# Background

The perinatal period, defined here as including the time from conception until first year postpartum (after birth), involves significant physiological and psychosocial change[[1]](#endnote-2). Pregnancy and parenting are life changing events that can result in new or increased behavioral health symptoms for the person who gave birth (i.e., gestational parent) as well as any non-gestational parent such as from co-parenting or adoption. 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 the wellbeing of the parent. Alcohol and substance use during pregnancy can cause psychological harm to the fetus and, along with depression, anxiety, and other symptoms, may increase in prevalence or severity postpartum. The term behavioral health includes mental health and alcohol and other substance misuse.

Postpartum depression impacts 10-15% of gestational parents with great variation in symptoms from minimal to severely disruptive in self and infant care.2,3 In some more rare cases, postpartum depression can include psychosis.[[2]](#endnote-3),[[3]](#endnote-4) Rates of postpartum depression are higher among those with a pre-pregnancy depression diagnosis, who are American Indian/Alaska Native, who smoked during or after pregnancy, experienced intimate partner violence before or during pregnancy, or whose infant died since birth.[[4]](#endnote-5) Postpartum anxiety disorders are also very common and estimated to occur in 21% of people postpartum.5,6 These anxiety disorders include posttraumatic stress disorder (1%), specific phobia (5%), and/or intrusive anxiety-provoking thoughts (e.g., such as harm coming to the newborn).[[5]](#endnote-6),[[6]](#endnote-7)

Effectiveness of screening for perinatal behavioral health conditions is contingent on availability of adequate follow up and treatment for those who screen positive. The American College of Obstetricians and Gynecologists (ACOG) consensus bundle on maternal mental health for perinatal depression and anxiety includes general guidance for onsite screening, intervention, referral, and follow-up.[[7]](#endnote-8) Behavioral health treatment in the perinatal period should be informed by symptom severity and patient preference. On most cases, mild to moderate depression and anxiety can be managed in the prenatal setting while patients with more severe symptoms or diagnoses such as bipolar disorder or psychosis may require a referral to specialty behavioral health. Health care professionals should use a validated tool (e.g., PHQ-9) to determine severity. ACOG recommends screening during the first prenatal visit, near or during the third trimester, and at postpartum visits using a serialized approach with the same screening tool (e.g., PHQ-3 screener followed by a PHQ-9 if positive.)[[8]](#endnote-9)

Pregnant and postpartum individuals with mental health concerns are at greater risk for substance use.[[9]](#endnote-10) Alcohol and substance use during the perinatal period, but especially during pregnancy, are likely underreported. Survey data shows about 6% of pregnant people using drugs other than those prescribed, 8.5% drinking alcohol, 16% smoking, and about 2.5% receiving at least one opioid prescription.[[10]](#endnote-11),[[11]](#endnote-12) Perinatal opioid use has increased as in the general population. ACOG recommends universal screening for opioid use, brief intervention, and referral to a higher level of treatment if needed without involving law enforcement.[[12]](#endnote-13) Similarly, ACOG recommends universal screening for alcohol use followed by brief interventions for positive screens.[[13]](#endnote-14)

Growing evidence supports integrated mental health treatments, especially for mild to moderate depression and anxiety, and is associated with better follow up and patient outcomes.[[14]](#endnote-15) Reimbursement options include fee-for-service co-located psychotherapy or using collaborative care codes, more information [here](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf).[[15]](#endnote-16) Better patient outcomes are reported with measurement-based treatment to target that forms the cornerstone of collaborative care.

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.[[16]](#endnote-17) 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.[[17]](#endnote-18) Agonist medication therapy, methadone, or buprenorphine, is generally recommended for patients who are pregnant. [[18]](#endnote-19),[[19]](#endnote-20)  Providers should follow the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion [Opioid Use and Opioid Use Disorder in Pregnancy](https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy) and the Bree Collaborative’s 2017 [Opioid Use Disorder Treatment Report and Recommendations](http://www.breecollaborative.org/wp-content/uploads/OUD-Treatment-Final-2017.pdf). 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.[[20]](#endnote-21)

**Focus Areas** (informed by AHRQ guidelines)[[21]](#endnote-22)

|  |  |
| --- | --- |
| Focus Area | Action Steps |
| Patient education and provider communication | * Communication between patient and provider
* Patient education
* Public health education
 |
| Integrated Behavioral Health  | * Universal Screening, Brief Intervention, Referral to Treatment protocols
* Co-located care and/or community linkages to higher levels of behavioral health care
* Integrated models of behavioral health (co-located care/collaborative care)
* Referral systems to higher levels of behavioral healthcare
* Coordinated Treatment for pregnant and postpartum individuals experiencing substance use disorders
 |
| Care Coordination | * Operational systems for quick coordination and triage
* Care coordinators/peer navigators role, workflow and integration
 |
| Community Linkages to social programs | * Referral pathways to community-based resources and organizations
* Partnerships with community
 |
| Expanded team roles  | * Roles of expanded providers in supporting perinatal behavioral health
* Expanded reimbursement?
 |

# Guidelines

## Health Care Professionals & Clinicians

Patient Education and Provider Communication and interaction

* 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.
* Educate patients on signs and symptoms of mental health concerns that may arise during pregnancy and after.
* Educate patients on the importance of integrated behavioral health care and how they can participate in care planning and shared decision-making[[22]](#endnote-23)
* Be educated on Harm Reduction techniques [[23]](#endnote-24)
* Examples of Educational Resources for Providers
	+ Lactation Guide[[24]](#endnote-25)
* Examples of Resources for Patients
	+ Maternal Mental Health Hotline[[25]](#endnote-26)

Integrated Behavioral Health

* Universal Screening, Brief Intervention and Referral
* 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, at least every trimester, at routine postpartum visits and at well-child pediatric visits using a validated instrument(s), 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),
		- 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>
	+ **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](http://www.breecollaborative.org/wp-content/uploads/Suicide-Care-Report-and-Recommendations-Final.pdf), 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](http://www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf), or more recent if available following the Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol.
* Screen every pregnant or postpartum person at annual visits, initial prenatal visit, later in pregnancy, and post-partum visits for Intimate Partner Violence (IPV) and Social Determinants of Health (SDOH). Universal screening for IPV, and other SDOH risk factors is essential for identifying pregnant and postpartum people at increased risk for perinatal behavioral health conditions and providing care that is trauma informed.[[26]](#endnote-27)
	+ **Intimate Partner Violence: need examples of tools**
	+ **Social Determinants of Health** (e.g., PRAPARE) Screen pregnant or postpartum person for SDOH needs utilizing a validated tool. Follow Foundation for Health Care Quality [Social Need Screening Report](https://www.qualityhealth.org/equity/wp-content/uploads/sites/10/2023/06/Final-Screening-Recommendations-0627.pdf) and [Social Need Interventions Report](https://www.qualityhealth.org/equity/wp-content/uploads/sites/10/2023/06/Final-Interventions-Recommendations-0627.pdf) to support a person with identified SDOH needs.
* Pediatricians: screen postpartum people for mental health concerns 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.[[27]](#endnote-28)
* 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 patient 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**.[[28]](#endnote-29)
	+ Connect patients with care team members, 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. Cultural humility relies on a life-long learning process in which a provider is “flexible and humble enough to assess anew the cultural dimensions of the experiences of each [person].”30 Rather than having a static endpoint, self-questioning and self-critique, and active listening become part of the process.[[29]](#endnote-30) See **Appendix X: Culturally Humble Care**
* Co-located Services and Community Linkages to Higher Levels of Behavioral Health Care
	+ When able, co-locate behavioral healthcare with primary care, OBGYNs and other health services for the perinatal patient
		- Example: Valley Medical Center co-located Behavioral Health Care Coordinator,
	+ Referral pathways?

Treatment for Opioid Use Disorder (OUD):

* Provide counseling and education on the medical and social impact of pharmacotherapy for OUD, continued use of legal and illicit substances while pregnant, and withdrawal from opioids while pregnant, and risks for pregnant person-baby dyad if a relapse occurs.
* Patients 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.
	+ Encourage and, if appropriate, prescribe pharmacological treatment for OUD during pregnancy[[30]](#endnote-31)[[31]](#endnote-32)
* Co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist.
* Use a supported referral (warm handoff) to a setting offering methadone or buprenorphine and harm reduction related services 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.
* Follow SAMSHA’s [Clinical Guidance for Treating Pregnant and Parenting Person With Opioid Use Disorder and Their Infants](https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054)[[32]](#endnote-33)

## Health Delivery System

Patient education and Provider communication and interaction

* 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.[[33]](#endnote-34)
		- Such as through perinatal support international, MONA (Marce Society of North America)
* 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.[[34]](#endnote-35)
* Track inequities along socioeconomic status and race/ethnicity.
* 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.

MaIntegrated behavioral health.

* Screening, Brief Intervention and Referral to Treatment
	+ - Consider new clinical delivery models that better integrate behavioral health into routine perinatal care, such as integrated behavioral health or collaborative care models.
			* Consider mobile services?
	+ In order to successfully implement perinatal mood disorder screening:
		- Engage with multidisciplinary staff members and partner with program champions.
		- Establish protocols that 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[[35]](#endnote-36) such as providing warm line for perinatal support WA: XXX
	+ Track rates of depression screening completed for pregnant people during pregnancy and the first 12 months postpartum.[[36]](#endnote-37)
	+ Track referrals of pregnant and postpartum people to a mental health provider.
* Co-located care and/or community linkages to higher levels of behavioral health care
	+ 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
		- Consider co-locating behavioral health services to improve referrals and increase access to behavioral health providers.

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.

Care coordination

* Strategies to increase access can be individual, social, and structural.
	+ Strategies to address individual barriers to care include:
		- Develop pathways to address or consider 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 adopting telehealth modalities of delivering care to improve access to regular perinatal care visits.

Community linkages to social programs

* Build relationships with Community Based Organizations to support the care and well-being of individuals experiencing mental health concerns or diagnosis.
* Bidirectional referrals?

Expanded team roles (doulas)

* Facilitate doulas’ inclusion in the care team when applicable and/or chosen by the patient

## Health Plans

Patient education and provider communication

* Educate members on signs and symptoms of behavioral health disorders during and after pregnancy.
* Educate members on pregnancy care options (e.g., OB, Midwife, Doula) offered by health plan.

Integrated behavioral health.

* 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
* Increase coverage for perinatal behavioral health services to reduce financial barriers to care, such as Medicaid programs offering behavioral health consultations, address coverage and reimbursement.
* 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.

Community linkages to social programs

* + - Develop pathways to address or consider individual social need, such as transportation to and from clinics, food insecurity and housing instability.

## DOH & Public Health Agencies

Patient Education and Provider Communication

* Strategies to increase access can be targeted towards barriers at the individual, social, and structural levels.
	+ Strategies to address individual barriers to care include:
		- Increase education around perinatal behavioral health to reduce stigma and increase awareness of existing services
* Create education campaigns on signs and symptoms of maternal behavioral health and where to go to receive care if a concern arises.
	+ Collaborate across all public health care and social needs agencies (i.e. DSHS, DCYF, HCA, DOH, ESD, Commerce) in unified educational messaging

Integrated Behavioral Health

* + 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.

Community linkages to social programs

* + - Develop pathways to address or consider individual social need, such as transportation to and from clinics, food insecurity and housing instability.
	+ 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.

## Purchasers

Integrated Behavioral Health

* Cover mental health consultation as part of perinatal health care and post-delivery in recognition of pregnancy being a significant life event.

Expanded team roles (doulas, etc)

* 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[[37]](#endnote-38))
* Expand coverage for community-based pregnancy and maternity care (e.g., midwives, home visits, group visits, community-based doulas)
	+ Are home births covered?

## Appendix X Person-Centered Care

Person-centered care starts with the use of non-stigmatizing language in written materials and in personal encounters. The University of California San Francisco offers the resource for HIV #LanguageMatters: Addressing Stigma by Using Preferred Language available [here](http://www.hiveonline.org/wp-content/uploads/2016/01/Anti-StigmaSign-Onletter1.pdf). Example: *Person living with HIV* rather than *HIV infected person*.[[38]](#endnote-39)

Abuse, violence, and other forms of trauma are widespread. The landmark 1998 study on adverse childhood experiences (ACEs) shows the high prevalence of ACEs across populations and links these experiences to a lifetime risk of poor health outcomes such as alcoholism, depression, heart disease, cancer, and obesity.[[39]](#endnote-40) While children are highly sensitive to trauma, as seen through these later health impacts, trauma is also impactful for adults. Trauma-informed care is built on understanding a person’s individual life experiences (e.g., asking what has happened to you) and the need for a clinical encounter to empower rather than re-traumatize a person.[[40]](#endnote-41) The term was developed to integrate an understanding and strategies to mitigate trauma into delivery of behavioral health care and has since been adapted to physical health services and to delivery of integrated physical and behavioral health services.[[41]](#endnote-42) Many of the individual elements have been regularly used in the delivery of care for decades including addressing a person’s distress, providing emotional support, encourages positive coping, but practice is ahead of literature and no best-practice guideline or widely used metric to track practitioner adherence to trauma-informed care exists.[[42]](#endnote-43)

Integrating trauma-related issues into counseling has had positive effects for survivors of physical and sexual abuse and shown reductions in mental health symptoms.[[43]](#endnote-44) In many cases, providers operate under the assumption that someone has experienced trauma without directly asking whether this is so, a universal precautions approach.[[44]](#endnote-45) Key aspects include fostering a person’s feeling of safety in the clinical encounter and developing a positive, trusting person-provider relationship. Trust is based in a one party being vulnerable, such as through having an illness or a lower level of knowledge and believing the other party will care for their interests.[[45]](#endnote-46) Fidelity, competency, honesty, and confidentiality are also dimensions of trust.39

Reproductive and sexual health questions and services can feel especially invasive for a person who has experienced trauma. Establishing or reaffirming a person-provider relationship rests on developing interpersonal skills including being non-judgmental, providing reassurance, reaffirming that the person can and should ask questions, and talking about the person’s goals of care or treatment.62 This workgroup does not endorse a single guideline for trauma-informed care as this care philosophy cannot be operationalized through a checklist, although checklists can serve as a starting point.

Many organizations have developed toolkits to support trauma-informed care. The Centers for Disease Control and Prevention lists six principles to a trauma-informed approach: [[46]](#endnote-47)

* **Safety**: Staff and people receiving care feel physically and psychologically safe
* **Trustworthiness and transparency**
* **Peer support**: Those with lived experience of trauma as allies in recovery or using stories
* **Collaboration and mutuality**: Decision making is shared, power differentials among staff or between providers and people receiving care is reduced
* **Choice**: Empowerment and self-advocacy
* **Cultural, historical and gender issues**: Recognizing and addressing historical trauma, removing provider bias, care that is responsive to cultural background

Moving to a trauma-informed approach in a clinical setting starts with being trauma-aware, as the Substance Abuse and Mental Health Services Association (SAMHSA) does through their four Rs:[[47]](#endnote-48)

* **Realization** that anyone may have experienced trauma and their behavior can be understood as a coping strategy to address past trauma
* **Recognize** the signs of trauma
* **Respond** to the above through using a universal precautions approach (e.g., all people are approached as though they have experienced trauma)
* **Resist Re-traumatization** by seeking to not create toxic or stressful environments

While a universal trauma precautions approach negates the need for explicit trauma screening, some practices, such as pediatric practices, have found screening to be helpful. The American Academy of Pediatrics offers clinical assessment tools for people who have been exposed to violence [here](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Clinical-Assessment-Tools.aspx), including adverse childhood experiences. The signs of trauma are diverse, varying from person to person, include emotional, physical, cognitive, and behavioral signs, and may change over time.[[48]](#endnote-49) A non-exhaustive list includes:

* Emotional: Emotional dysregulation anger, anxiety, sadness, and shame, numbing or detachment
* Physical: sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders
* Cognitive: Cognitive errors, misinterpreting situations dangerous, excessive or inappropriate guilt, idealization, rationalization, delusions, intrusive thoughts or memories

Behavioral: reenactments, self-harm or self-destructive behaviors

1. Garcia, E.R., Yim, I.S. 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 (2017). https://doi.org/10.1186/s12884-017-1495-1 [↑](#endnote-ref-2)
2. Anokye R, Acheampong E, Budu-Ainooson A, Obeng EI, Akwasi AG. Prevalence of postpartum depression and interventions utilized for its management. Ann Gen Psychiatry. 2018 May 9;17:18. [↑](#endnote-ref-3)
3. Zhou J, Ko JY, Haight SC, Tong VT. Treatment of Substance Use Disorders Among Women of Reproductive Age by Depression and Anxiety Disorder Status, 2008-2014. J Womens Health (Larchmt). 2019 Aug;28(8):1068-1076. [↑](#endnote-ref-4)
4. Bauman BL, Ko JY, Cox S, et al. Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018. MMWR Morb Mortal Wkly Rep 2020;69:575–581. [↑](#endnote-ref-5)
5. Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM. The Prevalence of Anxiety Disorders During Pregnancy and the Postpartum Period: A Multivariate Bayesian Meta-Analysis. J Clin Psychiatry. 2019 Jul 23;80(4):18r12527. [↑](#endnote-ref-6)
6. Dennis CL, Falah-Hassani K, Shiri R. Prevalence of antenatal and postnatal anxiety: systematic review and meta-analysis. Br J Psychiatry. 2017 May;210(5):315-323. doi: 10.1192/bjp.bp.116.187179. Epub 2017 Mar 16. PMID: 28302701. [↑](#endnote-ref-7)
7. S Kendig, JP Keats, MC Hoffman, LB Kay, ES Miller, TAM Simas, et al. Consensus bundle on maternal mental health: perinatal depression and anxiety. *Journal of Obstetric, Gynecologic & Neonatal Nursing*. 2007: *46*(2), 272-281 [↑](#endnote-ref-8)
8. [Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4: (washington.edu)](https://oce-ovid-com.offcampus.lib.washington.edu/article/00006250-202306000-00035/HTML#context-T2) [↑](#endnote-ref-9)
9. [perinatal mental and Substance Use Disorders (psychiatry.org)](https://www.psychiatry.org/getmedia/344c26e2-cdf5-47df-a5d7-a2d444fc1923/APA-CDC-Perinatal-Mental-and-Substance-Use-Disorders-Whitepaper.pdf) [↑](#endnote-ref-10)
10. Forray A. Substance use during pregnancy. F1000Res. 2016 May 13;5:F1000 Faculty Rev-887. doi: 10.12688/f1000research.7645.1. PMID: 27239283; PMCID: PMC4870985. [↑](#endnote-ref-11)
11. Prince MK, Daley SF, Ayers D. Substance Use in Pregnancy. [Updated 2023 Apr 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK542330/ [↑](#endnote-ref-12)
12. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy [↑](#endnote-ref-13)
13. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications> [↑](#endnote-ref-14)
14. 27. Miller ES, Grobman WA, Ciolino JD, Zumpf K, Sakowicz A, Gollan J, Wisner KL. Increased depression screening and treatment recommendations after implementation of a perinatal collaborative care program. Psychiatric Services. 2021 Nov 1;72(11):1268-75. <https://doi.org/10.1176/appi.ps.202000563>. Accessed August 18, 2022; Byatt N, Levin LL, Ziedonis D, Moore Simas TA, Allison J. Enhancing participation in depression care in outpatient perinatal care settings: A systematic review. Obstet Gynecol. 2015 Nov;126(5):1048-1058. <https://doi.org/10.1097/AOG.0000000000001067>. Accessed August 18, 2022.; Reiss-Brennan B, Brunisholz KD, Dredge C, Briot P, Grazier K, Wilcox A, Savitz L, James B. Association of integrated team-based care with health care quality, utilization, and cost. JAMA. 2016 Aug 23;316(8):826-34. <https://doi.org/10.1001/jama.2016.11232>. Accessed August 18, 2022.;Perinatal Mood Disorders in an Integrated Mul�-site Pediatric and Obstetric Se�ng. Matern Child Health J. 2019 Oct;23(10):1292-1298. doi: 10.1007/s10995-019-02780-x. PMID: 31222600 [↑](#endnote-ref-15)
15. NK Grote, WJ Katon, JE Russo, MJ Lohr, M Curran, E Galvin, E, et al. Collaborative care for perinatal depression in socioeconomically disadvantaged women: a randomized trial. *Depression and anxiety*. 2015: *32*(11), 821-834. [↑](#endnote-ref-16)
16. N Byatt, TAM Simas, RS Lundquist, JV Johnson, DM Ziedonis. Strategies for improving perinatal depression treatment in North American outpatient obstetric settings. *Journal of Psychosomatic Obstetrics & Gynecology*. 2012: *33*(4), 143-161. [↑](#endnote-ref-17)
17. Srivastava A, Kahan M, Nader M. Primary care management of opioid use disorders: Abstinence, methadone, or buprenorphine-naloxone? *Canadian Family Physician.* 2017;63(3):200-205. [↑](#endnote-ref-18)
18. NIH Consensus Statement Effective medical treatment of opiate addiction. 1997;15(6):1–38. [↑](#endnote-ref-19)
19. Opioid Use and Opioid Use Disorder in Pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. *Obstet Gynecol.* 2017; 130:e81-94. Available: [www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1&ts=20170918T1748041836](http://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1&ts=20170918T1748041836) [↑](#endnote-ref-20)
20. Forray A. Substance use during pregnancy. *F1000Res.* 2016;5:F1000 Faculty Rev-887. Published 2016 May 13. [↑](#endnote-ref-21)
21. <https://integrationacademy.ahrq.gov/products/topic-briefs/pregnant-postpartum-women?_gl=1%2Axtpsu2%2A_ga%2ANzEyNjE5MjgxLjE2OTMyMzg2ODQ.%2A_ga_1NPT56LE7J%2AMTY5NDQ1ODAwMy4yMi4xLjE2OTQ0NTgwNTYuNy4wLjA>. [↑](#endnote-ref-22)
22. [Teaching Patients: Integrated Ambulatory Care | The Academy (ahrq.gov)](https://integrationacademy.ahrq.gov/playbooks/behavioral-health-and-primary-care/implementing-plan/educate-patients-and-families-about-integrated-ambulatory-care) [↑](#endnote-ref-23)
23. <https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/#section2> [↑](#endnote-ref-24)
24. [141-087 LactationAndSubstanceUseGuidanceForHealthCareProfessionals (waportal.org)](https://waportal.org/sites/default/files/documents/Perinatal%20Substance%20Use/141-087%20Lactation%20and%20Substance%20Use%20Guidance%20for%20Health%20Care%20Professionals.pdf) [↑](#endnote-ref-25)
25. [National Maternal Mental Health Hotline | MCHB (hrsa.gov)](https://mchb.hrsa.gov/national-maternal-mental-health-hotline) [↑](#endnote-ref-26)
26. Lee King PA, Duan L, Amaro H. Clinical needs of in-treatment pregnant women with co-occurring disorders: implications for primary care. Matern Child Health J. 2015 Jan;19(1):180-7. doi: 10.1007/s10995-014-1508-x. PMID: 24770992. [↑](#endnote-ref-27)
27. [Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice](https://watermark.silverchair.com/peds_20183259.pdf?token=AQECAHi208BE49Ooan9kkhW_Ercy7Dm3ZL_9Cf3qfKAc485ysgAAAyswggMnBgkqhkiG9w0BBwagggMYMIIDFAIBADCCAw0GCSqGSIb3DQEHATAeBglghkgBZQMEAS4wEQQMBKjH7CuW2eVBcqUgAgEQgIIC3gx9YVFkaH9C8h6WQtG_2_5dGJENaOvl57K-A0Pw5VfUn17DM4cqVXwf4tMLHyHT6HeRL3NTnz1jiEgatDTfTHO_gyApYvq6ALFwQImEwkoQBq15GJtI61vjbEzLICp17iv1Lr7p-AzeRLloXUGufm0A0IW_QkThKDc47sAyxxFj2zHqrS_Z0fS5jVO8vwRXaZJZPINq5NQtyUr09NpuikRZ7H6FeRVZK3C5p2bk5DFziND89Q88X6QKxm_UXEwZvN9uLr14E81zDzfhyhOy-pS3S-WKhjUCBOnW6RscYhSHfgUqAvMXmmRyuR2TqhGAGcifjb-J-3XpudH6nCEeaoIaDdp7JdPmGkkBuC8-SUT0pTGDcCnifU-60x1Xclt6AfZ0-qBe3AuSvVD5QU2ey9ayK9J4Rhs_d0RG6X6DJV27KH6kkvp_jwNX7QkbFILk_SqtyEqpAj_IXwMIu7XxJrRRaocCM7AVM_3g2c0V8tBZTr6xt6DOsseCqkDB8FvvP_UOYmc1YMjysORrelF2u_YwDgZ8dCSz7II7KOXNPQgj3dbT_RRzK3-A0q3OYFP2nwrhb-_PFBNewdewiComJP9BdacTV1wU1Ok_YaWiiiFzzTSKfgVZmLsbcfHv7inS27B3xen6EjEmqMYZPMxzPTB8QQiC84aOf6CzB-PP02qhljZzh5hqp0hnXm0a462GrKPtsp7lb7-2bYSLj5DeFZB5S36eqdX_C0CYSLZvtaih8vEFda-xVumVGUjRWI2QgwWgkpF-VZ2-0p64rsVESidbe0KSABMsrEDq1WBpzEcOphYwJ8TKzD0XSesTZ4T0khi6hfeMdpnPpr9QXY3wPrmvDZfaIKmvK-JQbogrusYU8M15rtdZisy7Fpq7Tx21OIOy2Fx8KzBnubV2bNl_0gmE9QCEDQpjtHHknjT6w7U1jgk3rvfCdI52cvj05kJxVWKEiaVovZFbMz-_3o6x) [↑](#endnote-ref-28)
28. [Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum | ACOG](https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline/articles/2023/06/treatment-and-management-of-mental-health-conditions-during-pregnancy-and-postpartum) [↑](#endnote-ref-29)
29. Chang ES, Simon M, Dong X. Integrating cultural humility into healthcare professional education and training. Adv Health Sci Educ Theory Pract. 2012;17(2):269‐278. [↑](#endnote-ref-30)
30. [Waiver Removed for Buprenorphine Prescribing - Washington State Hospital Association (wsha.org)](https://www.wsha.org/articles/waiver-removed-for-buprenorphine-prescribing/)<https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/centers-excellence-perinatal-substance-use/certification> [↑](#endnote-ref-31)
31. [Center of Excellence for Perinatal Substance Use Certification | Washington State Department of Health](https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/centers-excellence-perinatal-substance-use/certification) [↑](#endnote-ref-32)
32. [Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants (samhsa.gov)](https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf) [↑](#endnote-ref-33)
33. <https://perinatalsupport.org/perinatal-trainings/> [↑](#endnote-ref-34)
34. [Many Women Report Mistreatment During Pregnancy and Delivery | VitalSigns | CDC](https://www.cdc.gov/vitalsigns/respectful-maternity-care/index.html) [↑](#endnote-ref-35)
35. Wright T, Terplan M, Ondersma S, Boyce C, Yonkers K, Chang C, Creanga A. 2016. The role of screening, brief intervention, and referral to treatment in the perinatal period. American Journal of Obstetrics and Gynecology. DOI: http://dx.doi.org/10.1016/j.ajog.2016.06.038 [↑](#endnote-ref-36)
36. Sidebottom, A., Vacquier, M., LaRusso, E. *et al.* Perinatal depression screening practices in a large health system: identifying current state and assessing opportunities to provide more equitable care. *Arch Womens Ment Health* **24**, 133–144 (2021). https://doi.org/10.1007/s00737-020-01035-x [↑](#endnote-ref-37)
37. Rousseau S, Katz D, Shlomi-Polachek I, Frenkel TI. Prospective risk from prenatal anxiety to post traumatic stress following childbirth: The mediating effects of acute stress assessed during the postnatal hospital stay and preliminary evidence for moderating effects of doula care. Midwifery. 2021 Dec;103:103143. doi: 10.1016/j.midw.2021.103143. Epub 2021 Sep 14. PMID: 34610495. [↑](#endnote-ref-38)
38. Lynn V, Watson C, Giwa-Onaiwu M, Ray V, Gallagher B, Wojciechowicz V. HIV #LanguageMatters: Addressing Stigma by Using Preferred Language. Accessed: May 2018. Available: <https://hiveonline.org/wp-content/uploads/2016/01/Anti-StigmaSign-Onletter1.pdf> [↑](#endnote-ref-39)
39. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14(4):245‐258. [↑](#endnote-ref-40)
40. Menschner C, Maul A, Center for Health Care Strategies. Key Ingredients for Successful Trauma-Informed Care Implementation. April 2016. Accessed: May 2020. Available: [www.samhsa.gov/sites/default/files/programs\_campaigns/childrens\_mental\_health/atc-whitepaper-040616.pdf.](http://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf.) [↑](#endnote-ref-41)
41. Harris M, Fallot RD. (Eds.). (2001).Using trauma theory to design service systems. 2001. Jossey-Bass/Wiley. [↑](#endnote-ref-42)
42. Marsac ML, Kassam-Adams N, Hildenbrand AK, et al. Implementing a Trauma-Informed Approach in Pediatric Health Care Networks. JAMA Pediatr. 2016;170(1):70-77. [↑](#endnote-ref-43)
43. Reeves E. A synthesis of the literature on trauma-informed care. Issues Ment Health Nurs. 2015;36(9):698-709. [↑](#endnote-ref-44)
44. Tello M. Trauma-informed care: What it is, and why it’s important. Harvard Health Blog. October 16, 2018. Available: [www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562](http://www.health.harvard.edu/blog/trauma-informed-care-what-it-is-and-why-its-important-2018101613562) [↑](#endnote-ref-45)
45. Dang BN, Westbrook RA, Njue SM, Giordano TP. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. BMC Med Educ. 2017;17(1):32. Published 2017 Feb 2. [↑](#endnote-ref-46)
46. Centers for Disease Control and Prevention. Infographic: 6 Guiding Principles To A Trauma-Informed Approach. Accessed May 2020. Available: <https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm> [↑](#endnote-ref-47)
47. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. October 2014. Accessed: June 2020. Available: <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf> [↑](#endnote-ref-48)
48. Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: [www.ncbi.nlm.nih.gov/books/NBK207191/](http://www.ncbi.nlm.nih.gov/books/NBK207191/) [↑](#endnote-ref-49)