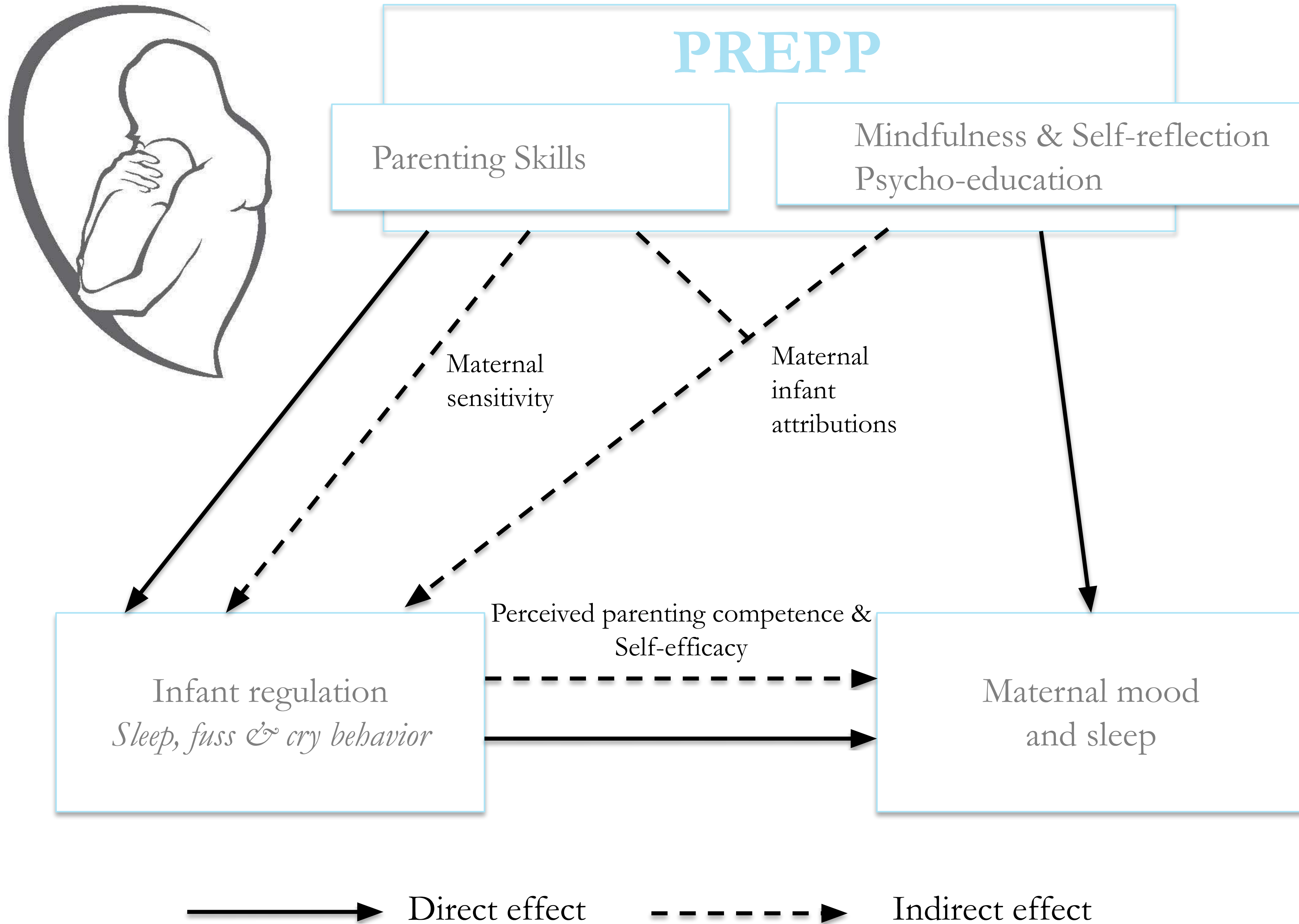
Comforting techniques
- Swaddling
- Carrying independent of crying

Build self– efficacy/ competence in parenting, foster positive infant attributions, and maternal sensitivity

Improve women's sleep, lessen distress

Sleep skills & mindfulness & self-reflection; Psychoeducation

Component 1 & 2



PREPP
Parenting Skills
Mindfulness & Self-reflection
Psycho-education
Maternal
sensitivity
Maternal
infant
attributions
Perceived parenting competence &
Self-efficacy
Infant regulation
Sleep, fuss & cry behavior
Maternal mood
and sleep
Direct effect
Indirect effect

PREPP: Improving Access to, & Uptake of, Prevention Services

- Shame in endorsing distress in the context of child bearing (Dennis & Chung-Lee, 2006)
  - **Focus on maternal role and infant—the dyad**

- Stigma associated with receiving mental health services (Dennis & Chung-Lee, 2006; Goodman, 2009)
  - **Coach; Name, PREPP: "Practical Resources for Effective Postpartum Parenting**
- Logistical challenges of attending added health care appointments at a different location (Byatt, Simas, Lundquist, Johnson, & Ziedonis, 2012; Goodman, 2009)
  - **Sessions adjunctive to OB prenatal visits and 6-week well-baby visit and via telehealth**
  - **Potential to incorporate into OB practices and prenatal care ecosystem**
  - **A variety of providers/disciplines can be trained**
- Disinclination to take medication while pregnant or breastfeeding (Battle, Salisbury, Schofield, & Ortiz-Hernandez, 2013; Goodman, 2009)
  - **Behavioral and cognitive foci**

- PPD risk factors/stressors:
  - Lives with her three teenage sisters and mother in a one bedroom apartment
  - Eviction threat
  - FOB absent
  - Unsure how to take care of a baby, no experience

- After PREPP
  - Felt more prepared for motherhood.
  - PREPP helped her manage the stress of caring for a crying baby in very cramped quarters
  - PREPP mindfulness techniques improved her sleep and management of her ruminations when she awakened in the night
  - "It helped me as a mom and as a person."

Patient Experiences — Lasia

- PPD risk factors/stressors
  - Lives in a two bedroom apartment with three younger brothers, step father, mother, and older brother with addiction problem
  - Just turned 20
- After PREPP
  - Empowered to help her family make a change in their living situation
  - PREPP helped her become the "type of mom [she] wants to be"
  - Has shared the PREPP pamphlet with her mother so that they "…could be on the same page" when caring for her newborn
  - "I really appreciated all the information on the [Period of Purple] crying – I would have freaked out if I didn't know that was coming at 2 weeks [postpartum]."

Next Session on PREPP

EFFICACY DATA

A MUCH CLOSER LOOK AT THE PREPP INTERVENTION

REACH OUT, STAY STRONG ESSENTIALS

for mothers of newborns

Jennifer Johnson, PhD

Charles Stewart Mott
Endowed Professor of Public Health
College of Human Medicine
Michigan State University

Caron Zlotnick, PhD

Professor (Research)
Department of Psychiatry and Human Behavior,
Medicine, and Ob/Gyn
Brown University

Honorary Professor
Department of Psychiatry and Mental Health
University of Cape Town, South Africa

Director of Research, Department of Medicine
Women and Infants Hospital, Rhode Island

ROSE:
An evidence-based intervention to prevent postpartum depression

Caron Zlotnick, Ph.D.

Caron_Zlotnick@brown.edu
Professor (Research) Brown, Dept. of Psychiatry and Human Behavior, Medicine, and Ob/Gyn
Honorary Professor, Dept. of Psychiatry and Mental Health, University of Cape Town, South Africa
Director of Research, Department of Medicine at Women and Infants Hospital

REACH OUT

STAY STRONG

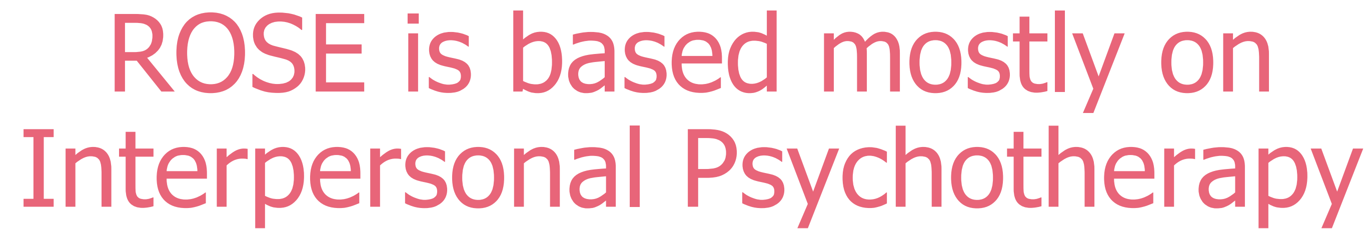
ESSENTIALS

ROSE

For Moms Of

Newborns

of



Interpersonal Psychotherapy is the frontline treatment for postpartum depression

ROSE

ROSE is based mostly on Interpersonal Psychotherapy

Interpersonal therapy targets risk factors for postpartum depression that are amenable to change (e.g., low levels of social support; isolation, interpersonal disputes)

ROSE

ROSE

Reach Out, Stay Strong, Essentials

for mothers of newborns

- ROSE is administered individually or in small groups during pregnancy.
- ROSE is presented as a course or support group to minimize stigma and emphasizes the program as an educational experience.
- ROSE consists of four +- 90-min group sessions (or ~60-min individual sessions) and a post-delivery individual booster/check-in session

ROSE

ROSE

Reach **O**ut, **S**tay **S**trong, **E**ssentials

for mothers of newborns

- Designed for prenatal clinics and other agencies offering prenatal services (e.g., Healthy Start Programs, Doula Services, WIC)
- Can be taught by non-mental health professionals (e.g., nurses, health educators, midwives) and paraprofessionals
- Intervention materials (educator manual, English and Spanish patient workbook, flashcards, slides for virtual delivery)

ROSE

ROSE Core Elements	ROSE Flexible Elements
Psychoeducation on: • Postpartum depression, postpartum blues • Managing Stress in transition to motherhood • Social support as a buffer against postpartum depression • Relevant postpartum resources Teaching: • Communication skills via role plays • Stress management skills • Building and enhancing social skills • Review/reinforce skills at postpartum session	• Group vs. individual • Office vs. home visit vs. Telehealth • Time during pregnancy • Order of sessions • Open enrollment of group • Missed sessions can be made up • Sessions can be split into shorter pieces or lumped together • Any outpatient prenatal setting (OBGYN, FQHC, visiting nurses, healthy start programs, etc) • Paraprofessional/non-mental health provider vs. mental health provider

ROSE Participant Workbook

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ROSE is an Evidence-Based Practice

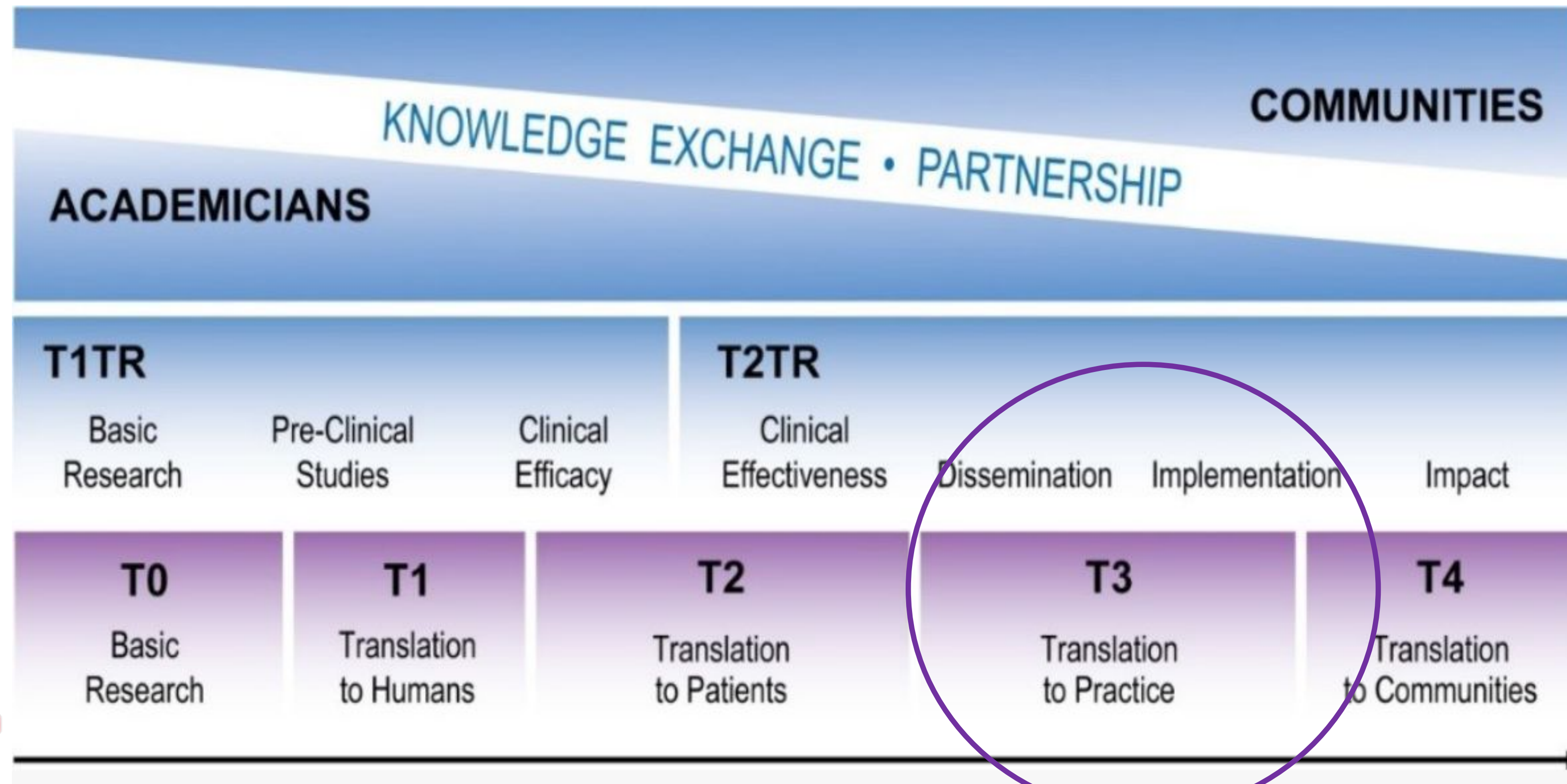
Four randomized clinical trials have shown that ROSE significantly reduces risk of postpartum depression in low-income women by half.

ROSE Studies:

- Significantly reduces cases of postpartum depression
- Used a validated diagnostic measure of postpartum depression
- Have replicated positive findings
- Tested in community settings with racially and ethnically diverse samples
- Tested in heterogeneous samples (e.g., teens and rural individuals)
- Samples were highly diverse

ROSE prevents half of postpartum depression cases among low-income ROSE participants

The Next Step for ROSE is Implementation and Scale-up



Implementation Trial of ROSE (R01 MH114883)

How much technical support is needed for clinics offering prenatal services to implement ROSE and sustain it over time?

The study has enrolled 98 prenatal agencies across the US

ROSES

The ROSE Sustainment Study

Johnson et al. (2018). Protocol for the ROSE Sustainment (ROSES) Study. *Implementation Science*, **13,** 115.

Thank You!

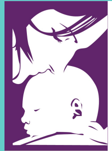
Women and Infants Hospital in Rhode Island has launched a website that provides materials and videos necessary to be trained in delivering the evidence-based ROSE Program to prevent postpartum depression

The link below takes you straight to the website
https://www.womenandinfants.org/rose-program-postpartum-depression

ROSE

THANK YOU!

BREAKOUT ROOOMS



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TRANSITION TO BREAKOUT ROOMS

To join a breakout room or move between breakout rooms:

- Select the 'Breakout Rooms' button on the bottom toolbar.
- Select the room you want to join.

To exit a breakout room and return to main room:

- Select 'Leave Room' in the bottom right corner of the screen.
- Select 'Leave Breakout Room.'

To exit the meeting:

- Select 'Leave Room' in the bottom right corner of the screen.
- Select 'Leave Meeting.'

??????

To ask a question:
Type it in the chat.

To ask for technical assistance:
Send a message to "Tech Support" in the chat.