Connecting All Birthing Parents with Perinatal Mental Health Services

Nydia Ntouda: On today's webinar, we have Darius Tandon, who will take it away from here. He will officially introduce himself. Darius?

Darius Tandon: Thanks so much for that introduction. Really delighted to be speaking to such a large group from all over the country and territories today. Very quickly, who am I? I'm an associate professor at Northwestern University's School of Medicine. I also direct our Center for Community Health.

I'm trained as a psychologist – a community psychologist and prevention researcher, and have been doing a lot of work in the early childhood and home visiting space for about two decades now. The topic today is one that is really near and dear to my heart in terms of how we are going to improve the health and particularly, the mental health of perinatal individuals. Next slide, please.

I want to start by trying to give you a sense of the landscape of where we are around addressing perinatal mental health. Many of you might be familiar with what I'm presenting in the next couple of slides. But I do think it's useful to give ourselves a pat on the back and give ourselves credit for things that we are doing well.

If we had been doing this webinar about a decade ago, I think it would be safe to say that we weren't doing a lot of screening for maternal depression. But we have national organizations like the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and others that really have been at the forefront of recommending screening for maternal depression and anxiety during the course of well-child visits, OB/GYN visits, and primary care.

We really have seen a huge uptick in the systematic screening for maternal depression. And we also know that there are an increasing number of states that are reimbursing for depression screening. These are positives. We also know that there are states that have actually enacted legislation related to perinatal mental health, requiring postpartum depression screening or education about postpartum depression. Many states have created awareness campaigns or task forces. Again, a lot of positives we can point to in terms of what we are doing. Next slide, please.

We also know that there are treatment and prevention approaches, particularly counseling and psychosocial interventions, that are effective in addressing perinatal mental health. About three years ago, there was a report put out by the U.S. Preventive Services Task Force Report on effective intervention strategies for preventing postpartum depression. More recently, there has been a systematic review on perinatal depression treatment interventions.

Without getting into all of the details, both of these reviews have indicated that there are indeed effective treatment approaches and preventive approaches for addressing perinatal depression and other perinatal mental health disorders. Next slide, please.

But let me pivot now and say that even though we have made considerable progress, the question that I always ask myself, my colleagues is, can we do more? I want to share just a few statistics with you that suggests that maybe we need to be doing more to be able to address the scope of need around perinatal mental health.

We know from 1997 to 2010, there's been a huge increase in unmet need for mental health services. Now I will say that statistic predates the emphasis on mental health screening and coverage for mental health that came from the Affordable Care Act or ACA. Nonetheless, what we have seen is that there is an increased need.

This also doesn't really take into consideration all of the emerging mental health needs that have come to the forefront in the last few years during the pandemic and on the heels of the COVID-19 pandemic. We also know that if we're looking at population rates of depression, those population rates of perinatal depression are not decreasing, and in fact, they are increasing.

Many of you are probably familiar with the pregnancy monitoring system, the PRAMS data that is run through the CDC. And if we take a snapshot at some of those PRAMS data from 2016 and then again in 2020, what we see is that there are actually increases in self-reported depressive symptoms three months before pregnancy. Increases in self-reported depression during pregnancy. Increases in self-reported postpartum depression. Postpartum depression symptoms.

This is all to say that yes, there's a lot that is being done at a state level; yes, there is work that is being done to systematically screen; yes, there are effective treatment and prevention approaches. But if we look at these data, we're not seeing the sorts of decreases in depressive symptomatology at a population level that we would really like to see to be able to say, “Hey, we really are doing a better job of addressing the mental health needs of perinatal individuals.” Next slide, please.

I want to now start to pivot in thinking about what should we be doing and what could we be doing? I like to think about these approaches through an implementation science lens. Without getting too geeky, too in the weeds with research terminology, I just want to briefly define what we mean by implementation science if folks aren't familiar with that phrase.

Implementation science as a field of study that really looks at methods and strategies that facilitate the uptake of evidence-based practice and research. So things that work, evidence-based things that work into regular use by practitioners and policymakers. The fundamental questions answered by implementation science are really on understanding how we get what works – the things with evidence – to the people who need it with greater speed, fidelity, efficiency, quality, and coverage. Next slide, please.

If you take a look at the implementation science field, there are a number of key implementation science outcomes that people speak to. There are two outcomes that really resonate with me, and I think resonate with the field when we think about whether we are doing a good job of improving the perinatal mental health of individuals.

The first outcome has to do with the reach of our approaches. When we talk about reach, we're talking about the number, the proportion, and also the representativeness of individuals who are willing to participate in a program, a service, or an intervention. An engagement is the extent to which individuals actually receive that content and actively participate in those programs or intervention activities. I really think of – and others think of – reach and engagement as issues of equity.

If we think about reach and engagement, the question that I like to reframe is and say is, are some perinatal individuals not able to easily receive – that's the reach piece – and/or participate – that's the engagement piece – in services or interventions aimed at improving perinatal mental health? I really want folks to be sort of thinking about the remainder of the webinar today from this perspective of, are we getting the things that we know that work to the range of perinatal individuals who can benefit from them? Even if we are getting it to them, are they actually engaging in those services, programs, and interventions? Next slide, please.

When we think about engaging perinatal populations, we really need to be thinking about how to reach and engage this diverse set of perinatal individuals. Going back to that previous slide, we know that if we are going to make a dent, if we're going to turn that curve down and start to see reductions in population-level depressive symptomatology and improve other mental health outcomes, what we need to do is we need to get our interventions into the hands and engage with different perinatal groups.

What you see on this slide are different specific perinatal populations that we really need to be thinking about doing work differently with in order to effectively reach and engage these populations. The remainder of the talk is really going to focus around different considerations and different approaches for working with racial and ethnic minority perinatal populations, sexual and gender minorities, immigrant and refugee populations, and tribal and Indigenous communities. Next slide, please.

What do we know about prevalence of mental health among diverse perinatal populations? We know that there are a number of studies that indicate that new mothers of color – African American mothers, Latina mothers, Asian American, Native American mothers – often have rates of postpartum depression higher than rates among all new mothers.

Really saying that there is something going on such that new mothers of colors are presenting with more depressive symptomatology than if you took a look at all mothers as an aggregate group. We also know that there's variability in prevalence based on the timing of assessment. We might see more depressive symptomatology at certain points in time, and we might see variability based on the screening tool that's being used.

Related to timing of assessment, something I'm not going to spend a lot of time talking about today but do think it's important for me to mention at least at this slide, is oftentimes, screening is done just at one point in time prenatally. We do know that there is this sensitive window about three to six months after delivery where we tend to see an uptick or a spike in depressive symptomatology.

Depending on when you are doing screening or your assessment, you might see some variability. It also speaks to the importance of potentially doing rescreening in that postpartum period between three to six months, recognizing that there may be an increase in symptomatology during that time point.

We also know that there is limited research on certain subgroups. We need to be careful when we talk about new mothers of color that are Asian American because Asian Americans are not a monolithic entity. Similarly if we're talking about sexual and gender minority individuals, that is not a monolithic entity. We just frankly don't have as much research right now disentangling prevalence rates for individuals from different Asian American ethnicities, for example, or lesbian versus bisexual individuals, for example.

I think that's another important point that I wanted to raise here. And certainly, as we move forward over the next few years, I think we are seeing more research being done across the country really trying to understand prevalence rates among these diverse subgroups. Next slide, please.

We also know that despite elevated risk for poor mental health, these diverse perinatal populations are typically less likely to seek mental health care than their less diverse counterparts. There's an article published just a couple of years ago that indicates that racial and ethnic minority birthing individuals are less likely to consult providers for poor mental health even when they have elevated depressive symptoms.

This is to say that, if you take a look at the previous slide and the current slide, we know that there are elevated rates of depressive symptomatology with diverse perinatal populations, but we're not seeing the uptake in engagement in mental health services with this population.

If we link this back with some of the earlier slides, maybe we are screening, maybe we are identifying individuals who could benefit from services and supports and interventions. But this slide suggests that unfortunately, even when we're identifying folks, we're not getting those individuals to the right types of services and supports. Next slide, please.

I also want to mention fathers. We're not going to be doing a deep dive into paternal depression today. But very quickly, we do know that paternal depression prevalence is estimated around 10%. Similarly, we see a spike three to six months postpartum. Paternal depression disproportionately affects low-income men across racial and ethnic groups.

Men who have partners who suffer from perinatal depression are 25% to 50% more likely to experience perinatal depression than men with partners who do not suffer from perinatal

depression. And we do know that perinatal depression independent of maternal depression – I think that was cut off at the bottom – independent of maternal depression, paternal depression is associated with negative parenting behaviors and child-internalizing and externalizing behavior.

I wanted to acknowledge that today we're not going to be doing the deep dive into fathers. In the coming year, there are plans to do a deeper dive, a webinar around paternal depression. But today, I'm really going to be focusing over the next few minutes on what is the state of affairs? What do we know about effective ways of engaging diverse perinatal populations other than fathers? Next slide, please.

We know that social determinants of health matter. These are conditions in environments where people are born, live, learn, work, play, worship, and age. And we know that diverse perinatal populations, mental health status is disproportionately impacted by these social determinants of health.

Again, if we think about those elevated prevalence rates or those prevalence rates that are greater among diverse individuals than non-diverse perinatal individuals, we know that things like racism and discrimination, trauma experiences, language and literacy skills, education, job opportunities, et cetera – these are things that matter. These are things that do impact perinatal mental health.

I want to present that up front because again, as we move forward with the webinar today, you'll see that many of the considerations really speak to how do we develop approaches, how do we implement approaches to meet the mental health needs of diverse perinatal populations that are, in some ways, trying to address these social determinants of health that we know matter in the lives of our perinatal populations that we're working with? Next slide, please.

Now, I'm going to start drilling down a little bit more into some of the specific perinatal populations that you saw on a previous slide. If we start by talking about Black or African-American birthing individuals, we know that Black birthing individuals tend to be – they're more likely to be the primary or sole head of household and be single.

We also know that being the primary head of household, being single, these are things that can be additional stressors that may relate to one's mental health. We also know that showing strength in high-stress moments is culturally sanctioned. There's been quite a bit of qualitative research that has been done that shows that Black birthing individuals internalize expectations of strength and don't allow stress to interfere with caretaking.

It's almost like the stress is there, but it's not being acknowledged. It's just something that is present and one needs to deal with. Sometimes this is a way of interfering with someone really recognizing that there is a need to address one's mental health needs when you have internalized these expectations of strength.

Also addressing stigma and shame around mental health services is an important starting point for service providers working with Black birthing individuals. I say that because one of the recommendations that you see in the literature is in working with Black or African American birthing individuals, a recommendation to develop or adopt resources that provide education on mental health symptoms and help-seeking behaviors.

Where this recommendation is really taken us is saying, as a starting point, we may not want to say, “Hey, here's a referral to a mental health service provider or a community mental health provider.” There may be stigma, there may be shame, there may be other issues that are interfering with Black or African American birthing individuals engaging in those referrals to mental health services.

As a starting point, as service providers, we need to be thinking about just providing some psychoeducation on what mental health or poor mental health might look like and what health-seeking behaviors might look like and what they could accomplish. Again, this idea that it's normal to have stress, but it's also OK to try to figure out approaches to address that stress that you are dealing with in your life. Next slide, please.

If we think about Latina birthing individuals, we know that gender roles and stigma may prevent Latinas from seeking mental health services. A colleague of mine at the University of Illinois Champaign-Urbana has done a lot of work on the concept of Marianismo, this notion of self-sacrificing individuals where motherhood and taking care of one's children and one's family comes first. As a result, self-care and taking care of one's own mental health is not prioritized. And in turn, that lack of prioritization in terms of one's own mental health care and self-care is associated with elevated depressive symptomatology.

We also know that there is emerging research that in Latina households, social support from a partner or a father is a very strong protective factor. A recommendation, again, that we see in the literature is, if you are working with Latina birthing individuals, recognizing that there are challenges in engaging with the entire ecosystem to really think about, are there ways to work not just with a perinatal individual, a birthing individual, but also their partner or the father of the baby?

Again, I recognize that this comes with some challenges if we're thinking about engaging an entire family unit. But based on what we around some of the gender roles and social support from partners and fathers in Latina households, this really seems to be an important recommendation for service providers to think about in terms of working with Latina birthing individuals. Next slide, please.

When we think about sexual and gender minorities, a couple of slides here and a few thoughts about approaches to working with this particular group of diverse perinatal individuals. This first comment is not necessarily unique to the perinatal period. But one of the things that is really important to consider is just the notion that many birthing individuals will not report their sexual or gender orientation to health care providers for fear of discrimination.

What does that mean? It means that the onus is really on you all, us as service providers to be asking the right question about sexual and gender orientation. These are a couple resources. And when you get the slide deck, you can click on these, and you'll see that these are resources on how would you actually engage initially in questions asking individuals about their sexual and gender orientation. Again, these resources, I think, can be helpful in having those initial conversations.

Then also, how do we connect sexual and gender minorities with supportive individuals or networks? In thinking about the types of resources and supports that we provide for perinatal individuals, many times the lists of resources that we provide are not ones that are going to be as accessed or as used by sexual and gender minority populations. Really, the idea here is to develop lists of SGM-focused social supports, social support groups that can be shared that are going to be more specific to sexual and gender minorities. Next slide, please.

We know that there are a couple of specific support lines specific to sexual and gender minorities. Again, both of them are listed here. The second one is probably one that many of you at least have heard of, the Trevor Project, which is more specific to adolescents or young adults. Again, I provide these resources because I think as we're thinking about improving perinatal mental health for diverse populations. Some of that does fall on us as service providers, but some of this also is providing access to resources and information.

Some of this might be information that you would provide to your clients who are sexual and gender minorities so that they can have additional resources or access to additional supports beyond what your program or agency might be providing. The second bullet point, really important, and I know that many of you have done this or are doing this already. If you're not, really important point around adapting language in program materials to be more affirming of sexual and gender minorities.

You can imagine, if you are a sexual/gender minority coming to a Head Start, an Early Head Start program and you see language that is not affirming of who you are in terms of your identity, that could be very off-putting. It may be something that keeps you from actually enrolling in a program or engaging in a program.

Very, very small things like changing language from pregnant woman to birthing individuals, changing imagery on your program flyers, brochures, and participant-facing materials. There's lots of, thankfully now, publicly accessible stock photos that one can download from the internet that are going to be more affirming of sexual/gender minorities. Again, I know many of you are already doing work in this area, but would really implore you to really think about this, because these program flyers and brochures, these are often the first things that families and clients are seeing when they're engaging in a program.

We also know that there are evidence-based preventive interventions that have been adapting materials specific to SGM. There is an intervention called ROSES that initially came out of Brown University. They are now doing work nationally. They do a lot of work in the context of pediatric primary care. Then the intervention that I have been working on for the last 10 to 15 years,

“Mothers and Babies,” we're in the process right now of developing adaptations of our curricula. We're calling it Parents and Babies to really be more inclusive of the array of sexual and gender minorities who are engaging in programs who could benefit from mental health resources.

I provided the websites for both of these interventions. And certainly, any questions related to “Mothers and Babies,” I'm happy to field direct questions about that as well. Next slide, please.

If we think about immigrant and refugee populations, we know one of the key considerations here is around promoting social cohesion and facilitating development of social networks. The reason for that is that may be more acceptable and feasible for immigrant and refugee populations than linking to, quote, "traditional mental health providers."

I say here that Early Head Start programs can really service catalysts for developing these social networks. These are things – these networks might be things that you would be doing through your agencies or through your systems. It can be a really important starting point for getting immigrant and refugee populations to be talking about mental health given that reluctance or sometimes skepticism of accessing more traditional mental health resources.

Then the second bullet point, to really think about developing alternative versions of participant materials. Again, I don't want to downplay the amount of time and the resources involved in doing this. But if you are working with individuals who have lower literacy levels, you can imagine that many immigrant and refugee populations, English may not be their first language. If you are presenting them with materials that are very text-heavy, that is going to be very hard for folks to, again, engage. Going back to those implementation science terms of reach and engagement.

Here, we may be able to get somebody to participate in Early Head Start or participate in mental health services, but are they really going to be able to engage if they aren't able to understand the material that is being provided to them? Increasing visuals and pictures, using emojis can be really useful approaches for engaging with these immigrant and refugee populations. Next slide, please.

Just showing this a little bit more. There are some screening tools that have been developed. There is a tool called the Emoji Current Mood and Experience Scale. And instead of using numbers and words to depict how stressed or how you feel, you have emojis, similar to what you see on this screen. Again, this is just one example of ways that you can take text and turn it into something that might be more visually engaging for some of the perinatal populations that you're working with. Next slide, please.

When we think about tribal and Indigenous communities, we know that there's a huge importance of culturally appropriate mental health care. We know prayer, ceremony, storytelling, interactions with traditional healers are very distinct from Western mental health care. I want to highlight that those approaches are culturally appropriate, culturally sanctioned,

and can really be thought of as complementing, or in some cases perhaps even replacing more traditional mental health services and supports.

Again, I think as service providers, you need to think about the extent to which individuals who are from tribal Indigenous communities are able to and willing to engage in Western mental health care. Oftentimes, the starting point might be to say, “Hey, talk about emotions, feelings with a traditional healer or in other ways,” and that might be a stepping stone to start to engage in conversations with more traditional mental health service providers.

Also really important to point out – and I'm sure those of you who work with tribal and Indigenous communities are familiar with these data around the added concern related to suicide risk with tribal and Indigenous communities. We know that rates are disproportionately high among tribal and Indigenous communities.

Really, really would implore all of you who are working with tribal Indigenous communities to engage in conversations about mental health and make sure that your agency and your system have suicide crisis resources available – that could be local, they could be national. But just given the prevalence rates that we know exist, making sure that you are equipped if, God forbid, somebody were to present with suicidal ideation or even a suicide plan.

If you are using a depression screening tool that does not ask about suicidal ideation – there are different depression screening tools that exist. Some do ask about suicidal ideation, some do not – if you use one that does not, I would encourage you to consider asking the questions around, are you thinking about harming yourself, killing yourself? Are you thinking about ending your life?

Being very, very direct. These are actually recommendations out from the field about being very, very direct in your wording, to be able to understand really the intent and the urgency of responding to potential risk or self-harm. Next slide, please.

We know that pregnancy in tribal Indigenous communities is viewed as a sacred journey and a gift from the Creator. Indigenous perinatal individuals are really taught to honor traditional teachings. We also know that support – because pregnancy is viewed as a sacred journey – we know that support from family and friends may be greater during pregnancy, but that support may taper off in the postpartum period.

Again, going back to things that we know that are true of all perinatal populations and also specific to the tribal and Indigenous perinatal populations, we do see increases in perinatal depression rates in that postpartum period. Knowing that for tribal Indigenous communities, we may see some of that tapering off of social support. It may be really important to reassess where folks are with their stress and depressive symptoms in that postpartum period. Next slide, please.

The next few slides are now going to talk more about cross-cutting recommendations. You saw in the previous slides, what I tried to do is give you a sense of some considerations and also

some things that might be specific for different types of diverse perinatal individuals. These next few slides are really intended to be more cross-cutting and potentially more applicable to all of those perinatal groups that I just mentioned.

I've talked about screening a few times, and I do think, again, screening is more systematically done now, and that's a real positive. But as you are thinking about the screening that you might be doing, some considerations for you in terms of things that you may want to do to change your approaches. Do you have the screening tool available in all of the appropriate languages? There are some screening tools that have been translated into a number of different languages.

Really encourage you to normalize the experience of screening. Even a question around, “Hey, we ask all mothers about how they are feeling,” makes it less stigmatizing when you are responding to questions about stress and mental health. Then also the importance of using clinical judgment when screening might be influenced by stigma, literacy, or trust. And what do I mean by that? I mean that there may be some cases where you do screen for depression or anxiety, and you might see a score that is really low.

And you as a service provider might say, “That doesn't really track with what I'm seeing or what I'm sensing as I'm working with that individual.” I don't want us to be so beholden to screening tools that that is all that we rely on. Really, really trust your clinical judgment because there may needs that you can clearly identify from your encounters and interactions with families that you're working with that maybe that screening tool isn't going to pick up on.

I mentioned this idea of time and periodicity of screening. I mentioned that research suggests that there may be different sensitive periods depending on the perinatal population, particularly in that three to six months postpartum. Again, I really would encourage you to think about screening both during pregnancy and the postpartum period. Next slide, please.

When we think about addressing social determinants of health, really important that we as service providers acknowledge and normalize the impact of social determinants of health. We want to really indicate that we know that these are things that matter and impact health and mental health and facilitate emotional awareness, regulation, and acceptance. Perhaps most importantly, that third bullet point, attribute challenges to social determinants rather than personal failings.

We see a lot of families who will say, “Well, I'm not able to do this, or I feel like I'm not doing this effectively.” Sometimes we start to think about that as a personal failing or something about ourselves as individuals. When in fact, the reason that we might be feeling that way has so much to do with the social determinants of health that exist in our lives, whether it's related to housing or education or finances.

That's a really important reframe that I would encourage all of you to think about as you're working with perinatal populations, to really get folks to do that pivot in thinking from personal failing to, “Hey, there's a lot going on in my environment that might be impacting the way that I feel.”

Recognize the importance of cultural humility and understanding and addressing the needs of birthing individuals with these different lived experiences. Also validate and build on the strengths of diverse perinatal populations. I mentioned a couple of minutes ago an adaptation that we have done of our “Mothers and Babies” curriculum for sexual and gender minorities.

We actually just recently completed an adaptation of our intervention for tribal and Indigenous communities working closely with folks in South Dakota that are part of the Lakota Tribe that incorporates the seven sacred laws of the Lakota. Really trying to build on the strengths of the Lakota population. That's just an image of what the cover art looks like on our revised intervention. Next slide, please.

When we talk about promoting social support. You've heard me say a few times this idea that it's really important to think about ways that we can develop social support networks for perinatal individuals because there may be reluctance or skepticism, stigma, shame around seeking formal mental health care. I would encourage programs to develop or expand your activities that can provide that social support. Again, acknowledging that takes time and that takes resources on your part.

There are also national groups. Postpartum Support International, Postpartum Progress, which have both in-person and online support groups. Bottom line here is, really important for you to think about ways that you could be meeting the needs of your perinatal populations by providing more opportunities for support, but don't feel like you have to do it all. There are these national organizations that you can also work with and link clients to that will be very helpful in that regard. Next slide, please.

You saw in the earlier slide where I talked about social determinants of health, the importance of trauma, and the relevance of trauma. When we think about addressing mental health, it's really important to think about ways that our approaches may need to be trauma informed.

If you think about trauma-informed approaches, we really see trauma informed approaches as incorporating a trauma-sensitive environment, trying to ensure a sense of safety in interactions with families, providing education for families on the connection between trauma and one's health and mental health, and then linking to resources and referrals that are more specialized.

That second bullet point I think is really one of the main takeaways here, that this idea of focusing on trauma does go above and beyond what many providers do to address perinatal mental health threat. Many of you may have gone through some trauma-informed trainings, may have some trauma-informed resources that you use. But I just want to acknowledge that trauma-informed approaches really do bring in a new set of considerations when we're working with families.

SAMHSA has a wonderful center on trauma-informed care with a lot of resources. Again, I would just encourage you to think about if you know that trauma is something that is highly prevalent in the populations that you're working with, to think about ways that you can provide

a core set of mental health services and supports. But also think about ways that you might be acknowledging trauma in your perinatal populations as well. Next slide, please.

There's one final thought, is that there are many things that we can do as service providers directly in working with families. But there are other things that I believe we need to be thinking about and influencing as service providers. We know that there's a lot of work that's being done right now to really promote Medicaid expansion.

If we are promoting Medicaid expansion through a child's first birthday, this would ensure more access to prevention and treatment resources. I know that we often feel a little helpless, perhaps, in terms of what our state might be doing around Medicaid and Medicaid expansion. I do believe that there is a place for us as service providers, as agencies, as systems to be advocating for some of these policy issues. Medicaid expansion being one.

I also think that there's a real set of interesting, emerging innovations around basic income strategies that we should be thinking about. Are these things that we can integrate into the work that we do as service providers or advocate for in the communities in which we work and live?

We know that things like cash transfers and universal basic income are being tested out in many places. And we know that finances are a key stressor for many perinatal individuals. If we go back to social determinants of health, we know that finances are a big issue. The question is, why aren't we doing more to address the fiscal piece? And I think that's where these basic income strategies fit in.

We also have a place helping to prioritize or incentivize expansion of the mental health workforce, including – and this is really important – practitioners who reflect the diversity of perinatal individuals. We know that there is a mental health workforce shortage, particularly diverse mental health providers. What can we do to incentivize more training, more resources for a diverse mental health workforce? Advocating for culturally congruent care among formal mental health providers and incorporating telehealth options.

This is all to say that these are things that we may not do directly as we are working with families. But these are all things that I would encourage us, again, to think about as service providers, as agencies, as systems, because these are things that we may also improve mental health of diverse perinatal populations similar to some of the earlier strategies that I just mentioned. Next slide, please.

This is a set of references. Some of the articles I cited are here. There were additional linkages to many of the resources in the slide deck. With that, I think we have about 13 minutes for questions. Really appreciate you listening to what I've shared and look forward to engaging with you over these next few minutes.

Steven Shuman: Thank you, Darius. This is Steve Shuman. I'm the director of Outreach and Distance Learning for the National Center, and just wonderful information to get us thinking

about this very important topic. Darius, a few questions have come in already, and we encourage other people to type into the Q&A box if they have more questions while we're speaking.

The first one is, you mentioned the parent – the Parents and Babies curriculum and development. Will you maintain the Fathers and Babies curriculum at the same time?

Darius: Yes. With our work that we're doing, just building on my comments about reach and engagement, we are really trying as a research program to figure out ways to improve the ways that we are reaching and engaging with diverse populations.

We, moving forward, hope to have the Parents and Babies materials ready to go in the next few months. The tribal Indigenous manuals are already available on our website. Our Fathers and Babies materials, we're going through just some slight revisions based on some feedback we've received from some of our father champions. I believe older versions might be on our website. If they're not, new versions will be there very soon.

We are definitely interested in promoting the use of all of those – Parents and Babies, the tribal Indigenous adaptations, and Fathers and Babies. Happy to engage with folks who are interested in using one or all of them.

Steve: Thank you. I'm sure that will make a lot of people very happy. You mentioned in one of the later slides about the workforce and the challenge to find a diverse workforce. Can you speak any more about that? About some strategies many programs may have had, their routine lists. But during COVID, people disappeared and …

Darius: Yep.

Steve: Go ahead.

Darius: Yeah, I would encourage the – my answer is going to be maybe a little bit circuitous. I do think it is a challenge, and I don't want to give this naive Pollyanna answer that, “Oh, you're going to be able to find the right mental health providers.” I do think it is a challenge.

What I would encourage folks to really think about are a couple of things. I put the links to Postpartum Support International, Postpartum Progress. I think that there are ways that individuals can access support outside of that traditional mental health provider model.

I know many perinatal individuals we work with say, "Oh my God, it was so wonderful to be connected with an online support group through Postpartum Support International or Postpartum Progress." I would encourage you to think about that perhaps as a stopgap if you are waiting for spaces to fill up with a service provider. I think that that's one viable approach.

The other thing that I would really encourage us to think about is, do we need to rely on formal mental health providers? I didn't really talk about this during the presentation. I know some of the work that we have done, and this is a real growing area of work, is to essentially sort of

transition mental health care from formal mental health providers to individuals who have less formal mental health training.

I think about our “Mothers and Babies” intervention. That intervention now is largely delivered by individuals who do not have formal mental health background. This is my way of saying that depending on what you are trying to do – now I would be cautious about working very intensively with somebody who's experienced a range of traumas. That might be something that you really want to link somebody with a formal mental health provider for.

I do think that there are interventions and supports that exist that individuals without formal mental health training, once they are effectively trained on those models or programs, can deliver. Again, my answer is less how to connect with those mental health providers, but what are some alternatives that might be viable?

Steve: Thank you. And we know that the Head Start and Early Head Start population, both staff and families, are diverse, and those are great opportunities there for them to support each other.

I just want to take a moment here. We got a bunch of questions about all the resources that you mentioned and the links. All of the URLs that are in the slides and have been mentioned today are in the handout. If you didn't download the handout from the chat, it will be sent with the recording in the next few days. Anybody who's registered, whether you attended or not, will receive all that.

The next question is about intersectionality, that idea that people fit in more than one box, if you will. If you are, for instance, an African American lesbian, can you reflect on the needs of meeting the needs of a perinatal population that fits into more than one spot?

Darius: Yeah. I think one of the things that I would really encourage providers to think about is understanding that intersectionality from the perspective of the family. I think oftentimes we may be quick to do the labeling of that intersectionality and not understand what it means to the perinatal individual.

As I sort take a look at the literature and see what other service providers recommend, again, I think that's probably where I would gravitate towards in terms of, before you say, “Oh, I'm going to link you with a certain type of resource, or I'm going to have certain types of conversations.” I think trying to ask some of those right initial questions to understand where somebody is coming from, where somebody is defining themselves, I think that that is a really important starting point.

I think – the other thing that I would mention there is when we start to talk about intersectionality, that also gets into the arena of, what are we necessarily know about different – I'm just going to call them subgroups. It's a terrible phrase, but just for the sake of conversation right now – what do we know about, as Steve gave the example, an African American lesbian individual?

Well, the specific data we have around that population might be fairly limited. I think there's also importance in us taking time to understand where that individual is coming from and really trying to, again, build from where that client is instead of saying, “well, we have all of the answers,” because I don't think we have all of the answers in terms of how we approach the intersectionality.

Steve: Thank you. The next question is, can you expand on strategies pivoting the failure mindset to one point towards the social determinants of health? It's so interesting to get this question that came up in another session yesterday. This idea that it's not personal failure and helping people move in that other direction.

Darius: Yeah. I'm somebody – again, I'm a psychologist. A lot of the intervention work that I do is using cognitive behavioral strategies. And I really do think that there are some specific cognitive behavioral strategies around reframing thoughts. If you were to look at the literature around Cognitive Behavioral Therapy or CBT, there are a lot of resources that would be publicly available. You can also take a look at some of the materials that we have developed with “Mothers and Babies” around reframing thoughts.

I think that's really where I would gravitate towards. Once we get a thought in our head, that tends to be the way that we think. And really, there's two steps. One is for us first to identify that thought that we have and that thought pattern. That's important for us to first understand that, “Oh, we're attributing this to a personal failing.” That's a first step. Then the second step is, what are some strategies for doing that reframe?

Just one quick example. We always talk about things overgeneralizing. Some families overgeneralize, or some families will blame themselves for things that happen. Instead of saying, “Well, this bad thing happened to me or my child because of a personal failing,” you can reframe that thought pattern to, “Oh, there's just a lot going on in my environment. I wasn't able to support my child in a certain way.”

I think it's identifying that unhelpful way of thinking and then trying to put in place some of those reframes. Again, not just our intervention, but other cognitive behavioral interventions, I think, can be really helpful in doing that reframe. And I think you'd be able to find some really good resources online in terms of how to do those reframing of thoughts.

Steve: Thank you. Last question. It seems like a good one to end on. You mentioned throughout the presentation about individual, cultural, and community strengths. I wonder if you could speak a little bit more about that, how they're identified and how to best help our family members access the resource of their own inner and cultural strengths.

Darius: Yeah. I know that Early Head Start does a lot of work in an engaged fashion with the families and the communities they work with. I think a lot of the work that we do comes from this engaged perspective as well.

What I would really encourage providers to do if you haven't already, or even if you have, is to just continue to have dialogue with your stakeholders, particularly the perinatal individuals – the diverse perinatal individuals that you are serving and working with to really understand some of those cultural and contextual considerations. Because we, as service providers, we may have an understanding, but the landscape changes. There are new resources that become available, there are new considerations that we need to think about.

I would really just encourage this ongoing engagement with the stakeholders that you're working with really to help guide some of those cultural considerations and cultural resources that you may want to develop, or you may want to revise. Because I think that's going to make whatever you develop be most relevant when it's responding directly to what your stakeholders are articulating their needs being.

Steve: Thank you so much, Darius. Now, we're going to turn it back to Lydia to close us out. I'm sure people have a lot to reflect on. Nydia?

Nydia: Sure. Thank you so much once again, Dr. Darius Tandon. Thank you, Steve Shuman for moderating the questions. If you have more questions, you may go to MyPeers or write to health@ecetta.info. The evaluation URL that will appear when the webinar ends. Do not close the Zoom platform or you won't see the evaluation pop up.

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