

# **U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

## **THE TASK FORCE ON MATERNAL MENTAL HEALTH'S REPORT TO CONGRESS**

*Per academic and publishing standards, this document includes bibliographic citations and other attributions to printed and digital sources and other research materials. This report has also been reviewed with industry-standard plagiarism-screening software. All flagged instances of potential previously published material have been thoroughly researched and, where appropriate, cited or attributed accordingly. This report incorporates information obtained from publicly solicited comments through [FR Doc. 2023-28890](#) and from hundreds of subject matter experts, and where possible, this document cites or attributes this information appropriately. However, federal solicitations for public comment make possible the incorporation of information or text from unpublished sources or other sources, which may not be cited or attributed herein.*

## CONTENTS

Section 1: Introduction and Executive Summary .....	1
Introduction.....	1
Executive Summary .....	2
Section 2: Background and Methods .....	6
Background.....	6
Part 1. Maternal Mortality Related to Mental Health Conditions and SUDs .....	9
Maternal Mortality Related to Mental Health Conditions and SUDs as a Single Category.....	9
Pregnancy-Related Deaths by Suicide.....	11
Pregnancy-Associated Deaths from Drug Overdoses/Poisonings .....	13
GBV: A Factor in Pregnancy-Associated Deaths from Suicide, Overdose, and Homicide .....	15
Part 2. Maternal Mental Health.....	17
Understanding Social Determinants of Health (SDOH).....	17
Perinatal Mental Health Conditions .....	18
Maternal Adverse Childhood Experiences (ACEs), PTSD, and Gender-Based Violence .....	21
Part 3. Perinatal SUDs and Co-occurring SUDs and Mental Health Conditions .....	23
Part 4. Social Determinants of Health and Perinatal Mental Health and Substance Use.....	25
SDOH and Perinatal Mental Health .....	25
SDOH and Perinatal Substance Use.....	26
Stigma and Other Barriers to Care for Maternal Mental Health Conditions and SUDs ...	28
Part 5. Unmet Need for Treatment of Maternal Mental Health and SUDs .....	30
Part 6. Challenges with Data on Maternal Mental Health .....	32
Part 7. Task Force Formation and Purpose.....	33
Task Force Composition and Structure as a Subcommittee of SAMHSA’s Advisory Committee for Women’s Services.....	34
Methods of the Task Force on Maternal Mental Health .....	36
Workgroup Meetings .....	37
Task Force Meetings and Full ACWS Meetings.....	37
Section 3: Best Practices .....	38
Communicating with and Engaging Communities to Address Maternal Mental Health Conditions.....	39
The Importance of Reaching the Relevant Audiences.....	39
The Importance of Community Engagement.....	42
Access to Services .....	43
Prevention of Maternal Mental Health Conditions and SUDs.....	47
Treatment-First Approach to Perinatal Substance Use Screening and SUD .....	47

## The Task Force on Maternal Mental Health’s Report to Congress

Screening for Perinatal Mental Health Conditions and SUDs.....	49
Barriers to Screening for Perinatal Mental Health Conditions and SUDs.....	49
Screening for Maternal Mental Health Conditions and SUDs Must Occur in Both Clinical and Nonclinical Settings.....	50
Diagnosis.....	51
Intervention and Treatment.....	52
Community-Based and Multigenerational Practices.....	59
Workforce Best Practices.....	61
Research and Data Collection.....	62
Section 4: Existing Federal Programs and Coordination.....	67
Programs by Agency.....	67
Administration for Children and Families (ACF).....	67
Agency for Healthcare Research and Quality (AHRQ).....	67
Centers for Disease Control and Prevention (CDC).....	68
Centers for Medicare & Medicaid Services (CMS).....	69
Food and Drug Administration (FDA).....	70
Health Resources and Services Administration (HRSA).....	70
Indian Health Service (IHS).....	74
National Institutes of Health (NIH).....	74
Office of the Assistance Secretary for Health (OASH), Office on Women’s Health (OWH).....	77
Substance Abuse and Mental Health Services Administration (SAMHSA).....	77
U.S. Department of Veterans Affairs (VA).....	78
Program Practices.....	80
Prevention.....	80
Screening.....	85
Diagnosis.....	89
Intervention.....	91
Community-Based and Multigenerational Practices.....	96
Treatment.....	98
Equity.....	102
Federal Collaboration Efforts.....	106
Conclusion.....	111
Section 5: Feedback From Listening Sessions and Opportunities for State and Local Partnerships.....	112
Part 1. The Current State of Affairs in Maternal Mental Health.....	113
SDOH, Stigma, and Gender-Based Violence (GBV).....	113
Workforce Shortages Affect Care Access.....	113
Service Coordination Could Be Improved.....	114

## The Task Force on Maternal Mental Health’s Report to Congress

States Are Integrating Mental and Maternal Health .....	114
Part 2. Model State and Local Programs Supporting Pregnant and Postpartum Individuals with Mental Health Conditions and SUDs .....	116
Understanding the State of Maternal Mental Health in the States .....	116
Addressing SDOH Through State Programs .....	116
State Programs to Increase Public Awareness of Maternal Mental Health Conditions and Services.....	116
Providing Integrated Care and Continuity of Care Through Home Visiting Programs ..	117
Addressing Maternal SUD .....	118
Addressing Maternal Mortality Related to Mental Health Conditions, SUDs, and Other Health Problems .....	118
Using Telehealth to Support Pregnant People, Postpartum Individuals, and Their Providers.....	120
Part 3. Federal, State, and Local Maternal Health Policies and Other Policies Affecting Maternal Mental Health .....	121
Policies Related to SDOH and Improving the Mental Health of Pregnant and Postpartum Individuals .....	121
Policies Related to the Criminalization and Decriminalization of Substance Use During Pregnancy .....	121
Medicaid Policies .....	122
Policies That Exacerbate or Ease Workforce Shortages .....	124
Part 4. The Workforce.....	125
The Need for Ongoing Training and Education.....	125
Extending the Workforce .....	128
Part 5. Data .....	130
Part 6. Equity .....	131
Opportunities for State and Local Partnerships .....	131
Conclusion .....	131
Section 6: Conclusion .....	133
Maternal Mental Health Conditions and SUDs in the United States .....	133
The Current State of Maternal Mental Health Services, Programs, and Best Practices.....	136
Next Steps for the Task Force .....	141
Appendix A: Glossary .....	A-1
Appendix B: Language Used in This Report to Congress .....	B-1
Appendix C: Roster of the Task Force on Maternal Mental Health .....	C-1
Federal Staff Members .....	C-1
Nonfederal Staff Members.....	C-4
Appendix D: References .....	D-1
Appendix E: Acknowledgments .....	E-1

## SECTION 1: INTRODUCTION AND EXECUTIVE SUMMARY

### INTRODUCTION

Incidents and conditions related to mental health and substance use disorders (SUDs) are the leading cause of pregnancy-related deaths in the United States, including suicides and drug overdoses (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022). Saving the lives of pregnant and postpartum individuals with maternal mental health conditions and SUDs requires an analysis of current national circumstances and the subgroups most affected, evaluation of the nation’s current efforts to address the problem, identification of best practices, and feedback from experts on how the federal government could coordinate programs to improve outcomes for pregnant and postpartum individuals. A directive from Congress (in the division of the [Consolidated Appropriations Act, 2023](#) called the Health Extenders, Improving Access to Medicare, Medicaid, and CHIP, and Strengthening Public Health Act of 2022 [Public Law 117–328, Section 1113]) authorized the establishment of the Task Force on Maternal Mental Health under the U.S. Department of Health and Human Services (HHS). With this directive, Congress took a step toward addressing the urgent public health problem of untreated mental health conditions and SUDs among women and other people during the perinatal period—i.e., pregnancy or postpartum (up to 1 year after the end of pregnancy).

The purpose of the task force is to document barriers to care and support, to evaluate relevant federal programs, to identify best practices, and to make actionable suggestions to coordinate and improve infrastructure in federal activities for addressing maternal mental health conditions and SUDs. This report’s companion publication, *The Task Force on Maternal Mental Health’s National Strategy to Improve Maternal Mental Health Care*, outlines these recommendations, which focus on ways to improve the prevention, identification (screening and diagnosis), timely referral and intervention (both in the community and in the clinic), and access to care and other supports for maternal mental health conditions and SUDs. Cutting across these crucial activities, the task force integrated considerations for enhancing access and equity, approaches that are sensitive to patient/client life experiences and circumstances, culturally relevant services, and federal coordination. Both the report to Congress and the national strategy were developed with input from the public, including people with lived experience of maternal mental health conditions; states; and frontline professionals working in communities across the nation. Quotations characterizing the perspectives of those with lived experience enrich both documents, and the national strategy uplifts their voices to highlight the challenges and recommendations for improving maternal mental health.

The findings described in *The Task Force on Maternal Mental Health’s Report to Congress* will help guide efforts to implement the national strategy. In response to the directive in the Consolidated Appropriations Act, 2023, this report to Congress has been prepared by two HHS agencies, the Office on Women’s Health (OWH), which is within the Office of the Assistant Secretary for Health (OASH), and the Substance Abuse and Mental Health Services Administration (SAMHSA). These agencies implemented the task force as a subcommittee of the existing Advisory Committee for Women’s Services (ACWS). Congress directed that the initial report to Congress be delivered within 1 year of the task force’s first meeting, with the national strategy following a year later. However, due to the critical nature of this public health crisis, the report and national strategy were expedited.

The work of the Task Force on Maternal Mental Health continues through September 30, 2027, including annual updates to this report in the subcommittee’s five areas of focus—(1) data, research, and quality improvement; (2) prevention, screening, and diagnosis; (3) evidence-based intervention and treatment; (4) evidence-based community practices; and (5) communications and community engagement—along with the cross-cutting issues mentioned above. After communications and outreach to support implementation of the national strategy, the task force will develop and disseminate a subsequent report to the governors of all states highlighting opportunities for state and local action and partnerships.

### EXECUTIVE SUMMARY

*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. This section also:

1. Summarizes the impact of maternal mental health conditions and SUDs on individuals, families, and society;
2. Underscores the links between maternal mental health and social determinants of health (SDOH);
3. Describes the effects of gender-based violence (GBV)—including intimate partner violence (IPV), domestic violence, stalking, and sexual violence—on maternal mental health and how GBV contributes to unmet treatment needs;
4. Notes the role punitive responses—such as judicial consequences for substance use during pregnancy—play in driving the high unmet need for treatment;
5. Discusses data challenges and the need for local, national, standardized, and integrated data collection; and
6. Describes research gaps resulting from the regular exclusion of pregnant and postpartum individuals from biomedical and biobehavioral research, from the lack of studies linking SDOH to maternal outcomes, and from other factors.

**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.

As federal agencies endeavor to incorporate and spur the implementation of best practices, some of these activities and models overlap with the programs discussed in **Section 4 (Existing Federal Programs and Coordination)**. This section details federal programs related to services, describes current coordination, and points to gaps and opportunities for improved collaborations among agencies. To understand the landscape of maternal mental health conditions and SUDs in states, U.S. territories, and local jurisdictions, HHS convened moderated listening sessions with key stakeholders—with the task force attending to take in the feedback.

**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*.

Input from the public submitted in response to a request for information, [FR Doc. 2023-28890](#), and input from people with lived experience compiled in a report prepared by the U.S. Digital Service informed this report to Congress.

Key themes about maternal mental health conditions and SUDs emerged from task force discussions, listening sessions, public comments, and the lived experience report. Those key themes include:

- **SDOH and Policy**
  - SDOH affect maternal mental health and the ability to access support and care. SDOH include factors such as access to food, access to stable housing, access to transportation, access to affordable child care, access to health care coverage, and income.
  - Discrimination against minoritized populations (e.g., certain racial/ethnic groups, LGBTQI+ individuals, members of some religious groups, individuals with disabilities, individuals residing in rural areas, and individuals adversely affected by persistent poverty or inequality) functions as a profound SDOH.
  - Multiple policies similarly affect maternal mental health and the ability to access support and care, including the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); Medicaid coverage; low reimbursement for services; and lack of paid family and medical leave.
  - SDOH and related policies intersect with equity.
- **Stigma**
  - Stigma surrounding mental health conditions and substance use disorders, idealized images of mothers, and a lack of awareness about maternal health challenges have negative effects on many individuals, families, and communities and can affect maternal mental health, SUDs, and treatment-seeking behaviors.
  - Mothers fear that reporting any substance use or mental health symptoms (e.g., thoughts of self-harm) would be reported to child protective services and that their children would be removed from the home.
  - Stigma intersects with SDOH, such as those affecting under-resourced populations, and affects maternal mental health and treatment. Stigma also disproportionately harms minoritized communities.
  - There is a need for non-stigmatizing, culturally relevant, and trauma-informed communications and education—for patients, families, communities, and providers—so people are comfortable discussing maternal mental health conditions and SUDs.

- **GBV**
  - All forms of gender-based violence can have a significant impact on maternal mental health and maternal mortality.
  - Interventions should address GBV-related trauma, ongoing IPV, and other forms and consequences of GBV.
- **Workforce**
  - Clinical workforce shortages compounded by the COVID-19 pandemic constitute a barrier to accessing all forms of health care, particularly care for maternal mental health conditions and SUDs.
  - Members of the workforce require specific training in maternal mental health conditions and SUDs, support for implementing collaborative or integrated care, assistance linking with relevant community-based resources, and access to perinatal psychiatric consultation.
  - Both clinical and community-based providers face challenges associated with burnout, training needs, no or low rates of reimbursement for related services, and limited resources for referral.
  - The community-based workforce—including community health workers, doulas, peer support specialists, peer navigators, and lactation consultants—can provide culturally relevant multigenerational services and supports to mothers and families. Scaling up training, credentialing, expansion, and reimbursement of this workforce could improve access and better support collaborative care systems.
  - Recruitment and retention incentives could enhance the pipeline of clinical and community-based workers.
- **Access, Affordability, and Continuity of Care**
  - Many providers of mental health and SUD treatment services do not accept insurance, compounding issues stemming from workforce shortages and service access.
  - Many community-based organizations that provide maternal mental health and SUD treatment services are underfunded.
  - No or low levels of reimbursement for mental health and SUD treatment services limit access and negatively affect mothers and their children—particularly in rural areas and other under-resourced communities.
  - Fragmented and disconnected health care and social services systems require multiple visits to different providers in various locations, resulting in additional stress for pregnant and postpartum individuals and contributing to a lack of continuity of care, to difficulty accessing services, and to many individuals not seeking support and treatment.
- **Data and Research**
  - Current research is limited regarding perinatal mental health conditions and SUDs and their effects on the life course of pregnant and postpartum individuals, their children, and their other family members, particularly those from under-resourced communities. Future research could investigate these effects, particularly the potential increased risk for later-life medical conditions. Research should prioritize the major knowledge gaps in the field of maternal mental health and SUDs to optimize the impact on the population.



- Data collection should be standardized and integrated at the local, county, state, and national levels. Collection of both cross-sectional and longitudinal data could improve the understanding of maternal mental health conditions and SUDs, and standards of excellence can establish standards for quality care.
- Maternal mortality review committees (MMRCs) provide data to inform prevention and perinatal quality collaboratives (PQCs), which implement quality improvement initiatives. MMRCs and PQCs remain crucial to maternal mental health improvement efforts and would benefit from the data collection practices described above.
- All research efforts and other initiatives to improve maternal health conditions and SUDs—including research studies, surveillance efforts, and quality improvement initiatives—must involve the participation of both the communities most affected and providers who routinely care for pregnant and postpartum individuals. Researchers should integrate community members and care providers throughout the research process, from study conceptualization/design to dissemination of findings.
- Multiple audiences require research findings and data from surveillance efforts on maternal mental health conditions, SUDs, associated discrimination, SDOH, GBV/IPV, and their intersection—as well as successful interventions and models of care—described in plain language so they can act within their spheres of influence.
- **Other Key Points**
  - To improve maternal mental health and SUD outcomes, individuals and families need culturally relevant wraparound services, perinatal supports, and health care for a minimum of 1 year postpartum (including telehealth options).
  - Universal access to the full spectrum of evidence-based maternal mental health and SUD services—prevention, screening, diagnosis, and interventions (both clinical and community-based)—is needed for holistic, culturally relevant care and support.
  - Best practices, integrated care models, and other model programs are available for clinical, community-based, and multigenerational services. However, nationwide, their implementation remains inconsistent.
  - Universal home visiting programs can offer individuals, parent–child dyads, and families valuable support in the perinatal period and can address many barriers to accessing services (e.g., a lack of transportation, long distances to clinics, and a need for child care).

**“Between chronic pain and insurance ... I couldn’t find someone who had availability, so it fell by the wayside. I was trying to juggle it all. It got really bad. My mental health got bad again after she turned 1. She’s screaming and crying when she should be sleeping. ... I was spiraling and taking it out on my partner and being mean. I didn’t want to be here, [telling myself], ‘Maybe [my child] would be better [if she] didn’t have a mom.’ It was really a hard time justifying why I should be around my husband and daughter.”**

**—A mother**

## SECTION 2: BACKGROUND AND METHODS

### BACKGROUND

In the United States, mental health conditions are the leading cause of pregnancy-related deaths (i.e., “a death while pregnant or within 1 year of the end of pregnancy from any cause related to or aggravated by the pregnancy,” as defined by the Centers for Disease Control and Prevention’s (CDC) Pregnancy Mortality Surveillance System (Centers for Disease Control and Prevention, n.d.-k)—accounting for 22.7 percent of these deaths, according to an analysis of 2017–2019 data from 36 states (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022). Here, note that mental health conditions affect thinking, feeling, mood, and behavior and can affect daily functioning and the ability to relate to others. These conditions may be intermittent or long-lasting (chronic). They are also called “mental disorders” or “mental illnesses” (MedlinePlus, 2024).

The high rates of maternal deaths associated with mental health conditions point to the pressing need to address maternal mental health conditions and substance use disorders (SUDs), including co-occurring disorders, to save women’s lives. SUDs “occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home,” according to the Substance Abuse and Mental Health Services Administration (2023d).

**“I was stressed out and sad because I didn’t know how I was going to make it work.”**

**–K.L., mother of two**

Additionally, maternal mental health conditions and SUDs have a significant impact on individuals, children, families, and society. Women with untreated mental health conditions during pregnancy are less likely to have good prenatal care and nutrition—which may affect their health and the health of their infants (Jahan et al., 2021).

Untreated maternal mental health conditions also increase the risk for substance use and negatively affect mothers’ ability to care for and respond to their babies (Fitelson et al., 2010; Zhou et al., 2019). The effects of untreated maternal mental health conditions on children can be longer-lasting; for example, they can lead to behavioral, cognitive, and emotional delays (Mughal et al., 2019). The cost of untreated maternal mental health conditions is estimated to be \$14 billion a year in the United States (Luca et al., 2020).

SUDs during pregnancy are associated with adverse health outcomes for women (e.g., maternal hypertension among those who use stimulants, overdose, withdrawal, suicide, and sexually transmitted infections [STIs]) and their infants (e.g., low birth weight, irritability, preterm birth, stillbirth, and difficulty sleeping) (Centers for Disease Control and Prevention, n.d.-j; Prince et al., 2024). Fetal alcohol spectrum disorders (FASDs) are among the leading preventable causes of birth defects and developmental disabilities requiring ongoing treatment (Centers for Disease

In the U.S., **mental health conditions\*** account for

**22.7%**

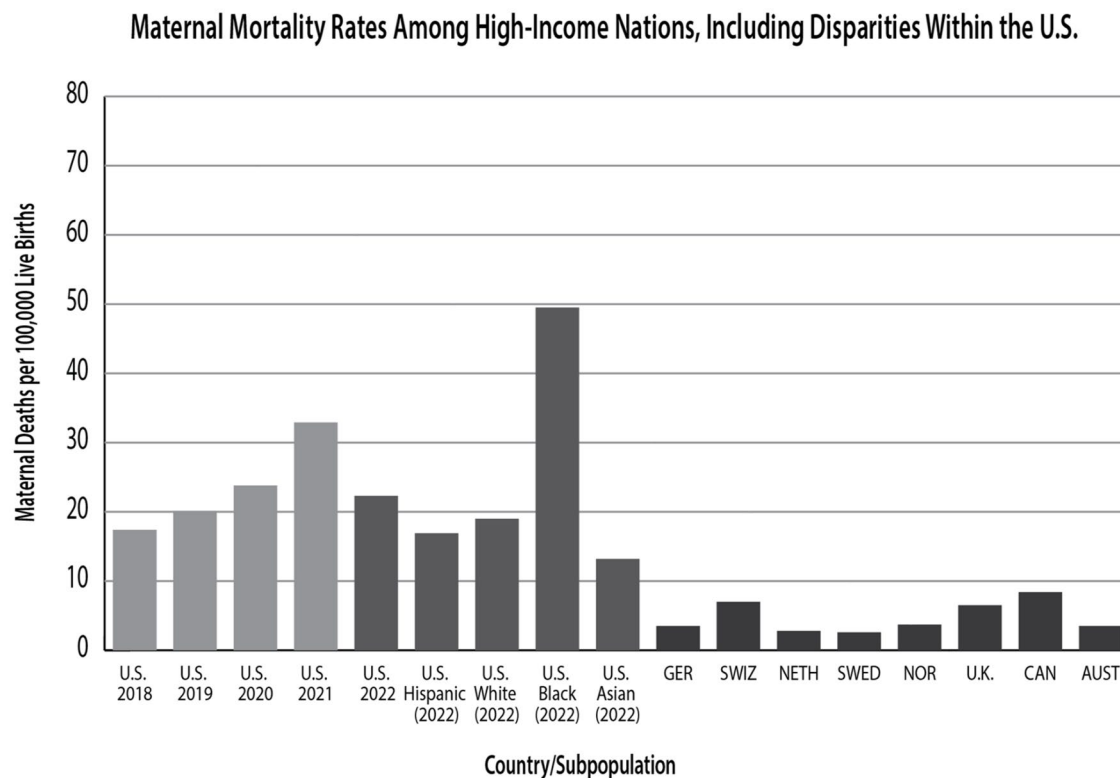
**of pregnancy-related deaths** and are the **leading cause** of such deaths.

*\* Here, the cited researchers use “mental health conditions” inclusively, and the term includes deaths by suicide, deaths by overdose or poisoning related to SUD, and other deaths that a maternal mortality review committee deemed related to a mental health condition or substance use disorder (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022).*

Control and Prevention, n.d.-e; Popova et al., 2023). “FASD” refers to the wide range of physical, behavioral, and cognitive impairments that are caused by alcohol exposure before birth (National Institute on Alcohol Abuse and Alcoholism, n.d.). The cost of FASDs is more than \$4 billion a year in the United States (Lupton et al., 2004). Exposure to psychotropic substances, including opioids, before birth may lead to neonatal abstinence syndrome (NAS), including neonatal opioid withdrawal syndrome (NOWS), which is characterized by various signs—such as excessive high-pitched crying, irritability, trouble sleeping, problems feeding, diarrhea, and vomiting—that require management (Anbalagan & Mendez, 2024; Hudak et al., 2012). NAS is a group of problems that can happen when an infant is exposed to drugs for a length of time before birth (March of Dimes, 2019). Some data also suggest that SUD may be associated with birth defects among infants exposed to opioids (including fentanyl) in utero. The average cost of a hospital stay for a newborn with NAS is nearly seven times that of infants without this condition (Centers for Disease Control and Prevention, n.d.-a). In addition, infants born to mothers who both drank and smoked beyond the first trimester of pregnancy have a twelvefold increased risk for sudden infant death syndrome (SIDS) compared with those unexposed or only exposed in the first trimester of pregnancy (Elliott et al., 2020).

The individual and societal consequences of untreated maternal mental health conditions and SUDs have prompted Congress to act. The U.S. Department of Health and Human Services (HHS) formed the Task Force on Maternal Mental Health in response to a directive from Congress ([Consolidated Appropriations Act, 2023](#), Public Law 117–328, Section 1113) to address this urgent public health problem. Dealing with these conditions includes preventing them, improving their identification (through enhanced screening and diagnosis), providing timely intervention (both in the community and in the clinic), and expanding access to treatment—including throughout the postpartum period. The task force’s findings described in this report will help guide efforts to implement the national strategy for addressing these conditions.

The overall U.S. maternal mortality rate—which is highest among high-income countries despite our spending the most on health care per person—had been increasing in recent years but decreased in 2022 compared with 2021 (Gunja et al., 2023; Hoyert, 2024).



Abbreviations: GER, Germany; SWIZ, Switzerland; NETH, Netherlands; SWED, Sweden; NOR, Norway; U.K., United Kingdom; CAN, Canada; AUST, Australia.

Sources: (Gunja et al., 2023; Hoyert, 2024; Organisation for Economic Co-operation and Development, 2023)

## **PART 1. MATERNAL MORTALITY RELATED TO MENTAL HEALTH CONDITIONS AND SUDS**

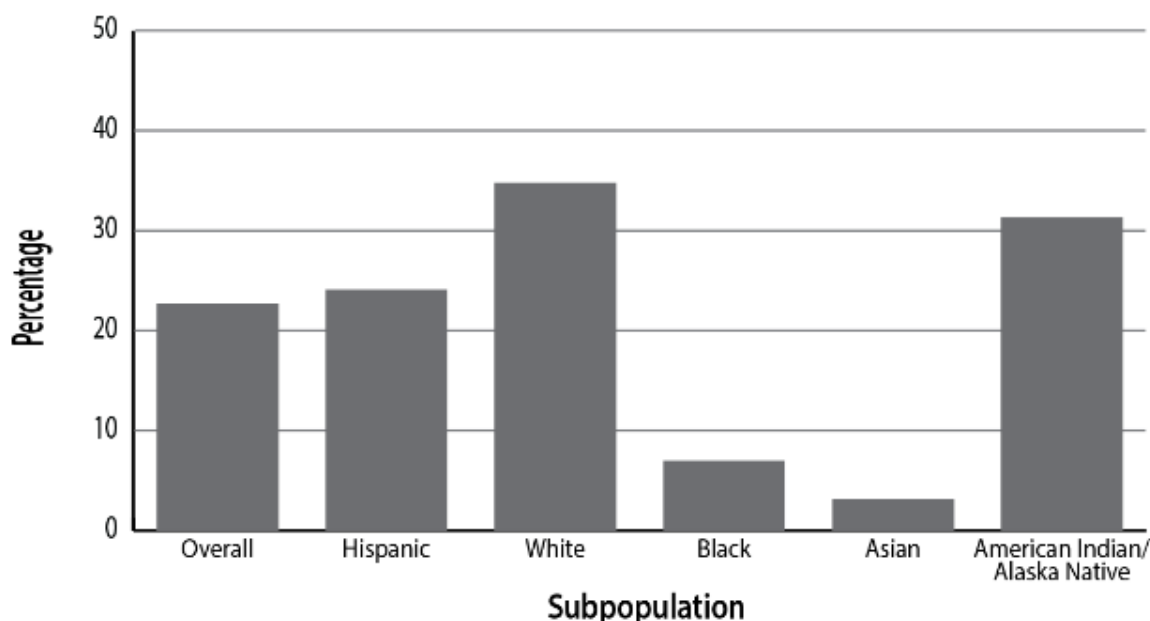
Untreated perinatal mental health conditions and SUDs can become more severe and even lead to preventable premature deaths—for example, by suicide and drug overdose or poisoning. This section provides more details on pregnancy-related deaths associated with maternal mental health conditions and SUDs, outlining the subpopulations with high mortality risk. These maternal deaths are first considered as a single category (i.e., all causes related to mental health conditions and SUDs) and then discussed separately by specific causes—namely, suicide and drug overdose. Finally, a subsection addresses GBV—which may influence maternal deaths by suicide and drug overdose, as well as pregnancy-related homicides.

### **Maternal Mortality Related to Mental Health Conditions and SUDs as a Single Category**

As noted previously, mental health–related incidents and conditions—which include fatalities from suicide, drug overdoses and poisonings, and certain traumatic experiences, including IPV—now represent the leading cause of pregnancy-related deaths in the United States. Taken together, these incidents accounted for 22.7 percent of pregnancy-related deaths, according to an analysis of 2017–2019 data from 36 states (Campbell et al., 2021; Joseph et al., 2024; Lawn & Koenen, 2022; Trost, Beauregard, Chandra, Njie, Berry, et al., 2022).

***Subpopulations Most Affected***—Trost and colleagues (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022) found that in data from the maternal mortality review committees (MMRCs) in 36 states, the proportions of pregnancy-related deaths caused by mental health conditions and SUD were not consistent across different racial and ethnic groups. These conditions were the leading cause of pregnancy-related deaths for White and Hispanic women and the sixth-leading cause of pregnancy-related deaths for Black women (with cardiac and coronary conditions being the leading cause for this group). In a separate analysis in which the sample sizes were adjusted to account for American Indian/Alaska Native (AI/AN) individuals in combination with other races, the results indicated that 31.3 percent of pregnancy-related deaths were caused by underlying mental health conditions and SUDs—the leading cause for this group (Trost, Beauregard, Chandra, Njie, Harvey, et al., 2022).

### Percentages of Pregnancy-Related Deaths with a Mental Health Condition\* as the Underlying Cause in 2017–2019, by Race/Ethnicity



\* Here, the cited researchers use “mental health conditions” inclusively, and the term includes deaths by suicide, deaths by overdose or poisoning related to SUD, and other deaths that a maternal mortality review committee deemed related to a mental health condition or SUD (Trost, Beauregard, Chandra, Njie, Harvey, et al., 2022).

**Timing and Preventability**—An analysis of data from 14 state MMRCs from 2008 to 2017 provides valuable insights into the timing and preventability of pregnancy-related deaths from suicide, drug overdoses, and other causes associated with mental health conditions and SUDs. MMRCs are “multidisciplinary committees that convene at the state or local level to comprehensively review deaths that occur during or within a year of pregnancy (pregnancy-associated deaths)” (Centers for Disease Control and Prevention, n.d.-d). Trost and colleagues (2021) found that among the 421 pregnancy-related deaths with an MMRC-determined underlying cause of death, 11 percent were determined to be related to mental health (from suicide, drug overdoses, and other causes associated with mental health conditions and SUDs). They also found that nearly two-thirds (63 percent) of these deaths occurred 43–365 days postpartum, compared with 18 percent of deaths from other causes. The MMRCs deemed that all of the pregnancy-related deaths caused by suicide, drug overdoses, and other incidents and conditions associated with mental health and SUDs were preventable (compared with 64 percent of deaths from other causes) (Trost et al., 2021).

The importance of adequate care and follow-up in the prevention of pregnancy-related deaths from suicide, drug overdoses, and other causes associated with mental health conditions and SUDs is also underscored by the findings of Trost and colleagues (Trost et al., 2021). In the same study, documented medical histories indicated that nearly three-quarters (72 percent) of people with a pregnancy-related death from a mental health condition or SUD had a history of depression, and 67 percent had past or current substance use. It is important to note that MMRCs

are not able to establish links between deaths from suicide or unintentional overdoses and the conditions that contribute to them (e.g., recent life events and experiencing violence and other trauma) unless they are documented in medical records or other available data sources. This gap in information represents a missed opportunity for intervention and prevention that could have helped many women.

#### Help Is Available

Pregnant people and new moms can call or text the National Maternal Mental Health Hotline at 1-833-TLC-MAMA (1-833-852-6262) for free and confidential support 24/7 in English or Spanish.

By dialing or texting 988, people can obtain free and confidential support 24/7 for suicidal crisis or emotional distress. SAMHSA’s Suicide & Crisis Lifeline helps thousands of people overcome crisis situations every day.

### Pregnancy-Related Deaths by Suicide

The analysis of 2017–2019 data on pregnancy-related deaths from MMRCs in 36 states by Trost and colleagues (2022) indicated that suicide was associated with 8.4 percent of pregnancy-related deaths. Another analysis found that among pregnancy-associated deaths that occurred between 2010 and 2019 in 33 states plus the District of Columbia, 5.4 percent were related to suicide (Margerison et al., 2022). Pregnancy-associated deaths are defined as those “that occur during pregnancy, at the time of delivery, or within 1 year postpartum, regardless of the cause, location of pregnancy, or pregnancy outcome” (National Center for Health Statistics, 2022). Some analyses include deaths from suicide, drug overdose, and homicide during pregnancy and within 1 year postpartum in this category, whereas others categorize them as pregnancy-related deaths. Similar results were reported from a recent analysis of MMRC data from 14 states, which found that in 2017, 5.7 percent of pregnancy-related deaths were caused by suicide (White et al., 2023). Between 2019 and 2020, pregnancy-associated deaths from suicide declined (Margerison et al., 2023). In the analysis published in 2021 by Trost and colleagues—which focused on pregnancy-related deaths from suicide, drug overdoses, and other causes associated with mental health conditions and SUDs—63 percent of the maternal fatalities attributable to health conditions were caused by suicide (Trost et al., 2021). In a 2024 study using data from CDC’s National Violent Death Reporting System (NVDRS), analysis of firearm-related suicides among females ages 15–44 found that pregnancy-associated suicides occurred more frequently among those who had experienced IPV within a month of death than non-pregnancy-associated suicides (4.2 percent versus 1.3 percent,  $P=0.005$ ) (Joseph et al., 2024).

***Subpopulations Most Affected***—Although limited, there is some information on groups of people most affected by pregnancy-associated deaths by suicide. Margerison and colleagues (2022) found that between 2010 and 2019, these deaths occurred most frequently among individuals ages 15–19, followed by women 35 or older. According to NVDRS data, in 2020 these deaths occurred most frequently among individuals ages 25–29, followed by women ages 20–24 (Centers for Disease Control and Prevention, 2020). Earlier research found that women who died by pregnancy-associated suicide were more likely to be age 40 or older, according to an analysis of 2003–2007 data from the NVDRS (Palladino et al., 2011). 2020 NVDRS data also reveal that pregnancy-associated deaths by suicide were highest among AI/AN individuals. This

accords with earlier research that found that these deaths were more likely among White individuals and AI/AN people (Palladino et al., 2011).

***Roles of Mental Health Conditions and Substance Use***—Findings from the California Pregnancy-Associated Mortality Review (CA-PAMR) provide insight into the roles that mental health conditions and substance use play in pregnancy-associated deaths by suicide (*The California Pregnancy-Associated Mortality Review Report: Pregnancy associated suicide, 2002-2012*, 2019). Mental health conditions were highly prevalent among women who died by suicide during pregnancy or within 1 year postpartum between 2002 and 2012. Almost two-thirds (62 percent) of these women had reported mental health conditions before becoming pregnant, whereas 24.5 percent experienced new-onset conditions after they became pregnant. Nearly a quarter of the women (23 percent) had a reported family history of mental health conditions. The CA-PAMR study also gathered data on the most prevalent diagnostic impressions identified by clinicians for women who died by suicide during pregnancy or within 1 year postpartum, which were depression (55.6 percent), substance use (32.3 percent), psychosis (24.2 percent), bipolar disorder (17.2 percent), anxiety (8.1 percent), personality disorder (6.1 percent), post-traumatic stress disorder (PTSD) (4.0 percent), and schizophrenia (4.0 percent). “Diagnostic impressions were based on available information that described women’s emotional states, behaviors, and any indication of diagnosed or treated mental illness during the perinatal period” (*The California Pregnancy-Associated Mortality Review Report: Pregnancy associated suicide, 2002-2012*, 2019). Substance use was often co-occurring with mental health conditions—with only 4.0 percent of women having only this problem (*The California Pregnancy-Associated Mortality Review Report: Pregnancy associated suicide, 2002-2012*, 2019).

***Timing and Preventability***—The CA-PAMR study also provided insight into the timing of these deaths. The majority of the women (83 percent) died in the late postpartum period (i.e., 43–365 days after the end of pregnancy). Specifically, 36 percent died between 43 days and 6 months, and 47 percent died more than 6 months postpartum (*The California Pregnancy-Associated Mortality Review Report: Pregnancy associated suicide, 2002-2012*, 2019). The findings from California accord with the results of a study that examined perinatal suicides in the Canadian province of Ontario between 1994 and 2008, which found that these deaths most often occurred 6 months or later postpartum (Grigoriadis et al., 2017). The CA-PAMR found only a single case (1 percent) of pregnancy-associated suicide in which there had been no chance to alter the outcome. About half (51 percent) of the pregnancy-associated deaths by suicide studied had a good-to-strong chance of being prevented, and 47 percent had some-to-no chance of preventability, supporting the assertion that deaths caused by pregnancy-associated suicide are preventable when proper treatment and support are available. (*The California Pregnancy-Associated Mortality Review Report: Pregnancy associated suicide, 2002-2012*, 2019).

“To be honest, a new mother should really be checked at 1 month, 6 weeks, 6 months, a year—just so you know that she is physically OK. ... A lot of women die shortly after birth because they don’t [receive] enough attention.”

—A mother

Other U.S. data suggest missed opportunities to prevent deaths by suicide during the perinatal period. An estimated 3.4 percent of pregnant women exhibited suicidal behaviors (i.e., suicidal ideation, planning suicide, and/or attempting suicide)—more prevalent during the first trimester—according to an analysis of 2009–2018 National Survey on Drug Use and Health data



(Kitsantas, Aljouidi, et al., 2021). Chin and colleagues (2022) emphasized the need for all clinicians to be aware of risk of suicide among their perinatal patients—particularly individuals with mental health diagnoses, prior suicide attempts, substance misuse, and SUDs. These authors noted that access to health care often increases during pregnancy and the year postpartum and highlighted the resulting opportunities to identify and intervene for suicide risk (Chin et al., 2022).

### **Pregnancy-Associated Deaths from Drug Overdoses/Poisonings**

Untreated SUDs are among the risk factors for drug overdose (Centers for Disease Control and Prevention, n.d.-l), but effective interventions (including medications for opioid use disorder [MOUD]) are not reaching many who need them (Volkow, 2022). (See “Stigma and Other Barriers to Care for Maternal Mental Health Conditions and SUDs” below.) Margerison and colleagues (2022) found that among pregnancy-associated deaths that occurred between 2010 and 2019 in 33 states plus the District of Columbia, 11.4 percent were related to drugs. A recent analysis of MMRC data from 14 states found that in 2017, nearly one-third (31.3 percent) of deaths among pregnant women and postpartum women were caused by accidental drug overdose (White et al., 2023).

***Upward Trends Driven by Opioids***—Studies also document the upward trend in overdose-related maternal deaths. An analysis of pregnancy-associated deaths between 2018 and 2021 found marked increases in overdose mortality—including rates that more than tripled among women ages 35–44 (Han et al., 2024). Margerison and colleagues (2022) found that these deaths increased by 190 percent between 2010 and 2019. Bruzelius and Martins (2022) reported a relative increase of 81 percent between 2017 and 2020. Regarding the particular drugs involved in pregnancy-associated overdose deaths, their study reported large increases in deaths involving fentanyl, other synthetic opioids, and psychostimulants (e.g., methamphetamine and cocaine) (Bruzelius & Martins, 2022)—a pattern that reflects the overall trends of drug overdose mortality in the United States (Centers for Disease Control and Prevention, n.d.-c). These findings are aligned with other research that observed more than a doubling of pregnancy-associated deaths involving opioids between 2007 and 2016 (Gemmill et al., 2019).

***Subpopulations Most Affected***—Han and colleagues’ study (2024) of pregnancy-associated deaths from overdoses showed particularly high rates among AI/AN women, which is consistent with the results of other studies (Margerison et al., 2022). Age also seems to be a factor in pregnancy-associated deaths linked to SUD. Two studies found particularly high risk for drug-related deaths among women age 35 or younger (Han et al., 2024; Margerison et al., 2022). Women in counties characterized by high income inequality were at higher risk for dying by overdose in Han and colleagues’ study (2024).

Data on rurality and pregnancy-associated deaths related to drugs are limited. However, drug overdose deaths in the general population—including among women—are higher among those who reside in rural areas (Spencer et al., 2022). Nationally, 47 percent to 90 percent of reproductive-aged women with an SUD report having experienced IPV, compared with 1 percent to 20 percent of non-SUD populations; 32 percent to 75 percent of women opioid users report having experienced IPV in the past year, and 75 percent of pregnant Appalachian women report having experienced IPV in the past year, versus the national average of 3 percent to 13 percent. Increased risk for IPV among pregnant and postpartum women is, in turn, a primary risk factor

for substance use, late prenatal care, low birth weight, preterm labor, injury, maternal homicide, and mental health concerns (Campbell et al., 2021; Shannon et al., 2016). Additionally, all-cause maternal mortality increases with rurality and living in medically underserved areas (i.e., regions with lower numbers of certain health care providers per capita) (Hoyert, 2023; U.S. Government Accountability Office, 2021).

**About 20 percent of the U.S. population lives in rural areas** (United States Census Bureau, 2017). In general, rural residents with SUD face numerous barriers to treatment and recovery, including fewer providers who prescribe MOUD (Bresett & Kruse-Diehr, 2023). As discussed below in the “Stigma and Other Barriers to Care for Maternal Mental Health Conditions and SUDs” section, the challenges are even greater for pregnant women with SUD, because in addition to treatment access problems, they may face stigma and concerns about the legal and child custody consequences of substance use (Bright et al., 2022; Choi et al., 2022).



About  
**20%**  
of the U.S. population  
lives in rural areas.

**Timing and Preventability**—Several studies indicated that overdose mortality rates are higher among people identified as being late postpartum compared with those who were pregnant or identified as being early postpartum (i.e., within 42 days of giving birth) (Bruzeliuss & Martins, 2022). Prevention of pregnancy-associated deaths by overdose may be possible through improvements in care and support for women with SUD, particularly opioid use disorder (OUD). Researchers have proposed the life course theory as a framework to increase sensitivity and understanding of how events in a person’s life contribute to her substance use, recovery, recurring substance use, or overdose (Cleveland et al., 2020). Interviews and focus groups with women in Texas who had resumed opioid use or experienced a nonfatal overdose and family members of those who had died from an opioid overdose during the perinatal period indicated the complex needs of this population. Their life course events included multiple traumas (e.g., histories of abuse and loss of a loved one through homicide or suicide) and limited social support. Ongoing problems—including interpersonal conflict with their partner and untreated mental health conditions—made recovery more challenging. Finally, women in the study described the losing of their children through the child welfare system as punitive, and it increased their risk for resuming substance use and overdose (Cleveland et al., 2020).

Given that opioids are a major driver of overdose deaths generally and among peripartum women, service providers and clinicians need guidance on the supports and care needed for women who use opioids or have OUD (Bruzeliuss & Martins, 2022). The SAMHSA Advisory series’ publication titled “Evidence-Based, Whole-Person Care for Pregnant People Who Have Opioid Use Disorder” outlined how obstetrician-gynecologists (ob-gyns), primary care physicians, and other professionals who treat pregnant people can take an active role in supporting the health of pregnant individuals who have OUD and the health of their babies. Whole-person care includes MOUD and plans to treat co-occurring mental health conditions (Substance Abuse and Mental Health Services Administration, 2024). The American College of Obstetricians and Gynecologists (ACOG) has issued a statement on the treatment of patients who use opioids during pregnancy with a coordinated multidisciplinary approach. This statement

includes early universal screening, brief intervention, and referral for treatment of pregnant women with opioid use and OUD. ACOG’s statement suggests long-term follow-up with these patients—including medical, developmental, and social support—and monitoring of their children for NAS by a pediatric care provider (Mascola et al., 2017).

**GBV: A Factor in Pregnancy-Associated Deaths from Suicide, Overdose, and Homicide**

Research shows that GBV during pregnancy, especially IPV, is a significant contributor to maternal deaths from suicide, overdose, and homicide (Campbell et al., 2021; Joseph et al., 2024; Lawn & Koenen, 2022; Noursi et al., 2020). A review by Mangla and colleagues (2019) identified IPV, depression, and SUD as common risk factors for pregnancy-associated suicide. Palladino and colleagues (2011) found that more than half (54.3 percent) of pregnancy-associated suicides involved intimate partner conflict as a circumstance that appeared to contribute. A recent study on firearm-related suicide and homicide found that pregnancy-associated suicides were more frequent among people who had experienced IPV within a month of death than non-pregnancy-associated suicides (4.2 percent versus 1.3 percent,  $P=0.005$ ) (Joseph et al., 2024). Links between GBV and pregnancy-related deaths caused by overdose are not fully established. However, experiencing IPV during one’s lifetime, current IPV, and a partner’s SUD are risk factors for drug overdose among women (El-Bassel et al., 2019; Gilbert et al., 2022).

In one of Trost and colleagues’ reports (2022), homicides were included under the “injury” category of pregnancy-related deaths rather than in the “mental health conditions” category. The authors found that 2.9 percent of pregnancy-related deaths occurred by manner of homicide. Another analysis found that 5.4 percent of pregnancy-associated deaths occurred by manner of homicide and that these fatalities rose by 63 percent between 2010 and 2019 (Margerison et al., 2022). The study by Palladino and colleagues (2011) found that 45.3 percent of pregnancy-associated homicides were linked to IPV. In the 2024 Joseph et al. study based on data from CDC’s NVDRS between 2008 and 2019, pregnancy-associated homicides were more likely to occur in the victim’s home than non-pregnancy-associated homicides (51.5 percent versus 46.7 percent,  $P=0.02$ ) and were more frequently related to ongoing conflict or violence between a current or former partner (61.6 percent versus 51.9 percent,  $P<0.001$ ) (Joseph et al., 2024). Taken together, these data underscore the importance of addressing both the impact of GBV-related trauma and the ongoing risks posed by an abusive partner.

### **Gender-Based Violence, IPV, and Women’s Mental Health and Substance Use**

Research has consistently documented that experiencing gender-based violence (GBV) is associated with a wide range of mental health consequences—including depression, anxiety, post-traumatic stress disorder (PTSD), substance use disorder, and suicide attempts—both in the general population (Beydoun et al., 2017; Warshaw & Zapata-Alma, 2020) and during pregnancy and postpartum (Brunton et al., 2021; Creech et al., 2021; D’Angelo et al., 2022; Hahn et al., 2018). In addition to the trauma-related effects of GBV across the lifespan, ongoing abuse by an intimate partner poses an additional layer of risks to maternal mental health (Hahn et al., 2018; Warshaw & Tinnon, 2018). For example, people who perpetrate intimate partner violence (IPV) often specifically target women’s mental health or use of substances as a tactic of control. Among women calling the National Domestic Violence Hotline (The Hotline) in 2012, 73.8 percent said that an abusive partner had deliberately done things to make them feel as if they were “going crazy” or losing their minds, according to a study conducted by the National Center on Domestic Violence, Trauma, and Mental Health and The Hotline (Warshaw et al., 2014). More than a quarter (27.0 percent) of the callers reported being forced or coerced into using substances. Additionally, 50 percent of those who called seeking help for their mental health and 60 percent of those seeking help for substance use said their partners had tried to prevent them from accessing treatment (Warshaw et al., 2014). These forms of abuse not only jeopardize women’s well-being but also compromise the effectiveness of mental health and substance use disorder treatment (Warshaw & Tinnon, 2018). Experiences of sexual violence can also increase the risk for pregnancy-related PTSD and create barriers for women in accessing prenatal care (Brunton et al., 2021; D’Angelo et al., 2022; Katon et al., 2020; Ward, 2020).

***Subpopulations Most Affected by Pregnancy-Related Homicide***—Research has found that Black women are at the highest risk of pregnancy-associated deaths from homicide (Margerison et al., 2022; Palladino et al., 2011). Pregnancy-associated deaths by homicide occur most frequently among females ages 15–19, followed by women ages 20–24 (Margerison et al., 2022). The analysis by Palladino and colleagues (2011) found that women who died by pregnancy-associated homicide were more likely to be at the extremes of reproductive age (i.e., either 24 or younger or 40 or older).

The patterns of maternal mortality related to suicide, overdose, and homicide—and the links between these deaths and untreated mental health conditions and SUD—underscore the urgency of the identification of and intervening with women affected by these issues. The sections that follow define maternal mental health and describe the landscape of maternal mental health conditions and SUDs, as well as their co-occurrence, in the United States. Information is provided on the conditions and other relevant factors (including their intersections with trauma, current IPV, and GBV more broadly), as well as health disparities and the influences of social determinants of health.

## PART 2. MATERNAL MENTAL HEALTH

Up to 85 percent of women experience the baby blues (e.g., crying, mood swings, anxiety, sleeplessness, and irritability) during the first 2 weeks after delivery (Byatt, Xu, et al., 2019; Centers for Disease Control and Prevention, n.d.-b). With adequate social support, the baby blues resolve without the need for treatment, and they are not considered a mental health condition. If these experiences do not resolve within 2 weeks, it may indicate depression and require professional care.

**“I anticipated challenges with the physical parts of pregnancy. I’d heard about the baby blues, but it didn’t occur to me to take care of my mental health.”**

**—R.R., mother of one**

“Maternal mental health” and “perinatal mental health” refer to “a [person’s] overall emotional, social, and mental well-being during and after pregnancy” (Zuloaga, 2020). Pregnancy is a time of intense physical and emotional demands and social and physiological changes. It is common for people to experience sadness, anxiety, and nervousness during pregnancy and after birthing. Those emotions are not considered to be a mental health condition and usually resolve on their own without the need for treatment (*Eunice Kennedy Shriver* National Institute of Child

Health and Human Development, n.d.). However, qualitative research has found that some pregnant people and postpartum individuals have a more intense experience of psychological distress (e.g., anxiety, depression, and perceived stress) in which they feel overwhelmed with societal expectations and thoughts that they are bad mothers (Staneva et al., 2017).

For some women, the perinatal period can be a window where mental health conditions emerge or are first diagnosed (Byatt, Mittal, et al., 2019; Williams, 2003). However, maternal mental health conditions often start before and persist beyond the perinatal period. Wisner and colleagues (2013) found that among women who screened positive for maternal mental health conditions, 26.5 percent had experienced symptoms prior to pregnancy. For 33.4 percent of these women, symptoms emerged during pregnancy, and symptoms emerged during the postpartum period for 40.1 percent (Wisner et al., 2013). It is important to note that even when women have mental health conditions prior to pregnancy, most can remain healthy with appropriate treatment (Clarke et al., 2023). Without treatment, maternal mental health conditions can persist, worsen, and increase risks for death (as discussed above).

### Understanding Social Determinants of Health (SDOH)

SDOH—the conditions in the environments where people are born, live, learn, work, play, worship, and age that influence health risks and outcomes—cover multiple domains: economic stability (e.g., wealth and food security), educational attainment (e.g., high school graduation and literacy), health care access and quality (e.g., access to health services and health literacy), neighborhood and built environment (e.g., access to affordable healthful foods and safe places for physical activity), and social and community context (e.g., discrimination and structural racism and pollution) (Healthy People 2030, n.d.). SDOH—particularly along the lines of race/ethnicity, educational attainment, income level, geography, and their interaction—tend to accumulate over the life course, be associated with lifestyle risk factors, and contribute to the marked health disparities and inequities in our country (National Academies of Sciences, 2021; Puka et al., 2022). Data indicate that Black, Hispanic, and AI/AN individuals, as well as people with less than a high school diploma (or an equivalent diploma) and rural residents, generally are

exposed to less favorable SDOH, bringing about worse health outcomes and less access to high-quality health care (Hill et al., 2023; Singh et al., 2017).

### Perinatal Mental Health Conditions

A variety of mental health conditions that range in severity (e.g., mood disorders, anxiety disorders, PTSD, and postpartum psychosis) can be experienced by pregnant people and postpartum individuals (Byatt, Mittal, et al., 2019). Perinatal mental health conditions may be increasing. An analysis of national data on health care utilization found that the rate of hospital stays for childbirth with at least one mental health disorder diagnosis increased by 52 percent between 2017 and 2020 (Weiss et al., 2022). Women with chronic severe mental health conditions who become pregnant often have particular support needs that have historically been neglected. Psychiatrists providing ongoing treatment to women with chronic mental health conditions can benefit from consultations regarding the use of medications during the perinatal period. Without training in perinatal mental health or reproductive psychiatry, many prescribers need guidance regarding pharmacological treatment, particularly given widespread media overestimation of the risk of perinatal treatment with psychotropic medication and failure to address the risk of untreated mental health disorders during pregnancy (Endres et al., 2023; Osborne et al., 2015).

**Childbirth hospital stays  
involving diagnoses of  
1+ mental health  
disorder increased by**

**52%**

**between 2017 and 2020.**

**“All this stuff happened postpartum for me. It was all in my chart, and I was having issues breastfeeding. I was calling my midwife a lot, and that was [difficult] for me—being postpartum, having medical issues with my son, and having medical issues of my own.”**

**—M.S., mother of two**

Certain populations may be at high risk for experiencing perinatal mental health conditions, including those who have unfavorable SDOH (e.g., a lack of social resources) and preexisting psychiatric challenges that may be worsened by pregnancy (Clarke et al., 2023; Endres et al., 2023). See the “Disparities, SDOH, and Perinatal Mental Health and Substance Use” section below for further discussion. As a recent American Psychiatric Association report points out, much of the research in this area has not necessarily been representative of the current U.S. population, and there are significant opportunities to improve perinatal mental health (Clarke et al., 2023; Endres et al., 2023). This section of the report briefly reviews some key conditions related to mental health that can occur during pregnancy and in the year postpartum.

### Perinatal Mood and Anxiety Disorders

Maternal mental health disorders are also referred to as perinatal mood and anxiety disorders. There are a range of disorders that must be understood, as clinicians and society often focus only on postpartum depression. These disorders include depression, anxiety disorders, obsessive-compulsive disorder (OCD), PTSD, and postpartum psychosis. Major depression is characterized by mood changes (sadness, low mood), lack of enjoyment or pleasure (anhedonia), and changes in sleep, energy, concentration, motivation, and appetite. To be diagnosed with major depression, these symptoms must interfere with a person’s daily activities and be present for at least two weeks, according to the fifth edition of the *Diagnostic and Statistical Manual of Mental*

*Disorders* (American Psychiatric Association, 2013). People with perinatal depression may also experience negative thinking (e.g., feelings of hopelessness and guilt), may not take care of themselves or their babies, and can have thoughts of self-harm or suicide (Byatt, Mittal, et al., 2019; Centers for Disease Control and Prevention, n.d.-b). Various conditions are considered anxiety disorders—such as OCD, generalized anxiety disorder, panic disorder, social anxiety disorder, and phobia-related disorders. Anxiety disorders are more severe and prolonged than fear and worry (National Institute of Mental Health, 2023). Perinatal OCD involves persistent disturbing thoughts (often about the baby) and related compulsive behaviors (e.g., rituals) (Byatt, Mittal, et al., 2019).

***Perinatal Depression***—According to CDC research, postpartum depressive symptoms affect about 1 in 8 postpartum women (Bauman et al., 2020). Diagnoses of depressive disorders during childbirth hospitalizations increased sevenfold between 2000 and 2015 (Haight et al., 2019). The prevalence of perinatal mood and anxiety disorders among people with delivery hospitalizations more than doubled from 2006 to 2015, according to a cross-sectional analysis of data from the Healthcare Cost and Utilization Project’s National Inpatient Sample (HCUP-NIS). This study also found that women with perinatal mood and anxiety disorders had a higher incidence of severe maternal morbidity and maternal mortality compared with women and other birthing individuals without these conditions (McKee et al., 2020). (Here, “severe maternal morbidity” is defined as unexpected outcomes of pregnancy and delivery that have short- or long-term consequences on health (Centers for Disease Control and Prevention, n.d.-m). Notably, this study only included maternal deaths that occurred during the delivery hospitalization and did not include deaths that occurred after hospital discharge, most likely underestimating mortality. Brown and colleagues (2021) found that 2.9 percent of people with delivery hospitalizations had a diagnosis of a depressive disorder, in their analysis of 2016–2017 HCUP-NIS data. Importantly, 25 percent of individuals who experience postpartum depression continue to have symptoms 3 years postpartum (Putnick et al., 2020). A number of studies have also found associations between peripartum depression, lifetime GBV, and current IPV (Ankerstjerne et al., 2022; Zhang et al., 2019).

***Perinatal Anxiety Disorders and OCD***—Recent research indicates that anxiety disorders and OCD were the most common type of diagnosed mental health disorder among people with delivery inpatient stays in the U.S. in 2020 (Weiss et al., 2022).

Up to about a quarter of women report symptoms of anxiety during pregnancy, and 15.2 percent had a clinical diagnosis of any anxiety disorder, according to one meta-analysis (Dennis et al., 2017). The same study indicated that 15 percent of postpartum women (i.e., women who had given birth in the previous 6 months) reported anxiety symptoms, with 9.9 percent having a clinical diagnosis of any anxiety disorder over the same period. Other research has suggested that as many as 1 in 5 pregnant women and postpartum women meet the diagnostic criteria for at least one anxiety disorder (Fawcett et al., 2019). A Canadian study found an OCD prevalence of 7.8 percent during the prenatal period and a prevalence of 16.9 percent during the postpartum period. The OCD prevalence gradually increased over the course of pregnancy, peaking at about 8 weeks postpartum, and then declined gradually (Fairbrother et al., 2021).

**“I had postpartum anxiety, different from depression. I was having intrusive thoughts, compulsions.”**

**—S.B., mother of two**

### **The High Prevalence of Trauma-Related Experiences and Conditions Among Women Highlights the Need for Trauma-Informed Care**

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood—such as abuse or neglect, experiencing or witnessing violence, household challenges, bullying, and parental mental health and/or substance use problems (Centers for Disease Control and Prevention, n.d.-f). ACEs and the long-lasting individual and societal harms that can result from them are preventable (Centers for Disease Control and Prevention, n.d.-f). ACEs are highly prevalent; nearly two-thirds (63.9 percent) of U.S. adults reported having had at least one, and 17.3 percent reported having had four or more—according to CDC data collected during 2011–2020 (Swedo, Aslam, et al., 2023). ACEs (particularly multiple adverse experiences) are linked to chronic health problems, mental illness, and substance misuse in adulthood, and CDC estimates that preventing these experiences could help reduce the number of adults with depression (Centers for Disease Control and Prevention, 2021). Women are among the groups that have a relatively high (19.2 percent) prevalence of having experienced four or more ACEs (Swedo, Aslam, et al., 2023).

Trauma is a prevalent mental health concern that occurs among individuals who have experienced an event or circumstance resulting in physical, emotional, and/or life-threatening harm (Substance Abuse and Mental Health Services Administration, 2022). Traumatic experiences include natural disasters, serious accidents, parental loss, terrorist acts, war/combat, historical trauma, bullying, sexual violence, and IPV (American Psychiatric Association, 2022). Trauma can be associated with negative and lasting effects on the risk for mental health conditions and SUDs—particularly if experienced during childhood, if experienced multiple times, and if treatment is not received (Center for Substance Abuse Treatment (US), 2014; Feriante & Sharma, 2024).

About half of women have experienced at least one traumatic event during their lives (Vogt, n.d.). One category of trauma that disproportionately affects women is sexual violence with physical contact—experienced by more than half of women (Centers for Disease Control and Prevention, n.d.-h). According to CDC, AI/AN and multiracial women are more likely to experience sexual violence (Centers for Disease Control and Prevention, n.d.-g). Women are also more likely to report having experienced IPV. According to CDC, about 41 percent of women (compared with 26 percent of men) have experienced sexual violence, physical violence, and/or stalking during their lifetimes.

Exposure to a potentially traumatic event that is beyond a typical stressor (i.e., severe and/or prolonged traumas) can result in PTSD. This mental health condition is characterized by persistent frightening thoughts and memories of the event(s), recurring dreams/nightmares, feeling detached or numb, and physiological arousal that can lead to symptoms such as being easily startled, disturbed sleep, and difficulty in concentrating or remembering (American Psychological Association, 2022; National Institute of Mental Health, n.d.). Of the 1 in 11 people diagnosed with PTSD at some point in their lives, women are twice as likely as men to have this condition (American Psychiatric Association, 2022). The lifetime prevalence of PTSD is about 10 percent to 12 percent in women and 5 percent to 6 percent among men (Olf, 2017). Multiple factors may contribute to the differential risk for PTSD, including women's exposure to high-impact trauma (e.g., sexual violence) at an earlier age compared with men (Olf, 2017).

Because of the high prevalence of trauma, the high prevalence of adverse experiences, and their intersection with mental health conditions and SUD, SAMHSA has developed a framework for organizations, systems, and service providers to take a trauma-informed approach to care (Substance Abuse and Mental Health Services Administration, 2014). A trauma-informed approach to care encompasses services that incorporate an understanding of trauma and an awareness of the impact it has. It also views trauma through a cultural lens and recognizes that context influences the perception and processing of traumatic events. Importantly, trauma-informed care anticipates and avoids institutional processes and individual practices that are likely to retraumatize individuals who already have histories of trauma (Substance Abuse and Mental Health Services Administration, 2015).



### **Maternal Adverse Childhood Experiences (ACEs), PTSD, and Gender-Based Violence**

Pregnant women who have experienced ACEs are at risk for perinatal mental health conditions and substance use. Foti and colleagues (2023) analyzed data from women screened for ACEs, mental health conditions, IPV, and substance use during prenatal care visits at a large multispecialty health care delivery system in Northern California. They found that 27.2 percent of these women reported having had one or two ACEs, and 14.6 percent reported having had three or more ACEs. Patients with any ACEs were more likely to have anxiety and depressive disorders, depressive symptoms, experience with IPV, and any prenatal substance use (Foti et al., 2023). For example, compared with women who had experienced no ACEs, those reporting having had three or more had a higher prevalence of an anxiety disorder (23.4 percent versus 8.9 percent), depressive disorder (33.5 percent versus 13.9 percent), experience with IPV (19.6 percent versus 4.6 percent), and substance use during early pregnancy (26.6 percent versus 14.9 percent) (Foti et al., 2023). In a recent study using 2016–2018 Pregnancy Risk Assessment Monitoring System (PRAMS) data collected from participants in Kansas, Michigan, North Dakota, Rhode Island, and South Dakota, over 50 percent of respondents reported having had at least one ACE, and 13 percent to 31 percent reported having had three or more ACEs, depending on the state. Significant associations were identified in all adjusted models between ACEs and unwanted pregnancy, smoking, physical abuse, and depression during pregnancy. Depending on the state, participants with one, two, or three or more ACEs had 1.3–3.5 times higher prevalence of depression during pregnancy than participants who had not had ACEs (Swedo, D'Angelo, et al., 2023). Importantly, ACEs often stem from violence in the home, untreated parental mental health conditions and SUDs, and/or having a parent die by suicide. These intergenerational effects highlight the importance of interventions for mothers experiencing these challenges and broader supports for families and communities as a way of preventing their children from experiencing ACEs (Centers for Disease Control and Prevention, n.d.-f).

***Experiences of Perinatal IPV***—An analysis of six states' 2016–2018 data from PRAMS found that 5.7 percent of women with a recent live birth reported having experienced some sort of IPV during pregnancy. Emotional violence was most prevalent (5.4 percent), followed by physical violence (1.5 percent) and sexual violence (0.9 percent) (D'Angelo et al., 2022). Hartwell and colleagues (2023) also analyzed PRAMS data (2016–2019), finding that 3.4 percent of women reported having experienced perinatal IPV. Kozhimannil and colleagues (2023) found a similar rate of perinatal IPV (3.5 percent) in an analysis of 2016–2019 PRAMS data. Among those who had experienced IPV, 58.7 percent, 26.9 percent, and 48.3 percent were not screened for IPV before, during, or after pregnancy, respectively.

In Hartwell and colleagues' (2023) study of perinatal IPV, many of the women reported a history of experiencing depression (41.4 percent) and/or anxiety (46 percent). Women who reported having experienced any type of perinatal violence were more likely to report depression and having experienced relationship problems (e.g., conflict or separation) with their partner (D'Angelo et al., 2022). O'Connor and Su's (2023) analysis of 2016–2017 PRAMS data found that 11.8 percent of women who reported symptoms of postpartum depression had experienced peripartum IPV, compared with 2 percent of those who did not report having experienced this form of violence (D'Angelo et al., 2022). O'Connor and Su's (2023) analysis of 2016–2017 PRAMS data found that 11.8 percent of women who reported symptoms of postpartum depression had experienced peripartum IPV, compared with 2 percent of those who did not report having experienced this form of violence.

**“I felt like a fish out of water. You’re not supposed to have a baby and get a diagnosis of PTSD.”**

**—M.P., mother of two**

***Perinatal PTSD***—As 10 percent to 12 percent of women experience lifetime PTSD, this may be a preexisting condition among those who become pregnant (Olf, 2017). In studies, the prevalence of prenatal PTSD ranges from 2.3 percent to 24 percent, but researchers often do not account for the possibility that this condition was present prior to pregnancy, according to a study by Geller and Stasko (2017). However, it is important to consider

PTSD history, as it is one of the risk factors for this condition’s developing or worsening during the perinatal period (Geller & Stasko, 2017). Other risk factors for PTSD in the perinatal period include prenatal depression and anxiety, a pre-pregnancy history of mental health conditions, a history of sexual trauma, childhood sexual abuse, and IPV. This study found that when preexisting PTSD was a controlled variable, postpartum rates of this condition were 2 percent to 4.7 percent (Geller & Stasko, 2017).

Perinatal PTSD occurs after giving birth in an estimated 2 percent to 9 percent of women (Byatt, Mittal, et al., 2019). Women who have experienced previous sexual trauma are at increased risk of experiencing obstetric complications (e.g., unplanned cesareans) and PTSD during childbirth (Berman et al., 2021). Past traumatic experiences, obstetric problems, perceived stress during delivery, and emergency childbirth are linked with this specific form of perinatal PTSD (Cirino & Knapp, 2019; Ertan et al., 2021).

### PART 3. PERINATAL SUDs AND CO-OCCURRING SUDs AND MENTAL HEALTH CONDITIONS

Some pregnant people who use substances reduce or stop using when they learn they are pregnant—as evidenced by the lower percentages of pregnant women reporting past-month illicit drug use and alcohol use (including binge drinking) compared with those ages 15–44 who were not pregnant in the 2022 National Survey on Drug Use and Health (NSDUH) (Substance Abuse and Mental Health Services Administration, 2023a). However, an analysis of 2015–2019 NSDUH data by Green and colleagues (2024) found that 7.1 percent of pregnant women had past-year SUD—a prevalence lower than that of their nonpregnant counterparts ages 15–44 (8.8 percent). A study of Medicaid claims and enrollment data from three states estimated that 3.6 percent of women had a specified SUD diagnosis first observed before or during the birth month; 1.7 percent had a specified SUD diagnosis first observed after the birth month; and 6.0 percent had an SUD diagnosis for which timing was not specified (Lynch et al., 2021). Notably, one-third of these women received their specified SUD diagnosis after the birth month. A retrospective analysis of the HCUP-NIS data set (2016–2018) found that 2.7 percent of pregnancy-related diagnoses were for SUD (Ndanga et al., 2022). In the study group, the specific SUDs included alcohol use disorder (0.1 percent), OUD (0.9 percent), cannabis use disorder (1.4 percent), cocaine use disorder (0.2 percent), and SUDs involving stimulants other than cocaine (0.4 percent). More than two-fifths (41 percent) of women who gave birth in the United States in 2021 were covered by Medicaid (Valenzuela & Osterman, 2023).

**“I was terrified my kids would be taken away from me [if I told my midwife or doctor] what was going on with me.”**

**—S.B., mother of two**

#### **Societal Stigma, Punitive Policies, and Underreporting of Perinatal Substance Use**

Stigma, requirements by providers to report substance use during pregnancy, and fear that children could be removed from the home by child protective services are realities for many women. These factors may hinder the reporting of substance use by pregnant people and postpartum individuals, and underreporting presents a challenge to obtaining accurate data on this topic (Clarke et al., 2023; Weber et al., 2021).

An analysis by CDC found that the number of pregnant women with OUD at labor and delivery more than quadrupled from 1999 to 2014 (Haight et al., 2018). The number of women with OUD documented at delivery increased by 131 percent between 2010 and 2017, according to an analysis of hospital discharge records in 47 states and the District of Columbia (Hirai et al., 2021). An analysis of 2017–2018 Medicaid claims in 39 states indicated that 2.7 percent of pregnant or postpartum enrollees had clinically documented OUD (Roberts et al., 2023). A study by Kitsantas and colleagues (2021) analyzed 2014–2017 NSDUH data to examine associations between OUD and the degree of mental health disability caused by emotional/behavioral problems in pregnant women. NSDUH assessment of adult mental health includes the use of a shortened version of the World Health Organization Disability Assessment Schedule (WHODAS), which measures the number of daily activities in which respondents indicate having no difficulty, mild difficulty, moderate difficulty, or severe difficulty performing because of problems with emotions, nerves, or mental health challenges. Responses are used to classify respondents as having no/mild disability or moderate/severe disability related to mental health. Kitsantas and colleagues (2021) found that about 30 percent of the 2,888 pregnant women

surveyed had moderate-to-severe mental health–related disabilities, and 2 percent reported OUD. Pregnant women who experienced moderate-to-severe mental health–related disabilities were over three times more likely to report OUD compared with pregnant women with no or mild disabilities.

Among women with perinatal SUDs, polysubstance use (i.e., use of more than one drug) is common. Jarlenski and Krans (2021) found that among women who delivered babies in a hospital from 2007 to 2016, 7 percent had an SUD. Among those women, more than 55 percent had co-occurring SUDs (SUD diagnoses for more than one substance). Among pregnant women with OUD, other SUDs and mental health conditions commonly co-occur, according to an analysis of 2009–2014 data from the Healthcare Cost and Utilization Project (Shen et al., 2020). Most pregnant women with OUD in this study had another SUD (78.2 percent), and a significant proportion had generalized anxiety disorder (38 percent) or major depressive disorder (36.9 percent) (Shen et al., 2020).

In the general population, experiencing IPV elevates the risk for SUDs (Beydoun et al., 2017). The study by D’Angelo and colleagues (2022) found that women who had experienced any type of IPV during pregnancy were more likely to report use of illicit substances compared with those not reporting having experienced violence. Among pregnant women visiting emergency departments, those who had experienced IPV were more likely to have an SUD diagnosis, according to an analysis of 2016 data from the Nationwide Emergency Department Sample (Murugan et al., 2021). The co-occurrence of PTSD and SUD—which is associated with worse functioning and outcomes than either condition alone—is particularly relevant for women and may require a tailored approach to treatment (Hien et al., 2020). Special considerations when providing treatment for pregnant women with SUDs include the high prevalence of trauma in this population and PTSD symptoms’ effects on parenting, this population’s high risk for GBV, the fact that many of these women have limited social networks, and the prevalence of discrimination related to substance use (Valentine et al., 2023). In addition, substance use coercion in the context of IPV (coerced use, treatment interference, recovery sabotage) also affects treatment engagement and outcomes (Ogden et al., 2022; Phillips et al., 2021; Warshaw & Tinnon, 2018).

#### PART 4. SOCIAL DETERMINANTS OF HEALTH AND PERINATAL MENTAL HEALTH AND SUBSTANCE USE

Emerging research suggests that social determinants of health (SDOH) influence perinatal mental health and substance use. This section touches upon only some of these SDOH and their specific effects on perinatal mental health and substance use among some groups of marginalized women. However, the task force acknowledges SDOH among groups not mentioned here—such as Hispanic, Asian, and Native Hawaiian and other Pacific Islander women and those who have immigrated, are seeking asylum, lack insurance, are experiencing homelessness, do not speak English as a first language, live in rural areas, have low educational attainment, have disabilities, or are members of the LGBTQI+ community. Their experiences may be stressful and most likely influence their perinatal mental health and substance use.

**“I needed to shield my mental health [from the pediatrician]. I don’t know what rabbit hole I would have gone down if I had said, ‘No, I don’t feel OK.’ I don’t know what is going to come out of my mouth. As a Black woman in [the office of a pediatrician] who is a mandatory reporter, there are certain things that you shield because you are scared that they might deem you unfit to care for your child.”**

**—F.P., pregnant mother of one**

##### Respect and Responsive Care for Every Mom

People who are pregnant and those who give birth have many sources of stress that are out of their control. But mistreatment during maternity care (e.g., violations of physical privacy, ignoring requests for help, and verbal abuse) should not be something that anyone experiences.

According to a CDC analysis of a survey of 2,402 mothers administered in 2023:

1. 20 percent of respondents reported having been mistreated during pregnancy care. The highest rates of reported mistreatment were among Black (30 percent), Hispanic (29 percent), and multiracial (27 percent) women.
2. 29 percent of respondents reported having experienced some form of discrimination during pregnancy care, with the highest prevalences of discrimination reported by Black (40 percent), multiracial (39 percent), and Hispanic (37 percent) respondents.
3. 45 percent of women reported holding back from asking questions or sharing concerns with providers during their maternity care.

(Mohamoud et al., 2023)

##### Highlighted Resource

The Association of Women’s Health, Obstetric and Neonatal Nurses released the [Respectful Maternity Care Implementation Toolkit](#) in 2023. This resource offers providers tools to implement a 10-step approach to respectful maternity care.

#### SDOH and Perinatal Mental Health

***Experiences of Racism and Discrimination***—Inequities and experiences of chronic stress related to racism and discrimination are among the SDOH that influence perinatal mental health conditions—particularly for Black and AI/AN women. Current experiences of racism and

discrimination compound the negative effects of historical traumas and systemic inequities experienced by Black and AI/AN women (Policy Center for Maternal Mental Health, 2023a, 2023b). For example, in one study, 11.4 percent of Black women who had recently given birth reported feeling upset because of experiences of racism, and the prevalence of depression during pregnancy in the same large sample was also 11.4 percent. Study participants who reported feeling upset because of the experience of racism in the perinatal period were more than twice as likely to have depression during pregnancy. This study, an analysis of 2018 PRAMS data from 11 states and New York City, took into account maternal characteristics known to affect perinatal depression (e.g., age, educational attainment, marital status, pre-pregnancy insurance type, region of residence, and pre-pregnancy depression status) (Bower et al., 2023). Another analysis of 2012–2015 PRAMS data from eight states and New York City had similar results (Weeks et al., 2022).

***Food Insecurity***—The economic and social condition of limited or uncertain access to adequate and/or healthful food (i.e., food insecurity) has been linked with poor maternal mental health, according to an analysis of data from the 2016–2017 National Survey of Children’s Health. In the overall sample of mothers of children ages 0–5 years, 4.5 percent of mothers reported having “fair” or “poor” mental health. Experiencing food insecurity is also among the SDOH associated with poor physical health and low levels of social capital (Linares et al., 2020). It also is linked with delayed or forgone health care among peripartum women, according to an analysis of 2019–2021 data from National Health Interview Surveys. This study found that 11 percent of peripartum women experienced suboptimal food security during the study period. Notably, 6 percent of peripartum women who required counseling or therapy from a mental health professional said they did not receive it, and 6 percent reported delaying mental health care during the study period. Peripartum women experiencing food insecurity were more likely to delay or forgo all types of health care because of cost concerns (including for their mental health) than their food-secure counterparts (Ujah et al., 2023).

***Experiencing Other Stressors***—In their analysis of PRAMS data, O’Connor and Su (2023) found that 3.5 percent of mothers self-reported postpartum depressive symptoms. Those who experienced psychosocial stress (e.g., IPV and considering their pregnancy unintended or mistimed) during pregnancy were more than three times as likely to report depressive symptoms as those who did not report this type of stress. IPV-related perinatal stress intersects with race and ethnicity, as experiences of this form of violence are highly prevalent in Black and AI/AN communities (Policy Center for Maternal Mental Health, 2023a, 2023b). In one recent study, more than half (54 percent) of mothers reporting postpartum depressive symptoms lived at or below the federal poverty line (O’Connor & Su, 2023). Prenatal obstetric conditions—such as pre-pregnancy diabetes, nausea, hypertension, and preterm labor—were associated with a postpartum depression diagnosis, according to an analysis of 2007–2008 PRAMS data from 23 states (Sundaram et al., 2014).

### **SDOH and Perinatal Substance Use**

Analyses of PRAMS data also suggest associations between SDOH and perinatal substance use. As with perinatal mental health, stressful life events in the 12 months before becoming pregnant, during pregnancy, and the postpartum period play a role in maternal substance use.

***Stressful Life Events and Perinatal Cannabis Use***—After analyzing 2016 PRAMS data from five states, Allen and colleagues (2020) found that 16.4 percent of women reported having used cannabis prior to pregnancy. Of these, more than a third (36.4 percent) continued cannabis use during pregnancy. Stressful life events—a spouse’s losing a job, problems paying bills, and the loss of someone close—were linked with a greater likelihood of continued cannabis use during

**“I didn’t go [to therapy] for months. There were wait lists. ... I was starting back to work and [trying to] find a day care. [Having a therapy] appointment ... felt [like] too much, another thing [for me to do].”**

**—S.B., mother of two**

pregnancy. Among those who did not report use during pregnancy, almost a quarter (23.2 percent) resumed cannabis use during the postpartum period. Postpartum recurrence of cannabis use was associated with two stressful life events—the woman’s partner’s saying they did not want the pregnancy and the partner’s or the woman’s going to jail (Allen et al., 2020). Ko and colleagues (2020) found that 9.8 percent of mothers self-reported that they had used marijuana before pregnancy, 4.2 percent said they had used marijuana during pregnancy, and 5.5 percent said they had used it after pregnancy. This analysis of 2017 PRAMS Marijuana

Supplement data from eight states also found that the most common reasons for use during pregnancy were to relieve stress or anxiety, nausea or vomiting, and pain (Ko et al., 2020). These findings suggest that an unmet need for mental and physical health care may contribute to perinatal marijuana use.

Stressful life events are also associated with perinatal prescription opioid use, according to an analysis of 2019 PRAMS data from 19 states. Testa and colleagues (2022) found that women with a greater accumulation of stressful life events in the 12 months prior to birth—particularly those who had experienced six or more—were more likely to use prescription opioids during pregnancy. Accumulating stressful life events were also associated with a higher risk of using multiple prescription opioids and opioid misuse. In this study, “opioid misuse” was defined as getting opioids from a source other than a health care provider or using opioids for a reason other than pain (Testa et al., 2022).

To understand the factors that may contribute to postpartum substance use, Stewart and colleagues (2023) conducted a study based on postpartum follow-up data from 2019 PRAMS respondents from seven states with high opioid overdose mortality rates 9–10 months after they gave birth. They found that 25.6 percent of the women reported postpartum substance use, and 5.9 percent reported polysubstance use. Women who had experienced ACEs before the age of 18 and women who had experienced stressful life events in the year before giving birth had higher prevalences of postpartum substance use and polysubstance use. Many women who had experienced six or more stressful life events during the year preceding the birth (67.1 percent) or four ACEs related to household dysfunction (57.9 percent) reported postpartum substance use. Postpartum polysubstance use was also prevalent among women who had experienced six or more stressful life events in the year before giving birth (20.8 percent) and those who had experienced four ACEs (26.3 percent) (Stewart et al., 2023).

Stewart and colleagues (2023) also found that women who had experienced depressive symptoms, depression, and anxiety were about twice as likely to report postpartum substance use as those without these conditions. Similarly, women who reported these conditions had a higher prevalence of polysubstance use compared with those without these problems. For depressive

symptoms, it was 17.5 percent versus 7.0 percent. For current depression, it was 17.3 percent versus 3.5 percent. And for anxiety, it was 13.0 percent versus 2.8 percent (Stewart et al., 2023).

Taken together, these findings underscore the connections between SDOH and perinatal mental health and substance use. They also suggest the importance of perinatal screening for SDOH, mental health conditions, and substance use and interventions that provide support and appropriate health care before, during, and after pregnancy.

### **Stigma and Other Barriers to Care for Maternal Mental Health Conditions and SUDs**

People who are perceived as being different in some way, including those who have a mental health condition and/or SUD, may be characterized as unacceptable by others. When that happens, the strong negative appraisal (called stigma) is attached to them (American Psychiatric Association, 2020). They may also attach stigma to themselves and face subtle or obvious prejudice and discrimination, which may prevent them from seeking necessary treatment or hinder their recovery when they do receive care (Alderdice & Kelly, 2019; American Psychiatric Association, 2020).

A society's idealized images of a "good" mother and "good mothering" (e.g., self-sacrifice for the care of children) can be a strong cultural norm that supports stigma against women with SUDs (Nichols et al., 2021). This ideal may contribute to stigmatizing interactions with health care and service providers and put up an unnecessary barrier to seeking both maternity care and treatment for SUDs (Alderdice & Kelly, 2019; Nichols et al., 2021; O'Connor et al., 2022; Weber et al., 2021). Stigmatized experiences are particularly common for people who have used substances during pregnancy, resulting in women's not discussing these problems with providers (Nichols et al., 2021; Weber et al., 2021). Mothers of infants with neonatal abstinence syndrome have said they have faced particularly strong stigmatizing experiences (e.g., ostracism, exclusion, and shaming), and nurses who have provided care for these dyads have reported experiencing ethical and moral distress, as well as compassion fatigue (Recto et al., 2020). (Compassion fatigue is a combination of professional burnout—i.e., "feelings of exhaustion, negative or cynical attitudes toward work, and a sense of not doing well or being effective in your work"—and secondary traumatic stress, i.e., being traumatized by hearing about the traumatic experiences of many other people) (Recto et al., 2020; Substance Abuse and Mental Health Services Administration, 2023b). Stigma in both community and health care settings is a challenge reported by women who have SUD and live in rural areas (Bright et al., 2022).

State policies requiring automatic removal of a child and the possibility of criminal charges of child abuse for women who use substances during pregnancy are a top-of-mind issue for both patients and providers, as well as a barrier to recovery (Choi et al., 2022; Nichols et al., 2021; Weber et al., 2021). Women who used opioids or had SUD during pregnancy have reported that it is difficult to find prenatal care providers with training in these conditions—which is particularly the case for individuals who live in rural areas (Bright et al., 2022; Declercq & Zephyrin, 2020; O'Connor et al., 2022). Financial hardship and practical difficulties also prevent treatment seeking among pregnant women and mothers with SUD (Choi et al., 2022). Researchers have suggested that barriers might be addressed, in part, through peer support programs and comprehensive health centers, particularly in rural areas (Bright et al., 2022).



Stigma and other barriers most likely lead to missed opportunities to engage women in care, as research shows that pregnancy is often a strong motivating factor in seeking SUD treatment (O’Connor et al., 2022). Choi and colleagues (2022) also found that child-related issues—such as loss of children, suspension or termination of parental rights, and anticipation of reuniting with children—were strong motivators for treatment seeking for pregnant women and mothers with SUD. Emotional support and social support of women were also positive factors that facilitated treatment seeking (Choi et al., 2022).

**“I felt supported until after I gave birth. I wish there [were] more literature on different medications [and their] risks. The training [on maternal mental health for perinatal providers] could be better. Filling out a piece of paper is not enough.”**

**—A mother**

Pregnant women who have a mental health condition may face a challenge in identifying that they have one, and stigma in maternity and mental health care is a barrier to treatment (Button et al., 2017; Cantwell, 2021). In a study of women experiencing perinatal mental health problems in the United Kingdom, Ford and colleagues (2019) found that participants deemed stigma and fear (including losing custody of children) to be the most significant barriers, followed by low levels of willingness to seek help and practical difficulties attending appointments. Other themes in research on the challenges faced by people with peripartum mental health conditions include an unmet need for collaborative and integrated care and health care professionals who do not address their psychological needs (Megnin-Viggars et al., 2015). Women with perinatal mental health conditions also may perceive that the care focus is on babies rather than mothers. They emphasize the need for nonjudgmental and compassionate support, their unmet need for information, and their desire to be involved in treatment decisions (Megnin-Viggars et al., 2015). Pregnant individuals with a mental health condition also may face difficult decisions about balancing the potential risks and benefits of treatment (e.g., medication) (Cantwell, 2021).

## PART 5. UNMET NEED FOR TREATMENT OF MATERNAL MENTAL HEALTH AND SUDS

More than 75 percent of individuals who experience maternal mental health conditions do not receive treatment, according to a systematic review (Byatt et al., 2015). Other research indicates that pregnant women with a mental health condition were less likely to receive mental health treatment than their counterparts who were not pregnant (Salameh et al., 2020). Cox and colleagues (2016) discussed this in their description of the “perinatal depression treatment

**“The job of finding a good therapist is [so big that most people] write it off before even starting.”**

**—M.S., mother of two**

cascade”—in which the majority of women identified as having postpartum depression do not receive adequate treatment and continue to have persistent depression (Cox et al., 2016). Individuals who are screened and referred for services may not seek specialty care because of stigma, lack of available providers, and the barriers previously discussed. Experts have also noted that

psychiatric professionals often lack specific training to care for peripartum patients and that the infrastructure for maternal care does not fully incorporate mental health (Byatt, Mittal, et al., 2019).

### Workforce Shortage Crises Are a Major Reason for Unmet Treatment Need

According to the Policy Center for Maternal Mental Health, 96 percent of birthing-aged women in the United States live in an area with a shortage of maternal mental health professionals. The majority (70 percent) of U.S. counties lack sufficient maternal mental health resources. Women in nearly 700 counties face a high risk for maternal mental health disorders, and more than 150 counties are “maternal mental health dark zones,” with both high risk and large resource gaps (Britt et al., 2023).

Unmet need for mental health and SUD professionals in the United States is significant and expected to continue to increase. The National Center for Health Workforce Analysis has projected growing shortages in mental health and SUD providers such as addiction counselors, mental health counselors, psychologists, and psychiatrists through 2036 (Health Resources & Services Administration, 2019). Within this broader workforce shortage, gaps between the number of adequately trained maternal mental health providers and the need for such providers are likely to similarly widen. In a survey of psychiatric residency training directors, Osborne and colleagues (2018) found that only 59 percent of programs required any training in reproductive psychiatry and that the quality of this training varied greatly from one program to the next.

In addition to a general unmet need for treatment among women with perinatal mental health conditions, racial/ethnic disparities have also been documented. According to a secondary analysis of 2008–2014 NSDUH data, the likelihood of receiving mental health treatment among Black and Hispanic pregnant women with mental health conditions and SUD was lower compared with that of White women—even when other relevant characteristics (e.g., educational attainment, employment status, income level, health insurance status, and type of condition) were taken into account. Regarding the barriers to accessing care, in that same analysis, pregnant women who reported that they perceived that their mental health treatment needs had been unmet cited opposition to treatment, stigma, time and transportation limitations, and not knowing where to go. A greater proportion of White women perceived cost as an obstacle to treatment access compared with those from other racial/ethnic groups (Salameh et al., 2019).

**“Almost half of the population lives in a maternal mental health desert. It’s even harder to find [mental health services] in rural areas.”**

**—Health care provider**

There is a similar problem of unmet need for treatment for people with peripartum SUD. In their analysis of 2015–2019 NSDUH data, Green and colleagues (2024) found that 12.8 percent of women who had past-year SUD and were pregnant received treatment. Receipt of SUD treatment in the postpartum period largely depends on whether women have health coverage (Ali et al., 2023). Even so, in another study among pregnant women and postpartum women who were enrolled in Medicaid and had a specified SUD diagnosis, less than two-thirds received any SUD treatment during the study period (Lynch et al., 2021).

Despite the increasing need for treatment of OUD among pregnant people and postpartum individuals, the prevalence in SUD treatment facilities of specialty care programs for this population was only 23 percent in 2018, according to data from the National Survey of Substance Abuse Treatment Services (Meinhofer et al., 2020). In 2017–2018, among Medicaid enrollees who had an OUD diagnosis and gave birth, an average of 55 percent received medication as part of their care, with variation by state. This study also observed racial/ethnic disparities persisting in the receipt of these medications. Whereas 53 percent to 57 percent of Hispanic and White enrollees received medication for OUD, a smaller percentage (31 percent) of Black enrollees with OUD received medications during the perinatal period (Roberts et al., 2023).

**Task Force Identifies Gaps in Federal Infrastructure,  
Potential Ways to Address Unmet Treatment Needs**

- **Gap:** Federal infrastructure is needed to support the field in implementing known evidence-based practices.
  - **Potential solution:** Across-the-board implementation of best practices—for example, in the delivery of services for screening, diagnosis, and treatment of maternal mental health conditions and SUDs during obstetric visits—would help ensure that all women have the standard level of care.
- **Gap:** Federal infrastructure is also needed to monitor the number and locations of key members of the workforce—maternal mental health specialists, reproductive psychiatrists, and addiction medicine experts.
  - **Potential solution:** Developing a system to monitor information about these key members of the workforce could lay the foundation for ensuring that all providers give access to their support via a telehealth consultation program across the country.

## **PART 6. CHALLENGES WITH DATA ON MATERNAL MENTAL HEALTH**

As referenced in the *White House Blueprint for Addressing the Maternal Health Crisis* and *The Surgeon General’s Call to Action to Improve Maternal Health*, there is a need to improve data reporting and quality in overall maternal health (Office of the Surgeon General, 2020; The White House, 2022). Challenges include the lack of standard definitions of “maternal mortality” and various measures of maternal mortality, misclassification of race/ethnicity and causes of death, and differences in coding (Chinn et al., 2020; MacDorman & Declercq, 2018; Office of the Surgeon General, 2020). Other data-related concerns and gaps include variation in data collection across states and lack of coordinated data collection across federal programs. To advance maternal mental health, it is crucial to support longitudinal research on the perinatal period—including surveillance and data collection to assess maternal mental health conditions, their intersection with comorbid conditions (e.g., hypertension and cardiovascular diseases), safety and efficacy of therapeutic medications (including the safety/risk of discontinuing medications for mental health conditions or SUDs), known risk factors, and the SDOH of mothers and children. Research efforts must include data collection on both qualitative lived experiences and quantitative measures. Actions such as passage of the [Preventing Maternal Deaths Act of 2018](#) (Public Law 115–344) and CDC’s Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program (Centers for Disease Control and Prevention, n.d.-d) are helping to standardize data collection by strengthening MMRCs in all states).

The 2020 *Surgeon General’s Call to Action to Improve Maternal Health* included the need to address mental health conditions and SUDs as part of broader efforts to improve outcomes (Office of the Surgeon General, 2020). Others—such as professional associations, state governments, and researchers—have increasingly issued calls to action, policy statements, and articles providing data on this topic (American Public Health Association, 2019; Glazer & Howell, 2021; Lewis Johnson et al., 2020; Margiotta et al., 2022; Maykin & Tsai, 2020; Posmontier et al., 2022; Rafferty et al., 2019; Thomas et al., 2023). Although calls for action on maternal mental health have been increasing with the rise in the proportion of pregnancy-associated deaths caused by mental health conditions, there is no compendium or summary of existing efforts to address the crisis. Evidence on these conditions is available, but it is not summarized in a federal report. The current maternal mental health crisis suggests that there are significant gaps and opportunities for improvement, scale-up, and increasing access and equity. Moreover, the field needs guidance on feasible evidence-based practices and other feedback to address barriers and support maternal mental health.

## PART 7. TASK FORCE FORMATION AND PURPOSE

Given the contribution of mental health conditions and SUDs to maternal mortality and severe maternal morbidity and the unmet need for treatment, in Section 1113 of the [Consolidated Appropriations Act, 2023](#) (Public Law 117–328), Congress directed HHS to form the Task Force on Maternal Mental Health or have the duties, meetings, and reports be undertaken by an existing federal coordinating entity. HHS Secretary Xavier Becerra [announced the formation of the task force](#)—co-chaired by HHS Assistant Secretary for Health Admiral Rachel Levine, M.D., and HHS Assistant Secretary for Mental Health and Substance Use Miriam E. Delphin-Rittmon, Ph.D.—on September 27, 2023. Dorothy Fink, M.D., who is the HHS Deputy Assistant Secretary for Women’s Health and the Director of the HHS Office of the Assistant Secretary for Health’s (OASH) Office on Women’s Health (OWH), and Nima Sheth, M.D., M.P.H., who is SAMHSA’s Associate Administrator for Women’s Services, serve as task force leads.

The purpose of the task force is to identify, evaluate, and provide recommendations to coordinate and improve federal activities related to addressing maternal mental health conditions and SUDs, including co-occurring disorders. Community engagement, ensuring [mental health parity and addiction care equity](#) and access, promoting [trauma-informed practices](#) and culturally relevant services, and improving federal coordination are cross-cutting areas for the task force. The task force has outlined recommendations across these areas in its national strategy (a simultaneously released companion document) informed by best practices in the areas of prevention, screening, and diagnosis; data on effective interventions and treatments; and evidence-based community and intergenerational practices. The task force’s findings on the state of maternal mental health, identification of best practices, evaluation of relevant federal programs, and input from state and local stakeholders are summarized in this report to Congress. Congress directed the first report to be submitted no later than the task force’s first meeting, with the national strategy to follow within 1 year later. However, with the urgency of the maternal mental health crisis, the national strategy was expedited and simultaneously published with this report to Congress.

The work of the task force will continue after the release of this document. Planned task force activities include the development of a report to the governors of all U.S. states that describes opportunities for local- and state-level partnerships, as well as regular updates of the report to Congress and national strategy. The sunset date for the task force is September 30, 2027.

The task force and its report to Congress and national strategy are an important part of broader federal efforts to address maternal health and mental health across the nation—for example, the [White House Blueprint for Addressing the Maternal Health Crisis](#). Some examples of other initiatives are shown in the table below.

<b><i>Federal Effort</i></b>	<b><i>Description</i></b>	<b><i>Agency/Agencies</i></b>
<a href="#">Talking Postpartum Depression</a>	A campaign that features women who have experienced and recovered from postpartum depression sharing their stories.	OWH

## The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Federal Effort</i></b>	<b><i>Description</i></b>	<b><i>Agency/Agencies</i></b>
<a href="#"><u>National Maternal Mental Health Hotline</u></a>	A hotline that offers free, confidential, 24/7 mental health support and resources via phone and text for moms and their families before, during, and after pregnancy. English- and Spanish-speaking counselors staff the hotline, with interpreters available for people who speak other languages.	Health Resources and Services Administration (HRSA)
<a href="#"><u>Maternal Health Awards</u></a>	Awards of \$90 million to reduce maternal deaths and improve maternal and infant health, of which over \$8 million address maternal mental health, with grants to 12 states. This investment expands screening and treatment for maternal mental health and SUDs, particularly in underserved communities.	HRSA
<a href="#"><u>Hear Her with resources for AI/AN individuals</u></a>	A campaign that raises awareness of the need to listen when a pregnant person indicates that something does not feel right, offering information and resources on the urgent warning signs of severe health problems that can occur during pregnancy and in the postpartum period.	CDC
<a href="#"><u>988 Suicide &amp; Crisis Lifeline</u></a>	Offers free and confidential support through suicidal crisis and other types of emotional distress 24/7.	SAMHSA
<a href="#"><u>Substance Use Disorder in Pregnancy: Improving Outcomes for Families</u></a>	A report that is part of the Biden–Harris administration’s concerted efforts to improve maternal health outcomes.	White House Office of National Drug Control Policy, with HHS, U.S. Department of Defense, and U.S. Department of Justice participation

### **Task Force Composition and Structure as a Subcommittee of SAMHSA’s Advisory Committee for Women’s Services**

Per the authorizing legislation, the task force comprises both federal and nonfederal members—including individuals with lived experience of maternal mental health conditions. The task force

## The Task Force on Maternal Mental Health’s Report to Congress

includes experts in obstetrics and gynecology, maternal and child health, clinical and research psychology, psychiatry, counseling, strategic policy, community behavioral health, and federal–community partnerships. The federal members lead departments and agencies (or are the designees of leaders) with purviews that include maternal and child health and health care, services for mental health conditions and SUDs, and surveillance efforts and data collection. Participating HHS agencies include the following:

- [Administration for Children and Families \(ACF\)](#)
- [Administration for Community Living \(ACL\)](#)
- [Agency for Healthcare Research and Quality \(AHRQ\)](#)
- [Office of the Assistant Secretary for Planning and Evaluation \(ASPE\)](#)
- [Centers for Disease Control and Prevention \(CDC\)](#)
- [Center for Faith-based and Neighborhood Partnerships \(Partnership Center\)](#)
- [Centers for Medicare & Medicaid Services \(CMS\)](#)
- [Food and Drug Administration \(FDA\)](#)
- [Health Resources and Services Administration \(HRSA\)](#)
- [Office of Intergovernmental and External Affairs \(IEA\)](#)
- [Indian Health Service \(IHS\)](#)
- [National Institutes of Health \(NIH\)](#)
- [Office of the Assistant Secretary for Health \(OASH\)](#)
- [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)

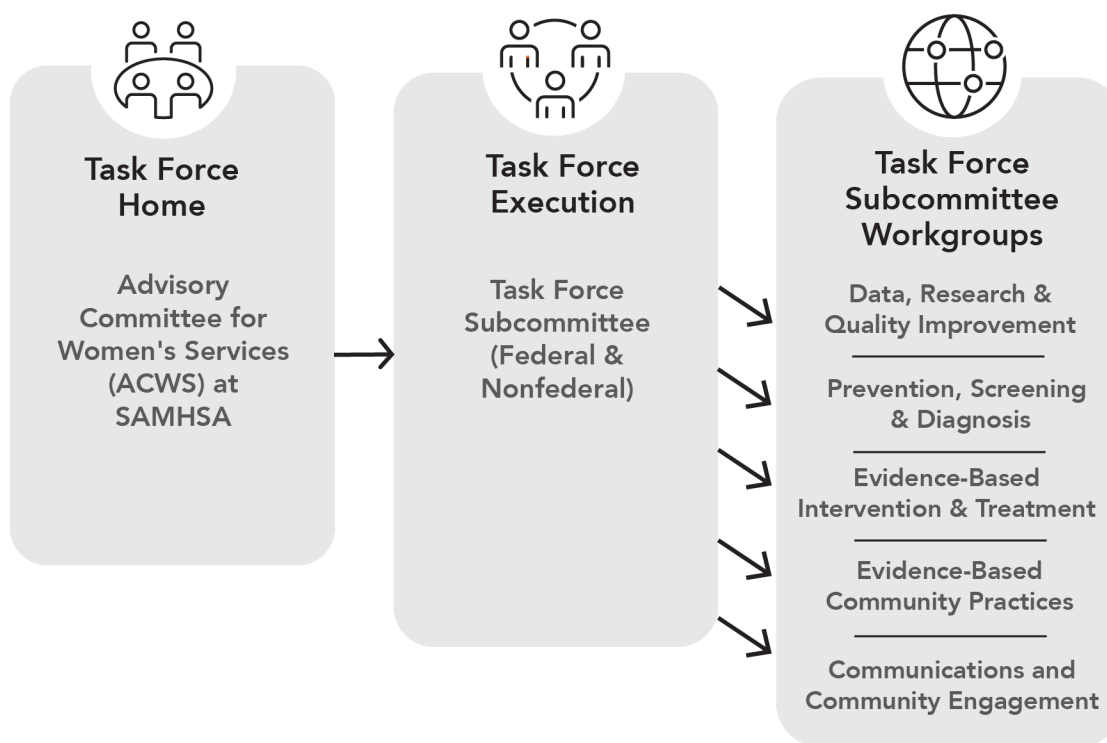
Other participating federal agencies include the following:

- [U.S. Department of Homeland Security \(DHS\)](#)
- [U.S. Department of Defense \(DOD\)](#)
- [U.S. Department of Labor \(DOL\)](#)
- [U.S. Department of Veterans Affairs \(VA\)](#)
- [U.S. Digital Service \(USDS\)](#)
- [Office of Management and Budget \(OMB\)](#)

To recruit nonfederal members of the task force, SAMHSA requested that interested organizations concerned with maternal mental health nominate individuals to serve as representatives through multiple notices in the *Federal Register* ([88 FR 19964](#), [88 FR 24622](#), and [88 FR 57965](#)). (See Appendix D for the complete roster.)

The task force is a subcommittee of [SAMHSA’s Advisory Committee for Women’s Services \(ACWS\)](#), which falls under the Federal Advisory Committee Act. The ACWS advises SAMHSA’s Associate Administrator for Women’s Services and HHS’s Assistant Secretary for Mental Health and Substance Use on appropriate activities to be undertaken by SAMHSA centers and offices with respect to women’s substance use and mental health services. ACWS members voted to approve the content of the task force’s report to Congress and the recommendations put forth in the national strategy. Members of the ACWS were active participants in the task force and co-chaired three of its five committees.

### Task Force on Maternal Mental Health Organization



### Methods of the Task Force on Maternal Mental Health

This section briefly summarizes the methods used by the task force to develop the report and national strategy. The task force’s workgroups met semimonthly from November 2023 to April 2024. During these 1–2-hour virtual meetings, task force members focused on generating findings for this report and recommendations for the national strategy within the purviews of their workgroups. They considered the following sources of information:

1. *Program Review*: HHS staff members evaluated and documented existing (A) federal efforts to address maternal mental health conditions and (B) local, state, and national programs and practices to track and enhance maternal mental health (both services and systems).
2. *Literature Review*: HHS provided the task force with a brief summary of data and research covering a range of topics related to maternal mental health—such as the most common perinatal and postpartum conditions, epidemiology, risk factors, protective factors, effects on families, intersection with gender-based violence, stigma, prevention, screening, diagnosis, and intervention at the individual and community levels.
3. *State and Local Input*: HHS convened four 1-hour virtual listening sessions with key stakeholders—the National Association of County and City Health Officials, the Association of Maternal & Child Health Programs, the National Association of State Alcohol and Drug Abuse Directors, and the National Association of State Mental Health Program Directors—in December 2023 and January 2024. Members of the task force



were present in listen-only mode. The task force developed a set of questions to guide the input of these stakeholders during the moderated listening sessions. Participants provided information on their approaches and successes, as well as ongoing challenges and gaps, in maternal mental health related to prevention, screening, diagnosis, intervention, and treatment provision to residents. The section “Opportunities for State and Local Partnerships” presents overarching themes from the four listening sessions.

4. *Public Comments*: The task force developed a set of questions to guide input from the public. HHS invited the public to comment on maternal mental health through the release of a request for information (RFI) on January 9, 2024, with a closing date of February 8, 2024 [[89 FR 1110](#)].
5. *Lived Experience Report*: To support the work of the task force, the U.S. Digital Service prepared *Maternal Mental Health: Lived Experience* in March 2024. This report—based on interviews with mothers, health care providers, subject matter experts, and telehealth providers—captured the perspectives of people with maternal mental health conditions. These perspectives—particularly those pertaining to navigating maternal mental health screening, diagnosis, and treatment—informed parts of the national strategy.

### **Workgroup Meetings**

Based on this foundational information and their own expertise, members of the workgroups discussed best practices and generated potential action steps. They followed the guidance provided by HHS on identifying and organizing issues, questions, and priorities and used a PICK chart to categorize the estimated level of impact and ease of implementation for specific recommendations. They discussed future opportunities for collaboration and partnerships, and they established priority strategies and recommendations (including for the reduction of disparities) during workgroup meetings. Task force members also generated questions for the public RFI and for the listening sessions with stakeholders. The workgroups developed findings for this report and proposed priority recommendations in their respective areas for the national strategy based on the program review, the literature review, state and local input, and public comments.

### **Task Force Meetings and Full ACWS Meetings**

Prior to meetings with the other ACWS members, task force members commented on and edited drafts of the report to Congress and national strategy—reaching a consensus on the recommendations—via email, further workgroup gatherings, and virtual meetings of the full subcommittee (March 11, 2024). The full ACWS convened for two 1-day virtual meetings (April 2 and April 17, 2024). The co-chairs of the task force’s workgroups presented their findings and recommendations for potential strategies at the April 2 meeting. The full ACWS met to review drafts of the text and proposed graphics for the report to Congress and national strategy on April 2, 2024. Task force members continued working to finalize the report throughout April (meeting virtually on April 11) and met with the other members of the ACWS for the last time on April 17, 2024. During this meeting, the ACWS reviewed and voted on the drafts of the report to Congress and national strategy.

### SECTION 3: BEST PRACTICES

The community-based services and clinical care provided for pregnant and postpartum individuals should use the most effective methods known to support their well-being and that of their families. Best practices underpin these supports, the infrastructure for research and data collection on maternal and child health, and systemwide efforts to advance equity and trauma-informed care. Members of the Task Force on Maternal Mental Health considered the term “best practices” to encompass specific activities and coherent approaches involving multiple components and/or programs that address maternal mental health conditions and substance use disorders (SUDs), as well as the multiple factors that contribute to these conditions. The task force evaluated practices that are:

1. **Evidence-based** (i.e., practices that are supported by research, often quantitative, and of good methodological quality and that can be replicated and implemented in various settings with appropriate modifications);
2. **Evidence-informed** (i.e., practices supported by research and integrated with practitioner experience and patient considerations); and
3. **Promising** (i.e., practices not yet supported by a body of research but considered by experts to have had positive results and be worthy of wider implementation and future study).

In its deliberations, the task force also recognized that the perinatal population is often excluded from research and that the evidence base for this population is insufficient to inform evidence-based care. Additionally, the task force acknowledged that empirical studies often exclude individuals likely to be affected by maternal mental health conditions and SUDs, such as people experiencing homelessness and incarceration; other under-resourced populations; and people experiencing or who have experienced gender-based violence (GBV) and/or other trauma. Finally, the task force recognized that narrowing the definition of “evidence” to the data and findings of empirical studies could limit the discussion of best practices related to maternal mental health and maternal SUDs. Thus, the task force considered a broader evidence base, inclusive of direct lived experiences, cultural traditions, and other factors.

This section presents the task force’s findings on best practices—that is, what task force members collectively consider the most effective ways to address maternal mental health conditions and SUDs. Prior to the presentation of best practices, contextual information is provided to describe the general landscape that may influence implementation. This contextual information emerged during the task force’s discussions, during the listening sessions, from public comments, and in the *Maternal Mental Health: Lived Experience* report. In addition to the best practices in the domains mentioned above, members of the task force identified several cross-cutting best practices: culturally relevant services, ongoing provider training specific to maternal mental health, a community-based workforce, integrated care, and a trauma-informed approach that addresses multiple forms of trauma, including GBV. The discussion below provides additional information on these cross-cutting best practices.

Note that some of the practices listed below are commercial ventures used by state and local governments as their primary programs in the community. We include these practices here not to endorse any commercial product but to reflect effective practices reported from the field.

## COMMUNICATING WITH AND ENGAGING COMMUNITIES TO ADDRESS MATERNAL MENTAL HEALTH CONDITIONS

### **The Importance of Reaching the Relevant Audiences**

Communication and engagement efforts with individuals affected or potentially affected by maternal mental health conditions and SUDs remain crucial to addressing these conditions. These efforts should involve not only the pregnant and postpartum individuals but their families, personal support networks, communities, and the clinicians and community-based practitioners who serve them. As anyone may know someone experiencing a maternal mental health condition or SUD, the public represents another important audience. Professionals involved in research and data collection on maternal and child health also must be aware of mental health conditions among pregnant and postpartum individuals, as well as the many complex risk and protective factors. Finally, federal, state, and local policies and regulations—including those directly related to health care and those that affect the broader set of forces and systems that affect the conditions of daily life—can profoundly affect maternal mental health. These policies and regulations can mitigate or exacerbate the effects of social determinants of health (SDOH) and create additional barriers to care (Centers for Disease Control and Prevention, n.d.-n; Crear-Perry et al., 2021; Linares et al., 2020).

As discussed in the *Background and Methods* section, maternal mental health conditions and SUDs have high individual, societal, and economic costs. Some researchers have argued that support services and interventions may enhance individual and societal financial well-being (Brown et al., 2021; Linares et al., 2020; Margiotta et al., 2022; McGovern et al., 2022). Thus, policymakers represent stakeholders and key audience members for communications and engagement in the national conversation on addressing maternal mental health conditions and SUDs.

### ***Best Practice: Communicating with and Engaging Providers***

Members of the task force focused on the need for provider training specific to maternal mental health conditions and SUDs. Providers who specialize in mental health and SUD services require training and resources specific to the perinatal population. Conversely, perinatal providers need training and resources on screening, treating, and referring those experiencing mental health conditions, SUDs, GBV, and other trauma. These trainings and resources need to be free, easily accessible, well promoted, and offered through familiar and trusted sources. (See “Workforce Best Practices” below.)

The task force recognized that [burnout represents a serious challenge](#) for individual health care providers, organizations, and service and care systems—with a significant impact on the workforce shortage and health care access. Communications and provider engagement efforts must address this issue. Self-care and resilience building represent best practices for providers, and associated federal resources for health care providers include:

- [Modules on self-care hosted on a Substance Abuse and Mental Health Services Administration \(SAMHSA\) webpage](#) (authorized by the Administration for Strategic Preparedness and Response [ASPR] Technical Resources, Assistance Center, and Information Exchange [TRACIE]);

- SAMHSA's [Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies](#) guidebook;
- [Resources from the Health Resources and Services Administration \(HRSA\)](#);
- [Trauma-specific resources from the VA](#);
- [Self-Care Tips for Family Services Professionals and Home Visitors from the Administration for Children and Families](#);
- [Mini Modules to Relieve Stress for Health care Workers from the Administration for Strategic Preparedness and Response](#);
- Resources from the Centers for Disease Control and Prevention ([CDC](#)); and
- [SAMHSA-funded resources offered in the context of the COVID-19 pandemic](#).

Federal agencies have provided guidance and suggested action steps for organizations to address burnout in the [general health care, mental health, and SUD treatment workforces](#). U.S. Department of Health and Human Services (HHS), through HRSA, directed \$103 million in American Rescue Plan funds to reduce professional burnout and to promote overall wellness among health care workers, including their mental health, thereby improving retention and helping to meet staffing needs.

***Best Practice: Communicating to Counter Stigma and Incorporating a Violence- and Trauma-Informed Approach***

A key contextual factor in communications and community engagement to address maternal mental health conditions and SUDs is the stigma individuals and society attach to these conditions. (See *Background and Methods*.) First and foremost, U.S. health care systems and the providers within them must combat stigma surrounding these disorders by routinely screening and discussing these disorders.

Information and messaging should include addressing common misconceptions about mental health conditions and SUDs and providing science-based information. CDC and the March of Dimes collaborated to develop [Beyond Labels](#), which offers guidance on reducing health-related stigma—including stigma associated with substance use and mental health conditions—among pregnant and postpartum individuals.

The task force also noted that violence (including GBV) represents a cross-cutting issue for communities and requires ongoing, supportive, and sensitive messaging that incorporates a trauma-informed approach. This trauma-informed approach should encompass past and ongoing trauma and violence, including GBV and other forms of coercive control contributing to maternal mental health conditions and SUDs and affecting access to care and recovery (Centers for Disease Control and Prevention, n.d.-i; The White House, 2023).

***Best Practice: Using Plain Language, Clear Communication, and Audience-Relevant Messaging***

Messages, materials, and resources (including those conveyed through digital media) on maternal mental health conditions and SUDs need to be brief, clear, repeatable, and easily consumable (Centers for Disease Control and Prevention, 2018, 2024; National Institutes of Health, 2021, n.d.-a). Some specific best practices identified by the task force include:

## The Task Force on Maternal Mental Health's Report to Congress

- Collaborating to create communications products with representative experts from multiple sectors (e.g., federal, health care, and nonprofits) and individuals with lived experience;
- Performing asset mapping prior to the development of messages, materials, and resources to avoid duplicative efforts.
- Using [plain language](#) and [storytelling](#) strategies to engage the audience;
- Focusing on positive prevention messaging (rather than, for instance, emphasizing the negative impacts of alcohol use on an unborn child) to avoid shaming and stigmatizing pregnant and postpartum individuals;
- [Communicating data/results visually](#) (e.g., with infographics);
- [Engaging](#) members of the community by inviting individuals with relevant personal experience to tell their stories; developing materials in partnership with members of the target audience, including community representation on advisory boards; and using cultural-competency practices;
- Considering all levels of [health literacy](#);
- [Addressing social determinants of health](#) (particularly in relating how SDOH can function as stressors that affect health);
- Focusing on a [single overriding communication objective](#) in each product;
- [Incorporating an equity lens](#) into [language, narratives, and concepts](#);
- Following [principles for inclusive and respectful communication](#);
- Showing [images](#) that reflect and resonate with the intended community;
- Reflecting an understanding of a [trauma-informed approach to communications](#) (Clements et al., 2021);
- Ensuring safe access to information (particularly in suspected cases of GBV, in which take-home materials may be contraindicated);
- [Translating messages and materials](#) into multiple languages as appropriate; and
- [Tailoring information](#) to the particular intended audience or population.

### ***Best Practice: Leveraging Traditional, Digital, and Social Media; Apps; and Community Programs***

Traditional media and digital spaces constitute important avenues for engagement. The task force considered how spokespersons such as the Surgeon General, leaders from CDC, and even social media influencers (or “mom-fluencers”) offer continued opportunities to destigmatize maternal mental health conditions and SUDs. Through traditional and social/digital media platforms, such spokespersons (and others) can deliver messages to increase engagement among pregnant and postpartum individuals and members of their support networks.

Research suggests that leveraging mobile health (mHealth)—including mobile applications and text messaging—holds promise as a cost-effective means of providing patient education, facilitating the management of health conditions, and supporting self-care (Rathbone & Prescott, 2017). Apps related to pregnancy are increasingly popular and offer opportunities for outreach and engagement. However, careful assessment of these apps should precede any recommendations for health communications. A systematic review published in 2024 identified more than 250 pregnancy-related apps that provide entertainment, information, and maternal health monitoring (Mazaheri Habibi et al., 2024). For example, the U.S. Department of Veterans Affairs’ (VA) National Center for PTSD has developed a [suite of free evidence-informed apps](#) to

help people live with post-traumatic stress disorder. Research on training VA providers—both those in mental health and those from other areas of care—suggests the feasibility of introducing these resources during visits (McGee-Vincent et al., 2023). Care providers should discuss any app-related safety concerns with pregnant and postpartum individuals (as well as other patients and clients) whose abusive partners may be tracking their technology ([NNEDV Safety Net Project](#)).

Programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and community-based organizations that provide critical resources (e.g., diaper drives) also represent important ways to reach the perinatal populations and members of their support networks. Of course, traditional media (e.g., radio, television, print, billboards, public transportation posters) continue to reach broad audiences as well.

### **The Importance of Community Engagement**

Community engagement is important for discussions of policy and funding issues, patient/client needs, research and data collection, and planning and implementing programs and services. State and local programs addressing maternal mental health conditions and SUDs may reach out to and include geographically and culturally specific community leaders, organizations, and individuals who work with the target audiences of these programs. Task force members recognized the value of liaising with trusted members of the community (sometimes called key informants or cultural brokers) and gathering individuals in places where people congregate for their ongoing activities.

Multiple organizations have provided resources on [cross-sector engagement](#), [toolkits](#), [frameworks](#), and [guidance](#) for engaging communities in this context. The National Academy of Medicine has developed a conceptual model for advancing health equity by leveraging community engagement to transform health systems, and this model could also inform efforts to address maternal mental health (Aguilar-Gaxiola et al., 2022). State and federal funding streams should support efforts to establish community collaborations and to develop innovative approaches tailored to each community and practice setting. Organizations such as [RACE for Equity](#) can assist community engagement efforts with culturally responsive, data-driven frameworks focused on the lived experiences of community members.

### ***Best Practice: Engaging Community Advisory Boards and Community-Based Organizations***

The task force considered integrating community engagement into all planning and implementation efforts related to programs and services that support maternal mental health. A best practice is to engage community advisory boards (CABs), which consist of trusted, established leaders involved in advocating for their communities. HRSA’s [Healthy Start](#) programs include community consortia that function as CABs. HRSA requires the [community health centers](#) it funds to include patients and other representative community members on [health center governing boards](#). Members of CABs can play a crucial role in reaching under-resourced communities; these individuals already serve as local experts and facilitators, understand policy, and can leverage established mechanisms to disseminate information to a wide audience. CAB members can also provide feedback on programs, thereby improving their effectiveness, especially in response to shifting community needs.

Similarly, community-based organizations that serve the perinatal population can function as valuable allies in reaching intended audiences and implementing programs. These organizations



can offer valuable insights on what does and does not work in their communities, and their voices could be included in the preparation of program-funding opportunities. Community-based workers can also conduct listening sessions with members of the intended audience to obtain insight into top-of-mind issues. In addition to federal programs such as Healthy Start and WIC, other groups that can facilitate community outreach and engagement include faith-based organizations, schools, and domestic violence and sexual assault programs.

Task force members identified **specific best practices for community engagement**, including:

- Anchoring work to the people most affected by maternal mental health conditions and SUDs;
- Allowing people most affected by the problem to engage throughout the entire process (not only at the end) and paying them for their time;
- Obtaining an understanding of the needs of the intended audiences (e.g., from surveys, focus groups/listening sessions, and providers who work with them);
- Reaching mothers/impacted communities by convening where they are;
- Ensuring that the messenger reflects the community and is trusted by its members; and
- Building, supporting, and maintaining local and regional collaborations to provide more seamless coordination of services (e.g., OB-GYN practices, birthing centers, SUD treatment providers, domestic violence programs, legal services, *promotores/promotoras de salud*, doulas, certified community behavioral health clinics, peer recovery specialists, and child protective services advocacy) and to ensure that individuals do not slip through cracks in the system.

***Best Practice: Communicating Scientific/Surveillance Results for Public Health Action***

Currently, researchers tend to focus on disseminating scientific and surveillance findings on maternal mental health to the scientific community. The majority of the research and data published are not translated into public-facing, easy-to-understand, and actionable materials. The task force noted the best practice of including community partners, practitioners, individuals affected by these conditions, and policymakers when disseminating research and surveillance findings. This best practice aligns with recommendations outlined in SAMHSA's [\*State Behavioral Health Planning Councils: An Introductory Manual\*](#). Translating the results into plain language and communicating them to many audiences help to inform policy, practice, and patient-centered care—including access to care and measuring care quality. One best practice, disseminating research results in accessible formats for diverse audiences (e.g., patient materials), can help to support informed decisions about health care. For example, all patients and clients should receive written materials that include information on mental health and substance use services (without a need for referral to care) with each prenatal and postpartum visit (although cases involving suspected GBV and/or coercion related to substance use, mental health, or reproductive health may contraindicate take-home materials). Also, care providers—perhaps with assistance from peer navigators—should ensure ongoing coordination of care services.

**Access to Services**

Those experiencing mental health conditions and SUDs often face challenges accessing services—a cross-cutting theme in the task force's findings. Underlying reasons for limited access to services include:

- Workforce shortages;
- Insufficient workforce training on maternal mental health conditions, GBV, trauma-informed care, and SUD (see (Seibert et al., 2022), for more information);
- Limited resources and support for community-based organizations that provide services, support, and education;
- Insufficient follow-up care and problems with continuity of care, which often result from lapses in insurance coverage (Admon et al., 2021);
- SDOH (e.g., financial barriers, transportation, child care, stable housing, historical discrimination, and systemic racism/bias);
- A lack of trusted messengers who can provide information and engage their communities in addressing maternal mental health and substance use (a particular problem in rural communities);
- Language barriers;
- Underrepresentation in service systems and a lack of culturally competent providers;
- Mistrust of systems, government, providers, and institutions;
- Treatment interference by abusive partners or family members (Warshaw & Tinnon, 2018);
- A lack of fully integrated gender-responsive services;
- A lack of knowledge about assistance with care and support among clients and providers;
- Criminalization of substance use during pregnancy; and
- Mandatory reporting laws and fear of child removal. In their deliberations, task force members identified best practices to address some of these challenges and expand access. Some of the issues—as well as potential solutions offered by these best practices—are discussed from different perspectives in other sections. (See *Existing Federal Programs and Coordination* and *Feedback from Listening Sessions and Opportunities for State and Local Partnerships*.)

### Digital Tools to Help People Locate Services

Searchable databases, phone lines, and maps that identify providers of specialized services for perinatal mental health conditions and SUDs would help expand access to communities across the country. Below are a few examples.

- [HRSA's listings of providers for screening and treatment for maternal mental health and substance use disorders](#)
- [HRSA's National Maternal Mental Health Hotline](#) (1-833-TLC-MAMA)
- [Postpartum Support International's provider directory](#)
- [SAMHSA's treatment locator](#) (1-800-662-HELP)
- [The Veterans Crisis Line](#)
- [The National Institute on Alcohol Abuse and Alcoholism's Alcohol Treatment Navigator](#)
- [MentalHealth.gov](#)
- [Utah's Maternal Mental Health Referral Network](#)
- [Mental Health America's BIPOC \(Black, Indigenous, People of Color\) page](#)
- An [online directory](#) from *Psychology Today*
- Verywell Mind's [best online therapy listings](#)
- Massachusetts General Hospital's [listing of BIPOC mental health resources](#)



***Best Practice: Employing Community-Based Workers***

Expanding the workforce with community-based workers—including peer support specialists, doulas, and community health workers—can increase access to services for maternal mental health conditions and SUDs. Many states now support the services of community-based workers through Medicaid reimbursements, and existing health care facilities can incorporate these workers to enhance access and engagement.

Task force members highlighted programs funded by the Title V Maternal and Child Health block grant as best practices, such as the Healthy Pregnancy Program (Iowa) and Project Swaddle (Indiana), both of which extend the workforce and expand access by employing community-based workers to provide services (and by other means). The [Healthy Pregnancy Program](#) is integrated into local WIC offices and public health departments.

**“I needed somebody to see how I was feeling ... and reflect back that it was familiar ... and they got through it—someone to commiserate with.”**

**—A mother**

Community-based workers called OB navigators meet with parents during early pregnancy and provide assessments in a medical setting. OB navigators start conversations about healthy pregnancy, assess needs, connect clients with resources to address individual needs, and support maternal mental health and overall well-being. The task force particularly noted that on-site child care facilitated access to the Healthy Pregnancy Program.

Indiana’s [Project Swaddle](#) is a home visiting program in which community paramedics help deliver wraparound care for pregnant and postpartum individuals, with the aim of improving health outcomes. The program focuses on serving pregnant and postpartum individuals in rural communities who face challenging SDOH and connecting pregnant and postpartum individuals with social workers and services. Project Swaddle represents a partnership between a medical facility and local paramedicine programs.

Integrating peer navigators before, during, and after pregnancy can reduce racial and ethnic differences in rates of infant death and associated disparities in maternal health outcomes. In an ongoing pilot project associated with [HRSA’s Healthy Start program](#), alumni navigators (peer mothers who recently completed the program) help families make the transition to parenthood by providing informational, emotional, and instrumental support. Peers have experience navigating enrollment in programs such as Medicaid and WIC (benefits bundle) and accessing key community resources and supports. Preliminary information from the pilot suggests that working with an alumna navigator reduces maternal stress. Various best practices (e.g., task shifting, peer support, and community navigators) informed the design of the [Benefits Bundle model](#).

Members of the task force identified task shifting, defined as “the rational redistribution of tasks among health workforce teams,” as a best practice in global health (World Health Organization et al., 2007). The task force identified several examples of task-shifting implementation in the United States to address maternal mental health conditions. One model involves community health workers who provide the best practice of [problem-solving therapy](#) (a cognitive behavioral intervention) (Chibanda et al., 2016). In addition to problem-solving therapy, community health workers lead group support activities—helping to increase access to mental health services in primary care settings. Originating in Zimbabwe, the problem-solving therapy model has been implemented globally. In New York City, the [Connections to Care \(C2C\)](#) program serves low-income clients, including pregnant and postpartum individuals and parents of children up to age

4. In the C2C program, trained staff members of community-based organizations provide evidence-informed interventions—mental health screening, psychoeducation, mental health first aid, and motivational interviewing. C2C community-based staff members also receive ongoing coaching and support from a mental health partner organization. These community-based workers provide nonmedical mental health services to pregnant and postpartum individuals and facilitate referrals for more intensive care as needed (Ayer et al., 2020).

Task force members identified peer support as a best practice to increase access through existing programs and cited multiple examples relevant to pregnant and postpartum individuals, such as [WIC-designated breastfeeding experts](#) and [peer support workers](#). For example, the sustainable, evidence-based intervention and integrated care model known as [MISSION \(Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking\)](#) incorporates peer workers. MISSION addresses the psychosocial needs of individuals with co-occurring mental health conditions and SUDs. The model incorporates the evidence-based best practice of peer support to facilitate engagement and bolster the effectiveness of the other MISSION components. An ongoing [research study](#) supported by the [NIH Helping to End Addiction Long-term \(HEAL\) Initiative](#) is examining the MISSION approach.

Developing meaningful partnerships with community-based domestic violence, sexual assault, and human trafficking programs is also critical to creating integrated services that fully address the needs of people dealing with perinatal mental health and substance use challenges.

#### ***Best Practice: Leveraging Psychiatry Access Programs***

Providing consultations with mental health specialists (such as reproductive psychiatrists and perinatal psychiatrists) via telehealth can increase access to services (including diagnosis) and serve as a means of training and education for providers—particularly in rural areas and other medically underserved areas.

Modes of telehealth can include telephone/teleconference consultation services with perinatal and reproductive mental health experts. Examples include:

- Texas’s Perinatal Psychiatry Access Network ([PeriPAN](#));
- Kansas Maternal & Child Health’s [psychiatric consultation and care coordination](#);
- Postpartum Support International’s [Perinatal Psychiatric Consult Line](#) (1-877-499-4773); and
- The University of Massachusetts Chan Medical School’s [Lifeline for Moms](#)’ national network of perinatal psychiatry access programs (508-856-8455).

In addition, the VA developed the [Reproductive Mental Health Consultation Program](#) to assist providers who care for veterans experiencing maternal mental health conditions. Through this consultation program, health care providers can ask questions about patients’ presentation of mental health conditions during pregnancy and postpartum (Miller et al., 2022). In addition to the consultation lines listed above, the Lifeline for Moms’ national network of perinatal psychiatry access programs also provides training and technical assistance to providers. In 2018, HRSA began funding a cohort of seven states to develop [perinatal psychiatric consultation programs](#) and recently funded a second cohort of 12 states, many of which participate in the Lifeline for Moms network.

Standardizing payment and reimbursement practices for collaborative care would also facilitate use of psychiatric services and similar programs.

#### **States Expand Psychiatric Consultation Access with HRSA Funding**

HRSA's [Screening and Treatment for Maternal Mental Health and Substance Use Disorders](#) program funded 12 states in fiscal year 2023 to help maternity care providers identify and address mental health concerns of women during and after pregnancy. Funding supports real-time provider-to-provider consultation, care coordination support, training, and collaboration across federally funded programs. States can use funds to expand service options (e.g., through telehealth) and develop resources to create local referral databases to link patients to care.

#### **Prevention of Maternal Mental Health Conditions and SUDs**

As noted in the *Background and Methods* section, research links stressful life events in the year prior to pregnancy and in the peripartum period with maternal mental health conditions and substance use. Members of the task force agreed that expanding access to support services for individuals prior to pregnancy and during the perinatal period would help prevent maternal mental health conditions and SUDs.

#### ***Best Practice: Offering Perinatal Support Services***

The task force emphasized the importance of preventing mental health conditions and SUDs by enhancing services for women and other people during the peripartum period—particularly women and others with low incomes and other negative SDOH. Task force members focused on the need to augment services related to child care, doula support (some doulas have training in mental health), transportation, and comprehensive birthing and parenting education. In addition, a series of randomized controlled trials showed that the evidence-based [ROSE](#) (which stands for “reach out, stay strong, essentials for mothers of newborns”) program reduces cases of postpartum depression among low-income women (Zlotnick et al., 2016). According to the [Care New England Health System](#), “the ROSE Program includes 4 or 8 prenatal sessions and one post-natal booster session. Topics include psychoeducation on postpartum depression, managing the transition to motherhood, managing relationships, self-care, assertiveness and goal-setting, and a review session. The intervention is highly structured, [is] easy to learn, and can be delivered in both Spanish and English. Nurses, health educators, and others with or without mental health expertise can successfully provide ROSE.”

#### **Treatment-First Approach to Perinatal Substance Use Screening and SUD**

Federal laws (e.g., the [Child Abuse Prevention and Treatment Act \[CAPTA\]](#)) require states to create policies that address child abuse and neglect. State policies (such as mandatory reporting), procedures, and investigation systems vary across many dimensions, including how states implement [plans of safe care \(POSCs\)](#), a requirement of the Comprehensive Addiction and Recovery Act (CARA; [Public Law 114–198](#)), which amended CAPTA. POSCs focus on the shared responsibility of child welfare, hospitals, service providers, child care and early childhood education settings, and others to promote the health and well-being of infants and their caregivers in the context of parental SUDs (Office of National Drug Control Policy, 2022). Typically, a designated local agency (e.g., child protection services or a public health agency) develops an individualized POSC for a family that is designed to foster the recovery of any parent with SUD

while ensuring the safety and well-being of the child (or children). POSCs aim to keep children in their homes with their birth parents when that can be accomplished safely (Office of National Drug Control Policy, 2022), and POSCs should enforce notification (as opposed to reporting) pathways in which maternal substance use is noted to facilitate appropriate linkages to services and follow-up.

Professional societies—including the American Medical Association (AMA) (Henry, 2023) and the American College of Obstetricians and Gynecologists (ACOG) (American College of Obstetricians and Gynecologists, n.d.)—have issued statements opposing punitive policies (such as mandatory reporting). These organizations posit that such policies and practices do not deter substance use but do function as a barrier to seeking care, thus harming both parents and infants. AMA and ACOG have stated that mandatory reporting policies and practices disproportionately affect people of color and individuals with low incomes. Consistent with AMA and ACOG, the American Society of Addiction Medicine (ASAM) also “strongly supports reforms to reverse the punitive approach taken to substance use and SUD during and after pregnancy and respond to the shared interests of the parent-newborn dyad by providing ethical, equitable, and accessible, evidence-based care” (American Society of Addiction Medicine, 2022). In its statement, ASAM makes 39 recommendations pertaining to prevention, screening, and toxicology testing; federal and state policy changes; hospital practices related to substance use; treatment in the peripartum period; treatment, harm reduction, and recovery supports; medical education; women and other pregnant or postpartum people who are incarcerated; and protecting people’s bodily autonomy.

The task force, stakeholders who participated in the listening sessions, and the public also noted other negative effects of these policies, such as the fear of losing children, stigma, and the violation of bodily autonomy, all of which may discourage pregnant and postpartum individuals from seeking or accepting treatment for SUD. The task force also discussed variation in the process across states (e.g., mandatory reporting versus notification and identifying individuals who use substances but do not pose an immediate danger to their children). In cases of GBV, abusive partners often leverage these policies as a tactic of control; for example, an abusive partner may understand mandatory reporting policies and then coerce or force a pregnant or postpartum individual to use substances to exert control (Phillips et al., 2021; Warshaw et al., 2014).

“The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination” (Centers for Medicare & Medicaid Services, n.d.-a). Similar policies could prevent criminal judicial proceedings for pregnant individuals with SUDs and encourage a treatment-first approach. Implementing this treatment-first approach could involve collaboration with child protective services organizations, law enforcement, judicial officers, and emergency departments.

In a recent large U.S. cohort study, Black individuals—regardless of history of substance use—were more likely to receive a urine test for substances when they gave birth than individuals from other racial groups. Black patients did not have a higher probability of a positive test result than other racial groups (Jarlenski et al., 2023).

### ***Best Practice: Leveraging Medicaid to Enhance Care Coordination***

In states that expanded Medicaid to include adults, the Medicaid program is required to cover the full range of preventive services required in the essential health benefits (Centers for Medicare &

**“Being asked about my mental health made me feel that mental health and emotions were a legitimate concern.”**

**—S.B., mother of two**

Medicaid Services, 2024). Members of the task force discussed the importance of expanding requirements for insurers, including Medicaid, to reimburse individuals for prevention programs recommended by the U.S. Preventive Services Task Force (USPSTF), such as the [Maternal Opioid Misuse \(MOM\) model](#). The [USPSTF](#) is “an independent volunteer panel of national experts in disease prevention and evidence-based medicine [and]

works to improve the health of people nationwide by making evidence-based recommendations about clinical preventive services.”

### **SCREENING FOR PERINATAL MENTAL HEALTH CONDITIONS AND SUDS**

Screening represents an initial step in educating women about the risks, signs, and symptoms of perinatal mental health conditions and SUDs, as well as potentially detecting them. A positive screen does not constitute a diagnosis. However, screening can put people on a path toward assessment, diagnosis, and intervention or treatment with a referral to an appropriate practitioner. Members of the task force also noted the importance of creating safe opportunities to talk with patients about screening for GBV during perinatal visits and other health care visits and to have conversations about reproductive coercion (Grace & Miller, 2023; Miller et al., 2017), mental health and substance use coercion (Grace & Miller, 2023; Miller et al., 2017; Warshaw & Tinnon, 2018), and experiences of sexual trauma that may affect mental health, safety, and engagement in care. [USPSTF recommendations](#) focus on screening and primary care–based counseling and can be incorporated into such provider–patient discussions. Perinatal visits can also prompt prevention-oriented conversations about and screening for anxiety, depression, suicide risk, tobacco and substance use, and perinatal depression.

### **Barriers to Screening for Perinatal Mental Health Conditions and SUDs**

In their discussions, task force members identified barriers to screening for perinatal mental health conditions and SUDs. The stigmatization of perinatal mental health conditions and SUDs is an overarching barrier that prevents screening. Screening tools could be improved, updated, and better informed by culturally sensitive practices and should encompass broader problems related to these conditions—including GBV, lifetime trauma, housing instability, transportation issues, lack of access to child care, stigma, and child abuse. Expanding the types of providers who can screen for these conditions would further improve access. Furthermore, after positive screens, providers need clear guidelines for referring patients to appropriate treatment, and services must be available to treat those patients.

The task force mentioned a lack of knowledge on these specific topics on the part of frontline providers, as well as workforce fears about the consequences of reporting positive substance use screens for women and families. The task force highlighted a lack of consistency in policies on reimbursement for screening and the need for provider accountability to ensure that screening occurs. Task force members also noted that perfunctory screening tends to be ineffective and that thorough screening requires establishing

**“This was covered by insurance, the lactation consultant and therapist. It would have been a huge barrier for me if insurance hadn’t covered it—mental and physical.”**

**—A mother**

trust, providing normalizing information, creating safe opportunities for discussion, and offering appropriate support and resources—particularly for people experiencing stigmatized circumstances or conditions (Hill et al., 2021; Warshaw & Tinnon, 2018).

The current national landscape of maternal mental health conditions and SUDs, as well as the unique opportunity for intervention that the perinatal period affords, prompted the American Psychiatric Association (APA) to call for universal screening for these conditions. APA recommends universal screening for mental health conditions and SUDs among all women of childbearing age (American Psychiatric Association, 2023a).

### **Screening for Maternal Mental Health Conditions and SUDs Must Occur in Both Clinical and Nonclinical Settings**

**“The survey was geared toward postpartum depression. I didn’t realize postpartum anxiety was a thing. It was not talked about.”**

**—T.Y., mother of one**

In clinical settings, obstetric services providers (e.g., ob-gyns, midwives, and family practice providers) should routinely screen for maternal mental health conditions and SUDs, just as providers check for signs of gestational diabetes. The task force emphasized that screening for maternal mental health conditions and SUDs should function to normalize conversations about these issues as a part of routine care and work to reduce stigma. Members of the task force drew a sharp distinction between SUD screening (i.e., a

typical part of care, with a positive screen leading to a referral for further assessment and diagnostic treatment if necessary) and routine drug testing (i.e., toxicology), which is controversial (American College of Obstetricians and Gynecologists, n.d.). Clinicians and non-clinicians can administer research-validated screening tools in any setting (e.g., a home, homeless shelter, WIC site, workplace, or school).

### ***Selected Validated Screening Tools for Perinatal Mental Health Conditions***

- The [Edinburgh Postnatal Depression Scale](#) identifies whether a parent is experiencing depression, anxiety, or thoughts of self-harm.
- The [Patient Health Questionnaire-9](#) screens parents for depressive symptoms.
- The [Perinatal Anxiety Screening Scale \(PASS\)](#) identifies whether parents are experiencing anxiety.
- The [PPNMSS](#) scale measures perceived prenatal maternal stress and facilitates an early detection of stress and depression among pregnant and postpartum individuals.
- The [Center for Epidemiological Studies-Depression](#) assessment measures how often patients experienced previous-week symptoms associated with depression.
- The [GAD-7](#) seven-item questionnaire screens for generalized anxiety disorder (GAD).

### ***Selected Validated Screening Tools for Perinatal SUDs***

- [Screening, brief intervention, and referral to treatment \(SBIRT\)](#) is a comprehensive integrated public health approach to the delivery of early intervention and treatment services for people with SUDs, as well as those who are at risk of developing these disorders.
- [TWEAK](#) (which stands for “tolerance, worried, eye-opener, amnesia, cut down”), a test developed for pregnant individuals, screens for alcohol misuse and potential alcohol use disorder.



## The Task Force on Maternal Mental Health’s Report to Congress

- The [Alcohol Use Disorders Identification Test-Concise \(AUDIT-C\)](#) is an alcohol screening tool to identify acute intoxication.
- The [Alcohol, Smoking and Substance Involvement Screening Test \(ASSIST\)](#) identifies early substance use–related health risks and SUDs.
- The [Substance Use Risk Profile-Pregnancy \(SURP-P\) scale](#) consists of three questions that can differentiate between populations of pregnant and postpartum individuals at low risk or high risk for substance use.
- The [4P’s Plus](#) (the four P’s are “parents,” “partners,” “past,” and “pregnancy”) screening instrument identifies substance use among pregnant and postpartum individuals and includes questions about depression and domestic violence.
- [T-ACE](#) (which stands for “tolerance, annoyance, cut down, eye-opener”) is a four-item screening tool that identifies drinking in pregnant and postpartum individuals.
- The National Institute on Drug Abuse (NIDA) provides multiple tools for screening for substance misuse and SUDs. See the [Screening and Assessment Tools Chart](#), the [Drug Abuse Screening Test \(DAST-10\)](#), and the [single-question screening test for illegal drug use](#).

Guidance and policy documents related to screening for perinatal mental health conditions and SUDs include the following:

- ACOG offers a document on screening—which can be adopted by any obstetric provider—and on the diagnosis of perinatal mental health conditions: [Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 4](#).
- AMA offers [recommendations for the screening and treatment of perinatal depression](#).
- ACOG offers an [opinion on opioid use and opioid use disorder \(OUD\) during pregnancy](#) (with recommendations and conclusions on screening, diagnosis, and treatment).
- [Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants](#) discusses assessments for perinatal OUD (Substance Abuse and Mental Health Services Administration, 2018).
- ACOG offers a [policy statement on SUD during pregnancy](#) (with a note about screening) and a [policy statement opposing the criminalization of individuals for SUD during pregnancy and the postpartum period](#).
- The National Center on Domestic Violence, Trauma, and Mental Health offers guidance on addressing [trauma, substance use, and mental health in the context of GBV, including intimate partner violence](#).

### **Policy Highlight: Need to Remove Preapproval or Referral Requirements**

Many insurance companies require preapproval for or referral to services needed by people with perinatal mental health conditions and SUDs. Removing these requirements would expand care access.

## **Diagnosis**

Many perinatal care providers hesitate to assess and treat mental health conditions and SUDs because of time constraints, billing issues, lack of training, or the perception that these conditions

are outside the scope of their practice. With limited access to appropriate services in many areas, perinatal providers may be uncertain about referrals for diagnosis, intervention, and treatment. The perinatal psychiatry access programs described above offer a best practice for addressing perinatal providers’ concerns. Another potential best practice is to provide care without a diagnosis. A perinatal mental health and substance use program similar to the youth- and parent-focused [I Matter](#) program in Colorado could be developed. I Matter offers up to six free therapy sessions to people without a diagnosis.

### **Intervention and Treatment**

Members of the task force discussed both community- and clinic-based interventions and acknowledged that the distinction between the two is not always clear and that their provision can overlap. Task force members grouped best practices into four categories:

1. Psychotherapy/interpersonal care;
2. Pharmacotherapy;
3. Integrated care models; and
4. Community-based interventions.

The task force recognizes that intervention and treatment during the perinatal period may overlap and involve multiple approaches for the same client or patient.

#### ***Best Practice: Psychotherapy/Interpersonal Care***

***Cognitive Behavioral Therapy (CBT)***—CBT is an evidence-based form of psychotherapy with demonstrated effectiveness for various mental health conditions (e.g., depression), SUDs, and other health conditions in the general population (American Psychological Association, 2017). In CBT, the therapist and client work to change thinking and behavioral patterns by focusing on the person’s current life circumstances. According to a systematic review and meta-analysis (Li et al., 2022), CBT is also effective in the treatment of perinatal depression, anxiety, and stress. Other evidence suggests that CBT is highly effective for perinatal depression and can be provided in various formats (e.g., individual, group, face-to-face, and internet-based) (Branquinho et al., 2021). CBT is not appropriate in cases of GBV.

“With my therapist and with my daughter—my second child—knowing that I had someone to talk to was very helpful, and it was built in. She visited me when I was in the hospital when I had the baby and met the baby and my husband. It’s not something I would have sought out if the midwife had not suggested it.”

—A mother

***Interpersonal Therapy (IPT)***—IPT is an evidence-based intervention used primarily for treating depression. This therapy operates from the principle that mental health conditions occur within a social context and focuses on improving interpersonal conflict, role transitions, grief, and weaknesses (Wheeler & Crowe, 2022). IPT is a brief, structured psychotherapeutic approach that has been applied to perinatal depression with positive effects, according to literature reviews (Stuart, 2012; Wang et al., 2023). A randomized controlled trial showed that culturally relevant, brief IPT intervention ameliorated depression during pregnancy, prevented depressive relapse, and improved social functioning up to 6 months postpartum among birthing people with low incomes (Grote et al., 2009). Similarly, IPT improved depressive symptoms among mothers with children enrolled in Head Start (Mennen et al., 2021).



***Dialectical Behavior Therapy (DBT)***—DBT is an evidence-based therapy that addresses borderline personality disorder, self-harm, suicidality, and substance use. DBT focuses on these conditions as problems that stem largely from emotional dysregulation (i.e., difficulty controlling feelings and acting upon them) in the general population. In DBT, therapists help people learn more adaptive behaviors for dealing with their emotions and new life skills. DBT involves individual therapy, group sessions, and phone coaching (Chapman & Dixon-Gordon, 2020). Rigorous studies on DBT as an intervention during the peripartum period are needed, but a review suggests that this approach could be helpful for a range of mental health symptoms (Hellberg et al., 2023).

***Family Therapy***—Family therapy is an evidence-based intervention that can address a wide range of problems and mental health conditions (Lebow & Stroud, 2016). Although a limited number of controlled trials on family therapeutic interventions for the perinatal population exist, the findings show that these types of interventions are effective for preventing and treating perinatal depression (Cluxton-Keller & Bruce, 2018). Practitioners should eliminate the possibility of GBV before referring patients for family therapy.

***Group Therapy***—With a trained facilitator, group therapy can provide an environment of mutual respect and understanding in which people in the general population can share their problems and concerns with the aim of improved self-understanding and interpersonal relationships (American Psychological Association, 2018).

***Best Practice: Pharmacotherapy***

Health care providers treat many mental health conditions and SUDs with pharmaceutical medications during and after pregnancy. However, providers may vary in their levels of comfort in providing pharmacotherapy to pregnant and postpartum individuals. The task force discussed how pregnant and postpartum patients who may require pharmaceutical treatment for mental health conditions and SUDs might benefit from multidisciplinary, integrated, or embedded care models; in this way, patients might benefit from the combined expertise of providers of perinatal, mental health, and SUD treatment and/or other types of care providers and receive more holistic treatment. According to the task force, systemic changes implementing these models could help to provide service to more patients in need, improve maternal and infant outcomes, and reduce the burden on overworked perinatal care providers.

Although some maternal mental health conditions and SUDs may warrant pharmacotherapy, no single best pharmacotherapy practice applies to all of these disorders. Pharmacotherapy may be required for a number of different mental health conditions and SUDs that can occur, recur, or emerge during pregnancy and the postpartum period. During these periods of physical, hormonal, and humoral (i.e., pertaining to bodily fluids) changes, medical and psychiatric needs can also change. For example, individuals with bipolar disorder or major depression who stop pharmacotherapy during pregnancy have a significant risk of relapse (Bayrampour et al., 2020; Cohen, 2006; Viguera et al., 2007). The decision to initiate or maintain pharmacotherapy through pregnancy or postpartum should involve:

- The diagnosis;
- The severity of the symptoms and the condition;
- The risks of discontinuing treatment;

## The Task Force on Maternal Mental Health’s Report to Congress

- The patient’s medical and psychiatric history;
- The patient’s past treatment response to medication;
- The reproductive safety of specific medications;
- The availability of other medication options;
- Other maternal factors; and
- Shared decision-making between the patient and health care providers trained in obstetrics, pharmacotherapy, mental health treatment, and SUD.

Task force experts discussed how care providers could receive appropriate training, adopt a framework of psychoeducation, and obtain informed consent for initiation, continuation, or discontinuation of pharmacotherapeutic agents for mental health conditions and SUD in pregnant and postpartum individuals. This decision-making process should include consideration of the impact on the pregnant or postpartum individual, the impact on the offspring, and the risk of untreated illness, a factor sometimes neglected or minimized in clinical settings. For example, untreated depression in pregnancy may increase the risk of prematurity, low birth weight, and intrauterine growth restriction (Gentile, 2017; Jahan et al., 2021; Jarde et al., 2016).

Health care providers may consider the following when making treatment recommendations to pregnant and postpartum individuals with mental health conditions or SUDs. First, data are limited on the use of common psychotropic medications in pregnant and postpartum individuals and lactating individuals, as researchers often exclude these populations from drug trials during research, development, and testing. Often, researchers, clinicians, and public health surveillance systems only collect these data once the medications have been administered. Many years may pass before providers have a sufficient evidence base to feel confident in prescribing these drugs to patients who are pregnant, postpartum, and/or lactating—particularly in the current medical–legal climate of perinatal care.

Future research practices may improve the evidence base for pharmacotherapy in pregnant and postpartum individuals with mental health conditions and SUDs. An [inclusion policy of the National Institutes of Health \(NIH\)](#) “strongly encourages including pregnant women in clinical research in all circumstances in which their inclusion is scientifically valid and ethically permissible.” FDA provides health care providers and patients with a webpage that has a [list of pregnancy exposure registries](#), such as the [National Pregnancy Registry for Psychiatric Medications](#). Information about the use of drugs during lactation can be found in NIH’s [LactMed](#) database. Task force members encourage providers and patients to participate in drug registries to increase the knowledge base about these medications among this population.

Task force members also point to other factors that can inform pharmacotherapy-related decisions for pregnant, postpartum, and/or lactating individuals, including (1) the evidence base associated with a potential medication, as well as its history of clinical use and associated risks and benefits; (2) the medications that the patient has responded to best in the past (while factoring in associated safety issues and contraindications); and (3) striving to minimize the number of drug exposures.

The information provided below on specific medication or medication classes is a broad overview and **does not constitute clinical guidance**. The best treatment for a given pregnant, postpartum, and/or lactating individual will vary depending on their specific situation.

***Selective Serotonin Reuptake Inhibitors (SSRIs)***—Some clinical guidelines suggest that SSRIs can be first-line medications for the treatment of perinatal depression or anxiety disorders (American College of Obstetricians and Gynecologists, 2023). Clinicians and pregnant and postpartum individuals with histories of these disorders should assess the risk of recurrent illness, discuss the options for pharmacotherapy, consider medications that have proved effective in the past, consider the reproductive safety profiles of these medications, and collaboratively make decisions about treatment. Data from observational studies indicate a high rate of relapse in pregnant and postpartum individuals—particularly those with histories of moderate or severe depression—who discontinue medication during pregnancy (Cohen, 2006). Although untreated mental health conditions in pregnant and postpartum individuals can have devastating effects on both them and their children, few research efforts have studied the benefits of pharmacotherapy in pregnant and postpartum individuals. The limited evidence suggests some benefits to these treatments, as well as the potential for an increased risk of adverse events (Viswanathan et al., 2021). Patients and providers can work together to make informed treatment decisions, and the research literature can help clinicians sort options (Cohen, 2006; Raffi et al., 2019).

***Tricyclic Antidepressants (TCAs)***—TCAs may be another pharmacotherapy option for pregnant and postpartum individuals with depression.

***Mood Stabilizers***—Mood stabilizers include lithium and certain anticonvulsant drugs, and clinicians prescribe these medications to treat bipolar disorder in the general population. Many prenatal providers hesitate to prescribe these medications, and conversely, many psychiatrists hesitate to treat pregnant and postpartum individuals. The task force again points out the benefits of multidisciplinary teams in contributing to patient-involved clinical decisions regarding treatment options, particularly for this class of medications. Some mood stabilizing drugs, such as valproic acid (e.g., Depakene, Stavzor, Dalpro, and Deproic) may increase the risk of certain birth defects when used by pregnant individuals. Decisions related to continuing these medications during pregnancy are often based on individual clinical situations.

***GABAergic Neuroactive Steroids***—Evidence suggests that neuroactive steroids and neurosteroids, some of which enhance the transmission of the neurochemical gamma-aminobutyric acid (GABA), influence the development of postpartum depression (Maguire, 2019). Given that acute and chronic stress may disrupt GABAergic neuroactive steroids, some experts believe that restoring the neurochemical state with medications may alleviate postpartum depression (Maguire, 2019). The synthetic neurosteroids brexanolone and zuranolone are FDA-approved medications for the treatment of postpartum depression (Deligiannidis et al., 2023; Kanes et al., 2017).

***Medications for Opioid Use Disorder (MOUD)***—Opioid agonist pharmacotherapies (e.g., buprenorphine and methadone) represent evidence-based pharmacotherapeutic approaches for pregnant and postpartum individuals with OUD. [SAMHSA guidelines](#) recommend against medically supervised withdrawal for pregnant and postpartum individuals.

***Antipsychotics***—Data remain limited on the use of antipsychotic medications in pregnant and postpartum individuals. However, effective treatment of psychosis safeguards the health of both parent and child. Recent reports from the National Pregnancy Registry for Atypical

Antipsychotics found no increased risk for birth defects associated with these drugs (Swetlik et al., 2024; Viguera et al., 2021; Viguera et al., 2023).

***Best Practice: Integrated Care Models***

One approach to expanding access to mental health care and SUD treatment during pregnancy and the peripartum period is to integrate specialty services for these conditions into prenatal, primary, and postnatal care. Many of these integrated care models follow a [collaborative care model](#) established by HHS (Seibert et al., 2022), and they are typically clinic-based or integrated into clinics, although some community programs offer integrated care. Quality improvement metrics for providers, hospital systems, and insurers underpin the implementation of integrated care models and the incorporation of evidence-based practices into care, and long-term tracking gathers data on these metrics (Fischer et al., 2000; Lora, 2013; National Academies of Sciences et al., 2020). Additionally, standardized quality care indicators and evidence-based outcomes must align with the priorities of mothers and community experts to ensure that all pregnant and postpartum individuals receive high-quality care. The relevant quality and cost metrics must incentivize health care entities and practitioners to provide the best practices in care for perinatal mental health conditions and SUDs regardless of individuals’ type of insurance, geographic location, or socioeconomic status. The Centers for Medicare & Medicaid Services (CMS) might support the evidence-based collaborative care model for treating people with depression and anxiety by clarifying its expansion of related billing codes (Little et al., 2022).

Below, we list several integrated care models, service providers that use the integrated care model, and related research and development initiatives.

***Group Prenatal Care***—One integrated care approach involves providing prenatal care in comfortable settings to groups of pregnant individuals who will give birth around the same time. Evidence demonstrates that this approach improves overall maternal and neonatal outcomes (e.g., preventing low birth weight). For example, [CenteringPregnancy](#) is an [evidence-based best practice](#) that follows the recommended schedule of 10 prenatal visits. Each visit lasts 90–120 minutes and gives pregnant individuals extended time with their provider. Mothers engage in their own care (e.g., measuring and recording some vital signs at home). [Expect With Me](#), a group prenatal care program, has shown good outcomes (Cunningham et al., 2017) and has been adapted for women in rural communities (Centers for Medicare & Medicaid Services, n.d.-b) and those who are incarcerated. Research by the [Prenatal-to-3 Policy Center](#) suggests that group prenatal care models can yield positive outcomes, including reductions in maternal mental health conditions.

***HealthySteps***—[HealthySteps](#) is an evidence-based program to nurture healthy parenting and child development for babies and toddlers. HealthySteps specialists identify whether children are reaching developmental milestones, help connect families with additional services, and answer families’ questions about child development and well-being. A strong evidence base also informs [HealthySteps’ screening and treatment of maternal depression](#).

***MAMA’s Neighborhood***—The [MAMA’s \(which stands for “maternity assessment and management access and service synergy”\) Neighborhood](#) program in Los Angeles offers prenatal care and comprehensive health care services with a mother-centered approach. Services include affordable health care, individualized care coordination, prenatal classes, breastfeeding

consultations, and hospital tours. The program addresses mental health, substance use, and SDOH (Saleebby et al., 2021).

***The Maternal Opioid Misuse (MOM) Model***—Designed for pregnant and postpartum individuals who have OUD and are Medicaid beneficiaries, the [MOM model](#) addresses fragmented care through state-driven transformation of the delivery system. This model supports the coordination of clinical care and the integration of other services critical for health, well-being, recovery, and the treatment of pregnant and postpartum individuals with OUD.

***The Mothers and Babies Program***—Northwestern University’s [Mothers and Babies program](#) addresses postpartum depression by providing brief, affordable interventions to families, communities, and systems across the United States. The program aims to make mental health services and supports widely available, easy to access, affordable, non-stigmatizing, and effective. Mothers and Babies is also a research program that aims to adapt the model and facilitate its expansion to advance health equity.

***The Alliance for Innovation on Maternal Health (AIM)***—[HRSA’s AIM program](#) promotes safety and quality of care during and immediately after childbirth through the development and uptake of patient safety bundles across the United States. AIM patient safety bundles are sets of straightforward proven practices used in birthing facilities that improve patient outcomes and reduce severe illness and death. Research shows that these practices are effective in improving health outcomes. AIM has produced [mental health](#) and [SUD](#) safety bundles (Kendig et al., 2017; Krans et al., 2019).

***Perinatal Quality Collaboratives (PQCs)***—[PQCs](#) are state or multistate networks of teams working to improve the quality of maternal and infant care. PQC members identify health care processes in need of improvement and use the best available methods to implement fast changes. PQCs have increased states’ capacity to identify pregnant individuals with OUD and to implement protocols for screening and treatment in delivery facilities (Ellick et al., 2024).

***Perinatal Reproductive Education Planning and Resources (PREPARE)***—The VA developed [PREPARE](#) to create accessible in-house services that provide education, integrated perinatal care, and support to veterans and their families. Providing services at the VA rather than in the community allows for specialized care and helps promote and maintain positive health outcomes for pregnant and postpartum veterans and their families.

***The Center for Addiction Recovery in Pregnancy and Parenting (CARPP)***—The multidisciplinary team at [CARPP](#) at the Dartmouth Hitchcock Medical Center treats pregnant and postpartum individuals who are recovering from SUD and promotes healthy growth and development in their babies. Integrated services include intensive outpatient and inpatient programs, obstetric services, pediatric care, and other on-site services.

***The Horizons Program***—The [Horizons Program](#) at the University of North Carolina School of Medicine implements integrated, trauma-informed, co-located care in a program that allows pregnant and postpartum individuals to engage treatment in a manner that best suits their needs. Services include individual and group SUD treatment, obstetric and gynecological (OB-GYN)

services (e.g., prenatal, coordinated hospital delivery, postpartum, and well-woman care), and counseling.

***Community Corrections Care***—Many pregnant and postpartum individuals who are incarcerated have high-risk pregnancies related to substance use and socioeconomic problems, such as poverty, poor education, and inadequate health care. Under the model of community corrections care, pregnant and postpartum individuals who are incarcerated leave the prison where they are serving their primary sentence for a predetermined period of time preceding and shortly after the birth of their children (Hotelling, 2008). During this window, pregnant and postpartum individuals reside in community-based correctional facilities that provide a homelike environment, OB-GYN services, access to Lamaze educators and doulas, SUD treatment, and other services replicating other model programs. One such program, [Mothers and Infants Nurturing Together \(MINT\)](#), is a nationwide network of community correctional sites providing integrated services on behalf of the Federal Bureau of Prisons. Research has linked these programs to improved parenting outcomes and decreased recidivism (Hotelling, 2008).

***The Maternal Opiate Medical Supports Plus (MOMS+) Hub-and-Spoke Model***—Hub-and-spoke model programs such as [MOMS+](#) are evidence-informed programs that provide MOUD, mental health therapy, and OB-GYN services. The “hub” location provides high-intensity care, tests innovative approaches, and maintains a full staff of treatment specialists. “Spoke” programs provide maintenance MOUD to stable clients in the community. This approach removes barriers to the expeditious application of evidence-based treatment by applying plan–do–study–act cycles. Teams communicate across sites during monthly meetings to review data and communicate about successes and barriers.

***Culturally and Linguistically Appropriate Models***—These programs target specific populations with culturally competent, language-appropriate staff members, resources, materials, and treatment. One example is the [Malama Family Recovery Center](#) in Maui, Hawaii, which provides gender-specific treatment services specifically for women in recovery from SUDs. Programs developed for Native Hawaiians and others include a residential substance use treatment program for pregnant and parenting women; an outreach and early intervention program for women who are at risk for tobacco, alcohol, and/or substance use; and other treatment services.

***The Drug Free Moms and Babies (DFMB) Program***—The [West Virginia DFMB program](#) represents a statewide comprehensive approach to supporting healthy outcomes for mothers and babies by providing prevention, early intervention, SUD treatment, and recovery support. The DFMB project works in communities by integrating medical and behavioral health care through a strong care coordination model that incorporates wraparound recovery support services and social services. Key project components include SBIRT services, maternity care clinics, home visitations, and comprehensive medical, mental health, and social services, including partnerships with community GBV programs.

***Integrated Maternal Health Services (IMHS)***—A recent HRSA grant-funding program, [IMHS](#), fosters the development of integrated care models such as the maternity medical home, sometimes referred to as the pregnancy medical home, which is modeled after the patient-centered medical home.



***The Alaska Families with Infants and Toddlers (FIT) Court***—[Alaska's FIT Court program](#) serves families who are involved with the Office of Children's Services (OCS). Parents who have pending court cases and children 36 months or younger in OCS custody can work with parent navigators and caseworkers to access services, including treatment for SUD, and can arrange visits with their children. Initial evidence suggests that FIT Court and other programs that coordinate services and address maternal SUD can change trajectories for whole families.

### **Community-Based and Multigenerational Practices**

Community-based interventions deliver most care and services in the community or home, not a clinic. Examples include HRSA's [Maternal, Infant, and Early Childhood Home Visiting](#) and [Healthy Start](#) programs.

#### ***Best Practice: Home Visiting Programs***

Home visiting programs emerged as an evidence-based best practice in the task force's discussions, in the listening sessions, and in the public's comments. Research shows that in addition to improving mental health and other health outcomes for pregnant and postpartum individuals and their infants, home visiting programs are effective in addressing GBV (Davidov et al., 2021; Niland et al., 2020). Below, we describe a few such programs.

***The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program***—[MIECHV](#) funds states, territories, and tribal entities so they can develop and implement home visiting programs, which must be based on evidence showing that they will be effective in meeting the needs of families. Currently, [24 models of home visiting care delivery](#) meet standards for Home Visiting Evidence of Effectiveness (HomVEE) and thus are eligible for funding through MIECHV.

One such model, [Family Connects](#), is a universal home visiting model (i.e., one that serves all families in a community) that offers early intervention for families with newborns, particularly those from under-resourced communities, to help them address health concerns and access supports. The program supplies information about local resources and how to navigate various systems so families can access services. Registered nurses (home visitors) provide free checkups to mothers and babies during the early postpartum period.

Another such program, the Johns Hopkins Center for Indigenous Health's [Family Spirit](#), is an evidence-based and culturally tailored home visiting program delivered by American Indian/Alaska Native (AI/AN) paraprofessionals to support families during pregnancy and early childhood. Caregivers of children gain knowledge and skills to achieve optimal development for their children across the domains of physical health, cognitive health, social-emotional well-being, language learning, and self-help. (See this presentation on outcomes: [The Family Spirit Program: Promoting Maternal and Child Health Through Early Childhood Home Visiting.](#))

Another example is the [Nurse-Family Partnership](#), an evidence-based home visiting program focused on first-time mothers affected by social and economic inequality. Nurses with special training provide home visits that begin during early pregnancy and continue until the child's second birthday. Parents receive care and support for healthy pregnancies, and nurses provide advice on parenting.

***Domestic Violence Enhanced (DOVE) Perinatal Home Visits***—This brief intervention complements home visitations of pregnant and postpartum women. Randomized clinical trials demonstrated that DOVE effectively decreases intimate partner violence (IPV). The brevity of the intervention facilitated DOVE’s incorporation into home visiting programs, well-woman care visits, and well-child care visits (Sharps et al., 2016).

***Other Home Visiting Programs***—The [Community Health Aide Program \(CHAP\)](#), supported by the Indian Health Service, consists of a network of approximately 550 community health aides and practitioners who work in more than 170 villages in rural Alaska. These providers work within the guidelines of the *Alaska Community Health Aide Manual* to assess and provide emergent, acute, and chronic care to residents of their respective communities and to serve as the frontline health care workers in their communities (Golnick et al., 2012; National Indian Health Board, n.d.).

***Best Practice: Multigenerational Support Programs***

The [CUB \(which stands for “caring for you and baby”\) Clinic](#) in Denver, Colorado, supports the mental health and developmental needs of pregnant and postpartum individuals, as well as families with infants and young children. The CUB Clinic provides services to caregivers, couples, family members, and their young children with a sliding-scale payment model (which accepts Medicaid/Health First Colorado). The CUB Clinic addresses perinatal concerns, including mood, anxiety, stress, adjustment, trauma, and relationship issues.

The [Celebrating Families!](#) curriculum offers a cognitive–behavioral support group model for families in which one or both parents misuse alcohol or other drugs and there is a high risk for domestic violence, child abuse, or neglect. The 16-week curriculum fosters adult recovery and nurtures the skills for healthy family living.

The [Healthy Families America](#) program is an evidence-based approach supported by MIECHV that promotes child well-being and prevents the abuse and neglect of children. It provides family-focused and empathic support in the home. Culturally respectful services empower parents to help children develop social, emotional, and cognitive skills.

**“[It helps to talk to] someone who has been through the experience who you know and trust.”**

**—A mother**

Another MIECHV-supported program, [Parents as Teachers](#) promotes the early development, learning, and health of children (from birth to kindergarten) by supporting and engaging their parents and caregivers. Features of this evidence-based home visiting program include comprehensive parent education, personal visits, connection to support groups, a resource network, and child and caregiver screening.

The [Parent Support Network of Rhode Island](#) provides family peer support to promote children’s mental health in the state. The peers have lived experience with mental health conditions and SUDs. Program participants are empowered through support, education, and advocacy. Program goals include preventing abuse and neglect, reducing disparities, and advancing toward universal health, wellness, and recovery.

Dyadic care programs for postpartum individuals with OUD and their infants and children (including opioid-exposed infants and children) work to create a framework for integrating



clinical care, public health surveillance, and research (Jilani et al., 2024). Future research may determine the efficacy of these promising programs.

***Best Practice: Federally Supported Community Clinics***

HRSA’s [health centers](#) are community-based and [patient-directed](#) organizations that provide affordable, accessible, high-quality primary health care services to individuals and families. Federally qualified health centers (FQHCs) provide primary care services for medically under-resourced areas and populations (e.g., people experiencing homelessness, agricultural workers, and residents of public housing), and payment is on a sliding scale.

SAMHSA’s [certified community behavioral health clinics \(CCBHCs\)](#) are designed to ensure access to coordinated comprehensive care for mental health conditions and SUDs. These clinics are required to serve anyone who requests care for mental health conditions or SUDs, regardless of their ability to pay, place of residence, or age. CCBHCs also establish partnerships with community-based IPV centers.

**Workforce Best Practices**

As limited access to services relates to the workforce shortage, the task force emphasizes the importance of increasing recruitment, training, and retention of providers. Members of the task force identified some best practices in this area, including:

- Targeted outreach programs;
- Mentoring/shadowing for students of and applicants to health care education and training programs;
- Opportunities for trainees to work with integrated care and community-based systems (internships); and
- Providing educational stipends and a maternal mental health certification, including for peer support specialists.

**Workforce Best Practice Highlight: Loan Reimbursement for Providers**

Programs that repay part of providers’ school loan debt can boost recruitment and retention in the health care workforce. See information on HRSA programs, which also place providers in areas experiencing shortages of mental health providers. Such programs might be leveraged to boost the workforce of perinatal mental health and SUD treatment providers.

***Best Practice: Training Providers to Address Perinatal Mental Health Conditions and SUDs***

Health care providers (e.g., in obstetrics, pediatrics, or family medicine) at all levels (e.g., physicians, advanced practice nurses, physician assistants, nurses, and nurse midwives) need specific training on how to address perinatal mental health conditions and SUDs. Mental health

**“My midwife did call me at one point before the 6-week appointment, and that was really appreciated, unexpected.”**

**—K.L., mother of two**

care providers (e.g., psychiatrists, psychologists, social workers, counselors, and therapists) also need specific training in perinatal conditions. Part of provider training should cover the risk factors (including GBV) for and subgroups most affected by perinatal mental health conditions and SUDs. The task force also noted that providers need ongoing support and supervision.

The task force identified the best practice of [training on trauma](#) (including GBV and [racial trauma](#)) for providers and [organizations](#) that see pregnant and postpartum individuals, as well as training on responding to the unique risks faced by people experiencing ongoing IPV. Such training can be implemented at all care encounters and in all settings for this population. Organizations that provide care can incorporate feedback and lived experience directly from communities (e.g., community advisory boards) and family members in the development of culturally safe programs. (See [SAMHSA’s treatment improvement protocol on improving cultural competence](#).) General training resources are also available for [practitioners in the fields of mental health and SUDs](#). To address the needs of pregnant and postpartum individuals, training is available [on the perinatal population for mental health and SUD treatment providers](#) and [on perinatal mental health for ob-gyns](#).

The task force also highlighted the need to implement education on perinatal mental health support across disciplines and settings so that providers’ core competencies include perinatal mental health, as well as the need to develop literature-based guidelines and trainings on screening and referral. The costs of training, certification, licensing, and education must also be addressed. The task force also stressed the need for diversity in the workforce—including among doulas, midwives, and community health workers. Examples of available trainings include:

- The [Maternal Mental Health Certificate Training for Mental Health and Clinical Professionals](#), from the Policy Center for Maternal Mental Health and Postpartum Support International;
- [Perinatal mental health certificate training courses](#) from Postpartum Support International;
- HRSA’s [Screening and Treatment for Maternal Mental Health and Substance Use Disorders](#) program, which bolsters skills and consultation in screening procedures for postpartum depression, anxiety, and SUD, as well as in identification, treatment, and referral.
- The [Lifeline4Moms Perinatal Mental Health Toolkit](#) and the free e-learning resource [Addressing Maternal Mental Health Conditions in Obstetric Settings](#), from ACOG and UMass Chan Medical School’s Lifeline for Moms program;
- Training related to perinatal GBV from the [IPT Institute](#); and
- Training on mental health, substance use, trauma, and IPV from the [National Center on Domestic Violence, Trauma, and Mental Health](#).

**Best Practice Potential Adaptation Highlight: Mental Health First Aid**

[Mental health first aid](#) is skills-based training that teaches participants how to identify, understand, and respond to signs of mental health conditions and SUDs. Such training could be adapted for pregnant and postpartum individuals experiencing these conditions.

## Research and Data Collection

Research and data collection are key to improving maternal mental health outcomes and the outcomes of children and families. However, pregnant and postpartum individuals with SUD may choose not to participate (or may not be invited to participate) in data collection efforts if the pregnant and postpartum individuals could face penalties (e.g., if a positive screen for substances

would result in legal problems or the possibility of losing a child). Additionally, data collection should directly result in improved care to foster participation.

***Best Practice: Including Pregnant People in Clinical Trials and Other Research***

The task force noted that researchers should include pregnant and postpartum individuals in clinical trials, as well as surveillance and monitoring studies—especially those trials studying potential medications for mental health conditions and SUDs. Such research supports the diversification of mental health treatment plans and a wider array of therapeutic options for these conditions. Researchers conducting such studies and public health practitioners collecting surveillance data should integrate obstetric and gynecological health information and social service records with appropriate safeguards for mental health and substance use records.

In response to a statement from the U.S. Preventive Services Task Force, the National Institute of Mental Health established a funding mechanism ([RFA-MH-21-240](#)) to support research on perinatal depression prevention interventions, particularly for populations experiencing mental health disparities.

***Best Practice: Involving a Diverse Group of Stakeholders in the Research Process***

Some stakeholders—particularly pregnant and postpartum individuals and other individuals with lived experience of maternal mental health conditions and SUDs—tend to be excluded from the design of research studies and data collection efforts. Approaches that involve people directly affected by conditions (e.g., community-based participatory research) in the design and conducting of studies promote health equity and reduce disparities (National Institute on Minority Health and Health Disparities, 2024; Wallerstein et al., 2018). An anthropological approach and qualitative research methods—as shown by a study of perinatal mood and anxiety disorders among rural residents by Statz and Bristow (2023)—may provide insights into the perceived barriers, needs, and preferences of people who experience these conditions. Members of the task force noted that this study underscored the crucial contribution of lived experience to public health and clinical research.

***Listening to Women with Chronic Conditions***—[This project](#), supported by the [Patient-Centered Outcomes Research Institute’s \(PCORI\) Eugene Washington PCORI Engagement Award Program](#), engaged in patient-centered research to improve reproductive and preconception health for women with chronic conditions, particularly among Black and AI/AN populations. Researchers engaged Black and AI/AN women of reproductive age with one or more chronic conditions, as well as providers and researchers to gather data and understand patient recommendations and priorities concerning preconception care and reproductive wellness.

***The Administration for Community Living (ACL)/National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) Long-Range Plan***—As mandated by the U.S. Congress, ACL and NIDILRR released the [2024–2028 Long-Range Plan](#), informed by extensive stakeholder input from people with disabilities. The plan includes provisions for improving pregnancy and maternal health outcomes among people with disabilities and reaffirms NIDILRR’s commitment to supporting research on evidence-based interventions, services, and support to this end.

**NIH’s Community Engagement Alliance (CEAL)**—Examples of community-based participatory research that engages people during the peripartum period include two programs of [CEAL](#), which involves partnerships between research teams and people from the communities at highest risk for pregnancy-related health conditions and death. The goal is to improve health and prevent death before, during, and after pregnancy.

1. The [Maternal Health Community Implementation Program](#) aims to reduce maternal deaths and improve health outcomes for pregnant and postpartum people, especially in populations that are disproportionately affected by high rates of pregnancy-related complications and deaths. The program develops and tests community-based implementation strategies to increase the adoption, uptake, scale-up, and scale-out of evidence-based interventions to improve health before, during, and after pregnancy. The program emphasizes community-engaged implementation research that is connected to and embedded in affected communities.
2. The [Implementing a Maternal health and PRenancy Outcomes Vision for Everyone \(IMPROVE\) initiative’s Community Implementation Program](#) aims to reduce preventable causes of maternal deaths and improve health before, during, and after pregnancy. This program focuses on health disparities and people most affected by maternal death and severe maternal illness—including the Black, AI/AN, and Hispanic communities, as well as people who live in rural areas and other under-resourced areas. Although IMPROVE does not focus specifically on maternal mental health, its research projects may incorporate mental health components.

***Best Practice: Inclusion of Pregnant People in Cross-Sectional and Longitudinal Surveillance and Data Collection***

The exclusion of pregnant and postpartum individuals from research studies and surveillance has resulted in a gap in the treatment evidence base, and barriers to their participation persist (Biggio, 2020). NIH “strongly encourages including pregnant women in clinical research in all circumstances in which their inclusion is scientifically valid and ethically permissible” (National Institutes of Health, n.d.-b). The task force noted that this best practice needs to be supported by changes in regulations and liability protections. Members of the task force stressed the importance of collecting and analyzing data—both cross-sectional and longitudinal—on the full range of experiences relevant to perinatal mental health conditions and SUDs. In addition to these conditions themselves, other areas for research include violence exposures (including abuse targeted toward substance use, mental health, and reproductive health), risk factors, SDOH, and demographics. Research and data collection efforts need to include the longer-term effects of medications on perinatal mental health conditions and SUDs among diverse populations of mothers and children.

**MAT-LINK**—In 2019, CDC established [MAT-LINK](#), a mother–infant-linked longitudinal surveillance network to address and improve the understanding of maternal, pregnancy, and infant/child outcomes associated with mental health conditions, OUD, and polysubstance use during pregnancy. MAT-LINK is a dedicated surveillance network of 11 clinical sites from diverse geographic areas in the United States that collect data on mother–infant dyads and serve patients from different backgrounds. MAT-LINK captures demographic and clinical information about people with mental health conditions and SUDs, including OUD, during pregnancy and examines the effects of different types of MOUD on outcomes. The data provide information on

best practices for clinical care and public health interventions for this population. MAT-LINK’s robust information technology architecture maintains strict data privacy (Miele et al., 2023).

***The Pregnancy Risk Assessment Monitoring System (PRAMS)***—Developed by CDC in 1987, [PRAMS](#) collects jurisdiction-specific population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The 50 participating PRAMS surveillance jurisdictions collect data on 81 percent of live births in the United States, including data on postpartum depressive symptoms and screening for depression, mental health conditions, and IPV. In 2019, PRAMS sites also collected supplemental data on prescription opioid use among pregnant women.

***Best Practice: Standardizing Data Collection During the Peripartum Period***

The lack of standardized data collection across important domains during the peripartum period limits our understanding of maternal mental health conditions and SUDs in various populations. The task force noted that the modernization of data collection and linkages across data repositories require investments to ensure standards. Standardized data collection facilitates valid combination, comparison, and analysis of the data, which in turn facilitates evidence-based practices and public health action. Connecting health data systems across states may require legislative approval but, according to the task force, offers great opportunities to improve maternal health.

***The Public Health Data Warehouse in Massachusetts***—This facility combines health care and social service data to address SDOH for women living with mental health conditions and SUDs. The warehouse links the electronic health records of mothers and their children. These data extend to up to 1 year postpartum.

***The Drug Free Moms and Babies Database in West Virginia***—The Drug Free Moms and Babies program collects data related to mental health, substance use, SDOH, and GBV from all West Virginia birthing centers.

**Data Standardization Highlight: A Uniform Definition of Neonatal Abstinence Syndrome (NAS)**

CDC collaborated with the Council of State and Territorial Epidemiologists to develop a standard public health case definition of NAS. This definition facilitates monitoring the number of infants born with this condition and the identification of mothers with OUD. Using consistent criteria to define NAS for public health reporting ensures that data are collected in a standardized way and can be compared across geographic areas—enabling targeted strategies (Mette et al., 2021).

***Best Practice: Enhancing Linkage of Data and Using Big Data***

CDC’s [Data Modernization Initiative](#) prioritizes enhancing linked data (e.g., linked mother–child electronic health records). The literature highlights the potential of linked data to improve maternal and child health (Ali et al., 2023; Magee et al., 2020). For example, North Carolina links data from the [North Carolina Violent Death Reporting System](#) with surveillance data on pregnancy-associated severe mental health outcomes (e.g., suicide and homicide). The effort captures the full breadth of outcomes and the scope of this public health problem in the state (Austin et al., 2016).

***Best Practice: Investment in Maternal Mortality Review Committees (MMRCs) and Perinatal Quality Collaboratives (PQCs) and Leveraging Their Efforts***

MMRCs facilitate the review of pregnancy-related deaths and improve the understanding of the circumstances of pregnancy-related deaths in which mental health, violence exposure, and/or SUDs contributed. These reviews facilitate the development of local, actionable recommendations that might help prevent similar deaths in the particular jurisdiction or health system in the future. PQCs work to improve maternal and infant health outcomes by advancing evidence-informed clinical practices and processes by using quality improvement principles to address gaps in care, including those related to mental health conditions and SUDs. Hospital- and state-based quality improvement initiatives should leverage the recommendations of MMRCs. Expanding related data collection efforts (e.g., capturing and processing data collected from birth and death certificates) might enrich the insights gained from MMRCs and PQCs.



## SECTION 4: EXISTING FEDERAL PROGRAMS AND COORDINATION

This chapter presents the landscape of federal programs that address specific challenges related to mental health and substance use or promote mental health in pregnant and postpartum people, their families, and the workforce and research that support them. Brief program descriptions are provided in tables organized by federal agency, and specific program components and activities are then listed in categorical sections, where applicable, according to focus areas addressed. These categories include prevention, screening, diagnosis, intervention, treatment, community-based and multigenerational practices, and equity. A final table provides information on federal collaboration and coordination efforts.

*Note: Individual federal agencies provided the descriptions below, and much of the text quotes or paraphrases their websites or other agency publications and materials. This report repurposes the text provided.*

### PROGRAMS BY AGENCY

#### Administration for Children and Families (ACF)

<a href="#">Young United Parents! (YUP!)</a>	
<i>Population(s) Served</i>	Parents of females ages 15 to 20 in Mississippi, Texas, Indiana, Kentucky, New Mexico, and Alaska
<i>Purpose</i>	To address factors that may lead to unplanned pregnancy and sexually transmitted infections (STIs), such as HIV, including social and emotional well-being, social determinants of health, social isolation, and other areas of physical, mental, and emotional health
<i>Duration</i>	September 2022–September 2026
<i>Categories</i>	Prevention, Intervention, Community-Based and Multigenerational Practices, Equity
<a href="#">SOAR (Stop, Observe, Ask, Respond) to Health and Wellness Training</a>	
<i>Population(s) Served</i>	Professionals, organizations, and communities that address human trafficking in health care, behavioral health, public health, and social services settings nationwide
<i>Purpose</i>	To help target audiences identify and respond to those who are at risk of, are currently experiencing, or have experienced trafficking and connect them with needed resources
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity

#### Agency for Healthcare Research and Quality (AHRQ)

<a href="#">Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Systematic Review of Perinatal Pharmacologic Interventions</a>	
<i>Population(s) Served</i>	Pregnant and postpartum people
<i>Purpose</i>	To identify medications to improve symptoms of maternal mental health conditions through a systematic review
<i>Duration</i>	July 2018–April 2021

## The Task Force on Maternal Mental Health's Report to Congress

<i>Categories</i>	Intervention, Treatment
<a href="#"><u>Nonpharmacologic Treatment for Maternal Mental Health Conditions</u></a> (Systematic Review)	
<i>Population(s) Served</i>	Pregnant and postpartum people
<i>Purpose</i>	To assess nonmedication therapies (e.g., cognitive behavioral therapy, interpersonal psychotherapy, explorative therapy, and self-hypnosis and relaxation) for the maternal population
<i>Duration</i>	Ongoing
<i>Categories</i>	Intervention, Treatment
<a href="#"><u>Evaluation of Mental Health Mobile Applications</u></a> (Technical Brief)	
<i>Population(s) Served</i>	Providers, patients, and caregivers
<i>Purpose</i>	To assist app developers interested in creating technologies that support mental health and wellness by developing a framework to assist stakeholders in evaluating technology
<i>Duration</i>	2022
<i>Categories</i>	Intervention, Treatment

## Centers for Disease Control and Prevention (CDC)

<a href="#"><u>The Comprehensive Suicide Prevention Program (CSP) and the Suicide Prevention Resource for Action</u></a> (Suicide Prevention Resource)	
<i>Population(s) Served</i>	Subpopulations disproportionately affected by suicide (e.g., veterans, tribal populations, rural communities, LGBTQI+ individuals, and youths/young adults)
<i>Purpose</i>	To implement and evaluate a comprehensive public health approach to suicide prevention, with a special focus on populations that are disproportionately affected by suicide
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Community-Based and Multigenerational Practices, Equity
<a href="#"><u>PS18-1802: Integrated Human Immunodeficiency Virus (HIV) Surveillance and Prevention Programs for Health Departments</u></a>	
<i>Population(s) Served</i>	Individuals at risk for acquiring HIV and people living with HIV, including women of childbearing age, pregnant women, and infants
<i>Purpose</i>	To implement a comprehensive HIV surveillance and prevention program to prevent new HIV infections and achieve viral suppression among people living with HIV
<i>Duration</i>	Applications are open for a new funding opportunity mirroring the above opportunity for an additional 5 years.
<i>Categories</i>	Prevention
<a href="#"><u>Improving Ob-Gyns' Ability to Support COVID-19 Vaccination, Mental Health, and Social Services</u></a>	
<i>Population(s) Served</i>	Ob-gyns and other clinicians focusing on women's health, and state perinatal psychiatry access programs nationwide
<i>Purpose</i>	To enhance the ability of clinicians to detect and assess perinatal mood and anxiety disorders



## The Task Force on Maternal Mental Health's Report to Congress

<i>Duration</i>	Completed, with ongoing resource availability
<i>Categories</i>	Screening, Diagnosis, Intervention, Treatment, Community-Based and Multigenerational Practices
<b><u>Tribal Suicide Prevention (TSP)</u></b>	
<i>Population(s) Served</i>	American Indians and Alaska Natives. Subpopulations include elders, veterans, men, and sexual orientation and gender identity minorities.
<i>Purpose</i>	To identify, create, implement, evaluate, and improve holistic community-based interventions that increase tribe/community-specific protective factors and reduce risk factors for suicide in a culturally centered way
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Community-Based and Multigenerational Practices, Equity
<b><u>Overdose Data to Action (OD2A)</u></b>	
<i>Population(s) Served</i>	Reproductive-aged, pregnant, and postpartum individuals. CDC's Division of Overdose Prevention collaborates with and extends subject matter expertise on neonatal abstinence syndrome and other maternal and infant effects of opioid exposure or other drug exposure during pregnancy.
<i>Purpose</i>	To address overdose risk factors and monitor the evolving opioid crisis. CDC funds 90 jurisdictions as part of OD2A across states and localities to monitor and respond to the evolving opioid crisis. Although maternal health is not a core focus of OD2A, states and localities may work to address and respond to overdose risk factors across a variety of populations.
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Intervention, Treatment, Community-Based and Multigenerational Practices, Equity
<b><u>MAT-LINK</u></b>	
<i>Population(s) Served</i>	Mother–infant dyads, including pregnant people with OUD, polysubstance use, and cytomegalovirus
<i>Purpose</i>	To address and improve the understanding of maternal, pregnancy, and infant/child outcomes associated with mental health conditions, opioid use disorder (OUD), and polysubstance use during pregnancy
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Treatment, Equity

## Centers for Medicare & Medicaid Services (CMS)

<b><u>Maternal Opioid Misuse (MOM) Model</u></b>	
<i>Population(s) Served</i>	Pregnant and postpartum Medicaid and Children's Health Insurance Program (CHIP) beneficiaries with OUD and their infants
<i>Purpose</i>	To address the fragmentation of care for the target population through state-driven transformation of service delivery systems
<i>Duration</i>	Through December 2024
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<b><u>Allowing Pediatricians to Bill for Maternal Postpartum Depression Screening (Policy)</u></b>	
<i>Population(s) Served</i>	Mothers (both Medicaid-eligible and non-Medicaid-eligible) and their children

## The Task Force on Maternal Mental Health’s Report to Congress

<i>Purpose</i>	To allow pediatricians to bill for maternal depression screening during well-child visits as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit
<i>Duration</i>	Ongoing
<i>Categories</i>	Screening
<a href="#"><u>Merit-Based Incentive Payment System (MIPS) Value Pathway Focusing on Women’s Health</u></a>	
<i>Population(s) Served</i>	Medicaid recipients
<i>Purpose</i>	To avoid screening out patients who have high social risk—e.g., are from underserved populations—or who have complex medical conditions, including maternal mental health conditions
<i>Duration</i>	To be available in 2024
<i>Categories</i>	Screening

### Food and Drug Administration (FDA)

<a href="#"><u>Pregnancy Exposure Registries</u></a>	
<i>Population(s) Served</i>	Pregnant and postpartum people
<i>Purpose</i>	To increase awareness about pregnancy registries that are open and enrolling volunteers. Pregnancy exposure registries are research studies that collect information about the effects that prescription medicines taken or vaccines received have on pregnant people.
<i>Duration</i>	Ongoing
<i>Categories</i>	Treatment
<a href="#"><u>Cooperative Agreement to Support an Evidence-Based Clinical Practice Guideline for the Management of Postoperative Pain After Surgeries in Obstetric Patients: Evidence, Dissemination, and Impact</u></a>	
<i>Population(s) Served</i>	Pregnant individuals who undergo surgery (including appendectomy) prior to childbirth, postpartum individuals following vaginal delivery, and postpartum individuals following cesarean delivery, with special consideration given to pregnant people with comorbid conditions, mental health conditions, and substance use that may affect pain experience
<i>Purpose</i>	To develop comprehensive evidence-based plans to advance safe prescribing of opioid analgesics for obstetric patients with postoperative pain
<i>Duration</i>	2022–2025
<i>Categories</i>	Prevention, Equity

### Health Resources and Services Administration (HRSA)

<a href="#"><u>Rural Communities Opioid Response Program–Neonatal Abstinence Syndrome (RCORP-NAS)</u></a>	
<i>Population(s) Served</i>	Pregnant women, mothers, and women of childbearing age who have a history of or who are at risk for SUD and their children, families, and caregivers who reside in HRSA-designated rural areas

The Task Force on Maternal Mental Health's Report to Congress

<i>Purpose</i>	To reduce the incidence and impact of neonatal abstinence syndrome (NAS) in rural communities
<i>Duration</i>	September 2023–August 2026
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Treatment, Equity
<a href="#"><u>Primary Care Training and Enhancement–Community Prevention and Maternal Health (PCTE-CPMH)</u></a>	
<i>Population(s) Served</i>	Women and adolescents of childbearing age
<i>Purpose</i>	To train primary care physicians in maternal health care clinical services or population health in order to improve maternal health outcomes
<i>Duration</i>	July 1, 2021–June 30, 2026
<i>Categories</i>	Screening, Diagnosis, Intervention, Treatment
<a href="#"><u>Behavioral Health and Substance Use Disorder Primary Care Integration Services Technical Assistance</u></a>	
<i>Population(s) Served</i>	Uninsured people, women of color, women who use drugs and alcohol during pregnancy across the United States and U.S. territories, and their providers
<i>Purpose</i>	To support mental health services integration in primary care at HRSA-supported health centers
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention
<a href="#"><u>National Health Service Corps Loan Repayment Program</u></a>	
<i>Population(s) Served</i>	Pregnant and postpartum people in designated health professional shortage areas
<i>Purpose</i>	To recruit and retain medical, nursing, dental, and mental health clinicians in health professional shortage areas, including maternity care health professionals in maternity care deserts
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<a href="#"><u>Rural Health Care Services Outreach Program grantee Healthy Acadia's PROSPER Initiative</u></a>	
<i>Population(s) Served</i>	Women with SUD during the prenatal, perinatal, and postnatal periods in Hancock and Washington counties in Maine
<i>Purpose</i>	To expand, improve, and enhance health services, systems, and outcomes for pregnant women experiencing SUD and their children
<i>Duration</i>	May 1, 2021–April 30, 2025
<i>Categories</i>	Intervention, Equity
<a href="#"><u>Quality Improvement Fund–Maternal Health (QIF-MH)</u></a>	
<i>Population(s) Served</i>	Pregnant and postpartum people at highest risk of adverse maternal and/or behavioral health outcomes nationwide
<i>Purpose</i>	To provide funding for 36 HRSA-funded health centers to develop and pilot innovative, patient-centered, scalable models of care delivery that address the clinical and health-related social needs of health center patients, improve maternal health indicators, and reduce racial and ethnic maternal health disparities
<i>Duration</i>	June 2023–May 2025

The Task Force on Maternal Mental Health's Report to Congress

<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<a href="#"><u>Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)</u></a>	
<i>Population(s) Served</i>	Low-income families, pregnant people younger than 21, families with a history of child abuse or neglect, families with a history of substance use, families that have users of tobacco in the home, families with children with low student achievement, families with children with developmental disabilities, and families with individuals who are serving or have served in the armed forces
<i>Purpose</i>	To support home visiting for expectant and new parents with children up to kindergarten entry age who live in communities that are at risk for poor maternal and child health outcomes
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<a href="#"><u>Infant-Toddler Court Program (ITCP)</u></a>	
<i>Population(s) Served</i>	Families involved in child welfare systems, caregivers of young children with SUD or trauma histories, and mothers and infants from the prenatal period to infant age of 3 years
<i>Purpose</i>	To improve policies and practices, access to services and supports, and equity in outcomes through implementation, scaling, and coordination of infant-toddler court teams
<i>Duration</i>	September 30, 2022–September 29, 2027
<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<a href="#"><u>Transforming Pediatrics for Early Childhood (TPEC)</u></a>	
<i>Population(s) Served</i>	Medicaid/CHIP-eligible and uninsured families with children ages 0–5
<i>Purpose</i>	To expand and sustain the availability of early childhood developmental promotion and preventive services in primary care settings, with a two-generation lens
<i>Duration</i>	September 30, 2022–September 29, 2026 (Cohort 1) September 30, 2023–September 29, 2027 (Cohort 2)
<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices, Equity
<a href="#"><u>National Maternal Mental Health Hotline</u></a>	
<i>Population(s) Served</i>	Pregnant people, new parents, their support networks, and health care providers and social service providers who serve them. The target population for the hotline is between the ages of 15 and 45 and includes Black, White, Indigenous, Hispanic, Asian American, and Pacific Islander individuals, as well as members of the LGBTQI+ community.
<i>Purpose</i>	To provide free, confidential emotional support, resources, and referrals 24/7 to any pregnant and postpartum people facing mental health challenges and their loved ones, via phone call or text messaging in English and Spanish
<i>Duration</i>	Ongoing

The Task Force on Maternal Mental Health’s Report to Congress

<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices, Equity
<a href="#"><u>Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD)</u></a>	
<i>Population(s) Served</i>	Maternity care health providers, mental and behavioral health clinicians, allied health professionals, and care coordinators and navigators
<i>Purpose</i>	To expand health care providers’ capacity to screen, assess, treat, and refer pregnant and postpartum people for maternal mental health conditions and SUD
<i>Duration</i>	September 30, 2023–September 29, 2028
<i>Categories</i>	Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment
<a href="#"><u>Healthy Start Initiative</u></a>	
<i>Population(s) Served</i>	Communities experiencing infant mortality rates at least 1.5 times the U.S. national average or high rates of preterm birth, low birth weight, and maternal illness and death
<i>Purpose</i>	To improve health outcomes before, during, and after pregnancy and reduce racial and ethnic differences in rates of infant death and maternal health outcomes, including maternal behavioral health
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices
<a href="#"><u>Alliance for Innovation on Maternal Health Community Care Initiative (AIM CCI)</u></a>	
<i>Population(s) Served</i>	Populations with high rates of maternal mortality and severe maternal morbidity
<i>Purpose</i>	To address preventable maternal mortality and severe maternal morbidity among pregnant and postpartum women outside of hospital and birthing facility settings through collaborative learning, quality improvement, and innovation at the community level by supporting development and implementation of non-hospital-focused maternal safety bundles
<i>Duration</i>	September 30, 2019–September 29, 2024
<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices, Equity
<a href="#"><u>Supporting Fetal Alcohol Spectrum Disorders Screening and Intervention (SFASDSI)</u></a>	
<i>Population(s) Served</i>	Providers in states, territories, tribes, or communities that have high rates of binge drinking among pregnant women
<i>Purpose</i>	To reduce the incidence of prenatal alcohol exposure and improve developmental outcomes in children with suspected or diagnosed fetal alcohol spectrum disorders
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention

## Indian Health Service (IHS)

<a href="#">Maternal and Child Health’s</a> Maternity Care Coordinator Program	
<i>Population(s) Served</i>	American Indian/Alaska Native (AI/AN) pregnant and postpartum people and their families
<i>Purpose</i>	To develop a coordinated approach to supporting pregnant, postpartum, and/or parenting people and their children in AI/AN communities
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Intervention, Treatment, Equity

## National Institutes of Health (NIH)

<a href="#">Pathways to Prevention (P2P)</a>	
<i>Population(s) Served</i>	Postpartum individuals
<i>Purpose</i>	To make evidence-based improvements in postpartum care by increasing research efforts to: <ul style="list-style-type: none"> <li>• Identify risk factors that contribute to poor postpartum outcomes at multiple levels</li> <li>• Address how the risk for poor postpartum outcomes is affected by social determinants of health</li> <li>• Characterize the impact of risk factors on postpartum morbidity and mortality</li> <li>• Develop approaches to reducing or preventing these risks</li> </ul>
<i>Duration</i>	2022–2023
<i>Categories</i>	Prevention, Screening, Intervention, Treatment, Community-Based and Multigenerational Practices, Equity
Implementing a Maternal Health and PRenancy Outcomes Vision for Everyone ( <a href="#">IMPROVE</a> ) Initiative	
<i>Population(s) Served</i>	Pregnant and postpartum people and other women of reproductive age, especially those who are in populations that experience health disparities
<i>Purpose</i>	To support research to reduce preventable causes of maternal deaths and improve health for women before, during, and after pregnancy
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis
<a href="#">R01MH118249</a> , <a href="#">R01MH118261</a> : Predictors and Course of Postpartum Obsessions and Compulsions	
<i>Population(s) Served</i>	Pregnant and postpartum women
<i>Purpose</i>	To explore factors that may predict which women are at highest risk for obsessive or compulsive thoughts and how these may be related to postpartum anxiety and depression
<i>Duration</i>	May 2023–April 2024
<i>Categories</i>	Screening



The Task Force on Maternal Mental Health’s Report to Congress

<a href="#">R01HD108619</a> : Defining Postpartum PTSD and Its Implications for Maternal Wellness and Child Development	
<i>Population(s) Served</i>	Pregnant and postpartum women
<i>Purpose</i>	To define the course and predictors of maternal childbirth-related post-traumatic stress disorder (PTSD) to improve diagnosis and treatment
<i>Duration</i>	Ongoing
<i>Categories</i>	Diagnosis
<a href="#">R01MH126040</a> : Efficacy of Digital Cognitive Behavioral Therapy for Insomnia for the Prevention of Perinatal Depression	
<i>Population(s) Served</i>	Pregnant and postpartum women
<i>Purpose</i>	To determine whether treating prenatal insomnia with digital cognitive behavioral therapy prevents depression during the perinatal period
<i>Duration</i>	July 2022–April 2027
<i>Categories</i>	Prevention, Intervention
<a href="#">R01HD094801</a> : Computerized Intervention for Reducing Intimate Partner Violence for Perinatal Women Seeking Mental Health Treatment	
<i>Population(s) Served</i>	Perinatal women seeking mental health care
<i>Purpose</i>	To test whether a brief self-efficacy intervention can reduce the incidence of intimate partner violence in pregnant women seeking mental health care
<i>Duration</i>	July 2019–June 2024
<i>Categories</i>	Intervention
<a href="#">R01MD016037</a> : Rosie the Chatbot: Leveraging Automated and Personalized Health Information Communication to Reduce Disparities in Maternal and Child Health	
<i>Population(s) Served</i>	New mothers, especially those from vulnerable populations
<i>Purpose</i>	To develop an automated and personalized health information tool to lower risk of postpartum depression, decrease emergency room visits, and increase attendance of well-baby visits by providing informational support to vulnerable moms across geographic regions
<i>Duration</i>	September 2021–June 2026
<i>Categories</i>	Prevention, Screening, Intervention, Equity
<a href="#">R01HD100395</a> : A Multisite Randomized Controlled Trial of an Internet-Based Program for Preventing and Reducing Perinatal Depressive Symptoms	
<i>Population(s) Served</i>	Pregnant and postpartum women across all geographic regions of the United States
<i>Purpose</i>	To adapt an internet-based self-management program for the prevention of and intervention in perinatal depressive symptoms
<i>Duration</i>	April 2020–March 2025
<i>Categories</i>	Prevention, Intervention, Equity

<a href="#">R01MD016026</a> : Reducing Racial Disparities in Severe Maternal Morbidity Post-COVID-19: Assessing the Integration of Maternal Safety Bundles and Community-Based Doulas to Improve Outcomes for Black Women	
<i>Population(s) Served</i>	Black women
<i>Purpose</i>	To explore the effect of incorporating doula-provided services into prenatal, birth, and postpartum care to reduce disparities in severe maternal morbidity and maternal mortality
<i>Duration</i>	September 2020–June 2025
<i>Categories</i>	Intervention, Community-Based and Multigenerational Practices, Equity
<a href="#">R21DA058407</a> : Community-Based Fetal Ultrasound and Care Navigation: An Approach to Engaging Pregnant Women with Substance Use Disorder in Prenatal Care and Substance Use Treatment	
<i>Population(s) Served</i>	Pregnant women with SUD from populations with health disparities
<i>Purpose</i>	To test a community-informed and -based intervention using a novel ultrasound protocol, motivational and strength-based education, and care coordination strategies
<i>Duration</i>	September 2022–August 2024
<i>Categories</i>	Intervention, Community-Based and Multigenerational Practices, Equity
<a href="#">R01MH121531</a> : A Wearable Morning Light Treatment for Postpartum Depression: Confirming Efficacy and Mechanisms	
<i>Population(s) Served</i>	Individuals with postpartum depression
<i>Purpose</i>	To test the efficacy of wearable bright light therapy for postpartum depression and lay the foundation for integration of morning bright light therapy into standard care for postpartum depression
<i>Duration</i>	February 2021–January 2025
<i>Categories</i>	Intervention, Treatment
<a href="#">R01MD017622</a> : Preventing Postpartum Depression Among Immigrant Latinas Through a Virtual Group Intervention	
<i>Population(s) Served</i>	Pregnant Latinx individuals and Latinx new mothers at risk for postpartum depression based on elevated depressive symptoms and/or other established risk factors enrolled in early childhood programs across Maryland and their children
<i>Purpose</i>	To test whether an evidence-based preventive intervention for postpartum depression, adapted for delivery via a virtual modality and for immigrant Latinas, will prevent postpartum depression and improve parenting practices
<i>Duration</i>	September 2022–April 2027
<i>Categories</i>	Intervention, Community-Based and Multigenerational Practices, Equity
<a href="#">R21MD017396</a> : A Randomized Controlled Trial of a Culturally Relevant Maternal Wellness App to Improve Black Maternal Mental Health Outcomes	
<i>Population(s) Served</i>	Black women in the perinatal period



## The Task Force on Maternal Mental Health's Report to Congress

<i>Purpose</i>	To determine the effectiveness of a culturally relevant mobile health intervention providing guidance for the clinical care of Black women during the perinatal period, with the goal of improving mental health and physical health outcomes, and to examine the relationship between the effects of the intervention on perinatal mood and anxiety disorders and inflammatory signatures
<i>Duration</i>	September 2022–May 2024
<i>Categories</i>	Prevention, Intervention, Equity
<a href="#"><u>Rapid Acceleration of Diagnostics Technology (RADx Tech) for Maternal Health Challenge</u></a>	
<i>Population(s) Served</i>	Pregnant and postpartum individuals
<i>Purpose</i>	To accelerate the development of home-based and point-of-care maternal health diagnostic devices, wearables, and other remote sensing technologies
<i>Duration</i>	Ongoing
<i>Categories</i>	Diagnosis, Intervention, Equity

### Office of the Assistance Secretary for Health (OASH), Office on Women's Health (OWH)

Violence Against Women and Substance Use Prevention Initiative (AST-WH-004)	
<i>Population(s) Served</i>	Pregnant women at risk of IPV and SUD
<i>Purpose</i>	To address the intersection of IPV and SUD during the pregnancy and postpartum period
<i>Duration</i>	Ongoing
<i>Categories</i>	Screening, Diagnosis, Community-based and multigenerational practices
State, Local, Tribal, and Territorial (SLTT) Partnership Programs to Reduce Maternal Deaths Due to Violence (WH-AST-21-003)	
<i>Population(s) Served</i>	Pregnant and postpartum women
<i>Purpose</i>	To establish SLTT partnership projects that bring together maternal health and mortality stakeholders with those working to prevent violence against women to identify and reduce deaths among pregnant and postpartum women due to violence
<i>Duration</i>	September, 2021–September 2025
<i>Categories</i>	Screening, Intervention, treatment

### Substance Abuse and Mental Health Services Administration (SAMHSA)

<a href="#"><u>Services Program for Residential Treatment for Pregnant and Postpartum Women and State Pilot Grant Program for Treatment for Pregnant and Postpartum Women</u></a>	
<i>Population(s) Served</i>	Pregnant and postpartum people experiencing SUD and/or mental illness nationwide
<i>Purpose</i>	To support the treatment of SUD and mental health among pregnant and postpartum women by funding family-based services and helping state agencies that provide a continuum of care, including preventive services
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Intervention, Community-Based and Multigenerational Practices, Treatment

## U.S. Department of Veterans Affairs (VA)

<a href="#">VA/DOD Clinical Practice Guidelines: Management of Pregnancy (2023)</a>	
<i>Population(s) Served</i>	Pregnant and postpartum people served by the VA and U.S. Department of Defense (DOD) health systems and the clinicians who serve them
<i>Purpose</i>	To provide evidence-based responses to key clinical questions about the management of pregnancy based on an 18-month structured review of clinical and epidemiological evidence
<i>Duration</i>	Clinical practice guidelines and patient-facing pregnancy guide and handout on postpartum depression finalized and available online
<i>Categories</i>	Prevention, Screening, Treatment
Maternity Care Coordination Expansion to the Full 12-Month Postpartum Period	
<i>Population(s) Served</i>	Pregnant and postpartum veterans
<i>Purpose</i>	To expand maternity care coordination and patient navigation services, including regular screening and connection to resources, beyond pregnancy through 12 months postpartum
<i>Duration</i>	Ongoing
<i>Categories</i>	Screening, Intervention, Treatment, Equity
<a href="#">Reproductive Mental Health Consultation Program</a>	
<i>Population(s) Served</i>	Veterans Health Administration (VHA) clinicians providing pregnancy planning and perinatal and postpartum care to veterans
<i>Purpose</i>	To provide evidence-based responses from a national team of reproductive mental health experts to VA clinicians with questions about pharmacological and nonpharmacological mental health care related to women's reproductive cycle stages and gynecological conditions, including consultation about contraception and mental health, preconception planning, pregnancy, infertility, the postpartum period, and pregnancy loss
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
Patient-Facing Health Campaigns for Perinatal Mood Disorders	
<i>Population(s) Served</i>	Pregnant and postpartum people using VHA health care facilities and following VHA patient-facing social media
<i>Purpose</i>	To increase awareness of pregnancy and postpartum depression, as well as VHA-provided supports
<i>Duration</i>	Campaign completed in May 2023
<i>Categories</i>	Diagnosis
Office of Mental Health and Suicide Prevention's Reproductive Mental Health Training Course	
<i>Population(s) Served</i>	VA clinicians
<i>Purpose</i>	To deepen VA clinicians' understanding of reproductive mental health, including perinatal mental health considerations, in a 12-part training series
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity

The Task Force on Maternal Mental Health's Report to Congress

<b>Interpersonal Therapy for Reproductive Mental Health</b>	
<i>Population(s) Served</i>	VA psychotherapists serving veterans with reproductive mental health concerns
<i>Purpose</i>	To provide VA psychotherapists with training in adapting interpersonal therapy for use with veterans experiencing mental health challenges related to reproductive concerns, such as pregnancy, the postpartum period, infertility, and pregnancy loss
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<b>VA/DOD Annual Women's Mental Health Mini-Residency</b>	
<i>Population(s) Served</i>	VA and DOD mental health providers
<i>Purpose</i>	To equip VA and DOD mental health providers with the clinical knowledge and skills needed to provide gender-sensitive and foundational mental health services to women veterans and service members. All participants develop and implement action plans locally that are designed to disseminate women's mental health practices at the facility level.
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<b>Women's Mental Health Champions Network</b>	
<i>Population(s) Served</i>	Women veterans with mental health and/or substance use concerns
<i>Purpose</i>	To create a collateral position that ensures at least one point of contact for women's mental health within each VA medical center who works to support the expansion and visibility of women's mental health resources at the local facility
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity
<b>Women's Mental Health Monthly Teleconference Series</b>	
<i>Population(s) Served</i>	VHA staff members
<i>Purpose</i>	To provide web-based information and training to VHA staff members about issues specific to women's mental health, including maternal mental health topics such as maternal morbidity, VA's PREPARE program (a multidisciplinary perinatal program identified as a promising emerging practice and funded for pilot dissemination by VHA's Office of Diffusion of Excellence), perinatal loss, mental health effects of abortion and abortion restriction, and equity and inclusion in perinatal mental health
<i>Duration</i>	Ongoing
<i>Categories</i>	Prevention, Screening, Diagnosis, Intervention, Community-Based and Multigenerational Practices, Treatment, Equity

## PROGRAM PRACTICES

### Prevention

Federal programs involve numerous practices to improve maternal mental health and substance use and reduce associated mortality (e.g., from suicide and drug overdose). These activities include providing educational content and training, increasing access to preventive services, and supporting studies to design prevention programs.

<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
<b>Substance Use Disorders</b>	
SAMHSA’s Services Grant Program for Residential Treatment for Pregnant and Postpartum Women (PPW)	<p>Evidence-based practice:</p> <ul style="list-style-type: none"> <li>• Nurturing parenting to build nurturing parenting skills</li> </ul>
CMS’s MOM Model	<p>Aims to:</p> <ul style="list-style-type: none"> <li>• Improve the quality of care and reduce costs for pregnant and postpartum women with OUD and their infants</li> <li>• Expand access, service delivery capacity, and infrastructure based on state-specific needs</li> <li>• Create sustainable coverage and payment strategies that support ongoing coordination and integration of care</li> </ul>
CDC OD2A	<p>Evidence-based practice:</p> <ul style="list-style-type: none"> <li>• Ensuring people who use drugs have access to overdose prevention and reversal tools, treatment options, and drug-checking equipment</li> </ul> <p>Promising practice:</p> <ul style="list-style-type: none"> <li>• Revising data dashboards and naloxone distribution to improve outreach, education, and distribution of naloxone in underserved rural communities</li> </ul>
HRSA’s RCORP-NAS	<p>Promising practice:</p> <ul style="list-style-type: none"> <li>• All grantees address community risk factors and social determinants of health (SDOH) in SUD</li> </ul> <p>Other practice:</p> <ul style="list-style-type: none"> <li>• Grantee-selected prevention strategies within selected focus areas of (1) improving integrated care and care coordination, (2) criminal justice, (3) increasing recovery capital, (4) improving access to care via telehealth, (5) improving access to care with transportation, (6) improving the provider workforce, and (7) establishing and/or enhancing family support services</li> </ul>

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s SFASDSI	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Telehealth approaches (e.g., tele-consultation, tele-mentoring, and Project ECHO) that improve the ability of primary care physicians serving pregnant women to screen their patient population for alcohol use, provide brief intervention, and refer high-risk pregnant women to specialty care</li> </ul>
<b>Suicide</b>	
CDC’s CSP & Suicide Prevention Resource for Action	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Funding to implement and evaluate a comprehensive public health approach to suicide prevention, with a special focus on populations disproportionately affected by suicide. Recipients advance strategies based on the best available evidence for suicide prevention, as detailed in the Suicide Prevention Resource for Action.</li> </ul>
<b>Risk Factors for Mental Health and Substance Use</b>	
ACF’s YUP!	<p>Promising practice:</p> <ul style="list-style-type: none"> <li>• An 8-week program that provides medically accurate information on sexual health and birth control, healthy relationships, self-care, goal achievement, pregnancy, birth, and parenting through self-guided educational videos, written content, and other resources (including a tool to set and track short-term goals)</li> </ul>
CDC’s PS18-1802	<p>Evidence-based practice:</p> <ul style="list-style-type: none"> <li>• Promotion of routine perinatal HIV testing of all pregnant women per CDC recommendations</li> <li>• Support for health departments in conducting case surveillance activities for women diagnosed with HIV and their infants</li> </ul>
ACF’s SOAR	<p>Promising practice:</p> <ul style="list-style-type: none"> <li>• Training professionals, organizations, and communities to identify and respond to those at risk of human trafficking, those experiencing human trafficking, and those who have experienced it and connecting them with the resources they need, including maternal mental health resources</li> </ul>
HRSA’s QIF-MH	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Use of integrated care models including behavioral health providers to deliver ongoing coordinated behavioral and maternal health services</li> </ul> <p>Promising practices:</p> <ul style="list-style-type: none"> <li>• Use of grant funding to hire new staff members— including enrollment specialists, community health workers, and doulas—to increase access to services</li> </ul>

<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
HRSA’s MIECHV	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Needs assessments to identify and prioritize populations and select home visiting service delivery models to best meet state and local needs</li> <li>• Home visiting that helps to address social and community factors</li> </ul>
HRSA’s AIM CCI	<p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• The Racial Equity Learning Series (RELS) to address the impact of racism on maternal health</li> <li>• Webinar on the intersection of mental health and maternal health</li> </ul>
VA’s Reproductive Mental Health Consultation Program	<p>Evidence-based practice:</p> <ul style="list-style-type: none"> <li>• Provides expert consultation for preconception planning, including evidence-based interventions for preventing maternal behavioral health conditions for individuals at high risk. Part of what places people at high risk are health disparities, which are explicitly addressed when relevant as part of the consultations.</li> </ul>
HRSA’s ITCP	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Expanding and increasing access to prevention services, such as promotion of positive parenting strategies and family strengths and protective factors (e.g., parental resilience, social connections, and concrete supports)</li> <li>• Application of data to advance systems change and policies to support families with young children</li> <li>• Dissemination of best practices for the improvement of behavioral health for families with young children</li> <li>• Implementation of activities ranging from primary to tertiary prevention</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Training and technical assistance on perinatal mental health topics for government officials and practitioners, including child welfare and dependency court professionals</li> </ul>
HRSA’s TPEC	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Expansion of promotion and prevention services that include positive parenting strategies, parent–child interactions, healthy relationships, and family strengths and protective factors (e.g., parental resilience, social connections, and concrete supports)</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Increasing connections of pediatric providers and patients to universal early childhood development–promoting community resources (e.g., libraries, parent support groups, and high-quality child care)</li> </ul>

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s National Maternal Mental Health Hotline	Evidence-based practices: <ul style="list-style-type: none"> <li>• Maternal and child health professionals providing real-time emotional support and resources for perinatal mental health needs related to pregnancy, the postpartum period, and perinatal loss</li> </ul>
HRSA’s Healthy Start	Evidence-based practices: <ul style="list-style-type: none"> <li>• Case management and care coordination models, curricula, and screening tools to provide: <ul style="list-style-type: none"> <li>○ Prenatal and postpartum care, screening, and referral to services for depression and interpersonal violence</li> <li>○ Outreach and case management to link parents with social services and educational programming, such as parental skill building</li> <li>○ Public health services such as immunizations and health education</li> <li>○ Continuing education and training on best practices for Healthy Start staff members and community partners</li> </ul> </li> </ul>
<b>Workforce Training</b>	
CDC’s Suicide Prevention Resource for Action	Evidence-based practices: <ul style="list-style-type: none"> <li>• Lists policies, programs, and practices that improve access and delivery of suicide care (e.g., <a href="#">Zero Suicide</a>) and improve provider education in <a href="#">applied suicide intervention skills training</a>, <a href="#">counseling on access to lethal means</a>, and <a href="#">safety assessment and follow-up evaluation within emergency departments</a></li> </ul>
HRSA’s Behavioral Health and Substance Use Disorder Primary Care Integration Services Technical Assistance	Evidence-based practices: <ul style="list-style-type: none"> <li>• Provides technical assistance (TA) addressing topic areas related to SUD and mental health—including maternal mental health—such as a webinar on NURTURE, an innovative practice-based care model that integrates OB-GYN, pediatric, and behavioral health services to provide comprehensive care for both the new parent and the baby throughout and after pregnancy</li> <li>• Provides individual coaching and a TA site visit if requested</li> </ul>
VA/DOD Clinical Practice Guidelines: Management of Pregnancy (2023)	Evidence-based practices: <ul style="list-style-type: none"> <li>• Used an evidence review of literature regarding screening and use of interpersonal psychotherapy and cognitive behavioral therapy for pregnant and postpartum individuals at risk of depression</li> </ul>
VA’s Reproductive Mental Health Training Course	Evidence-based practices: <ul style="list-style-type: none"> <li>• Course modules with evidence-based preventive interventions, with an explanation of the contribution of health disparities when relevant</li> </ul>

The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
VA’s Interpersonal Therapy for Reproductive Mental Health	Evidence-based practices: <ul style="list-style-type: none"> <li>• Trains VA psychotherapists in interpersonal therapy, which is strongly recommended for prevention of perinatal depression by the U.S. Preventive Services Task Force, as well as the VA/DOD clinical practice guideline for the management of pregnancy</li> </ul>
VA/DOD’s Annual Women’s Mental Health Mini-Residency	Evidence-based practices: <ul style="list-style-type: none"> <li>• Identification of individuals at high risk for perinatal behavioral health conditions and evidence-based preventive interventions</li> </ul>
VA’s Women’s Mental Health Champions (WMHC) Network	Evidence-based practices: <ul style="list-style-type: none"> <li>• WMHCs serving as local points of contact to support the expansion and visibility of women’s mental health resources</li> </ul>
VA’s Women’s Mental Health Monthly Teleconference Series	Evidence-based practices: <ul style="list-style-type: none"> <li>• Teleconference training that includes topics related to evidence-based prevention of maternal mental health conditions</li> </ul>
<b>Research</b>	
CDC’s MAT-LINK	Research activities: <ul style="list-style-type: none"> <li>• Analyses to identify the rate of overdose per 1,000 pregnancies in the current cohort of pregnancies complicated by opioid use disorder and to conduct time-to-event modeling for overdose during pregnancy and postpartum using modeling that controls for demographic variables to identify potential health disparities in overdose rates. These data can be used to inform clinical practice for early intervention and prevention of overdose morbidity and mortality.</li> <li>• Future analyses examining child welfare, utilization of services, and understanding pathways to care</li> </ul>
NIH R01MH126580	Research activities: <ul style="list-style-type: none"> <li>• Assessing differences in depression, anxiety, stress, and sleep between Latina and Black pregnant women utilizing a mindfulness intervention and those in a control program</li> </ul>
NIH R01MH126040	Research activities: <ul style="list-style-type: none"> <li>• Evaluating the efficacy of digital cognitive behavioral therapy for the prevention of depression during pregnancy and through 12 months postpartum</li> </ul>
NIH R01HD094801	Research activities: <ul style="list-style-type: none"> <li>• Testing whether a brief self-efficacy intervention can reduce the incidence of intimate partner violence in pregnant women seeking mental health care</li> </ul>



<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
NIH R01DA050636	Research activities: <ul style="list-style-type: none"> <li>Identifying characteristics that may confer increased risk for opioid relapse through the comparison of psychosocial and parenting stress in pregnant women receiving medications for the treatment of opioid use disorder (MOUD) and demographically matched pregnant women not receiving MOUD</li> </ul>

## Screening

Screening is an essential step in the continuum of care for mental health conditions, including SUDs. Screening—which can be integrated into practice routines, performed by a variety of service providers in multiple settings, and performed using evidence-based tools (e.g., surveys and questionnaires)—identifies individuals who are at risk for or have mental health conditions. Key aspects of screening include providers being trained and reimbursed for this service, patients receiving education and support, linkage to the next step in care, and the availability of practitioners who can diagnose the condition and intervene appropriately.

<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
<b>Incorporating Screening into Services for Individuals and Families</b>	
SAMHSA’s PPW Programs	Evidence-based practices: <ul style="list-style-type: none"> <li><a href="#">Screening, brief intervention, and referral to treatment (SBIRT)</a></li> <li>The <a href="#">Alcohol Use Disorders Identification Test-Concise (AUDIT-C)</a></li> <li>The National Institute on Drug Abuse’s (NIDA) <a href="#">single-question screening test for illegal drug use</a></li> <li>NIDA’s <a href="#">Drug Abuse Screening Test (DAST-10)</a></li> <li>The <a href="#">Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)</a></li> <li>The <a href="#">Edinburgh Postnatal Depression Scale (EPDS)</a></li> </ul>
OWH’s AST-WH-004	Evidence-based practices <ul style="list-style-type: none"> <li>Cross-sectional training for IPV and SUD providers to improve recognition of IPV and SUD in pregnant women</li> </ul>
OWH’s WH-AST-21-003	Evidence-based practices: <ul style="list-style-type: none"> <li>Establish or expand programs that review, identify, and track maternal deaths due to violence, such as homicide, suicide, and intimate partner violence</li> </ul>
CMS’s MOM Model	Evidence-based practices: <ul style="list-style-type: none"> <li><a href="#">SBIRT</a></li> <li>Adverse childhood experiences (ACEs) assessment</li> </ul>
VA/DOD Clinical Practice Guidelines: Management of Pregnancy (2023)	Evidence-based practices: <ul style="list-style-type: none"> <li>Incorporates results of an evidence review of screening for depression and PTSD in pregnancy and the postpartum period</li> </ul>

The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
VA’s Women’s Mental Health Champions (WMHC) Network	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• WMHCs partner with other local stakeholders at their facilities, such as maternity care coordinators and women veterans program managers. These partnerships can facilitate referral of those who screen positive for maternal mental health conditions to evidence-based care.</li> </ul>
HRSA’s QIF-MH	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• SBIRT screenings during prenatal and postpartum visits to identify SUDs and risky substance use behaviors</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Development of a trauma-informed care assessment to screen for behavioral health conditions</li> </ul>
HRSA’s RCORP-NAS	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Implementation of coordinated, evidence-based, trauma-informed, family-centered SUD services and other services (screening occurs within these systems)</li> </ul>
HRSA’s MIECHV	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Maternal depression screening and referral</li> <li>• Performance outcomes related to maternal depression screening and referral</li> <li>• Screening and referrals for tobacco cessation and substance use</li> </ul>
HRSA’s ITCP	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Facilitation of referrals to screening and use of screening instruments upon entry into the program (e.g., Patient Health Questionnaire-9 [PHQ-9] and EPDS)</li> <li>• Provision of technical assistance and capacity building for behavioral health screening to service providers</li> </ul>
HRSA’s TPEC	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Expansion of screening and surveillance services, in alignment with <a href="#">Bright Futures</a> guidelines, that capture a holistic review of child and family functioning, such as parental mental health and substance use, family violence and trauma history (e.g., ACEs), family strengths and early relational health, and social determinants of health</li> </ul>
HRSA’s National Maternal Mental Health Hotline	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Providing active listening and a risk assessment related to safety/need for a higher level of care</li> </ul>
HRSA’s Healthy Start	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Depression screening using a variety of screening tools (e.g., PHQ-2 and PHQ-9 embedded in participant intake forms)</li> </ul>

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s AIM CCI	<p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Providing the Community Care for Maternal Mental Health &amp; Wellness bundle to ensure that all pregnant and postpartum people receive the care and support needed in response to perinatal stress, trauma, anxiety, and depression</li> <li>• Providing the “Mental Health and Wellbeing for Mothers” learning module for professionals to provide information on how stress and depression affect health, especially during the time of pregnancy and the postpartum period</li> </ul>
<b>Workforce Training</b>	
HRSA’s PCTE-CPMH	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Bolsters skills in screening procedures for postpartum depression and SUD identification, treatment, and referral</li> <li>• Trains primary care physicians in clinical services for maternal health and population health in order to improve maternal health outcomes</li> </ul> <p>Other practices:</p> <ul style="list-style-type: none"> <li>• Includes screening for SUD in telehealth activities for prenatal care</li> </ul>
HRSA’s MMHSUD	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Supports training on evidence-based screening practices such as SBIRT, medication-assisted treatment, and use of standardized validated screening tools for perinatal depression and anxiety</li> </ul>
HRSA’s SFASDSI	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Training and skill building for primary care physicians to assist with the identification, management, and treatment of pregnant patients using alcohol, including training modules on fetal alcohol spectrum disorders (FASDs), stigma and bias, SBIRT, screening for alcohol use, documentation and legal issues, and polysubstance use in pregnancy</li> </ul>
CDC’s Improving Ob-Gyns’ Ability to Support COVID-19 Vaccination, Mental Health, and Social Services	<p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Supported the Lifeline for Moms program in developing the <a href="#">Guide for Integrating Mental Health Care into Obstetric Practice</a></li> <li>• Conducting two 90-minute webinars on culturally informed approaches to perinatal mental health care</li> </ul> <p>Other practices:</p> <ul style="list-style-type: none"> <li>• Supporting promotion and dissemination of resources, including the <a href="#">Addressing Maternal Mental Health Conditions in Obstetric Settings</a> e-module, the <a href="#">Perinatal Mental Health Tool Kit</a>, and the <a href="#">Guide for Integrating Mental Health Care into Obstetric Practice</a></li> </ul>

The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
VA’s Reproductive Mental Health Consultation Program	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Describing validated screening tools and providing these tools as needed</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Screening tools and practices for conditions for which validated tools are not available for perinatal use</li> </ul>
VA’s Reproductive Mental Health Training Course	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Having course modules with evidence-based screening tools</li> </ul>
VA/DOD’s Annual Women’s Mental Health Mini-Residency	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Sessions with information on how and when to screen and offering screenings tools</li> </ul>
VA’s Women’s Mental Health Monthly Teleconference Series	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Discussing validated screening tools and innovative, effective systems for integrating screening into systems of care</li> </ul>
<b>Research</b>	
CDC MAT-LINK	<p>Research activities:</p> <ul style="list-style-type: none"> <li>• Collection of data on maternal mental health screenings for anxiety, stress, depression, and other psychiatric conditions, as well as data on receipt of services</li> <li>• Collection of data on risk factors that may exacerbate mental health conditions, such as maternal history of homelessness, interpersonal violence, sexual abuse, and substance use at the individual, partner, and family levels</li> <li>• Collection of data on childhood developmental concerns through age 6, including information on referrals to services, developmental screening results, and childhood mental or developmental disorder diagnoses</li> </ul>
NIH R01MH118249 & R01MH118261	<p>Research activities:</p> <ul style="list-style-type: none"> <li>• Exploring factors that may predict which women are at highest risk for obsessive or compulsive thoughts and how these may be related to postpartum anxiety and depression</li> </ul>
NIH IMPROVE Centers of Excellence	<p>Research activities:</p> <ul style="list-style-type: none"> <li>• Addressing maternal mental health and maternal morbidity and mortality through an integrated multilevel approach encompassing structural, social, and biobehavioral research strategies related to significant contributing factors to maternal mental health conditions</li> </ul>

<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
<b>Policies</b>	
CMS's Allowing Pediatricians to Bill for Maternal Postpartum Depression Screening	Evidence-based practices/activities: <ul style="list-style-type: none"> <li>• Enables state Medicaid agencies to cover maternal depression screening as part of well-child visits</li> <li>• Requires states to cover any medically necessary treatment for children as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit</li> </ul>
CMS's MIPS Value Pathway Focusing on Women's Health	Evidence-based practice: <ul style="list-style-type: none"> <li>• Postpartum follow-up and care coordination to screen and diagnose postpartum depression</li> </ul>
VA's Maternity Care Coordination Expansion to the Full 12-Month Postpartum Period	Evidence-based practices: <ul style="list-style-type: none"> <li>• EPDS for depression screening</li> <li>• Evidence-based screenings for PTSD and relationship health and safety across all veterans using VHA benefits via telemedicine</li> </ul>

## Diagnosis

Accurate diagnoses are crucial to ensuring that patients receive the appropriate subsequent care and support. Diagnostic activities are intended to detect and diagnose mental health conditions among mothers and pregnant people. The federal program review found that very few federal programs outside of the VA contain activities that support the diagnosis of maternal mental health conditions. CMS's MOM Model and SAMHSA's PPW programs use the EPDS, which is an efficient way of identifying patients at risk for perinatal depression (i.e., a screening tool). However, providers cannot use it to diagnose postpartum depression or anxiety. Similarly, these programs screen for substance use but rely on referral to another provider for diagnosis.

<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
<b>Research</b>	
NIH R01HD108619	Research activities: <ul style="list-style-type: none"> <li>• Defining the course and predictors of maternal childbirth-related PTSD to improve diagnosis and treatment</li> </ul>
NIH's RADx Tech	Research activities: <ul style="list-style-type: none"> <li>• Development of home-based and point-of-care maternal health diagnostic devices, wearables, and other remote sensing technologies</li> </ul>
CDC's MAT-LINK	Research activities: <ul style="list-style-type: none"> <li>• Analyses to calculate sensitivity, specificity, positive predictive value, and negative predictive value of International Classification of Diseases (ICD) codes for overdose compared with abstracted medical record data, as well as analyses to estimate the prevalence of PTSD among pregnant people in the cohort</li> </ul>

<b>Program</b>	<b>Practices/Activities</b>
<b>Improving/Facilitating Diagnoses</b>	
VA’s Maternity Care Coordination Expansion to the Full 12-Month Postpartum Period	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>Referring positive screens for PTSD and depression, including warm handoff if needed, to appropriate clinicians within VHA for diagnosis and treatment</li> </ul>
VA’s Patient-Facing Health Campaigns for Perinatal Mood Disorders	<p>Other practices:</p> <ul style="list-style-type: none"> <li>Raising patient awareness of pregnancy and postpartum depression and available supports, facilitating diagnoses</li> </ul>
VA’s Women’s Mental Health Champions (WMHC) Network	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>As local points of contact, WMHCs spreading awareness of the Reproductive Mental Health Consultation Program and the Reproductive Mental Health training course to support clinicians’ ability to diagnose maternal behavioral health conditions</li> </ul>
HRSA’s QIF-MH	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>Depression screenings such as the EPDS, <a href="#">PHQ-2</a>, and <a href="#">PHQ-9</a> administered during pregnancy</li> </ul> <p>Promising practices:</p> <ul style="list-style-type: none"> <li>Increased frequency of administration of depression screenings during the prenatal and postpartum periods</li> </ul>
HRSA’s RCORP-NAS	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>Implementation of evidence-based services to strengthen the quality and sustainability of behavioral health care services for rural pregnant and postpartum people, which will aid in the diagnosis of maternal behavioral health conditions</li> </ul>
<b>Workforce Training</b>	
OWH’s AST-WH-004	<p>Evidence-based practice:</p> <ul style="list-style-type: none"> <li>Cross-sectional training for IPV and SUD providers to improve rates of screening and referral for pregnant women</li> </ul>
VA’s Reproductive Mental Health Consultation Program	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>Having a team that can help with differential diagnoses for presenting symptoms and give suggestions for how to come to definitive diagnoses</li> </ul>
VA’s Reproductive Mental Health Training Course	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>Having course modules with detailed descriptions of relevant perinatal mental health diagnoses</li> </ul>
VA’s Interpersonal Therapy for Reproductive Mental Health	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>Teaching about the interpersonal formulation and thus fostering rigorous diagnosis of maternal behavioral health conditions</li> </ul>

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
VA/DOD’s Annual Women’s Mental Health Mini-Residency	Evidence-based practices: <ul style="list-style-type: none"> <li>Sessions with opportunities to practice differential diagnosis and recognition of maternal behavioral health conditions through case-based discussion, role-playing, and other interactive exercises</li> </ul>
VA’s Women’s Mental Health Monthly Teleconference Series	Evidence-based practices: <ul style="list-style-type: none"> <li>Discussing a variety of maternal behavioral health diagnoses</li> </ul>
HRSA’s MMHSUD	Evidence-based practices: <ul style="list-style-type: none"> <li>Establishing, improving, and/or maintaining state-based projects that expand health care providers’ capacity to screen, assess, treat, and refer pregnant and postpartum people for maternal mental health conditions and related behavioral disorders</li> </ul>
HRSA’s SFASDSI	Evidence-based practices: <ul style="list-style-type: none"> <li>Training and skill building for primary care physicians to assist with the identification, management, and treatment of pregnant patients using alcohol, including training modules on FASDs, stigma and bias, SBIRT, screening for alcohol use, documentation and legal issues, and polysubstance use in pregnancy</li> </ul>

**Spotlight on Workforce Expansion: Offering Recruitment and Retention Incentives Through Student Loan Repayment from the National Health Service Corps (NHSC)**

HRSA’s [NHSC Loan Repayment Program](#) aims to recruit and retain medical, nursing, dental, and mental health clinicians in communities designated as health professional shortage areas (HPSAs). This ongoing program also supports the deployment of maternity care professionals in maternity care target areas within designated primary care HPSAs. As of September 30, 2023, NHSC had supported 619 maternity care professionals serving in underserved communities. In its Substance Use Disorder Workforce Loan Repayment Program and its Rural Community Loan Repayment Program, NHSC supported 49 maternity care professionals who promoted the integration of behavioral health and primary care.

## Intervention

Effective mental health interventions—which generally take place at community-based organizations—can help people reduce or stop substance use and can help reduce or stop the symptoms of mental health conditions. When individuals receive appropriate interventions, they learn to manage their conditions, overcome challenges, and lead productive lives. It is important for interventions to be tailored to the individual needs of clients—including those who are pregnant, postpartum, and/or parenting—and tailored to be culturally relevant. Evidence-based interventions for mental health conditions are available, but their use could be expanded.

<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
<b>Interventions for Individuals and Families</b>	
ACF’s YUP!	<p>Promising practices:</p> <ul style="list-style-type: none"> <li>• Incorporation of self-care addressing physical health and nutrition, coping with mental health and stress, reducing substance misuse, and stigma that young parents often face</li> <li>• Providing information on and help with accessing national resources available to support young parents and their children (e.g., health care and insurance, contraception, STI testing, mental health, food assistance, housing, child care, education, jobs and careers, and aid for legal needs)</li> <li>• Providing near-peer mentors who offer participants referrals and share their experiences</li> </ul>
CMS’s MOM Model	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Assessment of health-related social needs</li> <li>• Protocol for Responding to &amp; Assessing Patients’ Assets, Risks &amp; Experiences (PRAPARE)</li> <li>• Funding to states to support the development of necessary infrastructure and capacity to provide ongoing coordination and integration of care, including care delivery</li> </ul>
CMS’s MIPS Value Pathway Focusing on Women’s Health	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Postpartum depression screening and referral to a licensed behavioral health clinician to continue care</li> <li>• Specific metrics to assess clinicians’ capacity to close the referral loop</li> </ul>
HRSA’s QIF-MH	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Use of integrated care teams that include on-site behavioral health providers with workflows that enable same-day interventions for patients with positive behavioral health screens</li> </ul> <p>Promising practices:</p> <ul style="list-style-type: none"> <li>• Behavioral health apps for patients that provide access to resources and connection with providers</li> </ul>
HRSA’s RCORP-NAS	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Reduction of structural and systems-level barriers to increase access to behavioral health care</li> </ul>
HRSA’s MIECHV	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Home visitors screening for maternal behavioral health conditions and providing referrals and coordination to community resources and supports</li> </ul>



<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s ITCP	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Ongoing case management and referrals to behavioral health care, including mental health, substance use, and trauma treatment services for families involved in the program or who may be at risk for involvement in the child welfare system</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Trauma assessments and remediation of courtroom settings and judicial processes</li> </ul>
HRSA’s National Maternal Mental Health Hotline	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Provision of culturally appropriate and trauma-informed real-time emotional support, resources, and referrals for perinatal mental health needs related to pregnancy, the postpartum period, and perinatal loss</li> </ul>
HRSA’s Healthy Start	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Group counseling</li> <li>• One-on-one counseling</li> <li>• Behavioral health screening and referrals</li> <li>• Distribution of educational materials related to behavioral health topics</li> </ul>
HRSA’s AIM CCI	<p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Having a bundle, called Community Care for Postpartum Safety and Wellness, that provides steps to create a system of care for birthing people from the time they give birth through the first year postpartum, including establishing a stage-based emergency response protocol for birthing people presenting with medical, mental, or behavioral health symptoms or life-threatening conditions for acuity using a tiered response grounded in patient dignity</li> </ul>
HRSA’s SFASDSI	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Training and skill building for primary care physicians to assist with the identification, management, and treatment of pregnant patients using alcohol, including training modules on FASDs, stigma and bias, SBIRT, screening for alcohol use, documentation and legal issues; and polysubstance use in pregnancy</li> </ul>
SAMHSA’s PPW Programs	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• On-the-spot referral to behavioral health care through SBIRT</li> <li>• <a href="#">Nurturing Parenting Programs</a></li> <li>• The <a href="#">Celebrating Families! program</a></li> <li>• The TAMAR (which stands for “trauma, addictions, mental health, and recovery”) intervention, which helps people manage the symptoms of trauma in a positive way</li> </ul>

The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s Rural Health Care Services Outreach Program grantee Healthy Acadia’s PROSPER Initiative	Evidence-based practices: <ul style="list-style-type: none"> <li>• Medication-assisted treatment</li> </ul>
CDC’s Suicide Prevention Resource for Action	Evidence-based practices: <ul style="list-style-type: none"> <li>• Perinatal education and training programs to increase coping skills and problem-solving abilities and help reduce maternal depression and perinatal mood and anxiety disorders</li> </ul>
VA’s Maternity Care Coordination Expansion to the Full 12-Month Postpartum Period	Evidence-based practices: <ul style="list-style-type: none"> <li>• Referring positive screens for PTSD and depression, including warm handoff if needed, to appropriate clinicians within VHA</li> </ul>
VA’s Women’s Mental Health Champions (WMHC) Network	Evidence-based practices: <ul style="list-style-type: none"> <li>• Having quarterly calls as part of a national community of practice, with WMHCs remaining up to date about evidence-based maternal behavioral health interventions and disseminating information locally about relevant resources</li> </ul>
<b>Workforce Training</b>	
HRSA’s PCTE-CPMH	Evidence-based practices: <ul style="list-style-type: none"> <li>• Prescribing practices for medications for opioid use disorder (MOUD) postpartum</li> <li>• Early detection of SUD</li> <li>• Interconception care that reaches out to at-risk women to promote healthy pregnancy and delivery</li> </ul>
HRSA’s Behavioral Health and Substance Use Disorder Primary Care Integration Services Technical Assistance	Evidence-based practices: <ul style="list-style-type: none"> <li>• Integration of mental health services into primary care at HRSA-supported health centers, including those that address maternal mental health</li> </ul>
HRSA’s TPEC	Evidence-based practices: <ul style="list-style-type: none"> <li>• Provision of timely service referrals, care coordination, and targeted intervention when needs are identified via screening and surveillance</li> </ul> Evidence-informed practices: <ul style="list-style-type: none"> <li>• Technical assistance to improve care coordination and linkage to specialized assessment and intervention based on screening and surveillance results</li> </ul>

The Task Force on Maternal Mental Health's Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA's MMHSUD	Evidence-based practices: <ul style="list-style-type: none"> <li>• Real-time psychiatric consultation, care coordination, support services, and culturally and linguistically appropriate training to maternity care providers and clinical practices</li> </ul>
OWH's WH-AST-21-003	Evidence-based practices: <ul style="list-style-type: none"> <li>• SLTT partnership projects that bring together maternal health and mortality stakeholders with those working to prevent violence against women to identify and reduce deaths among pregnant and postpartum women</li> </ul>
VA's Reproductive Mental Health Consultation Program	Evidence-based practices: <ul style="list-style-type: none"> <li>• Explaining evidence-based interventions tailored to specific requests, sending consultation replies in less than one business day, and facilitating timely initiation of evidence-based interventions and, when needed, referrals</li> </ul>
VA's Reproductive Mental Health Training Course	Evidence-based practices: <ul style="list-style-type: none"> <li>• Describing evidence-based interventions for each topic and maintaining a roster of clinicians who have successfully completed the course, with the roster being used to identify clinicians for timely local referrals</li> </ul>
VA's Interpersonal Therapy for Reproductive Mental Health	Evidence-based practices: <ul style="list-style-type: none"> <li>• Focusing on expanding veterans' support networks in ways that fit veterans' specific situations</li> </ul>
VA/DOD's Annual Women's Mental Health Mini-Residency	Evidence-based practices: <ul style="list-style-type: none"> <li>• Offering opportunities to practice aspects of interventions</li> </ul>
VA's Women's Mental Health Monthly Teleconference Series	Evidence-based practices: <ul style="list-style-type: none"> <li>• Covering a variety of evidence-based interventions for maternal behavioral health conditions</li> </ul>
<b>Research</b>	
NIH R01MD016037	Research activities: <ul style="list-style-type: none"> <li>• Development of an automated and personalized health information tool designed to reduce the risk of postpartum depression, decrease emergency department utilization, and increase attendance of well-baby visits</li> </ul>
NIH R01HD100395	Research activities: <ul style="list-style-type: none"> <li>• Evaluation of the adaptation of an internet-based self-guided program to improve perinatal depressive symptoms by enhancing parents' self-efficacy, emotional self-regulation, and perceived social support</li> </ul>

## Community-Based and Multigenerational Practices

Some practices in mental and perinatal health care involve supports provided in the community or home. Community-based services may be provided by various members of the workforce—such as community health workers, peer support specialists, recovery coaches, parenting coaches, outreach workers, doulas (nonclinical birth workers), and midwives (trained birth workers). Some members of the community-based workforce have lived experience related to maternal mental health conditions. Multigenerational supports include interventions that aim to improve familial relationships and SDOH and thus improve physical and mental health.

<i><b>Program</b></i>	<i><b>Practices/Activities</b></i>
<b>Supports for Individuals and Families</b>	
ACF’s YUP!	Promising practices: <ul style="list-style-type: none"> <li>• Near-peer mentors being trained in <a href="#">motivational interviewing</a> and providing <a href="#">trauma-informed approaches</a></li> <li>• Having an online community of young parents</li> </ul>
CDC’s OD2A	Evidence-based practice: <ul style="list-style-type: none"> <li>• Community-based linkage to care: increased use of navigators to link people with SUD to care and evidence-based services</li> </ul>
OWH’s AST-WH-004	Evidence-based practices: <ul style="list-style-type: none"> <li>• Communities of practice developed by grantees to promote relationship-building and knowledge exchange between IPV and SUD providers</li> </ul>
SAMHSA’s PPW Programs	Evidence-based practices: <ul style="list-style-type: none"> <li>• The <a href="#">Celebrating Families!</a> intergenerational program</li> </ul>
VA’s Reproductive Mental Health Consultation Program	Evidence-based practices: <ul style="list-style-type: none"> <li>• When relevant, suggesting family interventions and/or peer support with trained specialists who facilitate recovery and reentry into the community</li> </ul>
VA Interpersonal Therapy for Reproductive Mental Health	Evidence-based practices: <ul style="list-style-type: none"> <li>• Helping veterans expand their support networks, including multigenerational and community support</li> </ul>
VA’s Women’s Mental Health Champions Network	Evidence-based practices: <ul style="list-style-type: none"> <li>• Maintaining awareness of relevant local resources such as family interventions and gender-specific peer support</li> </ul>
HRSA’s QIF-MH	Evidence-informed practices: <ul style="list-style-type: none"> <li>• Development of group prenatal care programs that create support networks among health center patients and increase access to health center staff members and providers</li> </ul>

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s MIECHV	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• A two-generation approach that aims to equip both parents and children with the tools they need to thrive while removing obstacles encompassing those related to mental health</li> <li>• Integration and coordination of maternal and child health services and adult support systems of care, such as adult mental health services, to address issues that include maternal depression, substance use, and child maltreatment</li> </ul>
HRSA’s ICTP	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Increasing access to family dyadic interventions, such as child–parent psychotherapy</li> <li>• Increasing timely access to prevention, early intervention, and therapeutic health and family support services</li> </ul>
HRSA’s National Maternal Mental Health Hotline	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Provision of real-time emotional support, resources, and referrals to local/community-based or telehealth providers when longer-term care and support are needed</li> </ul>
HRSA’s Healthy Start	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Collaborations with community-based mental and behavioral health organizations</li> </ul>
HRSA’s AIM CCI	<p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Development of a clinical–community integration road map as a framework to support a perinatal system of care at the local level to coalesce a network of providers around the shared goal of improving maternal outcomes, as well as guiding the establishment of local maternal safety workgroups</li> </ul>
<b>Workforce Training</b>	
VA’s Reproductive Mental Health Training Course	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Including information on family and peer interventions</li> </ul>
VA/DOD’s Annual Women’s Mental Health Mini-Residency	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Discussing family-, peer-, and community-based support</li> </ul>
VA’s Women’s Mental Health Monthly Teleconference Series	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Discussing the protective effect of social support and ways to enhance support</li> </ul>
HRSA’s TPEC	<p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Training and technical assistance for health providers related to early relational health, dyadic infant mental health, and child development in a multigenerational context</li> </ul>

## The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s MMHSUD	Evidence-based practices: <ul style="list-style-type: none"> <li>• Inclusion of evidence-based screening protocols and provider toolkits such as the 4P’s Plus screening tool—which identifies substance use risk factors, including the need for community services and support that can be addressed through care coordination—and aiming to build protective factors for pregnant women, their babies, and their families or communities</li> </ul>
<b>Research</b>	
NIH R01MD016026	Research practices: <ul style="list-style-type: none"> <li>• Analysis of qualitative data from interviews with Black women and focus groups with providers and community-based doulas to explore the effect of incorporating doula-provided services into prenatal, birth, and postpartum care to reduce disparities in severe maternal morbidity and maternal mortality</li> </ul>
NIH R21DA058407	Research practices: <ul style="list-style-type: none"> <li>• Testing of a community-informed and community-based intervention using a novel ultrasound protocol, motivational and strength-based education, and care coordination strategies</li> </ul>

### Treatment

Treatments for mental health conditions are generally provided in the clinic or health care setting. These treatments may be behavioral (nonpharmacological) therapies, medications, or a combination of both.

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
<b>Bolstering the Provision of Behavioral Therapies</b>	
SAMHSA’s PPW Programs	Evidence-based practices: <ul style="list-style-type: none"> <li>• <a href="#">Trauma-focused cognitive behavioral therapy (TF-CBT)</a></li> <li>• <a href="#">Dialectical behavior therapy</a></li> </ul>
HRSA’s RCORP-NAS	Activities: <ul style="list-style-type: none"> <li>• Implementation of activities to support rural residents who have SUD and are at risk of becoming pregnant, are currently pregnant, and/or have recently given birth, as well as their families</li> </ul>
VA/DOD Clinical Practice Guidelines: Management of Pregnancy (2023)	Evidence-based practices: <ul style="list-style-type: none"> <li>• Evidence review of literature for nonpharmacological interventions for anxiety and depression, including therapy and yoga</li> </ul>

<b>Program</b>	<b>Practices/Activities</b>
VA’s Interpersonal Therapy for Reproductive Mental Health	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Three-part experiential training in adapting Interpersonal psychotherapy (IPT) for use with women experiencing mental health challenges related to reproductive mental health (RMH) concerns</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Application of IPT-RMH for diagnoses other than depression when role transitions and a paucity of social support are key issues.</li> </ul>
HRSA’s QIF-MH	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Employing behavioral health providers (e.g., clinical psychologists and licensed clinical social workers) who conduct traditional therapy practices to treat behavioral health conditions</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• EMDR training for behavioral health providers</li> </ul>
HRSA’s RCORP-NAS	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Increasing access to behavioral health care and strengthening the quality and sustainability of behavioral health care systems</li> </ul>
HRSA’s ITCP	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Ongoing case management and referrals to behavioral health care, including mental health, substance use, and trauma treatment services for families involved in the program or who may be at risk for involvement in the child welfare system</li> </ul> <p>Evidence-informed practices:</p> <ul style="list-style-type: none"> <li>• Workforce development to increase the availability of trained behavioral health providers</li> <li>• Collaborative planning with Medicaid and other health payers to support reimbursement of and access to maternal behavioral health services</li> </ul>
<b>Facilitating the Provision of Medications</b>	
CMS’s MOM Model	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Funding to increase access to MOUD and other health care</li> <li>• Creation of sustainable coverage and payment strategies to support coordination and integration of care</li> <li>• <a href="#">Plans of safe care (POSCs)</a></li> </ul>
CMS’s MIPS Value Pathway Focusing on Women’s Health	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Postpartum visit expectations, postpartum depression screening, advice on having a healthy lifestyle, glucose screening, and breastfeeding education and evaluation</li> <li>• Family planning, immunization, tobacco screening, and nutrition counseling</li> </ul>

<b>Program</b>	<b>Practices/Activities</b>
OWH’s WH-AST-21-003	Evidence-based practices: <ul style="list-style-type: none"> <li>• Implementation of evidence-based interventions to improve outcomes and reduce deaths due to violence among pregnant and postpartum women</li> </ul>
<b>Expanding the Workforce to Improve Maternal Mental Health</b>	
HRSA’s PCTE-CPMH	Evidence-based practices: <ul style="list-style-type: none"> <li>• Increasing the number of primary care physicians who are trained in general preventive medicine and enhanced obstetric care and who offer referrals to SUD treatment clinics</li> <li>• Training the next generation of the maternal mental health care workforce by offering clinical learning experiences in SUD treatment for resident physicians and fellows</li> </ul>
HRSA’s MIECHV	Evidence-based practices: <ul style="list-style-type: none"> <li>• Home visiting programs that refer eligible caregivers to evidence-based treatment offered by community-based partner organizations</li> </ul>
VA’s Maternity Care Coordination Expansion to the Full 12-Month Postpartum Period	Evidence-based practices: <ul style="list-style-type: none"> <li>• Referring patients with positive screens to clinicians within the VHA for needed treatment</li> </ul>
VA’s Women’s Mental Health Champions Network	Evidence-based practices: <ul style="list-style-type: none"> <li>• Maintaining up-to-date knowledge of evidence-based and emerging treatments by attending the VA/DOD Women’s Mental Health Mini-Residency, participating in monthly teleconferences about women’s mental health, participating in quarterly continuing education calls, and disseminating new knowledge at local facilities</li> </ul>
<b>Providing Clinicians with Objective Information on the Treatment of Maternal Mental Health Conditions</b>	
AHRQ’s Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Systematic Review of Perinatal Pharmacologic Interventions	Evidence-based practices: <ul style="list-style-type: none"> <li>• Demonstrating that taking brexanolone for depression onset in the third trimester or in the postpartum period may improve depressive symptoms after 30 days of use and that sertraline may improve response, remission, and depressive symptoms (Viswanathan et al., 2021)</li> </ul>
AHRQ’s Nonpharmacologic Treatment for Maternal Mental Health Conditions	Evidence-based practices: <ul style="list-style-type: none"> <li>• Assessing nonmedication therapies (e.g., cognitive behavioral therapy, interpersonal psychotherapy, explorative therapy, and self-hypnosis and relaxation) for the maternal population</li> </ul>



The Task Force on Maternal Mental Health's Report to Congress

<b>Program</b>	<b>Practices/Activities</b>
AHRQ's Evaluation of Mental Health Mobile Applications	Evidence-based practices: <ul style="list-style-type: none"> <li>Reviewing published literature and gray literature and developing the Framework to Assist Stakeholders in Technology Evaluation for Recovery to Mental Health and Wellness</li> </ul>
CDC's OD2A	Evidence-based practice: <ul style="list-style-type: none"> <li>Academic detailing, a form of clinician education that uses a one-on-one interactive technique to deliver unbiased, evidence-based information to clinicians, with the goal of effecting behavior change</li> </ul>
VA's Reproductive Mental Health Consultation Program	Evidence-based practices: <ul style="list-style-type: none"> <li>Providing evidence-based summaries of perinatal risks of untreated mental health conditions compared with perinatal risks of effective treatments, such as medication and evidence-based psychotherapies</li> </ul> Evidence-informed practices: <ul style="list-style-type: none"> <li>Describing evidence-informed treatments such as phototherapy</li> </ul>
VA's Reproductive Mental Health Training Course	Evidence-based practices: <ul style="list-style-type: none"> <li>Summarizing evidence-based treatments for a wide array of maternal behavioral health conditions</li> </ul>
VA/DOD's Annual Women's Mental Health Mini-Residency	Evidence-based practices: <ul style="list-style-type: none"> <li>Summarizing evidence-based treatments and offering opportunities to practice treatment planning and aspects of treatments using case examples, role-playing, and other interactive modalities</li> </ul>
VA's Women's Mental Health Monthly Teleconference Series	Evidence-based practices: <ul style="list-style-type: none"> <li>Discussing a variety of evidence-based treatments for maternal behavioral health conditions</li> </ul>
HRSA's MMHSUD	Evidence-based practices: <ul style="list-style-type: none"> <li>Expanding health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum people for maternal mental health conditions and related behavioral disorders, such as anxiety and substance use disorder</li> </ul>
<b>Research</b>	
NIH R01MH121531	Research activities: <ul style="list-style-type: none"> <li>Testing the efficacy of wearable bright light therapy for postpartum depression</li> </ul>
NIH R01HD100579	Research activities: <ul style="list-style-type: none"> <li>Analyzing data from electronic health records to identify the predictors and perinatal effects of psychotherapy and antidepressant use for new episodes of depression during pregnancy</li> </ul>

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
CDC’s MAT-LINK	Research activities: <ul style="list-style-type: none"> <li>Collection of data on diagnosed mental health conditions and prenatal substance use including alcohol, tobacco, cannabis, and other illicit drugs in addition to OUD treatment details to inform clinical practice recommendations and decision-making</li> </ul>
FDA’s Pregnancy Exposure Registries	Research activities: <ul style="list-style-type: none"> <li>Registries are research studies that collect information about the effects that prescription medicines taken or vaccines received have on pregnant people.</li> </ul>

## Equity

In a society with health equity, everyone has “a fair and just opportunity to attain their highest level of health” (Centers for Disease Control and Prevention, 2022). Reducing disparities, overcoming barriers to health and health care, and addressing injustices are foundational to achieving health equity. Reducing disparities in federal programs and projects requires intentional actions to eliminate preventable differences in health conditions and in opportunities to achieve optimal health (Centers for Disease Control and Prevention, 2022). Expanding access and ensuring high-quality care for all people who participate in federal programs that support perinatal health, maternal mental health, and substance use is essential to improve outcomes.

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
<b>Integrating Equity into Service Provision</b>	
CMS’s MOM Model	Evidence-based practices: <ul style="list-style-type: none"> <li>Educating, training, and supporting rural general practitioners or other available health care representatives on the best practice treatment protocols for complex diseases they encounter in their communities</li> </ul> Promising practices: <ul style="list-style-type: none"> <li>Outreach using non-stigmatizing language and materials for non-English speakers</li> <li>Awardee public outreach campaigns, specifically to reach communities of color</li> <li>Opportunities for eligible awardees to apply for funding to incorporate activities that would promote equity in their programs</li> </ul>
IHS’s Maternity Care Coordinator Program	Evidence-informed practices: <ul style="list-style-type: none"> <li>Utilizing telehealth and home visiting to increase patient access to care, including mental health screening and resources for AI/AN pregnant and postpartum people and their families</li> </ul>

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
CDC’s Suicide Prevention Resource for Action	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Community-based, health care–related, and upstream strategies intended to strengthen economic supports, improve coverage of mental health conditions in health insurance policies (e.g., mental health parity laws), reduce provider shortages in underserved areas (e.g., telehealth services for mental health), and facilitate parenting skills and family relationship programs</li> <li>• Community-based strategies intended to reduce health disparities related to suicide and suicide attempts (e.g., <a href="#">Zero Suicide</a>)</li> <li>• Community-based approaches intended to reduce health disparities, including social–emotional learning programs and community engagement in shared activities</li> </ul>
CDC’s TSP	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Promoting connectedness as a community-based approach to suicide prevention</li> <li>• Identifying and supporting people at risk by linking them with resources</li> <li>• Assessing and strengthening local crisis identification and postvention resources to prevent suicide contagion/clusters</li> <li>• Using suicide surveillance data</li> </ul>
ACF’s SOAR	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Trainings with content on health disparities—related to race, ethnicity, geographic location, and other categories—that create risks</li> <li>• Trainings to equip learners to provide culturally and linguistically appropriate services</li> </ul>
CDC’s OD2A	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Health departments’ provision of technical assistance to partners to enhance their capacity to understand and interpret local overdose trends and burden, identify populations or communities most affected, and select and coordinate implementation of appropriate evidence/practice-based interventions to respond to community needs</li> <li>• Initiation, expansion, and support of efforts that center people with lived experience in programs and communities they represent, improving visibility and reach of peer service providers to reduce self-stigma, and developing and supporting interventions to increase contact among people with lived experience and others in the community</li> </ul>
VA’s Maternity Care Coordination Expansion to the Full 12-Month Postpartum Period	<p>Evidence-based practices:</p> <ul style="list-style-type: none"> <li>• Use of telemedicine to ensure that maternity care services are accessible in all areas and that these programs are offered to all pregnant veterans</li> </ul>

The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
VA’s Women’s Mental Health Champions (WMHC) Network	Evidence-based practices: <ul style="list-style-type: none"> <li>• Having at least one WMHC at each VA center, which expands access to evidence-based maternal behavioral health care for women veterans</li> </ul>
HRSA’s QIF-MH	Promising practices: <ul style="list-style-type: none"> <li>• Partnering with community-based organizations and/or employing medical interpreters, community health workers, doulas, and other people with lived experience in order to increase outreach to groups that have low access to care and are at the highest risk of adverse outcomes</li> </ul>
HRSA’s RCORP-NAS	Evidence-based practices: <ul style="list-style-type: none"> <li>• Addressing community risk factors and social determinants of health</li> </ul>
HRSA’s MIECHV	Evidence-based practices: <ul style="list-style-type: none"> <li>• Provision of voluntary evidence-based home visiting services to families in communities with high concentrations of issues such as poverty, crime, domestic violence, high rates of dropping out of high school, SUD, and unemployment</li> </ul>
HRSA’s ITCP	Evidence-based practices: <ul style="list-style-type: none"> <li>• Focused outreach to communities experiencing the greatest disparities</li> <li>• Selection of implementation sites in under-resourced areas, with a focus on populations experiencing the greatest disparities</li> <li>• Provision of intensive technical assistance to address disparities</li> <li>• Use of evidence-driven strategies and data to reduce disparities associated with poverty, race/ethnicity, and rurality in early developmental health and well-being outcomes for the priority population</li> </ul>
HRSA’s TPEC	Evidence-informed practices: <ul style="list-style-type: none"> <li>• Increasing access to comprehensive early childhood development services, with an emphasis on Medicaid/CHIP-eligible and uninsured families with children ages 0–5.</li> </ul>
HRSA’s National Maternal Mental Health Hotline	Evidence-based practices: <ul style="list-style-type: none"> <li>• Provision of real-time trauma-informed and culturally appropriate emotional support and resources and referrals for perinatal mental health needs in English or Spanish, with access to interpreter services for 60 other languages and a relay service for people who are deaf or hard of hearing</li> </ul>

The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
HRSA’s Rural Health Care Services Outreach Program grantee Healthy Acadia’s PROSPER Initiative	Evidence-based practices: <ul style="list-style-type: none"> <li>Care navigation and support provided by community health workers</li> </ul>
<b>Workforce Training</b>	
VA’s Reproductive Mental Health Consultation Program	Evidence-informed practices: <ul style="list-style-type: none"> <li>In cases of veterans being affected by health disparities, suggesting ways that the maternity care coordinators and clinicians can advocate for the veterans</li> </ul>
VA’s Reproductive Mental Health Training Course	Evidence-based practices: <ul style="list-style-type: none"> <li>Enhancing reproductive mental health knowledge among VHA clinicians, thus expanding access to evidence-based care for all women veterans</li> </ul>
VA’s Interpersonal Therapy for Reproductive Mental Health	Evidence-based practices: <ul style="list-style-type: none"> <li>Training more VA clinicians to provide perinatal interpersonal therapy, thus expanding access to evidence-based care for women veterans</li> </ul>
VA/DOD’s Annual Women’s Mental Health Mini-Residency	Evidence-based practices: <ul style="list-style-type: none"> <li>Training more VA clinicians on foundational aspects of perinatal mental health, thus expanding access to evidence-based maternal behavioral health care for women veterans</li> </ul>
VA’s Women’s Mental Health Monthly Teleconference Series	Evidence-based practices: <ul style="list-style-type: none"> <li>Focusing on health disparities</li> </ul>
HRSA’s AIM CCI	Evidence-informed practices: <ul style="list-style-type: none"> <li>The Racial Equity Learning Series (RELS) for professionals, addressing racism’s impact on maternal health, including modules on acknowledging and accepting racism, institutional change, and personal and systemic change</li> <li>Having a webinar on the intersection of mental health and maternal health and the challenges that women and birthing people of color encounter in this space because of racism</li> </ul>
<b>Supporting Research on Equity</b>	
NIH R01MD017622	Research activities: <ul style="list-style-type: none"> <li>Testing the effectiveness of an evidence-based intervention for postpartum depression prevention adapted for delivery via a virtual modality and for immigrant Latinas</li> </ul>

## The Task Force on Maternal Mental Health's Report to Congress

<b><i>Program</i></b>	<b><i>Practices/Activities</i></b>
NIH R21MD017396	Research activities: <ul style="list-style-type: none"> <li>• Evaluating a culturally relevant mobile health intervention providing guidance for the clinical care of Black women during the perinatal period, with the goal of improving mental health and physical health outcomes</li> <li>• Examining the relationship between the effects of the intervention on perinatal mood and anxiety disorders and inflammatory signatures among Black pregnant women</li> </ul>
CDC's MAT-LINK	Research activities: <ul style="list-style-type: none"> <li>• Expansion of the cohort to include 11 clinical sites across the U.S., with the aim of increasing the study population of pregnant people with varied racial, ethnic, and socioeconomic characteristics</li> </ul>

### Federal Collaboration Efforts

<b><i>Name of Federal Collaborative Group</i></b>	<b><i>Overview</i></b>
The Advisory Committee on Infant and Maternal Mortality (ACIMM)	Established in 1991, the ACIMM advises the Secretary of Health and Human Services on HHS activities, partnerships, policies, and programs directed at reducing infant mortality, maternal mortality, and severe maternal morbidity and improving the health statuses of infants and women before, during, and after pregnancy. The committee provides advice on how best to coordinate federal, state, local, tribal, and territorial governmental efforts designed to address these issues and to influence similar efforts in the private and voluntary sectors. With its focus on underlying causes of the disparities and inequities seen in birth outcomes for women and infants, the committee advises the Secretary on the health, social, economic, and environmental factors contributing to the inequities and proposes structural, policy, and/or systems-level changes.

## The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Name of Federal Collaborative Group</i></b>	<b><i>Overview</i></b>
HHS’s Goal Teams on Maternal Health (FY 2022–2023) and Behavioral Health (FY 2022–2023 and FY 2024–2025)	<a href="#">Agency priority goals (APGs)</a> are an agency’s near-term implementation-focused priorities set by major federal agency heads every two years. Through regular public reporting on Performance.gov, goal teams report their progress on their APGs, which serve as markers of an agency’s commitment to improving outcomes, customer experiences, and efficiency. Two of HHS’s goal teams include Maternal Health (FY 2022–2023) (with the goal of improving maternal health and advancing health equity across the life course by ensuring the equitable provision of evidence-based high-quality care and addressing racism, discrimination, and other biases) and Behavioral Health (FY 2022–2023) (with the goal of increasing equitable access to and utilization of prevention, treatment, and recovery services to improve health outcomes for those affected by behavioral health conditions). For FY 2024–2025, HHS commits to improving health outcomes for those affected by behavioral health conditions through increasing access and utilization of critical prevention, crisis intervention, treatment, and recovery services.
Breastfeeding	This group provides CDC with funding to promote hospital breastfeeding as part of the Baby-Friendly Hospital Initiative and to the Office on Women’s Health (OWH) to provide an analysis of U.S. breastfeeding rates and goals.
Coordinating Committee on Women’s Health	This committee was established in 1984 to advise the Assistant Secretary for Health on activities across HHS that would safeguard and improve the physical and mental health of all women in the United States. The coordinating committee is chaired by the OWH Director, and members include senior-level representatives from each of the federal agencies and offices within HHS.
Interagency Coordinating Committee on the Promotion of Optimal Birth Outcomes	This committee oversees and coordinates the HHS Action Plan to Improve Maternal Health in America.
Early Childhood Federal Partners Workgroup	This workgroup meets monthly and aims to support staff-level connection, planning, coordination, and action to advance the collective impact of federal early childhood and family-serving programs on improving health and well-being outcomes for young children and their families. There is an intentional focus on including a two-generation approach in an early childhood system and programs that address maternal mental health. (Participants are from HHS, the U.S. Department of Education, DOD, the U.S. Department of Agriculture, the U.S. Department of Labor, the Social Security Administration, and the Census Bureau.)

The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Name of Federal Collaborative Group</i></b>	<b><i>Overview</i></b>
National Syphilis and Congenital Syphilis Syndemic (NSCSS) Federal Task Force	The NSCSS Federal Task Force was established in August 2023 and led by the Office of the Assistant Secretary for Health (OASH). The NSCSS Federal Task Force aims to address the syndemic of syphilis and congenital syphilis, collaborating with federal partners across HHS and non-HHS agencies, with a focus on strengthening data and surveillance, developing prevention strategies, and improving screening, diagnosis, and treatment. The NSCSS Task Force also has a strong emphasis on health equity and community engagement. The overall goal of the task force is to reduce rates of primary, secondary, and congenital syphilis and to reduce syphilis health disparities in the United States.
HHS Maternal Health Leadership Team	This team operates as a working group under the Coordinating Committee on Women’s Health. It is open more broadly to all HHS staff members working in maternal health to unify efforts.
HHS Racial Equity in Postpartum Care Challenge	OWH and CMS support this challenge, which in turn supports innovative methods to improve equity of postpartum care for Black or African American and American Indian/Alaska Native (AI/AN) women enrolled in Medicaid or the Children’s Health Insurance Program (CHIP), including follow-up care for diabetes, postpartum depression and/or postpartum anxiety, hypertension, and SUD.
HHS Substance-Exposed Pregnancies (SEP) Workgroup	This workgroup meets quarterly and aims to facilitate collaboration and information sharing among federal experts on issues relevant to prenatal substance exposures and substance-exposed infants, including research, data and surveillance, prevention and treatment, and reimbursement. It includes representatives from across all HHS agencies.
Hear Her	CDC and the Office of Minority Health, in partnership with the CDC Foundation and with support from Merck for Mothers, released the American Indian and Alaska Native segment of the Hear Her campaign in November 2022. The goal of this effort is to amplify the voices of AI/AN people and to work to improve maternal health outcomes by sharing culturally appropriate materials that address this topic.
Infant Food and Nutrition Safety	FDA will establish the Office of Critical Foods, responsible for oversight, coordination, and facilitation of activities related to critical foods. (“Critical food” is defined as food that is an infant formula or medical foods.) This office along with the CDC will support maternal and infant health nutrition programs.



The Task Force on Maternal Mental Health’s Report to Congress

<b><i>Name of Federal Collaborative Group</i></b>	<b><i>Overview</i></b>
Interagency Coordinating Committee on Fetal Alcohol Spectrum Disorders (ICCFASD)	<p>This committee fosters improved communication, cooperation, and collaboration among disciplines and federal agencies that address issues related to prenatal alcohol exposure. The ICCFASD is sponsored and chaired by the National Institute on Alcohol Abuse and Alcoholism and meets annually.</p> <p>The Screening and Brief Intervention Workgroup in the ICCFASD meets monthly with a group of experts from CDC, NIH, CMS, HRSA, SAMHSA, ACF, and ASPE. The objective of the workgroup is to identify gaps and opportunities through enhanced information and resource sharing on screening and brief intervention services for pregnant and postpartum people, collaboration, and partnership for reducing the incidence of FASD and supporting families surrounding pregnancy and the postpartum period.</p>
Interagency Coordinating Committee on the Promotion of Optimal Birth Outcomes	Part of the <i>White House Blueprint for Addressing the Maternal Health Crisis</i> , the committee aims to promote optimal maternal outcomes by making evidence-based maternity care a national priority.
Interagency Task Force on Trauma-Informed Care	This task force develops best practices for trauma-informed identification, referral, and support.
Maternal Health Interagency Policy Committee (IPC)	Led by the White House Domestic Policy Council, this interagency policy committee aims to coordinate activities specifically focused on improving outcomes for pregnant women involved in or at risk of being involved in the child welfare system.
Maternal Health Working Group	This group operates under the Coordinating Committee on Women’s Health.
Newborn Supply Kit	HHS, in collaboration with Baby2Baby, partnered to create a pilot program to distribute a one-time Newborn Supply Kit and later created a website that includes information across all federal agencies for families on health, feeding, sleeping, and child development.

<b><i>Name of Federal Collaborative Group</i></b>	<b><i>Overview</i></b>
Stillbirth Working Group of Council	In 2022, the <i>Eunice Kennedy Shriver</i> National Institute of Child Health and Human Development (NICHD) formed the Stillbirth Working Group of Council in response to an HHS request to lead a congressionally mandated task force to examine stillbirth in the United States. The working group provided a report of its findings to HHS in March 2023, focusing on the current barriers to collecting data on stillbirths throughout the United States, communities at higher risk of stillbirth, the psychological impact and treatment for mothers after stillbirth, and known risk factors for stillbirth. The group plans to hold new meetings to continue its efforts to examine stillbirth by examining the following: current knowledge on stillbirth and prevention, areas of improvement for data collection, current resources for families affected by stillbirth, and next steps to gather data and lower the rate of stillbirth in the United States.
Postpartum Depression Campaign	This campaign helps to decrease stigma around postpartum depression (PPD) and raise awareness about available resources by sharing the “Talking PPD” messaging on social media.
Pregnant Women and Lactating Women Advisory Committee	This committee monitors and reports on the implementation of the recommendations from the Task Force on Research Specific to Pregnant Women and Lactating Women.
Postpartum Maternal Health Collaborative	This collaborative seeks to bring together state experts, local providers, community partners, and federal experts to develop a better understanding of the challenges being experienced among the postpartum population and support new solutions that will improve postpartum mortality. The vision of the collaborative is to change the trajectory of maternal morbidity and mortality to improve the lives of families in the first year after giving birth to a child in participating states. The six states that have agreed to participate in the Postpartum Maternal Health Collaborative are Iowa, Massachusetts, Maryland, Michigan, Minnesota, and New Mexico. The collaborative launched in February 2024 and will run until January 2025.
Behavioral Health Coordinating Committee	<a href="#">The Behavioral Health Coordinating Committee</a> “is a coordinating body within HHS that identifies and facilitates collaborative, action-oriented approaches to addressing the HHS behavioral health agenda.”

## **Conclusion**

Maternal mental health must be addressed on a national level. Several federal programs and projects aim to prevent, diagnose, and treat maternal mental health conditions. Some incorporate community or multigenerational supports and a health equity lens. Common strategies and gaps have been identified in the prevention, screening, diagnosis, and treatment activities of federal efforts. Providing education, creating resources, conducting training, and providing services are all useful strategies that federal programs have employed. Ongoing research on innovative methods to improve maternal mental health offers promise for the development of more effective and equitable practices for prevention, screening, diagnosis, and interventions. Sharpening the focus on maternal mental health at the federal level will facilitate improved outcomes in pregnant people and postpartum people across the nation.

## **SECTION 5: FEEDBACK FROM LISTENING SESSIONS AND OPPORTUNITIES FOR STATE AND LOCAL PARTNERSHIPS**

In December 2023 and January 2024, HHS convened four 1-hour virtual listening sessions with the following organizations (presented in alphabetical order):

- The [Association of Maternal & Child Health Programs](#) (AMCHP) (January 9, 2024);
- The [National Association of County and City Health Officials](#) (NACCHO) (December 14, 2023);
- The [National Association of State Alcohol and Drug Abuse Directors](#) (NASADAD) (January 10, 2024); and
- The [National Association of State Mental Health Program Directors](#) (NASMHPD) (January 11, 2024).

Three of these national professional groups—NASMHPD, NASADAD, and AMCHP—represent state organizations, and the fourth, NACCHO, represents county and local organizations. The four associations provide services related to public health, maternal health, child health, mental health, and substance use disorders (SUDs). A total of 125 professionals in the field and 25 association staff members participated in the listening sessions. The participants were located in 43 U.S. states and territories. Additionally, members of the Task Force on Maternal Mental Health and some HHS staff members not on the task force attended the moderated sessions in listen-only mode; some members of the task force and HHS staff members subsequently provided clarification and additional information (included below). Overarching themes from the listening sessions are highlighted in bold text throughout.

In gathering information for the state and local partnerships proposed in the national strategy, the task force considered input on approaches, successes, challenges, and gaps related to maternal mental health conditions and SUDs in the areas of prevention, screening, diagnosis, interventions, and treatment. Below, this report organizes feedback from the frontline professionals participating in the listening sessions (as well as subsequent comments from members of the task force) into the following categories:

1. The current state of affairs in maternal mental health;
2. Model state and local programs supporting pregnant and postpartum individuals with mental health conditions and SUDs and their families;
3. Federal, state, and local maternal health policies (and other policies that affect maternal mental health);
4. The maternal mental health workforce;
5. Data relevant to maternal mental health; and
6. Equity in maternal mental health.

Upon publication of this report, the task force will use this feedback to develop a report to state governors that details opportunities to implement the national strategy through local- and state-level partnerships.

## **PART 1. THE CURRENT STATE OF AFFAIRS IN MATERNAL MENTAL HEALTH**

All four of the professional organizations participating in the listening sessions identified problems associated with access to and the availability of maternal mental health and SUD treatment services, with coordination between the limited available services, with mental health workforce shortages (discussed in greater detail in Part 4 below), and with the effects of social determinants of health (SDOH) and stigma—all of which contribute to adverse maternal mental health outcomes.

### **SDOH, Stigma, and Gender-Based Violence (GBV)**

**Pregnant and postpartum individuals often face challenging SDOH, such as food insecurity and financial insecurity, including difficulties affording housing, transportation, and child care.** Negative SDOH affect mental health and the ability to seek care. However, addressing SDOH can help to improve maternal mental health outcomes.

**The stigma surrounding mental health conditions negatively affects pregnant and postpartum individuals.** Societal stigma limits treatment seeking for maternal mental health conditions. Pregnant people with SUD may face amplified effects of social stigma—even from those otherwise educated on SUDs and their treatment, including health care workers (Weber et al., 2021) and, according to listening session participants, other individuals in recovery from SUD who participate in peer support networks (e.g., Alcoholics Anonymous). These stigmas intersect with systemic racism and other societal biases, such that pregnant and postpartum individuals with mental health conditions and SUDs may face particular discrimination, reproach, and barriers to treatment.

**GBV, particularly intimate partner violence (IPV), constitutes another major barrier to care,** especially in cases when abusive partners leverage stigma and SDOH-related concerns to prevent pregnant and postpartum individuals from accessing treatment or maintaining recovery from SUD (e.g., by withholding transportation or child care; by threatening loss of housing, custody, or benefits; or by threatening involvement of law enforcement or incarceration) (Phillips et al., 2021).

### **Workforce Shortages Affect Care Access**

Across all jurisdictions, workforce shortages limit access to mental health services for pregnant and postpartum individuals with mental health conditions and their families. The current need for support, intervention, and treatment far outweighs the number of available specialty care providers and services for maternal mental health. Overall,

professionals who work with these populations and their families have perceived more severe mental health problems

than in the past—a situation exacerbated by the COVID-19 pandemic (Britz et al., 2022).

Workforce shortages limit the ability of states and localities to expand programs for maternal mental health. Additionally, many of the community-based organizations (CBOs) that could potentially support people with maternal mental health conditions have low levels of funding and staff shortages that limit service provision. Members of the workforce face multiple challenges—including burnout and a need for additional training and education. Problems with access further deepen the low levels of identifying maternal mental health conditions. For ethical reasons,

**“When I was in distress and having to maintain the follow-through—the fact it took me weeks to find someone, that was unexpected. I was battling it on a daily basis.”**

**—E.L., mother of one**

providers may not screen pregnant individuals for mental health conditions or GBV when services for those conditions are lacking. Further, some providers may hesitate or lack appropriate training to provide pharmacotherapy to pregnant or breastfeeding treatment-seeking patients. The overall workforce shortage and low funding levels for CBOs constrain the capacity to provide culturally competent care.

**“A lot of Medicaid-accepting clinics screen ... but what happens with those patients when they screen positive and have nowhere to go?”**

**—Health care provider**

**Workforce shortages and lack of access to mental health services particularly affect pregnant and postpartum individuals in rural areas.** Drive times and limited public transportation can pose major treatment barriers for this population and may add practical and stress-related burdens. Rural counties often lack a diverse care provider workforce; thus, delivering culturally competent care in these areas can be challenging. Although states have implemented telehealth

options to extend the perinatal mental health workforce in rural and semirural areas, poor internet service in many such regions and the costs of electronic devices and internet connectivity limit access to telehealth treatment for many patients.

### **Service Coordination Could Be Improved**

**Wraparound services for perinatal mental health and medical care are not coordinated, and the continuity of care should extend from pregnancy to the postpartum period for both birthing individuals and infants.** The lack of coordination of services relates, in part, to the different funding streams for maternal and child health, mental health, child welfare, addressing IPV and sexual assault, and public health. Support services may not connect with clinical care. Siloed state and community programs limit communication and collaboration among the organizations that represent the touchpoints of care systems for pregnant people and their families. More general problems related to lack of access to mental health services for this population include **a lack of integration with SUD treatment programs, other mental health treatment programs (including for complex trauma), and support services for IPV and sexual violence.** Nonacceptance of pregnant individuals in the third trimester into residential mental health treatment programs further limits care access, and research suggests that pregnant people with SUDs face additional barriers to treatment (Patrick et al., 2020).

**Pregnant and postpartum individuals often lack knowledge of how to access care, available services, and Medicaid coverage.** A single information source on services and a unified referral system at the state level would benefit pregnant and postpartum individuals and their families.

### **States Are Integrating Mental and Maternal Health**

To address the maternal mental health crisis, states have begun to integrate mental health and perinatal services. **One approach adds mental health experts to perinatal quality collaboratives (PQCs) to help inform and guide efforts.** These collaboratives assess the extent of the state's maternal mental health problem, develop solutions, and educate providers about perinatal and postpartum mental health conditions. Other approaches to integration include collaborating across state executive departments (e.g., departments of maternal and child health, mental health, substance use, and child welfare). **Some states incorporate mental health services into community health clinics, and others are building strong state- and local-level collaborations between providers of legal services and health care and social service**

**providers for pregnant and postpartum individuals, mental health conditions, SUDs, and cases of GBV.** Integration of mental and maternal health requires training and educating providers on the relevant issues. For example, the [PROUD](#) (Parents Recovering from Opioid Use Disorders) program includes both service delivery and training to equalize knowledge about opioid use disorder (OUD) among medical and mental health providers.

## **PART 2. MODEL STATE AND LOCAL PROGRAMS SUPPORTING PREGNANT AND POSTPARTUM INDIVIDUALS WITH MENTAL HEALTH CONDITIONS AND SUDs**

Model evidence-based programs represent ways that states intentionally deliver services to offer better and more comprehensive support to pregnant and postpartum individuals with mental health conditions and SUDs and their families.

### **Understanding the State of Maternal Mental Health in the States**

**To provide better services to this population, states must understand maternal health outcomes, including those related to mental health.** PQC’s adopt a team approach to improving the quality of care for birthing individuals and babies. To address maternal mental health care specifically, some state PQC’s involve the public health and mental health departments in planning efforts. A movement in New England advocates development of a regional PQC in addition to the individual collaboratives of each state. Currently, the Centers for Disease Control and Prevention (CDC) provides support for 36 state-based PQC’s (Centers for Disease Control and Prevention, 2023).

### **Addressing SDOH Through State Programs**

States and territories can address SDOH through the federal [Temporary Assistance for Needy Families \(TANF\)](#) program, which gives jurisdictions flexibility in operating programs designed to help low-income families with children. The program funds monthly cash assistance payments to these families, along with a wide range of services, so that families can achieve economic self-sufficiency. Expanding TANF would allow states and territories to address SDOH among more families.

**Multiple states also acknowledged the importance of safe and stable housing—as provided by the Housing First model** (U.S. Department of Housing and Urban Development, 2014)—in supporting pregnant and postpartum individuals and their families. Through Housing First programs, heads of households with disabling conditions—including mental health conditions or SUDs—can obtain subsidized housing for an unlimited time period. Housing First participants are encouraged, but not required, to abstain from drugs and alcohol. The Community Preventive Services Task Force recommends Housing First programs based on strong evidence of effectiveness. Evidence demonstrates that these programs reduce homelessness, increase housing stability, improve participants’ quality of life, decrease hospitalization and emergency department visits, and enhance the health of people living with HIV (Community Preventive Services Task Force, 2021; Healthy People 2030, n.d.).

### **State Programs to Increase Public Awareness of Maternal Mental Health Conditions and Services**

**Many people—including pregnant individuals and members of their personal networks—may not be aware of maternal mental health conditions.** For example, some may not understand the difference between the temporary “baby blues” that many people experience and postpartum depression (Centers for Disease Control and Prevention, n.d.-b). Moreover, some may not know what action to take when an individual shows signs of postpartum depression. Thus, several states have initiated public awareness campaigns to increase general knowledge about maternal mental health

**“I was looking for a Latina, someone who has had a home birth experience, an experience they could share with me.”**

**—F.P., pregnant mother of one**



conditions and related state services. For instance, Colorado's [Tough as a Mother](#) campaign increases public awareness about maternal mental health to reduce the stigma of SUD. This initiative also connects parents and children to treatment services and support groups.

### **Providing Integrated Care and Continuity of Care Through Home Visiting Programs**

#### **Many states implement home visiting programs, an approach that has benefits for clients.**

From the state perspective, home visiting provides excellent wraparound services, meets people where they are, and offers opportunities for helpful in-home observations. Although the departments overseeing such programs vary by state, families report positively on the home visiting programs. Such client-centered programs offer at-home services (including screening) for SUDs and other mental health conditions, a practice that helps counter stigma. In some locations, the home visiting programs embed peer support specialists with nurses on home visits. Listening session participants reported that individuals with SUD are less likely to enroll in voluntary home visiting programs than those with non-SUD mental health conditions but may be more likely to accept virtual home visiting services. Challenges include a lack of funding to expand home visiting programs, as well as insufficient awareness among potential clients and providers about these services and how to receive them. **Adaptations to current home visiting programs can provide culturally relevant support for pregnant and postpartum individuals from underserved communities (e.g., American Indians and Alaska Natives). Home visiting programs have also been successfully adapted to address IPV** (Davidov et al., 2021; Niland et al., 2020).

Representatives from several states highlighted the following models of integrated care.

- The [Help Me Grow](#) program connects people in Washington state with services such as SUD treatment, parenting support, and mental health care in their communities. Public health departments in the state offer integrated education and comprehensive single-site providers of social services, mental health care, perinatal health care, and other health care. Residential facilities house both women and children and provide a full range of services (e.g., SUD treatment, education on parenting skills, and employment assistance) that build support around the core family unit to create natural linkages (as opposed to crisis intervention).
- Connecticut's [Women's REACH \(Recovery, Engagement, Access, Coaching, and Healing\) program](#) offers a robust continuum of services and coordinates with family care. Women's REACH incorporates services by peer specialists from various communities (e.g., women in recovery, their family members, and nontraditional parents).
- The [FOCUS Early Intervention Program](#) at the University of New Mexico provides wraparound services from the prenatal period through age 3. The program serves families affected by a range of issues—including parental substance use, parental mental health conditions, violence, prenatal exposure to alcohol and other drugs, and unsupported teen parenting. FOCUS integrates family medical care with a continuum of interdisciplinary services, such as developmental assessment, early intervention, and support for the parent–child relationship.
- [Weave West Virginia](#) is a partnership between state-level organizations, institutions of higher education, and national organizations. Weave West Virginia works to improve health, well-being, and safety outcomes for pregnant and postpartum people experiencing IPV and substance use. The initiative uses a multitiered approach to building accessible

and empowering networks of integrated care through statewide partnerships, stakeholder engagement, training and technical assistance, and regional collaborations among birthing centers, certified community behavioral health clinics, domestic violence programs, and other community resources.

### **Addressing Maternal SUD**

Unintentional overdose related to SUD among pregnant and postpartum individuals contributes to pregnancy-associated deaths (Han et al., 2024). States address this issue in numerous ways that contribute to positive outcomes and protective effects. For example, some local health departments provide obstetric care and buprenorphine to pregnant individuals with OUD. In other states, outpatient SUD treatment facilities have specialists who work with pregnant and postpartum individuals to support long-term recovery for the parent–child dyad. Some states have realized good results by offering a quick response time to support pregnant individuals who have SUD with warm handoffs to other care services. In some states, local service organizations provide assistance with alternate housing, detoxification, medication for OUD (MOUD), intensive outpatient program, and/or relapse counseling. A model program (part of a broader state health initiative) addresses the relatively high risk of relapse and drug overdose during the postpartum period (from 43 days after birth to 1 year after birth) by providing services throughout pregnancy and up to 1 year after giving birth. Clients work with a recovery specialist, a case manager, and a person who links them with services. (See [Nurture NJ's website](#).)

In some states, families are eligible for available SUD treatment slots regardless of their region of residence. All programs have multiple components that support families, including residential programs for pregnant individuals and their children. One effective practice involves engaging with pregnant individuals and their families until they obtain the needed services. The [MaineMOM](#) program improves care for pregnant and postpartum individuals with OUD and their infants by integrating maternal treatment services with SUD treatment. This program offers a team-based approach to care, including a perinatal provider, substance use counselor, patient navigator, nurse care manager, mental health clinician, and recovery coach. The [TAMAR \(Trauma, Addictions, Mental Health, and Recovery\) program](#) addresses these intertwined issues by providing tools and resources that promote self-regulation. This evidence-based program has been adapted for a variety of settings and populations (e.g., incarcerated individuals and students).

The West Virginia Perinatal Partnership's [Drug Free Moms and Babies \(DFMB\)](#) is a statewide comprehensive program that supports healthy outcomes for mothers and babies by providing prevention, early intervention, SUD treatment, and recovery support until up to 2 years postpartum. DFMB integrates medical care, mental health care, wraparound recovery support services, social services, and other services. DFMB also partners with community IPV programs.

### **Addressing Maternal Mortality Related to Mental Health Conditions, SUDs, and Other Health Problems**

**State-level programs can address causes of maternal mortality related to mental health, SUD, and suicide.** [Delaware's Healthy Women, Healthy Babies \(HWHB\) program](#) (Table 1) provides services to women in Delaware who are at risk for adverse birth outcomes, including women with mental health conditions. Delaware developed HWHB in response to increasing rates of infant mortality and widening racial disparities, and an evaluation found HWHB to be a

promising practice in improving outcomes of infants born to program participants (Hussaini et al., 2020).

<b>Table 1. Healthy Women, Healthy Babies Program—Delaware</b>	
Subpopulations Served	<p>Delaware women who:</p> <ul style="list-style-type: none"> <li>• Are African American;</li> <li>• Had an earlier pregnancy that resulted in serious problems (e.g., miscarriage, prematurity, infant health problems, low birth weight, stillbirth, infant death); or</li> <li>• Have at least two of the following risk factors: <ul style="list-style-type: none"> <li>○ Chronic disease (e.g., diabetes, high blood pressure);</li> <li>○ Obesity (i.e., a body mass index of 30 or more);</li> <li>○ Stress, depression, or mental health issues;</li> <li>○ Being pregnant and younger than 18 or older than 35;</li> <li>○ Being pregnant for 3 or more months without prenatal care;</li> <li>○ Being at risk for disabilities because of family history or exposure to toxic material; and/or</li> <li>○ Living in a high-risk zone for below-average birth outcomes.</li> </ul> </li> </ul>
Issues Addressed	<p>Adverse infant outcomes General health and wellness</p>
Activities	<p>Prenatal care Personal health and wellness Nutrition Family planning Mental health</p>
Setting	Community-based organizations (CBOs)
Duration	Ongoing, with HWHB Year 1 implemented and evaluated and HWHB Year 2 evaluation underway
Geographic Coverage	Delaware
Category	<ul style="list-style-type: none"> <li>• Referral</li> <li>• Community-based services</li> </ul>
Practices Incorporated	<ul style="list-style-type: none"> <li>• The <a href="#">HWHB program is considered a promising practice</a>.</li> <li>• The HWHB program integrates evidence-based practices: recruitment through CBOs in high-risk zones (see the <a href="#">webpage for what qualifies</a>); the screening, brief intervention, and referral to treatment (SBIRT) model; and Patient Health Questionnaire-9 (PHQ-9) tools.</li> </ul>
Notes	<ul style="list-style-type: none"> <li>• The <a href="#">HWHB program’s webpage</a> has more information.</li> <li>• The <a href="#">HWHB Year 1 evaluation report</a> is available, and the <a href="#">findings</a> have been published.</li> <li>• The HWHB program provides state funds to federally qualified health centers (FQHCs), providers affiliated with birthing hospitals, and CBOs.</li> </ul>

### **Using Telehealth to Support Pregnant People, Postpartum Individuals, and Their Providers**

**Telehealth approaches can extend the workforce and enhance access to services, particularly in rural areas.** Multiple states sponsor consultation phone lines staffed by licensed individuals who take calls from pregnant people, family members, and professionals to support maternal mental health. These consultation phone lines give screening and information to callers about available services. Consultation phone line specialists also provide ongoing training to local health department staff members. In Texas, the [Perinatal Psychiatry Access Network](#) enables real-time access to a multidisciplinary network of mental health experts, including reproductive psychiatrists. The network offers peer-to-peer consultations by phone, vetted and personalized referrals and resources, and mental health–related continuing medical education credits. Providers in the state enroll in the network and can reach a mental health expert within 5 minutes for a local and individualized referral that is sent within one business day.

The Medical University of South Carolina's [Mom's IMPACTT](#) (IMProving Access to Maternal Mental Health and Substance Use Disorder Care Through Telemedicine and Tele-Mentoring) provides on-demand referrals and resources to anyone in the state who is pregnant or less than 12 months postpartum and who has an SUD or mental health condition. Mom's IMPACTT also offers real-time psychiatric consultations for providers caring for this population. Other states use telehealth to provide specialty consultations for maternal mental health, particularly for rural residents, and other states are working to establish similar telehealth services. Some of these state-level efforts have encountered barriers related to federal payment regulations for the rehabilitation model. Under these regulations, either the care recipient or the provider must be present at the clinic.

### **PART 3. FEDERAL, STATE, AND LOCAL MATERNAL HEALTH POLICIES AND OTHER POLICIES AFFECTING MATERNAL MENTAL HEALTH**

Federal, state, and local policies relevant to maternal mental health and SUDs can function to improve outcomes by providing necessary mental health services and other support services. However, other policies—such as reporting pregnant and postpartum individuals to child welfare agencies or the criminalization of substance use during pregnancy—can contribute to adverse outcomes. As such, policies function as SDOH. Indeed, CDC’s description of SDOH recognizes that they include “the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems” (Centers for Disease Control and Prevention, n.d.-n). In general, the frontline workers contributing to this report endorsed the Task Force on Maternal Mental Health’s priorities (e.g., “Establish policies that support non-stigmatizing and non-punitive approaches to screening for substance use disorders and mental health conditions in pregnant and postpartum individuals and ensure access to culturally responsive, evidence-based, trauma-informed, patient-centered care”). **Most of the policies discussed here operate at the state level; the federal policy levers are limited.**

#### **Policies Related to SDOH and Improving the Mental Health of Pregnant and Postpartum Individuals**

**Policies—those related to health care and social services, as well as ones that influence other aspects of life—can affect SDOH and equity for pregnant and postpartum**

**“I had paid leave, 12 weeks paid. My husband had 2 weeks paid and took 2 weeks of regular leave. It [was terrible]. It was really hard. I was still not recovered in terms of energy.”**

**—M.S., mother of two**

**individuals.** Frontline workers from the maternal health and mental health arenas suggested that addressing broad policy issues related to SDOH would help improve the mental health of the populations they serve. **These workers strongly endorsed policies that would provide paid family and medical leave and increase the supply of affordable child care as a way to enhance maternal mental health.** Participants in the listening sessions also mentioned the potential benefits of policies ensuring affordable housing and livable wages.

#### **Policies Related to the Criminalization and Decriminalization of Substance Use During Pregnancy**

**Frontline workers from the maternal health and mental health fields particularly noted the benefits to maternal health of decriminalizing substance use during pregnancy and not categorizing it as a form of child abuse or neglect.** Similarly, these workers believe that maternal mental health outcomes would benefit from eliminating policy mandates for reporting individuals who use substances during pregnancy or for drug screening—consistent with policy statements from the [American Society of Addiction Medicine \(ASAM\)](#) and the [American College of Obstetricians and Gynecologists \(ACOG\)](#). In some states where such mandates have been implemented, the necessary infrastructure support—such as expansion of services, building capacity in the treatment system, educating providers, and enhancing the workforce in terms of increased numbers and through training—has not been developed. (See also Roberts et al., 2024, Training health professionals to reduce overreporting of birthing people who use drugs to child welfare, *Addiction Science & Clinical Practice*; [Prenatal Drug Exposure: CAPTA Reporting Requirements for Medical Professionals](#); and [Doing Right at Birth](#).)

**States have implemented plans of safe care (POSCs)**, which are intended to address the services and supports needed by an infant with prenatal substance exposure and their parent. These plans ensure that both the parent and the child remain safe and healthy by connecting them with services—such as home visiting and wraparound supports, early intervention, parenting education, and assistance with recovery—and following up over time. **Some states have adopted the Safe Babies Court model**, a collaborative approach that focuses on supporting young children and their families within the child welfare system, providing them with targeted and timely connection with services and resources. Additionally, states are engaged in **efforts to educate primary care physicians, frontline workers in child welfare, and ob-gyns about the need to treat pregnant and postpartum individuals with SUD**. However, implementation varies widely, and many states continue to enforce punitive policies, against ASAM and ACOG recommendations. Also, some legal projects and partnerships, such as [Legal Aid of West Virginia](#), specifically address the critical civil and legal issues that can function as barriers to recovery from SUD, such as those related to criminal records, housing, employment, driver’s licenses, public benefits, and child custody. The [National Center for State Courts’ series called “Promoting Well-Being in Domestic Relations Court”](#) is also designed to improve outcomes for families experiencing mental health and substance use challenges while also factoring in the role of mental health and substance use coercion in the context of IPV.

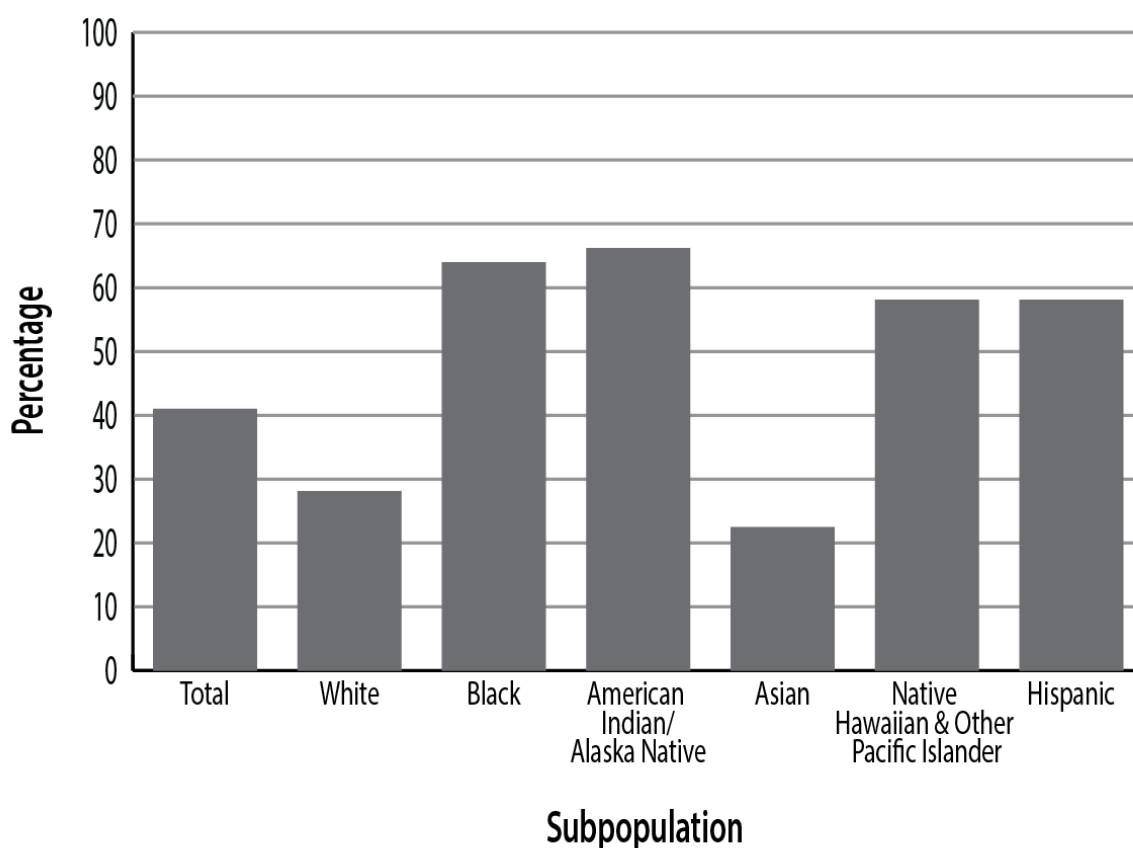
### Medicaid Policies

Medicaid policies represent one way that the federal government affects maternal mental health. Medicaid policies are highly relevant to maternal health, as Medicaid is the source of payment for 41 percent of births in the United States (Osterman et al., 2023). Under-resourced populations particularly rely on Medicaid benefits (Osterman et al., 2023).

**“The hardest part is finding someone who takes Medicaid. I can call all the therapists in the area, but not everyone takes Medicaid.”**

**—F.P., pregnant mother of one**

## Percentages of People Who Use Medicaid as a Source of Payment for Births in 2021, by Race/Ethnicity



Source: (Osterman et al., 2023).

At least 45 states, the District of Columbia, and the U.S. Virgin Islands have expanded Medicaid to cover maternity care for up to 1 year postpartum (U.S. Department of Health and Human Services, 2024). In the listening sessions, **individuals who work in the field, across all states and territories, strongly endorsed the maternal mental health benefits of expanding Medicaid to cover maternity care for up to 1 year postpartum. However, increasing awareness of this policy change among providers, as well as pregnant and postpartum individuals, in all states should become a priority.** Some states have worked with their Medicaid programs to cover the services of additional workforce members (such as community health workers and state-certified peer recovery specialists) who help support maternal mental health. The Medicaid programs of some states cover the services of doulas—trained nonclinical professionals who provide emotional, physical, and informational support before, during, and after labor and birth (Knocke et al., 2022). One state representative participating in the listening sessions noted that the state extends Medicaid coverage to pregnant and postpartum individuals regardless of their immigration status.



**States have found ways to address the Medicaid coverage challenges experienced by parents with SUDs.** Parents with SUDs or whose children are placed in protective services may put their own Medicaid coverage at risk, and a loss of coverage might impede behavioral change by reducing access to SUD treatment and other care to support recovery. To address this challenge, one state participating in the listening sessions implements the Medicaid Section 1115 waiver for SUD treatment. The waiver maintains coverage for parents who would have lost insurance when their children were placed in protective services. Parents are covered for SUD treatment services while they work toward reunification. Another state participating in the listening sessions implements Medicaid waivers for home- and community-based services (authorized in Section 1915[c] of the Social Security Act). This policy permits the provision of clinical and home visiting services based on the characteristics of parents and the risk of their children's being placed into state care.

#### **Policies That Exacerbate or Ease Workforce Shortages**

From the frontline perspective, **state policies that exacerbate workforce shortages and limit access to services** include increased supervision and clinical requirements for licensure of professionals from other states. Limits on the number of advanced practice nurses who can be sponsored by psychiatrists also worsen workforce shortages. **State policies that ease workforce shortages and improve access to services** include expansion of the types of providers who can prescribe MOUD and the removal of a cap on the number of patients who can receive this therapy (implemented during the COVID-19 pandemic). **Difficulty recruiting and retaining SUD treatment providers** after they have been trained contributes to the general workforce shortages in all states and territories. To address this challenge, one state that participated in the listening sessions noted that it supports licensure or certification to enhance the retention of current workforce members.



#### **PART 4. THE WORKFORCE**

**States, territories, and local areas face workforce-related challenges, in addition to a chronic shortage of providers. Shortages fall mostly in the area of education and training, and members of the workforce identified this area as a high priority.** During the listening sessions, many state representatives reported that they use workforce feedback to determine training topics. These representatives also mentioned innovative ways to address workforce training needs and increase the number of perinatal and mental health providers through the employment of nonclinical peer support specialists, doulas, community health workers, and other community-based workers.

##### **The Need for Ongoing Training and Education**

**State representatives reported that members of the mental health workforce, the perinatal care workforce, and other professionals who work with pregnant and postpartum individuals have indicated a need for ongoing training related to maternal mental health, particularly in the following areas:**

- Maternal mental health conditions in general;
- Co-occurring disorders;
- Trauma (e.g., trauma-informed care, including GBV- and IPV-informed care, tailored to specific professional roles; responding to GBV and mental health/substance use coercion; and provider self-care for vicarious trauma);
- Medications for SUDs, including MOUD; and
- Addressing the lack of stable housing among clients.

**States have developed ways to address the maternal mental health–related training needs of their mental health, perinatal, and maternity care workforces.** One approach is to adopt a train-the-trainer model. One state reported taking this approach to address the need for training related to trauma, lack of stable housing among clients, and GBV. A state participating in the listening sessions mentioned training recovery support specialists in mental health first aid. Another state serves as a centralized source of targeted training on maternal mental health, which removes the burden from individual agencies and ensures a baseline level of knowledge. One state has developed a [provider toolkit](#) and training videos with information on identifying and treating perinatal mood and anxiety disorders. Another offers free webinars that focus on maternal mental health conditions and fulfill continuing education requirements. Finally, one state reported that it reconceptualized what SUD treatment providers can do based on the [ASAM Criteria](#) and changed reimbursement accordingly. Some adjacent states have established interstate compacts and reciprocal agreements so that licensed professionals can practice without geographical restrictions.

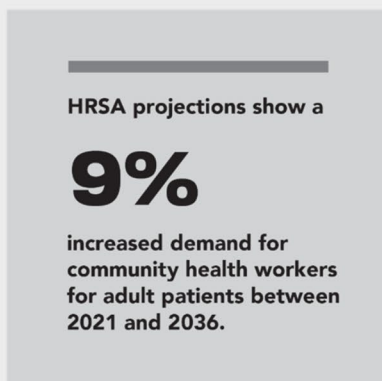
Some states provide perinatal care specialists with training in SUD and other mental health conditions, racial equity, cultural competency, trauma-informed care, maternal health equity, and perinatal depression. Others train primary care practitioners so they can support maternal mental health services. Some nonprofit organizations (e.g., the [Spokane Tribal Network](#) and the [Shades of Motherhood Network](#)) train members of under-resourced racial and ethnic groups in providing doula services and in some aspects of maternal mental health care.

**States leverage university medical centers to provide training and education on maternal mental health to professionals.** For example, Emory University's [PEACE \(which stands for "perinatal psychiatry, education, access, and community engagement"\) for Moms](#) program educates physicians, nurse practitioners, midwives, and physician assistants to provide needed mental health treatment to women who are uninsured, are underinsured, or live in communities that lack access to care. Similarly, the University of Nebraska Medical Center's child psychiatry center offers workforce trainings on maternal mental health.

### The Roles of Peer Support Specialists, Doulas, and Community Health Workers

Peer support specialists are individuals in recovery from SUD and other mental health conditions who assist others experiencing similar situations. Specifically, peer support workers help people become and remain engaged in the recovery process and reduce the likelihood of recurring substance use (Substance Abuse and Mental Health Services Administration, 2023e). Peers can provide services—including sharing resources and building skills, leading recovery group activities, and mentoring and setting goals—to clients beyond the clinic and in the community. With input from subject matter experts and the public, SAMHSA developed a description of core competencies for peer support workers to guide training and workforce expansion efforts (Substance Abuse and Mental Health Services Administration, 2023c). States have the option to cover certified peer support professionals through Medicaid (Policy Center for Maternal Mental Health, 2022).

Doulas are trained nonclinical professionals who provide emotional, physical, and informational support before, during, and after labor and birth (Knocke et al., 2022). The continuity of doula care is notable and may contribute to enhanced maternal mental health (e.g., satisfaction, increased well-being, and decreased anxiety) and better birth outcomes (e.g., fewer infants with low birth weight and improved breastfeeding uptake), according to literature reviews (Ramey-Collier et al., 2023; Sobczak et al., 2023). Evidence also suggests that in addition to regular nursing care, continual one-to-one emotional support provided by doulas and other support personnel is associated with improved outcomes for women in labor (American College of Obstetricians and Gynecologists, 2019). Doulas also have been shown to advance maternal health equity among under-resourced populations (Van Eijk et al., 2022). Despite these positive outcomes and [ACOG support of doula care](#) (American College of Obstetricians and Gynecologists, 2019), health insurance seldom reimburses people for doula services (Safon et al., 2021).



Community health workers (CHWs)—also known as community health advisers, outreach workers, patient navigators, health coaches, and *promotoras/promotores de salud*—are people who work with the local health care system. CHWs usually share the background (e.g., ethnicity, first language, and socioeconomic status) with the people in their communities—primarily underserved communities. CHWs may have life experiences that inform their work and can often interpret, translate, educate, and inform in a culturally appropriate way; help link people to care; offer informal guidance on health behaviors; advocate for individual and community health needs; and provide some direct services (e.g., blood pressure screening). CHWs improve care coordination, health equity, and overall population health; are valuable resources for members of their communities by reaching them where they live, eat, play, work, and worship; and act as frontline agents of change to reduce health disparities (Health Resources & Services Administration, 2019; U.S. Department of Health and Human Services, 2022). However, CHW training and educational requirements are not standardized. CHWs typically have a high school diploma and on-the-job training; state certification programs are available.

The Health Resources and Services Administration’s (HRSA) National Center for Health Workforce Analysis projects a 9 percent increase in the demand for adult-serving CHWs between 2021 and 2036 (Health Resources & Services Administration, 2019). HRSA plans to train 13,000 CHWs through the [Community Health Worker Training Program](#).

### Extending the Workforce

Representatives from several states noted that they are **extending the workforce with nonclinical providers—such as peer support specialists, doulas, and CHWs—to supplement the services provided by licensed clinical social workers, psychotherapists, licensed professional counselors, and licensed marriage and family counselors.** Nonclinical providers can meet with clients in home- and community-based settings, and many frontline workers advocate the reimbursement of their services through Medicaid.

**“My husband and I joined a mindfulness birthing group. ... The tools that I learned there were most valuable.”**

**—A mother**

**Training and credentialing these nonclinical members of the workforce to provide services related to maternal mental health remains a priority for states.** (See “The Roles of Peer Support Specialists, Doulas, and Community Health Workers.”) One innovative approach involves developing educational programs specific to maternal and child health. To achieve this

**“I joined the Black women’s center. They have a doula on staff to help. She makes me appointments [and] has child care. That’s how I kept it together.”**

**—J.N., pregnant mother of one**

aim, people in the field work with state legislators and others to build the social work profession (e.g., providing field supervision) to offset the critical shortage of licensed providers. Listening session input from one state indicated that midwifery practices have incorporated doulas and have agreed upon a value-based package with the state’s Medicaid program. Therefore, in this state,

doulas are reimbursed through the midwifery practice rather than directly from Medicaid. This state is working toward Medicaid reimbursement for doula services, currently an optional Medicaid service.

Peer support specialists are a growing part of the mental health workforce, and **increasing the number of peer providers with expertise in maternal mental health is crucial for expanding access to services.** Colorado’s

[Alma](#) is an evidence-based program that trains

individuals who have lived experience with maternal mental health conditions to mentor others. The program has expanded to include peer mentoring for parents with current substance use or a history of substance use. In other states, peer specialists support pregnant and parenting members of the American Indian and Alaska Native community. Peer specialists in other states educate neonatal intensive care unit staff members on talking with parents about seeking SUD treatment when an infant experiences opioid withdrawal.

**“Having someone who looks like me being my peer does give me a different feeling.”**

**—J.N., pregnant mother of one**

**State Medicaid Reimbursement of Peers, Doulas, and CHWs**

- In 2022, Medicaid covered mental health services delivered by peers for adults age 21 or older in 40 states (Guth et al., 2023; KFF, n.d.).
- A 2022 policy analysis found that the Medicaid programs of eight states (Florida, Maryland, Minnesota, New Jersey, Nevada, Oregon, Rhode Island, and Virginia) and the District of Columbia cover doula services (Knocke et al., 2022). California began similar coverage in January 2024.
- In the Medicaid Budget Survey for State Fiscal Years 2023 and 2024, 12 states (Colorado, Delaware, Illinois, Kansas, Massachusetts, Michigan, Nevada, New Hampshire, New York, Ohio, Oklahoma, and Pennsylvania) and the District of Columbia reported that they were expanding coverage of doula services (Hinton et al., 2023). As of July 1, 2022, more than half of states (29 of 48) that had responded to this survey reported allowing Medicaid payment for services provided by CHWs (Haldar & Hinton, 2023). Some states reported that they were planning to implement coverage of or payment for CHW services for fiscal year 2023, with a few targeting CHW interventions to pregnant and postpartum populations (Haldar & Hinton, 2023).

## **PART 5. DATA**

**Listening session feedback identified various data gaps, needs, and challenges from the states' perspectives.** Generally, public health organizations rely on state-level data. Although county-level data would most likely prove informative, such data are generally not available. The numbers of people in specific racial and ethnic groups are often too small for counties to report on maternal health outcomes by race and ethnicity at the local level. Further, national data collection and surveillance remain limited for U.S. territories and U.S.-affiliated Pacific islands, and such data are needed to understand the burden of maternal mental health conditions in these areas. Participants in the listening sessions indicated that these gaps in data collection, along with difficulties in sharing data across systems, prevent states from identifying issues and targeting interventions and services accordingly; thus, data limitations have an adverse effect on outcomes.

**Local public health departments rely on data-sharing contracts across agencies and working with community-based groups to support their data reports.** However, listening session participants also noted that data on mental health conditions are federally protected and cannot be shared without patient permission. POSCs may also limit data sharing. These limitations present challenges to obtaining data that could help improve care.

**Many states employ maternal mortality review committees (MMRCs), which are local review boards that analyze government, medical, and social data to understand the causes of maternal mortality, including those related to maternal mental health and substance use and how these causes intersect with SDOH, structural inequities, and other factors, including trauma and IPV.** Some states (such as [Illinois](#)) have separate MMRCs that specifically focus on overdose, suicide, and homicide, including IPV-related homicide. MMRCs face challenges related to data collection—particularly uneven documentation by providers, state medical examiners, and other recordkeepers.

**States may face multiple challenges related to data—including different definitions, incompatible systems, and the expense of creating a data culture.** However, researchers, policymakers, and others have great interest in data on people who experience mental health disorders, including pregnant and postpartum individuals. State SUD treatment directors and their stakeholders need data relevant to the maternal population, including SDOH, rates of substance use, and the prevalence of maternal mental health conditions, trauma, and GBV. Outcomes associated with the screening, brief intervention, and referral to treatment (SBIRT) approach with this population warrant further study, and how often a positive screen results in intervention and treatment remains an important outstanding question.

## **PART 6. EQUITY**

**States report that comprehensive services—including assistance with alternate housing, detoxification, SUD medications, and linkage with an intensive outpatient program and relapse counseling—address SDOH, help advance equity, and improve outcomes.** Warm handoffs to service providers also help counter barriers related to SDOH. Some states have improved equity by establishing conditions of award to local grantees that require counties to describe their equity-focused efforts to receive funds for local mental health projects and services. States also are working on equity training in collaboration with various agencies and associations. One approach to coordinating equity efforts involves placing them within the purview of the governor’s mental health council. States could potentially leverage federal funding for recovery housing support with Medicaid 1115 waivers (Shiovitz, 2023).

Participants in the listening sessions noted that collaboration with tribal communities can help to advance equity. However, individual tribes have unique requirements, such as determining which set of tribal community professionals should work with state officials. Additionally, sharing information regarding POSCs requires great conscientiousness.

### **Opportunities for State and Local Partnerships**

One area for potential partnerships between federal agencies involved in data collection on maternal health and states relates to the use of this information in practice. The data are often published in the research literature and not used for specific direct public health action. Relevant federal and state agencies might form partnerships focused on coordinating a needs assessment and monitoring the unmet counseling and treatment needs of pregnant people to guide changes in service delivery. Additionally, agencies could use a similar approach to monitor and track workforce recruitment and retention, including collecting data regarding workforce initiatives and innovation, to guide staffing levels and training efforts.

As mentioned, the listening session feedback included mention of the lack of county-level data on maternal mental health. CDC’s PRAMS—which supports public health research that focuses on the impact of SUDs and other mental health conditions on maternal, infant, and child health—has expanded its county-level indicators to include more measures related to depression and anxiety. In addition, state and local partnerships could focus on leveraging these data to improve access to care and reduce health disparities.

## **CONCLUSION**

Input from listening sessions with four national associations representing professional groups in the fields of public health, maternal and child health, substance use treatment, and mental health support provided the task force and HHS staff members with valuable insights into maternal mental health. Feedback from 150 participants located in 43 U.S. states and territories specifically addressed:

1. The current state of affairs in maternal mental health;
2. Model state and local programs supporting pregnant and postpartum individuals with mental health conditions and SUDs and their families;
3. Federal, state, and local maternal health policies (and other policies that affect maternal mental health);
4. The maternal mental health workforce;

5. Data relevant to maternal mental health; and
6. Equity in maternal mental health.

The task force incorporated this input, along with public comments solicited by the request for information and additional comments from task force reviewers, into the findings presented in this report to Congress and the recommendations in the national strategy on maternal mental health care. The feedback detailed above will also inform a later report to state governors that details opportunities to implement the national strategy through local- and state-level partnerships.



## SECTION 6: CONCLUSION

The U.S. Department of Health and Human Services (HHS) formed the Task Force on Maternal Mental Health in response to a directive from the U.S. Congress. The task force is a subcommittee of SAMHSA’s Advisory Committee for Women’s Services and falls under the Federal Advisory Committee Act. In establishing this task force, Congress took a step toward saving the lives of women and others with perinatal mental health conditions and substance use disorders (SUDs). This report has summarized current trends and problems and other information associated with perinatal mental health conditions and SUDs—including their impact on maternal mortality and other outcomes, the subgroups most affected by these problems, the nation’s current efforts to address the crisis, best practices for addressing these health conditions, relevant policies, and an evaluation of federal programs and opportunities for further coordination to improve outcomes for mothers and their children. Below, we highlight key points from this report.

### MATERNAL MENTAL HEALTH CONDITIONS AND SUDs IN THE UNITED STATES

Task force members and other medical and policy experts have identified an urgent public health problem of untreated mental health conditions and SUDs among pregnant and postpartum individuals—that is, throughout pregnancy and up to 1 year after birthing. Although up to 85 percent of individuals experience the baby blues (e.g., crying, mood swings, anxiety, and sleeplessness) in the first 2 weeks after delivery, these symptoms generally resolve quickly, do not require treatment, and do not constitute a mental health condition (Byatt, Mittal, et al., 2019; Centers for Disease Control and Prevention, n.d.-b). However, for some women and other individuals, maternal mental health conditions can begin earlier and persist beyond the perinatal period. One study found that among women screening positive for maternal mental health conditions, 26.5 percent experienced symptoms prior to pregnancy, 33.4 percent had symptoms that emerged during pregnancy, and 40.1 percent had symptoms that emerged postpartum (Wisner et al., 2013). Individuals with prior or emerging mental health conditions can remain healthy throughout pregnancy and the postpartum period with appropriate treatment (American Psychiatric Association, 2023b). However, without treatment, maternal mental health conditions can persist, worsen, and increase risks for death and other adverse outcomes for the mother and infant.

Perinatal mental health conditions are common—affecting an estimated 1 in 5 childbearing individuals annually (American Psychiatric Association, 2023b). Mental health conditions range in severity and include major depression; anxiety disorders; post-traumatic stress disorder (PTSD) and other conditions related to past traumas (e.g., sexual trauma, adverse childhood experiences, and gender-based violence [GBV]), as well as ongoing intimate partner violence (IPV); perinatal obsessive-compulsive disorder (OCD); and postpartum psychosis (Byatt, Mittal, et al., 2019; Clarke et al., 2023). In the United States, perinatal mental health conditions are on the rise, with one study finding a 52 percent increase between 2017 and 2020 in the rate of hospital stays for childbirth with the birthing parent having at least one mental health disorder diagnosis (Weiss et al., 2022).

**“How can anyone go through the process of becoming a new mother without having a therapist? It felt so important to have someone to talk to.”**

**—A mother**

## The Task Force on Maternal Mental Health's Report to Congress

Below are some of the key findings cited by the task force in this report.

- Maternal mortality
  - The United States has the highest maternal mortality rate among high-income countries (Gunja et al., 2022). The U.S. maternal mortality rate had been increasing in recent years but decreased in 2022 compared with 2021 (Hoyert, 2024).
  - Suicide, drug overdose, and other causes related to mental health conditions and SUDs are the leading cause of pregnancy-related deaths in the United States and account for 22.7 percent of these deaths (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022). GBV, particularly current IPV, is a significant contributor to maternal mortality from suicide, overdose, and homicide (Campbell et al., 2021; Joseph et al., 2024).
  - Maternal mortality review committees concluded that all pregnancy-related deaths from suicides, drug overdoses, and other causes associated with mental health conditions and SUDs are preventable (compared with 64 percent of deaths from other causes). Documented medical histories indicate that 72 percent of individuals with pregnancy-related deaths caused by mental health conditions had a history of depression; 67 percent had past or current substance use (Trost et al., 2021).
- Maternal mental health conditions
  - The cost of untreated maternal mental health conditions is estimated to be \$14 billion a year in the United States (Luca et al., 2020).
  - Less than 20 percent of pregnant and postpartum individuals are screened for maternal mental health disorders (Burkhard & Britt, 2022).
  - More than 75 percent of individuals who experience maternal mental health conditions do not receive treatment (Byatt et al., 2015).
  - Women with untreated mental health conditions during pregnancy are at increased risk for substance use and are less likely to have good prenatal care and nutrition, which may affect the health of their infants (Jahan et al., 2021). Children of parents with untreated maternal mental health conditions may have long-lasting health effects, including behavioral, cognitive, and emotional delays (Mughal et al., 2019).
- Maternal SUD
  - SUDs during pregnancy are also associated with negative outcomes for women and their babies, including maternal hypertension, stillbirth, birth defects, developmental disabilities in the children, low birth weight, neonatal abstinence syndrome, and fetal alcohol spectrum disorders (FASDs) (Centers for Disease Control and Prevention, n.d.-j; Prince et al., 2024).
  - The cost of FASDs alone is more than \$4 billion a year in the United States, and the average cost of a hospital stay for a newborn with neonatal abstinence syndrome is nearly seven times that of infants without this condition (Centers for Disease Control and Prevention, n.d.-a; Lupton et al., 2004).
- Social determinants of health (SDOH) and policy
  - SDOH—such as food insecurity, financial insecurity, racism, discrimination, housing instability, lack of access to transportation, and lack of access to child

care—influence maternal mental health and the ability to access support or care (Ujah et al., 2023). Addressing SDOH can help to improve maternal mental health outcomes.

- Federal, state, and local policies—such as postpartum Medicaid coverage, paid family and medical leave, and reimbursement for health care and mental health services—influence maternal and child health. Policy changes could improve outcomes for mothers and their babies (Wisner et al., 2024).
- Multiple disparities related to maternal mental health and substance use outcomes persist among demographic subpopulations (e.g., those related to race, ethnicity, age, socioeconomic status, educational achievement, and geographic location)—with Black and American Indian/Alaska Native (AI/AN) people disproportionately affected (Policy Center for Maternal Mental Health, 2023a, 2023b; Wisner et al., 2024).
- Black people, Hispanic people, AI/AN people, individuals residing in rural areas, and individuals with less than a high school education generally are exposed to less favorable SDOH, resulting in worse health outcomes and less access to high-quality health care (Hill et al., 2023; Singh et al., 2017).
- The proportion of pregnancy-related deaths caused by mental health conditions differs by race and ethnicity. These conditions were the highest causes of pregnancy-related deaths among White, Hispanic, and AI/AN populations (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022; Trost, Beauregard, Chandra, Njie, Harvey, et al., 2022).
- The proportion of pregnancy-associated deaths from suicide varies by age group and by race and ethnicity. Different studies found higher rates of pregnancy-associated deaths from suicide among several age groups (15–19, 20–24, and 40 or older) and among White and AI/AN populations (Margerison et al., 2022; Palladino et al., 2011).
- The proportion of pregnancy-associated deaths caused by overdose differs by race and ethnicity (with high rates among AI/AN women), by age (with higher rates among women 35 or younger), and by geographic location (with higher rates among those living in rural areas and counties characterized by high income inequality) (Han et al., 2024; Margerison et al., 2022).
- Stigma
  - Stigma, idealized images of mothers, and a lack of awareness about maternal health challenges have negative effects on many individuals, families, and communities.
  - Mothers fear that reporting any substance use or mental health symptoms will be reported and that their children will be removed from the home (Nichols et al., 2021; Weber et al., 2021).
  - Abusive partners leverage these legitimate fears as a tactic of control (Phillips et al., 2021; Warshaw et al., 2014).
  - Destigmatizing, culturally relevant, and trauma-informed communications and education could mitigate stigma associated with maternal mental health conditions and SUDs and could encourage treatment seeking.

- Gender-based violence
  - GBV, including ongoing IPV, has a significant impact on maternal mental health and maternal mortality and contributes to other adverse maternal and infant outcomes. Interventions need to address all forms of GBV, including the traumatic effects of GBV across the lifespan and ongoing risks from abusive partners.
- Challenges in the health care workforce and system
  - Several health care workforce challenges, many exacerbated by the COVID-19 pandemic, have a negative impact on maternal mental health and SUD outcomes (Britt et al., 2023).
  - Shortages in the health care workforce (including mental health care providers and providers of treatment for SUDs) and workforce burnout limit access to care and negatively affect mothers and their children.
  - Workforce shortages are a major cause of unmet treatment needs.
  - Most birthing-aged women in the United States (96 percent) live in an area with a shortage of maternal mental health professionals (Britt et al., 2023).
  - In listening sessions with state and local stakeholders, participants reported that underfunding of community-based organizations and no or low levels of reimbursement for health care services related to mental health conditions and SUDs further limit access to care, particularly in rural and under-resourced communities.
  - Fragmented and disconnected health care and social services systems in the United States result in a lack of continuity of care for individuals with maternal mental health conditions and SUDs, often require patients to make multiple visits to different providers in various locations, create additional stress throughout the perinatal period, discourage individuals from seeking treatment and support, and cause difficulty in accessing services.

#### THE CURRENT STATE OF MATERNAL MENTAL HEALTH SERVICES, PROGRAMS, AND BEST PRACTICES

The Task Force on Maternal Mental Health collected and summarized information on current best practices, programs, and policies related to this public health crisis; promising solutions, some already in effect on the small scale, that could help to address these problems in the future with appropriate support and implementation; and longer-term directions for future research and practice. Below, we highlight key task force findings from this report.

- **Access to Services Is Limited.** Pregnant and postpartum individuals with mental health conditions and SUDs, particularly under-resourced individuals and those living in under-resourced communities, often face challenges accessing treatment services. Providing greater access to services will involve manifold long-term initiatives to address workforce shortages and training, to improve continuity of care along with associated insurance/Medicaid coverage and reimbursement, and to address systemic issues, individual circumstances, and SDOH preventing access to care. However, short- and medium-term steps to improve access to services could include the following:
  - Helping people locate affordable services by providing digital tools, supporting professional and peer navigators, engaging primary and perinatal care providers, leveraging psychiatry access programs (e.g., telehealth), supporting partnerships

- with community-based GBV service providers, and developing other ways to connect patients to care;
  - Continuing and expanding Medicaid coverage of maternal mental health and SUD treatment services (with Medicaid being the source of payment for 41 percent of births in the United States and under-resourced populations particularly relying on Medicaid benefits) (Valenzuela & Osterman, 2023);
  - Expanding psychiatric consultation access so that providers can speak with maternal mental health experts for guidance and supporting such consultations with Health Resources and Services Administration funding; and
  - Adopting a “treatment-first” approach for maternal SUDs and perinatal substance use screening, discontinuing mandatory reporting policies and punitive/judicial practices, decriminalizing substance use during pregnancy, and ceasing categorization of substance use as a form of child abuse or neglect to encourage treatment seeking.
- **Evidence-Based Prevention, Screening, Diagnosis, and Treatment Need to Be Enhanced.** Researchers, clinicians, task force members, and other experts and stakeholders have identified effective, evidence-based prevention efforts, screening methods, diagnostics, and treatment for maternal mental health conditions and SUDs. Federal, state, and local support for these practices (through Medicaid, federally supported community clinics, and other mechanisms) could continue and expand access to care and implementation of these proven interventions, thereby improving outcomes for mothers, their children, and their families.
    - **Prevention.** Expanding access to support services for individuals prior to pregnancy and during the perinatal and postpartum periods would help prevent maternal mental health conditions and SUDs, particularly among under-resourced populations, and address barriers to care, including SDOH and GBV-related barriers.
    - **Screening.** Screening for perinatal mental health conditions and SUDs represents an initial step in educating pregnant and postpartum individuals about the risks of such conditions and in referring them as needed for diagnostic consultations or treatment. Screening can occur in clinical settings (e.g., primary care, obstetric services, and other health care services), and both clinicians and non-clinicians can administer many research-validated screening tools in any setting. Culturally adapted screening tools are needed. Screening should represent an opportunity to normalize conversations about mental health and substance use as a part of routine care—*not* an excuse for drug testing or toxicology. Creating safe opportunities to talk with patients about ongoing IPV and GBV-related trauma can also help to reduce barriers to care.
    - **Diagnosis.** Perinatal care providers, other health care providers, and nonclinical personnel performing screening with evidence-based tools should refer patients and clients to appropriate diagnostic services after a positive screen. In-person or telehealth consultations with mental health specialists constitute a best diagnostic practice under such circumstances. Another potential best practice currently under study and discussed above involves providing mental health care without a formal diagnosis under certain circumstances.

- **Treatment.** Evidence-based treatment practices for maternal mental health conditions and SUDs include psychotherapies, pharmacotherapies, integrated care models (in which prenatal, primary, and postnatal care integrates specialty services for mental health care and SUD treatment), home visiting programs, multigenerational support programs, federally supported community clinics, gender-responsive services, and culturally competent, linguistically appropriate services. Promising approaches include the integration of GBV services and/or partnerships.
- **Continuity of Care Is Lacking for Most Mothers.** Fully integrated, universal access to the full spectrum of evidence-based maternal mental health and SUD treatment services—from prevention to screening to diagnosis to intervention—would improve outcomes for mothers and their children. Continuity of care stems from thorough follow-up care coordination by clinicians and support personnel (including peer navigators) and facilitated connection between treatment services. Addressing lapses in insurance coverage and the fragmented, disconnected nature of health care and social service systems could also improve continuity of care, treatment seeking, and access to services. Leveraging and expanding Medicaid programs could similarly enhance care coordination.
- **Workforce Issues Drive Limited Access.** Workforce shortages, training issues, and associated problems exacerbate maternal mental health conditions and SUDs and continue to limit access to services. The task force emphasizes the importance of increasing recruitment, training, and retention of providers in the following findings:
  - Additional workforce training specific to maternal mental health conditions and SUDs is needed. Mental health providers require training specific to pregnant and postpartum individuals, and conversely, perinatal providers need training on screening, treating, and referring pregnant and postpartum individuals experiencing mental health conditions, SUDs, and/or gender-based violence or other traumas, as well as IPV-specific safety, confidentiality, and access concerns. Members of the workforce also require specific training in implementing collaborative or integrated care, linking patients and clients to relevant community-based resources, and referring patients and clients to perinatal psychiatric consultations.
  - Targeted outreach programs, mentoring programs for health care students and applicants, recruitment and retention incentives, addressing workforce burnout, educational loan reimbursements for providers, and educational stipends could increase recruitment and retention.
  - Expanding opportunities for trainees to intern with integrated-care and community-based systems could increase expertise among the workforce, as could establishing maternal mental health certification programs and leveraging existing programs.
  - The community-based workforce—including community health workers, doulas, peer support specialists, peer navigators, and lactation consultants—can provide culturally relevant multigenerational services and supports to mothers and families. Expanded training and credentialing of this workforce could improve access. Peer support specialists can supplement clinical personnel, and expanded Medicaid reimbursement could increase the utility of and foster growth in the nonclinical community workforce.

- Changing policies that restrict service providers (e.g., increased supervision/licensure of out-of-state professionals and limits on the number of advanced practice nurses who can be sponsored by psychiatrists) could ease workforce shortages.
- **Additional Research on Perinatal Mental Health Is Needed.** Current research is inadequate for understanding perinatal mental health conditions and SUDs and their effects on the life course of individuals and their family members—particularly those from under-resourced communities. Research is also needed on a range of integrated approaches, tailored to the needs of specific communities. Federal support and other support for research efforts in the areas of prevention, intervention, treatment, and implementation science are needed.
- **Community Engagement Would Facilitate Change.** All efforts to improve maternal mental health conditions and SUDs—including research studies, surveillance efforts, and quality improvement initiatives—must involve the participation of the communities most affected. The task force emphasizes the importance of intentionality and outreach to leaders, organizations, and individuals from communities in specific geographic areas and culturally specific communities. Multiple frameworks and conceptual models have guided efforts to advance health equity by leveraging community engagement to transform health systems, and these models could similarly inform efforts to address maternal mental health. Specific best practices include the following:
  - Engaging community advisory boards and community-based organizations;
  - Using trusted messengers to provide information and to engage their communities about maternal mental health;
  - Employing plain language and clear communication strategies in all messages, materials, and resources on maternal mental health conditions and SUDs;
  - Addressing language barriers with language-appropriate materials and communication efforts;
  - Leveraging traditional, digital, and social media to reach target communities and selecting media channels popular among these audiences;
  - Striving for appropriate representation in service systems and employing culturally competent providers;
  - Addressing community mistrust of systems, government, providers, and institutions;
  - Communicating scientific findings and surveillance results to communities in public-facing, comprehensible messages that convey actionable items;
  - Including community partners, practitioners, individuals affected by maternal mental health conditions or SUDs, and policymakers in efforts to disseminate research and surveillance findings;
  - Addressing the stigma of maternal mental health conditions and SUDs and countering common misconceptions in all communication and community engagement efforts; and

**“[I wish that] one of my mom friends had said, ‘I’m just checking in on you. I happen to have this experience, and if you are having a similar one, let me help you walk through it.’ I’ve tried to do it for my friends.”**

**—M.P., mother of two**

- Safely providing information about the connections among maternal mental health, substance use, and GBV.
- **Improvements and Standardized Data Collection, Management, and Analysis Are Needed.** *The Surgeon General's Call to Action to Improve Maternal Health* references the need to improve data reporting and quality in overall maternal health. To date, data collection across states and federal programs has suffered from a lack of standardized definitions, measures, and codes associated with maternal mortality, race, ethnicity, causes of death, and other factors. The task force noted that the following activities could improve data collection, quality, management, and analysis:
  - Supporting longitudinal research on the perinatal period, including surveillance and data collection to assess maternal mental health conditions; their intersection with comorbid conditions; known risk factors, such as GBV; and social determinants of health;
  - Collecting data on qualitative lived experiences, as well as quantitative measures;
  - Including pregnant individuals in clinical trials and other research, including cross-sectional and longitudinal surveillance and data collection;
  - Standardizing data collection across the peripartum period and integrating data sources to improve the understanding of perinatal mental health conditions and SUDs at the national, state, and local levels;
  - Supporting and leveraging maternal mortality review committees and perinatal quality collaboratives;
  - Reporting research findings and data from surveillance efforts on maternal mental health conditions and SUDs to multiple audiences in plain language so they can act within their spheres of influence;
  - Involving a diverse group of stakeholders (e.g., pregnant and postpartum individuals, individuals with perinatal mental health conditions, individuals with maternal SUDs, clinicians, and policymakers) in the research process; and
  - Enhancing the linkages between data sources and using modern “big data” practices.
- **Federal Efforts Are Ongoing.** Several federal agencies have spearheaded initiatives to promote maternal mental health and address perinatal substance use, including programs to support the following:
  - Prevention of maternal morbidity and mortality related to mental health conditions and substance use;
  - Widespread implementation of evidence-based screening measures and diagnostic methods;
  - Expansion of the workforce of and provision of additional training to mental health clinicians, maternal health clinicians, and peer support specialists;
  - Coordination and integration of clinical care;
  - Improved access to and availability of treatment;
  - Community-based and multigenerational practices, including preventive services and evidence-based interventions;
  - Reduction of disparities in maternal mental health and SUDs and increased support for under-resourced communities;
  - Research and information dissemination of new and enhanced preventive, diagnostic, and therapeutic strategies; and



## The Task Force on Maternal Mental Health's Report to Congress

- Statewide initiatives to address SUD and IPV among pregnant and postpartum individuals.
- **Federal Agencies Collaborate to Promote Maternal Mental Health and Address Perinatal Substance Use.** Federal organizations have also collaborated to establish committees, workgroups, task forces, and campaigns to streamline initiatives and ensure optimal utilization of resources and coordination of efforts.

### NEXT STEPS FOR THE TASK FORCE

Upon release of this report, the task force will develop a report to the governors of all U.S. states that describes opportunities for local- and state-level partnerships. The task force will also make regular updates to the U.S. Congress on this report and the national strategy. The task force, this report to Congress, and the national strategy are important parts of broader federal efforts to address maternal health across the nation and are aligned with the *White House Blueprint for Addressing the Maternal Health Crisis*. The sunset date for the task force is September 30, 2027.

## APPENDIX A: GLOSSARY

***Note: The following abbreviations and terms may appear in The Task Force on Maternal Mental Health’s Report to Congress and The Task Force on Maternal Mental Health’s National Strategy to Improve Maternal Mental Health Care.***

AAP	American Academy of Pediatrics
AASTEC	Albuquerque Area Southwest Tribal Epidemiology Center
ACA	Affordable Care Act of 2010
ACE	adverse childhood experience
ACF	Administration for Children and Families
ACIMM	Advisory Committee on Infant and Maternal Mortality
ACL	Administration for Community Living
ACP	American College of Physicians
ACOG	American College of Obstetricians and Gynecologists
ACWS	Advisory Committee for Women’s Services
ACYF	Administration on Children, Youth, and Families
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian/Alaska Native
AIM	HRSA’s Alliance for Innovation on Maternal Health program
AIMS Center	Advancing Integrated Mental Health Solutions Center at the University of Washington
AMA	American Medical Association
AMCHP	Association of Maternal & Child Health Programs
AMI	any mental illness
APA	American Psychiatric Association
APG	agency priority goal
APM	alternative payment model
ARP	American Rescue Plan Act of 2021

## The Task Force on Maternal Mental Health’s Report to Congress

ASAM	American Society of Addiction Medicine
ASPE	HHS’s Office of the Assistant Secretary for Planning and Evaluation
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUD	alcohol use disorder
AUDIT-C	Alcohol Use Disorders Identification Test-Concise
BHW	Bureau of Health Workforce
BIPOC	Black, Indigenous, people of color
BMI	body mass index
C2C	Connections to Care
CAB	community advisory board
CA-PAMR	California Pregnancy-Associated Mortality Review
CAPTA	Child Abuse Prevention and Treatment Act
CARA	Comprehensive Addiction and Recovery Act
CARPP	Center for Addiction Recovery in Pregnancy and Parenting
CBO	community-based organization
CBT	cognitive behavioral therapy
CCBHC	certified community behavioral health clinic
CCDF	Child Care and Development Fund
CDC	Centers for Disease Control and Prevention
CEAL	NIH Community Engagement Alliance
CHAP	Community Health Aide Program
CHIP	Medicaid’s Children’s Health Insurance Program
CHW	community health worker
CLAS	culturally and linguistically appropriate services

## The Task Force on Maternal Mental Health’s Report to Congress

CMS	Centers for Medicare & Medicaid Services
COVID-19	coronavirus disease 2019
CPG	clinical practice guideline
CSP	CDC’s Comprehensive Suicide Prevention Program
CUB Clinic	Caring for YOU and Baby Clinic
DAST-10	Drug Abuse Screening Test
DBT	dialectical behavior therapy
DFMB	Drug Free Moms and Babies program
DHS	U.S. Department of Homeland Security
DOD	U.S. Department of Defense
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
DOVE	Domestic Violence Enhanced Perinatal Home Visits
ECE	early childhood education
ED	U.S. Department of Education
EMTALA	Emergency Medical Treatment and Labor Act
EPDS	Edinburgh Postnatal Depression Scale
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ERASE MM	CDC’s Enhancing Reviews and Surveillance to Eliminate Maternal Mortality Program
ERISA	Employee Retirement Income Security Act of 1974
FACA	Federal Advisory Committee Act
FASD	fetal alcohol spectrum disorder
FDA	Food and Drug Administration
FIT Court	Alaska Families with Infants & Toddlers Court program
FQHD	federally qualified health center

## The Task Force on Maternal Mental Health’s Report to Congress

GABA	gamma-aminobutyric acid
GAD	generalized anxiety disorder
GAP-REACH	Group for the Advancement of Psychiatry’s checklist on Race, Ethnicity, And Culture in Health
GBV	gender-based violence
HCUP-NIS	Healthcare Cost and Utilization Project’s National Inpatient Sample
HEAL	NIH’s Helping to End Addiction Long-term Initiative
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIV	human immunodeficiency virus
HMO	health maintenance organization
HomVEE	Home Visiting Evidence of Effectiveness
HP2030	Healthy People 2030 initiative
HRSA	Health Resources and Services Administration
HRSN	health-related social need
HUD	U.S. Department of Housing and Urban Development
HWHB	Delaware’s Healthy Women, Healthy Babies program
ICCFASD	Interagency Coordinating Committee on Fetal Alcohol Spectrum Disorders
ICD	International Classification of Diseases
IEA	HHS’s Office of Intergovernmental & External Affairs
IHS	Indian Health Service
IMHS	HHS’s Integrated Maternal Health Services grant program
IMPACTT	South Carolina’s Mom’s IMProving Access to Maternal Mental Health and Substance Use Disorder Care Through Telemedicine and Tele-Mentoring program

## The Task Force on Maternal Mental Health’s Report to Congress

IMPROVE	NIH’s Implementing a Maternal health and PRegnancy Outcomes Vision for Everyone initiative
IPC	Interagency Policy Committee
IPT	interpersonal therapy/psychotherapy
IPV	intimate partner violence
LGBTQ+, LGBTQI+, LGBTQIA+	lesbian, gay, bisexual, transgender, queer/questioning, (intersex,) (asexual,) and other sexual and gender minority populations
MAMA’s Neighborhood	Maternity Assessment and Management Access and service synergy Neighborhood program
MAT	medication-assisted treatment
MAT-LINK	The MATernaL and Infant NetworK, a surveillance system to monitor maternal, infant, and child health outcomes associated with MOUD during pregnancy
MCC	maternity care center
MCHB	Maternal and Child Health Bureau
MDE	major depressive episode
MEPS	Medical Expenditure Panel Survey
MIECHV	HRSA’s Maternal, Infant, and Early Childhood Home Visiting program
MINT	Mothers and Infants Nurturing Together
MIPS	Merit-based Incentive Payment System
MISSION	Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking
MMH	maternal mental health
MMRC	maternal mortality review committee
MOM Model	Maternal Opioid Misuse Model
MOMs+ Model	Maternal Opiate Medical Supports Plus Model
MOUD	medications for opioid use disorder

## The Task Force on Maternal Mental Health’s Report to Congress

MQCC	maternal quality care collaborative
MST	military sexual trauma
MVP	MIPS Value Pathway
NACCHO	National Association of County and City Health Officials
NAS	neonatal abstinence syndrome
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASHP	National Academy for State Health Policy
NASMHPD	National Association of State Mental Health Program Directors
NCQA	National Committee for Quality Assurance
NHOPI	Native Hawaiian or Other Pacific Islander
NHSC	National Health Service Corps
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NICHD	<i>Eunice Kennedy Shriver</i> National Institute of Child Health and Human Development
NICU	neonatal intensive care unit
NIDA	National Institute on Drug Abuse
NIDILRR	National Institute on Disability, Independent Living, and Rehabilitation Research
NIH	National Institutes of Health
NNEDV	National Network to End Domestic Violence
NOWS	neonatal opioid withdrawal syndrome
NSCSS Federal Task Force	National Syphilis and Congenital Syphilis Syndemic Federal Task Force
NSDUH	National Survey on Drug Use and Health
NVDRS	National Violent Death Reporting System

## The Task Force on Maternal Mental Health’s Report to Congress

OASH	HHS’s Office of the Assistant Secretary for Health
OB	obstetrician or obstetrics
OB-GYN	obstetrics and gynecology
ob-gyn	obstetrician-gynecologist
OCD	obsessive-compulsive disorder
OMB	Office of Management and Budget of the U.S. National Archives and Records Administration
OMHSP	VA’s Office of Mental Health and Suicide Prevention
OMOP	Observational Medical Outcomes Partnership Common Data Model
ONC	Office of the National Coordinator for Health Information Technology
OUD	opioid use disorder
OWH	HHS’s Office on Women’s Health
P2P	NIH’s Pathways to Prevention
PASS	Perinatal Anxiety Screening Scale
PCORI	Patient-Centered Outcomes Research Institute of the National Patient-Centered Clinical Research Network
PCTE-CPMH	Primary Care Training and Enhancement–Community Prevention and Maternal Health
PEACE	Emory University’s Perinatal psychiatry, Education, Access, and Community Engagement for Moms program
PeriPAN	Texas’s Perinatal Psychiatry Access Network
PMADs	perinatal mood and anxiety disorders
PMHCA	Pediatric Mental Health Care Access program
POSC	plan of safe care
PPD	postpartum depression
PPNMSS	Perceived PreNatal Maternal Stress Scale



## The Task Force on Maternal Mental Health’s Report to Congress

PQC	perinatal quality collaborative
PRAMS	Pregnancy Risk Assessment Monitoring System
PRAPARE	Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
PREPARE	Perinatal Reproductive Education Planning and Resources
PREPP	Practical Resources for Effective Postpartum Parenting
PRGLAC	Task Force on Research Specific to Pregnant Women and Lactating Women
Project ECHO	Project Extension for Community Healthcare Outcome
PROSPER	Pre/Peri/Post-natal and Parenting Resources and Other Support Systems for Pregnant Women/Families Engaging in Recovery Initiative
PROUD	Parents Recovering from Opioid Use Disorders
PPW	pregnant and postpartum women
PSI	Postpartum Support International
PTSD	post-traumatic stress disorder
RACE for Equity	Results Achieved through Community Engagement for Equity
RADx Tech	Rapid Acceleration of Diagnostics Technology
RCORP-NAS	Rural Communities Opioid Response Program–Neonatal Abstinence Syndrome
RFI	request for information
RMH	reproductive mental health
ROSE Program	The Reach Out, Stay Strong, Essentials program to prevent postpartum depression
RVU	relative value unit
SAMHSA	Substance Abuse and Mental Health Services Administration
SBI	screening and brief intervention

## The Task Force on Maternal Mental Health’s Report to Congress

SBIRT	screening, brief intervention, and referral to treatment
SDOH	social determinant of health/social determinants of health
SEP	substance-exposed pregnancy
SIDS	sudden infant death syndrome
SMI	serious mental illness
SMM	severe maternal morbidity
SOAR	ACF’s Stop, Observe, Ask, Respond to Health and Wellness Training Program
SSA	Social Security Administration
SSRI	selective serotonin reuptake inhibitor
STI	sexually transmitted infection
SUD	substance use disorder
SURP-P Scale	Substance Use Risk Profile-Pregnancy Scale
T-ACE	Tolerance, Annoyance, Cut down, Eye-opener Screening Tool
TAMAR	trauma, addictions, mental health, and recovery intervention
TANF	Temporary Assistance for Needy Families program
TCA	tricyclic antidepressant
TEFCA	Trusted Exchange Framework and Common Agreement
TF-CBT	trauma-focused cognitive behavioral therapy
TMaH	CMS’s Transforming Maternal Health Model
TWEAK Test	Tolerance, Worried, Eye-opener, Amnesia, K(C)ut down Test
USDA	U.S. Department of Agriculture
USDS	U.S. Digital Service
USPSTF	U.S. Preventive Services Task Force

## The Task Force on Maternal Mental Health’s Report to Congress

VA	U.S. Department of Veterans Affairs
VHA	Veterans Health Administration
WHODAS	World Health Organization Disability Assessment Schedule
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children
WMH	women’s mental health
Women’s REACH	Women’s Recovery, Engagement, Access, Coaching, and Healing Program
YUP!	Young United Parents!

## **APPENDIX B: LANGUAGE USED IN THIS REPORT TO CONGRESS**

*Prenatal, Perinatal, and Postpartum.* Unless otherwise noted in this report, “prenatal” refers to the period of pregnancy (i.e., before birth occurs) and is synonymous with “antenatal.”

“Perinatal” refers to the period of pregnancy and 1 year after the end of the pregnancy.

“Postpartum” refers to the 12-month period after pregnancy (Garcia & Yim, 2017; National Cancer Institute, n.d.; Saldanha et al., 2023), regardless of pregnancy outcome; see *Postpartum and After Pregnancy* below. Throughout, “maternal” and “perinatal” are used interchangeably when describing the referenced conditions. Note that some health care practitioners narrow the postpartum period to 12 weeks after giving birth—sometimes referred to as the “fourth trimester”—given medical considerations particular to postpartum individuals and their babies during this time period (American College of Obstetricians and Gynecologists, 2018). This report specifies when sources refer to a postpartum period other than up to 12 months after pregnancy.

*Postpartum and After Pregnancy.* Although “postpartum” often describes the period after the delivery of a child (Berens, 2024), the task force’s more inclusive definition of the term describes the period after the conclusion of a pregnancy even when the pregnancy did not result in a live birth or delivery. Often, the task force uses more inclusive language such as “after pregnancy.”

*Maternal Mental Health.* This report uses “maternal mental health” to reflect the language used in the congressional authorization to establish the Task Force on Maternal Mental Health.

“Maternal mental health, also known as perinatal mental health, is a [person’s] overall emotional, social, and mental well-being during and after pregnancy” (Zuloaga, 2020).

*Mental Health Conditions and Substance Use Disorders (SUDs).* The language used in the congressional authorization and the name of the task force include the phrase “maternal mental health.” Task force feedback foregrounds the importance of addressing mental health conditions, SUDs, co-occurring conditions, and the overall social, emotional, and mental well-being of pregnant and postpartum individuals. In this report, “mental health conditions and SUDs” and similar phrases are synonymous with other common terms (e.g., “mental health disorders” and “mental illnesses”); however, in some cases, this report may specifically refer to SUDs alone, to mental health conditions alone, or to “substance use” to reflect a narrower focus or the language and definitions of cited sources.

*Gender-Based Violence (GBV) and Intimate Partner Violence (IPV).* Violence against pregnant and postpartum individuals can result in adverse outcomes for the mental and physical health of those individuals and their babies. This report uses “GBV” as a general term to refer to all types of violence against individuals who are pregnant or postpartum or who may become pregnant. This report also refers to specific types of GBV—including IPV and domestic violence—and trauma resulting from GBV, IPV, or sexual violence. The specific terms used reflect the categories and study parameters of the sources cited. (See the [\*U.S. National Plan to End Gender-Based Violence: Strategies for Action\*](#) for more definitions of these and related terms.)

*Pregnancy-Related and Pregnancy-Associated.* This report uses these terms as [defined by the National Center for Health Statistics of the Centers for Disease Control and Prevention \(CDC\)](#). “Pregnancy-related” refers to medical conditions or deaths occurring during or within 1 year of the end of a pregnancy from any cause related to or aggravated by the pregnancy or its

management (not from accidental or incidental causes). “Pregnancy-associated” refers to medical conditions or deaths within the same time frame and includes both pregnancy-related and incidental causes.

*Race and Ethnicity.* This report uses the categories of race and ethnicity detailed in the [Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity](#), published by the Office of Management and Budget (OMB) in 1997. These standards set a minimum of five categories of race—“American Indian or Alaska Native,” “Asian,” “Black or African American,” “Native Hawaiian or Other Pacific Islander” (NHOPI), and “White”—as well as two categories for data on ethnicity: “Hispanic or Latino” and “Not Hispanic or Latino.” These standards were revised on March 29, 2024 ([Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity](#)); however, research and literature cited in this report predate the 2024 revisions and therefore reference the racial and ethnic categories set forth in 1997. In line with OMB’s definitions, this report recognizes race and ethnicity as sociopolitical constructs rather than biological or genetic categories. However, these constructs often function as important social determinants of health and are thus included herein. This report notes when sources use categories or definitions of race and ethnicity that differ from those of OMB.

*Under-Resourced and Underserved.* In this report, the task force uses the term “under-resourced” to refer to subpopulations and other demographic groups described by the White House’s term “underserved communities.” The [Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](#) defines “underserved communities” as “populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life.” The White House language specifies that such groups may include “Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.” Other under-resourced populations may include migrant groups, immigrant groups, and others. This report uses the term “underserved” to refer to areas with shortages of health care providers or those residing in them.

*Evidence-Based, Evidence-Informed, and Promising.* “Evidence-based practices” (e.g., practices whose safety and efficacy have been specifically examined in biomedical and/or biobehavioral research studies) differ from “evidence-informed practices” (e.g., practices informed by biomedical and/or biobehavioral research studies but not specifically examined in such studies) and from “promising practices” (e.g., practices that clinical data, anecdotal information, or other information suggests may improve outcomes but that have little or no research evidence basis). This report describes many best practices within the field of maternal mental health and SUD treatment and often uses the term “evidence-based practices” broadly to refer to evidence-informed and promising practices, as well as in the narrower way defined above. The task force currently endorses all evidence-based, evidence-informed, and promising practices described herein.

*Equity.* “[’]Equity[’] refers to fair and just practices and policies that ensure all community members can thrive. Equity is different [from] equality in that equality implies treating everyone as if their experiences [were] exactly the same. Being equitable means acknowledging and

addressing structural inequalities—historic[al] and current—that advantage some and disadvantage others. Equal treatment results in equity only if everyone starts with equal access to opportunities” (University of Iowa Division of Diversity Equity and Inclusion, n.d.).

*Primary, Secondary, and Tertiary Prevention.* The task force supports primary, secondary, and tertiary prevention efforts for maternal mental health conditions and SUDs. Primary prevention aims to prevent conditions from ever occurring among healthy individuals. Secondary prevention aims to prevent conditions among people who do not have overt symptoms but have experienced changes trending toward a disease. Clinical screening is a form of secondary prevention. Tertiary prevention aims to reduce the severity of an established condition and problems associated with it (Kisling & Das, 2023).

## **APPENDIX C: ROSTER OF THE TASK FORCE ON MATERNAL MENTAL HEALTH**

### **FEDERAL STAFF MEMBERS**

#### **Administration for Children and Families (ACF)**

Lauren Behsudi, B.A., M.P.M.

Francine White, M.A., LPC

#### **Administration for Community Living (ACL)**

Naomi Hess, B.S.

Elizabeth Leef, B.S.

#### **Agency for Healthcare Research and Quality (AHRQ)**

Emily Chew, M.P.H.

Kamila Mistry, Ph.D., M.P.H.

#### **Centers for Disease Control and Prevention (CDC)**

Katharyn Baca, Ph.D., M.P.H., M.A.

Wanda Barfield, M.D., M.P.H., FAAP

Ashley Busacker, Ph.D.

Ada Dieke, Dr.P.H., M.P.H.

Meghan T. Frey, M.A., M.P.H.

Laurin Kasehagen, Ph.D., M.A.

Jean Ko, Ph.D.

Dana Meaney-Delman, M.D. §

Mohinee Mukherjee, M.P.H.

Angela Rohan, Ph.D.

Karen Remley, M.D., M.B.A., M.P.H., FAAP

Charlene Wong, M.D.

#### **Center for Faith-based and Neighborhood Partnerships (HHS/Partnership Center)**

Que English, D.Min., M.A. §

#### **Centers for Medicare & Medicaid Services (CMS)**

Adam Conway, M.P.H., B.A.

Andrea Harmon, M.P.P.

Amanda Johnson, RN, CCM

Hannah Katch, M.P.P.

Aditi Mallick, M.D. §

Tequila Terry, M.B.A., M.P.H.

Ellen-Marie Whelan, Ph.D., CRNP, FAAN

#### **U.S. Department of Defense (DOD)**

Holly Hoffmeyer, Ph.D.

Kimberly Lahm, LMFT

**U.S. Department of Health and Human Services Office of Intergovernmental and External Affairs (IEA)**

Marvin Figueroa, M.S.

Caryn Marks, M.P.P.

**U.S. Department of Homeland Security (DHS)**

Ryan Farah

Amelia MacIntyre, M.S., D.O.

Margaret Schaefer, M.A.

**U.S. Department of Labor (DOL)**

Gayle Goldin, M.S.

**U.S. Department of Veterans Affairs (VA)**

Sally Haskell, M.D.

Sophia Hill-Smith M.S.N., RN

Amanda Johnson, M.D., FACOG

Meg Kabat, LCSW-C, CCM

Lisa Kearney, Ph.D., ABPP

Laura Miller, M.D.

Elizabeth Patton, M.D., M.Phil., M.Sc., FACOG

Jennifer Strauss, Ph.D.

Lourdes Tiglao, M.B.A.

**Food and Drug Administration (FDA)**

Joyce Obidi, Ph.D.

Joshua Rising, M.D., M.P.H.

Catherine Roca, M.D.

Julia Tierney, J.D.

Anna Weissman, M.D.

**Health Resources and Services Administration (HRSA)**

Dawn Levinson, M.S.W. §

CDR Sandra M. Sayegh, Pharm.D., M.B.A, M.S.

Melodye Watson, M.A, LCSW-C

**Indian Health Service (IHS)**

Tamara James, Ph.D.

Tina Pattara-Lau, M.D., FACOG§

Glorinda Segay, D.B.H., M.S.

**National Institutes of Health (NIH)**

Alison Cernich, Ph.D.

Tamara Lewis Johnson, M.P.H., M.B.A.



**Office of the Assistant Secretary for Health (OASH)**

Cyntrice Bellamy, Psy.D., M.S., M.Ed.  
Dorothy Fink, M.D. †  
Jennifer Gillissen, PMP, CMP, CGMP, VEMM  
Deborah Kilday, M.S.N., RN  
Richelle Marshall, M.B.A.  
Abayomi Walker, B.S.N., M.S.N., WHNP-BC

**Office of the Assistant Secretary for Health Office of Regional Health Operations (ORHO)**

David Johnson, M.P.H.  
CDR Luz Rivera, Psy.D.

**Office of the Assistant Secretary for Health Office of Minority Health (OMH)**

Jasmine Lusane, M.P.H.

**Office of the Assistant Secretary for Health Office of Population Affairs (OPA)**

Ciara Davis, Ph.D., M.S.W.

**Office of the Assistant Secretary for Health Office of the Surgeon General (OSG)**

Melea Atkins, M.B.A., B.A.  
Tyiesha Short, M.P.H.

**Office of the Assistant Secretary for Planning and Evaluation (ASPE)**

Andre Chappel, Ph.D.  
Kristina West, M.S., LL.M.

**Office of Management and Budget (OMB)**

Maya Mechenbier, J.D.

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

Joe Bañez, B.S.  
Somer Brown, J.D.  
Zayna Fulton, M.P.H., M.Sc., CHW  
Madonna Green, LICSW  
Mirna Herrera, M.A., MT-BC, CPS  
Martha Kent, M.A., LPCC, NCC  
Valerie Kolick, DFO, M.A.  
Amanda Sharp, Ph.D.  
Nima Sheth, M.D., M.P.H. † (ACWS Chair)  
Amy Smith, M.A., LPC, SAP

**United States Digital Service (USDS)**

Amy Bontrager, M.S.  
Arabella Crawford  
Maya Mechenbier, J.D.  
T. Annie Nguyen, M.Des.  
Whitney Robinson  
Elana Shneyer

## The Task Force on Maternal Mental Health's Report to Congress

### NONFEDERAL STAFF MEMBERS

**Rebecca Alderfer, M.P.P.**

Chief Executive Officer  
Colorado Perinatal Care Quality Collaborative

**Jeanne Alhusen, Ph.D., CRNP, RN**

Board Director  
Association of Women's Health, Obstetric and Neonatal Nurses

**Nicole Barnett, M.S.W., LCSW-C, PMH-C \*§**

Perinatal Mental Health Educator and Advocate

**Tina Beilinson Keshani, M.B.A.**

Co-Founder and Chief Executive Officer  
Seven Starling

**Joy Burkhard, M.B.A.**

Founder & Executive Director  
Policy Center for Maternal Mental Health

**Stacey Burns, LMSW, LCDC**

Chief Clinical Officer  
Nexus Recovery Center

**Patricia Capo, M.D., FACOG**

OB-GYN physician  
Alaska Native Medical Center and Southcentral Foundation

**Le Ondra Clark Harvey, Psy.D. †§**

Commissioner  
California Council of Community Behavioral Health Agencies

**Lisa M. Cleveland, Ph.D., APRN, CPNP-PC, IBCLC, FAAN**

Professor  
The University of Texas Health Science Center at San Antonio School of Nursing

**Wendy Davis, Ph.D., PMH-C**

Executive Director  
Postpartum Support International

**Ludmila De Faria, M.D.**

Chair  
The American Psychiatric Association's Council on Women's Mental Health

**Emily Dossett, M.D., M.T.S.**

Psychiatrist  
MAMA'S Neighborhood

## The Task Force on Maternal Mental Health's Report to Congress

### **Kristina Dulaney, RN, PMH-C \***

Founder

Cherished Mom

### **Kelley Franklin, M.S.N., RN**

Associate Project Director

The Joint Commission

### **Anique Forrester, M.D.**

Assistant Professor, Department of Psychiatry

University of Maryland School of Medicine

### **Sara Gilbertson Mertz, M.S., CNM, PMH-C**

Chair

The American College of Nurse-Midwives' Mental Health Committee

### **Adrienne Griffen, M.P.P. \***

Executive Director

Maternal Mental Health Leadership Alliance

### **Octavia Harris, M.S. \*†**

United States Navy (retired)

### **Kathryn Icenhower, Ph.D. †§**

Chief Executive Officer

SHIELDS for Families

### **Emmanuella Kiyieih, LMSC, LCDC**

Philanthropy & Grant Manager

Nexus Recovery Center

### **Lisa Kunkel, B.A., ICADC, SAP**

Social Worker

Iowa Specialty Hospital

### **Jennifer Law, B.A. \***

Maternal Health Leader

Philips

### **Lily J. Lou, M.D., FAAP**

Immediate Past Chair, Section on Neonatal-Perinatal Medicine

American Academy of Pediatrics

### **Kay Matthews, LCHW \***

Executive Director

Shades of Blue Project

## The Task Force on Maternal Mental Health's Report to Congress

### **Elizabeth McClaine**

Vice President of Medicaid and Commercial Products  
Neighborhood Health Plan of Rhode Island

### **Arin McClune, M.S.N., RNC-OB, CHC**

Senior Quality Performance Consultant  
Blue Cross Blue Shield Association

### **Devon McCormick, M.A.Sc., M.A.C.P.**

Project Specialist  
Elevate Policy Lab at Yale

### **Emily Miller, M.D.**

Associate Professor of Obstetrics and Gynecology and the Division Director of Maternal-Fetal Medicine  
The Warren Alpert Medical School of Brown University

### **Tiffany A. Moore Simas, M.D., M.P.H., M.Ed.**

Chair  
UMass Memorial Health's Department of Obstetrics and Gynecology

### **Lavita Nadkarni, Ph.D. †**

Associate Dean  
The University of Denver's Graduate School of Professional Psychology

### **Joanne Nicholson, Ph.D. †§**

Professor  
Brandeis University Institute for Behavioral Health

### **Kelly O'Connor, M.S.**

Executive Director  
Maternal Mental Health Now

### **Beth Oller, M.D., FAAFP**

Physician  
American Academy of Family Physicians

### **Erica Pulliam, B.A.**

Manager of Community Engagement and Relations, Perinatal Doula  
The Center for Great Expectations

### **Arlene Remick, M.P.H.**

Program Director  
American College of Obstetricians and Gynecologists

### **Roxanne Rosenberg, LCMHC, PMH-C**

Co-Founder & Clinical Director  
Anchor Perinatal Wellness

## The Task Force on Maternal Mental Health's Report to Congress

### **Lisa Saul, M.D., M.B.A.**

National Medical Director of Women's Health  
UnitedHealth Group

### **Leslie Schrock, B.S. \***

Author of "Bumpin': The Modern Guide to Pregnancy"

### **Alpa C. Shah, M.D.**

Physician, Psychiatrist  
American Hospital Association

### **Meredith Shockley-Smith, Ph.D. §**

Executive Director  
Cradle Cincinnati

### **Kim Smith, FACHE \***

Founder/CEO  
Health Evolve Technologies, LLC

### **Shaneca Smith, B.S.N., RN, CNOR(E)**

Manager of Quality Improvement  
Arkansas Foundation for Medical Care

### **Tanisha Thomas-Frederick, CLC \*†**

Founder  
Beautiful as You Are

### **Barbara Tunstall \***

Peer Recovery Specialist

### **Carole Warshaw, M.D.**

Director  
National Center on Domestic Violence, Trauma, and Mental Health

### **Ashleigh Wiederin, B.S., RN \***

Outreach Coordinator, Maternal Health Services  
St. Anthony Regional Hospital

\* Person with lived experience

† ACWS member

‡ Task Force on Maternal Mental Health co-lead

§ Workgroup co-chair

## APPENDIX D: REFERENCES

- Admon, L. K., Zivin, K., & Kozhimannil, K. B. (2021). Perinatal insurance coverage and behavioural health-related maternal mortality. *International Review of Psychiatry*, 33(6), 553–556. <https://doi.org/10.1080/09540261.2021.1903843>
- Aguilar-Gaxiola, S., Ahmed, S., Anise, A., Azzahir, A., Baker, K., Cupito, A., Eder, M., Everette, T. D., Erwin, K., Felzien, M., Freeman, E., Gibbs, D., Greene-Moton, E., Hernandez-Cancio, S., Hwang, A., Jones, F., Jones, G., Jones, M., Khodyakov, D., . . . Zaldivar, R. (2022). Assessing meaningful community engagement: A conceptual model to advance health equity through transformed systems for health. *NAM Perspectives*, 22(2). <https://doi.org/10.31478/202202c>
- Alderdice, F., & Kelly, L. (2019). Stigma and maternity care. *Journal of Reproductive and Infant Psychology*, 37(2), 105–107. <https://doi.org/10.1080/02646838.2019.1589758>
- Ali, M. M., West, K. D., Natzke, B., & Luhr, M. (2023). Postpartum medicaid coverage and behavioral health treatment among pregnant women with substance use disorder. *General Hospital Psychiatry*, 83, 194–195. <https://doi.org/10.1016/j.genhosppsych.2023.03.008>
- Allen, A. M., Jung, A. M., Alexander, A. C., Allen, S. S., Ward, K. D., & Al'Absi, M. (2020). Cannabis use and stressful life events during the perinatal period: Cross-sectional results from Pregnancy Risk Assessment Monitoring System (PRAMS) data, 2016. *Addiction*, 115(9), 1707–1716. <https://doi.org/10.1111/add.15003>
- American College of Obstetricians and Gynecologists. (2018). Optimizing postpartum care. ACOG Committee Opinion No. 736. *Obstetrics & Gynecology*, 131, e140–150.
- American College of Obstetricians and Gynecologists. (2019). ACOG Committee Opinion No. 766: Approaches to limit intervention during labor and birth. *Obstetrics & Gynecology*, 133(2). [https://journals.lww.com/greenjournal/fulltext/2019/02000/acog\\_committee\\_opinion\\_no\\_766\\_approaches\\_to.44.aspx](https://journals.lww.com/greenjournal/fulltext/2019/02000/acog_committee_opinion_no_766_approaches_to.44.aspx)
- American College of Obstetricians and Gynecologists. (2023). Treatment and management of mental health conditions during pregnancy and postpartum: ACOG Clinical Practice Guideline No. 5. *Obstetrics & Gynecology*, 141(6), 1262–1288. <https://doi.org/10.1097/aog.0000000000005202>
- American College of Obstetricians and Gynecologists. (n.d.). *Substance use disorder in pregnancy*. <https://www.acog.org/advocacy/policy-priorities/substance-use-disorder-in-pregnancy>
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

## The Task Force on Maternal Mental Health's Report to Congress

- American Psychiatric Association. (2020). *Stigma, prejudice, and discrimination against people with mental illness*. American Psychiatric Association. Retrieved March 25, 2024, from <https://www.psychiatry.org/Patients-Families/Stigma-and-Discrimination>
- American Psychiatric Association. (2022). *What is posttraumatic stress disorder (PTSD)?* <https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd>
- American Psychiatric Association. (2023a). *Perinatal mental and substance use disorders* [White Paper]. <https://www.psychiatry.org/getmedia/344c26e2-cdf5-47df-a5d7-a2d444fc1923/APA-CDC-Perinatal-Mental-and-Substance-Use-Disorders-Whitepaper.pdf>
- American Psychiatric Association. (2023b, August 31). Pregnancy, mental and substance use conditions and treatment: Advice from mental health experts. <https://www.psychiatry.org:443/news-room/apa-blogs/pregnancy-and-mental-health-conditions>
- American Psychological Association. (2017). *What is cognitive behavioral therapy?* <https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral>
- American Psychological Association. (2018). *Group therapy*. <https://dictionary.apa.org/group-therapy>
- American Psychological Association. (2022). *Posttraumatic stress disorder*. <https://www.apa.org/topics/ptsd>
- American Public Health Association. (2019). *A global call to action to improve health through investment in maternal mental health* [Policy Statement]. <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2020/01/10/a-global-call-to-action-to-improve-health-through-investment-in-maternal-mental-health>
- American Society of Addiction Medicine. (2022). *Substance use and substance use disorder among pregnant and postpartum people* [Policy Statement]. <https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/10/12/substance-use-and-substance-use-disorder-among-pregnant-and-postpartum-people>
- Anbalagan, S., & Mendez, M. (2024). Neonatal abstinence syndrome. In *StatPearls* [Internet]. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK551498/>
- Ankerstjerne, L. B. S., Laizer, S. N., Andreasen, K., Normann, A. K., Wu, A., Linde, D. S., & Rasch, V. (2022). Landscaping the evidence of intimate partner violence and postpartum depression: A systematic review. *BMJ Open*, 12(5). <https://doi.org/10.1136/bmjopen-2021-051426>
- Austin, A. E., Vladutiu, C. J., Jones-Vessey, K. A., Norwood, T. S., Proescholdbell, S. K., & Menard, M. K. (2016). Improved ascertainment of pregnancy-associated suicides and

- homicides in North Carolina. *American Journal of Preventive Medicine*, 51(5), S234–S240. <https://doi.org/10.1016/j.amepre.2016.04.023>
- Ayer, L., Dunbar, M. S., Martineau, M., Stevens, C., Schultz, D., Chan, W. Y., Abbott, M., Weir, R., Liu, H. H., Siconolfi, D., & Towe, V. L. (2020). Evaluation of the Connections to Care (C2C) initiative: Interim report. *RAND Health Quarterly*, 9(1), 5.
- Bauman, B. L., Ko, J. Y., Cox, S., D'Angelo, M., Denise V., Warner, L., Folger, S., Tevendale, H. D., Coy, K. C., Harrison, L., & Barfield, W. D. (2020). Vital Signs: Postpartum depressive symptoms and provider discussions about perinatal depression — United States, 2018. *Morbidity and Mortality Weekly Report*, 69(19), 575–581. <https://doi.org/10.15585/mmwr.mm6919a2>
- Bayrampour, H., Kapoor, A., Bunka, M., & Ryan, D. (2020). The risk of relapse of depression during pregnancy after discontinuation of antidepressants. *The Journal of Clinical Psychiatry*, 81(4). <https://doi.org/10.4088/jcp.19r13134>
- Berens, P. (2024). Overview of the postpartum period: Normal physiology and routine maternal care. In R. F. Connor (Ed.), *UpToDate*. Wolters Kluwer. <https://www.uptodate.com/contents/overview-of-the-postpartum-period-normal-physiology-and-routine-maternal-care>
- Berman, Z., Thiel, F., Kaimal, A. J., & Dekel, S. (2021). Association of sexual assault history with traumatic childbirth and subsequent PTSD. *Archives of Women's Mental Health*, 24(5), 767–771. <https://doi.org/10.1007/s00737-021-01129-0>
- Beydoun, H. A., Williams, M., Beydoun, M. A., Eid, S. M., & Zonderman, A. B. (2017). Relationship of physical intimate partner violence with mental health diagnoses in the Nationwide Emergency Department Sample. *Journal of Women's Health*, 26(2), 141–151. <https://doi.org/10.1089/jwh.2016.5840>
- Biggio, J. R. (2020). Research in pregnant subjects: Increasingly important, but challenging. *Ochsner Journal*, 20(1), 39–43. <https://doi.org/10.31486/toj.19.0077>
- Bower, K. M., Geller, R. J., Jeffers, N., McDonald, M., & Alhusen, J. (2023). Experiences of racism and perinatal depression: Findings from the Pregnancy Risk Assessment Monitoring System, 2018. *Journal of Advanced Nursing*, 79(5), 1982–1993. <https://doi.org/10.1111/jan.15519>
- Branquinho, M., Rodriguez-Muñoz, M. F., Maia, B. R., Marques, M., Matos, M., Osma, J., Moreno-Peral, P., Conejo-Cerón, S., Fonseca, A., & Voursoura, E. (2021). Effectiveness of psychological interventions in the treatment of perinatal depression: A systematic review of systematic reviews and meta-analyses. *Journal of Affective Disorders*, 291, 294–306. <https://doi.org/10.1016/j.jad.2021.05.010>
- Bresett, J. W., & Kruse-Diehr, A. J. (2023). Medications for opioid use disorder in rural United States: A critical review of the literature, 2004-2021. *Substance Use and Misuse*, 58(1), 111–118. <https://doi.org/10.1080/10826084.2022.2149244>



- Bright, V., Riddle, J., & Kerver, J. (2022). Stigma experienced by rural pregnant women with substance use disorder: A scoping review and qualitative synthesis. *International Journal of Environmental Research and Public Health*, 19(22), 15065. <https://doi.org/10.3390/ijerph192215065>
- Britt, R., Burkhard, J., Murphy, C., & Childers, A. (2023). U.S. “maternal mental health dark zones” — counties with the highest risk and lowest resources revealed. Policy Center for Maternal Mental Health. <https://www.2020mom.org/us-maternal-mental-health-dark-zones-revealed>
- Britz, J. B., Huffstetler, A. N., Henry, T. L., Ragunathan, B., Britton, E., Doshi, N., Stange, K. C., & Etz, R. S. (2022). Primary care: A critical stopgap of mental health services during the COVID-19 pandemic. *The Journal of the American Board of Family Medicine*, 35(5), 891–896. <https://doi.org/10.3122/jabfm.2022.05.210523>
- Brown, C. C., Adams, C. E., George, K. E., & Moore, J. E. (2021). Mental health conditions increase severe maternal morbidity by 50 percent and cost \$102 million yearly in the United States. *Health Affairs*, 40(10), 1575–1584. <https://doi.org/10.1377/hlthaff.2021.00759>
- Brunton, R., Gosper, K., & Dryer, R. (2021). Psychometric evaluation of the pregnancy-related anxiety scale: Acceptance of pregnancy, avoidance, and worry about self subscales. *Journal of Affective Disorders*, 278, 341–349. <https://doi.org/10.1016/j.jad.2020.09.064>
- Bruzeliuss, E., & Martins, S. S. (2022). US trends in drug overdose mortality among pregnant and postpartum persons, 2017-2020. *JAMA*, 328(21), 2159. <https://doi.org/10.1001/jama.2022.17045>
- Burkhard, J., & Britt, R. (2022). U.S. maternal depression screening rates released for the first time through HEDIS. *Closing Gaps in Maternal Mental Healthcare*. <https://www.2020mom.org/blog/2022/11/14/us-maternal-depression-screening-rates-released-for-the-first-time-through-hedis>
- Button, S., Thornton, A., Lee, S., Shakespeare, J., & Ayers, S. (2017). Seeking help for perinatal psychological distress: A meta-synthesis of women's experiences. *British Journal of General Practice*, 67(663), e692–e699. <https://doi.org/10.3399/bjgp17x692549>
- Byatt, N., Levin, L. L., Ziedonis, D., Moore Simas, T. A., & Allison, J. (2015). Enhancing participation in depression care in outpatient perinatal care settings. *Obstetrics & Gynecology*, 126(5), 1048–1058. <https://doi.org/10.1097/aog.0000000000001067>
- Byatt, N., Mittal, L., Brenckle, L., Logan, D., Masters, G., Bergman, A., & Moore Simas, T. (2019). Lifeline4Moms Perinatal Mental Health Toolkit. *Psychiatry Information in Brief*, 16(7). <https://doi.org/10.7191/pib.1140>
- Byatt, N., Xu, W., Levin, L. L., & Moore Simas, T. A. (2019). Perinatal depression care pathway for obstetric settings. *International Review of Psychiatry*, 31(3), 210–228. <https://doi.org/10.1080/09540261.2018.1534725>

*The California Pregnancy-Associated Mortality Review Report: Pregnancy associated suicide, 2002-2012.* (2019). Sacramento: California Department of Public Health, Maternal, Child & Adolescent Health Division.

Campbell, J., Matoff-Stepp, S., Velez, M. L., Cox, H. H., & Laughon, K. (2021). Pregnancy-associated deaths from homicide, suicide, and drug overdose: Review of research and the intersection with intimate partner violence. *Journal of Women's Health, 30*(2), 236–244. <https://doi.org/10.1089/jwh.2020.8875>

Cantwell, R. (2021). Mental disorder in pregnancy and the early postpartum. *Anaesthesia, 76*(S4), 76–83. <https://doi.org/10.1111/anae.15424>

Center for Substance Abuse Treatment (US). (2014). Chapter 3: Understanding the impact of trauma. In *Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series, No. 57*. Substance Abuse and Mental Health Services Administration. <https://www.ncbi.nlm.nih.gov/books/NBK207191/>

Centers for Disease Control and Prevention. (2018). *Health communication playbook: Resources to help you create effective materials*. <https://www.cdc.gov/nceh/clearwriting/docs/health-comm-playbook-508.pdf>

Centers for Disease Control and Prevention. (2020). *Web-based injury statistics query and reporting system (WISQARS)*. <https://www.cdc.gov/injury/wisqars/index.html>

Centers for Disease Control and Prevention. (2021, August 23). *Adverse childhood experiences (ACEs): Preventing early trauma to improve adult health*. Vital Signs. <https://www.cdc.gov/vitalsigns/aces/index.html>

Centers for Disease Control and Prevention. (2022). *What is health equity?* <https://www.cdc.gov/healthequity/whatis/index.html>

Centers for Disease Control and Prevention. (2023). *State perinatal quality collaboratives*. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc-states.html>

Centers for Disease Control and Prevention. (2024). *Health communication strategies and resources*. <https://npin.cdc.gov/pages/health-communication-strategies-and-resources>

Centers for Disease Control and Prevention. (n.d.-a). *Data and statistics about opioid use during pregnancy*. <https://www.cdc.gov/pregnancy/opioids/data.html>

Centers for Disease Control and Prevention. (n.d.-b). *Depression during and after pregnancy*. <https://www.cdc.gov/reproductivehealth/features/maternal-depression/index.html>

Centers for Disease Control and Prevention. (n.d.-c). *Drug overdose deaths*. <https://www.cdc.gov/drugoverdose/deaths/index.html>

## The Task Force on Maternal Mental Health's Report to Congress

Centers for Disease Control and Prevention. (n.d.-d). *Enhancing reviews and surveillance to eliminate maternal mortality (ERASE MM)*.

<https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html>

Centers for Disease Control and Prevention. (n.d.-e). *FASDs: Treatments*.

<https://www.cdc.gov/ncbddd/fasd/treatments.html>

Centers for Disease Control and Prevention. (n.d.-f). *Fast facts: Preventing adverse childhood experiences*. <https://www.cdc.gov/violenceprevention/aces/fastfact.html>

Centers for Disease Control and Prevention. (n.d.-g). *Fast facts: Preventing intimate partner violence*. <https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html>

Centers for Disease Control and Prevention. (n.d.-h). *Fast facts: Preventing sexual violence*. <https://www.cdc.gov/violenceprevention/sexualviolence/fastfact.html>

Centers for Disease Control and Prevention. (n.d.-i). *Infographic: 6 guiding principles to a trauma-informed approach*.

[https://www.cdc.gov/orr/infographics/6\\_principles\\_trauma\\_info.htm](https://www.cdc.gov/orr/infographics/6_principles_trauma_info.htm)

Centers for Disease Control and Prevention. (n.d.-j). *Polysubstance use during pregnancy*.

<https://www.cdc.gov/pregnancy/polysubstance-use-in-pregnancy.html>

Centers for Disease Control and Prevention. (n.d.-k). *Pregnancy Mortality Surveillance System*.

<https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm>

Centers for Disease Control and Prevention. (n.d.-l). *Risks and how to reduce them*.

<https://www.cdc.gov/opioids/patients/reduce-risks.html>

Centers for Disease Control and Prevention. (n.d.-m). *Severe maternal morbidity in the United States*.

<https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>

Centers for Disease Control and Prevention. (n.d.-n). *Social determinants of health at CDC*.

<https://www.cdc.gov/about/sdoh/index.html>

Centers for Medicare & Medicaid Services. (2024, April 16). *Information on essential health benefits (EHB) benchmark plans*.

<https://www.cms.gov/marketplace/resources/data/essential-health-benefits>

Centers for Medicare & Medicaid Services. (n.d.-a). *Certification and compliance for the Emergency Medical Treatment and Labor Act (EMTALA)*.

<https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/downloads/emtala.pdf>

- Centers for Medicare & Medicaid Services. (n.d.-b). *Improving access to maternal health care in rural communities* [Issue Brief]. <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/09032019-Maternal-Health-Care-in-Rural-Communities.pdf>
- Chapman, A. L., & Dixon-Gordon, K. L. (2020). *Dialectical behavior therapy*. American Psychological Association. <https://doi.org/doi.org/10.1037/0000188-000>
- Chibanda, D., Weiss, H. A., Verhey, R., Simms, V., Munjoma, R., Rusakaniko, S., Chingono, A., Munetsi, E., Bere, T., Manda, E., Abas, M., & Araya, R. (2016). Effect of a primary care-based psychological intervention on symptoms of common mental disorders in Zimbabwe. *JAMA*, 316(24), 2618. <https://doi.org/10.1001/jama.2016.19102>
- Chin, K., Wendt, A., Bennett, I. M., & Bhat, A. (2022). Suicide and maternal mortality. *Current Psychiatry Reports*, 24(4), 239–275. <https://doi.org/10.1007/s11920-022-01334-3>
- Chinn, J. J., Eisenberg, E., Artis Dickerson, S., King, R. B., Chakhtoura, N., Lim, I. A. L., Grantz, K. L., Lamar, C., & Bianchi, D. W. (2020). Maternal mortality in the United States: Research gaps, opportunities, and priorities. *American Journal of Obstetrics and Gynecology*, 223(4), 486–492.e486. <https://doi.org/10.1016/j.ajog.2020.07.021>
- Choi, S., Rosenbloom, D., Stein, M. D., Raifman, J., & Clark, J. A. (2022). Differential gateways, facilitators, and barriers to substance use disorder treatment for pregnant women and mothers: A scoping systematic review. *Journal of Addiction Medicine*, 16(3), e185–e196. <https://doi.org/10.1097/adm.0000000000000909>
- Cirino, N. H., & Knapp, J. M. (2019). Perinatal posttraumatic stress disorder: A review of risk factors, diagnosis, and treatment. *Obstetrical & Gynecological Survey*, 74(6), 369–376. <https://doi.org/10.1097/ogx.0000000000000680>
- Clarke, D., De Faria, L., Alpert, J., The Perinatal Mental Health Advisory Panel, & The Perinatal Mental Health Research Team. (2023). *Perinatal mental and substance use disorder* [White Paper]. American Psychiatric Association. <https://www.psychiatry.org/maternal>
- Clements, A. D., Cyphers, N. A., Whittaker, D. L., Hamilton, B., & Mccarty, B. (2021). Using trauma informed principles in health communication: Improving faith/science/clinical collaboration to address addiction. *Frontiers in Psychology*, 12. <https://doi.org/10.3389/fpsyg.2021.781484>
- Cleveland, L. M., McGlothen-Bell, K., Scott, L. A., & Recto, P. (2020). A life-course theory exploration of opioid-related maternal mortality in the United States. *Addiction*, 115(11), 2079–2088. <https://doi.org/10.1111/add.15054>
- Cluxton-Keller, F., & Bruce, M. L. (2018). Clinical effectiveness of family therapeutic interventions in the prevention and treatment of perinatal depression: A systematic review and meta-analysis. *PloS One*, 13(6), e0198730. <https://doi.org/10.1371/journal.pone.0198730>

- Cohen, L. S. (2006). Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA*, 295(5), 499.  
<https://doi.org/10.1001/jama.295.5.499>
- Community Preventive Services Task Force. (2021). *Task force finding and rationale statement: Social determinants of health: Permanent supportive housing with Housing First (Housing First programs)*. The Community Guide.  
<https://www.thecommunityguide.org/pages/tffrs-social-determinants-health-housing-first-programs.html#:~:text=The%20Community%20Preventive%20Services%20Task,who%20are%20experiencing%20homelessness%20and>
- Cox, E. Q., Sowa, N. A., Meltzer-Brody, S. E., & Gaynes, B. N. (2016). The perinatal depression treatment cascade. *The Journal of Clinical Psychiatry*, 77(09), 1189–1200.  
<https://doi.org/10.4088/jcp.15r10174>
- Crear-Perry, J., Correa-De-Araujo, R., Lewis Johnson, T., McLemore, M. R., Neilson, E., & Wallace, M. (2021). Social and structural determinants of health inequities in maternal health. *Journal of Women's Health*, 30(2), 230–235.  
<https://doi.org/10.1089/jwh.2020.8882>
- Creech, S. K., Pulverman, C. S., Kroll-Desrosiers, A., Kinney, R., Dichter, M. E., & Mattocks, K. (2021). Intimate partner violence among pregnant veterans: Prevalence, associated mental health conditions, and health care utilization. *Journal of General Internal Medicine*, 36(10), 2982–2988. <https://doi.org/10.1007/s11606-020-06498-3>
- Cunningham, S. D., Lewis, J. B., Thomas, J. L., Grilo, S. A., & Ickovics, J. R. (2017). Expect with me: Development and evaluation design for an innovative model of group prenatal care to improve perinatal outcomes. *BMC Pregnancy and Childbirth*, 17(1).  
<https://doi.org/10.1186/s12884-017-1327-3>
- D'Angelo, D. V., Bombard, J. M., Lee, R. D., Kortsmidt, K., Kapaya, M., & Fasula, A. (2022). Prevalence of experiencing physical, emotional, and sexual violence by a current intimate partner during pregnancy: Population-based estimates from the Pregnancy Risk Assessment Monitoring System. *Journal of Family Violence*, 38(1), 117–126.  
<https://doi.org/10.1007/s10896-022-00356-y>
- Davidov, D. M., Coffman, J., Dyer, A., Bias, T. K., Kristjansson, A. L., Mann, M. J., Vasile, E., & Abildso, C. G. (2021). Assessment and response to intimate partner violence in home visitation: A qualitative needs assessment with home visitors in a statewide program. *Journal of Interpersonal Violence*, 36(3-4), NP1762–1787NP.  
<https://doi.org/10.1177/0886260518754869>
- Declercq, E., & Zephyrin, L. (2020). *Maternal mortality in the United States: A primer* [Issue Brief & Report]. The Commonwealth Fund.  
<https://www.commonwealthfund.org/publications/issue-brief-report/2020/dec/maternal-mortality-united-states-primer>

- Deligiannidis, K. M., Meltzer-Brody, S., Maximos, B., Peeper, E. Q., Freeman, M., Lasser, R., Bullock, A., Kotecha, M., Li, S., Forrestal, F., Rana, N., Garcia, M., Leclair, B., & Doherty, J. (2023). Zuranolone for the treatment of postpartum depression. *American Journal of Psychiatry*, 180(9), 668–675. <https://doi.org/10.1176/appi.ajp.20220785>
- Dennis, C.-L., Falah-Hassani, K., & Shiri, R. (2017). Prevalence of antenatal and postnatal anxiety: Systematic review and meta-analysis. *British Journal of Psychiatry*, 210(5), 315–323. <https://doi.org/10.1192/bjp.bp.116.187179>
- El-Bassel, N., Marotta, P. L., Goddard-Eckrich, D., Chang, M., Hunt, T., Wu, E., & Gilbert, L. (2019). Drug overdose among women in intimate relationships: The role of partner violence, adversity and relationship dependencies. *PloS One*, 14(12), e0225854. <https://doi.org/10.1371/journal.pone.0225854>
- Ellick, K. L., Kroelinger, C. D., Chang, K., McGown, M., McReynolds, M., Velonis, A. J., Bronson, E., Riehle-Colarusso, T., Pliska, E., Akbarali, S., Mueller, T., Dronamraju, R., Cox, S., & Barfield, W. D. (2024). Increasing access to quality care for pregnant and postpartum people with opioid use disorder: Coordination of services, provider awareness and training, extended postpartum coverage, and perinatal quality collaboratives. *Journal of Substance Use & Addiction Treatment*, 156, 209208. <https://doi.org/https://doi.org/10.1016/j.josat.2023.209208>
- Elliott, A. J., Kinney, H. C., Haynes, R. L., Dempers, J. D., Wright, C., Fifer, W. P., Angal, J., Boyd, T. K., Burd, L., Burger, E., Folkerth, R. D., Groenewald, C., Hankins, G., Hereld, D., Hoffman, H. J., Holm, I. A., Myers, M. M., Nelsen, L. L., Odendaal, H. J., . . . Dukes, K. A. (2020). Concurrent prenatal drinking and smoking increases risk for SIDS: Safe passage study report. *EClinicalMedicine*, 19, 100247. <https://doi.org/10.1016/j.eclinm.2019.100247>
- Endres, K., Haigler, K., Sbrilli, M., Jasani, S., & Laurent, H. (2023). Social determinants of perinatal mental health during the COVID-19 pandemic. *General Hospital Psychiatry*, 84, 39–43. <https://doi.org/10.1016/j.genhosppsych.2023.05.010>
- Ertan, D., Hingray, C., Burlacu, E., Sterlé, A., & El-Hage, W. (2021). Post-traumatic stress disorder following childbirth. *BMC Psychiatry*, 21(1). <https://doi.org/10.1186/s12888-021-03158-6>
- Eunice Kennedy Shriver National Institute of Child Health and Human Development. (n.d.). *Moms' mental health matters*. <https://www.nichd.nih.gov/ncmh/ncmh/ncmh/initiatives/moms-mental-health-matters/moms>
- Fairbrother, N., Collardeau, F., Albert, A. Y. K., Challacombe, F. L., Thordarson, D. S., Woody, S. R., & Janssen, P. A. (2021). High prevalence and incidence of obsessive-compulsive disorder among women across pregnancy and the postpartum. *The Journal of Clinical Psychiatry*, 82(2). <https://doi.org/10.4088/jcp.20m13398>



- Fawcett, E. J., Fairbrother, N., Cox, M. L., White, I. R., & Fawcett, J. M. (2019). The prevalence of anxiety disorders during pregnancy and the postpartum period. *The Journal of Clinical Psychiatry*, 80(4). <https://doi.org/10.4088/jcp.18r12527>
- Feriante, J., & Sharma, N. P. (2024). Acute and chronic mental health trauma. In *Statpearls*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK594231>
- Fischer, E. P., Marder, S. R., Smith, G. R., Owen, R. R., Rubenstein, L., Hedrick, S. C., & Curran, G. M. (2000). Quality Enhancement Research Initiative in mental health. *Medical Care*, 38(6 Suppl 1), I-70–I-81. <https://doi.org/10.1097/00005650-200006001-00008>
- Fitelson, E., Leight, K., Kim, S., & Baker, A. (2010). Treatment of post-partum depression: A review of clinical, psychological and pharmacological options. *International Journal of Women's Health*, 1. <https://doi.org/10.2147/ijwh.s6938>
- Ford, E., Roomi, H., Hugh, H., & Van Marwijk, H. (2019). Understanding barriers to women seeking and receiving help for perinatal mental health problems in UK general practice: Development of a questionnaire. *Primary Health Care Research & Development*, 20. <https://doi.org/10.1017/s1463423619000902>
- Foti, T. R., Watson, C., Adams, S. R., Rios, N., Staunton, M., Wei, J., Sterling, S. A., Ridout, K. K., & Young-Wolff, K. C. (2023). Associations between adverse childhood experiences (ACEs) and prenatal mental health and substance use. *International Journal of Environmental Research and Public Health*, 20(13), 6289. <https://doi.org/10.3390/ijerph20136289>
- Garcia, E. R., & Yim, I. S. (2017). A systematic review of concepts related to women's empowerment in the perinatal period and their associations with perinatal depressive symptoms and premature birth. *BMC Pregnancy and Childbirth*, 17(S2). <https://doi.org/10.1186/s12884-017-1495-1>
- Geller, P. A., & Stasko, E. C. (2017). Effect of previous posttraumatic stress in the perinatal period. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 46(6), 912–922. <https://doi.org/10.1016/j.jogn.2017.04.136>
- Gemmell, A., Kiang, M. V., & Alexander, M. J. (2019). Trends in pregnancy-associated mortality involving opioids in the United States, 2007–2016. *American Journal of Obstetrics and Gynecology*, 220(1), 115–116. <https://doi.org/10.1016/j.ajog.2018.09.028>
- Gentile, S. (2017). Untreated depression during pregnancy: Short- and long-term effects in offspring. A systematic review. *Neuroscience*, 342, 154–166. <https://doi.org/10.1016/j.neuroscience.2015.09.001>
- Gilbert, L., Marotta, P. L., Goddard-Eckrich, D., Richer, A., Akuffo, J., Hunt, T., Wu, E., & El-Bassel, N. (2022). Association between multiple experiences of violence and drug overdose among Black women in community supervision programs in New York City. *Journal of Interpersonal Violence*, 37(23-24), NP21502–NP21524. <https://doi.org/10.1177/08862605211057269>

- Glazer, K. B., & Howell, E. A. (2021). A way forward in the maternal mortality crisis: Addressing maternal health disparities and mental health. *Archives of Women's Mental Health*, 24(5), 823–830. <https://doi.org/10.1007/s00737-021-01161-0>
- Golnick, C., Asay, E., Provost, E., Van Liere, D., Bosshart, C., Rounds-Riley, J., Cueva, K., & Hennessy, T. W. (2012). Innovative primary care delivery in rural Alaska: A review of patient encounters seen by community health aides. *International Journal of Circumpolar Health*, 71(1), 18543. <https://doi.org/10.3402/ijch.v71i0.18543>
- Grace, K. T., & Miller, E. (2023). Future directions for reproductive coercion and abuse research. *Reproductive Health*, 20(1). <https://doi.org/10.1186/s12978-022-01550-3>
- Green, V. R., Kennedy-Hendricks, A., Saloner, B., & Bandara, S. (2024). Substance use and treatment characteristics among pregnant and non-pregnant females, 2015-2019. *Drug and Alcohol Dependence*, 254, 111041. <https://doi.org/10.1016/j.drugalcdep.2023.111041>
- Grigoriadis, S., Wilton, A. S., Kurdyak, P. A., Rhodes, A. E., Vonderporten, E. H., Levitt, A., Cheung, A., & Vigod, S. N. (2017). Perinatal suicide in Ontario, Canada: A 15-year population-based study. *Canadian Medical Association Journal*, 189(34), E1085–E1092. <https://doi.org/10.1503/cmaj.170088>
- Grote, N. K., Swartz, H. A., Geibel, S. L., Zuckoff, A., Houck, P. R., & Frank, E. (2009). A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. *Psychiatric Services*, 60(3), 313–321. <https://doi.org/10.1176/ps.2009.60.3.313>
- Gunja, M. Z., Gumas, E. D., & Williams, R. D., II. (2022, December 1). The U.S. maternal mortality crisis continues to worsen: An international comparison. *To the Point*. <https://doi.org/10.26099/8vem-fc65>
- Gunja, M. Z., Gumas, E. D., & Williams, R. D., II. (2023). *U.S. health care from a global perspective, 2022: Accelerating spending, worsening outcomes* [Issue Brief]. The Commonwealth Fund. <https://doi.org/10.26099/8ejy-yc74>
- Guth, M., Saunders, H., Corallo, B., & Moreno, S. (2023). *Medicaid coverage of behavioral health services in 2022: Findings from a survey of state Medicaid programs*. KFF. <https://www.kff.org/mental-health/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/>
- Hahn, C. K., Gilmore, A. K., Aguayo, R. O., & Rheingold, A. A. (2018). Perinatal intimate partner violence. *Obstetrics and Gynecology Clinics of North America*, 45(3), 535–547. <https://doi.org/10.1016/j.ogc.2018.04.008>
- Haight, S. C., Byatt, N., Moore Simas, T. A., Robbins, C. L., & Ko, J. Y. (2019). Recorded diagnoses of depression during delivery hospitalizations in the United States, 2000–2015. *Obstetrics & Gynecology*, 133(6), 1216–1223. <https://doi.org/10.1097/aog.0000000000003291>



- Haight, S. C., Ko, J. Y., Tong, V. T., Bohm, M. K., & Callaghan, W. M. (2018). Opioid use disorder documented at delivery hospitalization — United States, 1999–2014. *Morbidity and Mortality Weekly Report*, 67(31), 845–849. <https://doi.org/10.15585/mmwr.mm6731a1>
- Haldar, S., & Hinton, E. (2023). *State policies for expanding Medicaid coverage of community health worker (CHW) services*. KFF. <https://www.kff.org/medicaid/issue-brief/state-policies-for-expanding-medicaid-coverage-of-community-health-worker-chw-services/>
- Han, B., Compton, W. M., Einstein, E. B., Elder, E., & Volkow, N. D. (2024). Pregnancy and postpartum drug overdose deaths in the US before and during the COVID-19 pandemic. *JAMA Psychiatry*, 81(3), 270. <https://doi.org/10.1001/jamapsychiatry.2023.4523>
- Hartwell, M., Keener, A., Robling, K., Enmeier, M., Sajjadi, N. B., Greiner, B., & Price, J. (2023). Associations of intimate partner violence and maternal comorbidities: A cross-sectional analysis of the Pregnancy Risk Assessment Monitoring System. *Journal of Osteopathic Medicine*, 123(8), 405–410. <https://doi.org/10.1515/jom-2023-0018>
- Health Resources & Services Administration, Bureau of Health Workforce. (2019). *Allied health workforce projections, 2016-2030: Community health workers*. <https://bhwh.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/community-health-workers-2016-2030.pdf>
- Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). *Social determinants of health*. Retrieved February 28, 2023,, from <https://health.gov/healthypeople/priority-areas/social-determinants-health>
- Hellberg, S. N., Bruening, A. B., Thompson, K. A., & Hopkins, T. A. (2023). Applications of dialectical behavioural therapy in the perinatal period: A scoping review. *Clinical Psychology & Psychotherapy*. <https://doi.org/10.1002/cpp.2937>
- Henry, T. A. (2023). *Don’t criminalize pregnant patients with substance-use disorders*. American Medical Association. <https://www.ama-assn.org/delivering-care/overdose-epidemic/don-t-criminalize-pregnant-patients-substance-use-disorders>
- Hien, D., Kropp, F., Wells, E. A., Campbell, A., Hatch-Maillette, M., Hodgkins, C., Killeen, T., Lopez-Castro, T., Morgan-Lopez, A., Ruglass, L. M., Saavedra, L., & Nunes, E. V. (2020). The “Women and Trauma” study and its national impact on advancing trauma specific approaches in community substance use treatment and research. *Journal of Substance Abuse Treatment*, 112, 12–17. <https://doi.org/10.1016/j.jsat.2020.02.003>
- Hill, A. L., Miller, E., Borrero, S., Zelazny, S., Miller-Walfish, S., Talis, J., Switzer, G. E., Abebe, K. Z., & Chang, J. C. (2021). Family planning providers’ assessment of intimate partner violence and substance use. *Journal of Women’s Health*, 30(9), 1225–1232. <https://doi.org/10.1089/jwh.2020.8699>

- Hill, L., Ndugga, N., & Artiga, S. (2023). *Key data on health and health care by race and ethnicity*. KFF. Retrieved March 17, 2023, from <https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/>
- Hinton, E., Williams, E., Raphael, J., Mudumala, A., Rudowitz, R., Gifford, K., Lashbrook, C. K., Kidder, B., & Snyder, B. (2023). *Amid unwinding of pandemic-era policies, Medicaid programs continue to focus on delivery systems, benefits, and reimbursement rates: Results from an annual Medicaid budget survey for state fiscal years 2023 and 2024*. KFF. <https://www.kff.org/medicaid/report/50-state-medicaid-budget-survey-fy-2023-2024/>
- Hirai, A. H., Ko, J. Y., Owens, P. L., Stocks, C., & Patrick, S. W. (2021). Neonatal abstinence syndrome and maternal opioid-related diagnoses in the US, 2010-2017. *JAMA*, 325(2), 146. <https://doi.org/10.1001/jama.2020.24991>
- Hotelling, B. A. (2008). Perinatal needs of pregnant, incarcerated women. *Journal of Perinatal Education*, 17(2), 37–44. <https://doi.org/10.1624/105812408x298372>
- Hoyert, D. L. (2023, March 20, 2023). *National Vital Statistics System maternal mortality [presentation]* Advisory Committee on Infant and Maternal Mortality Meeting, Online. <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/infant-mortality/meetings/hoyert-national-vital-statistics.pdf>
- Hoyert, D. L. (2024). *Maternal mortality rates in the United States, 2022*. NCHS Health E-Stats. <https://dx.doi.org/10.15620/cdc/152992>
- Hudak, M. L., Tan, R. C., Frattarelli, D. A. C., Galinkin, J. L., Green, T. P., Neville, K. A., Paul, I. M., Van Den Anker, J. N., Papile, L.-A., Baley, J. E., Bhutani, V. K., Carlo, W. A., Cummings, J., Kumar, P., Polin, R. A., Wang, K. S., & Watterberg, K. L. (2012). Neonatal drug withdrawal. *Pediatrics*, 129(2), e540–e560. <https://doi.org/10.1542/peds.2011-3212>
- Hussaini, K. S., Gardesey, M. D., Yocher, G., & Paul, D. A. (2020). Evaluating the health outcomes of the Healthy Women Healthy Babies program in Delaware. *Maternal and Child Health Journal*, 24(10), 1259–1266. <https://doi.org/10.1007/s10995-020-02972-w>
- Jahan, N., Went, T. R., Sultan, W., Sapkota, A., Khurshid, H., Qureshi, I. A., & Alfonso, M. (2021). Untreated depression during pregnancy and its effect on pregnancy outcomes: A systematic review. *Cureus*. <https://doi.org/10.7759/cureus.17251>
- Jarde, A., Morais, M., Kingston, D., Giallo, R., MacQueen, G. M., Giglia, L., Beyene, J., Wang, Y., & McDonald, S. D. (2016). Neonatal outcomes in women with untreated antenatal depression compared with women without depression. *JAMA Psychiatry*, 73(8), 826. <https://doi.org/10.1001/jamapsychiatry.2016.0934>
- Jarlenski, M., & Krans, E. E. (2021). Co-occurring substance use disorders identified among delivery hospitalizations in the United States. *Journal of Addiction Medicine*, 15(6), 504–507. <https://doi.org/10.1097/adm.0000000000000792>

- Jarlenski, M., Shroff, J., Terplan, M., Roberts, S. C. M., Brown-Podgorski, B., & Krans, E. E. (2023). Association of race with urine toxicology testing among pregnant patients during labor and delivery. *JAMA Health Forum*, 4(4), e230441. <https://doi.org/10.1001/jamahealthforum.2023.0441>
- Jilani, S. M., Davis, J. M., Grossman, M., Jones, H. E., Terplan, M., & Jansson, L. M. (2024). A dyadic framework of care for opioid-exposed birthing persons and their infants and children. *The Journal of Pediatrics*, 266, 113893. <https://doi.org/10.1016/j.jpeds.2023.113893>
- Joseph, N. T., Prater, L. C., & Modest, A. M. (2024). Pregnancy-associated firearm mortality in the U.S., 2008–2019. *American Journal of Preventive Medicine*. <https://doi.org/https://doi.org/10.1016/j.amepre.2024.02.022>
- Kanes, S., Colquhoun, H., Gunduz-Bruce, H., Raines, S., Arnold, R., Schacterle, A., Doherty, J., Epperson, C. N., Deligiannidis, K. M., Riesenber, R., Hoffmann, E., Rubinow, D., Jonas, J., Paul, S., & Meltzer-Brody, S. (2017). Brexanolone (SAGE-547 injection) in post-partum depression: A randomised controlled trial. *The Lancet*, 390(10093), 480–489. [https://doi.org/10.1016/s0140-6736\(17\)31264-3](https://doi.org/10.1016/s0140-6736(17)31264-3)
- Katon, J. G., Gerber, M. R., Nillni, Y. I., & Patton, E. W. (2020). Consequences of military sexual trauma for perinatal mental health: How do we improve care for pregnant veterans with a history of sexual trauma? *Journal of Women's Health*, 29(1), 5–6. <https://doi.org/10.1089/jwh.2019.8154>
- Kendig, S., Keats, J. P., Hoffman, M. C., Kay, L. B., Miller, E. S., Moore Simas, T. A., Frieder, A., Hackley, B., Indman, P., Raines, C., Semenuk, K., Wisner, K. L., & Lemieux, L. A. (2017). Consensus bundle on maternal mental health. *Obstetrics & Gynecology*, 129(3), 422–430. <https://doi.org/10.1097/aog.0000000000001902>
- KFF. (n.d.). *Medicaid behavioral health services: Peer support services*. <https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-peer-support-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>
- Kisling, L. A., & Das, J. M. (2023). Prevention strategies. In *StatPearls [Internet]*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK537222/>
- Kitsantas, P., Adams, A. R., Cheema, J., & Kornides, M. L. (2021). Opioid use in pregnant women with mental health-related disabilities. *Archives of Gynecology and Obstetrics*, 303(6), 1531–1537. <https://doi.org/10.1007/s00404-020-05953-0>
- Kitsantas, P., Aljouadi, S. M., Adams, A. R., & Booth, E. J. (2021). Prevalence and correlates of suicidal behaviors during pregnancy: Evidence from the National Survey on Drug Use and Health. *Archives of Women's Mental Health*, 24(3), 473–481. <https://doi.org/10.1007/s00737-020-01089-x>

- Knocke, K., Chappel, A., Sugar, S., De Lew, N., Sommers, B. D., & United States Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation Office of Health Policy. (2022). *Doula care and maternal health: An evidence review* [Issue Brief]. Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy.  
[https://www.aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf?\\_ga=2.145261812.1347344851.1677077207-1130840302.1677077206](https://www.aspe.hhs.gov/sites/default/files/documents/dfcd768f1caf6fabf3d281f762e8d068/ASPE-Doula-Issue-Brief-12-13-22.pdf?_ga=2.145261812.1347344851.1677077207-1130840302.1677077206)
- Ko, J. Y., Coy, K. C., Haight, S. C., Haegerich, T. M., Williams, L., Cox, S., Njai, R., & Grant, A. M. (2020). Characteristics of marijuana use during pregnancy — eight states, Pregnancy Risk Assessment Monitoring System, 2017. *Morbidity and Mortality Weekly Report*, 69(32), 1058–1063. <https://doi.org/10.15585/mmwr.mm6932a2>
- Kozhimannil, K. B., Lewis, V. A., Interrante, J. D., Chastain, P. L., & Admon, L. (2023). Screening for and experiences of intimate partner violence in the United States before, during, and after pregnancy, 2016–2019. *American Journal of Public Health*, 113(3), 297–305. <https://doi.org/10.2105/ajph.2022.307195>
- Krans, E. E., Campopiano, M., Cleveland, L. M., Goodman, D., Kilday, D., Kendig, S., Leffert, L. R., Main, E. K., Mitchell, K. T., O’Gurek, D. T., D’Oria, R., McDaniel, D., & Terplan, M. (2019). National Partnership for Maternal Safety: Consensus bundle on obstetric care for women with opioid use disorder. *Obstetrics & Gynecology*, 134(2), 365–375.  
<https://doi.org/10.1097/aog.0000000000003381>
- Lawn, R. B., & Koenen, K. C. (2022). Homicide is a leading cause of death for pregnant women in US. *BMJ*, o2499. <https://doi.org/10.1136/bmj.o2499>
- Lebow, J. L., & Stroud, C. B. (2016). Family therapy. In *APA handbook of clinical psychology: Applications and methods*, vol. 3 (pp. 327–349). American Psychological Association.  
<https://doi.org/10.1037/14861-017>
- Lewis Johnson, T. E., Clare, C. A., Johnson, J. E., & Simon, M. A. (2020). Preventing perinatal depression now: A call to action. *Journal of Women’s Health*, 29(9), 1143–1147.  
<https://doi.org/10.1089/jwh.2020.8646>
- Li, X., Laplante, D. P., Paquin, V., Lafortune, S., Elgbeili, G., & King, S. (2022). Effectiveness of cognitive behavioral therapy for perinatal maternal depression, anxiety and stress: A systematic review and meta-analysis of randomized controlled trials. *Clinical Psychology Review*, 92, 102129. <https://doi.org/10.1016/j.cpr.2022.102129>
- Linares, D. E., Azuine, R. E., & Singh, G. K. (2020). Social determinants of health associated with mental health among U.S. mothers with children aged 0–5 years. *Journal of Women’s Health*, 29(8), 1039–1051. <https://doi.org/10.1089/jwh.2019.8111>
- Little, V., Mallow, A., & Gatanaga, O. (2022). Years after CMS approved new billing codes for collaborative care, confusion persists. *Health Affairs Forefront*, .

<https://www.healthaffairs.org/content/forefront/years-after-cms-approved-new-billing-codes-collaborative-care-confusion-persists>

- Lora, A. (2013). Call for information, call for quality in mental health care. *Epidemiology and Psychiatric Sciences*, 22(1), 9–13. <https://doi.org/10.1017/s2045796012000716>
- Luca, D. L., Margiotta, C., Staatz, C., Garlow, E., Christensen, A., & Zivin, K. (2020). Financial toll of untreated perinatal mood and anxiety disorders among 2017 births in the United States. *American Journal of Public Health*, 110(6), 888–896. <https://doi.org/10.2105/ajph.2020.305619>
- Lupton, C., Burd, L., & Harwood, R. (2004). Cost of fetal alcohol spectrum disorders. *American Journal of Medical Genetics. Part C: Seminars in Medical Genetics*, 127c(1), 42–50. <https://doi.org/10.1002/ajmg.c.30015>
- Lynch, V., Clemans-Cope, L., Howell, E., & Hill, I. (2021). Diagnosis and treatment of substance use disorder among pregnant women in three state Medicaid programs from 2013 to 2016. *Journal of Substance Abuse Treatment*, 124, 108265. <https://doi.org/10.1016/j.jsat.2020.108265>
- MacDorman, M. F., & Declercq, E. (2018). The failure of United States maternal mortality reporting and its impact on women's lives [Editorial Material]. *Birth*, 45(2), 105–108. <https://doi.org/10.1111/birt.12333>
- Magee, L. A., Strang, A., Li, L., Tu, D., Tumtawetikul, W., Craik, R., Daniele, M., Etyang, A. K., D'Alessandro, U., Ogochukwu, O., Roca, A., Sevene, E., Chin, P., Tchavana, C., Temmerman, M., & Von Dadelszen, P. (2020). The PRECISE (PREgnancy Care Integrating translational Science, Everywhere) database: Open-access data collection in maternal and newborn health. *Reproductive Health*, 17(S1). <https://doi.org/10.1186/s12978-020-0873-8>
- Maguire, J. (2019). Neuroactive steroids and gabaergic involvement in the neuroendocrine dysfunction associated with major depressive disorder and postpartum depression. *Frontiers in Cellular Neuroscience*, 13. <https://doi.org/10.3389/fncel.2019.00083>
- Mangla, K., Hoffman, M. C., Trumpff, C., O'Grady, S., & Monk, C. (2019). Maternal self-harm deaths: An unrecognized and preventable outcome. *American Journal of Obstetrics and Gynecology*, 221(4), 295–303. <https://doi.org/10.1016/j.ajog.2019.02.056>
- March of Dimes. (2019). *Neonatal abstinence syndrome (NAS)*. <https://www.marchofdimes.org/find-support/topics/planning-baby/neonatal-abstinence-syndrome-nas>
- Margerison, C. E., Roberts, M. H., Gemmill, A., & Goldman-Mellor, S. (2022). Pregnancy-associated deaths due to drugs, suicide, and homicide in the United States, 2010-2019. *Obstetrics & Gynecology*, 139(2), 172–180. <https://doi.org/10.1097/aog.0000000000004649>



- Margerison, C. E., Wang, X. S., Gemmill, A., & Goldman-Mellor, S. (2023). Changes in pregnancy-associated deaths in the US during the COVID-19 pandemic in 2020. *JAMA Network Open*, 6(2), Article e2254287. <https://doi.org/10.1001/jamanetworkopen.2022.54287>
- Margiotta, C., Gao, J., O'Neil, S., Vohra, D., & Zivin, K. (2022). The economic impact of untreated maternal mental health conditions in Texas. *BMC Pregnancy and Childbirth*, 22(1), 700. <https://doi.org/10.1186/s12884-022-05001-6>
- Mascola, M. A., Borders, A. E., Terplan, M., Comm Obstet, P., & American Soc Addiction, M. (2017). Opioid use and opioid use disorder in pregnancy [Article]. *Obstetrics & Gynecology*, 130(2), e81–e94. <https://doi.org/10.1097/AOG.0000000000002235>
- Maykin, M., & Tsai, S. P. (2020). Our mothers are dying: The current state of maternal mortality in Hawai'i and the United States. *Hawai'i Journal of Health & Social Welfare*, 79(10), 302–305.
- Mazaheri Habibi, M. R., Moghbeli, F., Langarizadeh, M., & Fatemi Aghda, S. A. (2024). Mobile health apps for pregnant women usability and quality rating scales: A systematic review. *BMC Pregnancy and Childbirth*, 24(1). <https://doi.org/10.1186/s12884-023-06206-z>
- McGee-Vincent, P., Mackintosh, M.-A., Jamison, A. L., Juhasz, K., Becket-Davenport, C., Bosch, J., Avery, T. J., Glamb, L., & Hampole, S. (2023). Training staff across the Veterans Affairs health care system to use mobile mental health apps: A national quality improvement project. *JMIR Mental Health*, 10, e41773. <https://doi.org/10.2196/41773>
- McGovern, M. E., Rokicki, S., & Reichman, N. E. (2022). Maternal depression and economic well-being: A quasi-experimental approach. *Social Science and Medicine*, 305, 115017. <https://doi.org/10.1016/j.socscimed.2022.115017>
- McKee, K., Admon, L. K., Winkelman, T. N. A., Muzik, M., Hall, S., Dalton, V. K., & Zivin, K. (2020). Perinatal mood and anxiety disorders, serious mental illness, and delivery-related health outcomes, United States, 2006–2015. *BMC Women's Health*, 20(1). <https://doi.org/10.1186/s12905-020-00996-6>
- MedlinePlus. (2024, April 11). *Mental disorders*. National Library of Medicine (US). <https://medlineplus.gov/mentaldisorders.html>
- Megnin-Viggars, O., Symington, I., Howard, L. M., & Pilling, S. (2015). Experience of care for mental health problems in the antenatal or postnatal period for women in the UK: A systematic review and meta-synthesis of qualitative research. *Archives of Women's Mental Health*, 18(6), 745–759. <https://doi.org/10.1007/s00737-015-0548-6>
- Meinhofer, A., Hinde, J. M., & Ali, M. M. (2020). Substance use disorder treatment services for pregnant and postpartum women in residential and outpatient settings. *Journal of Substance Use & Addiction Treatment*, 110, 9–17. <https://doi.org/10.1016/j.jsat.2019.12.005>

- Mennen, F. E., Palmer Molina, A., Monroe, W. L., Duan, L., Stuart, S., & Sosna, T. (2021). Effectiveness of an interpersonal psychotherapy (IPT) group depression treatment for Head Start mothers: A cluster-randomized controlled trial. *Journal of Affective Disorders*, 280(Pt B), 39–48. <https://doi.org/10.1016/j.jad.2020.11.074>
- Mette, E., Manz, J., Purington, K., & Antezzo, M. (2021). *State approaches to leveraging neonatal abstinence syndrome data to inform policymaking*. National Academy for State Health Policy. <https://nashp.org/state-approaches-to-leveraging-neonatal-abstinence-syndrome-data-to-inform-policymaking>
- Miele, K., Kim, S. Y., Jones, R., Rembert, J. H., Wachman, E. M., Shrestha, H., Henninger, M. L., Kimes, T. M., Schneider, P. D., Sivaloganathan, V., Sward, K. A., Deshmukh, V. G., Sanjuan, P. M., Maxwell, J. R., Seligman, N. S., Caveglia, S., Louis, J. M., Wright, T., Bennett, C. C., . . . Gilboa, S. M. (2023). Medication for opioid use disorder during pregnancy — Maternal and Infant Network to Understand Outcomes Associated with Use of Medication for Opioid Use Disorder During Pregnancy (MAT-LINK), 2014–2021. *Morbidity and Mortality Weekly Report. Surveillance Summaries*, 72(3), 1–14. <https://doi.org/10.15585/mmwr.ss7203a1>
- Miller, E., McCauley, H. L., Decker, M. R., Levenson, R., Zelazny, S., Jones, K. A., Anderson, H., & Silverman, J. G. (2017). Implementation of a family planning clinic-based partner violence and reproductive coercion intervention: Provider and patient perspectives. *Perspectives on Sexual and Reproductive Health*, 49(2), 85–93. <https://doi.org/10.1363/psrh.12021>
- Miller, L. J., Rowlands, S., Esposito, L., Altemus, M., & Strauss, J. L. (2022). The Veterans Health Administration Reproductive Mental Health Consultation Program: An innovation to improve access to specialty care. *Journal of General Internal Medicine*, 37(S3), 833–836. <https://doi.org/10.1007/s11606-022-07583-5>
- Mohamoud, Y. A., Cassidy, E., Fuchs, E., Womack, L. S., Romero, L., Kipling, L., Oza-Frank, R., Baca, K., Galang, R. R., Stewart, A., Carrigan, S., Mullen, J., Busacker, A., Behm, B., Hollier, L. M., Kroelinger, C., Mueller, T., Barfield, W. D., & Cox, S. (2023). Vital Signs: Maternity care experiences - United States, April 2023. *Morbidity and Mortality Weekly Report*, 72(35), 961–967. <https://doi.org/10.15585/mmwr.mm7235e1>
- Mughal, M. K., Giallo, R., Arnold, P. D., Kehler, H., Bright, K., Benzies, K., Wajid, A., & Kingston, D. (2019). Trajectories of maternal distress and risk of child developmental delays: Findings from the All Our Families (AOF) pregnancy cohort. *Journal of Affective Disorders*, 248, 1–12. <https://doi.org/10.1016/j.jad.2018.12.132>
- Murugan, V., Holzer, K. J., Termos, M., & Vaughn, M. (2021). Intimate partner violence among pregnant women reporting to the emergency department: Findings from a nationwide sample. *BMJ Sexual & Reproductive Health*, 47(3), e7–e7. <https://doi.org/10.1136/bmj.srh-2020-200761>

## The Task Force on Maternal Mental Health's Report to Congress

National Academies of Sciences, Engineering, and Medicine. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. The National Academies Press. <https://doi.org/doi:10.17226/25982>

National Academies of Sciences, Engineering, Medicine, Health and Medicine Division, Board on Population Health and Public Health Practice, & Committee on the Review of Specific Programs in the Comprehensive Addiction and Recovery Act. (2020). *Measuring success in substance use grant programs: Outcomes and metrics for improvement*. National Academies Press (US). <https://doi.org/10.17226/25745>

National Cancer Institute. (n.d.). *NCI dictionary of cancer terms* <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/prenatal>

National Center for Health Statistics. (2022). *A reference guide for certification of deaths associated with pregnancy on death certificates* [Reference Guide]. <https://stacks.cdc.gov/view/cdc/114453>

National Indian Health Board. (n.d.). *Creation of a national Indian Health Service Community Health Aide Program*. <https://www.nihb.org/docs/06292016/FINAL%20CHAP%20and%20CHRP%20Background.pdf>

National Institute of Mental Health. (2023). *Anxiety disorders*. <https://www.nimh.nih.gov/health/topics/anxiety-disorders>

National Institute of Mental Health. (n.d.). *Post-traumatic stress disorder (PTSD)*. <https://www.nimh.nih.gov/health/statistics/post-traumatic-stress-disorder-ptsd>

National Institute on Alcohol Abuse and Alcoholism. (n.d.). *Understanding fetal alcohol spectrum disorders*. <https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-fetal-alcohol-spectrum-disorders>

National Institute on Minority Health and Health Disparities. (2024). *Community-Based Participatory Research Program (CBPR)*. <https://www.nimhd.nih.gov/programs/extramural/community-based-participatory.html>

National Institutes of Health. (2021). *Clear communication: Clear & simple*. <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/clear-simple>

National Institutes of Health. (n.d.-a). *Clear communication*. <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication>

National Institutes of Health. (n.d.-b). *NIH Inclusion Outreach Toolkit: How to engage, recruit, and retain women in clinical research*. <https://orwh.od.nih.gov/toolkit/nih-policies-inclusion/guidelines>



- Ndanga, M., Sulley, S., & Saka, A. K. (2022). Trend analysis of substance use disorder during pregnancy. *Cureus*. <https://doi.org/10.7759/cureus.23548>
- Nichols, T. R., Welborn, A., Gringle, M. R., & Lee, A. (2021). Social stigma and perinatal substance use services: Recognizing the power of the good mother ideal [Article]. *Contemporary Drug Problems*, 48(1), 19–37. <https://doi.org/10.1177/0091450920969200>
- Niland, K., Zukiewicz, M., & Sama-Miller, E. (2020). *What the evidence says: Intimate partner violence and home visiting* (OPRE Report #2020-19). R. Office of Planning, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. [https://homvee.acf.hhs.gov/sites/default/files/2020-08/Home\\_Visiting\\_IPV\\_Research\\_Brief\\_1.pdf](https://homvee.acf.hhs.gov/sites/default/files/2020-08/Home_Visiting_IPV_Research_Brief_1.pdf)
- Noursi, S., Clayton, J. A., Campbell, J., & Sharps, P. (2020). The intersection of maternal morbidity and mortality and intimate partner violence in the United States [Review]. *Current Womens Health Reviews*, 16(4), 298–312. <https://doi.org/10.2174/1573404816999200502024742>
- O'Connor, S., & Su, L. J. (2023). Postpartum depressive symptoms: An analysis of social determinants using the Pregnancy Risk Assessment Monitoring System. *Women's Health Reports*, 4(1), 584–593. <https://doi.org/10.1089/whr.2023.0050>
- O'Connor, M., Czarnik, M., Morrow, B., & D'Angelo, D. (2022). Opioid use during pregnancy: An analysis of comment data from the 2016 Pregnancy Risk Assessment Monitoring System survey. *Substance Abuse*, 43(1), 649–656. <https://doi.org/10.1080/08897077.2021.1986878>
- O'Connor, S., & Su, L. J. (2023). Postpartum depressive symptoms: An analysis of social determinants using the Pregnancy Risk Assessment Monitoring System. *Women's Health Reports*, 4(1), 584–593. <https://doi.org/10.1089/whr.2023.0050>
- Office of National Drug Control Policy. (2022). *Substance use disorder in pregnancy: Improving outcomes for families*. [https://www.whitehouse.gov/wp-content/uploads/2021/10/ONDCP\\_Report-Substance-Use-Disorder-and-Pregnancy.pdf](https://www.whitehouse.gov/wp-content/uploads/2021/10/ONDCP_Report-Substance-Use-Disorder-and-Pregnancy.pdf)
- Office of the Surgeon General. (2020). The Surgeon General's call to action to improve maternal health. In *Publications and reports of the Surgeon General*. US Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK568220/>
- Ogden, S. N., Dichter, M. E., & Bazzi, A. R. (2022). Intimate partner violence as a predictor of substance use outcomes among women: A systematic review. *Addictive Behaviors*, 127, 107214. <https://doi.org/10.1016/j.addbeh.2021.107214>
- Olf, M. (2017). Sex and gender differences in post-traumatic stress disorder: An update. *European Journal of Psychotraumatology*, 8(sup4), 1351204. <https://doi.org/10.1080/20008198.2017.1351204>

Organisation for Economic Co-operation and Development. (2023). *Health status*.

[https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH\\_STAT](https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_STAT)

Osborne, L. M., Hermann, A., Burt, V., Driscoll, K., Fitelson, E., Meltzer-Brody, S., Barzilay, E. M., Yang, S. N., & Miller, L. (2015). Reproductive psychiatry: The gap between clinical need and education. *American Journal of Psychiatry*, 172(10), 946–948.

<https://doi.org/10.1176/appi.ajp.2015.15060837>

Osborne, L. M., Maclean, J. V., Barzilay, E. M., Meltzer-Brody, S., Miller, L., & Yang, S. N. (2018). Reproductive psychiatry residency training: A survey of psychiatric residency program directors. *Academic Psychiatry*, 42(2), 197–201. <https://doi.org/10.1007/s40596-017-0672-x>

Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., & Valenzuela, C. P. (2023). Births: Final data for 2021. *National Vital Statistics Reports*, 72(1), 1–53.

Palladino, C. L., Singh, V., Campbell, J., Flynn, H., & Gold, K. J. (2011). Homicide and suicide during the perinatal period. *Obstetrics & Gynecology*, 118(5), 1056–1063.

<https://doi.org/10.1097/aog.0b013e31823294da>

Patrick, S. W., Richards, M. R., Dupont, W. D., Mcneer, E., Buntin, M. B., Martin, P. R., Davis, M. M., Davis, C. S., Hartmann, K. E., Leech, A. A., Lovell, K. S., Stein, B. D., & Cooper, W. O. (2020). Association of pregnancy and insurance status with treatment access for opioid use disorder. *JAMA Network Open*, 3(8), e2013456.

<https://doi.org/10.1001/jamanetworkopen.2020.13456>

Phillips, H., Lyon, E., Krans, E. E., Warshaw, C., Chang, J. C., & Pallatino, C. (2021). Barriers to help-seeking among intimate partner violence survivors with opioid use disorder [Article]. *International Review of Psychiatry*, 33(6), 534–542.

<https://doi.org/10.1080/09540261.2021.1898350>

Policy Center for Maternal Mental Health. (2022). *A significant solution for maternal mental health: Certified peer specialists* [Issue Brief]. <https://www.2020mom.org/issue-briefs-and-papers>

Policy Center for Maternal Mental Health. (2023a). *American indian and alaskan native (ai/an) maternal mental health* [Fact Sheet]. <https://www.2020mom.org/issue-briefs-and-papers>

Policy Center for Maternal Mental Health. (2023b). *Black maternal mental health* [Issue Brief]. <https://www.2020mom.org/blog/issue-brief-black-maternal-mental-health>

Popova, S., Charness, M. E., Burd, L., Crawford, A., Hoyme, H. E., Mukherjee, R. A. S., Riley, E. P., & Elliott, E. J. (2023). Fetal alcohol spectrum disorders. *Nature Reviews Disease Primers*, 9(1). <https://doi.org/10.1038/s41572-023-00420-x>

Posmontier, B., Geller, P. A., Horowitz, J. A., Elgohail, M., & Chiarello, L. (2022). Intensive perinatal mental health programs in the United States: A call to action. *Psychiatric Services*, 73(8), 930–932. <https://doi.org/10.1176/appi.ps.202100384>

- Prince, M. K., Daley, S. F., & Ayers, D. (2024). Substance use in pregnancy. In *StatPearls [Internet]*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK542330/>
- Puka, K., Buckley, C., Mulia, N., Lasserre, A. M., Rehm, J., & Probst, C. (2022). Educational attainment and lifestyle risk factors associated with all-cause mortality in the US [Article]. *JAMA Health Forum*, 3(4), 12, Article e220401. <https://doi.org/10.1001/jamahealthforum.2022.0401>
- Putnick, D. L., Sundaram, R., Bell, E. M., Ghassabian, A., Goldstein, R. B., Robinson, S. L., Vafai, Y., Gilman, S. E., & Yeung, E. (2020). Trajectories of maternal postpartum depressive symptoms. *Pediatrics*, 146(5), e20200857. <https://doi.org/10.1542/peds.2020-0857>
- Rafferty, J., Mattson, G., Earls, M. F., & Yogman, M. W. (2019). Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics*, 143(1), e20183260. <https://doi.org/10.1542/peds.2018-3260>
- Raffi, E. R., Nonacs, R., & Cohen, L. S. (2019). Safety of psychotropic medications during pregnancy. *Clinics in Perinatology*, 46(2), 215–234. <https://doi.org/10.1016/j.clp.2019.02.004>
- Ramey-Collier, K., Jackson, M., Malloy, A., McMillan, C., Scraders-Pyatt, A., & Wheeler, S. M. (2023). Doula care: A review of outcomes and impact on birth experience. *Obstetrical & Gynecological Survey*, 78(2), 124–127. <https://doi.org/10.1097/ogx.0000000000001103>
- Rathbone, A. L., & Prescott, J. (2017). The use of mobile apps and SMS messaging as physical and mental health interventions: Systematic review. *Journal of Medical Internet Research*, 19(8), e295. <https://doi.org/10.2196/jmir.7740>
- Recto, P., McGlothen-Bell, K., McGrath, J., Brownell, E., & Cleveland, L. M. (2020). The role of stigma in the nursing care of families impacted by neonatal abstinence syndrome. *Advances in Neonatal Care*, 20(5), 354–363. <https://doi.org/10.1097/anc.0000000000000778>
- Roberts, S. C. M., Taylor, K. J., Alexander, K., Goodman, D., Martinez, N., & Terplan, M. (2024). Training health professionals to reduce overreporting of birthing people who use drugs to child welfare. *Addiction Science & Clinical Practice*, 19(1), 32. <https://doi.org/10.1186/s13722-024-00466-6>
- Roberts, T., Frederiksen, B., Saunders, H., & Salganicoff, A. (2023). *Opioid use disorder and treatment among pregnant and postpartum Medicaid enrollees* [Issue Brief]. KFF. <https://www.kff.org/medicaid/issue-brief/opioid-use-disorder-and-treatment-among-pregnant-and-postpartum-medicaid-enrollees/>
- Safon, C. B., McCloskey, L., Ezekwesili, C., Feyman, Y., & Gordon, S. H. (2021, May 26). Doula care saves lives, improves equity, and empowers mothers: State Medicaid programs should pay for it. *Health Affairs Forefront*. DOI: 10.1377/hblog20210525.295915

- Salameh, T. N., Hall, L. A., Crawford, T. N., Staten, R. R., & Hall, M. T. (2019). Racial/ethnic differences in mental health treatment among a national sample of pregnant women with mental health and/or substance use disorders in the United States. *Journal of Psychosomatic Research*, 121, 74–80. <https://doi.org/https://doi.org/10.1016/j.jpsychores.2019.03.015>
- Salameh, T. N., Hall, L. A., Crawford, T. N., Staten, R. R., & Hall, M. T. (2020). Trends in mental health and substance use disorders and treatment receipt among pregnant and nonpregnant women in the United States, 2008–2014. *Journal of Psychosomatic Obstetrics & Gynecology*, 41(4), 298–307. <https://doi.org/10.1080/0167482x.2019.1689949>
- Saldanha, I. J., Adam, G. P., Kanaan, G., Zahradnik, M. L., Steele, D. W., Danilack, V. A., Peahl, A. F., Chen, K. K., Stuebe, A. M., & Balk, E. M. (2023). Postpartum care up to 1 year after pregnancy: A systematic review and meta-analysis. In *AHRQ Comparative Effectiveness Reviews*. Agency for Healthcare Research and Quality. <https://doi.org/10.23970/ahrqepccer261>
- Saleeby, E., Scibetta, E., Greenwell, L., Jackson, A., & Robinson, N. (2021). MAMA's Neighborhood: Reimagining prenatal care to support mothers and reduce stress. *NEJM Catalyst*, 2(5). <https://doi.org/10.1056/cat.20.0654>
- Seibert, J., Dobbins, E., Theis, E., Murray, M., Stockdale, H., Feinberg, R., Hinde, J., & Karon, S. L. (2022). *Integrating SUD and OB/GYN care: Policy challenges and opportunities final report*. HHS Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/reports/integrating-sud-obgyn-care>
- Shannon, L., Nash, S., & Jackson, A. (2016). Examining intimate partner violence and health factors among rural appalachian pregnant women. *Journal of Interpersonal Violence*, 31(15), 2622–2640. <https://doi.org/10.1177/0886260515579508>
- Sharps, P. W., Bullock, L. F., Campbell, J. C., Alhusen, J. L., Ghazarian, S. R., Bhandari, S. S., & Schminkey, D. L. (2016). Domestic violence enhanced perinatal home visits: The DOVE randomized clinical trial. *Journal of Women's Health*, 25(11), 1129–1138. <https://doi.org/10.1089/jwh.2015.5547>
- Shen, Y., Lo-Ciganic, W.-H., Segal, R., & Goodin, A. J. (2020). Prevalence of substance use disorder and psychiatric comorbidity burden among pregnant women with opioid use disorder in a large administrative database, 2009–2014. *Journal of Psychosomatic Obstetrics & Gynecology*, 1–7. <https://doi.org/10.1080/0167482x.2020.1727882>
- Shiovitz, J. (2023). *Funding housing supports with Medicaid 1115 waivers*. Council of State Governments East. <https://csg-erc.org/funding-housing-supports-with-medicaid-1115-waivers/>
- Singh, G. K., Daus, G. P., Allender, M., Ramey, C. T., Martin, E. K., Perry, C., Reyes, A. A. L., & Vedamuthu, I. P. (2017). Social determinants of health in the United States:

## The Task Force on Maternal Mental Health's Report to Congress

- Addressing major health inequality trends for the nation, 1935-2016. *International Journal of MCH and AIDS*, 6(2), 139–164. <https://doi.org/10.21106/ijma.236>
- Sobczak, A., Taylor, L., Solomon, S., Ho, J., Kemper, S., Phillips, B., Jacobson, K., Castellano, C., Ring, A., Castellano, B., & Jacobs, R. J. (2023). The effect of doulas on maternal and birth outcomes: A scoping review. *Cureus*. <https://doi.org/10.7759/cureus.39451>
- Spencer, M. R., Miniño, A. M., & Warner, M. (2022). Drug overdose deaths in the United States, 2001-2021. *NCHS Data Brief*(457), 1–8.
- Staneva, A. A., Bogossian, F., Morawska, A., & Wittkowski, A. (2017). “I just feel like I am broken. I am the worst pregnant woman ever”: A qualitative exploration of the “at odds” experience of women’s antenatal distress. *Health Care for Women International*, 38(6), 658–686. <https://doi.org/10.1080/07399332.2017.1297448>
- Statz, M., & Bristow, M. (2023). Addressing perinatal mood and anxiety disorders (PMADs) in rural places: A knowledge infrastructure. *Wellbeing, Space and Society*, 4, 100131. <https://doi.org/https://doi.org/10.1016/j.wss.2023.100131>
- Stewart, A., Ko, J., Salvesen Von Essen, B., Levecke, M., D’Angelo, D. V., Romero, L., Cox, S., Warner, L., & Barfield, W. (2023). Association of mental health conditions, recent stressful life events, and adverse childhood experiences with postpartum substance use — seven states, 2019–2020. *Morbidity and Mortality Weekly Report*, 72(16), 416–420. <https://doi.org/10.15585/mmwr.mm7216a1>
- Stuart, S. (2012). Interpersonal psychotherapy for postpartum depression. *Clinical Psychology & Psychotherapy*, 19(2), 134–140. <https://doi.org/10.1002/cpp.1778>
- Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (SMA14-4884). <https://store.samhsa.gov/product/samhsas-concept-trauma-and-guidance-trauma-informed-approach/sma14-4884>
- Substance Abuse and Mental Health Services Administration. (2015). *Trauma-informed care in behavioral health services: Quick guide for clinicians (based on tip 57)* (SMA15-4912). <https://store.samhsa.gov/product/trauma-informed-care-behavioral-health-services-quick-guide-clinicians-based-tip-57/sma15>
- Substance Abuse and Mental Health Services Administration. (2018). *Clinical guidance for treating pregnant and parenting women with opioid use disorder and their infants* (SMA18-5054). <https://store.samhsa.gov/product/clinical-guidance-treating-pregnant-and-parenting-women-opioid-use-disorder-and-their>
- Substance Abuse and Mental Health Services Administration. (2022). *Trauma and violence*. <https://www.samhsa.gov/trauma-violence>
- Substance Abuse and Mental Health Services Administration. (2023a). *2022 NSDUH detailed tables*. <https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables>



## The Task Force on Maternal Mental Health's Report to Congress

- Substance Abuse and Mental Health Services Administration. (2023b). *Compassion fatigue and self-care for crisis counselors*. <https://www.samhsa.gov/dtac/ccp-toolkit/self-care-for-crisis-counselors>
- Substance Abuse and Mental Health Services Administration. (2023c). *Core competencies for peer workers*. <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers>
- Substance Abuse and Mental Health Services Administration. (2023d, June 9). *Mental health and substance use disorders*. <https://www.samhsa.gov/find-help/disorders>
- Substance Abuse and Mental Health Services Administration. (2023e). *Peer support workers for those in recovery*. <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>
- Substance Abuse and Mental Health Services Administration. (2024). *Advisory: Evidence-based, whole person care of pregnant people who have opioid use disorder* (SAMSHA Publ. No. PEP23-02-01-002). <https://store.samhsa.gov/sites/default/files/whole-person-care-pregnant-people-oud-pep23-02-01-002.pdf>
- Sundaram, S., Harman, J. S., & Cook, R. L. (2014). Maternal morbidities and postpartum depression: An analysis using the 2007 and 2008 Pregnancy Risk Assessment Monitoring System. *Women's Health Issues*, 24(4), e381–e388. <https://doi.org/10.1016/j.whi.2014.05.001>
- Swedo, E. A., Aslam, M. V., Dahlberg, L. L., Niolon, P. H., Guinn, A. S., Simon, T. R., & Mercy, J. A. (2023). Prevalence of adverse childhood experiences among US adults — Behavioral Risk Factor Surveillance System, 2011-2020 [Article]. *Morbidity and Mortality Weekly Report*, 72(26), 707–715. <http://dx.doi.org/10.15585/mmwr.mm7226a2>
- Swedo, E. A., D'Angelo, D. V., Fasula, A. M., Clayton, H. B., & Ports, K. A. (2023). Associations of adverse childhood experiences with pregnancy and infant health. *American Journal of Preventive Medicine*, 64(4), 512-524. <https://doi.org/https://doi.org/10.1016/j.amepre.2022.10.017>
- Swetlik, C., Cohen, L. S., Kobylski, L. A., Sojka, E. T., Killenberg, P. C., Freeman, M. P., & Viguera, A. C. (2024). Effects of prenatal exposure to second-generation antipsychotics on development and behavior among preschool-aged children. *The Journal of Clinical Psychiatry*, 85(1). <https://doi.org/10.4088/jcp.23m14965>
- Testa, A., Crawford, A. D., Jackson, D. B., & Gemmill, A. (2022). Stressful life events and prescription opioid use during pregnancy: Findings from the 2019 Pregnancy Risk Assessment Monitoring System. *Social Psychiatry and Psychiatric Epidemiology*, 57(11), 2181–2191. <https://doi.org/10.1007/s00127-022-02349-0>
- The White House. (2022, June 24). *White house blueprint for addressing the maternal health crisis*. <https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf>

## The Task Force on Maternal Mental Health's Report to Congress

- The White House. (2023). *U.S. national plan to end gender-based violence: Strategies for action*. Retrieved from <https://www.whitehouse.gov/wp-content/uploads/2023/05/National-Plan-to-End-GBV.pdf>
- Thomas, N., Bever, J., Biviji, R., Moton, H., & Lober, A. (2023, November 2). Addressing perinatal mental health with a diverse workforce: A national call to action. *Health Affairs Forefront*. <https://www.healthaffairs.org/doi/10.1377/forefront.20231030.235383>
- Trost, S., Beauregard, J., Chandra, G., Njie, F., Berry, J., Harvey, A., & Goodman, D. A. (2022). *Pregnancy-related deaths: Data from maternal mortality review committees in 36 US states, 2017-2019*. Centers for Disease Control and Prevention, US Department of Health and Human Services.
- Trost, S., Beauregard, J., Chandra, G., Njie, F., Harvey, A., Berry, J., & Goodman, D. A. (2022). *Pregnancy-related deaths among American Indian or Alaska Native persons: Data from maternal mortality review committees in 36 US states, 2017–2019*. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. <https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc-aian.html>
- Trost, S. L., Beauregard, J. L., Smoots, A. N., Ko, J. Y., Haight, S. C., Moore Simas, T. A., Byatt, N., Madni, S. A., & Goodman, D. (2021). Preventing pregnancy-related mental health deaths: Insights from 14 US maternal mortality review committees, 2008–17. *Health Affairs*, 40(10), 1551–1559. <https://doi.org/10.1377/hlthaff.2021.00615>
- U.S. Department of Health and Human Services. (2022). *HHS announces \$226.5 million to launch community health worker training program* <https://www.hhs.gov/about/news/2022/04/15/hhs-announces-226-million-launch-community-health-worker-training-program.html>
- U.S. Department of Health and Human Services. (2024, March 19). *Biden-Harris Administration announces Utah's Medicaid and CHIP postpartum coverage expansion; 45 states now offer full year of coverage after pregnancy*. <https://www.hhs.gov/about/news/2024/03/08/biden-harris-administration-announces-utahs-medicaid-chip-postpartum-coverage-expansion.html>
- U.S. Department of Housing and Urban Development. (2014). *Housing First in permanent supportive housing brief*. <https://www.hudexchange.info/resource/3892/housing-first-in-permanent-supportive-housing-brief/>
- U.S. Government Accountability Office. (2021). *Maternal mortality and morbidity: Additional efforts needed to assess program data for rural and underserved areas*. (GAO-21-283). Retrieved from <https://www.gao.gov/products/gao-21-283>
- Ujah, O. I., LeCounte, E. S., Ogbu, C. E., & Kirby, R. S. (2023). Food insecurity and delayed or forgone health care among pregnant and postpartum women in the United States, 2019-2021. *Nutrition*, 116, 112165. <https://doi.org/10.1016/j.nut.2023.112165>

- United States Census Bureau, America Counts Staff. (2017). One in five Americans live in rural areas. *America Counts: Stories*. <https://www.census.gov/library/stories/2017/08/rural-america.html>
- University of Iowa Division of Diversity Equity and Inclusion. (n.d.). *Dei definitions*. University of Iowa. Retrieved April 23, 2024, from <https://diversity.uiowa.edu/resources/dei-definitions>
- Valentine, S. E., Alshabani, N., Godfrey, L. B., Paul, E., Clark, C., Giovannini, K., & Nillni, Y. I. (2023). Considerations for the provision of PTSD treatment among pregnant women with substance use histories: A clinical conceptual model based on case consultation field notes. *General Hospital Psychiatry*, 84, 3–11. <https://doi.org/10.1016/j.genhosppsych.2023.05.013>
- Valenzuela, C. P., & Osterman, M. J. K. (2023). Characteristics of mothers by source of payment for the delivery: United States, 2021. *NCHS Data Brief*(468), 1–8.
- Van Eijk, M. S., Guenther, G. A., Kett, P. M., Jopson, A. D., Frogner, B. K., & Skillman, S. M. (2022). Addressing systemic racism in birth doula services to reduce health inequities in the United States. *Health Equity*, 6(1), 98–105. <https://doi.org/10.1089/heq.2021.0033>
- Viguera, A. C., Freeman, M. P., Góez-Mogollón, L., Sosinsky, A. Z., McElheny, S. A., Church, T. R., Young, A. V., Caplin, P. S., Chitayat, D., Hernández-Díaz, S., & Cohen, L. S. (2021). Reproductive safety of second-generation antipsychotics. *The Journal of Clinical Psychiatry*, 82(4). <https://doi.org/10.4088/jcp.20m13745>
- Viguera, A. C., Freeman, M. P., Kobylski, L. A., Rossa, E. T., Gaccione, P., Chitayat, D., Hernández-Díaz, S., & Cohen, L. S. (2023). Risk of major malformations following first-trimester exposure to olanzapine: Preliminary data from the Massachusetts General Hospital National Pregnancy Registry for Psychiatric Medications. *Journal of Clinical Psychopharmacology*, 43(2), 106–112. <https://doi.org/10.1097/jcp.0000000000001665>
- Viguera, A. C., Whitfield, T., Baldessarini, R. J., Newport, D. J., Stowe, Z., Reminick, A., Zurick, A., & Cohen, L. S. (2007). Risk of recurrence in women with bipolar disorder during pregnancy: Prospective study of mood stabilizer discontinuation. *American Journal of Psychiatry*, 164(12), 1817–1824; quiz 1923. <https://doi.org/10.1176/appi.ajp.2007.06101639>
- Viswanathan, M., Cook Middleton, J., Stuebe, A., Berkman, N., Goulding, A. N., McLaurin-Jiang, S., Dotson, A. B., Coker-Schwimmer, M., Baker, C., Voisin, C., Bann, C., & Gaynes, B. N. (2021). *Maternal, fetal, and child outcomes of mental health treatments in women: A systematic review of perinatal pharmacologic interventions*. Agency for Healthcare Research and Quality (AHRQ).
- Vogt, D. (n.d.). *Research on women, trauma and PTSD*. U.S. Department of Veterans Affairs. [https://www.ptsd.va.gov/professional/treat/specific/ptsd\\_research\\_women.asp](https://www.ptsd.va.gov/professional/treat/specific/ptsd_research_women.asp)



- Volkow, N. (2022). Five areas where “more research” isn’t needed to curb the overdose crisis. *Nora’s Blog*. <https://nida.nih.gov/about-nida/noras-blog/2022/08/five-areas-where-more-research-isnt-needed-to-curb-overdose-crisis>
- Wallerstein, N., Duran, B., Oetzel, J. G., & Minkler, M. (2018). *Community-based participatory research for health : Advancing social and health equity* (Third edition. ed.). Jossey-Bass, a Wiley Brand.
- Wang, X., Qiu, Q., Shen, Z., Yang, S., & Shen, X. (2023). A systematic review of interpersonal psychotherapy for postpartum depression. *Journal of Affective Disorders*, 339, 823–831. <https://doi.org/10.1016/j.jad.2023.07.067>
- Ward, L. G. (2020). Trauma-informed perinatal healthcare for survivors of sexual violence. *Journal of Perinatal and Neonatal Nursing*, 34(3), 199–202. <https://doi.org/10.1097/jpn.0000000000000501>
- Warshaw, C., Lyon, E., Bland, P. J., Phillips, H., & Hooper, M. (2014). *Mental health and substance use coercion surveys: Report from the National Center on Domestic Violence, Trauma, and Mental Health and the National Domestic Violence Hotline*. <https://ncdvtmh.org/resource/mental-health-and-substance-use-coercion-surveys-report/>
- Warshaw, C., & Tinnon, E. (2018). *Coercion related to mental health and substance use in the context of intimate partner violence: A toolkit for screening, assessment, and brief counseling in primary care and behavioral health settings*. National Center on Domestic Violence, Trauma & Mental Health,. [https://ncdvtmh.org/wp-content/uploads/2022/10/NCDVTMH\\_MHSUCoercionToolkit2018.pdf](https://ncdvtmh.org/wp-content/uploads/2022/10/NCDVTMH_MHSUCoercionToolkit2018.pdf)
- Warshaw, C., & Zapata-Alma, G. A. (2020). Mental health treatment in the context of intimate partner violence. In R. Geffner, J. W. White, L. K. Hamberger, A. Rosenbaum, V. Vaughan-Eden, & V. I. Vieth (Eds.), *Handbook of interpersonal violence and abuse across the lifespan: A project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)* (pp. 1–23). Springer International Publishing. [https://doi.org/10.1007/978-3-319-62122-7\\_282-3](https://doi.org/10.1007/978-3-319-62122-7_282-3)
- Weber, A., Miskle, B., Lynch, A., Arndt, S., & Acion, L. (2021). Substance use in pregnancy: Identifying stigma and improving care. *Substance Abuse and Rehabilitation, Volume 12*, 105–121. <https://doi.org/10.2147/sar.s319180>
- Weeks, F., Zapata, J., Rohan, A., & Green, T. (2022). Are experiences of racial discrimination associated with postpartum depressive symptoms? A multistate analysis of Pregnancy Risk Assessment Monitoring System data. *Journal of Women’s Health*, 31(2), 158–166. <https://doi.org/10.1089/jwh.2021.0426>
- Weiss, A. J., Head, M. A., & Reid, L. D. (2022). Mental health disorders among delivery inpatient stays by patient race and ethnicity, 2020. In *Healthcare Cost and Utilization Project (HCUP) statistical briefs*. Agency for Healthcare Research and Quality (US). <https://www.ncbi.nlm.nih.gov/books/NBK588377>

- Wheeler, K., & Crowe, M. (2022). Interpersonal psychotherapy. In *Psychotherapy for the advanced practice psychiatric nurse: A how-to guide for evidence-based practice*, 3rd ed. (pp. 419–440). Springer Publishing Company.
- White, W. R., Ray-Griffith, S. L., & Coker, J. L. (2023). Time to pay attention: An underrecognized casualty of the opioid epidemic. *Archives of Women's Mental Health*, 26(4), 561–563. <https://doi.org/10.1007/s00737-023-01334-z>
- Williams, D. (2003). Pregnancy: A stress test for life. *Current Opinion in Obstetrics and Gynecology*, 15(6), 465–471. <https://doi.org/10.1097/00001703-200312000-00002>
- Wisner, K. L., Murphy, C., & Thomas, M. M. (2024). Prioritizing maternal mental health in addressing morbidity and mortality. *JAMA Psychiatry*. <https://doi.org/10.1001/jamapsychiatry.2023.5648>
- Wisner, K. L., Sit, D. K., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., Eng, H. F., Luther, J. F., Wisniewski, S. R., Costantino, M. L., Confer, A. L., Moses-Kolko, E. L., Famy, C. S., & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*, 70(5), 490–498. <https://doi.org/10.1001/jamapsychiatry.2013.87>
- World Health Organization, PEPFAR, & UNAIDS. (2007). *Task shifting: Rational redistribution of tasks among health workforce teams: Global recommendations and guidelines*. Geneva: World Health Organization Retrieved from <https://iris.who.int/handle/10665/43821>
- Zhang, S., Wang, L., Yang, T., Chen, L., Qiu, X., Wang, T., Chen, L., Zhao, L., Ye, Z., Zheng, Z., & Qin, J. (2019). Maternal violence experiences and risk of postpartum depression: A meta-analysis of cohort studies. *European Psychiatry*, 55, 90–101. <https://doi.org/10.1016/j.eurpsy.2018.10.005>
- Zhou, J., Ko, J. Y., Haight, S. C., & Tong, V. T. (2019). Treatment of substance use disorders among women of reproductive age by depression and anxiety disorder status, 2008–2014. *Journal of Women's Health*, 28(8), 1068–1076. <https://doi.org/10.1089/jwh.2018.7597>
- Zlotnick, C., Tzilos, G., Miller, I., Seifer, R., & Stout, R. (2016). Randomized controlled trial to prevent postpartum depression in mothers on public assistance. *Journal of Affective Disorders*, 189, 263–268. <https://doi.org/10.1016/j.jad.2015.09.059>
- Zuloaga, A. (2020, January). *What to know about maternal mental health*. American Association of Psychiatric Pharmacists. [https://www.nami.org/wp-content/uploads/2023/07/Maternal-Mental-Health\\_2023.pdf](https://www.nami.org/wp-content/uploads/2023/07/Maternal-Mental-Health_2023.pdf)

## **APPENDIX E: ACKNOWLEDGMENTS**

Task force co-chairs Dr. Delphin-Rittmon and Admiral Levine acknowledge the efforts of every task force member, the guidance of the subcommittee co-chairs, and the members of the parent committee, the Advisory Committee for Women’s Services.

Dorothy Fink and Nima Sheth, the task force’s federal points of contact, were vital in managing the course of the task force and its deliverables, the report to Congress and the national strategy. Additional federal leads of the task force include Cyntrice Bellamy and Madonna Green.

Federal staff members integral to supporting task force efforts include Jennifer Gillissen, Somer Brown, Caryn Marks, and Amy Smith.

The support of leadership was also invaluable, and the co-chairs wish to thank Stephen Cha, Rachel Pryor, Rose Sullivan, and Meg Sullivan.

The co-chairs would also like to thank senior agency leadership—including Sarah Boateng, Sonia Chessen, and Shalini Wickramatilake—as well as center and office leadership, including Anita Everett, Richelle Marshall, and Lauresa Washington.

Additionally, the co-chairs appreciate Maya Mechenbier’s leadership and the U.S. Digital Service team members for their invaluable contribution in conducting a research sprint that produced *Maternal Mental Health: Lived Experience*. This report was instrumental in guiding and informing the development of the national strategy.

*The Task Force on Maternal Mental Health’s Report to Congress* was developed with the assistance of Synergy Enterprises, Inc., under contract #HHSP233201500134I/75P00123F37002, “Behavior Health Change and Bridging Evidence to Practice in Women’s Health,” awarded by the U.S. Department of Health and Human Services (HHS). Lori Whitten, Ph.D., Michelle Gaugh, M.A., and Eric Sarlin, M.A., M.Ed., served as the science writers. David Yontz performed the copyedit. Maggie Bray designed the graphics. Kali Fry carried out desktop publishing for the document.

The co-chairs also acknowledge the work of the following individuals at the Center for Children and Family Futures and the National Center on Substance Abuse and Child Welfare: Katie Findley-Bhatta, Ph.D., M.S.W.; Teri Kook, M.S.W.; Graciela Mesa, B.A.; Giorgi Minasovi, M.Sc.; Sean Stielow, M.A.T.; and Nancy K. Young, Ph.D., M.S.W.