Bree Maternal/Perinatal Mental Health Workgroup
Updated: August 14, 2023

Background

Pregnancy and parenting are life changing events and can result in detrimental behavioral health symptoms for the gestational parent and/or the non-gestational parent. These behavioral health diagnoses can be disruptive and concerning to the person experiencing them and have a negative impact on the newborn as the strongest predictor of infant health is well-being of the parent. Postpartum depression impacts 10-15% of gestational parents, from minimal to severely disruptive and can include psychosis.[1,2] Rates of postpartum depression are higher among those who reported a previous diagnosis of depression, were American Indian/Alaska Native, smoked during or after pregnancy, experienced intimate partner violence before or during pregnancy, or whose infant died since birth.[3] Anxiety disorders postpartum are also prevalent and estimated to be 21%, including posttraumatic stress disorder (1%), specific phobia (5%), and intrusive anxiety-provoking thoughts.[4,5] Alcohol and substance use during pregnancy and postpartum are likely underreported and surveys have shown just under 6% of pregnant people using drugs, 8.5% drinking alcohol, 16% smoking, and about 2.5% receiving at least one opioid prescription.[6,7]

Effectiveness of screening for perinatal behavioral health conditions is contingent on availability of adequate follow up for those who screen positive. The ACOG's consensus bundle on maternal mental health for perinatal depression and anxiety includes general guidance to include perinatal mood and anxiety disorder screening, intervention, referral, and follow-up into maternity care practices.[8] Behavioral health treatment in the perinatal period should be informed by symptom severity and patient preference. Common mental disorders such as depression and anxiety can be managed in the prenatal setting while patients with bipolar disorder or psychosis may require a referral to specialty mental health. The pathways described previously recommend using a validated symptom measure such as the PHQ-9 to help determine intensity and type of treatment for common mental disorders. For example:

- For mild depression (PHQ-9 score 5 -10) – education, psychotherapy
- For moderate depression (PHQ-9 score 10 - 15) – psychotherapy and / or medication management
- For severe depression (PHQ-9 score >15) – psychotherapy and medication management. More information: http://www.cqaimh.org/pdf/tool_phq9.pdf

If prenatal providers opt to refer patients out for specialty mental health treatment, attempts should be made to track on these referrals as evidence suggests that less than 20% of patients follow up on specialty mental health referrals.[9] Should prenatal providers opt to provide integrated mental health treatments (which is preferable especially for mild to moderate depression and anxiety, and is associated with better follow up and patient outcomes), reimbursement options include fee-for-service co-located psychotherapy or using collaborative care codes, more information here: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf.[10] Better patient outcomes are reported with measurement-based treatment to target that forms the cornerstone of collaborative care.

Medication-assisted opioid use disorder treatment should be informed by individual patient characteristics and preferences. Medications differ in the location from which they can be dispensed, how they can be prescribed, side effects, and how they work chemically.[11] Agonist medication therapy, methadone or buprenorphine, is generally recommended for patients who are pregnant. [12,13] Providers

should follow the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion Opioid Use and Opioid Use Disorder in Pregnancy and the Bree Collaborative's 2017 Opioid Use Disorder Treatment Report and Recommendations. Buprenorphine services for patients who are pregnant with opioid use disorder are available among primary care providers with obstetrics privileges, group buprenorphine care, case management, patient navigation and maternal support services

Pregnancy presents a unique opportunity to engage people in and connect to ongoing clinical care, especially for those who are marginalized or who may not have regular encounters with the medical system. This is especially important for those with comorbid behavioral health diagnoses, use of illicit drugs during pregnancy not being uncommon.[14]

Guidelines

Health Care Professionals & Clinicians

Screening

- Explain to patients the purpose of screening for depression, anxiety, suicidality, alcohol misuse, and drug use including the safety and security of the information.
- Screen every pregnant person for depression, anxiety, suicidality, and tobacco, marijuana, alcohol, and/or other drug use at intake and at least every trimester using a validated instrument(s), routine postpartum visits, and at well-child pediatric visits, as recommended by the American Academy of Obstetricians and Gynecologists and the US Preventive Services Task Force.
    - **Depression** (e.g. Patient Health Questionnaire-2, PHQ-3 and/or PHQ-9) and **anxiety** (e.g., Generalized Anxiety Disorder-2), follow guidelines within the 2017 Bree Collaborative Behavioral Health Integration Report and Recommendations.
    - **Suicidality** (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts). If suicide risk is detected, follow guidelines within the 2018 Bree Collaborative Suicide Care Report and Recommendations, or more recent if available.
    - **Tobacco, marijuana, alcohol** (e.g., AUDIT-C), and **drug use** (e.g., single-item screener, ASSIST, DAST-10, single item cannabis and other drug use questions). If alcohol misuse or illicit drug use is detected, follow guidelines within 2015 Bree Collaborative Addiction and Dependence Treatment Report and Recommendations, or more recent if available following the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol.
- Pediatricians: screen postpartum people for mental health according to AAP, USPSTF, and Bright Futures guidelines of 1-, 2-, 4-, and 6-month well-child visit.
    - Coordinate care with parent's postpartum clinician
    - Refer parent to community resources for the further assessment and treatment of the parent with depression as well as for the support of the parent-child dyad.[1]
- If screenings are negative, provide education to pregnant or postpartum people and support system on signs and symptoms of mental health concerns that may arise during pregnancy or after birth.
- If screenings are positive, screening for perinatal mood disorders is most effective when connected to interventions. Develop a plan for intervening when perinatal mood disorders or other mental health concerns are identified.
    - Inform and educate client on findings, diagnosis, and resources to support them.
    - For clinical providers, follow the American College of Obstetrician and Gynecologists' Guideline on the Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum.

[1] Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice

    - Connect patients with care team member, Case manager, Social Worker to support their referral to interventions and community support.
- Inquire about patient's mental health, life stressors and well-being through trauma informed culturally humble care during each visit.

Treatment for Opioid Use Disorder:

- Gestational parents who have opioid use disorder should start 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.
- Co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist.
- Use urine drug testing to detect or confirm suspected use with informed consent.
- Use a supported referral to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence. Initiate treatment with opioid replacement therapy as early as possible. Hospitalization during initiation may be advisable.
- Include screening for substance use and opioid use following the SBIRT (Screening – Brief Intervention – Referral to Treatment) model.

Patient-Provider Interactions:

- Provide trauma-informed, patient-centered, and culturally humble maternity care from all obstetricians, midwives, other clinicians, and other community service supporters of pregnant and postpartum people.
- Become educated on Maternal Mental Health and Substance Use Disorders

Health Delivery System

Screening

- In order to successfully implement perinatal mood disorder screening:
    - Engage with multidisciplinary staff members and partner with program champions.
    - Incorporate screening into routine clinical practices during routine visits.
        - Provide screening in multiple languages at an 8th grade reading level
        - Have screening accessible to complete online via patient portal prior to visit
    - Train staff to appropriately administer screening.
    - Train staff on providing behavioral health referrals and offer an easy-to-access referral list for providers to use with pregnant people who screen positive.
    - Ensure screening is universally and equitably administered. Track inequities in screening rates among racial/ethnic groups and among patients with private insurance compared to Medicaid/Medicare.
- Screening for perinatal mood disorders is most effective when connected to interventions. When perinatal mood disorders or other mental health concerns are identified, provide next steps according to onsite available resources and/or known community resources and the severity of the person's symptoms. Next steps can include:
    - Brief Intervention: XXX

    - Warm handoff to onsite integrated behavioral health professional
    - Warm handoff to behavioral health professional and some kind of follow-up.
    - Address access and availability of behavioral health resources.
- Track rates of depression screening completed for pregnant people during pregnancy and the first 12 months postpartum.
- Track referrals of pregnant and postpartum people to a mental health provider.

Treatment for Opioid Use Disorder:

    - Use a supported referral to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence. Initiate treatment with opioid replacement therapy as early as possible. Hospitalization during initiation may be advisable.

Patient-Provider Interactions:

- Offer learning and development opportunities to all providers who treat pregnant and post-partum people. Specific learning and development opportunities include:
    - Trauma-informed care principles.
    - Implicit bias and antiracism training.
    - Patient-centered care.
    - Mental Health and Substance Use Disorder among individuals who are pregnant and postpartum.
- Offer to connect pregnant and perinatal patients to a racial or gender-identity concordant provider when possible.
- Track patient-reported outcome measures (PROMs) on perceived discrimination and mistreatment during pregnancy.
- Track inequities along socioeconomic status and race/ethnicity.

Access

- In addition to screening, provide pre-conception counseling services that acknowledge the risk of perinatal mood disorders with pregnant people, and work to identify pregnant people who will need additional mental health resources or support.
    - Schedule pregnant people for a mental health consultation as part of perinatal health care and post-delivery in recognition of pregnancy being a significant life event.
- Work to increase access to prenatal care, regular perinatal care, and behavioral health services.
- Strategies to increase access can be individual, social, and structural.
    - Strategies to address individual barriers to care include:
        - Develop pathways to address or take into account individual social need, such as transportation to and from clinics.
    - Strategies to address social barriers to care include:
        - Increase communication across members of the care team, including clinicians, community services, and behavioral health.
    - Strategies to address structural barriers to care include:

        - Change clinical policy to address structural barriers in care. Suggested strategies include increasing the hours or creating child-friendly waiting and examination rooms.
        - Consider new clinical delivery models that better integrate behavioral health into routine perinatal care, such as integrated behavioral health or collaborative care models.
        - Consider co-locating behavioral health services to improve referrals and increase access to behavioral health providers.
        - Consider adopting telehealth modalities of delivering care to improve access to regular perinatal care visits.
- Build relationships with Community Based Organizations to support the care and well-being of individuals experiencing mental health concerns or diagnosis.

Bi-directional referrals?

Health Plans

<u>Clinical Structure:</u>

- Consider alternative models of maternal care delivery to address maternal mental health concerns. Potential models include:
    - Integrated behavioral health and maternal health care
    - Collaborative care models with a team made up of a provider, a care manager, and a psychiatric consultant
    - Home visits by a doula for psychosocial support, feeding, parenting and sleep support
        - Information, emotional support and practical care
    - Home visits by nurse for perinatal care
    - Group prenatal care
    - Telemedicine
    - Community midwife models
    - Community health workers

<u>Access:</u>

- Educate clients on signs and symptoms of behavioral health disorders during and after pregnancy.
- Educate clients on pregnancy care options (e.g., OB, Midwife, Doula) offered by health plan.
- Work to increase access to prenatal care, regular perinatal care, and behavioral health services.
- Strategies to increase access can be individual, social, and structural.
    - Strategies to address individual barriers to care include:
        - Increase coverage for perinatal mental health services to reduce financial barriers to care, such as Medicaid programs offering behavioral health consultations, address coverage and reimbursement
        - Develop pathways to address or take into account individual social need, such as transportation to and from clinics.
    - Strategies to address structural barriers to care include:

        - Consider new clinical delivery models that better integrate behavioral health into routine perinatal care, such as integrated behavioral health or collaborative care models.
        - Consider adopting telehealth modalities of delivering care to improve access to regular perinatal care visits.

DOH & Public Health Agencies

Access:

- Strategies to increase access can be individual, social, and structural.
    - Strategies to address individual barriers to care include:
        - Increase education around perinatal mental health to reduce stigma and increase awareness of existing services.
        - Develop pathways to address or take into account individual social need, such as transportation to and from clinics.
    - Strategies to address social barriers to care include:
        - Increase community education through partnerships with community organizations and public health agencies to reduce stigma and increase awareness.
    - Strategies to address structural barriers to care include:
        - Consider new clinical delivery models that better integrate behavioral health into routine perinatal care, such as integrated behavioral health or collaborative care models.

Education

- Create education campaigns on signs and symptoms of maternal health and where to go to receive care if a concern arises.

Purchasers

- Provide Paid Parental leave
- Cover diverse options for individual to receive perinatal care so the person may choose a care that best aligns with them and their desired birthing process (e.g., OB, hospital birth, community birth, birthing support from doulas)
- Expand coverage for community-based pregnancy and maternity care (e.g., midwives, home visits, group visits)
- Cover mental health consultation as part of perinatal health care and post-delivery in recognition of pregnancy being a significant life event.

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