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## **Interdisciplinary Recommendations for Psychosocial Support of NICU Parents**

**Developed by**

**The Workgroup for Psychosocial Support of NICU Parents**

**(Convened by the National Perinatal Association)**

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### **Recommendations for mental health professionals in the NICU (NMHPs)**

#### **A. General recommendations:**

1. All NICUs with 20 or more beds shall have at least one full-time masters' level social worker and one full-time or part-time doctoral level psychologist embedded in the NICU staff. NICUs should also consider having full-time or part time psychiatrists and psychiatric nurses on staff. Larger NICUs should have proportionally more NMHPs on staff.
2. All NICUs should provide at least one comfortable area for group discussions among parents (e.g., parent lounge) and one comfortable room per 20 beds for confidential discussions between NICU families and NMHPs.
3. The "Standards for Social Work Services in the NICU" of the National Association for Perinatal Social Workers (NAPSW) are endorsed, along with the NAPSW standards for social workers regarding postpartum depression and perinatal bereavement.
4. The roles of social work and psychology can overlap regarding activities such as counseling, screening, providing staff education and teaching parenting skills.
5. Procurement of benefits and services for families from outside agencies should continue to be one of the roles of social workers. Social workers, psychologists and psychiatric staff should have dedicated time to provide verbal therapeutic support to all parents and family members.
6. Roles of psychologists, psychiatric staff or advanced clinical social workers (when within the scope of their credentials) can include:
  - a. Conducting research in the following areas:
    - i. Use of assessment devices, test interpretation and outcome evaluation.

- ii. Identifying risk for the development of psychological disorders in NICU parents.
    - iii. Parent-infant attachment and therapy.
    - iv. The effects of parental emotional distress on both the parent-child relationship, the parental couple and the long term outcomes of the child (both physical and emotional).
  - b. Providing the following clinical services for families:
    - i. Assessments, test interpretation, and outcome evaluation.
    - ii. Differential diagnoses of psychiatric disorders and recognition of sub-clinical symptoms.
    - iii. A variety of treatment approaches; including interpersonal therapy, short-term dynamic therapy, cognitive therapy, behavior therapy, couples and family therapy, mindfulness training and infant mental health.
  - c. Educating NICU staff about both the centrality of the parent dyad-infant relationship in all interactions and communicating with families who are a) guilt and shame-ridden, b) distressed and angry, c) possibly struggling with substance abuse, d) bereaved and e) coping with prior traumas and perinatal losses including multiple trials of assisted reproductive technology and miscarriages.
- 7. Social workers, psychiatric staff and psychologists who work in NICUs should provide support to staff as well as to families (see “Recommendations for enhancing psychosocial support of NICU parents through staff education and support,” in the comprehensive document\*). Supporting roles include acting as liaisons between staff and families along with direct educational support by discussions of family dynamics and family/staff interactions. These discussions should occur in a variety of settings including rounds, case conferences, faculty meetings, debriefing sessions, etc. Such support is necessary to minimize and ameliorate burnout, compassion fatigue and secondary traumatic stress. Pastoral care staff can also be instrumental in providing this support.

**B. Recommendations for layered levels of emotional support for NICU parents and families:**

1. The family-centered NICU environment should include an active peer-to peer support organization, ideally with a position for a paid parent support coordinator embedded in the NICU staff.
2. All NMHPs should strive to meet with all parents/caregivers to screen and identify parents at high risk for emotional disorders and those who with sub-clinical symptoms. Clinical judgment and a consideration of other risk factors should determine the outcome of a screen.
3. All NICUs with at least 40 beds should have parent education groups with a therapeutic orientation, which meet at least once a week. These groups should be led by NMHPs and should supplement any group meetings conducted by the parent-to-parent group.

4. All NICUs should have resources within the NICU and affiliated hospital and for caring for the 20-30% (or higher) of NICU parents likely to experience a diagnosable mental disorder. All NICUs should also have referral mechanisms in place for treatment outside of the hospital by social workers, psychologists, psychiatric nurses and psychiatrists.
5. Utilizing the NICU's standards of confidentiality, NMHPs should strive to communicate the identified mental health needs of parents/caregivers with the obstetric care provider and the family's primary care provider, pediatrician and other care providers.

**C. Recommendations for screening in the NICU for emotional distress:**

1. NMHPs should strive to meet with all parents/primary care-givers within 1-3 days of admission to establish a working relationship, normalize emotional distress, and evaluate risk factors for all forms of emotional distress. Hynan *et al.*<sup>6</sup> reported a table of replicated predictors of elevated scores for PPD and PTSD. Whenever possible NMHPs should utilize standardized measures for evaluation. There are many validated screens for PPD and PTSD.<sup>6</sup>
2. Screening should be done within the first week (both mothers and fathers).
3. NICU parent/caregivers should be re-screened later: a) whenever deemed important and b) within 48 hours prior to discharge (for NICU stays greater than 1 week).
4. Screening methods can include any of the following (in order of complexity):
  - a. Quick screens for depression (2 questions)<sup>7</sup> and PTSD (4 questions),<sup>8</sup>
  - b. Validated PPD and PTSD questionnaires,<sup>9-16</sup>
  - c. Inventories, such as the Psychological Assessment Tool-NICU,<sup>17</sup> and
  - d. Interviews, such as the Clinical Interview for Premature Parents (CLIP).<sup>18,19</sup>
5. Positive screens at a less complex level should be followed-up with more complex screens.
6. Screening should be incorporated into the NICU procedures as quality assurance.
7. Screening should only be implemented if there is psychological treatment available either within the NICU or through outside referral.
8. Screening for emotional distress should be offered to parents returning with their babies for developmental follow-up visits.

**D. Recommendations for telemedicine support:**

1. Telemedicine can be used for both screening and treatment, potentially increasing accessibility for families in low resource settings.
2. Telemedicine services shall be conducted in accordance with accepted standards for training, providers' credentials, confidentiality and HIPPA compliance, as developed (for example) by The American Telemedicine Association. Teletherapy and screening for NICU parents should follow the guidelines of the American Psychological Association.
3. Many NICU parents utilize social media from Internet sites for both information and emotional support. NICU staff should familiarize themselves with web-based support sites to guide parents to reliable sources.

#### E. Recommendations for antenatal screening and support:

1. When a NICU stay is anticipated, parent support coordinators and NMHPs should initiate a relationship with the family before the birth to provide both emotional support and prenatal screening for emotional distress.

\*The comprehensive document is “Interdisciplinary Recommendations for Psychosocial Support of NICU Parents,” available elsewhere on this website ([www.support4NICUparents.org](http://www.support4NICUparents.org)).

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