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Integrating Mental Health In Perinatal Care: Perspectives Of Interprofessional Clinicians

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ABSTRACT Despite the prevalence of perinatal mental health issues in the United States, gaps in care persist. To address this, perinatal health care settings are asked to focus on patients' mental health by administering standardized screening and, increasingly, by integrating mental health teams in their clinics. Using in-depth interviews and ethnographic observations, I investigated these emerging practices, exploring the experiences of certified nurse-midwives, obstetricians, and mental health clinicians. I found that certified nurse-midwives and obstetricians lack time, resources, and expertise, restricting their ability to address patients' mental health. Integrated mental health clinicians are constrained by the stratified organization of health care and structural deprioritization of mental health. Redesigning perinatal health care and de-siloing mental health training are necessary to increase clinicians' effectiveness and to improve perinatal health outcomes.

Mental health conditions are a leading cause of pregnancy-related death in the United States and are referred to as the most common complication of childbirth.[1,2] Some estimates suggest that up to 40 percent of people experience mental health complications, mainly depression or anxiety, during or after pregnancy.[3] Despite the prevalence of perinatal mental health issues, they are persistently underaddressed.[4,5] Also, both the occurrence of perinatal mental health issues and access to mental health care have been negatively affected by the COVID-19 pandemic.[6,7] As perinatal mental health advocates seek solutions to this problem, perinatal health care settings are increasingly called on to address patients' mental health. As the front line of perinatal health care, certified nurse-midwives and obstetricians are asked by state laws and health care institutions to incorporate mental health into their clinical practice, usually by implementing standardized depression screening. Perinatal health care settings are also encouraged to integrate mental health programs on site, staffing their clinics with clinical social workers, professional counselors, psychologists, and psychiatric nurse practitioners or psychiatrists.[8,9] However, the integration of mental health care in perinatal care has proved to be a challenge. This article draws on the experiences of interprofessional clinicians to examine processes of mental health integration in perinatal health care.

Although the landscape of perinatal health has transformed in the US, the predominant biomedical model of perinatal health care has remained largely unchanged since its inception in 1930.[10] It is characterized by brief appointment times, a fixed prenatal care schedule, and a lack of postpartum care. Certified nurse-midwives and obstetricians today face high patient volume and growing clinical demands within an outdated model of care that is further complicated by fragmented health systems, a lack of mental health resources, and payer limitations.[11] This confluence of issues impedes the incorporation of patients' mental health in perinatal health

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care, and the research on mental health screening in perinatal health care shows mixed results. Although screening sometimes leads to identifying patients' mental health issues, the efficacy of this practice as a pathway to care is disputed because of numerous systemic barriers (for example, lack of time and limited access to resources), inconsistencies among clinicians in administering screening tools, and variable engagement by patients (typically due to mental health stigma and the fear of state-based interventions).[12–16]

Integrating mental health clinicians in perinatal health care settings is one potential mitigation strategy, but it is limited by dynamics in the organization of health care. In integrated perinatal health care settings, certified nurse-midwives, obstetricians, and mental health clinicians face a shared challenge: pressure to respond to perinatal mental health stakeholders' recommendations in an underresourced system. Yet clinicians are systemically categorized and positioned hierarchically in the organization of health care, where physicians hold medical authority and others are seen as secondary experts. Such social stratification of health professionals is well documented.[17–19] Research on the hierarchical organization of health care shows its significant impacts on health professionals and health care, such as the maintenance of gender-based and racial inequalities, a sense of powerlessness among lower-ranking health professionals, and ineffective communication about patient care.[20] Although they are increasingly incorporated in biomedical institutions, mental health clinicians are marginalized in the hierarchical order of these settings, their roles are at times poorly defined or not well understood, and their services remain inadequately compensated by insurance companies.[21–23] Together, these issues pose a challenge for the successful integration of mental health care and health systems' investment in mental health teams, constraining mental health clinicians' influence and leading to workflow and collaboration challenges. This article sheds light on these organizational realities and the impact they have on efforts to integrate mental health in perinatal health care.

Study Data And Methods

This study used constructivist grounded theory[24] to guide data collection and analysis. Grounded theory is a systematic, yet flexible, inductive qualitative research process. Data were collected through semistructured, in-depth interviews and ethnographic observations.

DATA COLLECTION This article draws on thirty-four in-depth clinician interviews, including mental health clinicians who were psychologists, clinical social workers, professional counselors, and psychiatric nurse practitioners working in integrated mental health programs ($n = 20$); certified nurse-midwives ($n = 10$); and obstetricians ($n = 4$). All clinicians worked in the same West Coast metropolitan area. I recruited interview participants from within the setting where I conducted ethnographic observations, by respondent-driven sampling, and by emailing all clinicians on the public websites of predominant perinatal health care organizations in my community. The overall sample reflects the national demographics of certified nurse-midwives, obstetricians, and mental health clinicians, a majority of whom are White women[25–27] (see exhibit 1). Clinician interviews focused on experiences addressing mental health in their professional roles, perceived challenges and gains while integrating mental health in perinatal health care, interprofessional work, and the impact of the COVID-19 pandemic. All interviews were conducted through the teleconferencing platform Zoom, and oral consent was recorded at the beginning of each interview.

From 2019 to 2021, I conducted observations of one integrated mental health program in a large perinatal health care organization, Umbrella Health,[28] which includes fifteen clinics and serves a broad population of people with private insurance and Medicaid. I conducted seventy-five hours of observations, primarily during mental health team meetings, where clinicians discussed patient cases and developed the mental health program (see online appendix exhibit A1).[29] Observations allowed me to study how mental health clinicians in perinatal health care settings conducted their work, conceptualized their role, and transformed their program over time. Near-verbatim field notes were taken during each observation. Study procedures were approved by the University of California San Francisco Institutional Review Board.

DATA ANALYSIS I used established procedures for constructivist grounded theory[24] to analyze data, including inductively developing codes in a multistep process. First, I did a close reading of data from clinician interviews, coding sections of text using words that reflect action (for example, "feeling valued" and "facing high workload"). Initial coding was mostly open-ended, although it was informed by findings in literatures on mental health integration, interprofessional work, and perinatal health care. Next, I engaged in focused coding, making decisions about which initial codes had the most analytic salience about integrating mental health in perinatal health care. This produced a codebook of approximately sixty-five codes. Using the quali-

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EXHIBIT 1

Characteristics of certified nurse-midwives, obstetricians, and mental health clinicians, qualitative study on integrating mental health in perinatal care, 2019–21

Characteristics	Number	Percent
Clinician type		
Certified nurse-midwife	10	29
Obstetrician	4	12
Mental health clinician	20	59
Age, years		
25–30	1	3
31–40	11	32
41–50	15	44
51–60	5	15
Older than 60	2	6
Racial or ethnic identity		
Asian	1	3
Black or African American	1	3
Hispanic or Latino	4	12
White	28	82
Gender identity		
Cisgender woman	34	100
Years providing health care		
Less than 5	5	15
6–10	14	41
More than 10	15	44

SOURCE Data from author's qualitative interviews of clinicians ($N = 34$) from a single West Coast metropolitan area.

tative data analysis software ATLAS.ti, I coded field notes from ethnographic observations and transcripts of clinician interviews (see appendix exhibit A2).[29]

STRENGTHS The qualitative methodology of this study drew on clinicians' perspectives, which shaped these novel insights about mental health integration in perinatal health care settings. My research began before and continued throughout the COVID-19 pandemic, which allowed me to observe the amplification of preexisting stressors in health care, the rapid adoption of telehealth for mental health care, and the unique ways in which mental health integration developed under the strain of COVID-19.

LIMITATIONS The pandemic limited my ability to observe interprofessional clinicians' interactions in clinic settings, and it negatively affected interview participant recruitment, limiting my sample of certified nurse-midwives and obstetricians.

Study Results

THE SITE OF MENTAL HEALTH INTEGRATION Mental health integration in perinatal health care is an emerging model of care with various evolving approaches. In my study, mental health teams in perinatal health care settings typically consisted of seven to twelve clinical social workers, professional counselors, and psychologists who provided most mental health care, usually via thirty-to-fifty-minute individual appointments. Most care was clinic based, although one program staffed a home visiting nurse. Some organizations employed one psychiatric nurse practitioner or psychiatrist who provided psychiatric evaluation and medication management for pregnant and postpartum patients and psychiatric medication consultation for certified nurse-midwives and obstetricians. Mental health team staffing was unstable and changed many times over the course of my research. Most commonly, referrals to mental health teams were based on the discretion of nurse-midwives and obstetricians and on standardized screening measures, such as patient scores from the Edinburgh Postnatal Depression Scale. Integrated mental health programs were supported by health care organization funds; short-term grants; and, mainly, insurance reimbursement for billable mental health services.

FRONT-LINE CHALLENGES: PERINATAL HEALTH CLINICIANS AND MENTAL HEALTH Efforts to implement mental health screening in perinatal health care, whether by administering the Edinburgh Postnatal Depression Scale or asking patients unscripted questions about mental health, generated discomfort among nurse-midwives and obstetricians. They encountered a tension between this emerging philosophy of care and multiple forces impeding their efforts. Challenges were compounded during the COVID-19 pandemic, when patients' mental health worsened and the stress of providing perinatal health care intensified. Multiple clinicians said that they were afraid to "open Pandora's box"—worried that if they asked about mental health issues, patients might disclose something that was beyond their comfort to address or for which they would lack time and access to appropriate care strategies.

Given the brevity of most perinatal health care visits, nurse-midwives and obstetricians worried that they would need to interrupt a distressed patient and leave abruptly without a satisfactory care plan. Jackie,[28] a nurse-midwife, explained that asking about a patient's mental health can set in motion a difficult clinical encounter, saying, "That question right there is, like, a whole visit." Obstetrician Rachel said, "I don't have the bandwidth to get into that. …It's one of those Pandora's box things. When you bring it up, you have to be able to follow through, and I can't do that adequately." Because other needs often take priority, Rachel expressed that clinicians find it challenging to engage discussions about mental health.

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Mental health clinicians and perinatal health clinicians had different notions of what constituted a mental health issue.

Some nurse-midwives and obstetricians cited common psychiatric medications, such as selective serotonin reuptake inhibitors, as the only reliable "tool" they were equipped to offer, and expressed worry about treatment options beyond that. Nurse-midwife Angela explained: "If it seems like a fairly straightforward issue—some anxiety, some depression—and the person is really feeling like they're needing to start medication…and we've talked about the pros and cons of starting meds, I'm happy to start them on a medication. I don't always feel comfortable managing it, or if a medication isn't working for them, I'm not comfortable figuring out which one is better for them. I feel like it's just not my area of expertise, and I want to get them to someone [who is an expert] to get them on the best thing as quickly as possible."

Despite their ability to offer medications, clinicians such as Angela still felt out of their depth when it came to addressing mental health, and perinatal health clinicians overwhelmingly expressed the belief that they were undertrained to adequately address their patients' mental health. Nurse-midwife Hailey said, "If we're not being trained on it, then it's really fearful to jump into that whole new world." This led to a fundamental lack of confidence with the terrain of mental health, and it permeated clinicians' experiences providing care.

Multiple clinicians said that they would try "two rounds of antidepressants" with patients, but if both trials failed, they sought psychiatric consultation or a psychiatric referral—a scarce resource that was not always accessible, even in perinatal health care settings with integrated mental health programs. This challenge was compounded by limited availability for patient follow-up. Not being able to have frequent or consistent contact with patients was a rationale deployed by nurse-midwife Hailey, who explained that "for safety reasons," addressing mental health "is not necessarily always the best choice for us." For her and others, prescribing medications felt risky because their schedules did not allow close monitoring of patients.

Key barriers for nurse-midwives and obstetricians include a lack of resources, time, and expertise, all underscored by diagnostic ambiguity in mental health, leading clinicians to fear that they might either fail to identify mental health issues or identify mental health issues they would not be able to adequately address.

MENTAL HEALTH CLINICIANS IN PERINATAL CARE: PROFESSIONAL DISPARITY AND HIGH DEMAND Certified nurse-midwives and obstetricians faced a paradox. Although being called on to address patients' mental health, they were structurally constrained and lacked the expertise to confidently do so. Integrating mental health clinicians in perinatal health care settings was seen as a logical solution to this quandary. However, a high ratio of perinatal health clinicians to mental health clinicians, referral ambiguity, and interprofessional dynamics generated high patient volume and ethical concerns for mental health teams.

In the absence of clear referral standards, many nurse-midwives and obstetricians employed a liberal referral strategy for patients. For instance, the mental health team at Umbrella Health received thirty referrals per day and maintained a waitlist of nearly eighty people. Mental health clinicians reported being routinely pulled into exam rooms by nurse-midwives and obstetricians for warm handoffs, a practice that was used as brief crisis intervention and to increase the likelihood that patients would follow through with a mental health referral. Warm handoffs primarily brought comfort to clinicians seeking resolution to a patient's problem. Karla, a clinical social worker, pointed out that having the mental health team readily available "is a satisfier for providers. [Nurse-midwives and obstetricians] know they can't just say [to their patients], 'Well, here's a referral list. You should try that out.' I mean, that fails almost a hundred percent of the time." But for Ruth, a psychologist, warm handoffs and frequent informal "hallway consults" with her perinatal health clinician colleagues were disruptive. She said, "You can't keep up with your workload if you're getting sucked into all these consults about sad stories during the day." Although nurse-midwives and obstetricians benefited from access to mental health clinicians, this approach was burdensome and disrupted mental health clinicians' patient care.

Critically, mental health clinicians and perinatal health clinicians had different notions of

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what constituted a mental health issue. In one observation of a mental health team meeting at Umbrella Health, psychologist Lynne explained, "If someone cries, it's a crisis client, even if it is just grief. They cry. Sometimes that makes [nurse-midwives and obstetricians] uncomfortable. So, their [definition of] crisis is different than mine. They don't understand what crisis means to us." Other members of the mental health team agreed and saw opportunities for nurse-midwives and obstetricians to be more discerning. Professional counselor Bethany responded to Lynne, saying, "I feel like it [is important for] clinicians who are not mental health oriented to become more competent with just sitting with someone when they cry, because we get a ton of warm handoffs, like 'This person's crying. I don't know what to do. Can you come talk to them?'" Mental health clinicians' perspectives reflect perinatal health clinicians' concerns that they are unprepared to address their patients' mental health, and it highlights another piece of the puzzle in the quest to address patients' mental health: What constitutes a mental health issue requiring specialty mental health care?

In part because of this lack of clarity, pressure to respond to every referral was evident among integrated mental health teams. This pressure also reflected interprofessional dynamics in the stratified perinatal health care setting. Some said that they felt they had to "be in a yes place," always responding positively to nurse-midwives and obstetricians. Although mental health clinicians sometimes felt valued by their colleagues, they also articulated feeling "less than" in the social order of the perinatal health care clinic. As clinical social worker Hannah remarked, "Because we're at the bottom of the rank, the team's always set up to feel like they have to say yes in order to prove their value and contribution to the team." Mental health clinicians perceived that they were obligated to respond to perinatal health clinicians' requests, even if their clinical judgment about a patient's mental health led them to a different conclusion. Professional hierarchy, combined with a professional ethos to be supportive, contributed to integrated mental health teams' unmanageable workloads.

Meeting the high demand for their services led to concerns about diminished quality of care, and many mental health clinicians struggled with professional ethics as a result. Clinical social worker Jennifer described her workload as "crushing," and she and others explained the compromises mental health teams had to make to get by. She said, "For a while, our model was able to sustain five to six patients a day. They'd have a full counseling hour. We could see them every two weeks. And they were actually able to make progress. But the volume can't sustain that anymore. We've had to do more of a short-term intervention model, which is hard because some of those diagnoses don't really respond all that well to short-term [intervention]."

It is crucial to de-silo mental health, making it a prime focus rather than an auxiliary component of perinatal health care training.

Mental health clinicians reported that in addition to reduced appointment times and shorter-term care, patients frequently waited four to six weeks between appointments, but their standard of care is to see most patients at least every two weeks. As clinical social worker Mariana explained, "People are really, really distressed in that moment, and then having to wait a little while, and especially if they're in the third trimester and we're really wanting to set them up, you know, it's not ideal." Because the perinatal period is fleeting and early intervention improves health outcomes, mental health clinicians understood the acute need for timely mental health care. Thus, they saw lengthy wait times and limited sessions as incongruent with ethical and effective mental health care.

Hannah, a clinical social worker, addressed the disparity between patient need and access to high-quality care, saying, "It's a tension and contradiction people are always holding." She pointed to potential consequences of this for clinicians, saying, "It's not good practice to be burnt out and fried when meeting with people." There were no easy ways to manage these challenges, and some clinicians compromised their own well-being by working longer hours to accommodate more patient appointments.

COVID-19 AS A CATALYST FOR CHANGE At Umbrella Health, the COVID-19 pandemic became an important catalyst for the mental health team to consider questions about referral workflow and role boundaries. At a meeting in December 2021, the team discussed how telehealth reduced their physical contact with certified nurse-mid-

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wives, obstetricians, and patients in the clinics. At that point, nearly two years had been spent providing patient care without warm handoffs. The team discussed "being realistic about the value of warm handoffs," with multiple clinicians suggesting that they are not a direct line to future patient engagement. The mental health team welcomed this change, which they felt protected their capacity for direct patient care, instead of being "continuously available" to nurse-midwives and obstetricians. Because the mental health team's migration to telehealth during the COVID-19 pandemic led to a "natural death" of warm handoffs, the mental health clinicians were able to experience a significant positive change to their practice without confronting the hierarchical dynamics of the perinatal health care setting. This unique situation clarified the team's preferences about how to provide care as mental health experts situated in perinatal health care.

At the same time, the mental health team also established a standardized referral protocol with strict criteria, which included a diagnosis of a fetal anomaly or other perinatal loss, an Edinburgh Postnatal Depression Scale score of 15 or higher, or a medication consultation with the team's psychiatric nurse practitioner. Pivoting away from the norm of saying "yes" to referrals, the mental health director instructed their referral manager to, "when in doubt, say no." This was a significant shift for the team, and it made an impact. In one stretch of five days, the mental health team triaged 120 referrals, of which only 5 met the new threshold. This protocol had mixed effects, as it simultaneously defined an appropriate mental health referral; limited nurse-midwives', obstetricians', and patients' access to mental health care; and protected the mental health team's workload, which underscores the competing needs inherent in mental health integration in perinatal health care.

Discussion

Understanding and tackling the challenges that clinicians face on the quest to address perinatal mental health is central to the development of health care that both is sustainable for clinicians and reflects the mental health needs of pregnant and postpartum people. This research points to several opportunities for health care practice and policy in the ongoing effort to improve perinatal health and health care. Certified nurse-midwives and obstetricians routinely face patients with mental health concerns, but they lack time, resources, and strategies to provide meaningful care with confidence. Addressing this gap is key to improving perinatal health care and health outcomes. Beginning with midwifery and medical education and continuing throughout professional development, it is crucial to de-silo mental health, making it a prime focus rather than an auxiliary component of perinatal health care training. Professional organizations, licensing bodies, and educational institutions can support this aim by developing educational modules that are widely distributed and accessible. Redesigning the structure of perinatal care to include more time in the clinical encounter and postpartum visits made early, often, and through the first year after childbirth would improve the system-level conditions for clinicians to better address patients' mental health, as would expanding the use of models shown to positively affect perinatal mental health, such as CenteringPregnancy and CenteringParenting.[30,31]

Mental health teams in perinatal health care settings should be staffed to a size that reflects the significance of mental health needs in pregnancy and postpartum. If clinic space is a barrier to expansion, there is promise in the use of telemental health services, especially for pregnant and postpartum people.[32–35] As shown in my research, integrated mental health teams may benefit from the implementation of mental health referral protocols, effectively communicating these standards with their nurse-midwife and obstetrician colleagues. Warm handoffs are limited in their efficacy,[36] and my research found that they were burdensome and contributed to a perceived lack of autonomy for mental health clinicians. This practice should be carefully evaluated in integrated settings. Group therapy or facilitated peer support as part of integrated programs could address workload challenges, more expediently meet patients' needs, and enable higher levels of social support for patient populations,[37,38] as long as they are adequately supported by insurance payers. The primary structural barrier to sustaining mental health programs in perinatal health care is the quagmire of managing multiple private and public payers' demands, limitations, and reimbursement shortfalls, all of which contribute to health systems' lack of investment in mental health care. Health policy must prioritize securing sustainable reimbursement rates and billing procedures that are not administratively burdensome.

Conclusion

This study investigated mental health integration in perinatal care, analyzing the perspectives of interprofessional clinicians on the front lines of this emerging model of perinatal health care. Integrating mental health clinicians with certified nurse-midwives and obstetricians in

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perinatal health care settings is regarded as progress toward addressing patients' mental health needs. However, this well-intended intervention for perinatal mental health is structurally constrained in its effectiveness. For nurse-midwives and obstetricians, limited time in the clinical encounter and a lack of mental health competence impedes their ability to effectively address their patients' mental health needs. For mental health clinicians in perinatal health care, high patient volume and marginalization in the stratified organization of perinatal health care settings compromise the care they provide. Initiatives to improve the structure of perinatal health care and substantially increase mental health care access in innovative ways is necessary for clinicians to thrive in their work and for patients to receive the holistic perinatal health care they deserve. ■

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