Task Force on Maternal Mental Health

Task Force on Maternal Mental Health [Sec 1113]

Establishment: Within 180 days after enactment the Secretary shall establish a task force to be known as the Task Force on Maternal Mental Health*

- SAMHSA and OASH/OWH are collaborating to use the existing SAMHSA Advisory Committee for Women's Services (ACWS) to implement the Task Force

Co-Chairs: The Assistant Secretary for Health and the Assistant Secretary for Mental Health and Substance Use shall serve as co-chairs

Purpose of Task Force: Identify, evaluate, and make recommendations to coordinate and improve Federal activities related to addressing maternal mental health conditions and co-occurring substance use disorders

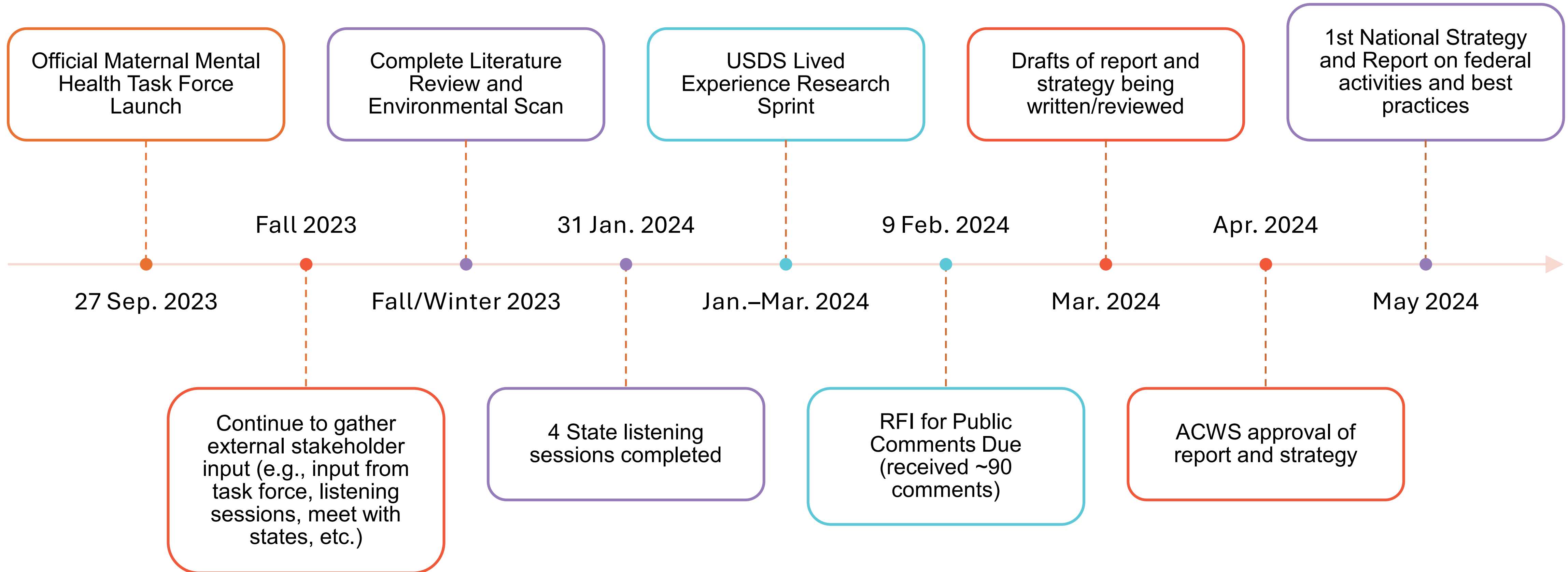
Activities/Reports Required:

- Prepare and regularly update a report that analyzes and evaluates the state of maternal mental health programs at the Federal level and identifies best practices with respect to maternal mental health
- Develop and regularly update a national strategy for maternal mental health, taking into consideration the findings of the report
- Solicit public comments from stakeholders for the report and the national strategy
- Develop reports required at various times to be sent to Congress and Governors

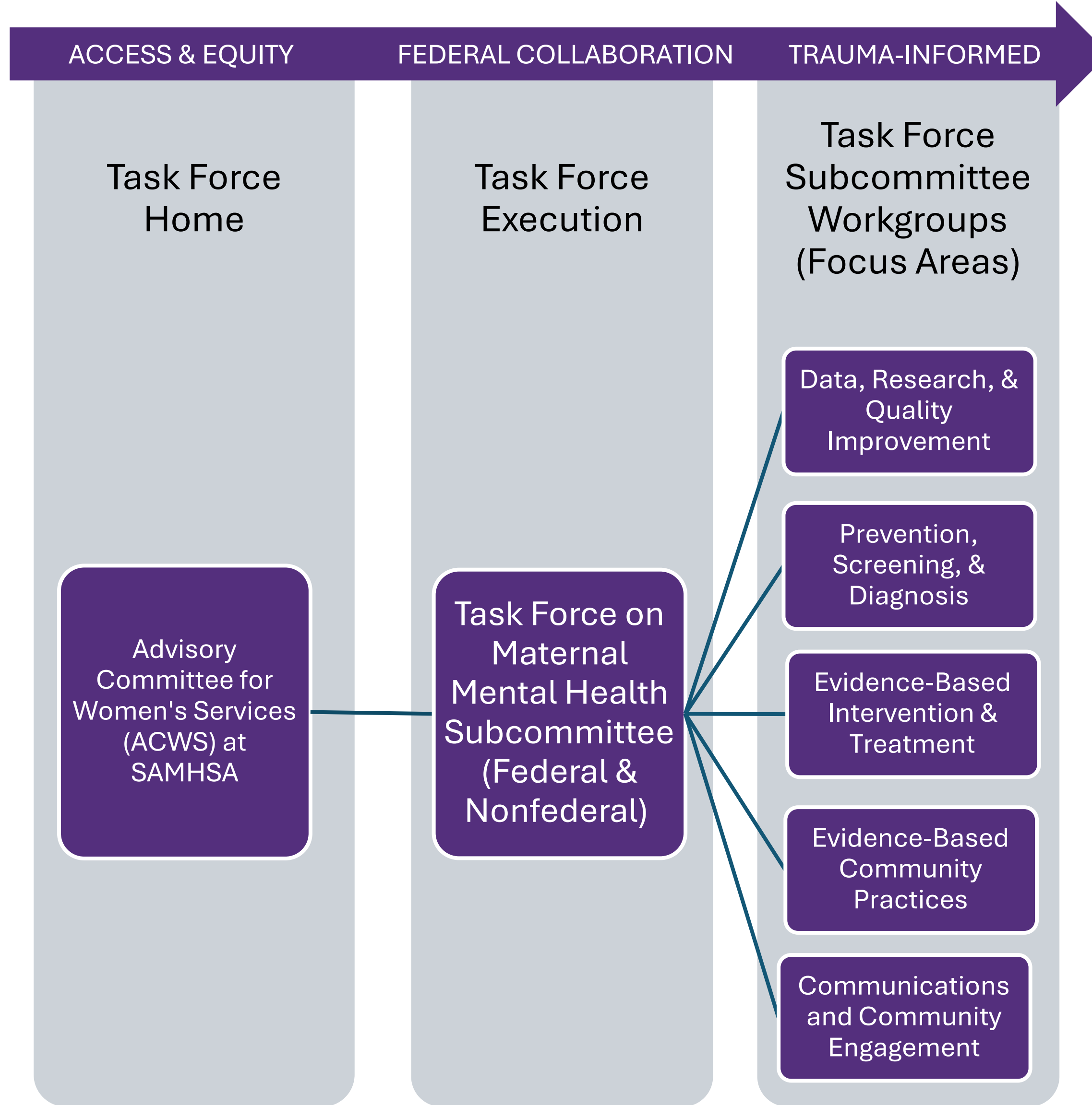
Sunset: September 30, 2027

**Maternal Mental Health Task Force will also cover substance use*

Task Force Timeline



Structure & Scope



Scope:
The Task Force will highlight recommendations that fall within the pregnancy and postpartum (up to 1 year after pregnancy) periods for individuals with or at risk for mental health and substance use conditions.

Advisory Committee for Women's Services

CHAIR

Nima Sheth, MD, MPH
Substance Abuse and Mental Health Services Administration
Associate Administrator for Women's Services
Senior Medical Advisor, Center for Mental Health Services

DESIGNATED FEDERAL OFFICIAL

Valerie Kolick
Substance Abuse and Mental Health Services Administration
Special Assistant, OIPA

MEMBERS

- **Kathryn Icenhower, Ph.D.,** Shields for Families
- **Lavita Nadkarni, Ph.D.,** Associate Dean, Director of Forensic Studies, University of Denver's Graduate School of Professional Psychology
- **Judge Duane Slone**, Judge of Circuit Court, Fourth Judicial District, State of Tennessee
- **Joanne Nicholson, Ph.D.,** Professor, The Heller School for Social Policy and Management, Brandeis University
- **Le Ondra Clark Harvey, Ph.D.,** Chief Executive Officer, California Council of Community Behavioral Health Agencies
- **Tanisha L. Frederick,** Founder, Beautiful as You Are (BAYA)
- **Octavia Harris,** Expert Leader Veteran Care
- **Kelly Andrzejczyk-Beatty, D.O**., Outpatient Psychiatrist, Choctaw Nation Health Services Authority

Participating Federal Agencies

- The United States Department of Health and Human Services (HHS)
- Administration for Children and Families (ACF)
- HHS Administration for Community Living (ACL)
- HHS Agency for Healthcare Research and Quality (AHRQ)
- HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- HHS Centers for Disease Control and Prevention (CDC)
- HHS Center for Faith-based and Neighborhood Partnerships (Partnership Center)
- HHS Centers for Medicare & Medicaid Services (CMS)
- HHS Food and Drug Administration (FDA)
- HHS Health Resources and Services Administration (HRSA)
- HHS Office of Intergovernmental & External Affairs (IEA)
- HHS Indian Health Service (IHS)
- HHS National Institutes of Health (NIH)
- HHS Office of the Assistant Secretary for Health (OASH)
- HHS Substance Abuse and Mental Health Services Administration (SAMHSA)
- The United States Department of Homeland Security (DHS)
- The United States Department of Defense (DOD)
- The United States Department of Labor (DOL)
- The United States Department of Veterans Affairs (VA)
- The United States Digital Service (USDS)
- The United States Office of Management and Budget (OMB)

Participating Nonfederal Entities

- Alaska Native Medical Center and Southcentral Foundation
- American Academy of Family Physicians
- American Academy of Pediatrics
- American College of Obstetricians and Gynecologists
- American Hospital Association
- Anchor Perinatal Wellness
- Arkansas Foundation for Medical Care
- Association of Women's Health, Obstetric and Neonatal Nurses
- Beautiful as You Are
- Blue Cross Blue Shield Association
- Brandeis University Institute for Behavioral Health
- California Council of Community Behavioral Health Agencies
- Cherished Mom
- Colorado Perinatal Care Quality Collaborative
- Cradle Cincinnati
- Elevate Policy Lab at Yale
- Health Evolve Technologies, LLC
- MAMA'S Neighborhood
- Maternal Mental Health Leadership Alliance
- Maternal Mental Health Now
- National Center on Domestic Violence, Trauma, and Mental Health
- Neighborhood Health Plan of Rhode Island
- Nexus Recovery Center
- Philips
- Policy Center for Maternal Mental Health
- Postpartum Support International
- Seven Starling
- Shades of Blue Project
- SHIELDS for Families
- The American Psychiatric Association's Council on Women's Mental Health
- The Joint Commission
- The American College of Nurse-Midwives' Mental Health Committee
- The Center for Great Expectations
- The University of Denver's Graduate School of Professional Psychology
- The University of Texas Health Science Center at San Antonio School of Nursing
- The Warren Alpert Medical School of Brown University UnitedHealth Group
- UMass Memorial Health's Department of Obstetrics and Gynecology
- University of Maryland School of Medicine

Task Force Workgroup Co-Chairs

Data, Research, and Quality Improvement

- Dana Meaney Delman, M.D., Centers for Disease Control and Prevention (CDC)
- Joanne Nicholson, Brandeis University, Massachusetts, Member of the ACWS

Prevention, Screening, and Diagnosis

- Dawn Levinson, M.S.W., Health Resources and Services Administration (HRSA)
- Nicole Barnett, M.S.W., LCSW-C, PMH-C, Lived Experience

Evidence-Based Intervention and Treatment

- Tina Pattara-Lau, M.D., FACOG, Indian Health Service (IHS)
- Kathryn Icenhower, Shields for Families, California, Member of the ACWS

Evidence-based Community Practices

- Aditi Mallick, MD, Centers for Medicare & Medicaid Services (CMS)
- Le Ondra Clark Harvey, Psy.D, Council of Community Behavioral Health Agencies, California, Member of the ACWS

Communications and Community Engagement

- Rev. Dr. Que English, M.A., Center for Faith-based and Neighborhood Partnerships (HHS Partnership Center)
- Meredith Shockley-Smith, Cradle Cincinnati, Ohio

Overview

The task force’s national strategy and report to Congress are an important part of broader federal efforts to address women’s overall health (including their mental health) and maternal health in particular across the nation. The task force’s documents are aligned with multiple ongoing initiatives, including but not limited to:

- **White House Initiative on Women’s Health Research**
- **White House Blueprint for Addressing the Maternal Health Crisis**
- **Talking Postpartum Depression campaign** (HHS Office on Women’s Health), National Maternal Mental Health Hotline (Health Resources and Services Administration [HRSA])
- **HHS Postpartum Mental Health Collaborative** (HRSA and six participating states: Iowa, Massachusetts, Maryland, Michigan, Minnesota, and New Mexico)
- **Hear Her** (with resources for AI/AN individuals) campaign (Center for Disease Control and Prevention [CDC])
- **Maternity Care Action Plan** (Centers for Medicare & Medicaid Services [CMS])
- **Maternal Health Initiatives** (HRSA)
- **Transforming Maternal Health Model** (CMS)

Report to Congress Highlights

- The Task Force on Maternal Mental Health's Report to Congress presents the ACWS subcommittee's findings on maternal mental health conditions and SUDs in the United States, related federal programs, and best practices.
- Section 2 (Background and Methods) describes current data on the prevalence of maternal mental health conditions and SUDs and pregnancy-related deaths linked to them, highlighting the subgroups most affected.
- Section 3 (Best Practices) features a subset of best practices (i.e., specific activities and model programs) in the task force's areas of focus—highlighting ones that advance access, trauma-informed approaches, and culturally relevant services. This section covers best practices that are evidence-based, evidence-informed, and promising.

Report to Congress Highlights

- Section 4 (Existing Federal Programs and Coordination) details federal programs related to services, describes current coordination, and points to gaps and opportunities for improved collaborations among agencies.
- Section 5 (Opportunities for State and Local Partnerships) describes the overarching themes of these listening sessions and opportunities for state and local partnerships.
- Section 6 (Conclusion) presents a summary of the state of national policies and programs related to maternal mental health conditions and SUDs, along with best practices that might be leveraged during implementation of The Task Force on Maternal Mental Health's National Strategy to Improve Maternal Mental Health Care.

TASK FORCE ON MATERNAL MENTAL HEALTH

Whole-Person & Dyad Perinatal MH/SUD Care

Build National Infrastructure Prioritizing Perinatal Mental Health & Well-Being

Make Care and Services Accessible, Affordable, and Equitable

Use Data and Research to Improve Outcomes and Accountability

Promote Prevention and Engage, Educate, and Partner with Communities

Lift up Lived Experience

EQUITY AND ACCESS • FEDERAL COLLABORATION • TRAUMA-INFORMED APPROACHES • CULTURALLY RELEVANT SUPPORT

Vision

The task force expects that its work—this National Strategy, the report to Congress, and subsequent reports and updates—will improve maternal mental health and well-being for all individuals and communities across the nation.

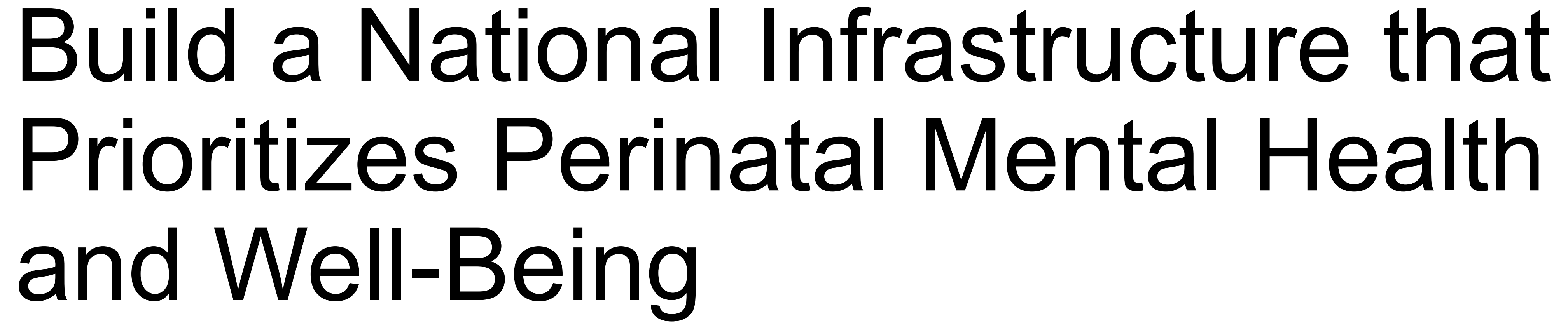
The task force envisions that perinatal mental health and substance use care in our nation will be seamless and integrated across medical, community, and social systems, such that there will no longer be a distinction between physical and mental health care and that models of care and support will be innovative and sensitive to the individual's experiences, culture and community.

Audience

The primary target audience for this national strategy is the Federal Government - Congress, the Executive Branch, and the many federal departments and agencies that spearhead the provision of health care and services in communities.

The federal government's work cannot be carried out without collaborations and partnerships with states, public–private entities, industry, advocates, medical and professional societies, communities, and individuals with lived experience and their families.

Note that at times the recommendations specify a particular entity within federal government when relevant and in other cases, no particular agency or entity is specified because it is implied that **a whole-of-government approach is needed**.



PILLAR 1

Priority 1.1:
Establish and Enhance Federal Policies That Promote Integrated Perinatal and Mental Health/SUD Care Models with Holistic Support for Mother-Infant Dyads and Families from Multidisciplinary and Interdisciplinary Teams

RECOMMENDATION 1.1.1: Enact federal laws and align incentives for states, D.C., & territories to mirror the expansion, funding, and enhancement of federal- and state-level integrated perinatal and mental health/SUD care models involving multidisciplinary and interdisciplinary teams that extend from pregnancy through at least 1 year postpartum—including two-generation (maternal and pediatric care) practices, evidence-based screening and prevention, provision of treatment, and linkages to follow-up and support services.

RECOMMENDATION 1.1.2: Enact federal laws that require the implementation of six (6) months of paid family and medical leave and universal child-care in all states, D.C., and U.S. territories.

Priority 1.1:
Establish and Enhance Federal Policies That Promote Integrated Perinatal and Mental Health/SUD Care Models with Holistic Support for Maternal-Infant Dyads and Families from Multi- and Interdisciplinary Teams

RECOMMENDATION 1.1.3: Establish policies that support non-stigmatizing and non-punitive approaches to screening for substance use disorders, mental health conditions, and suicide in pregnant and postpartum individuals and ensure access to culturally responsive, evidence-based, trauma- informed, family-centered care.

RECOMMENDATION 1.1.4: Invest federal funding to create trauma-informed, accessible and equitable family-friendly health care facilities across the spectrums of inpatient, residential, and outpatient care by ensuring free embedded child-care.

RECOMMENDATION 1.1.5: Increase the implementation of well-deliberated, clinically sound recommendations, practice guidelines, and evidence-based interventions related to the treatment and support of individuals and mother-infant dyads with perinatal mental health conditions, substance use, and SUDs in all relevant health care systems.

Priority 1.2: Establish and Enhance Federal Policies That Promote Perinatal Mental Health and Well-Being with a Focus on Reducing Disparities

RECOMMENDATION 1.2.1: Expand, enhance, and increase funding for federal programs serving perinatal populations to ensure that mental health, SUD, and GBV screening and preventive services, linkages to timely holistic treatment, and resources and referrals to community-based recovery support services for mental health conditions and SUDs are included.

RECOMMENDATION 1.2.2: Recognize the effects that structural racism and historical trauma have on creating and worsening mental health and SUDs and prioritize solutions for improving racial equity, addressing trauma and resolving disparities in care.

RECOMMENDATION 1.2.3: Appropriate sufficient funds to maintain and federally administer the work of the current Task Force on Maternal Mental Health to enhance, coordinate, and sustain efforts and partnerships on perinatal mental health and substance use. Establish in future legislation with funding - before the 2027 sunset of the task force - an ongoing coordinating committee on maternal mental health that includes federal and nonfederal representatives.

PILLAR 2

Priority 2.1:
Implement culturally relevant and trauma-informed clinical screening and diagnosis and improve linkages to accessible timely intervention and treatment.

RECOMMENDATION 2.1.1: Establish comprehensive pathways to improve routine culturally relevant and trauma-informed screening for the presence of and assessment of risk factors related to developing perinatal mental health conditions and substance use, and SUDs, along with GBV, trauma, and SDOH—with the provision of appropriate preventive resources, referrals, and linkages to timely intervention in all relevant care settings.

RECOMMENDATION 2.1.2: Clarify, modify, and adopt universal diagnostic criteria (e.g., language and definitions) that reflect more accurate symptom presentation, range, timing, frequency, and severity of perinatal mental health disorders and that improve reimbursement for screening, assessment, and intervention.

Priority 2.2: Create Accessible and Integrated Evidence-Based Services That Are Affordable and Reimbursable

RECOMMENDATION 2.2.1: Create federal mechanisms to fund and develop infrastructure that supports innovation in care delivery models for mental health conditions, substance use, and SUDs, and GBV during the perinatal period to reduce barriers to more accessible, holistic, and multigenerational dyadic care.

RECOMMENDATION 2.2.2: Improve federal funding and support for implementation of integrated crisis intervention services for perinatal populations and their families, training of the workforce on crisis care provision that is trauma-informed and culturally relevant, and development of infrastructure that leverages the support of state and local crisis systems.

Priority 2.2: Create Accessible and Integrated Evidence-Based Services That Are Affordable and Reimbursable

RECOMMENDATION 2.2.3: Work with states and all payors to help establish financial incentives, including increased reimbursement, and support for perinatal mental health and SUD interventions that demonstrate positive outcomes.

RECOMMENDATION 2.2.4: Strengthen the continuity of care in the community by encouraging federal agencies to add requirements to their notices of funding opportunities that direct recipients to collaborate with other federally funded programs and develop partnerships with community-based organizations, and regional/state programs, to expand access and referral to treatment and recovery support services.

Priority 2.3:
Build Capacity by Training, Expanding, and Diversifying the Perinatal Mental Health Workforce

RECOMMENDATION 2.3.1: Require all relevant existing federally funded training, curricula, and technical assistance programs to incorporate how to prevent, screen, assess, and treat perinatal mental health conditions, inclusive of SUD and GBV.

RECOMMENDATION 2.3.2: Educate future and current clinical providers in perinatal mental health conditions, substance use, SUDs, and GBV by ensuring that these topics are included in the curricula for both health care and mental health care providers (e.g., in medical and nursing school, mental health and substance use training programs, and allied health and mental health programs) and in continuing education requirements.

Priority 2.3:
Build Capacity by Training, Expanding, and Diversifying the Perinatal Mental Health Workforce

RECOMMENDATION 2.3.3: Allocate long-term funding to establish, expand, and sustain perinatal mental health, substance use, and GBV consultation programs for medical, mental health and substance use, nursing, allied health providers, as well as non-clinical community-based workers.

RECOMMENDATION 2.3.4: Fund, incentivize, and bolster recruitment and training efforts to expand and diversify the perinatal clinical and non-clinical mental health and substance use workforce, particularly in under-resourced areas.

Use Data and Research to Improve Outcomes and Accountability

PILLAR 3

Priority 3.1:
Use Data and Research to Support Strategies and Innovations That Improve Outcomes

RECOMMENDATION 3.1.1: Establish an interdisciplinary, interagency expert panel to determine high-priority areas of research, surveillance, and implementation science that will directly affect national improvements in perinatal mental health conditions and SUDs. The expert panel would be charged with ensuring coordination across the federal government, translating data to action, and monitoring and sustaining research and surveillance in this area.

RECOMMENDATION 3.1.2: Invest in ways to build the trust of under-resourced communities who have experienced abuses when participating in research and data collection efforts. Rebuild safety by engaging communities- namely pregnant and postpartum people with higher risk- in partnerships (e.g., through community-based participatory research) to ensure that research, data collection, analysis and reporting on perinatal mental health and substance use are equity-focused, are representative, are culturally relevant, are trauma-informed, and maintain necessary confidentiality protections with the highest ethical regard for vulnerable and under-resourced populations.

Priority 3.1:
Use Data and Research to Support Strategies and Innovations That Improve Outcomes

RECOMMENDATION 3.1.3: Support and fund integrated data systems by sharing data across health care and community-based services while preserving patient confidentiality. Use data to inform and drive the development of more equitable policies, effective practices, innovative interventions and approaches to treatment, and improved outcomes.

RECOMMENDATION 3.1.4: Increase investment in current perinatal health data collection programs and create a central clearinghouse of information so that providers, public health and government officials, and the public can quickly identify and use resources for perinatal health data.

RECOMMENDATION 3.1.5: Create mechanisms to pair implementation guidance and dissemination strategies with research, scientific and surveillance findings on perinatal mental health, substance use, SUDs, and GBV for wide use, application, and adoption of the most up-to-date interventions, guidelines, and data.

Priority 3.2:
Build a Foundation for Accountability in Prevention, Screening, Intervention, and Treatment

RECOMMENDATION 3.2.1: Establish and implement quality improvement metrics for providers, hospital systems, and insurers—with multiyear longitudinal tracking of costs and outcomes. Create mechanisms to ensure implementation of evidence-based solutions.

RECOMMENDATION 3.2.2: Fully fund and expand support for perinatal quality collaboratives (PQCs) fully in all 50 states, D.C., and all U.S. territories, including military and veteran spaces.

RECOMMENDATION 3.2.3: Continue to fully fund maternal mortality review committees (MMRCs) in all 50 states, D.C., and all U.S. territories.

PILLAR 4

Priority 4.1:
Promote and Fund Primary Prevention Strategies at the Community Level

RECOMMENDATION 4.1.1: Elevate and fund the implementation of evidence-based best practices and programs that promote person-centered, culturally relevant, and community-level detection and prevention of perinatal mental health conditions and SUDs, especially in under-resourced communities at high risk for these conditions and ensure related Medicaid and private payer coverage.

Priority 4.2:
Elevate Education of the Public About Perinatal Mental Health and Substance Use and Engage Communities with Outreach and Communications

RECOMMENDATION 4.2.1: Support a nationwide approach to clarifying the messaging and target audiences of all mental health, SUD, GBV and crisis support warmlines and hotlines for the perinatal populations and their families.

RECOMMENDATION 4.2.2: Improve federal strategies to communicate with and engage families, personal networks, those with lived experience, and communities in conversations about perinatal mental health, substance use, SUDs, and care—with a focus on decreasing stigma, raising awareness, and addressing safety—on an ongoing basis.

PILLAR 5

Priority 5.1: Listen to the Perspectives and Voices of People with Lived Experience*

- Continue to Focus on and Care for Mothers
- Build Trust
- Understand Mothers as People and What Is Happening in Their Lives
- Respond to the Needs of Mothers and Their Families

**from the USDS Lived Experience Report*

Priority 5.2: Prioritize the Recommendations from People with Lived Experience*

- Opportunities to connect to experienced mothers to build community
- Information, preparation, and community connections during early pregnancy
- Access to high-quality care for everyone
- Perinatal mental health check-ins with providers (having conversations about mental health early and often)
- Education about available medications that benefit people with mental health conditions and using them during the perinatal period
- Clear information on continuing medications for mental health conditions during pregnancy and during breastfeeding
- Recognition that breastfeeding greatly affects perinatal mental health
- Services that meet mothers and babies where they are
- Sleep strategies and support during early pregnancy
- Acknowledgment that screening alone is not enough, and the need for providers to make time for personal connection and explanation
- Recognition that care for perinatal mental health is health care
- Acknowledgment that paid family and medical leave improves outcomes for the entire family
- Specialty training in perinatal mental health support for diverse members of the workforce

**from the USDS Lived Experience Report*

Priority 5.2:
Prioritize the Recommendations from People with Lived Experience*

- A national paid family and medical leave policy *(Rec 1.1.2)*
- A diverse, interdisciplinary, culturally competent perinatal health workforce *(Priority 2.3)*
- Peer support and a group care model *(Priority 2.3)*
- Measures of the quality of patients’ experiences with maternity care, including mental health care *(Priority 3.2)*
- Holistic care models that integrate treatment of both mothers and babies *(Priority 1.1; Rec 2.2.1)*
- Screenings for different types of perinatal mood and anxiety disorders (PMADs), such as anxiety, obsessive-compulsive disorder, and bipolar disorder *(Pillar 1, Pillar 2)*
- Human-centered training and implementation of PMAD screening *(Priority 2.3)*
- Closed-loop referral systems for perinatal mental health *(Priority 2.1, Rec 2.1.1)*
- Continuing education requirements for perinatal mental health providers, including medication management (*Priority 2.3, Rec 2.3.2)*

**from the USDS Lived Experience Report*

- Implementation Planning
- Report to Governors
- Annual Updates

Thank You!

Task Force Leads

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