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**Request for Information: Inviting Comments and Suggestions for a Proposed Research Initiative to Decrease Maternal Mortality (NOT-OD-20-063)**

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On behalf of the American Psychiatric Association (APA), the medical specialty society representing 38,800 psychiatrists, thank you for the opportunity to comment on the research initiative focused on decreasing maternal mortality. In a recent and large meta-analysis, the global prevalence of postpartum depression was found to be approximately 17.7%.<sup>i,ii</sup> The incidence of mood and/or anxiety disorders in the antenatal and postnatal periods in the United States has become a serious public health problem with research showing 1 out of 7–10 pregnant women and 1 out of 5–8 postpartum women will develop a depressive and/or anxiety disorder,<sup>iii</sup> and 1 out of 1,000 perinatal women will develop a psychotic psychosis.<sup>iv,v</sup> The incidence of these disorders is highest in women from lower socioeconomic backgrounds.<sup>vi</sup>

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New mothers are at high risk for postpartum psychiatric illnesses with the most concerning being postpartum manic, depressive, and mixed episodes with psychotic features and psychoses not otherwise specified. Pregnancy-associated suicide accounts for more deaths than many other obstetric complications, including hemorrhage, obstetric embolism, or preeclampsia/eclampsia,<sup>vii</sup> and needs more urgent attention and research.

Administration  
Saul Levin, M.D., M.P.A.  
*CEO and Medical Director*

We applaud your work on this understudied issue, and are pleased to offer the following comments:

**Maternal mental health in the peripartum period is essential.** Even though depressive disorders are among the most common, emerging evidence warrants a more comprehensive conceptualization of perinatal psychiatric illness to include bipolar disorder and common comorbid illnesses such as general anxiety disorder, obsessive compulsive disorder, and panic disorder. Many studies have shown that depressive symptoms during pregnancy are associated with decreased prenatal care and adverse perinatal outcomes such as preterm birth and low birth weight. Perinatal mental health disorders can be

severe; post-partum suicides account for up to 20% of postpartum deaths.<sup>viii</sup> Maternal suicide is one of the leading causes of death among postpartum women,<sup>ix</sup> and approximately 33.9 per 100,000 people occur in the United States each year.

**Mood disorders, psychosis, substance use and suicide, and recognition of serious mental illness are factors in disparities in perinatal care and maternal-fetal outcomes.** Postpartum depression is one of the most common complications of pregnancy, affecting as many as one in seven women.<sup>x</sup> Meanwhile, opioid use disorder has risen more than four times among pregnant women with four times as many infants born with neonatal abstinence syndrome in 2014 than in 1999.<sup>xi</sup> These are associated with numerous adverse effects on both mother and baby, including poor healthcare utilization, reduced breastfeeding, poor mother-infant interactions, increased psychopathology in children,<sup>xii,xiii,xiv,xv,xvi,xvii,xviii</sup> as well as both suicide and infanticide.<sup>xix,xx</sup>

Aware of the importance of these issues, the American College of Obstetrics and Gynecologists recommends to screen for depression/anxiety at least once during the peripartum period followed by referral and treatment with appropriate behavioral health resources when indicated.<sup>xxi</sup> Despite the availability of evidence-based treatments, most pregnant and postpartum women with these disorders do not receive adequate assessment or treatment. In addition, although significant issues with suicide exist in this population, there are difficulties determining accurate prevalence of suicide due to barriers in reporting. This is especially important with suicide being the second leading cause of postpartum maternal mortality.

**To improve access to care, more population-level public health data is necessary on barriers to accessing health care including insurance coverage and network adequacy (for mental health and substance use disorders, as well as prenatal and obstetric care.)** Finding appropriate psychiatric care in the setting of pregnancy or the post-partum period can be very challenging. There is already a shortage of psychiatrists and insurance networks are very often inadequate. Health plan participants lack equitable access to in-network specialty physician services for mental health and substance use disorder (MH/SUD) conditions, as compared to access for medical surgical conditions, is a significant parity problem. Network adequacy, or inadequacy, is a nonquantitative treatment limitation (NQTL) issue and subject to analysis per the established regulatory tests.

Numerous studies have documented that participation of psychiatrists in insurance networks and/or the availability of psychiatrists who are participating in-network is very poor. This is especially evidenced by high out-of-network (OON) utilization rates as compared to those for medical-surgical conditions, lack of timely appointment availability and sometimes grossly inaccurate health plan provider directories which is an undue burden for plan participants. A key contributing factor to physician non-participation or availability are the payment rates plans reimburse. It is well documented that psychiatrists receive lower in-network reimbursement (sometimes exceeding 60% less) than non-psychiatrist physicians and mental health professionals for the same services.

**More research is needed in how to implement evidence-based models that make it easy for women to access care.** Identifying a local treatment facility can be difficult, especially in rural and remote areas or for a woman who can't take time off work and afford childcare to seek treatment. Effective models of care need to be flexible to make it easy for women to access services in a location convenient for them, such as through an obstetrics practice and in the home through telepsychiatry. A recent report, **Evaluation of Telepsychiatry-Enabled Perinatal Integrated Care**, found identification and treatment of behavioral health issues exceeded nationally published rates and that telepsychiatry is an effective tool for expanding perinatal integrated care. This adds to a growing body of evidence for the use of telepsychiatry-supported integrated care that need to be translated into practice.

Other population-based models, such as the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms builds on providers capacity to treat perinatal mental health and substance use disorders through 1) trainings and toolkits, 2) telephonic access to perinatal psychiatric consultation, and 3) facilitating referral to community resources. This provides access to immediate resource provision and referrals and psychiatric telephone consultation with perinatal psychiatrists for obstetric, pediatric, adult psychiatric, adult primary care providers, or any other health care provider serving pregnant or postpartum women. Active outreach, engagement, and enrollment are targeted to obstetric practices and health care providers because they are frontline health care providers for pregnant and postpartum women. Many communities across the country don't have access to such a program that improves detection and treatment of perinatal mental health and substance use.

Thank you again for the opportunity to comment on this important issue. We are pleased to be a resource as you develop the initiative.

Sincerely,



Saul M. Levin, M.D., M.P.A., FRCP-E, FRPsych  
CEO and Medical Director

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