



ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH



Perinatal Mental Health Conditions

Element Implementation Details



Perinatal Mental Health Conditions

Readiness — Every Unit

| Readiness Element | Key Points |
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| Develop workflows for integrating mental health care into obstetric care during pregnancy through the postpartum period including provision of pharmacotherapy when indicated. | <p>While integrating perinatal mental health care into obstetric practice has common core elements, it requires tailoring that accounts for the specifics of each unique obstetric care setting.</p> <p>The following core strategies, aims, implementation phases and steps are aligned with general approaches to quality improvement efforts and were specifically developed for the integration of obstetric and mental health care. Additional information and details can be found in the Lifeline for Moms self-guided 'Guide for Integrating Mental Health Care into Obstetric Practice,' which is supported by 4 how-to videos. (See Resources)</p> <p>Core Strategies:</p> <ul style="list-style-type: none">• Identify champions and establish a quality improvement team that identifies and implements needed practice change(s)• Conduct a baseline assessment, establish measurable goals for change, design and implement needed workflows, and then iteratively alter workflows and procedures <p>Goals:</p> <ul style="list-style-type: none">• Provide psychoeducation, destigmatize perinatal mental health conditions. Engage perinatal individuals in mental health care using a strength-based, culturally responsive approach• Implement screening for depression, anxiety, and anxiety-related disorders twice during pregnancy and at least once in the postpartum period• Implement screening for bipolar disorder at initiation of care or after a positive depression or anxiety screen and prior to implementing pharmacotherapy• When a perinatal mental health screening tool is positive, assess the patient and determine treatment approach• Develop and use a repository of mental health resources and treatment referral sources tailored to the needs of specific patient populations• Refer patients who screen positive for psychotherapy, group therapy, or other treatment and support options |

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| | <ul style="list-style-type: none"> • Start medication treatment when indicated • Follow up and monitor perinatal mental health conditions once treatment is initiated • Ensure mental health care is ongoing until at least one year postpartum with transition to primary care or another provider as needed <p>The Aims summarize what to accomplish when integrating perinatal mental health into practice, the following steps guide how to accomplish it using a 3-phase implementation approach. Communication throughout all phases and steps, with all members of the care team from front desk staff through physicians and referral partners, is essential in all steps.</p> <p>Phase & Steps of Implementation:</p> <p>Phase 1 – Planning – Prepare & Organize</p> <p>Step 1: Establish implementation champions</p> <p>Step 2: Establish practice quality improvement team</p> <p>Step 3: Complete baseline assessment</p> <p>Step 4: Draft specific, measurable, attainable, realistic, and timely (SMART) goals</p> <p>Step 5: Develop workflows</p> <p>Step 6: Identify tasks, roles, and responsibilities</p> <p>Phase 2 – Implementation – Change, Integrate, and Adapt</p> <p>Step 7: Provide training for clinical and non-clinical staff</p> <p>Step 8: implement changes based on goals and workflow</p> <p>Phase 3 – Sustainment – Assess and Revise</p> <p>Step 9: Evaluate the implementation and review progress towards goals</p> <p>Step 10: Revise procedures based on lessons learned and continue iterative improvement process</p> <p>Links to full details and accompanying resources and tools can be found in resources.</p> <p>Perinatal mental health care includes care throughout the full first postpartum year. Most patients do not see their obstetric care provider much beyond the first 6-12 weeks postpartum. It is essential for screening and related mental health care to continue in the pediatric setting where there is significant contact with parents at well child and other visits. It is important to recognize that Pediatric care clinicians may not treat the parent, thus referral back to OB care or Primary Care Provider (PCP) will be needed and should be facilitated when applicable.</p> |

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| | <p data-bbox="581 199 1503 390">Patients that experience complications via pregnancy loss or demise, or an infant in the NICU, are at increased risk of mental health complications. Yet, they have less scheduled regular routine contact with pediatricians. Purposeful planning for follow-up and screening throughout the first postpartum year is needed.</p> <p data-bbox="581 438 1503 548">The American Academy of Pediatrics (AAP) recommends screening for postpartum depression during regularly scheduled well child visits during the first year of life:</p> <ul data-bbox="609 558 1503 1304" style="list-style-type: none"> • Clinical care guidelines support an active role of pediatric clinicians in implementing surveillance and universal screening • For pediatric practices that identify a parent with a positive depression screen, referral is recommended to an onsite counselor or social worker • In the absence of such onsite resources, referral to home visiting and community-based resources, such as Healthy Start, nurse home visitors, community based postpartum support groups, Postpartum Support International, and other resources is encouraged • Pediatric referral back to the parent's obstetric care or primary care provider may expedite diagnosis and treatment, in addition to referrals to psychiatric clinicians with expertise in perinatal care • Evidence suggests that mothers who receive clear communication from pediatric care clinicians about postpartum depression and the need to see an adult care clinician are more likely to seek treatment. Challenges such as competing demands on the time, difficulty, or frustration in contacting recommended resources, and lack of transportation inhibit access and engagement • Accessing care in clinics with embedded mental health services results in greater follow-up <p data-bbox="581 1352 1503 1503">Implementing mechanisms to support communication between obstetric and primary care clinicians and pediatric clinicians may help to improve maternal follow up for assessment and treatment following screening in a pediatric office. Implementation considerations include:</p> <ul data-bbox="609 1514 1503 1860" style="list-style-type: none"> • Explicit referral back to the obstetric care or primary care clinician and notifications via the EMR messaging function when clinicians are within the same system • Developing collaborative relationships between obstetric, primary care and pediatric clinicians in the community • Providing patients with clear information about signs and symptoms of perinatal mental health conditions, and when to contact their clinician, including if they are informed of a positive screen during a pediatric newborn visit |

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| | <ul style="list-style-type: none"> • Providing a short summary document of key elements of the patient's prenatal/postpartum course, names and contact information of obstetric provider, primary and specialty care providers, pediatrician, and mental health providers as applicable, to assure easy access to referral information for the patient and clinicians. • Perinatal quality collaboratives and other quality collaborative models may support integration of these practices via letter from the birthing hospital to affiliated pediatric offices with selected screening tools, protocols, office plan worksheet for incorporating screening, uploading into patient medical record, and provider communication protocols. |
| <p>Identify mental health screening tools to be made available in every clinical setting where obstetric patients may present.</p> | <p>Screening for depression and/or anxiety in pregnant and postpartum individuals, using validated screening tools and in the context of systems that ensure accurate diagnosis, effective treatment, and appropriate follow-up, is recommended by relevant professional societies and governmental agencies including but not limited to USPSTF, WPSI, AIM, ACOG, APA, AAFP, WHNP and ACNM.</p> <p>Talk about mental health conditions. Introduce screening opportunities using an inclusive, strengths-based, culturally aware approach. (See guidance on p. 6 and 8 of Lifeline for Moms toolkit in Resources)</p> <p>Use validated screening tools to identify mental health conditions. The following are examples of validated, commonly used tools that have a significant evidence-base in perinatal populations, and that are readily accessible including in many electronic medical records. Many have been validated in numerous languages. In addition to those included below, there exist numerous other screeners. It is important to use a validated tool and to administer is universally at the recommended time points.</p> <p>With the exception of the bipolar disorder screening instruments, the remainder query current symptoms, or symptoms in the past 7 days to 1 month. Thus, administering screening instruments serially over the perinatal period is recommended. The bipolar disorder screeners query lifetime experience. Recommended timing is discussed in a different element.</p> <p>Choose one validated tool from each category below. Except where indicated, all are self-administered and take less than 5 minutes to complete.</p> <p>Commonly used validated screening instruments for perinatal <u>Depression</u> include:</p> <ul style="list-style-type: none"> • Edinburgh Postnatal Depression Screen (EPDS), 10 questions, question 10 queries about self-harm or suicidality** |

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| | <ul style="list-style-type: none"> • Patient Health Questionnaire-9 (PHQ-9), 9 questions, question 9 queries about self-harm or suicidality** <p>Commonly used validated screening instruments for perinatal Anxiety include:</p> <ul style="list-style-type: none"> • General Anxiety Disorder 7 Screen (GAD-7), 7 questions • Edinburgh Postnatal Depression Screen (EPDS) anxiety sub-scale, usually questions 3, 4, & 5 • State-Trait Anxiety Inventory, state and short version (STAI-6), 6 questions <p>Validated screening instruments for Bipolar Disorder include:</p> <ul style="list-style-type: none"> • Mood Disorder Questionnaire (MDQ), 3 questions, the first question has 13 items • Composite International Diagnostic Interview (CIDI), 2-3 questions with branching logic, provider-administered <p>** When concern exists for suicidality due to response in depression screening tool or interaction with patient, further assessment is required. This is done with a clinical interview and can include a suicidality specific screening instrument.</p> <p>Validated screening instruments for Suicidality include:</p> <ul style="list-style-type: none"> • Columbia Suicide Severity Rating Scale (C-SSRS), 2-5 questions plus additional with branching logic, provider-administered • Patient Safety Screener (PSS), 3-9 questions with branching logic, provider administered <p>When assessing for thoughts of harm to self or others including the infant, it is important to distinguish between intrusive thoughts on which the perinatal individual does not intend to act and those for which action may be taken. Both are important considerations when determining diagnosis and disease severity. However, differences contribute to what immediate actions are or are not needed.</p> <p>Universal screening for posttraumatic stress disorder (PTSD) is not currently recommended. Acknowledging the prevalence and effect of trauma on patients and the health care team, ACOG recommends universal screening for current trauma and a history of trauma. Given the association of PTSD as an anxiety-related disorder historically, and its co-occurrence with depression and anxiety, PTSD screening should be considered in instances of concern related to depression and anxiety symptoms or positive screening and based on patient presentation.</p> |

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| | <p>Validated screening instruments for Posttraumatic Stress Disorder (PTSD) include:</p> <ul style="list-style-type: none"> • Primary Care PTSD for DSM-5 (PC-PTSD-5), 1 to 6 questions PTSD Check List - Civilian Version (PCL-C), 17 questions |
| <p>Educate clinicians, office staff, patients, and patients' designated support networks on optimal care across the perinatal mental health pathway including prevention, detection, assessment, treatment, monitoring, and follow-up best practices.</p> | <p>Education should emphasize:</p> <ul style="list-style-type: none"> • Perinatal mental health conditions are medical illnesses that can and should be treated. Perinatal mental health conditions are the most common conditions complicating pregnancy and the first year postpartum, and inclusive of suicide and overdose, are the most common cause of maternal mortality. • Perinatal mental health conditions have significant negative effects on maternal, obstetric, birth, offspring, partner and family outcomes. They are a preventable cause of maternal morbidity and mortality. • Stigma, bias and discrimination negatively impact perinatal individuals with mental health conditions and their ability to receive high quality care; self-reflection for clinicians and staff on individual biases is recommended. • Perinatal mental health conditions are underdiagnosed, untreated or under-treated without purposeful effort. • Evidence-based, effective treatments that mitigate risks and improve outcomes are available and safe in pregnancy and lactation. Psychotherapy, pharmacotherapy, and adjunctive interventions (e.g. self-care plans, sleep hygiene, balanced nutrition, exercise, mindfulness, meditation) are the main pillars of treatment. The risks and benefits of treatment must be framed in the context of treated versus untreated disease as untreated disease is associated with significant risk. Symptom resolution is the goal. <p>Clinical Training should include evidenced-based approaches to:</p> <ul style="list-style-type: none"> • Prevention: providing psychoeducation and resources aimed at preventing perinatal mental health conditions for all. <ul style="list-style-type: none"> • For those at increased risk, counseling interventions such as cognitive behavior therapy (CBT, e.g., Mothers & Babies program) and interpersonal therapy (IPT, e.g., Reach out, Stay Strong, Essentials for parents of newborns (ROSE) program), are recommended by the USPSTF, given their effectiveness in preventing perinatal depression. • Detection: screening for depression, anxiety, PTSD, and bipolar disorder using validated screening instruments • Assessment: evaluating for specific psychiatric illnesses and assessing illness severity, including risk of harm to self, the infant, or others |

| Readiness Element | Key Points |
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| | <ul style="list-style-type: none"> • Treatment: providing pharmacotherapy, referring for psychotherapy, and encouraging adjunctive interventions • Monitoring: following-up and monitoring after treatment initiation using validated screening instruments to measure improvement, or lack of improvement, in symptoms • Follow-up: adjusting treatment accordingly in response to measurement-based monitoring • Regional and local support services, programs, and resources • Work-flow changes that will facilitate implementation of each step in the perinatal mental health care pathway • Strengths-based non-stigmatizing care and environments • Trauma-sensitive care in all perinatal health care settings • Anti-racism and bias training/awareness by clinicians and staff • Obstetric care clinicians can access perinatal psychiatry access programs for support in addressing perinatal mental health conditions. <p>Patient and support person(s) education should additionally include:</p> <ul style="list-style-type: none"> • Anticipatory guidance on risk factors associated with perinatal mental health conditions and symptoms including onset or worsening • The impact of perinatal mental health conditions on pregnancy, the postpartum period and long-term maternal-child health • Providing psychoeducation and resources aimed at preventing perinatal mental health conditions • Online resources to help with detection and lifestyle habits and changes that can improve overall mental and physical health for perinatal populations • Ways to access online and local treatment options and adjuncts to treatment • General information about anticipated treatment courses, follow-up, and treatment safety • Access to 24/7 crisis hotlines locally and nationally • Comprehensive reproductive life planning discussions and resources. • Other regional/local support services, programs, and resources |
| <p>Develop and maintain a set of referral resources and communication pathways between obstetric providers, community-based organizations, and state and public health agencies to address patient needs, including social drivers of mental and physical health.</p> | <p>Perinatal mental health resources at both the national and state level have expanded and are readily available to providers, care givers and patients experiencing perinatal mental health concerns. Endeavor to ensure that:</p> <ul style="list-style-type: none"> • Hospital/prenatal sites implement resource mapping independently or in partnership with their perinatal psychiatry access program to identify and vet local behavioral health and other resource, referral, and support services |

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| | <ul style="list-style-type: none"> • Patient and family resource needs to address social drivers of health are met (i.e. wrap-around services such as housing, childcare, transportation, and home visitation; also see screening information under Recognition & Prevention below) • Pregnant and postpartum people have access to behavioral health services, substance use disorder counseling and treatment as needed <p>Endeavor to ensure that:</p> <ul style="list-style-type: none"> • Every clinical setting, health system, and provider are welcoming and inclusive of all people no matter backgrounds, race, ethnicity, gender, social class, language, ability and other personal or social identities and characteristics <p>Recognize that:</p> <ul style="list-style-type: none"> • Some of the identities above may be marginalized. To care for people in an intersectional manner is to treat the patient as a whole person and acknowledge all the identities that might impact equitable, supportive, and quality care <p>Connect with:</p> <ul style="list-style-type: none"> • State Perinatal Psychiatric Access Programs (where applicable) or the national consult line through Postpartum Support International (PSI) to understand what services they offer, how services can be integrated into local approaches to treatment, resource and referral, and how to foster bidirectional engagement to increase access to treatment for perinatal individuals with mental health conditions |
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Recognition & Prevention — Every Patient

| Recognition Element | Key Points |
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| Obtain individual and family mental health history at intake, with review and update as needed. | <p>Mental health history should include:</p> <ul style="list-style-type: none"> • Past psychiatric symptoms, diagnosis, and treatment • Previous suicide attempt(s) • Previous psychiatric hospitalizations • Past psychiatric treatments (medications & therapy) • Current psychiatric treatments (medications & therapy) • Symptoms including frequency, duration, and how daily functioning is impacted • Recent stressors • Family history of psychiatric illnesses and treatments |

| Recognition Element | Key Points |
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| <p>Screen for depression and anxiety at the initial prenatal visit, later in pregnancy, and at postpartum visits</p> | <p>Universal screening is associated with higher rates of treatment.</p> <p>As onset of perinatal mental health conditions occur nearly equally across pre-pregnancy, in pregnancy, and postpartum, and early detection and treatment benefits symptom improvement and resolution, the following time points are recommended at a minimum:</p> <ul style="list-style-type: none"> • At Initial prenatal visit, ideally in first trimester, to identify onset that occurred prior to or early in pregnancy • At time point later in pregnancy, to identify onset during mid to later pregnancy; associating with 24-28 week gestational diabetes screening visit can facilitate systematic implementation • At postpartum visits to identify late pregnancy or postpartum onset, with consideration of early postpartum visits for high-risk identified patients <p>Those with risk factors for mental health conditions may merit additional screening. Risk factors during pregnancy and postpartum include but are not limited to history of mental health conditions, life stress, decreased social support, single/unpartnered relationship status, intimate partner violence, childcare stress, infants with difficulty feeding, sleeping, and soothing, young age, military veteran, unintended pregnancy, and marginalization by race/ethnicity or socioeconomic disadvantage.</p> <p>Screening improves accurate identification of perinatal individuals with mental health conditions. Positive screening results should lead to additional assessment that considers severity of disease, comorbid psychological problems, alternate diagnoses, and medical conditions. Programs combining screening with adequate support systems to assure access to treatment and follow-up improve clinical outcomes.</p> <p>The American Academy of Pediatrics (AAP) recommends screening for postpartum depression during regularly scheduled well newborn visits during the first year of life.</p> <p>For perinatal individuals that do not have well newborn visits (e.g. newborn in NICU, stillbirth/demise), screening at same cadence should happen in an alternative environment including obstetric care settings. Special efforts to screen parents of hospitalized infants should be considered.</p> |

| Recognition Element | Key Points |
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| <p>Screen for bipolar disorder before initiating pharmacotherapy for anxiety and depression</p> | <p>1 in 5 perinatal individuals who screen positive for depression may have bipolar disorder.</p> <p>Depressive symptoms and episodes are more common than manic or hypomanic symptoms or episodes of bipolar disorder.</p> <p>Treating unrecognized bipolar disorder with an antidepressant alone is contraindicated as it is associated with non-response, worsening of mood symptoms and may precipitate mania or psychosis, which increases risk of both suicide and infanticide.</p> <p>Systematizing screening by combining with other self-administered instruments at the initial obstetric visit is recommended. Minimally it must be done prior to prescribing an anti-depressant for depression, anxiety, or anxiety-related condition like PTSD or OCD. Treatment of bipolar disorder with a mood stabilizer is generally indicated. If bipolar disorder is suspected, consultation with or referral to psychiatry for further assessment is indicated.</p> <p>Given that the bipolar disorder screening instruments query lifetime experience, they can typically be administered once in the perinatal period and do not need to be done serially like those for depression, anxiety, or anxiety related conditions.</p> |
| <p>Screen for structural and social drivers of health that may impact clinical recommendations or treatment plans and provide linkage to resources.</p> | <p>Screening should include:</p> <ul style="list-style-type: none"> • Medical needs • Mental health needs, including substance use disorder needs • Structural and social drivers of health <p>All provided resources should align with the pregnant or postpartum patient's:</p> <ul style="list-style-type: none"> • Health literacy • Cultural needs • Language proficiency • Geographic location and access |

Response — Every Event

| Response Element | Key Points |
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| <p>Initiate an evidence-based, patient-centered response protocol that is tailored to illness severity, and is strength-based, culturally relevant, and responsive to the patient's values and needs.</p> | <ul style="list-style-type: none"> • Discussions surrounding treatment should incorporate shared-decision-making approaches to care • Counseling regarding treatment of mental health conditions in pregnancy must recognize the risks associated with un- or under-treated illness and balance those against treatment risks. • For most women with mild perinatal depression and/or anxiety, psychotherapy is a preferred first-line treatment. Therapy is not always accessible or acceptable; thus, pharmacotherapy should be discussed as an alternative. Additionally, there is a growing number of digital approaches to therapy which merit consideration and further study given their accessibility and potential increased acceptability. • For women with moderate or severe perinatal depression or anxiety, pharmacotherapy should be considered, ideally in conjunction with psychotherapy • For women with bipolar disorder, pharmacotherapy is recommended given its associated risks including postpartum psychosis • As a general rule, pharmacotherapy should use the lowest effective dose, avoid polypharmacy, and minimize medication switches during pregnancy and postpartum • Tracking symptom response is a critical component of any treatment plan, with protocolized stepped-care (or up-titration of treatment). |
| <p>Establish care pathways that facilitate coordination and follow-up among multiple providers throughout the perinatal period for pregnant and postpartum people referred to mental health treatment.</p> | <p>Obtain all needed consents and permissions to disclose patient information for coordination and collaboration of care.</p> <p>Collaborators in care, coordination, and follow-up may include:</p> <ul style="list-style-type: none"> • Obstetric care providers* • Pediatric providers* including NICU where applicable • Psychiatric providers* • Psychology providers • Social workers • Nursing • Lactation counselor or consultant • Patient navigator • Peer supports and those with lived expertise • Family and other supports • Doulas <p>*Providers may include physicians, certified nurse midwives, nurse practitioners, physician assistants and others</p> |

Reporting and Systems Learning - Every Unit

| Reporting Element | Key Points |
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| <p>Identify and monitor data related to perinatal mental health care, with disaggregation by race and ethnicity at a minimum, to evaluate disparities in processes of care.</p> | <p>Systems collecting and reporting quality improvement data should consider:</p> <ul style="list-style-type: none"> • Persons marginalized by racism and socioeconomic disadvantage, experience inequities at every step along the perinatal mental health care pathway especially in access to treatment. Maternity care programs should review their data, disaggregated by race, ethnicity, and payor (as surrogate for income level) to identify and address discriminatory practices. • Disaggregating data by various parameters may result in small numbers for certain subgroups which may have implications for the feasibility of data comparisons. • Participation in a state or national collaborative, if available, may be helpful for sharing data, comparing performance, and driving quality improvement. • Monitored data could include elements such as screening, linkage to treatment, hospitalization/SMM related to perinatal mental health, maternal mortality (including both pregnancy-related and pregnancy associated) related to perinatal mental health. |
| <p>Convene inpatient and outpatient providers in an ongoing way to share successful strategies and identify opportunities for prevention and evaluation of undesired outcomes related to perinatal mental health.</p> | <p>Every effort should be made to include behavioral health and pediatric providers in this convening and review process.</p> |

Respectful, Equitable, and Supportive Care — Every Unit/Provider/Team Member

| Respectful Care Element | Key Points |
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| Include each pregnant and postpartum person and their identified support network as respected members of and contributors to the multidisciplinary care team. | <p>Patient support networks may include nonfamilial supports, such as doulas and home visitors, who should be welcomed with the pregnant or postpartum person's permission.</p> <p>Inclusion should involve:</p> <ul style="list-style-type: none">• Establishment of trust• Informed, bidirectional shared decision-making• Recognizing patient values and goals as the primary driver of this process• Align with health literacy, culture, language, and accessibility needs |

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