JOURNAL OF WOMEN'S HEALTH
Volume 29, Number 7, 2020

DOI: 10.1089/jwh.2019.8287

Training Frontline Providers in the Detection and Management of Perinatal Mood and Anxiety Disorders

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Results from an investigation of 1103 pregnant or postpartum women in regard to their interaction with the health care system are reported by Masters et al.[1] in this issue of the *Journal of Women's Health*. Data from the 2005–2016 National Health and Nutrition Examination Surveys[2,3] were examined to identify potential differences in the patterns of health care utilization between women with and without depressive symptoms. Specifically, the research team hypothesized that perinatal women with depressive symptoms would be both more likely to tap acute medical services and less likely to have established routine care relative to their nondepressed peers—this hypothesis was confirmed by the study results. In addition, women with depressive symptoms had poorer overall health, and higher rates of being uninsured and of substance abuse.[1] The authors conclude, ''Such approaches, including establishing and maintaining insurance coverage and aiding frontline providers in detecting, assessing, and managing perinatal depression may help improve maternal and child health care and outcomes and decrease healthcare costs.'' Although the importance and necessity of health insurance cannot be overstated, the readiness of frontline providers in detecting and treating perinatal mood and anxiety disorders (PMADs) is also topic that warrants further discussion.

Current Physician Workforce

There is consensus around the issue of maternal depression/PMADs screening, with the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the U.S. Preventive Services Task Force (USPSTF), the American Psychological Association (APA), and the American Psychiatric Association (APA) all in support.[4–8] Despite these evidence-based recommendations, ''screening rates for PPD (postpartum depression) are inconsistent and low among physicians.''[9] In interviewing clinicians, there are legitimate reasons that they are not currently screening for depression. Pediatric providers cite a lack of maternal mental health training, that the mother is not their patient, a lack of access to the mother's medical history, and administrative burden for both the mother and the clinical staff.[10] On the obstetrics and gynecology (OB/GYN) side, the lack of PMADs-specific training is also a top concern. Statements akin to, ''The only drug I'm comfortable prescribing is Zoloft…I wasn't trained for this.'' or ''Would you ask a psychiatrist to deliver a baby?'' abound when discussing screening recommendations with providers who feel under pressure to comply but ill-equipped to execute.

The pharmacology surrounding pregnant and postpartum women is complicated, as one must assess risk in terms of the mother and fetus. Although most commonly used drugs are safe for breastfed babies,[11] potential transmission through breast milk is also a consideration. Furthermore, these risks must be evaluated in context—severe unchecked PMADs symptoms carry their own risk for the mother–infant dyad.[12] In fact, an increasing amount of data illustrates that the risks related to impaired caregiver mental health extend beyond infancy in both developed and undeveloped countries.[13,14] Another obstacle for practicing clinicians who interact with this patient population is the follow-up plan for women who screen positive for depression. In-house mental health consultation would be ideal but is relatively rare. Mental health professionals are often at a premium or absent in rural or underserved areas—never mind perinatal mental health *specialists*.[15] This lack of access to trained specialists begs the question, ''If my patient screens positive what do I do with them?'' Although it is easy to agree that OB/GYNs were not trained specifically to treat mental health, this problem is not going away anytime soon. In fact, as ACOG rolls out its recommendations for ''the fourth trimester,''[16] OB/GYNs may have more contact with postpartum women as compared with the current structure, which includes a single postpartum visit at 6 weeks. The good news is that there are solutions on the horizon and we need to mobilize toward utilizing them more broadly.

Postpartum Support International (PSI)[17] offers 2-Day and Advanced In-Person PMADs Certificate Trainings, Advanced Psychotherapy and Psychopharmacology Trainings and Frontline Provider Trainings; there are also online offerings, ''lunch and learns,'' and educational webinars. The trainings are relatively brief (from a couple of hours to 2–3 days, depending on the consumer's needs) and inexpensive.

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On the patient side, they offer a warm line facilitated by a trained volunteer that is available 24 hours a day, various online support groups, and other resources for struggling mothers (and fathers). For geographic locations where mental health providers are scarce, PSI represents a lifeline and all providers who interact with postpartum women should be educated as to its services—this education is also provided as part of the various training modalities.

A recent and exciting development is the launch of the National Curriculum in Reproductive Psychiatry (NCRP).[18] The NCRP is an interactive curriculum, offered online, with the purpose of educating mental health professionals in reproductive psychiatry. It can be navigated within an educational program or on a self-guided basis and covers women's health across the lifespan and the epidemiology, etiology, pathophysiology, and treatment of PMADs during pregnancy and in the postpartum period. Although the NCRP was designed with psychiatry residents in mind, the materials are written such that they can be used across specialties. Within the NCRP, a ''5 Hour Essentials'' course is currently being piloted with family practice residents and an OB/GYN-specific ''toolkit'' is in progress. All this to say, the training materials exist—we just need the collective and political will to encourage participation on a broader scale. A more uniformly trained workforce would likely increase screening rates and, therefore, adherence to the recommendations from organizations such as ACOG and AAP.

Aspiring Health Care Professionals

Perhaps the most logical way to address the PMADs training deficit in frontline providers for the future is to implement the curriculum during the fourth year of medical school, after students have indicated their interest in either OB/GYN, pediatrics, family practice, internal medicine, or psychiatry. PMADs-specific curriculum could also be integrated into nursing, physician's assistant, and other clinical programs after thoughtful consideration has been given to timing and placement. These recommendations regarding both aspiring health care professionals and the current physician workforce (in regard to PMADs training) reinforce each other. Even earlier on in medical school, students often rotate through various practices to learn and hone their clinical skills. As it stands, they may or may not have the opportunity to observe maternal mental health screening and treatment firsthand because it has not been uniformly implemented across all relevant practices and as per recommendation.

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