Perinatal Behavioral Health Guideline Checklist

Clinician
Level 2

DR. ROBERT BREE COLLABORATIVE

The current state of the issue

The perinatal period, **defined here as including the time from conception until the end of the first year after birth,** involves significant physiological and psychosocial change. **The term behavioral health includes both mental health and alcohol or other substance misuse (e.g., opioids).** Pregnancy and parenting are both life altering events that may result in new or increased behavioral health symptoms for the gestational parent and their families.[1] Postpartum depression is common, impacting 10-15% of gestational parents, while postpartum anxiety disorders are estimated to occur in 21% of gestational parents.[2,3,4] Pregnant and postpartum individuals with mental health concerns are at greater risk for substance use and abuse.[5] According to the Washington State Maternal Mortality Review Panel: Maternal Death 2017-2020 Report, the leading underlying causes of pregnancy-related deaths were behavioral health conditions (32%), predominantly by suicide and overdose.[6]

Care Coordination

- [ ] If patient is at risk for perinatal mood and anxiety disorders, provide or refer to evidence-based preventative counseling per USPSTF recommendations.
- [ ] Refer to peer support services through Perinatal Support Washington as applicable.

Integrated Behavioral Health

- [ ] If someone is undergoing active treatment for a behavioral health diagnosis, coordinate care with other providers.
- [ ] Depression and anxiety: For mild depression and anxiety (depending on scale used), provide education and referral to therapy; for moderate-severe depression, provide therapy and/or medication management.
  - [ ] Ensure patient is connected to evidence-based follow-up treatment using warm-handoff and direct follow-up if same-day treatment is not possible.
  - [ ] Prior to beginning pharmacotherapy for depression, screen for bipolar disorder using a validated instrument.

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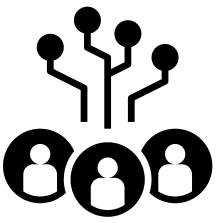
- [ ] If suicide risk is detected, make a suicide safety plan and follow guidelines within the 2018 Bree Collaborative Suicide Care Report and Recommendations, or more recent guidance if available.
  - [ ] Ensure individuals at risk of suicide have pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment).
  - [ ] Use effective evidence-based treatments provided onsite that directly target suicidal thoughts and behaviors (rather than focusing primarily on specific mental health diagnoses) through integrated behavioral health or off-site with a supported referral.
  - [ ] Engage patients family/support system in collaborative safety planning.
  - [ ] If possible, involve family members or other key support people in suicide risk management.
- [ ] Provide counseling and education on pharmacotherapy for opioid use disorder, continued use of legal and illicit substances while pregnant, withdrawal from opioids while pregnant, and risks for pregnant person-baby dyad if relapse occurs.
  - [ ] Start patients on opioid maintenance therapy as early as possible in pregnancy to help reduce the severity of neonatal abstinence syndrome.
  - [ ] After a positive screen for opioid use disorder, medical examination and psychosocial assessment should be performed by a qualified provider.
  - [ ] Co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist as available.
  - [ ] Use a supported referral or warm handoff, such as reviewing the care plan in person or over the phone during handoff, to a setting offering methadone or buprenorphine and harm reduction related services rather than withdrawal management or abstinence. Hospitalization during initiation may be advisable.
  - [ ] For patients in need of hospitalization, consider a supported referral to Substance Using Pregnant People (SUPP) Program for individuals who are pregnant, covered through WA Apple Health and have a substance use history. See more details here.
  - [ ] Follow SAMSHA's Clinical Guidance for Treating Pregnant and Parenting Person With Opioid Use Disorder and Their Infants
- [ ] Provide contact and support during transition from inpatient to outpatient sites, and from out-patient to no behavioral health treatment.

Screenings

- [ ] Provide warm handoff to specialty behavioral health if warranted based on results.

Community Linkages and social programs

- [ ] Educate patients on the benefits of community and culturally aligned that these resources can provide.
- [ ] Provide educational and community resources to patients to support perinatal and postpartum needs as appropriate.



Resources

- The Bree Report on Perinatal Behavioral Health is meant to supplement these resources.
- Full Bree Report on Perinatal Behavioral Health: https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2024/02/Bree-Perinatal-Behavioral-Health-FINAL-012424.pdf
- Perinatal Support Washington: https://perinatalsupport.org/
- Perinatal Psychiatry Consultation Line for Providers (Perinatal PCL): https://perc.psychiatry.uw.edu/perinatal-pcl/
- MAP ECHO: Perinatal Psychiatry Case Conference Series: https://perc.psychiatry.uw.edu/map-echo-perinatal-psychiatry-case-conference-series/
- Maternal* Mental Health Access (MaMHA): https://waportal.org/partners/maternal-mental-health-access-mamha/resources
- Training Interprofessional Teams to Manage Miscarriage: https://www.miscarriagemanagement.org/get-trained-folder
- Washington State Perinatal Collaborative (WSPC): https://doh.wa.gov/you-and-your-family/womens-health/washington-state-perinatal-collaborative-wspc#ParentID-9337
- 988 Suicide & Crisis Lifeline: https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/988-suicide-crisis-lifeline

Read the full Bree Report on Perinatal Behavioral Health online by scanning the QR code:

Connect with the Bree Collaborative at bree@qualityhealth.org

References: 1.Garcia, E.R., & Yim, I.S. (2017). A systematic review of concepts related to women's empowerment in the perinatal period and their associations with perinatal depressive symptoms and premature birth. BMC Pregnancy Childbirth, 17(Suppl 2), 347. 2. Centers for Disease Control and Prevention. (n.d.). Mental health of children and parents — a strong connection. Retrieved from https://www.cdc.gov/childrensmentalhealth/features/mental-health-children-and-parents.html 3. Anokye, R., Acheampong, E., Budu-Ainooson, A., Obeng, E.I., & Akwasi, A.G. (2018). Prevalence of postpartum depression and interventions utilized for its management. Ann Gen Psychiatry, 17, 18. 4. Bauman, B.L., Ko, J.Y., Cox, S., et al. (2020). Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018. MMWR Morb Mortal Wkly Rep, 69, 575–581. 5. American Psychiatric Association. (2023). Perinatal Mental and Substance Use Disorders [Whitepaper]. Retrieved from https://www.psychiatry.org/getmedia/344c26e2-cdf5-47df-a5d7-a2d444fc1923/APA-CDC-Perinatal-Mental-and-Substance-Use-Disorders-Whitepaper.pdf. 6. Stein, B.S., Sedano, C. Gardner, D., Silverman, E., Mentzer, K., Tibbs Christensen, T. (2023) Washington State Maternal Mortality Review Panel: Maternal Deaths 2017–2020. Washington State Department of Health Prevention and Community Health Division. Olympia, WA. Retrieved from: https://doh.wa.gov/sites/default/files/2023-02/141-070-MaternalMortalityReviewPanelReport-2023.pdf