



October 17, 2022

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Carol M. Mangione, MD, MSPH
Chair, U.S. Preventive Services Task Force
5600 Fishers Lane
Mail Stop 06E53A
Rockville, MD 20857

Re: USPSTF Recommendation on Depression and Suicide Risk in Adults

Dear Dr. Mangione,

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the USPSTF recommendation on Screening for Depression and Suicide Risk in Adults.

As detailed below, we strongly support the USPSTF's goals of identifying depression early and preventing its progression. To achieve that end, we believe that screening and early detection must be coupled with evidence-based clinical interventions, particularly by incorporating brief interventions for depression into the USPSTF's formal preventive health recommendations in addition to screening. APA also supports selected suicide screening (e.g., for those screening positive for depression), rather than no screening for suicide risk.

Screening with Brief Intervention

As is the case with other USPSTF recommendations (i.e., Tobacco Smoking Cessation, Unhealthy Alcohol Use) **we strongly encourage the USPSTF recommendation regarding depression screening be expanded to include screening with brief intervention as opposed to screening alone.**

APA recommends that clinicians conducting screening for depression and suicide risk should have training to follow-up positive screens with more detailed assessments and use of clinical judgment to determine the likely clinical significance and need for treatment, and if necessary, provide brief evidence-based interventions. Clinicians should also be familiar with first-line approaches for clinically significant depression (psychoeducation, psychotherapy, and/or pharmacotherapy) and be equipped to implement these interventions if needed and/or to make appropriate mental health referrals for further evaluation and treatment. Mere screening for any mental or substance use disorder, such as depression, or associated conditions, including suicide risk, without appropriate follow-up has not been shown to be effective and is potentially harmful.

It is widely known that most individuals initially seek care for mental health or substance use disorders in primary care settings. In the usual management of depression, patients who screen positive for depression are often referred to specialty care where they fail to follow-up, experience delays accessing care, or quickly fall out of treatment.¹ Screening followed by brief interventions, as described in the billing requirements of the initial month of Collaborative Care (operationalized by CPT code 99492) – patient engagement, initial assessment, and treatment planning, tracking of progress through the routine use of screening tools, and consultation and caseload review by a psychiatric consultant – has been shown to improve patient engagement and has a positive impact on patient outcomes with improvement occurring more quickly than those not receiving care within that same timeframe.^{2,3}

Screening for Suicide

Isolated screening for suicide may have limited utility, but screening for suicide among individuals who screen positive for depression not only has the potential to reduce one of the leading preventable causes of mortality but also is an important factor in considering the acuity of a referral (e.g., to an ED or for on-site mental health consultation vs. a routine outpatient consult, potentially several weeks or months off) and in considering the appropriate level of care (e.g., inpatient vs. outpatient).

Obviously not everyone at risk for suicide will have a positive screen for depression, but we also understand the burden on primary care and other practitioners and the challenges of universal screening for suicide risk. **Overall, it seems that a recommendation for targeted suicide screening (e.g., those screening positive for depression) would be a more balanced and reasonable recommendation than not screening for suicide risk. This is especially important in groups at high risk for suicide such as individuals over the age of 65.**

Pharmacotherapy Statement Regarding Maternal Healthcare for Depression

APA is concerned that USPSTF statement, “*Given the potential harms to the fetus and newborn child from certain pharmacologic agents, clinicians are encouraged to consider cognitive behavioral therapy or other evidence-based counseling interventions when managing depression in pregnant or breastfeeding persons.*” has the potential to be harmful rather than helpful to pregnant persons with depression. The statement can be interpreted as a recommendation against medications for depression during pregnancy and postpartum in that it may reinforce the already reflexive tendency on the part of many clinicians to

¹ Unützer, J., Schoenbaum, M., Druss, B. G., & Katon, W. J. (2006). Transforming mental health care at the interface with general medicine: report for the presidents commission. *Psychiatric services (Washington, D.C.)*, 57(1), 37–47. <https://doi.org/10.1176/appi.ps.57.1.37>

² Bao, Y., Druss, B. G., Jung, H. Y., Chan, Y. F., & Unützer, J. (2016). Unpacking Collaborative Care for Depression: Examining Two Essential Tasks for Implementation. *Psychiatric services (Washington, D.C.)*, 67(4), 418–424. <https://doi.org/10.1176/appi.ps.201400577>

³ Bao, Y., McGuire, T. G., Chan, Y. F., Eggman, A. A., Ryan, A. M., Bruce, M. L., Pincus, H. A., Hafer, E., & Unützer, J. (2017). Value-based payment in implementing evidence-based care: the Mental Health Integration Program in Washington state. *The American journal of managed care*, 23(1), 48–53.

discontinue (or avoid) psychotropic medications during pregnancy for those individuals who might need and benefit from them.

For the most part, when a person has been depressed during pregnancy and has been taking antidepressant medications, they should continue taking medications during the postpartum period and while breastfeeding.^{4,5} In general, antidepressant use during breastfeeding is considered safe with most studies demonstrating low or undetectable blood levels in the infant with few adverse effects.⁶ Exposing the fetus or infant to the mother's mental health condition carries risk in itself. APA strongly suggests that recommendations about pharmacotherapy should encourage providers to discuss the risk and benefits with their pregnant patients.

NOTE: We have attached ([Attachment A](#)) a more detailed response to the recommendations related to maternal mental health that was developed by APA's Committee on Women's Mental Health.

Thank you for the opportunity to review and comment on the draft recommendations. If you have questions or would like to discuss these comments in more detail, please contact Becky Yowell, Director Reimbursement Policy and Quality at byowell@psych.org or Nitin Gogtay, MD, Chief of Research & Deputy Medical Director at ngogtay@psych.org.

Sincerely,


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

⁴Payne, J. L. (2017). Psychopharmacology in Pregnancy and Breastfeeding. *The Psychiatric Clinics of North America*, 40(2), 217–238. <https://doi.org/10.1016/j.psc.2017.01.001>

⁵ Laskey, C. S. (2021). Antidepressant Use in the Breastfeeding Patient. *US Pharm*. 46(5):17-22.

⁶ Lanza di Scalea, T., & Wisner, K. L. (2009). Antidepressant medication use during breastfeeding. *Clinical obstetrics and gynecology*, 52(3), 483–497. <https://doi.org/10.1097/GRF.0b013e3181b52bd6>

SCREENING FOR DEPRESSION AND SUICIDE RISK IN ADULTS

IMPORTANCE

It is important to recognize the specific and unique aspects of mental health during the perinatal period (during pregnancy and first year following pregnancy):

1. ***Pregnancy and the postpartum period are a time of increased risk of psychiatric illness***, including an increased risk of depression and suicide.
2. ***Mental health conditions are the most common complication of pregnancy and childbirth***, impacting at least 1 in 5 childbearing individuals in the general population, or approximately 800,000 families each year (ACOG Committee Opinion 757; Fawcett, 2019; Gavin, 2005). Individuals facing racial or economic inequities, military parents, individuals with a history of psychiatric illness, and parents with a baby in the neonatal intensive care unit experience even higher rate perinatal psychiatric illness at a rate of 1 in 3 (Byatt et al, 2020; Cherry et al, 2016; Guintivano et al, 2018; Postpartum Support International, 2021; Smorti et al, 2019).
3. ***Suicide and overdose combined are the leading cause of death for women in the first year postpartum*** according to the Centers for Disease Control and Prevention ([statement dated September 19, 2022](#)). Moreover, ***99% of deaths by suicide were preventable***.
4. ***Untreated perinatal mental health conditions can have long-term negative impact on mother, baby, family, and society.***
 - Pregnant individuals with untreated psychiatric illness are at higher risk of not receiving adequate prenatal care, substance use, and poor nutrition, all of which can increase the risk of poor birth outcomes including low birth weight, small gestational size, and increased admissions to the neonatal intensive care unit (Zhou, 2019; Field, 2010; Sriraman, 2017; Fitelson, 2011; Byatt et al, 2020).
 - Postpartum individuals with untreated psychiatric illness may be less responsive to their baby’s cues, have fewer positive interactions with their baby, experience breastfeeding challenges, and question their competence as parents. Children of parents with untreated psychiatric illness are themselves more likely to require psychiatric care throughout their lifetime (Sriraman, 2017; Fitelson, 2011; Grote, 2010; Kelly, 2002; Cherry, 2016; Stein, 2014).
 - The cost of untreated perinatal mood and anxiety disorders is \$14 billion each year (Luca et al, 2019).

Items 1, 2, and 3 should be included in the text in this section.

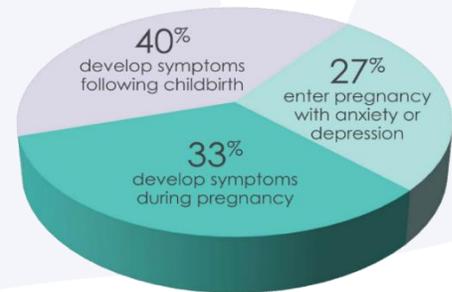
PRACTICE CONSIDERATIONS

Assessment of Risk. Individuals at increased risk of experiencing perinatal depression include those who face racial or economic inequities, military mothers, and parents with a baby in the neonatal intensive care unit (Byatt et al, 2020; Cherry et al, 2016; Guintivano et al, 2018; Postpartum Support International, 2021; Smorti et al, 2019).

Screening Intervals. Of individuals who experience postpartum depression, roughly

- 1/3 enter pregnancy with underlying symptoms,
- 1/3 development symptoms during pregnancy,
- 1/3 develop symptoms in the postpartum period.

(Wisner et al, 2012).



Wisner et al, 2012.

The peak onset of postpartum depression is 3-6 months postpartum, and the peak incidence of postpartum suicide is 6-9 months postpartum. (California Pregnancy-Related Maternal Mortality Review, 2019; Grigoriadis, 2017).

Taken together, these facts suggest that childbearing people should be screened for depression routinely throughout the two-year perinatal timeframe.

Treatment or Interventions. This section includes the following sentence: “Given the potential harms to the fetus and newborn child from certain pharmacologic agents, clinicians are encouraged to consider cognitive behavioral therapy or other evidence-based counseling interventions when managing depression in pregnant or breastfeeding persons.”

This statement is incorrect and contradicts evidence-based practice.

Medications can and should be used to treat the depression among individuals who are pregnant or breastfeeding (Payne, 2017). When clinically indicated, the use of many antidepressants, including SSRIs, carry less risk than exposing mother and child to untreated depression (Muzik & Hamilton, 2016).

Moreover, undertreating or not treating depression carries a risk for the fetus and infant. As noted in the section above on importance, untreated perinatal depression can have negative long-term impact on the developing child, both in utero and following birth.

Too often pregnant people believe, or are incorrectly counseled, that they should cease taking their psychotropic medication. In fact, individuals who become pregnant and while taking medication for their mental health should continue their medication as the risk of relapse is significant, especially for those who experiencing bipolar disorder (McAllister-Williams et al, 2016; Payne, 2017; Laskey, 2021, NIMH website.).

For the most part, when a woman has been depressed during pregnancy and has been taking antidepressant medications, they should continue to do so during the postpartum period and while breastfeeding (Payne, 2017; Laskey, 2021). In general, antidepressant use during breastfeeding is considered safe with most studies demonstrating low or undetectable blood levels in the infant with few adverse effects (Moretti, 2009). Exposing the fetus or infant to the mother’s mental health condition carries risk in itself. Physicians should discuss the risk and benefits with their patients.

Finally, the National Institute of Mental Health includes the following information on its [website](#) about psychotropic medication in pregnancy and while breastfeeding:

- **Women with perinatal depression are most commonly treated with antidepressants**, which are medications used to treat depression.

- Women who are pregnant or breastfeeding should notify their health care provider before starting antidepressants so their health care provider can work to minimize the baby’s exposure to the medication during pregnancy or breastfeeding.
- **The risk of birth defects and other problems for babies of mothers who take antidepressants during pregnancy is very low;** however, women should work with their health care provider to weigh the risks and benefits of treatment and to find the best solution for their situation.
- **Do not stop taking antidepressants without the help of a health care provider.** When a woman and her health care provider have decided it is time to stop the medication, the health care provider will help her to decrease the dose slowly and safely.

Suggestions for Practice Regarding the I Statement.

Potential Preventable Burden

Suicide and overdose combined are the leading cause of death for women in the first year following pregnancy (CDC, September 2022). The following statistics pertain to new mothers who die by suicide:

- Over 50% have a documented mental health diagnosis, with 92% documented prior to delivery (Massachusetts MMRC report, Sept 2017).
- 34% had a documented previous suicide attempt (Smoots et al, 2017)
- > 50% visit a hospital emergency department in the month prior to death, (Goldman-Mellor and Margerison, 2019; Metz et al, 2016).

The draft recommendation states that “men are more than 3 time more likely to die from suicide than women;” this is because men often use the more violent forms of suicide (gunshot, hanging, jumping) than women (overdose and cutting). It is important to note that women who die by suicide in the postpartum period use the most violent forms of death (gunshot, hanging, jumping) (Goldman-Mellor and Margerison, 2019; Metz et al, 2016; Grigoriadis, 2017; CDC September 2022).

RECOMMENDATIONS OF OTHERS

The following organizations also recommend screening for mental health disorders during the perinatal period:

- The American Academy of Pediatrics recommends screening for maternal depression at the 1-, 2-, 4-, and 6-month well-child visits. (2017 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Fourth Edition).
- The American Psychiatric Association recommends that all pregnant and postpartum women should be assessed for the presence of and the risks for a psychiatric disorder at least twice during pregnancy and at the 1-, 2-, 4-, and 6-month well-child visits. (APA Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum, 2018).
- The Association of Women’s Health, Obstetric and Neonatal Nurses maintains that individuals should be screened for mood and anxiety disorders, especially during pregnancy and the postpartum period. It is imperative that on-going screening and referral to treatment occurs in both the perinatal and pediatric setting. (AWHONN Position Statement, Perinatal Mood and Anxiety Disorders, 2022).

TABLE 1: SUMMARY OF USPSTF RATIONALE

The table includes the following information about pregnant and postpartum persons:

- Benefits of early detection and intervention: inadequate evidence on pharmacotherapy in pregnant and postpartum persons.

This statement is not correct. There is evidence that pharmacotherapy are effective and often indicated in pregnant and postpartum persons; see section above (**Treatments or Interventions**). Articles with information pointing to effective pharmacotherapy in pregnant and postpartum persons include:

Dalfen, 2019: *Perinatal Mood and Anxiety Disorders: Pharmacotherapy*.

- Goulding et al, 2022: *Pharmacologic Treatment for Perinatal Mental Health Disorders*.
- Laskey, 2022: *Antidepressant Use in the Breastfeeding Patient*.
- Payne, 2016: *Psychopharmacology in Pregnancy and Breastfeeding*.
- Viswanathan et al, 2021; *Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Meta-analysis of Pharmacotherapy*.



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Chair, U.S. Preventive Services Task Force
5600 Fishers Lane
Mail Stop 06E53A
Rockville, MD 20857

Re: USPSTF Recommendation on Screening for Anxiety

Dear Dr. Mangione,

The American Psychiatric Association (APA), the national medical specialty society representing over 37,000 psychiatric physicians and their patients, welcomes the opportunity to comment on the USPSTF recommendation on Screening for Anxiety. As detailed below we strongly support the USPSTF's goals of identifying anxiety early and preventing its progression.

APA appreciates the thoughtful review of the evidence for prevalence and impact of anxiety disorders and current gaps in addressing anxiety disorders which often remain underdiagnosed in primary care settings and untreated or treated only after many years of distress and potential impairment. APA also appreciates the attention paid to anxiety across racial/ethnic groups as well as to structural issues impacting presentation and screening for anxiety. However, the APA had a few concerns and suggestions:

Assessment of Risk

APA recommends that childhood abuse/neglect be added to the list of risk factors for anxiety. Currently, there is mention only of "*psychosocial factors (stressful life events or smoking and alcohol use)*," which implies contemporary events, rather than historical ones. However, childhood maltreatment is also associated with elevated risk for clinically significant anxiety.

Screening Intervals

The document states:

"There is little evidence regarding the optimal timing for screening, and the optimal interval for screening for anxiety is unknown. More evidence is needed to identify ideal screening intervals for all populations. A pragmatic approach in the absence of data might include screening all adults who have not been screened previously and using clinical judgment in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted."

The recommendation to screen only adults “who have not been screened previously” may be unnecessarily vague. Patients may not have reliable recollection of past screening. In addition, severity of anxiety may vary across time. APA recommends screening adults with a short, standardized instrument on all initial evaluations as well as consideration of follow-up screening annually. Instruments such as the GAD-2 can be efficiently administered along with other mental health instruments (e.g., PHQ-2) that are already part of current routine screening in primary care.

Furthermore, the USPSTF stated that there is insufficient evidence to recommend screening for anxiety in individuals 65 and older primarily because of the lack of anxiety screening tools specifically geared at this population. APA acknowledges that existing anxiety screening tools tend to include somatic items that can be affected by general medical problems thus limiting their effectiveness in the older adult population. That said, given the prevalence of anxiety in the older adult population and the impact of untreated anxiety on general medical conditions and their quality of life, APA recommends a multimethod clinical assessment approach that starts with a short, standardized screening instrument such as the GAD-2.

Screening with Brief Intervention

As is the case with other USPSTF recommendations (i.e., Tobacco Smoking Cessation, Unhealthy Alcohol Use) **APA strongly encourages that the USPSTF recommendation regarding anxiety screening be expanded to include screening with brief interventions as opposed to screening alone.**

We recommended that clinicians conducting screening should have training to follow-up positive screens with brief interventions. Questions to determine the likely clinical significance and need for treatment following initial screening should focus on duration of symptoms, degree of distress and impairment, and current or previous treatment history. Clinicians should also be familiar with first-line approaches for clinically significant anxiety (psychoeducation, psychotherapy, and/or pharmacotherapy) and be equipped to implement these interventions if needed and/or to make appropriate mental health referrals for further evaluation and treatment. Screening without appropriate follow-up has not been shown to be effective and is potentially harmful.

It is widely known that most individuals initially seek care for mental health or substance use disorders in primary care settings, where the collaborative care model has been shown to be useful in engaging patients with depression in care and improving their depression and could be applied to the screening and management of anxiety.¹ As with depression patients who screen positive for anxiety are often referred to specialty care where they fail to follow-up, experience delays accessing care, or quickly fall out of treatment. Screening followed by brief interventions as described in the billing requirements of the initial month of Collaborative Care (operationalized by CPT code 99492) -- patient engagement, initial assessment, and treatment planning, tracking of progress through the routine use of screening tools, and consultation and caseload review by a psychiatric consultant – has been shown to improve patient

¹ Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *The Cochrane database of systematic reviews*, 10, CD006525. <https://doi.org/10.1002/14651858.CD006525.pub2>

engagement and has a positive impact on patient outcomes with improvement occurring more quickly than those not receiving care within that same timeframe.²

Pharmacotherapy Statement Regarding Maternal Healthcare for Anxiety

APA is concerned that clinicians will misconstrue the USPSTF's statement that "For pregnant persons, there is inadequate evidence on pharmacotherapy" for anxiety treatment, as a recommendation against medications for anxiety during pregnancy and that it may reinforce the already reflexive tendency on the part of many clinicians to discontinue (or avoid) psychotropic medications during pregnancy for those individuals who might need and benefit from them. In fact, a number of studies have documented the safety and effectiveness of pharmacotherapeutic treatment of anxiety in pregnant and breast-feeding persons.^{3,4,5,6,7}

Furthermore, the state of the evidence on pharmacotherapy for anxiety during pregnancy is not related to a suspected lack of efficacy of pharmacotherapy for anxiety treatment during the perinatal period but due to the unfortunate limited of research in this population that we recognize to be an orphan in psychopharmacology research as in other areas of biomedical research. There is abundant evidence for the efficacy of pharmacotherapy for anxiety disorders (particularly SSRIs, SNRIs, and benzodiazepines). There is no reason to believe that anxiety during or after pregnancy is less responsive to pharmacotherapy than in other individuals. Moreover, many pregnant individuals with clinically significant anxiety are also individuals who have experienced clinical anxiety prior to pregnancy and may already be on pharmacological treatment or have benefitted from such treatment in the past.

As the relative safety of first-line anxiety pharmacotherapy (including serotonergic antidepressants and low dose benzodiazepines) during pregnancy is increasingly well established, APA is concerned about any guideline, recommendation, or statement that seems likely to discourage clinicians from considering the continuation of or the initiation of such treatment in pregnant persons.

² Bao, Y., McGuire, T. G., Chan, Y. F., Eggman, A. A., Ryan, A. M., Bruce, M. L., Pincus, H. A., Hafer, E., & Unützer, J. (2017). Value-based payment in implementing evidence-based care: the Mental Health Integration Program in Washington state. *The American journal of managed care*, 23(1), 48–53.

³ Dalfen, A. (2019) *Perinatal Mood and Anxiety Disorders: Pharmacotherapy*. camh.ca/en/professionals/treating-conditions-and-disorders/perinatal-mood-and-anxiety-disorders/perinatal-mood---treatment/perinatal-mood---pharmacotherapy

⁴ Goulding A. N., Metz, T. D., Middleton, J. C., Hoffman, M. C., Miller, E. S., Moore Simas, T. A., Stuebe, A., Viswanathan, M., & Gaynes, B. N. (2022). Pharmacologic Treatment for Perinatal Mental Health Disorders. *Obstetrics and gynecology*, 139(2), 297–303. <https://doi.org/10.1097/AOG.0000000000004638>.

⁵ Laskey, C. S. (2021). Antidepressant Use in the Breastfeeding Patient. *US Pharm*. 46(5):17-22.

⁶ Payne, J. L. Psychopharmacology in Pregnancy and Breastfeeding. *The Psychiatric Clinics of North America*, 40(2), 217–238. <https://doi.org/10.1016/j.psc.2017.01.001>

⁷ Viswanathan, M Middleton, J. C., Stuebe, A., Berkman, N., Goulding, A. N., McLaurin-Jiang, S., Dotson, A. B., Coker-Schwimmer, M., Baker, C., Voisin, C., Bann, C., & Gaynes, B. N. (2021). *Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Systematic Review of Perinatal Pharmacologic Interventions*. Agency for Healthcare Research and Quality (US).

Psychotherapy treatments for anxiety are also highly effective and should always be considered. However, for individuals who have been stably treated with pharmacotherapy for anxiety or for whom anxiety is severe and acute or may not be responding fully to psychotherapy, medications should be considered as an option for pregnant persons as they are for people who are not pregnant. Again, the paucity of evidence on efficacy in this population is not related to a hypothesis about less efficacy in this population than others but is more so related to a lack of research in this population.

APA questions the utility of this statement and notes the possible harm it may pose if misconstrued. We recommend that the statement could be changed to “For pregnant persons with anxiety disorders, there is inadequate evidence for or against pharmacotherapeutic treatment. As such, a review of past treatment is important and clinical judgement needs to be exercised when working with pregnant persons who present with an anxiety disorder.”

NOTE: We have attached ([Attachment A](#)) a more detailed response to the recommendations related to maternal mental health that was developed by APA’s Committee on Women’s Mental Health.

Thank you for the opportunity to review and comment on the draft recommendations. If you have questions or would like to discuss these comments in more detail, please contact Becky Yowell, Director Reimbursement Policy and Quality at byowell@psych.org or Nitin Gogtay, MD, Chief of Research & Deputy Medical Director at ngogtay@psych.org.

Sincerely



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

COMMENTS REGARDING SCREENING FOR ANXIETY IN ADULTS

IMPORTANCE
<p>It is important to recognize the specific and unique aspects of mental health during the perinatal period (during pregnancy and first year following pregnancy):</p> <ol style="list-style-type: none">1. <i>Pregnancy and the postpartum period are time of high risk for anxiety disorders.</i>2. <i>Perinatal anxiety impacts 20% of perinatal individuals,</i> and research suggests that anxiety is more prevalent than depression during pregnancy and the postpartum period (Fawcett et al, 2019; Wenzel et al, 2005).3. <i>The impact of untreated perinatal anxiety is significant:</i> (Fawcett et al, 2019;<ul style="list-style-type: none">o Prenatal anxiety has been associated with adverse pregnancy outcomes such as miscarriage, pre-eclampsia, pre-term delivery, and low birth weight (Huizink et al, 2004; Kofman, 2002; Mulder et al, 2002; Wadhwa et al, 2002; Qiu et al, 2009; Kirki et al, 2009; Dingel et al, 2014).o New mothers experiencing anxiety have been found to interact less skillfully and communicate less with their infants (Field et al, 2005; Manassis et al, 1995).o Mothers with anxiety disorders are more likely to have children who are behaviorally inhibited and insecurely attached (Schreier et al, 2008; O’Connor et al, 2002; O’Connor et al, 2003; Mennes et al, 2006).4. <i>Pregnant and postpartum individuals’ visit a healthcare provider an average of 25 times</i> during the perinatal period for routine obstetric and pediatric care, offering ample opportunity to discuss and screen for anxiety.
PRACTICE CONSIDERATIONS
<p>Assessment of Risk.</p> <p>Prenatal anxiety has also been identified as a very strong predictor of postpartum depression (Matthey et al, 2003; Robertson et al, 2004; Sutter-Dallay et al, 2004).</p> <p>Risk factors identified for both perinatal mood and anxiety include being Hispanic, low socioeconomic situation, low educational attainment, lack of stable partner relationships, history of psychiatric illness, adverse circumstances around the pregnancy and birth, history of interpersonal violence, adverse life events, high perceived stress, being single, and unplanned or unwanted pregnancy (Grote et al, 2010; Robinson et al, 2016; Furtado et al, 2018; Leach et al, 2017; Biaggi et al, 2016).</p>
RECOMMENDATIONS OF OTHERS
<p>The following organizations also recommend screening for mental health disorders during the perinatal period:</p>

- The American Psychiatric Association recommends that all pregnant and postpartum women should be assessed for the presence of and the risks for a psychiatric disorder at least twice during pregnancy and at the 1-, 2-, 4-, and 6-month well-child visits. (APA Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum, 2018).
- The Association of Women’s Health, Obstetric and Neonatal Nurses maintains that individuals should be screened for mood and anxiety disorders, especially during pregnancy and the postpartum period. It is imperative that on-going screening and referral to treatment occurs in both the perinatal and pediatric setting. (AWHONN Position Statement, Perinatal Mood and Anxiety Disorders, 2022).

TABLE 1: SUMMARY OF USPSTF RATIONALE

The table includes the following statement: For pregnant persons, there is inadequate evidence on pharmacotherapy.

This statement is not correct. There is evidence that pharmacotherapy are effective and often indicated in pregnant and postpartum persons; see section above (**Treatments or Interventions**). This statement is not correct. Articles with information regarding the use pharmacotherapy in pregnant and postpartum persons include:

- Dalfen, 2019: Perinatal Mood and Anxiety Disorders: Pharmacotherapy.
- Goulding et al, 2022: Pharmacologic Treatment for Perinatal Mental Health Disorders.
- Laskey, 2022: Antidepressant Use in the Breastfeeding Patient.
- Payne, 2016: Psychopharmacology in Pregnancy and Breastfeeding.
- Viswanathan et al, 2021; Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Meta-analysis of Pharmacotherapy.