The PROMISE of Perinatal Intervention for Mom-Baby Mental Health

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Abstract
The University of Colorado PROMISE Clinic is an integrated mental health program housed in the obstetrics/gynecology outpatient clinics. A team of medical and mental health professionals care for a racially, ethnically, and socioeconomically diverse patient population. They provide integrated mental health services from consultation through co-located treatments and take a mom–baby approach, as they work to bolster the resilience and overcome stress in mothers and their infants, benefiting two generations at once. They engage in cross-disciplinary and trainee educational efforts and hope to impact more dispersed communities with telehealth consultation in the future.

Fatima was 25 years old when she came to the obstetric (OB) clinic in the second trimester of her second pregnancy (her first daughter is 7 years old), having been diagnosed with genital herpes (HSV-2), which she contracted from her husband. She felt betrayed and shared that she thought her husband might have been unfaithful, and they subsequently separated. She had few friends or supports in the United States, and her extended family was living in Pakistan. She worried about carrying her child to term with her recent HSV-2 diagnosis. While excited about her baby boy, she felt concerned that he would remind her of her husband, making it difficult to bond with him. On several occasions, she expressed ambivalence about the pregnancy to OB providers, who were concerned about her mental health, given her prior diagnosis of bipolar disorder and current depressive symptoms. Thus, she was referred to the integrated mental health team. Upon assessment, she did not meet criteria for a past manic/hypomanic episode, though she did meet for major depressive disorder and prior posttraumatic stress disorder with residual symptoms. She struggled with mood dysregulation and emotional lability, engaging quite differently with providers during appointments that were only 1 week apart, and her symptoms were often associated with the amount of

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The need for effective perinatal mental health treatment is clear to providers taking care of pregnant and postpartum women.

contact with her estranged husband between visits. Multiple discussions occurred between Fatima, her mental health and OB providers, and the OB social worker regarding her ambivalence and demoralization about the pregnancy in the context of the relationship with her estranged husband. Her feelings toward her male baby, her depressive symptoms, and her reticence about taking psychotropic medications were all areas of concern. Motivational interviewing and close follow-up with her psychiatrist and therapist in a team approach occurred throughout her pregnancy. Her psychotherapist provided ongoing psychoeducation about Fatima's symptoms and engaged in collaborative care with OB providers, thereby creating a supportive environment within the clinic. During psychotherapy sessions spanning from pregnancy into the postpartum period, Fatima was able to talk about her feelings about her baby, with whom she was increasingly beginning to connect.

History, Funding, and Structure of the PROMISE Program

Integrated perinatal mental health practice on the University of Colorado (CU) Anschutz Medical campus began more than a decade ago with the development of two parallel programs serving unique patient populations. The Colorado Adolescent Maternity Program was created as an OB medical home for pregnant and postpartum teen mothers, given the significant impact of the social determinants of health and psychosocial risk factors in this population (Stevens-Simon, Fullar, & McAnarney, 1992). At that time, universal screening for depression and anxiety was initiated, and adolescents with positive screens were referred to community mental health centers, with a meager 10% of referred patients actually connecting with care. By 2006, due to these low rates of follow-up, Drs. Stephen Scott and Bethany Ashby established a partnership with the Department of Psychiatry to integrate perinatal mental health treatment into the infrastructure of this clinic, forming the Healthy Expectations Adolescent Response Team program.

At around the same time, we incorporated universal mental health screening on the labor and delivery floor of the hospital, integrating this initiative within the CU faculty adult OB and midwifery practices. Further, a single obstetrician with an interest in perinatal mental health, Dr. Judith Mikacich, invited a psychiatrist to develop a small clinic to address mental health concerns within the OB private practice group. By 2010, these individual efforts were recognized by the Walton Family Foundation and two Endowment gifts were established within the Departments of Obstetrics and Gynecology (OB/GYN) and Psychiatry, which resulted in broader investment from both departments, CU Anschutz School of Medicine, CU School of Nursing, University of Colorado Hospital, and Children's Hospital Colorado. During the past decade these generous gifts have allowed this program to develop and expand. Eventually, this perinatal mental health clinic housed in the Department of OB/GYN was formally recognized and named the PROMISE Clinic, which stands for Perinatal Resource Offering Mood Services and Evaluation. With the addition of faculty and staff, we expanded services to all adult OB clinics, including the faculty practice, high-risk clinic, resident clinic, and two midwifery clinics. In 2018, the state of Colorado initiated grants to support greater availability of services to patients insured by Medicaid, and we received one of these "upper payment limit" grants, which helps to subsidize care in clinics working with underserved populations. Currently, the PROMISE clinic has one obstetrician, two psychiatrists, multiple psychiatry resident trainees, two psychologists, one psychology trainee, two masters-level clinicians, a social worker housed in OB with whom we actively collaborate, a behavioral health coordinator, and one professional research assistant. The treatment model has evolved from a co-located referral resource to a multidisciplinary integrated program performing universal screening within OB clinics, providing consultations during OB visits, and providing evidenced-based psychotherapy and psychopharmacology services.

Mental Health and OB Care Coordination

The need for effective perinatal mental health treatment is clear to providers taking care of pregnant and postpartum women. American College of Obstetricians and Gynecologists (ACOG) guidelines recommend that all women receive mental health screening during pregnancy or the postpartum period and recommend referral or initiation of treatment by the OB service ("ACOG Committee Opinion No. 757 Summary: Screening for Perinatal Depression," 2018). Unfortunately, OB providers often feel ill equipped to adhere to this standard for several reasons. Upon interviewing providers at 28 OB and midwifery clinics in the Denver Metro Area, the Walton Family Foundation initiative noted that while two thirds of practices screened for postpartum depression, less than 15% screened during pregnancy (Scott, 2017). Most felt that additional screening would open up a "Pandora's box" in identifying patients in

need of mental health care who could not access the care that they needed.

Referral options to community mental health providers are limited, particularly with respect to psychotropic medication providers who have an adequate level of comfort and expertise in treating peripartum populations. Although patients with Medicaid do have access to community mental health centers, the wait times for psychotherapy intake are long, and even longer for medication evaluations. In addition, there is a scarcity of providers in the community who accept private insurance, partially due to poor reimbursement rates by insurance companies for mental health treatment despite parity legislation. Undocumented women in the United States have even more limited options for care.

OB clinic treatment options for mental health are often no better, with OB providers citing lack of training in mental health care, lack of interest, and no sustainable financial model to incorporate mental health treatments into their busy clinic schedules. Other complicating factors are that OB appointments tend to be shorter than mental health appointments and the practice model in OB is one where women see different providers depending on the day, within a group practice. While this model is an excellent adaptation for OB care as women get to know most providers in the practice during pregnancy, which facilitates delivery-room continuity, from a mental health perspective the model is challenging as it may increase miscommunication between different providers and also does not build rapport with one provider, which is critical for mental health care. Further, many psychiatric diagnoses are arrived at over time, via an iterative process which involves the provider and patient meeting together over a series of visits, given that patients may present differently visit to visit.

Current solutions to train OB providers to expand mental health treatment practices are inadequate. General Medical Education governance recommends increased mental health lectures during resident education (Stevens & Diehl, 2003), which would likely not be sufficient for learning. Just as OB training requires hands-on surgical practice to develop mastery, mental health clinical skills acquisition, too, would require OB trainees to work with patients in order to obtain the skills and confidence necessary for providing mental health treatment upon graduation from their training program.

Understanding barriers to OB participation in mental health care has informed the PROMISE model. As workforce capacity has increased in PROMISE, referrals have become easier. While the OB practice originally relied on its providers to screen and initiate referrals for treatment, PROMISE did not have mechanisms in place to identify at what stage in the process a patient failed to receive appropriate care. Another issue which contributed to inefficiencies was that patients with concerns related to social determinants of health (e.g., food or housing insecurity) but without more specific mental health problems were referred through the same channel, without a clear mechanism by which they could be triaged based on mental health needs.

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During obstetrician visits, interventions focus on health promotion and early intervention, including exploring the emerging mother-baby relationship.

Evolution from a co-located model to an integrated one significantly enhanced patient triage and access to needed care. Behavioral health clinicians now actively review all OB visits and identify relevant risks (e.g., elevated Edinburgh Postnatal Depression Scale screening questionnaire (EPDS), pregnancy complications, previous mood/anxiety or substance use issues, history of sexual abuse or assault, and young maternal age) using screening tools given at the new OB visit and during the third trimester. During OB visits, interventions focus on health promotion and early intervention, including exploring the emerging mother-baby relationship. Behavioral health clinicians provide ongoing psychotherapy, specifically targeting symptoms that impact patients' parenting and relationship skills, in addition to addressing mental health symptoms. Many patients also have histories of trauma and loss; in this case, therapy emphasizes self-regulation, supports healthy interpersonal relationships, and facilitates bonding with baby. OB providers are notified of flagged visits so that they may consider consultation, and have enthusiastically participated in this model, which shares responsibility for identification of at-risk patients and decision-making as to type of care indicated. Providers feel that their clinics are able to maintain efficiency while leveraging mental health expertise, all provided within one clinic visit. This model also helps to mitigate the stigma associated with obtaining mental health treatment, as placement of the consultation service within the OB clinic and universal screening emphasize the integral importance of mental health care.

From the early stages of PROMISE, obstetricians and midwives have participated in clinic alongside social workers, psychologists, and psychiatrists. Bidirectional education has resulted in OB providers expanding their mental health skills within appropriate boundaries, as well as mental health providers gaining a greater understanding of treatment during a high-risk pregnancy, women with chronic medical illnesses, or those who are hospitalized in the course of their pregnancy. They also have learned the "language" of OB and the nuances of the obstetrician-patient relationship that

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There is a growing body of literature that supports using an infant-parent psychotherapy approach during pregnancy and then switching to dyadic therapy in the postpartum period to treat depressive symptoms and to support the mother-infant relationship.

may seem contrary to how care is approached in standalone mental health clinics. This collaborative approach has led to an integrated model which is unique to both disciplines, where knowledge is being disseminated between providers from both fields. Currently, psychiatry and psychology trainees in PROMISE hear the perspectives of the OB providers. Further, a PROMISE psychiatry trainee curriculum is being developed by OB/GYN and psychiatry departments that can be digestible and administered within this integrated care environment, which emphasizes three main objectives: (1) provide foundational perinatal mental health training, including an overview of epidemiology, diagnosis, and treatment of mental health conditions in pregnancy and the postpartum period; (2) engage residents in a curriculum highlighting societal implications of clinical neuroscience for population health; and (3) provide intensive small-group didactics on reading translational and clinical neuroscience literature as it relates to parenting and maternal-infant mental health in a nuanced and critical manner, identifying how to apply translational and mechanistic studies to practice, while acknowledging study limitations and important areas for future research.

The Therapist's Perspective

The impact of individual psychotherapy is usually limited by the patient's disclosures, reported presenting concerns, and willingness to seek mental health treatment independently of other health care. In integrated behavioral health care, clinicians are uniquely positioned to provide mental health treatment to patients as part of their medical care, significantly reducing barriers to access and utilization of mental health treatment, including cultural or societal stigma. Within this model, behavioral health clinicians are privy to medical providers' impressions, knowledge, and concerns for the patient, in addition to the patient's report. Providers are also able to support one another in taking care of patients who require more time and who have more complex psychosocial situations. Valuable information and collaboration between providers occurs within this context, in addition to the complex dynamics of supporting a patient's health and well-being while navigating multiple providers' relationships with one patient. Thus, the role of the integrated behavioral health clinician extends beyond providing mental health treatment to patients in isolation and can include promoting adherence and understanding of medical recommendations and treatment, coordinating with social work on connection with community resources, referring back to medical providers to address patient concerns (e.g., breastfeeding issues), and providing support and communication to all providers involved in the patient's care to promote understanding of patient priorities and conceptualization and to address provider worries and concerns. Likewise, this collaborative approach allows for additional support for patients with lower levels of health literacy and other barriers to understanding their medical conditions. For instance, if a patient is struggling more emotionally during a medical appointment, she might not be able to ask questions of her OB provider as she would if she were at her baseline. Thus, having the therapist integrated into the OB clinic allows for that therapist to support her in asking her questions at a different appointment or in coordinating directly with the OB provider if the patient is amenable to this option. This aspect of coordination is particularly important given disparities in care which are particularly prominent for underserved minority groups.

Integrating Care of Mothers, Infant, and the Mother-Infant Dyad

Integrated behavioral health services are well-established in family medicine and pediatric clinics (Ader et al., 2015; Heath, Wise Romero, & Reynolds, 2013), but are not as common in OB and midwifery settings. In recognition of the importance of these services in pregnancy, ACOG has issued guidelines recommending that providers address depression, smoking, exposure to domestic violence, and substance abuse during routine obstetric care ("ACOG Committee Opinion No. 518: Intimate Partner Violence," 2012; "ACOG Committee Opinion No. 633: Alcohol Abuse and Other Substance Use Disorders: Ethical Issues in Obstetric and Gynecologic Practice," 2015; "ACOG Committee Opinion No. 757 Summary: Screening for Perinatal Depression," 2018; "ACOG Committee Opinion Summary, Number 807: Tobacco and Nicotine Cessation During Pregnancy," 2020). There is a growing body of literature that supports using an infant-parent psychotherapy approach during pregnancy and then switching to dyadic therapy in the postpartum period to treat depressive symptoms and to support the mother-infant relationship. One group conducted a feasibility study of psychotherapy using both dyadic and interpersonal approaches in which they reported improvement in depressive scores and positive impact on infant socioemotional development (Lenze, Rodgers, & Luby, 2015). A second group described a perinatal adaptation of child-parent psychotherapy, reporting improvement in maternal depression and parenting attitudes (Lavi et al., 2015).

Specific developmental milestones must be achieved by women as they navigate transitions associated with pregnancy, the postpartum period, and parenting. Slade et al. (2009) identified the importance of developing an identity as a parent and transforming internal representations of self and others. This process includes the mother's reworking of her own relationship with her mother. This process is likely affected by adverse early experiences and intergenerational factors. For instance, mothers with a less optimal relationship with their own parent during childhood have been shown to have differences in neural processing of infant cues (Iyengar et al., 2014), which may be impacted by how mothers understand their feelings about their own early experiences (Iyengar et al., 2014). Developing feelings of connectedness to the baby is another important task of pregnancy, as is developing an internal representation of the developing baby, and the nature of these early processes has been demonstrated in some studies to impact mother-infant outcomes (Schwerdtfeger & Goff, 2007; Siddiqui & Hagglof, 2000). In the PROMISE Clinic, we have implemented an integrated OB behavioral health model using an infant mental health framework to support patients in adapting to pregnancy and transitioning to parenting. Although not all of our PROMISE providers have specific training in infant mental health, this approach is used in the care provided, and treatment teams promote maternal responsiveness and sensitivity. At its core, our work prioritizes the importance of the parent-child relationship. We approach our work in this way as we believe that it is the best way to promote the physical, mental, and socioemotional health of two generations at once.

Placement of the consultation service within the obstetrics clinic and universal screening emphasize the integral importance of mental health care.

OB and midwifery practices are fast-paced work environments where demands on providers' time and requirements for billable services co-exist and may conflict with pregnant women's hopes, dreams, and desires for their babies as well as patients' own histories of loss and trauma. Our approach to prenatal care attends to the experience of the medical providers, as well as to the experiences of the patients. This awareness of creating space to hold two potentially opposing perspectives is critical to our work. This approach allows us to support medical providers who lack training in infant mental health in beginning to reflect on their experiences. Reflective practice enables us to slow down and to notice the thoughts and feelings that we have about patients, providers, and other medical staff, allowing us to identify these responses, rather than react to them, ultimately creating more space to be present for patients.

The Role of Psychiatry in the PROMISE Clinic

Psychiatrists in this integrated mental health clinic housed in OB/GYN have a few different roles. One role is to perform diagnostic evaluations of women in the clinic, which often is a collaborative process if another provider such as a therapist has seen the patient previously. Psychiatric diagnosis is an iterative process, most particularly in complex patients who have had difficult or traumatic life events, may have cultural or language differences, and may be at different points along the motivational interviewing spectrum in terms of their desire to engage in use of psychotropic medications, behavioral change, or both. Given that we not infrequently see women who are first-generation immigrants, refugees, from underserved racial or ethnic minority groups, and/or who struggle with lower socioeconomic status, it is critical that providers are both mindful of possible barriers to care and aware of their own implicit biases. As recommended by Dr. Arthur Kleinman in his cultural psychiatry work, it is also useful to check in about what patients believe is causing their symptoms (one of Kleinman's 8 questions), as at times patients may have an explanation for their symptoms that is not related to a medical issue, but rather, a spiritual or cultural phenomenon (Kleinman, 1980). This type of explanation may certainly alter patient behavior in ways that a psychiatrist might not expect (e.g., making a patient less comfortable with medication use) unless we specifically ask about the patient's thoughts.

Addressing food insecurity, housing challenges, and other psychosocial needs in coordination with the clinic social worker is essential, as poverty in parents affects two generations simultaneously (Sobowale & Ross, 2018). In addition, understanding the nature of ambivalence about pregnancy and motherhood is of the utmost importance, particularly in women with trauma exposure and difficult relationships with the father of the baby. This process requires close collaboration between mental health and OB providers. Introducing this collaboration in the context of a first appointment can be helpful. For instance, during initial assessments, one might introduce the idea of care collaboration with the OB team and an in-person introduction to a therapist during the visit if the provider is available in the clinic at that time. Thus, the patient can put a face with a name and this experience may increase her level of comfort about following up with a provider. The introduction also reinforces the relationship between providers, which allows for a therapist to approach the psychiatrist to advocate for the patient to be seen sooner, or to relay concerns which arose during the course of care. The last important component of psychiatric care in our clinic model is motivational interviewing. If patients are unsure about the idea of taking a medication, asking about the meaning of medication to them, engaging in discussion about the level of willingness to try a medication, and cultivating discrepancy can all be useful. The psychological meaning which patients attribute (consciously or unconsciously) to taking a medication can be closely tied to a patient's "readiness for change," which is a critical factor in

how one can conceptualize responses to medications (Mintz, 2002). Further, sometimes a patient will not want to engage in therapy, but they might feel more comfortable coming to a psychiatrist to check in, as they consider their options. If the rapport-building process is successful, it may result in a patient who is more willing to engage in care after a few sessions.

Applications of PROMISE Principles

In Fatima's case, the OB provider reached out to the integrated behavioral health team to discuss concerns regarding Fatima's flat affect, reported mental health history, and ambivalence about her pregnancy. The provider seemed overwhelmed by Fatima's circumstances, particularly her lack of social support and psychosocial complexity. Fatima had come to the United States as a refugee, fleeing violence in her small village in Pakistan, after having been married at a very young age to her husband. In the past few years, her relationship with her husband had deteriorated. Her experiences with medical providers in her home community had been limited due to lack of access and her perception that asking questions of providers was "being difficult." The medical provider for this current pregnancy initially managed her anxiety and concerns about the patient and her baby by involving PROMISE and recommending therapy and psychiatric evaluation, as well as the OB social worker, who addressed psychosocial needs and supports. Fatima was willing to meet with the PROMISE team and the social worker; however, she was hesitant about engaging in treatment, and this reluctance of Fatima exacerbated the anxiety of the OB provider. The PROMISE team initially focused on assessing risk and building rapport with Fatima while collaborating closely with social work and medical providers to create a holding environment for provider concerns and for the patient.

During the COVID-19 pandemic, the PROMISE Team has weekly virtual meetings to coordinate care for patients.

Although direct mental health intervention with Fatima was slow and often felt minimal, the behavioral health clinicians promoted understanding for the medical providers regarding the cultural stigma of mental health treatment which contributed to Fatima's reluctance to start medication and to engage in therapy. Behavioral health clinicians supported providers in conceptualizing Fatima's pregnancy-related ambivalence and difficulties bonding with her baby in utero due to ongoing marital dynamics, cultural implications of separation from her husband, and her HSV-2-related medical concerns. As behavioral health clinicians worked with Fatima, it became apparent that her disconnection from her baby was a means of protection and coping related to her fear of delivering the baby prematurely (due to HSV-2) and him not surviving.

This understanding helped both the behavioral health clinicians and the medical providers to approach Fatima's care in a different way by focusing more on her understanding of her medical condition and the associated risks. Fatima was able to use a sleep aid during her second trimester, which she opted to discontinue prior to delivery. As Fatima moved through her pregnancy, the medical team focused more on the baby's development and ability to survive, which in turn, allowed Fatima to feel more connected and to build a relationship with the baby before delivery that was separate from her relationship issues with her husband. Toward the end of her pregnancy, she shared her happiness with her provider as she began to prepare for her baby's arrival, making the initial purchases she needed. Fatima has since delivered her baby and continues to use the PROMISE team for behavioral health support in the postpartum period. Collaboration and support among all involved providers was essential in providing the best medical care possible to this high-risk mother and family.

Aviva K. Olsavsky, MD, is a senior instructor in psychiatry and obstetrics and gynecology at the University of Colorado School of Medicine and Children's Hospital Colorado. Her clinical work focuses on providing psychiatric consultation to integrated care clinics, both in adolescent and adult perinatal clinics (Colorado Adolescent Maternity Program, Young Mothers Clinic, and the PROMISE Clinic), as well as in pediatrics, where she engages in clinical teaching with pediatrics and psychiatry trainees. She also enjoys didactic teaching of residents and fellows in adult and child psychiatry, and trainees in pediatrics and adolescent medicine—in particular, she enjoys working to increase the skills of residents and fellows to actively and critically engage with and become excited about clinical neuroscience research. Dr. Olsavsky's research uses neuroimaging and focuses on how stressful life experiences act upon the maternal brain across development, and how these neural processes impact the way that mothers engage with their baby's cues and how reinforcement learning occurs in the context of the parent-child relationship.

Amelia Ehmer, PsyD, is an assistant professor of psychiatry, pediatrics, and obstetrics and gynecology at the University of Colorado School of Medicine. Her clinical work focuses on the implementation of integrated behavioral health services and co-located psychotherapy for high-risk women during the perinatal period. She serves as a supervising psychologist in the Young Mother's Clinic at Children's Hospital Colorado and in the PROMISE Clinic at the University of Colorado Hospital. She is particularly interested in implementing trauma-informed care in integrated settings, improving access to mental health care for underserved populations, and providing mental health support to adolescent mothers.

Debbie Carter, MD, is an associate professor of psychiatry at the University of Colorado School of Medicine and Children's Hospital Colorado. Dr. Carter has worked with a vast array of underserved clinical populations, including Native American populations in the context of her work in the U.S. Public Health Service and children and adolescents in the juvenile justice system. Most recently, she provides consultation

to multiple integrated care clinics, including the PROMISE clinic, in which she works with mother-baby dyads, the TRUE Center for Gender Diversity, which focuses on gender-diverse pediatric populations, and the CHIP Clinic (Children's Hospital Immunodeficiency Program), where she provides high-quality integrated care to children, adolescents, and pregnant women living with HIV. In addition to her clinical roles, she has consistently mentored and taught the next generation of child and adult psychiatrists the context of the residency and fellowship programs at the University of Colorado.

Stephen Scott, MD, MPH, is an associate professor of obstetrics and gynecology, pediatrics, and psychiatry at the University of Colorado School of Medicine and is the Endowed Chair for Perinatal Mental Health in the Department of Obstetrics and Gynecology. His clinical work has focused on the development of an integrated Obstetric Medical Home for pregnant and parenting adolescents that incorporates multidisciplinary treatment for social and behavioral health during pregnancy. He serves as the director of the department's Colorado Adolescent Maternity Program, and is the associate director of the PROMISE Clinic, which provides mental health services for pregnant and postpartum women at the University of Colorado Hospital. Dr. Scott is particularly interested in epigenetic factors that influence the intergenerational association of depression and anxiety among teens and their children.

Bethany Ashby, PsyD, is an associate professor of psychiatry and obstetrics and gynecology at the University of Colorado School of Medicine. Her clinical work has focused on the development of integrated behavioral health programs in obstetric settings. She serves as director of behavioral health services for the Colorado Adolescent Maternity Program and the Young Mothers Clinic at Children's Hospital Colorado, as well as the director of the PROMISE Clinic, which provides mental health services for pregnant and postpartum women at the University of Colorado Hospital. Dr. Ashby is particularly interested in the impact and treatment of complex trauma in the perinatal period.

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