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Needs Assessment: Expanding Perinatal Psychiatry Access Programs to Support Infant Care Professionals and Postpartum Individuals

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Research Article

Keywords: maternal mental health, perinatal care, mental health, needs assessment

Posted Date: May 13th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9372318/v1

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Additional Declarations: Competing interest reported. Dr. Byatt has received salary and/or funding support from Massachusetts Department of Mental Health via the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms). She is also the Medical Director of Research and Evaluation for MCPAP for Moms and the Executive Director of the Lifeline for Families Center at UMass

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Abstract

Background

The Perinatal Psychiatry Access Program model (i.e., Access Program) aims to address mental health (MH) inequities among pregnant and postpartum individuals by providing MH training and support to perinatal care professionals. Despite program expansion, perinatal MH and substance use disorders (SUDs) remain significant contributors to postpartum maternal mortality. Collaborating with infant care professionals may enhance detection and access to MH/SUD treatment. This needs assessment explored infant care professionals' interest in recognizing and responding to the MH/SUD needs of pregnant and postpartum individuals and assessed the degree to which the statewide Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms), could meet the needs of these professionals.

Methods

We conducted four focus groups (n = 33) and 20 interviews (n = 22) with public health professionals, MCPAP for Moms staff, and child-focused professionals. Sessions were transcribed and coded using iterative thematic analysis.

Results

Although most infant care professionals expressed interest in perinatal MH/SUDs, this interest varied based on their recognition of parental MH as within their purview. Training and systematic support for perinatal MH/SUDs was not common in infant care settings.

Conclusions

These findings highlight infant care professionals' interest in supporting postpartum individuals with perinatal MH/SUDs as well as the need for an increased prioritization of workforce development to serve the infant care system and ultimately improve the lives of families. Hiring additional staff, including a liaison from the early childhood community, and leveraging existing networks to improve consultation, resource referrals, and communication with infant care professionals is recommended.

Introduction

Untreated perinatal mental health and substance use disorders (MH and SUDs) can have lasting effects on both the pregnant individual and the child, negatively impacting an infant's early development, attachment, and socio-emotional development [1]. They are also the leading cause of mortality during the perinatal period, contributing to 23% of maternal deaths [2].

The American College of Obstetrics and Gynecology (ACOG) recommends screening for depression at least twice during pregnancy and again at postpartum visits [3]. Given the impact of perinatal MH and SUDs on maternal and child physical and mental well-being, efforts have expanded to improve the detection and treatment of perinatal MH and SUDs. For instance, the Perinatal Psychiatry Access Program model (i.e., Access Program model) aims to reduce mental health inequities among pregnant and postpartum individuals at the patient, clinician, practice, community, and policy levels by building the capacity of perinatal care professionals to address MH and SUDs [4]. They do this by providing training, implementation assistance, consultation, and resource linkages to various care settings (e.g., OB/GYN, primary care, psychiatry). As of 2024, there are 30 state, regional, or national programs using this model [5].

Despite ACOG's recommendations and the growth of Access Programs across the US, perinatal MH and SUDs remain largely underdiagnosed and untreated [6]. One potential area for improvement is diagnosis and treatment during the postpartum period when the risk for morbidity and death is heightened [7, 8]. Although Access Programs support obstetric, primary care, and psychiatry providers in addressing perinatal MH and SUDs [9], these providers have less impact postpartum, as there is a reduction in contact with OB/GYNs or primary care providers compared to the prepartum period [10]. Further, marginalized communities often experience additional barriers to accessing quality perinatal MH care, necessitating targeted strategies to improve access to perinatal MH and substance misuse support and treatment [11].

Collaboration with professionals who regularly engage with perinatal populations may improve detection and treatment access for postpartum individuals with MH and SUD challenges. Child-focused professionals – especially *infant care professionals* such as childcare, Early Head Start, and home visiting staff working with infants (birth to 12 months) – frequently interact with perinatal individuals in the postpartum period. They may have multiple opportunities to recognize signs of perinatal MH and SUDs and offer support in day-to-day interactions. Furthermore, they often have trusted relationships with families, which may facilitate referrals to MH resources [12].

This needs assessment was conducted as part of a larger Quality Improvement initiative for the Massachusetts Department of Mental Health and the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms) [13]. We sought to explore ways to address perinatal MH in child-focused care settings and learn how the MCPAP for Moms program could be expanded to address the MH/SUD needs of pregnant and postpartum individuals. Specifically, we set out to answer: 1) Are infant care professionals interested in and comfortable recognizing and referring pregnant and postpartum individuals at risk for perinatal MH and SUDs to needed services?; 2) Is it feasible for infant care professionals to recognize and respond to pregnant and postpartum individuals at risk for perinatal MH and SUDs?; 3) What MCPAP for Moms components can feasibly be leveraged to meet the needs of infant care professionals?; and 4) What enhancements need to be made to the current MCPAP for Moms' model to build the capacity of infant care models to recognize and refer pregnant and postpartum individuals at risk for perinatal MH and SUDs to services?

Method

Setting and Procedures

We conducted a qualitative needs assessment as part of a broader quality improvement initiative requested by the Massachusetts Department of Mental Health. The needs assessment involved four focus groups (n = 33) and 20 individual interviews (n = 22) with professionals working in early childhood (birth to 5 years), infant care (birth to 12 months), or MH settings in Massachusetts (e.g., MCPAP for Moms, perinatal MH providers, and public health advocates). Interviews were conducted virtually over Zoom over a six-month period in 2021. Respondents provided contact information for potential interviewees. An email was sent to prospective respondents describing the goals of the needs assessment, reimbursement details, and confidentiality measures.

During interviews, respondents were asked about current or potential barriers and facilitators to an infant care professionals' ability to recognize and respond to the needs of pregnant and postpartum individuals with perinatal MH and substance misuse. They were also asked about potential partnerships, infrastructure, and training that might facilitate this process. Child-focused professionals were asked about their experience and confidence with identifying substance misuse and MH challenges (See Supplemental Materials). Interviews and focus groups lasted no longer than one hour and were audio-recorded with attendees' permission. The project coordinator and interview facilitator each took field notes during the interviews/focus groups to capture initial impressions and major themes. Next, audio recordings were transcribed and de-identified by a professional transcription service. Lastly, respondents completed a brief demographic survey and were offered a $50 electronic gift card as reimbursement. This quality improvement initiative was reviewed by the [*blinding*] IRB, and it was determined that it did not meet the criteria for human subjects' research.

Data Analysis

An iterative thematic analysis approach was used to code and analyze the content of the interviews and focus groups. A project coordinator tracked frequencies of commonly discussed topics in a spreadsheet, organized by respondent type and interview question. These frequencies guided monthly meetings with the quality improvement team (coauthors and perinatal MH experts). The team monitored for representation of diverse perspectives (geographic, racial/ethnic) and concluded interviews when thematic saturation was achieved with adequate representation. After the final interview, two project coordinators (*blinded initials)* created a codebook, based on the frequency tracking spreadsheet, that was used to formally code each interview transcript. Project coordinators came to a consensus on any sections with coding discrepancies through discussion. The final codebook guided the thematic analysis and identification of primary themes by the QI team.

Results

Respondents

We interviewed (N = 55) MH and public health professionals (n = 30), staff members at MCPAP for Moms (n = 6), and child-focused professionals (n = 19) spanning Massachusetts (see Fig. 1). Of the 19 child-focused professionals, 14 reported providing direct infant care. We received 41 responses to our demographics survey. Our respondents (n = 41) were predominantly female (95.1%). The most common age group was 40–49 years (34.2%), closely followed by 50–59 years (26.8%). On average, respondents had 20 years of experience working with perinatal populations.

Most respondents identified as white (75.6%) and non-Latina/o/a/e (95.1%); 7.3% identified as Asian, 7.3% identified as Black/African American, 7.3% identified as multiracial, and 2.5% did not disclosure their race. Among child-focused professionals, all respondents to the survey (n = 15) reported having at least some postsecondary education; 13.3% had some college experience, 40.0% had earned a bachelor's degree, and 46.7% had earned a graduate degree.

1.1. Child-Focused Professionals' Interest and Level of Comfort

Overall, respondents communicated a need for additional resources and guidance in addressing both general and perinatal MH. Many were passionate about addressing family dynamics and the idea of MH or SUD-related training and screening tools (See Table 1, 1.1). However, variability existed with respect to the recognition of parental MH as within the infant care professionals' purview. Some programs reported a family-focused model that emphasized family dynamics and the impact of the parent's MH on the child. These professionals described being integrated into the family, maintaining a connection, and consistently communicating with the parents – one participant even referred to their staff as serving a "co-parenting" role (See Table 1, 1.1).

Table 1
Interviewee Responses

Theme	Response
1.1. Child-Focused Professionals' Interest and Level of Comfort	
Interest in MH/SUD-related training and screening tools	*I think trainings would be super helpful. I feel like it would be just another step in being proactive, like we do with our screenings. I think it would just make the process of service just more fluid because then the teachers could connect with a family service coordinator, and they could connect with mental health if they needed to. And then we can kind of go from there.*
'Family-focused' model	*[Child-focused professionals] spend their day with children and see themselves as experts, so when the parents come to pick up their child, they're assessing them. Like, 'I've just been with your child for 10 hours. Are you good to take them?' They're very much co-parenting.*
'Child-focused' model	*When the parents come, they usually just come, say hi and drop off the kids. We don't really talk. Each day, I send them updates to let them know about the child's day. Were they happy? Did they eat? I just don't really talk with the parents that much.*
2.1 Feasibility: Needs of Infant Care Professionals	
Education and Training	*[Child-focused professionals] respond to training. We trained staff on how to use the Edinburgh, and I think it was really successful. I know many of them love feeling more skilled at diagnosing. It makes them feel like their job has some credentialing behind it, and can be a morale booster for them to learn this kind of stuff.*
More accessible consultation services	*We'd love to have a clinical social worker on staff for [consultation]. If we see a family struggling, we could get them connecting with that clinical social worker for a one-on-one consultation and maybe some supportive sessions for 3 months to help them develop a plan.*
Resource and referral specialist	*I think that it [resource and referral specialist] would only be an added benefit, because this is a clinical program, and we're not clinicians. We're very clear about that and the work that we do when we communicate with community partners and our families.*
Need for partnerships and community	*If we have all of these people (e.g., doulas, childbirth educators, lactation consultants, OB/GYNs, midwives, mental health professionals, social workers, WIC providers, church auxiliary clubs, home visiting programs) on the same page as an overarching bubble for our new families, then and only then will we see a decrease in postpartum depression so that we can focus on the families that really need that [intense] care.*
2.2 Feasibility: Perceived Needs of Pregnant and Postpartum Individuals	
Accessible mental health services	*I think one barrier is that we're dealing with a very stressed profession, but the need is still there. People want to know what to do with the mom who's crying in the hallway. What resources can I provide her? What if she speaks Spanish? Where can I send her?*
Lengthy waitlists	*I was speaking with a mom at pickup, and she rolled her eyes and said, 'his name has been on [a] waiting list for 6 months, so I don't know what you want*

Note. Quotations have been slightly modified and paraphrased to protect confidentiality.

Theme	Response
	me to do, but we're just waiting.' The same is true for adults. The system set up in this referral base where then you go sit on a wait list and you have no idea when someone's going to call, people tend to just not want to follow up with it, because it's just another thing that they'll be frustrated about.
Trusted partners and support	*I think a benefit would be accessing information through a trusted partner and not from a stranger. People really do trust their early childhood professionals.*
Increased mental health awareness	*I noticed a huge change. I was really lazy, tired, and unmotivated to cook, clean or take care of myself. But on the outside, I hid it. I was smiling and laughing. It's tricky to recognize that parents have depression, because they can hide it like I used to. Sometimes we don't know how to ask for help, and we just need someone to tell us they know someone who can help.*
Unmet social needs	*I think that there are some additional questions in terms of racial equity for families and existing resources at a community level. If you do not have access to diapers, formula, and food for a child within your community, you're not necessarily going to be focusing on the developmental needs. That may not be your priority at the moment.*
2.3 Emergent Themes: A Need for Caution in the Expansion of Access Programs for Infant Care Professionals	
Generational and community-based trauma	*The challenge to having people in the same community serving each other is they've had the same lived experience. So [it] has become normalized. If depressive symptoms are all I've ever seen, and that's how I feel, how am I supposed to know that it's something that needs attention?*
Exacerbation of existing inequalities	*I specialize in seeing people of color in the perinatal period, and I work a lot with people who are children of immigrants. Every single one of my clients of color says, 'I'm never seeing a white therapist again.' A lot of [access] has to do with race and ethnicity of the client, or the language they speak, and these sorts of basic identity access points are going to affect where I look for resources for them.*
4.2 Infrastructure Enhancements	
Bottleneck effect	*If this works, you're going to be overrun with referrals. If you're working with early childhood, you're solving one problem, but you're exposing another. These folks are going to need referrals, and you might find that there aren't enough [providers]. It's good to expose that problem though, because I don't think we really know the need that's out there… but it's a problem that the state needs to figure out how to address.*
Note. Quotations have been slightly modified and paraphrased to protect confidentiality.	

Other programs reported a more 'child-focused' model, and those respondents were less likely to view addressing the parents' MH as a priority as they were more focused on the mental well-being of the children in their care. These professionals reported more limited communication with parents, with conversations mostly centered around the daily events log or the physical care provided to the child (e.g., feeding, sleeping) (See Table 1, 1.1).

Lastly, the comfort of professionals to respond to parents' needs differed based on their access to resources and the integration of MH into their current model of care. Those who worked at agencies located in rural or remote areas reported having fewer MH resources compared to those in urban communities. Professionals working at child-serving agencies lacking existing partnerships with MH resources reported being less equipped to address perinatal MH and SUDs than those with established MH networks.

2.1 Feasibility: Needs of Infant Care Professionals

Education and Training

Several child-focused program directors reported their staff were enthusiastic and receptive to MH-related training. Although most agencies had not received training specific to perinatal MH, many professionals believed the inclusion of perinatal-specific training would be beneficial and well-received (See Table 1, 2.1). Frequently requested training topics included: perinatal (32.7%) and general (i.e., symptoms, indicators) (18.2%) MH, MH resources (21.8%), and having difficult conversations with parents about MH and SUDs (18.2%). See Table 2 for a complete list of recommended subjects for training sessions.

Table 2
Recommended Training Topics

Training Topic	Overall (N = 55)		MCPAP for Moms Staff (n = 6)		Public Health Professionals (n = 30)		Child-Focused Professionals (n = 19)	
	n	%	n	%	n	%	n	%
Perinatal MH	18	32.7%	3	50.0%	6	20.0%	9	47.4%
Mental Health Resources	12	21.8%	4	66.7%	4	13.3%	4	21.1%
Mental Health (general)	10	18.2%	2	33.3%	2	6.7%	6	31.6%
Having Difficult Conversations with Parents	10	18.2%	0	0%	4	13.3%	6	31.6%
How to Use General/Perinatal MH Screening Tools	9	16.4%	2	33.3%	3	10.0%	4	21.1%
Access Program (i.e., MCPAP for Moms)	9	16.4%	4	66.7%	3	10.0%	2	10.5%
Trauma/Trauma Informed Care	7	12.7%	1	16.7%	2	6.7%	4	21.1%
Substance Use Disorder	7	12.7%	3	50.0%	1	3.3%	3	15.8%
Domestic Violence	6	10.9%	0	0%	1	3.3%	5	26.3%
Crisis Intervention	3	5.5%	0	0%	2	6.7%	1	5.3%
Multidisciplinary Trainings	2	3.6%	0	0%	0	0%	2	10.5%
Cross-cultural	1	1.8%	0	0%	1	3.3%	0	0%

More Accessible Consultation Services

Child-focused care professionals also described a need for accessible consultation services which would allow them to ask questions of someone with expertise in perinatal MH. They also indicated that consultation could provide additional guidance for infant care professionals to expand their skills in communicating with families about perinatal MH and SUDs and offering needed support (See Table 1, 2.1).

Resource and Referral Specialist

Some infant care professionals reported having a resource binder including resources related to MH, housing, food, financial crises, social support, etc. Many professionals expressed interest in a resource and referral specialist who could connect families to MH services (e.g., peer support, and therapy). One respondent also noted the importance of infant care professionals having knowledge of unmet social needs in addition to mental health community resources (See Table 1, 2.1).

Need for Partnerships and Community

Although respondents acknowledged that perinatal MH education and training for infant care professionals could be a step in the right direction, they also noted the vital need for interagency collaboration among agencies that serve the postpartum community (See Table 1, 2.1). Respondents believed this would reduce duplicate efforts or services and allow professionals with various roles in the lives of perinatal individuals to come together and support families' MH more holistically.

2.2 Feasibility: Perceived Needs of Pregnant and Postpartum Individuals

Accessible Mental Health Services

Respondents consistently identified a dearth of MH providers within their communities, especially in the wake of COVID-19. Many communities experienced budget cuts for MH care or depletion of the MH workforce. Additionally, the MH workforce was described as overwhelmed and overworked, with many agencies over or at full capacity. They reported that families' access to services differed based on their insurance provider, location, and primary language (See Table 1, 2.2).

Families were often placed on lengthy waitlists which can be a frustrating and dejecting process. Without the proper infrastructure and resources in place, respondents worried that an increase in referrals to MH providers without a warm handoff or appointment availability could have unintended negative consequences (See Table 1, 2.2).

Trusted Partners and Support

Respondents emphasized that infant care professionals are seen as "trusted partners". Respondents expressed that if a parent felt comfortable with a childcare professional, they would be much more likely to disclose information related to MH or substance misuse (See Table 1, 2.2). Respondents noted it would also be important for infant care professionals to maintain this trusted relationship and supportive role throughout the referral process and connection to care for MH or substance misuse. Respondents believed infant care professionals would need training on navigating conversations about perinatal MH or the referral process. Respondents feared that a lack of available MH providers or training in communication about perinatal MH and SUDs could have negative impacts on this trust after disclosure. However, with training, respondents suggested the infant care professional could serve as a support person for the family or connect families to support groups until MH or SUD care was available.

Increased Mental Health Awareness

Respondents believed that, due to the lack of education about perinatal MH and SUDs, many postpartum individuals do not realize they are suffering from a postpartum perinatal MH condition or SUD. However, even if a perinatal individual recognized they were struggling, knowing who to reach out to for help and feeling comfortable doing so posed additional challenges. One respondent reflected on her personal experience with postpartum depression (See Table 1, 2.2). Therefore, respondents stated it would be important to disseminate information related to perinatal MH and SUD symptoms and resources directly to pregnant and postpartum individuals.

Unmet Social Needs

Many respondents discussed how unmet social needs contributed to perinatal MH challenges. For many postpartum individuals, the stress of accessing and/or affording basic resources (e.g., food, diapers, housing) can be overwhelming and might take priority over their MH. Also, respondents reported that struggling to provide for one's family could be a major source of anxiety and/or depression in and of itself (See Table 1, 2.2).

2.3 Emergent Themes: A Need for Caution in the Expansion of Access Programs for Infant Care Professionals

Infant care professionals raised concerns that without the proper support and service model in place, there could be unintended consequences of extending the MCPAP for Moms' model to include services for infant care professionals. Consequences could impact both infant care professionals and pregnant and postpartum individuals. The desire for education and training on perinatal MH substance misuse was one of the most common themes brought up by child-focused care professionals. However, respondents cautioned it was critical for the services model to be equipped to handle an influx of referrals before training infant care professionals to screen and refer pregnant and postpartum individuals.

Respondents also commented on the implications for the families in need of services. As stated above, identifying the presence of perinatal MH and substance misuse in oneself can be difficult. Reaching out for help can be just as overwhelming. MH and substance misuse are stigmatized and can be difficult to talk about. Therefore, respondents cautioned that if a pregnant and postpartum individual 1) identifies these symptoms in themself and 2) reaches out for help, the response must be available in a timely and supportive manner. Otherwise, they may lose trust in infant care professionals and the referral process.

Additionally, many infant care professionals serve communities where they were raised or currently live. They may share life experiences and traumas (i.e., generational and community-based) with those they serve. These commonalities may improve their ability to empathize, connect, and engender trust with families, yet may cause infant care professionals to become overly invested, triggered, misinterpret a family's experience influenced by their own life experience, and be at greater risk for secondary traumatic stress and vicarious traumatization (See Table 1, 2.3).

Respondents also reported a fear of rupturing close infant care professional-parent relationships. They expressed that discussion of or screening for MH and substance misuse could potentially change relationships, particularly if it conjured fear of child welfare service involvement among parents. These potential unintended consequences were noted to be unique to infant carers, and not observed in the current MCPAP for Moms' model catering to medical providers.

Notably, respondents also discussed the risk of exacerbating existing inequalities. The challenges noted above vary by race, ethnicity, language, and geography. For example, long waitlists for therapists may be worse for non-English speakers or in geographic areas with fewer resources. Similarly, the stress that MH screening could impart on infant care professionals may be worse among communities that have experienced greater trauma or systemic racism (See Table 1, 2.3).

3.1 Feasibility for Expanding the MCPAP for Moms' Model to Infant Care Professionals

Respondents noted that additional funding and expansion of team member expertise would be necessary for MCPAP for Moms to address many of the need areas identified by child-focused professionals. Currently, the model provides education and training with respect to medication treatment of psychiatric disorders (e.g., ADHD, anxiety, depression), risk assessment, and resources to integrate behavioral health into perinatal care. Additional agency partnerships would also be needed to increase the model's capacity to implement perinatal MH and substance misuse-related education and training to infant care professionals, with the goal of recognizing pregnant and postpartum individuals at risk of perinatal MH and SUDs or identifying resources to assist families in need of support.

MCPAP for Moms also provides consultation services and training opportunities for patient-specific issues and for questions related to perinatal psychiatry, behavioral health, and community resources. Respondents described the current model as a framework that could be used for developing consultation services with infant care professionals, while also supporting professionals' MH as they begin to address perinatal MH and SUDs in infant care settings. Lastly, the model currently has resource and referral specialists who are trained to identify and maintain up-to-date MH resources across the state. However, since the expansion would presumably result in an influx of new referrals, respondents cautioned that MCPAP for Moms would need to hire additional resource and referral specialists with greater expertise in the postpartum period.

4.1 Enhancements to the MCPAP for Moms' Model

As described above, respondents believed that additional staffing would be required to assist with consultation, resource and referrals, administrative tasks, and communication with infant care professionals. Respondents advised the need to hire a representative from the early childhood community to facilitate buy-in from infant care and early childhood professionals by serving as a liaison between these providers and the Access Programs.

4.2 Infrastructure Enhancements

As stated above, respondents frequently commented on the lack of available MH services and providers. Thus, respondents cautioned that expansion could create a bottleneck effect, in which there would be an influx of families in need of services with nowhere to send them. This influx could also add to existing, lengthy waiting lists for services (See Table 1, 4.2).

In addition, variation in access to MH and SUD services is largely impacted by factors such as socioeconomic status, geographic location, insurance provider, and racial/ethnic identities. Although the MCPAP for Moms' model does not current address these issues directly, support with referrals to address unmet social needs could be an area of potential expansion in the future, particularly if it is a common cause of concern for families referred by infant care professionals. Respondents recommended tapping into existing networks to 1) avoid "reinventing the wheel" or providing duplicate services, 2) garner partnerships from other providers who support families at different stages, and 3) ensure equitable access to services to avoid disparities among historically marginalized communities.

Discussion

This needs assessment addressed the potential to expand postpartum individuals' access to MH care and support in Massachusetts via linkage between infant care settings and mental health Access Programs. Through interviews with public health professionals, MCPAP for Moms staff, and child-focused professionals, we were able to gauge infant care professionals' interest in and comfort with recognizing and supporting pregnant and postpartum individuals at risk for perinatal MH and SUDs. We found a high degree of interest in perinatal MH training among infant care professionals that has not been well documented in the literature [14]. However, we note that this interest varied across and within specific infant care models depending on the mission and orientation of the agencies as family-focused vs. child-focused. The distinction between 'family-focused' and 'child-focused' care professionals also presents an opportunity to shift the paradigm among 'child-focused' professionals. For example, to truly be 'child-focused,' it is critical to include the parent and family members due to the substantial impact of parents' well-being on that of the child.

We also assessed the perceived feasibility of infant care professionals to recognize and respond to pregnant and postpartum individuals at risk for perinatal MH difficulties and SUD. We identified recommendations for enhancements that would need to be made to the current MCPAP for Moms' model to support infant care professionals. Access Programs may already be poised to provide much of the training and consultative support desired by infant care professionals. However, this expansion would likely require hiring new staff with expertise in infant systems of care. This would likely require additional funding and the prioritization of workforce development on a policy level. In addition, it may require greater connection and networking with agencies addressing social determinants of health for pregnant and postpartum individuals.

While interest and feasibility among infant care professionals and the MCPAP for Moms team clearly exist, respondents also identified the need for caution. For example, the unique needs of infant care

professionals, the sensitivity of the provider-parent relationships, and the significant shortage of MH specialists to meet the needs of families could result in unintended consequences of expanding services to this workforce. Consistent with the literature, we heard that it is vital for treatment resources and access to be in place before training infant care professionals on screening and referral for perinatal MH and SUDs [15, 16]. Once these infant care professionals are educated and equipped to identify MH concerns, there needs to be a place or system to refer families for treatment.

Infant care professionals may be uniquely positioned to engage families in perinatal MH services because of their own lived experiences and roles within their communities. We see a similar phenomenon in other care settings such as those that employ patient navigators, peer coaches, social workers, etc. [17]. Intimate relationships with families may also make some providers effective trusted allies and advocates for families.

However, these intimate relationships as well as shared community-based trauma (e.g., secondary trauma or sharing similar trauma with parents) have the potential to negatively impact infant care professionals addressing perinatal MH challenges in the families they serve [17, 18]. These concerns, coupled with poor access to services, could unintentionally exacerbate existing inequities in MH among historically marginalized communities. Therefore, in designing services for this population of providers, we recommend placing an emphasis on safeguarding individual provider mental health while also respecting their autonomy and ability to engage with families, especially within marginalized communities.

Limitations

There are several limitations of this needs assessment. First, despite efforts to diversify our pool of participants, over 75% of our respondents identified as white, consistent with the demographics of Massachusetts but not representative of communities most impacted by disparate access to postpartum care. Although many of our infant care professionals were people of color, most of the public health professionals and program directors we interviewed were more likely to identify as white, also a reflection of disparities in these workforces. Additionally, all our interviews were conducted in English despite offering interviews in different languages. Second, we did not recruit pregnant or postpartum individuals, as we wanted to establish the interest and feasibility for an expansion among professionals as our first step. Although several of the respondents shared their lived experiences of motherhood and perinatal MH and SUDs, we do not have robust data from pregnant and postpartum individuals. It would be beneficial to also speak to this population directly to gain their perspective.

Conclusion

This needs assessment demonstrates an interest by infant care professionals in providing greater support for postpartum individuals with perinatal MH and SUDs. There was significant, though not universal, interest among infant care professionals in MH-related training and assistance with referral

and consultation for perinatal MH and SUDs. However, we highlight the nuances and potential challenges that should be considered for the expansion of the MCPAP for Moms' model to serve the infant care system which are not currently addressed in the model for the healthcare system. Innovation and policies, such as parent support groups and increased investment in workforce development, would be needed to address the limited availability of MH treatments and ultimately improve the lives of families.

Declarations

Ethical Approval

Human Ethics and Consent to Participate declarations: not applicable. This needs assessment was deemed "not human subjects research" by the Internal Review Board (IRB) at [blinding institution name] Medical Center. This IRB is accredited and follows the guidelines of Association for the Accreditation of Human Research Protection Programs, Inc. (AAHRPP). Consent was not obtained given that this project did not meet criteria of a research study.

Funding

This project was funded by the Massachusetts Department of Mental Health.

Availability of data and materials

Upon guidance from the IRB, we were advised not to share direct transcript data from this project.

Author Contribution

L.M: Data curation, Formal Analysis; Writing- original draft; M.R.O – Conceptualization, Project Administration, Supervision; J.G: Project Administration, Writing – Review & Editing; H.F: Project Administration, Writing – Review & Editing; L.X: Formal Analysis; Writing – Review & Editing; N.B: Conceptualization, Project Administration, Supervision, Writing – Review & Editing; E.P: Data curation; Project Administration, Supervision, Writing- original draft

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Figures

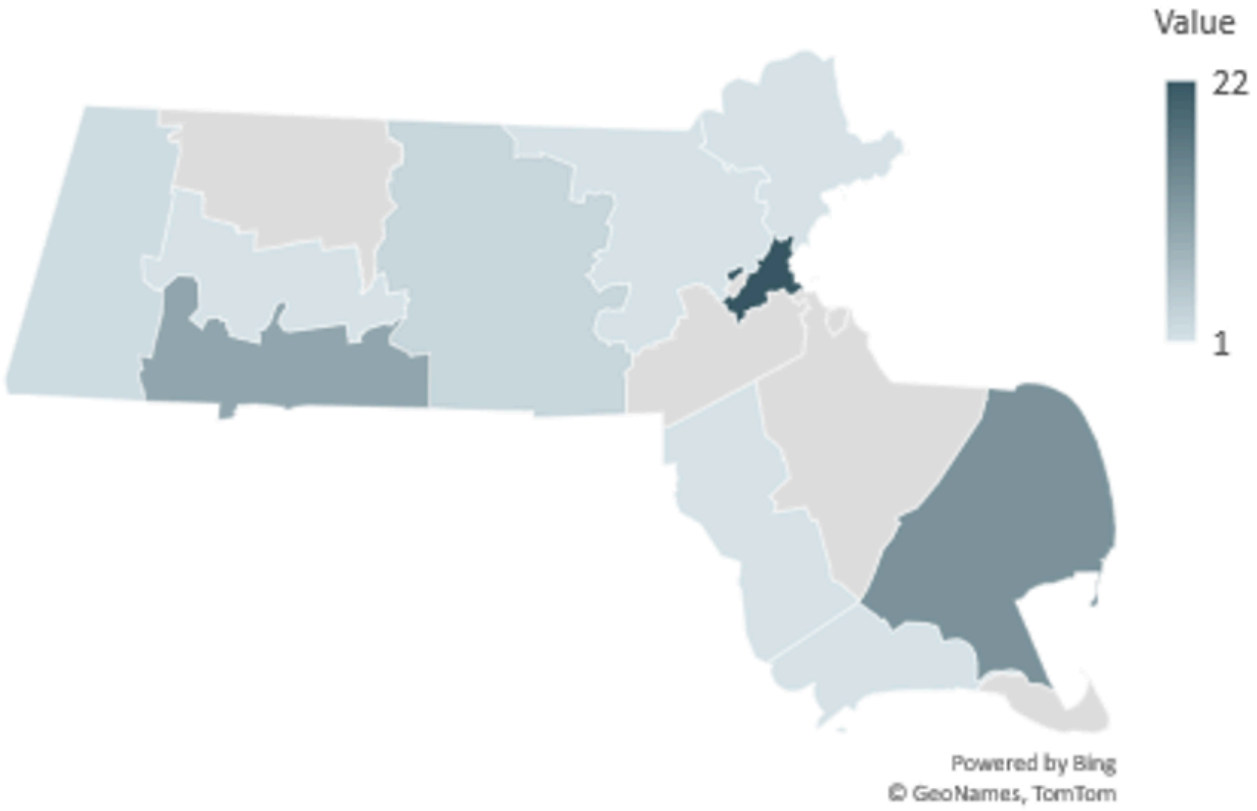


Figure 1

Geographic Representation of Respondents

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