Maternal Mental Health Leadership Alliance
www.mmhla.org
Working With Policymakers to Address Maternal Mental Health

September 13, 2021

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Office of Research on Women's Health
6707 Democracy Boulevard
Suite 400
Bethesda, MD 20817

Re: Request for Information: Inviting Comments to Inform the Women's Health Consensus Conference

Dr. Barr,

The Maternal Mental Health Leadership Alliance (MMHLA) is pleased to provide comments in response to the Request for Information (RFI): Inviting Comments to Inform the Women's Health Consensus Conference.

We are encouraged to see that Congress has directed the National Institutes of Health to evaluate research related to women's health; excited that the Office of Research on Women's Health is seeking input on women's health research; and honored to be able to provide input.

MMHLA is a relatively new organization, founded in 2018, with a specific focus on national policy around maternal mental health, i.e., the mental health of women and childbearing individuals during pregnancy and the first year postpartum. Our comments are thus confined to the specific topic of maternal mental health and its impact on maternal mortality and morbidity.

About Maternal Mental Health

Maternal mental health (MMH) conditions are the most common complications of pregnancy and childbirth, affecting 1 in 5 women or 800,000 families each year in the United States.[1,2,3] Once simply known as "postpartum depression," MMH conditions can occur anytime in the two-year perinatal timeframe from conception through first year postpartum and include unipolar and bipolar depression; anxiety disorders; obsessive-compulsive disorder; posttraumatic stress disorder; and substance use disorder.[4] Of those experiencing postpartum depression, 27 percent enter pregnancy with depressive symptoms, 33 develop symptoms during pregnancy, and 40 percent become symptomatic after childbirth.[5] The peak onset of MMH conditions is 3-6 months postpartum, with a recent study showing that symptoms can persist for up to three years.[3,6] The COVID-19 pandemic has fueled a threefold increase in women reporting symptoms of anxiety and depression during or following pregnancy.[7,8]

As many as 75% of those impacted by MMH conditions go untreated, increasing the risk of multigenerational long-term negative impact on the mother's and child's physical, emotional, and development health.[9] ***Tragically, suicide and overdose combined are the leading cause of death for new mothers,*** according to information from several Maternal Mortality Review Committees.[10,11,12] In addition to the human cost, the cost to society is significant, estimated at $14.2 billion in the United States in 2017 in addressing poor health outcomes of mother and baby and accounting for lost wages and productivity of the mother.[13]

Individuals at increased risk for experiencing MMH conditions include those who have a personal or family history of mental illness, lack social support, have experienced a traumatic birth or previous sexual trauma, or have a baby in the neonatal intensive care unit.[3,14] MMH conditions disproportionately affect parents facing racial or economic inequities, and these parents are less likely to be screened or to receive care.[15] Barriers to care include lack of access to health care, particularly to culturally appropriate mental health care; systemic racism; logistical barriers, such as access to child care or transportation; and reluctance to disclose mental health conditions for fear that Child Protective Services or immigration agencies will become involved.[16,17] Military mothers are a particular subgroup at risk for MMH conditions as they often are far from their families of origin, lack social support, and face unique stresses due to deployments and concerns about impact on career.[18]

Access to mental health care is critical to the overall health of mothers, babies, families, and society. While it has always been difficult for childbearing women experiencing anxiety or depression to access appropriate mental health care, the current situation – with an increase in the range and intensity of mental health issues coupled with the increased pressure on the healthcare system -- has made it even more challenging to access appropriate mental health services.

Fortunately, MMH conditions are often temporary and treatable, with a well-established path to recovery that includes low-cost interventions such as improved self-care and social support, along with more costly options such as psychotherapy and medication.[1920] However, all too often both maternal health providers as well as mental health professionals are not trained in screening, diagnosing, or treating MMH conditions; as a result, women remain undiagnosed and untreated, or worse yet, receive poor or improper treatment.

Recommendations Addressing Research Gaps in Maternal Mental Health

MMHLA proposes several areas to address gaps in research about MMH conditions, including data-gathering, screening, models of care, and focusing on the needs of special populations.

1. **Data gathering.** Additional data is needed to more fully understand the risk factors, causes of, and treatment for MMH conditions. Specific recommendations are to:
    a. Create a comprehensive summary of data available related to maternal mortality and morbidity -- with a specific focus on MMH conditions, including opioid and substance use and suicide -- at federal, state, regional, health system and patient levels to determine gaps in data and knowledge.

b. Identify and understand possible risk factors contributing to MMH conditions in order to develop more targeted screening and prevention. These could include pre-existing mental health conditions; physical health and psychosocial co-morbidities; medication use and stopping of medications during pregnancy (particularly related to mental health); history of pregnancy complications; prior and current birth outcomes (including premature or pre-term, NICU, etc.); adverse childhood experiences, particularly sexual abuse; social support and isolation; and social determinants such as income, education, housing; and demographic factors.
c. Research the role of culture and beliefs in MMH and care.
d. Identify disparities in MMH care specifically related to race and ethnicity, age, gender identification, geographic area or location (rural/urban, regional, state).
e. Research the role of stigma in seeking care and participating in treatment for MMH, particularly suicidal ideations. Identify public health interventions to address stigma.
f. Understand the links between MMH, trauma and violence, and suicide; and the links between MMH and other maternal physical health morbidity and mortality.
g. Research the prevalence and causes of suicide in the perinatal period.

2. **Screening and referral.** The screening tool used most often to assess for MMH conditions is the Edinburgh Postnatal Depression Scale, which has not been updated since it was created in 1987; many women report that it is out-of-date and does not capture the culture of non-White women. Specific recommendations are to:
    a. Update, validate, and/or create a screening tool for MMH conditions that is culturally and linguistically relevant.
    b. Include information on the screening tool about next steps, including treatment, follow-up, and connection to resources (such as Postpartum Support International or the new national maternal mental health hotline launching in 2022).
    c. Validate screening measures across different ethnic and cultural groups.

3. **Models of care.**
    a. Research the efficacy of health care models that identify and treat MMH conditions, such as integrated and/or collaborative care models of primary care and mental health; integration of maternal and child health systems to address MMH; resource and referral programs; and perinatal psychiatry access programs.
    b. Identify best practices for screening for MMH conditions and risk assessment, case-finding, diagnostic tools, and treatment engagement.
    c. Identify innovative non-pharmacological approaches that may have the potential to improve the effectiveness of identifying and treating MMH conditions, including technology, telehealth, peer support, family and social support, complementary and alternative/integrative therapies, and interventions that address social determinants.
    d. Examine population-based approaches to reduce MMH conditions in the community through educational campaigns and other media and technology communications.

4. **Focus on special population needs**, including the LGBTQ, military, veterans, homeless, and other communities that are traditionally underserved such as women who are immigrants or who live in poverty.

Thank you again for the opportunity to share input on women's health and in particular on the important topic of maternal mental health. Should you have any questions or need any additional information, please contact me at agriffen@mmhla.org.

Sincerely,

Adrienne Griffen, MPP
Executive Director
Maternal Mental Health Leadership Alliance

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[1] American College of Obstetricians and Gynecologists. ACOG Committee Opinion 7575: Screening for Perinatal Depression. Obstet Gynecol. 2018:132(5):E208-12.
[2] Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM. The prevalence of anxiety disorders during pregnancy and the postpartum period: a multivariate Bayesian meta-analysis. J Clin Psychiatry. 2019:80(4):18r12527.
[3] Gavin NI, Gayness BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol. 2005;106(5 Pt 1):1071-83.
[4] Kendig S, Keats JP, Hoffman MC, Kay LB, Miller ES, Moore Simas TA. Consensus bundle on maternal mental health: perinatal depression and anxiety. Obstet Gynecol. 2017:129(3):422-30. Erratum in: Obstet Gynecol. 2019:133(6):1288.
[5] Wisner KL, Sit DK, McShea MC, Rizzo DM, Zoretich RA, Hughes CL. Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. JAMA Psychiatry. 2013;70(5):490-8.
[6] Putnick DL, Sundaram R. Bell EM, Ghassabian A., Goldstein RB, Robins SL. Trajectories of maternal postpartum depressive symptoms. Pediatrics. 2020:46(5); e20200857.
[7] Davenport MH, Meyer S., Meah VL, Strynadka MC, Khurana R. Moms are not OK: COVID-19 and maternal mental health. Frontiers in Global Women's Health [serial on the Intern]. 2020 Jun 19.
[8] Lebel C, MacKinnon A, Bagshawe M, Tomfohr-Madsen L, Giesbrecht G. Elevated depression and anxiety symptoms among pregnant individuals during the COVID-19 pandemic. J Affect Disorder. 2020;1(277):5-13.
[9] Byatt N., Levin LL, Ziedonis D, Moore Simas TA, Allison J. Enhancing participation in depression care in outpatient perinatal care settings: a systematic review. Obstet Gynecol. 2015;126(5):1048-58.
[10] Davis NL, Smoots, AN, Goodman DA. Pregnancy-related deaths: data from 4 U.S. Maternal Mortality Review Committees, 2008-2017 [Internet] Atlanta (GA): Centers for Disease Control and Prevention; 2019.
[11] Goldman-Mellor D, Margerison CE. Maternal drug-related death and suicide are leading causes of postpartum death in California. Am J Obstet Gynecol. 2019;221:489.e1-9.
[12] Metz TD, Rovner P, Hoffman MC, Allshouse AA, Beckwith KM, Binswanger IA. Maternal deaths from suicide and overdose in Colorado, 2004-2012. Obstet Gynecol. 2016:128(6):1233-1240.
[13] Luca DL, Margiotta C, Staatz C., Garlow E, Christensen A, Zivin K. Financial toll of untreated perinatal mood and anxiety disorders among 2017 births in the United States. Am J Public Health. 2020;110(6):888-96.
[14] Compton MT, Shim RS. The social determinants of mental health. Focus. 2015;13(4):419-25.
[15] Sidebottom A., Vacquier M, LaRusso E, Erickson D, Hardeman R. Perinatal depression screening practices in a large health system: Identifying current state and assessing opportunities to provide more equitable care. Arch Womens Ment Health. 2021;24(1):133-44.
[16] Byatt N, Biebel K, Friedman L, Debordes-Jackson G, Ziedonis D, Pbert L. Patients' views on depression care in obstetric settings: how do they compare to the view of perinatal health care professionals? Gen Hosp Psychiatry. 2013;35(6):598-604.
[17] Hansotte E, Payne SI, Babich SM. Positive postpartum depression screening practices and subsequent mental health treatment for low-income women in Western countries: a systematic literature review. Public Health Rev. 2017;38:3.
[18] Appolonio KK. Postpartum depression in a military sample. Military Medicine. 2008;173(11):1085-1091.
[19] Dennis CL, Brown JVE, Brown HK. Interventions (other than psychosocial, psychological, and pharmacological) for treating postpartum depression. Cochrane Database Syst Rev. 2019;(11):CD013460.
[20] Fitelson E, Kim S, Baker AS, Leight K. Treatmetn of postpartum depression: clinical, psychological, and pharmacological options. Int J Womens Health. 2010;3:1-14.