

Concept Paper

Addressing Perinatal Mental Health and Suicide: Developing an Intervention to Disseminate Tools and Resources to Low Resource Populations

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Abstract

Perinatal mental health challenges are the number one complication of pregnancy and childbearing. Despite the growing need, substantial barriers to addressing perinatal mental health exist, including lack of infrastructure, policies, and workforce. Baby Talk, a free prenatal education program, sought to address this growing need through a brief intervention for those with a positive screening. Baby Talk partnered with a local suicide prevention program to develop a tool to enhance access to care and to support emotional regulation, safety, and connection during moments of crisis. The Growing Hope Kit is a tangible tool inspired by Dialectical Behavior Therapy and Cognitive Behavioral Therapy principles. Content was curated to decrease symptoms related to depression, anxiety, substance use and suicidal ideation. Development focused on a social-ecological model to enhance individual abilities, promote social connection (interpersonal and community), and highlight societal resources (organizational and public policy). The kit was also developed with a positive psychology



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perspective addressing multiple sources of strength (e.g., physical health, mental health, spirituality), which have been shown to promote protective factors for mental health. Expert review identified gaps in kit content and suggestions for modification. Perinatal community health workers and prenatal education staff confirmed face validity of final kit content. Low-cost, effective interventions are needed to support those experiencing depression, anxiety and other mental health conditions during the perinatal period. The partnership to design the Growing Hope Kit was the first step in the development of a community-based intervention to expand access to care and enhance coping skills. Next steps include assessing perceptions of usability and acceptability of the Growing Hope Kit by birthing persons, followed by future effectiveness testing through a rigorously controlled trial. If successful, this intervention will promote perinatal mental health resource and provide those experiencing mental health challenges with tools and resources, especially in low-resourced areas.

Keywords

Perinatal mental health; dialectical behavioral therapy; cognitive behavioral therapy; positive psychology; social-ecological model

1. Introduction

1.1 Perinatal Prevalence, Impact and Infant Outcomes

The perinatal period, defined as pregnancy through the first year postpartum, often includes dealing with new or exacerbated mental health challenges which can impact both parent and infant health if not treated. Perinatal mental health conditions, such as depression and anxiety, are increasing at alarming rates and are now one of the most common complications of pregnancy [1-5]. The cost of untreated maternal mental health challenges is estimated at over \$14 billion annually in the United States [6]. These conditions disproportionately impact populations experiencing other challenges related to community impacts on health, such as lack of insurance and lower socioeconomic and education status [7, 8]. In addition, those who are younger (≤ 24 years of age) and non-White have increased risk and adverse outcomes [8-10].

Perinatal mental health conditions have been linked to adverse birth outcomes, including intrauterine growth restriction, preterm birth, low birth weight, and neonatal or infant death [9, 11-13]. Such conditions can also lead to increased medical expenses, decreased breastfeeding initiation or cessation, and increased risk of child abuse and neglect [12-14]. Longer term infant outcomes include impacts to social, emotional, and cognitive development, including elevated reactivity to stress, sleep disturbances, attention-deficit hyperactivity disorder, conduct disorders, and cognitive deficits [15-17]. Ineffective parenting due to mental health challenges may result in further negative impacts to infant/child functioning [18].

Despite the growing need, substantial barriers exist to addressing perinatal mental health, including lack of infrastructure, policies, and workforce. To address these barriers, the Taskforce on Maternal Mental Health has recommended innovative approaches to integrate care across medical, community and social systems [5].

1.2 Addressing Perinatal Mental Health and Suicide

Universal screening and access to evidence-based treatment (e.g., cognitive behavioral therapy, medication) are well-identified strategies to reduce perinatal mental health conditions, such as depression and suicide [1, 19, 20]. While those with perinatal mental health concerns have increased use of both psychiatric and non-psychiatric services, access to services is a treatment barrier, especially for those of lower socioeconomic status [7, 21]. Lack of knowledge, cultural complexities, and stigma are also recognized barriers to treatment [22].

Community-based interventions to address perinatal mental health conditions have shown some success. Integration of mental health interventions (e.g., staff training, participant screening, and referral) into perinatal home visitation programs, has reduced depression and anxiety symptoms [1, 23]. Further, parenting interventions can reduce perinatal depression, possibly due to enhanced perceived ability to care for the infant [24, 25]. Organized peer support has also shown some success in improving wellbeing in the perinatal period [26, 27].

In terms of suicide in the perinatal period, few prevention strategies have been described beyond universal screening and access to treatment [20]. Both perinatal women who experienced suicidal thoughts and perinatal mental health professionals recommend developing interventions prioritizing components to (a) support distancing oneself from the appeal of suicide; and, (b) establish positive connections between the birthing person and therapist, baby, and parenthood [28]. Yet there is a paucity of research on interventions to reduce mothers' suicidal experiences during the perinatal period, especially in resource-poor communities [28].

2. Project Design and Setting

This study explains the interdisciplinary partnerships and steps to develop a community-based intervention to address perinatal mental health, substance use, and suicide.

2.1 Baby Talk Prenatal Group Education Program

Baby Talk is a free prenatal education program and part of the statewide Kansas Perinatal Community Collaborative (KPCC) program [29]. It is funded through Title V Aid to Local grants and managed by the University of Kansas School of Medicine (KUSM) Center for Research for Infant Birth and Survival (CRIBS). Labor and delivery nurses teach six 2-hour sessions on topics, including healthy pregnancy, labor and birth, feeding and infant care, and postpartum health. The modes of instruction include didactics, videos, demonstrations, and hands-on activities. Participants who complete all six sessions receive infant safety items, such as a car seat or a portable crib. Classes are available both day and evening, virtual (statewide) and in-person (Sedgwick and Harvey Counties). Baby Talk aims to reduce infant mortality, improve maternal health, and improve birth outcomes. Program participants have shown significant increases in knowledge and intentions related to having a healthy pregnancy and following safe and healthy infant care practices [30]. Participants in KPCC programs, including Baby Talk, have lower preterm birth rates than Kansas overall [31]. The longest-running KPCCs have seen significant reductions in infant mortality [31].

While the Baby Talk curriculum has always addressed perinatal mental health topics, in late 2020 a maternal mental health screening was introduced. The Edinburgh Postpartum Depression Scale (EPDS) is a validated tool for assessing depression and anxiety during the perinatal period and

includes an item on suicidal ideation [32]. All Baby Talk staff are trained and authorized to administer the EPDS. The EPDS is administered upon program enrollment (prenatal) and ~6 weeks postpartum; however, completion is optional. Rescreening can be done anytime a concern is expressed by the participant, their support persons or a staff member. Approximately 30% of Baby Talk participants have at least one positive EPDS [33].

For those with a positive screening, Baby Talk staff offer a brief intervention and resources, such as referral, if appropriate. However, while urban areas, such as Sedgwick County, have some perinatal mental health resources available, most counties are designated as both mental health and obstetrical deserts, with 96 of 105 counties designated as mental health shortage areas and 71 of 105 counties considered to have maternity care shortages [34].

2.2 Suspenders4Hope^R Program

In 2015, Wichita State University (WSU) developed the #WSUWeSupportU awareness campaign, which expanded in 2020 to the Suspenders4Hope^R program. Suspenders4Hope^R is a comprehensive, strategic approach to promoting mental health wellness, preventing suicide, substance use, and sexual violence. In 2023, the program began distribution of Hope Kits to individuals who screened positive for suicidal ideation at the WSU Student Wellness Center and the Sedgwick County community crisis center, Comcare [35-37]. Hope kits were inspired by the concept of distress tolerance kits, an established practice in Dialectical Behavioral Therapy (DBT) and Cognitive Behavioral Therapy for Suicide (CBT-S), where patients meet regularly with a trained therapist and learn skills to engage in mindfulness, cognitive restructuring, emotion regulation and distress tolerance to reduce suicide behaviors [37-39]. Over the course of several weeks, patients work with their therapist to create a personal kit with items to prompt use of the new skills in a crisis and increase hopefulness about the future. The Suspenders4Hope^R program recognized that not all people in crisis have access to mental health professionals and support. When there is access to care, there may be significant wait times before meaningful treatment can begin, and the service providers available may not be trained in evidenced-based treatments for suicide prevention like DBT and CBT-S. This is a rate-limiting factor in reducing suicide and self-harm as the effectiveness of DBT and CBT-S in reducing depression and suicidality is well established [40-42]. Therefore, the Hope Kit project was developed to address the gaps in access to care and to connect persons to needed support, skills, resources and services.

2.3 Developing the Partnership

Recognizing the need for perinatal mental health resources and the strengths of the evidence-based interventions offered by the Suspenders4Hope^R program, CRIBS staff reached out to WSU to explore the opportunity to partner in the development of a Hope Kit specifically for those in the perinatal period. WSU staff were excited to pursue the opportunity, and a development team was convened. The development team consisted of the following members:

- CRIBS Director – a community psychologist with expertise in developing and leading maternal and infant health promotion programs.
- CRIBS Manager – maternal and infant health researcher with expertise in evaluation, data collection, and grant management.

- WSU Assistant Vice President for Wellness – Clinical psychologist with expertise in suicide prevention, developing trainings for suicide prevention and co-creator of the Suspenders4Hope^R Kit.
- WSU HOPE Services Director – Clinical Psychologist, Suspenders4Hope^R program co-creator and manager, and co-creator of the Suspenders4Hope^R Kit.

An advisory panel of perinatal mental health experts was convened to provide guidance and review materials for appropriateness and relevance, provide recommendations for improvement, and ensure the kit content prioritized evidence-based information and tools. The advisory panel included a licensed social worker with perinatal mental health certification who was also chair of the Kansas Chapter of Postpartum Support International; the Kansas Department of Health and Environment Behavioral Health Consultant; and a Reproductive Psychiatric Mental Health advance practice registered nurse who was also founder of community-based perinatal mental health program.

2.4 Developing the Growing Hope Kit

The specific purpose of the perinatal focused Kit was to develop a scalable, low-barrier, cost-effective way to provide mental health tools and information to the perinatal population, especially in low resource areas. As such the Growing Hope Kit content was curated to address the following goals and decrease symptoms related to depression, anxiety, substance use and suicidal ideation. Kit goals included:

1. Enhance access to mental health and parenting support resources.
2. Educate on strategies for healthy pregnancy/postpartum choices, safe infant care practices, coping strategies during times of stress or crisis, and infant mental health promotion.
3. Build skills around DBT coping strategies, such as mindfulness, cognitive restructuring, emotion regulation and distress tolerance.
4. Provide tools to support DBT coping skills such as distract (coloring book), safeguard surroundings (gun lock, med lock), reach out (links to support groups, therapist lists and emergency services).
5. Reduce stigma.

Previous work by CRIBS identified strategies to reduce barriers to perinatal mental health care as perceived by perinatal persons, physicians and mental health professionals [43]. In addition, review of the literature regarding pertinent topics, such as perinatal mental health, pregnancy-related suicide and infant care provided evidence-based strategies and best practices that informed kit content. For example, qualitative research identified factors believed to trigger or maintain suicidal thoughts and behaviors for birthing persons, including isolation, loss of control, self-perception of being a “bad” parent or unable to meet baby’s needs, and gaps in expectations versus reality of parenthood [25, 44-46]. Further, interventions to improve the mother/infant interaction improve outcomes for both mother and infant [47]. Strategic efforts were made to address these drivers with inclusion of resources related to parenting (e.g., group prenatal education; one-on-one support through home visiting), many of which also provide tangible supports, such as diapers. Efforts were also made to ensure the kit was adaptive, engaging, universally appealing, appropriate for both prenatal and postpartum periods, and used clear and simple language.

The development team reviewed items from the original Suspenders4Hope^R Kit and determined the Hope box, love letter, coping skills activity page, gun lock and medication lock would be appropriate when updated with perinatal themes (Table 1). In addition, multiple perinatal-themed coloring books were purchased and reviewed for content to identify the most appealing and universally appropriate version to included (e.g., did not reference “husband” as many Baby Talk program participants report being single).

Table 1 Comparison of items from the original Suspenders4Hope^R Kit and the perinatal Growing Hope Kit.

Suspenders4Hope^R Kit	Growing Hope Kit
HOPE box	Updated to include perinatal branding
Love letter explaining the box. its content and instructions for personalizing the kit	Updated to include perinatal branding and background information on perinatal mental health
A coping skills activity page outlining suggestions for handling crisis situations	Updated to include perinatal branding
Items to create a safe environment (e.g., locking cap for medication, gun lock)	Included
Adult coloring book and colored pencils	Updated to a perinatal adult coloring book
Kansas Tobacco QUITLINE palm card	Updated to include Kansas Tobacco QUITLINE perinatal palm card
Suspenders4Hope ^R magnetic lapel pin	Not included
Suspenders4Hope ^R t-shirt	Not included
988 wallet card for crisis support	Included
NAMI Kansas and NAMI Wichita resources directory	Modified to perinatal resource list of state and/or national resources to ensure access in both rural and urban areas
AVC and COMCARE Behavioral Crisis resources	Updated to National Maternal Mental Health Crisis Line card
	A Perinatal HOPE Card Deck of activities and affirmations developed by CRIBS and WSU
	Suspenders4Hope ^R string bracelet with mindfulness exercises developed by WSU
	National Institutes for Health Action Plan for Depression and Anxiety Around Pregnancy
	Perinatal mental health book (Kleiman 2019) added on recommendation of expert panel on perinatal mental health

Abbreviations: CRIBS – University of Kansas School of Medicine-Wichita Center for Research for Infant Birth and Survival; WSU – Wichita State University.

Several items from the original kits were not included. The Suspenders4Hope^R Kit provided a t-shirt in each kit. However, the challenge of sizing during the perinatal period along with the

substantial cost of maternity t-shirts, made this both logistically and financially prohibitive. The original kit also included a magnetic lapel pin. The United States Consumer Product Safety Commission has issued numerous warnings and recalls due to the dangers of injury or death in children due to ingesting small magnets [48]. To prevent potential adverse events, this item was not included.

To address other mental health and parenting skills and resources, several new items were developed for inclusion in the Growing Hope Kit:

1. Perinatal resource list. This list included free statewide or national resources related to parenting (e.g., prenatal education, home visiting, breastfeeding supports), mental health (e.g., peer supports, crisis hotlines), and substance use (e.g., web-based community app), as well as links to find mental health professionals with perinatal expertise.
2. Perinatal HOPE Card Deck. Suspenders4Hope^R developed a card deck of activities to promote mental health in the workplace or classroom. This idea was expanded upon to develop a 40-card deck addressing perinatal activities (n = 24) and affirmations (n = 16). The activity cards are related to DBT and CBT skills as well as parenting topics. Development focused on a social-ecological model to enhance individual abilities, promote social connection (interpersonal and community), and highlight societal resources (organizational and public policy) (Figure 1) [49]. The cards were developed with a positive psychology perspective addressing multiple sources of strength (e.g., physical health, mental health, spirituality), which have been shown to promote protective factors for mental health [50]. The cards also provided words of affirmation related to coping and parenting, such as “It is healthy to ask for help,” and “There is no such thing as a perfect parent”.
3. A beaded string bracelet, with the Suspenders4Hope^R logo was added as an alternative to the t-shirt included in the original box, as the flexible sizing and ability to offer a single version of the kit was much more practical. As an added bonus, a mindfulness breathing exercise was designed to utilize the bracelet beads and included on the packaging.



Figure 1 Growing Hope Card deck items to address aspects of the social-ecological model impacting perinatal mental health.

These initial items were drafted and revised by the development team between February and May 2024.

2.5 Ethics Statement

A protocol approval was not needed by an ethics committee to conduct this project.

3. Review of Growing Hope Kit Materials and Next Steps

3.1 Expert Review

Following initial development, the items were sent to the expert panel for review and feedback. After review, all items were retained, but wording and resource links were updated (e.g., resource page, card deck). A book on perinatal mental health was also added to the kit based on expert panel recommendation. Once content was finalized, a WSU graphic designer assisted with branding and designed the new box, letter and card deck.

3.2 Face Validity Review

Once content was finalized, CRIBS prenatal education and home visiting staff reviewed the Kit regarding perceived usefulness and appropriateness for perinatal clients to ensure face validity of materials. Staff were overwhelmingly supportive of the Kit and content with only minor changes suggested.

3.3 Growing Hope Kit Production, Distribution and Evaluation Plans

With the Growing Hope Kit design finalized, next steps involved production, distribution and recipient feedback of the kit. Production began in July 2024, with anticipated distribution beginning in October 2024. For the pilot project, 250 kits were built at a cost of approximately \$55 each, with lower costs per kit expected if more kits are created. Shipping was anticipated between \$15 and \$20 per kit.

Baby Talk participants who screen positive for mental health or substance use concerns, or who disclose a pre-existing mental health condition will receive standard care, but in addition will be offered a Growing Hope Kit. Kits will be distributed in-person (Sedgwick and Harvey Counties) or by mail (virtual participants). Approximately 6 weeks after distribution, an electronic survey will be sent to request participant feedback on the kit. Survey administration will be managed through Research Electronic Data Capture (REDCap) a secure, web-based data capture application hosted at the University of Kansas Medical Center [51, 52]. Evaluation will focus on three primary areas: (1) overall look and impression of the kit; (2) use and function of items in the kits; and (3) self-report of mental health symptoms and behavior changes after receiving the kit. It is anticipated that feedback from the end user will result in further modifications to the kit.

4. Discussion

The major outcome of this project was the development of the Growing Hope Kit to provide mental health tools and information to the perinatal population. This project presents strategies and tools informed by prior research and evidence on mental health promotion and suicide prevention. There is a solid evidence base supporting the effectiveness of hope kits as an intervention strategy [40-42]. The development of the Growing Hope Kit represents an adaptation of the hope kit model, in general, and the Suspenders4Hope kit, specifically, for use with a prioritized population that may have limited access to evidence-based interventions such as CBT and DBT.

Previous evidence also suggests providing a “package” of tools, information and resources is an effective strategy for sharing pregnancy and parenting materials [53]. The Growing Hope Kit offers a variety of tools and strategies to address the complex nature of perinatal mental health and the diversity of environments in which birthing persons may reside. Instructions are included in the kit to encourage adaptation of the materials by the recipient to ensure inclusion of meaningful and functional “personal” items. Sending a physical kit to participants also reduces some barriers, such as transportation, childcare or internet access, which are reported barriers to engagement and retention for in-person and virtual perinatal mental health interventions [54, 55]. Further, the relatively low cost of the intervention could enhance reach, adoption and sustainability of the intervention, if effective [56, 57].

An additional strength of the proposed intervention is ensuring materials address multiple levels of the socioecological framework [49]. A systematic review of 37 non-pharmacological interventions found a dearth of perinatal health interventions that went beyond individual factors [58]. While many of the materials in the Growing Hope Kit directly address individual strengths, a strategic effort was made to address other levels of intervention and support. Social connection is promoted through actions such as group prenatal education, activities involving friends/family or community groups, and access to peer support (e.g., breastfeeding, mental health). Many of the Growing Hope Kit resources also provide information on organizations or public policies either directly (e.g., crisis lines, tobacco support services, safe infant sleep trainings) or indirectly (e.g., breastfeeding resources provide information on Medicaid provision of breast pumps and laws on nursing in public).

Finally, to ensure feasibility, face validity and content validity, multidisciplinary perspectives were engaged through stakeholders with expertise in CBT, DBT and suicide prevention; perinatal community services and parent education; and perinatal mental health care. Modifications to the content based on suggestions from stakeholders improved the materials and further tailored them to the priority population. The next step will be to assess the perceptions of the user population and make improvements based on their feedback. It is recognized that the intervention includes diverse materials and information, but ultimately, the ability of the perinatal population to interpret and implement the materials is critical for outcomes to be impacted.

The proposed intervention is also limited as it does not expand direct access to mental health or substance use professionals with perinatal expertise, although resources to connect participants with direct services are included. It also does not address the critical relationship between pregnant persons and their healthcare providers, who often are the primary source of screening and education and represent a critical partner in addressing perinatal mental health. Other potential sources of bias in development of the Growing Hope Kit may include selection bias of items included in the Kit, subjectivity due to the composition of the expert panel, and lack of a structured or standardized tool for reviewer feedback.

The Kit is intended to provide information to enhance the understanding of perinatal mental health challenges, highlight evidence-based skills and strategies to reduce emotional dysregulation and stress, and decrease stigma. However, these are just the first steps to enhancing wellness and professional support is likely needed for long term support. Yet, substantial barriers to accessing these services continue to exist. Without increased access to perinatal mental health services through systemic changes and enhanced reimbursement policies, impacts of such community-based initiatives will remain limited [58].

5. Conclusion

In conclusion, low-cost, effective interventions are needed to support those experiencing depression, anxiety and other mental health conditions during the perinatal period. The partnership to design the Growing Hope Kit is the first step in the development of a community-based intervention. Next steps will involve assessing perceptions of usability and acceptability of the Growing Hope Kit by birthing persons, followed by effectiveness testing of impacts on outcomes such as mental health symptoms, access to care and coping skills. If successful, this intervention will promote perinatal mental health resources and provide those experiencing mental health

challenges with tools and resources, especially in low-resourced areas. Future evaluations will determine the acceptability and impact of the kits.

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Author Contributions

Carolyn R. Ahlers-Schmidt: Conceptualization, Funding acquisition, Methodology, Project administration, Resources, Visualization, Writing-original draft, Writing-review & editing. Jessica Provines: Conceptualization, Methodology, Resources, Visualization, Writing-review & editing. Marci Young: Conceptualization, Resources Visualization, Writing-review & editing. Ashley Hervey: Conceptualization, Project administration, Resources, Visualization, Writing-original draft, Writing-review & editing.

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Competing Interests

The authors have declared that no competing interests exist.

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