

ONE PATHWAY TWO LIVES INTEGRATING  
PRECONCEPTION AND PERINATAL  
PSYCHIATRIC CARE: MODELS, CHALLENGES  
AND SOLUTIONS

**GOOD PRACTICE GUIDELINES AND GAPS IN SERVICES DURING THE INTEGRATION OF  
CARE**

DR.SARMISHTHA CHAKRABARTI

DPM, FRCPSYCH (UK)

CONSULTANT PSYCHIATRIST, MANIPAL HOSPITAL ,KOLKATA ,INDIA

# CLINICAL EVIDENCE BASE

- **PREVALENCE AND MORTALITY IMPACT**

Depression and anxiety affects 15- 20 % of women perinatally

Untreated conditions increase adverse outcome 2-3 fold .

Maternal suicide remains the leading cause of indirect maternal death in developed countries ,with recognition rate below 10% in south asia.

Burden in South Asia is depression prevalence of 18-47%, Anxiety 8 -35%

Risk factors being gender based violence , poverty, limited autonomy,high stigma and a treatment gap of more than 80%.

## **TREATMENT OUTCOMES ACROSS PHASES**

Integrated care models demonstrate significantly improved outcomes when treatment is provided preconception, antenatal and postpartum compared to untreated populations, supporting evidence based intervention strategies.

# Why integration matters

<b>MATERNAL MENTAL HEALTH MATTERS</b>	<b>PRECONCEPTION PLANNING BENEFITS</b>	<b>EARLY IDENTIFICATION ADVANTAGES</b>	<b>CONTINUITY OF CARE OUTCOMES</b>
MATERNAL MENTAL HEALTH DIRECTLY DETERMINES INFANT NEURODEVELOPMENT , ATTACHMENT SECURITY AND LONG TERM PSYCHOLOGICAL OUTCOMES OF CHILDREN	PRECONCEPTION PLANNING PREVENTS MEDICATION DISCONTINUATION RISKS ,ENSURING SAFE PREGNANCY MANAGEMENT AND REDUCING RELAPSE COMPLICATIONS	EARLY IDENTIFICATION OF MENTAL HEALTH CONDITIONS REDUCES PERINATAL CRISIS PRESENTATIONS AND EMERGENCY INTERVENTIONS DURING VULNERABLE PREGNANCY PERIOD	CONTINUITY OF CARE IMPROVES MEDICATION ADHERENCE , PSYCHOSOCIAL SUPPORT, CONSISTENCY AND OVERALL TREATMENT ENGAGEMENT THROUGHOUT PERINATAL PERIOD.

# CURRENT SERVICE FRAGMENTATION

- Primary care, OB/gyn and psychiatry operate in silos with minimal communication and coordination between specialities

FRAGMENTED  
CARE MODEL

- Unified coordination across all disciplines ensures seamless communication, timely diagnosis and comprehensive perinatal mental health support.

INTEGRATED  
CARE MODEL

- Lack of coordination causes delayed diagnosis, medication uncertainties and inadequate perinatal mental health training

KEY GAPS

# ESTABLISHED INTEGRATED MODELS

- **COLLABORATIVE CARE MODEL:** OB/GYN, psychiatry and primary care professionals partner to provide coordinated comprehensive perinatal mental health support services
- **PERINATAL PSYCHIATRY CLINICS:** specialist led joint consultation between psychiatrists and obstetric teams ensure integrated assessment and treatment planning for pregnant patients
- **PRIMARY CARE LED SCREENING:** universal mental health assessment with psychiatric consultation backup enables early identification and intervention in community settings
- **COMMUNITY MIDWIFERY MODEL:** midwives for early identification ,support and referral of perinatal mental health concerns.

# PERINATAL PSYCHIATRY BEST PRACTICE GUIDELINES

Preconception Risk Assessment	Antenatal Care Pathway	Intrapartum liaison	Postpartum intensive support	Long term follow up
Evaluate mental health history, medication safety profiles ,and psychosocial factors comprehensively for pregnancy planning	Monitor trimester specific changes, review medications regularly, and implement psychosocial interventions throughout pregnancy	Coordinate obstetric psychiatric care , communicate clinical risks and develop individualized birth management plans collaboratively	Screen early for complications, facilitate mother infant bonding and engage family members in recovery support	Review child development outcomes, assess maternal recovery progress, and implement recurrence prevention strategies systematically.

# Evidence from leading Health care systems

- **UK perinatal mental health services**

Integrated model implementation achieved 45% reduction in maternal suicide rates between 2016 -2020 demonstrating significant clinical impact and effectiveness of coordinated care delivery.

- **Australia s PIMH Model outcomes**

Model demonstrated 35 % improvement in treatment engagement and 50% reduction in hospital admissions ,highlighting enhanced accessibility and reduced need for acute interventions

- **NICE guidelines CG192-** antenatal and postnatal mental health

Covers recognition, assessment and treatment of depression , anxiety disorders, eating disorders , substance use disorders and severe mental illness( schizophrenia and bipolar disorder) in women planning pregnancy , pregnant or up to 1 yr postpartum.It emphasizes shared decision making , stepped care models and continuity of care across primary care , obstetrics and psychiatry

**WHO guidelines** for integration of perinatal mental health in maternal and child health services.

Focusses on integrating mental health screening and basic interventions into antenatal care and post natal check ups, especially in low resource settings.

Recommends using brief validated tools ( eg PHQ-9,EPDS) and training non specialist providers to detect and manage common perinatal disorders.

- **CANMAT 2024 guidelines** on perinatal mood and anxiety disorders ( PMAD)
- Provides updated recommendations for depression , anxiety, OCD and PTSD in the perinatal period including pharmacological and psychotherapeutic options
- Highlights rapid risk assessment ( suicidality , harm to infant ) and multimodal care ( medication , psychotherapy and social support).

# South Asian landscape

- **Political environment**

Limited integration of maternal mental health policies within national health care frameworks.

- **Social environment**

Persistent stigma around mental illness affects treatment seeking behaviour .Gender role constraints limit women's autonomy in health care decisions .Limited family support and deep rooted cultural barriers impede psychiatric treatment engagement.

- **Economic environment**

Insufficient budgeting dedicated to perinatal psychiatry services.

- **Technological barriers**

Underdeveloped digital health infrastructure limits mental health service delivery capabilities .Telemedicine capacity remains severely constrained .Fragmented data systems hinder integrated care coordination and information sharing.

# DEEP ROOTED CHALLENGES ,PERCEPTIONS AND BARRIERS

<p><b>Son Preference</b> Cultural preference for male offspring creates profound psychological distress, with research showing odds ratio of 2.6 for perinatal depression among women with unwanted girl children.</p>	<p><b>Economic hardships</b> Poor economic conditions , financial stress and lack of resources creates chronic stress that manifests as depression and anxiety during vulnerable periods.</p>	<p><b>Health comorbidities</b> Preexisting physical health conditions including anaemia, gestational diabetes and chronic illnesses compound mental health risks during perinatal period</p>
<p><b>Unwanted pregnancies</b> Lack of reproductive autonomy and unplanned pregnancies contribute substantially to perinatal mental health vulnerability and distress.</p>	<p><b>Limited support</b> Absence of family support systems , particularly from partners and in laws , significantly predicts perinatal depression across south Asian countries</p>	<p><b>Stigma and shame</b> Deeply internalized stigma around mental illness prevents disclosure and help seeking with women fearing judgement , rejection and damage to marriage prospects.</p>

# DYADIC AND HOLISTIC FOCUS

- Treat the mother and infant as an interconnected unit .
- A dyadic focus involves
- Facilitating bonding
- Integrated physical support with breast feeding and sleep support.
- Coordinated monitoring –systematic review of child development outcomes alongside assessment of maternal recovery progress
- Mother –baby units-in severe cases referral to specialized MBUs where mother and baby can stay together.
- Family centred recovery-involving family members in the recovery process
- Long term prevention by focusing on the dyad , model aims to implement recurrence prevention strategies that protect mother from relapse.

# Critical services gaps in South Asia

- **1. Community level gaps** –no early detection mechanism , limited awareness and poor linkage to care preventing timely community based intervention and support.
- **2. System level challenges** -absence of integrated national guidelines and fragmented policy frameworks limiting coordinated mental health care delivery across regions.
- **3. Lack of dedicated perinatal psychiatry services** with minimal obstetrics psychiatry coordination impeding comprehensive patient care.
- **4. Operational level deficiencies** inadequate work force training in perinatal mental health and insufficient screening protocols reducing early intervention capacity.
- **5. Insurance policy gaps**- Largely many of the Hospital set ups are private which is expensive and if there is a psychiatry label insurance refuses to pay the benefits.

# Regional challenges and barrier

- **Workforce crisis**- only 0.3 % psychiatrists per 100k population vs 2.5 globally with minimal perinatal specialization available.
- **Infrastructure gaps**-limited maternal mental health clinics and no integrated OBG-psychiatry units exist in most regional settings.
- **Training deficits**-Obstetric curricula lack maternal mental health content,psychiatry training also has very little perinatal training.
- **Evidence scarcity**-limited south Asian research on perinatal mental health outcomes and service delivery models available recently.

# Proposed solutions for South Asia

- **Core strategy**-phased implementation of integrated care through capacity building and systematic policy reform for sustainable progress.
- **Evidence Based guidelines**-develop national perinatal mental health guidelines grounded in evidence for standardized care across regions.
- **Workforce development**-Establish comprehensive training programme for obstetrics and psychiatry professionals to enhance service delivery capacity.
- **Integrated care models**-create integrated clinic models in tertiary centres enabling coordinated preconception and perinatal psychiatric care delivery.
- **Community based support**-Launch community screening and psychosocial support programmes extending mental health services to underserved population
- **Digital solutions**-leverage digital tools and telemedicine addressing resources constraints in South Asian healthcare systems.

**Let's commit to  
Bridging these gaps  
... For two lives , one  
Pathway and a  
Healthier future  
Together.**

**THANKYOU**

