



TASK FORCE ON MATERNAL MENTAL HEALTH

National Strategy to Improve
Maternal Mental
Health Care

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Executive Summary

Maternal mental health conditions, substance use disorders (SUDs), and their co-occurrence have reached crisis levels in the United States and are among the most common complications of pregnancy. Suicide, drug overdose, and other incidents and conditions related to mental health and SUDs are the leading cause of pregnancy-related deaths. The lack of sufficient U.S. infrastructure (i.e., environment, policies, systems, and programs) and workforce capacity makes it challenging to support maternal mental health holistically. Although best practices have been developed to address some aspects of the problem, they have not been implemented uniformly. Because a national infrastructure and workforce capacity are lacking, our system does not deliver the right care at the right time to all who experience maternal mental health conditions and SUDs. The lack of a robust infrastructure is an important factor that shapes a national landscape in which these conditions often remain undetected and untreated. This results in negative consequences for individuals, their children, their families, and their communities and a high cost for our nation. Moreover, these conditions and associated negative outcomes disproportionately affect subgroups with challenging social determinants of health (e.g., economic difficulties, food and diaper insecurity, experiences of discrimination, a lack of stable housing, a lack of access to transportation, a lack of access to child care, and a lack of access to health care and insurance) and life situations (e.g., having these conditions prior to pregnancy and experiencing gender-based violence and other traumas).

Aligned with broader efforts to address women's overall health and maternal health across the nation, Congress directed the U.S. Department of Health and Human Services (HHS) either to form the Task Force on Maternal Mental Health or to incorporate specified duties, public meetings, and reports into existing relevant federal committees or workgroups ([Consolidated Appropriations Act, 2023 \[Public Law 117–328, Section 1113\]](#)). The Secretary of HHS determined that these duties, public meetings, and reports should be incorporated into [SAMHSA's Advisory Committee for Women's Services \(ACWS\)](#).

ACWS's Task Force on Maternal Mental Health is a panel of experts from multiple complementary disciplines—some of whom have lived experience—who represent federal and nonfederal organizations with a bearing on care for maternal mental health conditions and SUDs. **This national strategy features the ACWS's task force's recommendations for a whole-government approach to build the necessary infrastructure to improve care for maternal mental health conditions and SUDs.** The recommendations in this strategy represent the general consensus of the task force. Single recommendations may not have the full support of the more than 100 organizations represented by the members of the task force.

A companion report, *The Task Force on Maternal Mental Health's Report to Congress*, provides a detailed discussion of the U.S. maternal mental health crisis, the task force's methods, best practices, existing federal programs and coordination, and feedback from listening sessions with state and local stakeholders.

The vision set forth by this national strategy is one in which maternal mental health (also known as perinatal mental health) and substance use care is seamless and integrated across medical, community, and social systems. The vision includes models of care and support that are innovative and sensitive to individuals' experiences, culture, and community and does not distinguish between physical health care and mental health care. Building upon existing federal government efforts, the task force outlines a path to achieve the vision within a framework consisting of the following five pillars, each with supporting priorities and recommendations.

1. **Build a national infrastructure that prioritizes perinatal mental health and well-being**, which entails establishing and enhancing federal policies that promote perinatal mental health and well-being—with a focus on reducing disparities—and federal policies that promote care models from multidisciplinary and interdisciplinary teams that integrate perinatal care and mental health and SUD care with holistic support for mother–infant dyads and their families.
2. **Make care and services accessible, affordable, and equitable**, which will advance the implementation of culturally relevant and trauma-informed clinical screening, improve linkages to accessible early intervention and treatment, create accessible and integrated evidence-based services that are affordable and reimbursable, and build capacity by training, expanding, and diversifying the perinatal mental health workforce.
3. **Use data and research to improve outcomes and accountability**, which encompasses the evidence-driven support of strategies and innovations that improve outcomes and build a foundation for accountability in prevention, screening, intervention, and treatment.
4. **Promote prevention and engage, educate, and partner with communities**, which will involve promoting and funding prevention strategies, elevating education of the public about perinatal mental health and substance use, and engaging communities with outreach and communications.
5. **Lift up lived experience**, which includes listening to the perspectives and voices of people with lived experience and prioritizing their recommendations (many of which overlap with those of the task force) as outlined in a specially prepared report by the U.S. Digital Service and summarized in this national strategy.

The five pillars of this national strategy highlight the cross-cutting imperatives of (1) increasing equity and access, (2) improving federal coordination, (3) elevating culturally relevant supports, and (4) using trauma-informed approaches to bolster maternal mental health and enhance care for perinatal mental health conditions and SUDs. The national strategy also spotlights evidence-based, evidence-informed, and promising practices (e.g., programs) with supporting resources and expertise that can be scaled up for widespread implementation. Throughout, the task force points out opportunities for the federal government to collaborate with diverse groups of partners to spearhead the implementation of the national strategy and lift up the voices of people with lived experience (highlighted in quotation marks). Finally, the task force notes that this national strategy is a living document that will be regularly updated. It focuses on ways that the federal government can lead efforts, but it also calls upon many types of partners (e.g., states, advocates, medical and professional societies, and individuals with lived experience) to help build the necessary infrastructure to support the mental health and well-being of the nation's mothers and their children, families, and communities.

The National Strategy to Improve Maternal Mental Health Care: Pillars, Priorities, and Recommendations

Background

The ACWS's Task Force on Maternal Mental Health sets forth this national strategy and the accompanying report to Congress to address an urgent national public health crisis. As these documents demonstrate, maternal mental health conditions are among the most common complications of pregnancy. Currently, the United States does not have the infrastructure, systems, policies, or workforce in place to support optimal maternal mental health for everyone. Without a supportive infrastructure and environment, the nation will not be able to address the high prevalence and negative consequences of

“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).

maternal mental health conditions, substance use disorders (SUDs), and their co-occurrence. This national strategy features the task force’s recommendations for the federal government to enhance internal, public–private, and state collaboration and coordination to build the necessary infrastructure to spearhead efforts to improve care for maternal mental health conditions and SUDs.

U.S. Maternal Mental Health

Mental health conditions and SUDs during pregnancy and the postpartum period affect an estimated 1 in 5 individuals annually in the United States (American Psychiatric Association, 2023). Maternal mental health conditions (e.g., mood disorders, anxiety disorders, trauma-related disorders, obsessive-compulsive disorder, and postpartum psychosis) and SUDs range in type and severity (American College of Obstetricians and Gynecologists, 2023; Clarke et al., 2023). Preexisting maternal mental health conditions and SUDs, including serious mental illnesses such as schizophrenia and bipolar affective disorders, may be affected by pregnancy and the postpartum period with risk of increased relapses (Taylor et al., 2019). When left untreated, maternal mental health conditions and SUDs can have long-lasting negative effects on individuals and families—with costs estimated to be more than \$14 billion a year in the United States (Centers for Disease Control and Prevention, n.d.-a, n.d.-f; Jahan et al., 2021; Luca et al., 2020; Lupton et al., 2004; Mughal et al., 2019; Prince et al., 2024). For example, research links maternal perinatal depression and anxiety with problems in children’s social–emotional, cognitive, language, motor, and adaptive behavior development, all the way into adolescence (Rogers et al., 2020). Ongoing research is examining the complex biological mechanisms underlying these links (e.g., elevated maternal glucocorticoids, alteration of placental function and perfusion, and epigenetic mechanisms) (Lewis et al., 2015). In our current system, most individuals who experience maternal mental health conditions and SUDs do not receive treatment (Byatt et al., 2015; Lynch et al., 2021). Moreover, clinical screening—one way that these conditions can be detected—is not typically provided for the most prevalent conditions (e.g., perinatal depression) (Britt et al., 2023).

“In Massachusetts, we had two local moms who [died by suicide] in postpartum 2 to 3 days after birth and one after a month. It’s on every new mom’s mind.”

- A provider who coordinates new-mom groups

The unmet need for treatment of maternal mental health conditions and SUDs has reached a crisis point. From 2017 to 2019, suicide, drug overdose, and other incidents and conditions related to mental health and SUDs were the leading cause of pregnancy-related deaths in the United States—accounting for 22.7 percent of these deaths (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022). By comparison, the next

leading causes of pregnancy-related deaths were hemorrhage (13.7 percent), cardiac and coronary conditions (12.8 percent), and infection (9.2 percent) (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022). Pregnancy-related deaths from suicide, drug overdose, and other causes related to mental health conditions and SUDs are discussed in greater detail in the report to Congress. Here, the task force notes that these deaths are often preventable, are marked by disparities, and occur up to 1 year postpartum (Trost, Beauregard, Chandra, Njie, Berry, et al., 2022; Trost, Beauregard, Chandra, Njie, Harvey, et al., 2022). These findings have heightened attention to the mental health of pregnant and postpartum individuals and the care and services landscape in the United States. Concern about maternal mental health conditions and SUDs is further amplified by broader initiatives in response to the high overall U.S. maternal mortality rate—which is the highest among high-income countries despite our spending the most on health care per person (Gunja et al., 2023; Hoyert, 2024).

Risk Factors and Disparities Addressed in the National Strategy

The perinatal period is a time of intense physical and emotional demands and physiological and social changes. Although the factors underlying the risk for mental health conditions, substance use, and SUDs are complex and multifactorial (e.g., biological factors, environmental factors, and components that entail the interaction of biological and environmental factors), the task force highlights a number of subgroups at high risk because they experience challenging situations and stressors. These challenges and stressors can contribute to mental health conditions, substance use, and SUDs that occur prior to pregnancy and precipitate onset or relapse during the perinatal period. Therefore, these subgroups are briefly mentioned here and have been integrated throughout the recommendations of this national strategy.

Subgroups at high risk for these conditions include individuals who are members of the under-resourced and underserved populations highlighted in “Language Used in This National Strategy,” such as under-resourced racial and ethnic groups. Additional subgroups at high risk for these conditions include individuals who are incarcerated; parents of children in neonatal intensive care units (NICUs); people who have experienced pregnancy loss, forcible displacement, trafficking, or gender-based violence (GBV); active-duty service members; veterans; and people with preexisting mental health conditions and SUDs, including those with severe mental illness (Shah & Christophersen, 2010). As described in the report to Congress, adverse childhood experiences (ACEs) and trauma* are highly prevalent and 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 (Centers for Disease Control and Prevention, n.d.-g; Feriante & Sharma, 2024; Substance Abuse and Mental Health Services Administration, 2015). The report to Congress also details the intersection of experiencing ACEs and trauma, including GBV, with maternal mental health conditions and SUDs. The special considerations for supporting people who experience GBV in general and intimate partner violence (IPV) in particular are noted throughout this national strategy. For example, the discussion under some recommendations mentions that not everyone has safe family members or personal networks to support them during the perinatal period. Because of the high prevalence of ACEs and trauma—including IPV and other types of GBV—the task force underscores the need for providers, programs, and organizations to be educated about trauma-informed approaches and to implement them in health care and services (Centers for Disease Control and Prevention, n.d.-c; D’Angelo et al., 2022; Foti et al., 2023; Substance Abuse and Mental Health Services Administration, 2014).

* 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 [CDC, 2023]. Trauma is a mental health concern that occurs among individuals who have experienced an event or circumstance resulting in physical, emotional, and/or life-threatening harm [SAMHSA, 2022].

Trauma-Informed Approaches

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 retraumatizing processes and practices (Substance Abuse and Mental Health Services Administration, 2023).

Of note, when assessing for concerns around trauma, including GBV, traditional screening practices are not often the best fit, because the goal is not to detect or diagnose but rather to create trauma-informed safe spaces to enable individuals to discuss their concerns and experiences openly with their providers, who can then offer support and resources and address any immediate safety concerns.

Challenging life situations and barriers that influence maternal mental health and the risk for maternal mental health conditions and SUDs often considerably overlap with negative social determinants of health (SDOH).[†] When discussing maternal mental health conditions and SUDs in the national strategy, the task force considers SDOH—particularly along the lines of race/ethnicity, educational attainment, income level, and geographic location, as well as their interaction—as these social drivers tend to accumulate over the life course, be associated with risk factors, and contribute to the marked health disparities and inequities in the United States (National Academies of Sciences, Engineering, and Medicine, 2021; Puka et al., 2022). Maternal mental health conditions, substance use, and SUDs disproportionately affect Black and American Indian/Alaska Native women and other people in under-resourced communities (Policy Center for Maternal Mental Health, 2023a, 2023b). Negative SDOH (e.g., economic difficulties, food and diaper insecurity, experiences of discrimination, lack of stable housing, lack of access to transportation, lack of access to child care, and lack of access to health care and insurance) during the perinatal period can be enormously stressful and may contribute to maternal mental health conditions and SUDs. Subgroups that are at high risk for maternal mental health conditions and SUDs also often face challenges related to SDOH and systemic barriers to receiving the supports and care they need (discussed below in “Barriers Related to the Lack of a Supportive Infrastructure and Environment”).

Accessing Maternity Care Can Be Difficult

- The United States has a critical and growing shortage of obstetric care providers. More than 2.2 million people who are of childbearing age live in a maternity care desert, defined as “any county ... without a hospital or birth center offering obstetric care and without any obstetric providers” (March of Dimes, 2022). More than one-third of U.S. counties are designated as maternity care deserts, and two-thirds of those are in rural counties (March of Dimes, 2022).
- 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 (Britt et al., 2023).
- 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).

Barriers Related to the Lack of a Supportive Infrastructure and Environment

This national strategy and its recommendations need to be understood in the context of the systemic barriers that those who are pregnant and those who are postpartum face. These barriers are not the fault of

[†] Social determinants of health (SDOH) are “the conditions in the environments where people are born, live, learn, work, play, worship, and age that influence health risks and outcomes” [Healthy People 2030].

the individual. Rather, they occur because the United States lacks the infrastructure and environment needed to sufficiently support maternal mental health and well-being. An overarching barrier is that mental health conditions and SUDs in general are seen as nonmedical and are therefore more likely to be misunderstood, stigmatized, and perceived to be outside the purview of the health care system. Because of this erroneous classification, mental health conditions and SUDs do not have the same research base, reimbursement parity, and focus in the medical and health care system. They tend to be addressed in different care systems. This overarching issue is magnified in the context of maternal mental health. Both providers, including clinicians (Clarke et al., 2023), and community-based non-clinicians lack specific education about these conditions. Additionally, stigmatization of people who experience perinatal mental health conditions and SUDs can affect whether individuals seek care and how they are treated in the health care and social service systems (Cantwell, 2021; O'Connor et al., 2022). The topic of stigma and maternal mental health conditions and SUDs is discussed in more detail in the report to Congress.

Policies Contributing to Stigma and Fears of Parent–Child Separations

The perception that mental health conditions and SUDs are nonmedical persists, and their stigmatization continues. Stigma toward people with SUDs manifests in punitive policies (Adams & Volkow, 2020). Evidence indicates that family separation, criminalization, and incarceration for SUD during pregnancy is ineffective at deterring substance use and is harmful to the health of pregnant people and their infants (American College of Obstetricians and Gynecologists, 2020; Office of National Drug Control Policy,

“I was terrified my kids would be taken away from me.”

- S.B., mother of two

2022). Yet service providers in many states are mandated to report substance use by pregnant and postpartum individuals. Some state statutes also have implications for mandated “test and report” policies—i.e., urine toxicology testing for substances during the perinatal period and reporting to child protective services. State or county child protective service departments may take the extreme

measure of removing a child from a parent’s custody. Such policies are often applied in ways that disproportionately affect Black women—for example, testing them even if they do not have a history of substance use (Jarlenski et al., 2023). Punitive policies related to child removal also apply to women with mental health conditions (such as schizophrenia, schizoaffective disorder, and other mental health conditions involving psychosis). In the context of experiencing IPV, abusive partners may use punitive policies as a means of continued control and coercion, as discussed in the report to Congress. Such policies leave many individuals in understandable fear and cause them to mistrust service providers and organizations. These factors affect treatment seeking and willingness to have honest conversations about mental health and substance use (Alderdice & Kelly, 2019; Choi et al., 2022; Megnin-Viggars et al., 2015; O'Connor et al., 2022). People with lived experience of maternal mental health conditions and SUDs voice these concerns. (See “Pillar 5: Lift Up Lived Experience.”)

Federal laws (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).

Highlighted Resource: The National Center on Substance Abuse and Child Welfare Technical Assistance

The National Center on Substance Abuse and Child Welfare offers [technical assistance](#) (e.g., trainings, videos, and webinars) to localities on how to implement CAPTA POSCs. The assistance is designed to improve (1) the safety and well-being of infants affected by prenatal substance exposure and (2) the recovery outcomes for their caregivers.

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.

Society and professionals have a duty to keep children safe. In the current policy climate, providers are concerned about children and the risk of harm and neglect, as well as losing their licenses to practice if they do not comply with policies. However, the fear that parents with mental health conditions or SUD have of mandatory reporting of maternal mental health symptoms and substance use to child welfare services and the possibility of their children being removed from their homes and placed in foster care is a barrier to their seeking SUD treatment (Office of National Drug Control Policy, 2022). In line with the Biden–Harris administration’s report titled *Substance Use Disorder in Pregnancy: Improving Outcomes for Families*, it is crucial that policies, procedures, and practices support family preservation and parental access to treatment while keeping children safe. Additionally, the racial bias in parent–child separations must be addressed. In addition to seeing this issue in their professional experience, members of the task force heard this concern in listening sessions with staff members from state and local agencies and in the public comments generated by a [request for information](#). The National Center on Substance Abuse and Child Welfare offers resources to help providers understand policies and how to implement POSCs. Ultimately, there are multilayered contributing factors to these punitive policies and practices, and solutions need to involve greater educational investment and cross-disciplinary collaboration among policymakers, hospital administrators, health care providers, community leaders, and people with lived experience.

Workforce Shortages and Difficulties Accessing Services

The shortage of obstetric providers and the lack of a national infrastructure for maternal health care, services, and supports are systemic barriers that put undue stress on pregnant and postpartum individuals (March of Dimes, 2022). Additionally, our nation has a chronic shortage and geographic maldistribution of mental health and SUD care providers, such that the majority of U.S. counties do not have the resources to support pregnant and postpartum individuals with these conditions (Britt et al., 2023; Health Resources & Services Administration, 2024a). In particular, this workforce shortage plays a significant role in both the discomfort referring providers feel with screening and diagnosing these disorders (because of a lack of referral pathways) and the limited access to timely and appropriate care for patients. Systemic barriers further intersect with individual challenges, SDOH, and inequities to influence maternal mental health conditions, substance use, and SUDs. Accessing affordable and comprehensive reproductive care, maternity care, and care for perinatal mental health conditions and SUDs is difficult for many individuals (Britt et al., 2023; Choi et al., 2022; Salameh et al., 2019). Difficulties accessing care

“Even if we could have swung it financially, [paying for therapy] would have felt indulgent.”

- E.L., mother of one

occur on many levels (e.g., problems with transportation to appointments or lack of child care preventing attendance at perinatal care visits). The task force recognizes those individual barriers but generally refers to problems with access as the larger systemic issues that make it difficult for individuals to get the right care that meets their needs at the right time.

Lack of access is primarily driven by a significant shortage in the workforce members, both clinical and nonclinical, who provide perinatal services—a shortage that causes widespread maternity care deserts. Access is also affected by other factors, including the need to go to different facilities for various types of care and a lack of reimbursement for needed services (e.g., patient education and screening). Only 32 percent of substance use treatment facilities accept pregnant women as patients, according to the 2022 National Substance Use and Mental Health Services Survey (Substance Abuse and Mental Health

Services Administration, 2023c). Additionally, health care and services that are culturally relevant to the individual may not be available. Existing health care and social service systems serving this population are highly fragmented and typically do not meet the needs of the whole person or the mother-child dyad. For example, billing systems typically support reimbursement for services provided to an individual patient rather than the mother-child dyad. Fragmented and non-holistic systems contribute to missed opportunities to identify maternal mental health conditions and SUDs, link people with the appropriate interventions, and provide the necessary continuity of care (Byatt et al., 2015; Green et al., 2024). Based on the expertise and experience of the task force, complicated insurance systems and processes can be difficult and stressful to navigate. The cost of care—and the trend of providers of care for mental health conditions and SUDs not accepting insurance, causing all fees to be out-of-pocket expenses—is a significant barrier for many.

Acknowledging the Challenges That Providers Face

Frontline providers who care for pregnant and postpartum individuals and their infants face significant challenges when addressing maternal mental health conditions and SUDs. The task force has found that although the nation has many providers who are experts in perinatal mental health and SUD care, topics in perinatal mental health and SUDs are typically not covered well in education and training systems for obstetric, pediatric, and primary care providers. Similarly, many mental health and SUD care providers may lack sufficient training in the unique needs and considerations of pregnant and postpartum individuals (Clarke et al., 2023). Workforce shortages affect both clinical and nonclinical providers, who are increasingly asked to perform more services in 15- or 30-minute visits. Other provider challenges include burnout, administrative burden, and billing issues (Herd & Moynihan, 2021). Providers also may be unaware of (and often don't have the staffing to help find) community resources to support people with maternal mental health conditions, SUDs, and various life situations that affect their well-being (e.g., SDOH and experiences of trauma, including GBV). Providers may also have concerns about protecting the safety and confidentiality of patients/clients experiencing IPV.

A Fragmented Health Care System

Task force discussions focused on the considerable fragmentation of the U.S. health care system and its effects on access to maternal mental health and SUD care. In the experience of the task force, our system does not address the holistic needs of the mother-child dyad. The major challenges include integrating services into the workflow and electronic medical records, issues with insurance reimbursement, the workforce shortage and need for specific training, and the lack of clinical-community partnerships. For example, bundled payment for perinatal care often does not incorporate services for mental health conditions and SUDs, and vice versa. Additionally, clinical facilities (including birthing hospitals) often lack familiarity with community resources that support maternal mental health and new parents. Moreover, these facilities are not co-located with the support services that new parents often need. In contrast, co-located or integrated perinatal (or primary) care provided by interdisciplinary teams offers access to evidence-based services for mental health conditions and SUDs. Integrated care reduces stigma and reduces the burdens and negative SDOH that many people face—such as lack of access to transportation and child care and time constraints—when they need to access these services (including services for IPV). In areas with workforce shortages, co-located and integrated care can reduce the number of required support staff members. Facilities that offer integrated care might be more likely to use perinatal psychiatry access programs to address gaps in expertise rather than refusing to treat perinatal mental health conditions and SUDs. On-site resources (e.g., team members with the time and expertise to talk with patients about complex concerns) and established community partnerships also increase the ability of busy providers to support people who are experiencing IPV, other GBV-related trauma, and/or negative SDOH. Telehealth collaborations could represent another pathway to better care coordination.

Lack of Systemic Supports During Postpartum Challenges

Pregnancy and the postpartum period represent major life course events. The physical, mental, emotional, and practical challenges—including sleep deprivation, costs associated with medical care and caring for a newborn, and around-the-clock caregiving on top of other responsibilities—of caring for an infant are considerable. Our nation lacks the federal- and state-level infrastructure needed to fully support these major life events. Such infrastructure would include guaranteed paid family and medical leave, universal child care, full support for parents and infants getting proper nutrition, and equitable, full access to culturally relevant, trauma-informed medical and mental health care services. Systemic issues—including mostly separated medical and mental health systems, complicated insurance processes, a lack of workforce members to address perinatal mental health conditions and SUDs, a lack of knowledge about support resources, and mandatory reporting and other punitive measures—also present challenges during the postpartum period. Moreover, the federal government lacks the infrastructure to lead efforts to address these systemic issues.

The lack of paid family and medical leave remains a primary concern, as well as access to affordable healthful foods for parents and infants in all communities. Current social safety net programs (e.g., the Special Supplemental Nutrition Program for Women, Infants, and Children [[WIC](#)]; the Children's Health Insurance Program [[CHIP](#)]; Temporary Assistance for Needy Families [[TANF](#)]; and the Supplemental Nutrition Assistance Program [[SNAP](#)]) and housing assistance significantly mitigate the impact of poverty and food insecurity; however, given their limitations or requirements—such as insufficient coverage for those in deep poverty, income limits/requirements, stringent work requirements, difficult application processes, program implementation challenges, and time limitations on services—these support programs do not sufficiently address these social problems (Marti-Castanar et al., 2022; Shaefer et al., 2020; Giannarelli et al., 2017; Danziger, 2010 as cited in Marti-Castanar et al., 2022).

In fact, the United States is one of the few high-income nations that does not yet provide paid family and medical leave (Livingston & Thomas, 2019). Paid family and medical leave policies allow workers to receive compensation when taking longer periods of time away from work for qualifying reasons (e.g., having a new child, being ill, or having a family member who is ill) (U.S. Department of Labor, n.d.). Currently, no federal law influences these policies for the U.S. private sector. A growing number of states have established their own policies. Paid family and medical leave policies are important because they permit workers to engage in employment and other economic activities rather than exit the workforce to care for loved ones (U.S. Department of Labor, n.d.). Although the [Family and Medical Leave Act of 1993](#) is available, researchers have pointed out that the law's requirements for a minimum number of hours worked, duration of employment, and employer size generate inequities (Heymann et al., 2021). Some researchers have argued that policies for national paid leave (such as paid sick leave) could help reduce health and socioeconomic inequities (Heymann & Sprague, 2021).

“With my second [child] ... I would have done better if I had taken more time to properly heal. [That would have been better for] both ... me and [my] baby.”

- C.S., pregnant mother of two

On the whole, our nation's fragmented infrastructure and limited resources often put the burden of managing all the challenges of the perinatal period on individuals and families, which strains parental mental health and well-being. Moreover, some individuals have limited or no support systems to help with the practical and emotional aspects of pregnancy and the postpartum period. People who lack in-person and day-to-day support and resources during the initial months after delivery face many challenges that may affect their mental health. They, in particular, would benefit from a care system that assesses the level of support that individuals have and bolsters assistance. It is also critical that infrastructure and systems be tailored to address the unique considerations faced by pregnant and postpartum adolescents who have little or no support, as their needs will differ from those of adults.

"I felt like I had to do it all, like Superwoman. I didn't disclose that I was sad or crying."

- J.S., mother of one

As the United States does not have a federal paid family and medical leave policy, many people must return to work before they are ready. This situation is compounded by a shortage of affordable high-quality child care and may negatively affect maternal mental health. (See "Pillar 5: Lift Up Lived Experience"). One issue that arises during the postpartum period

as new parents return to work is infant feeding. A postpartum individual's informed decision of whether to breastfeed as part of their approach to infant feeding should be supported by their provider and those they trust. The method of infant feeding is a major consideration for postpartum individuals. Although there are many clear benefits to both the mother and the baby from breastfeeding—including breastfeeding's being associated with improved mental health outcomes—lactation may not always be easy. Some evidence suggests that people who experience challenges with breastfeeding that do not match their expectations may be likelier to experience negative mental health outcomes (Yuen et al., 2022). The necessary supports to start and succeed at breastfeeding (e.g., high-quality breast pumps, lactation consultants, coaches, and peer support programs) may not be available, covered by insurance, or affordable. Lack of infrastructure in the workplace (e.g., designated rooms for lactation, refrigerators, and time accommodation for pumping) may be a barrier. Pressure from others may play into the decision of whether to breastfeed and its effects on mental health. Maternal conditions, including mental health diagnoses or SUDs, may require medications, and risks and benefits must be taken into consideration when choosing optimal infant feeding strategies. Both providers and patients need current, evidence-based information so they can engage in shared decision-making about the risks and benefits of breastfeeding for their individual situation and also about continuation of medications during pregnancy and in the postpartum period. Mental health repercussions should be routinely recognized and addressed.

The Perinatal Period: An Opportunity to Address Mental Health Conditions and SUDs

The perinatal period offers a unique opportunity to engage pregnant and postpartum individuals in discussions about mental health and substance use and to intervene with those who have mental health conditions and SUDs. It also provides opportunities to address issues that affect maternal mental health and well-being, such as negative SDOH and experiences of GBV and other trauma. Generally, pregnant and postpartum individuals are actively engaged in the health care system. A person with an uncomplicated pregnancy has an average of 25 interactions with health care providers during the perinatal period. But some experiences, such as NICU hospitalization of the infant or prolonged hospitalization of the mother, may disrupt screening opportunities for perinatal mental health conditions and SUDs. System supports could help ensure that opportunities for detecting these conditions are not missed. Additionally, pregnant and postpartum individuals often interact with nonmedical community-based providers—such as doulas, childbirth educators, lactation consultants, home visitors, and community health workers. These nonmedical community-based providers often have strong and trusted relationships with their clients and are well situated to provide education about maternal mental health conditions, SUDs, and other issues, as well as sharing resources. The perinatal period also offers a unique opportunity to have a two-generation approach by addressing these issues that, if left untreated, can have long-term negative effects on the life course of the parent and the life course of the child.

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

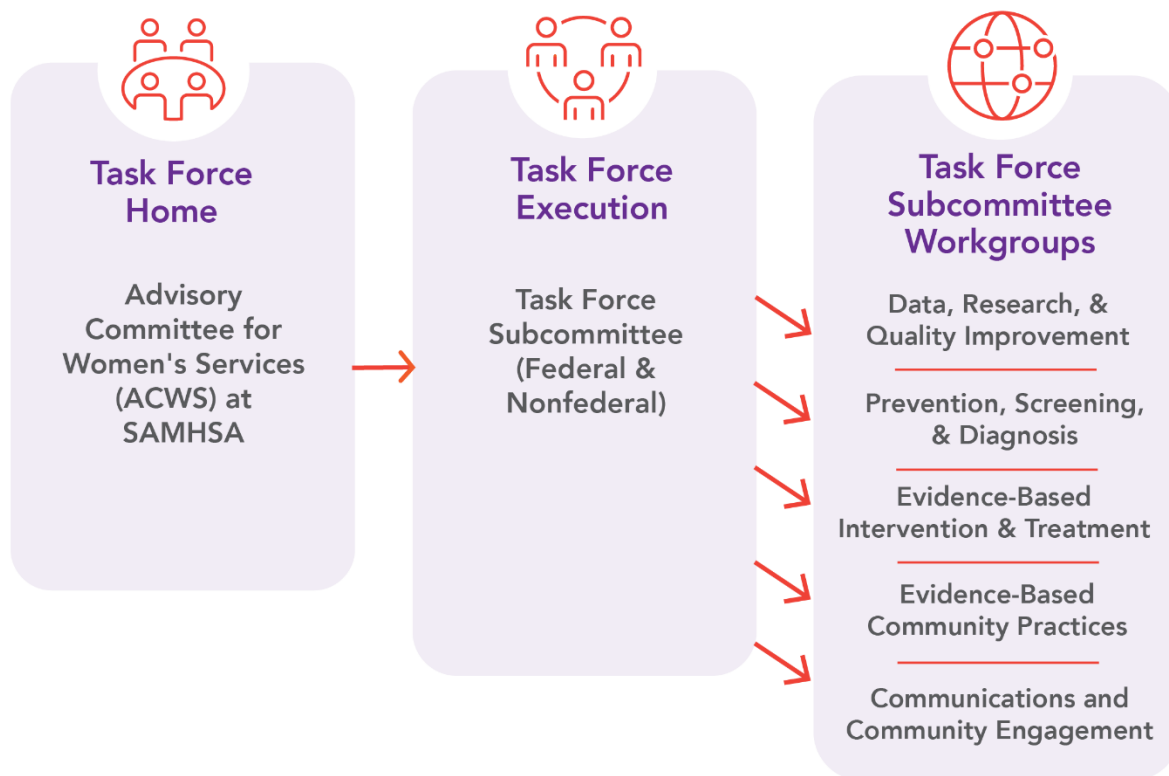
- S.B., mother of two

Introduction

Congress's authorization of the task force's meeting and reporting requirements aims to address the crisis of maternal mental health by calling for greater collaboration within the federal government, emphasizing best practices related to maternal mental health conditions and substance use disorders (SUDs), and requiring the Task Force on Maternal Mental Health to develop a national strategy to serve as a blueprint for improving maternal mental health and SUD care. Congressional action was prompted by the individual and societal consequences of these conditions when left untreated, as well as advocacy efforts. HHS formed the Task Force on Maternal Mental Health as a subcommittee of SAMHSA's ACWS in response to a directive from Congress to address this public health crisis ([Consolidated Appropriations Act, 2023 \[Public Law 117–328, Section 1113\]](#)). The members of the task force developed the recommendations in this national strategy based on their collective expertise and discussions, review of the relevant literature, listening sessions with state- and local-level stakeholders, and public comments. The task force also considered input from people who have direct knowledge and experience of these conditions (including providers). (See "Pillar 5: Lift Up Lived Experience.") Given the urgency of the maternal mental health crisis, the publication of this document and the complementary *Task Force on Maternal Mental Health's Report to Congress* was expedited to accelerate implementation of the task force's recommendations. The report to Congress details the committee's methods.

The task force is a subcommittee of [SAMHSA's ACWS](#) and falls under the Federal Advisory Committee Act (FACA). The lead agencies are the HHS Office of the Assistant Secretary for Health's (OASH) Office on Women's Health (OWH) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Task Force on Maternal Mental Health Organization



At a Glance: Task Force Members and Methods

Task Force Members

- Experts in obstetrics and gynecology, maternal and child health, clinical and research psychology, psychiatry, counseling, gender-based violence (GBV), strategic policy, community behavioral health, federal–community partnerships, and other relevant areas
- More than 100 members from diverse backgrounds
- Both federal and nonfederal members
- Federal members leading departments and agencies (or 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
- Nonfederal members with expertise in maternal mental health, recruited through multiple notices in the *Federal Register*, including advocates, representatives from nonprofit entities, representatives from policy centers, providers, representatives from medical and professional societies, industry representatives, and those with lived experience
- Individuals with lived experience of maternal mental health conditions and SUDs (including as providers of care)

Task Force Methods

- The task force consulted federal and national program reviews, consulted a literature review, held four 1-hour virtual listening sessions for state- and local-level input from representatives of key national groups of stakeholders, obtained public comments through a request for information (RFI), and consulted the report titled *Maternal Mental Health: Lived Experience*, completed by the U.S. Digital Service (USDS).
- Five task force workgroups met virtually about 40 times (1–2 hours each time) between November 2023 and April 2024 to generate the findings and write recommendations for this national strategy.
- There were 10 workgroup co-chair check-in meetings between November 2023 and April 2024.
- There were five meetings of the entire task force and two meetings of federal task force members to refine drafts of the national strategy in March and April 2024.
- There were two meetings with the ACWS to approve the national strategy and its recommendations (the first meeting was for approval in principle, and the second meeting was for approval of the final language) in April 2024.
- There is ongoing work to update and supplement the report to Congress and national strategy regularly, with a sunset date of September 30, 2027.

Participating Federal Agencies

- [Administration for Children and Families \(ACF\)](#)
- [Administration for Community Living \(ACL\)](#)
- [Agency for Healthcare Research and Quality \(AHRQ\)](#)
- [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 \(HRSA\)](#)
- [HHS Office of the Assistant Secretary for Health \(OASH\)](#)
- [HHS Office of the Assistant Secretary for Planning and Evaluation \(ASPE\)](#)
- [HHS Office of Intergovernmental and External Affairs \(IEA\)](#)
- [Indian Health Service \(IHS\)](#)
- [National Institutes of Health \(NIH\)](#)
- [Office of Management and Budget \(OMB\)](#)

At a Glance: Task Force Members and Methods

- [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#)
- [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 \(USDS\)](#)

The Task Force on Maternal Mental Health's national strategy and report to Congress are an important part of broader federal efforts to address women's overall health (including their mental health) and maternal health in particular across the nation. The task force's documents are aligned with multiple ongoing initiatives, including the following:

- [The White House Initiative on Women's Health Research](#);
- [White House Blueprint for Addressing the Maternal Health Crisis](#);
 - The task force notes that the *White House Blueprint for Addressing the Maternal Health Crisis* makes **recommendations that address maternal mental health**, including:
 - improving data collection
 - focusing on veterans
 - expanding the National Maternal Mental Health Hotline
 - integrating supports for mental health conditions and SUDs in community settings
 - To accompany the blueprint, [Substance Use Disorder in Pregnancy: Improving Outcomes for Families](#) was developed by the Office of National Drug Control Policy with input from other federal agencies, including SAMHSA.
- The [HHS Secretary's Postpartum Maternal Health Collaborative](#) with six states (Iowa, Massachusetts, Maryland, Michigan, Minnesota, and New Mexico);
- The [Hear Her](#) (with [resources for American Indian/Alaska Native individuals](#)) campaign (CDC);
- The [Maternity Care Action Plan](#) (CMS);
- The [Transforming Maternal Health Model](#) (CMS);
- The [Enhancing Maternal Health Initiative](#) (HRSA);
- The [National Maternal Mental Health Hotline](#) (HRSA);
- The [Talking Postpartum Depression](#) campaign (OWH); and
- The State Technical Assistance Maternal Mental Health Learning Communities (SAMHSA).

Coordination among federal agencies, along with collaboration with the federal government's many partners, is essential to maximize the impact of these efforts. With the release of this national strategy, the Task Force on Maternal Mental Health indicates a path forward for the whole federal government to coordinate its many ongoing activities, initiatives, and programs with the goal of addressing the barriers discussed. Individual federal agencies provided information on federal programs discussed for the recommendations, and some of the text quotes or paraphrases their websites and agencies' other publications and materials. The federal government's work must include ongoing partnerships with states, U.S. territories, local jurisdictions, and tribes. Although the report to Congress and this national strategy discuss recommendations and potential partnerships with states, the task force will also develop a report to all governors in the U.S. that details further opportunities for local- and state-level partnerships and recommendations specific to states. Federal government collaborations also must include public-private entities, industry, advocates, medical and professional societies, communities, and individuals with lived experience and their families. Throughout this national strategy, there is a focus on leveraging and expanding federal programs, resources, and expertise—as well as evidence-based practices.

Implementation of the national strategy will provide a blueprint for building the necessary infrastructure to support the mental health and well-being of all pregnant and postpartum individuals, their children, their families, and communities across the nation.

The Audience, Scope, and Vision for the National Strategy

Audience

The primary target audience for this national strategy is the federal government—namely, Congress and the executive branch, including the many federal departments and agencies that spearhead the provision of health care and services in communities. Note that at times the recommendations specify a particular entity within the federal government and that at other times no particular agency or entity is specified because it is implied that a whole-government approach is needed.

However, the federal government's work cannot be carried out without collaborations and partnerships with states, public–private entities, industry, advocates, medical and professional societies, communities, and individuals with lived experience and their families. Therefore, this national strategy also speaks to those collaborators and partners and identifies opportunities for them to come together to change the national landscape of perinatal mental health and substance use care.

Scope

Congress charged the task force with lifting up best practices and improving federal coordination to address perinatal mental health, substance use, and their co-occurrence (Consolidated Appropriations Act, 2023). Per the authorizing legislation, the scope of the national strategy is to describe how the Task Force on Maternal Mental Health (as well as those federal departments and agencies represented on the task force) “may improve coordination with respect to addressing maternal mental health conditions, including by:

- Increasing the prevention, screening, diagnosis, intervention, treatment, and access to maternal mental health care, including clinical care and non-clinical care—such as those provided by peer-support and community health workers, through the public and private sectors;
- Providing support relating to the prevention, screening, diagnosis, intervention, and treatment of perinatal mental health conditions, including families, as appropriate;
- Reducing racial, ethnic, geographic, and other health disparities related to prevention, diagnosis, intervention, treatment, and access to maternal mental health care;
- Identifying opportunities to modify, strengthen, and better coordinate existing federal infant and maternal health programs to improve perinatal mental health and SUD screening, diagnosis, research, prevention, identification, intervention, and treatment with respect to maternal mental health; and
- Improving planning, coordination, and collaboration across Federal departments, agencies, offices, and programs.”

The task force highlights the following cross-cutting imperatives throughout this national strategy:

- The need to improve **equity and access** to perinatal care and services by directing resources to the individuals, families, and communities that disproportionately experience these maternal mental health conditions, substance use, and SUDs;
- The important role of **federal coordination** in building an infrastructure and an environment that support maternal mental health and families;
- The essential contribution of **culturally relevant support** and care provided by workforce members who understand the role of perspectives of mothers from under-resourced communities in bolstering maternal mental health; and
- The need for **trauma-informed approaches** to care and services and the importance of training and education in this area among providers, programs, and organizations.

Vision

The task force expects that its work—this national strategy, the report to Congress, and subsequent reports and updates—will improve maternal mental health and well-being for all individuals and communities across the nation. **The task force envisions that perinatal mental health and substance use care in our nation will be seamless and integrated across medical, community, and social systems, such that there will no longer be a distinction between physical and mental health care and that models of care and support will be innovative and sensitive to individuals' experiences, culture, and community.**

Call to Action

The task force summarizes the current national landscape for maternal mental health conditions and SUDs:

- There is a high prevalence of pregnancy-related deaths, and maternal mental health conditions and SUDs are significant contributors to that.
- Disparities disproportionately affect individuals at higher risk for perinatal mental health conditions and SUDs.
- GBV and social determinants of health (SDOH) are contributing factors.
- There is a lack of cohesive policies, programs, and systems; and
- There have been many missed opportunities to engage pregnant and postpartum individuals.

Given this landscape, the task force calls for the following in order to achieve the aforementioned vision:

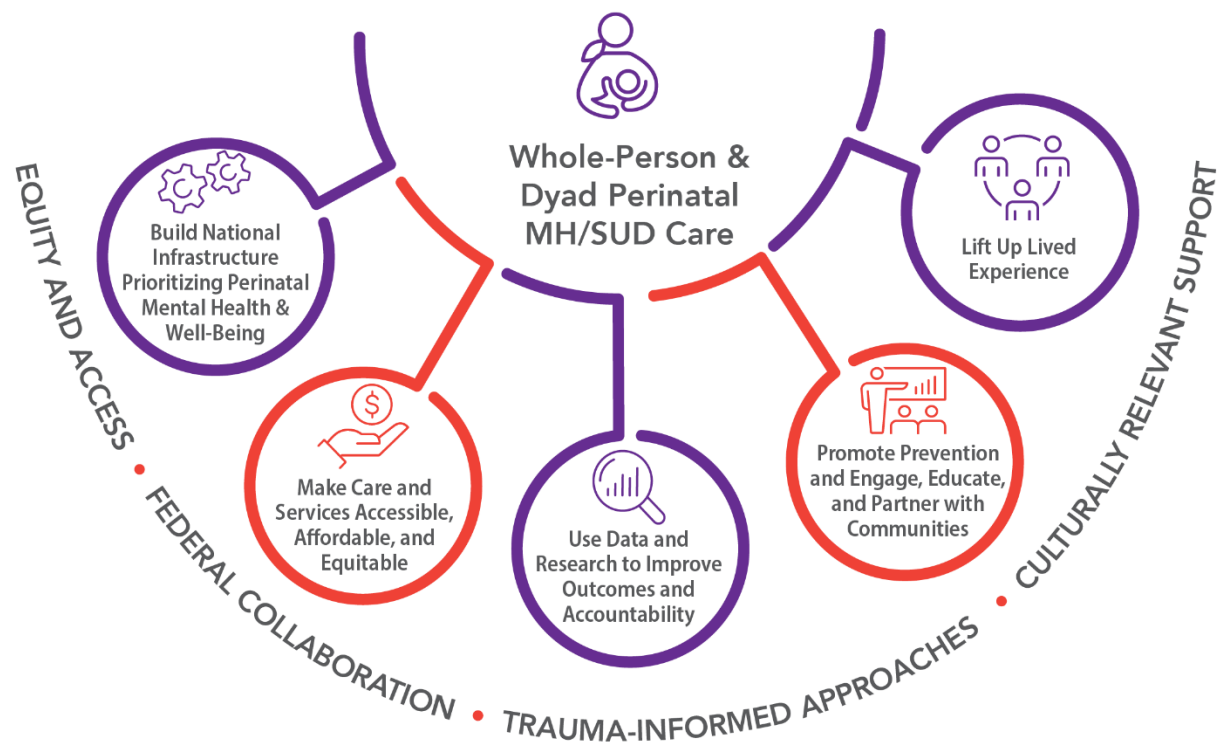
- Regular and respectful education about, discussion of, and screening for maternal mental health conditions and SUDs (along with consideration of SDOH and GBV) for all individuals during the perinatal period;
- Clear pathways to connect individuals affected by maternal mental health conditions and SUDs with care that is holistic, equitable, affordable, trauma-informed, patient-centered, and culturally and linguistically relevant; and
- Adequately staffed care that focuses on the mother–infant dyad with two-generational approaches and ensures that the right treatment is available at the right time.

As described in the report to Congress, federal programs, as well as state and local efforts, are ongoing to realize this vision. These efforts employ evidence-based, evidence-informed, and promising practices (see definitions in “Language Used in This National Strategy”), many of which are also detailed in the report to Congress. Throughout this national strategy, the task force highlights some federal programs, state and local efforts, models, and best practices—suggesting ways that federal coordination could scale up these effective measures. The task force also outlines what the federal government could do—in collaboration with its diverse array of public and private partners—to promote maternal mental health and prevent SUDs for all pregnant and postpartum individuals.

Some of the recommendations described in this national strategy are actionable in the short term, whereas others represent aspirational goals to work toward over many years. The national strategy is framed around five pillars, each of which is supported by priorities and recommendations to improve care and services for maternal mental health conditions and SUDs. The voices of people with lived experience are uplifted throughout this national strategy, including in quotations from *Maternal Mental Health: Lived Experience*. The Task Force on Maternal Mental Health will regularly update the national strategy—a living document that will inform Congress of the federal government's efforts and describe the current status of this crucial area of public health in the United States.

Recommendations from the Task Force on Maternal Mental Health

As a subcommittee of the ACWS, the Task Force on Maternal Mental Health developed recommendations to coordinate and improve federal activities related to addressing maternal mental health conditions and SUDs. Its parent FACA committee approved all of the recommendations, which are presented within the framework of five pillars (with priorities under each). The recommendations do not necessarily reflect the views, opinions, or positions of any of the participating departments or agencies. The organizational framework for the recommendations is shown in the figure below. Although the background section of this national strategy provides the overarching reasons for the recommendations as a whole, each recommendation is supported by a brief rationale (“Why?”) and suggested federal government implementation activities (“How?”). The activities are broad and ambitious and will depend on federal collaboration with multiple partners—including state, local, tribal, and territorial governments; industry; professional and scientific associations; community-based organizations; and communities across the country—to change the national landscape of perinatal mental health and substance use care and ultimately improve the lives of people with these conditions.



Pillar 1: Build a National Infrastructure That Prioritizes Perinatal Mental Health and Well-Being

Our nation currently lacks the infrastructure and environment to sufficiently support maternal mental health and well-being. There is a lack of federal laws and policy to support parental leave and child care; activities at the federal level require better coordination; systems of care are often fragmented and do not meet the needs of the mother–infant dyad; and some policies are stigmatizing and punitive, especially

around maternal substance use disorders (SUDs). Recommendations supporting Pillar 1 include establishing relevant federal laws, policies, programs, and mechanisms to prioritize and destigmatize perinatal mental health and SUD care; improving disparities; integrating physical and mental health care; and implementing universal education, prevention, screening, treatment, and recovery support for maternal mental health conditions and SUDs.

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

Recommendation 1.1.1

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

Why?

In integrated health care, teams of multidisciplinary health professionals collaborate to provide patient care. This approach features a high degree of collaboration and communication among members of the health care team. All health professionals on the team share patient care information so an individualized comprehensive treatment plan can be developed (American Psychological Association, 2013). In the experience of the task force, integrated perinatal care is holistic and considers the effects of life situations (e.g., social determinants of health [SDOH] and intimate partner violence [IPV]) on health and the ability to engage in care. Integrated care models do not separate physical and mental health, and they focus on health promotion and prevention rather than treatment. This recommendation also builds on a strategic priority outlined in the [HHS Roadmap for Behavioral Health Integration](#).

In the experience of the task force, integrated care models facilitate universal screening of perinatal health conditions and SUDs—a practice that reduces stigma and offers opportunities to provide patient education and resources (e.g., brochures, videos, mobile apps, and websites). Existing evidence-based integrated care models are effective and could be enhanced and expanded, with the potential for a significant increase in positive outcomes. For example, Seattle and King County's public health system's implementation of MOMCare for pregnant women with major depressive disorder or dysthymia led to a reduction in depression severity. This program—which was found to be cost-effective—improved rates of adherence to care and depression remission (Grote et al., 2015). As described in the task force's report to Congress, federal programs that offer integrated care include the Maternal Opioid Misuse (MOM) Model and Perinatal Reproductive Education Planning and Resources (PREPARE).

Research supports extending coverage for pregnancy care for up to 1 year postpartum. Among pregnancy-related deaths from suicide, drug overdoses, and other causes associated with mental health conditions and SUDs analyzed between 2008 and 2017, nearly two-thirds (63 percent) occurred 43–365 days postpartum (compared with 18 percent of deaths from other causes) (Trost et al., 2021). Among women who reported postpartum depressive symptoms at 9 to 10 months, 57.4 percent did not report these experiences at 2 to 6 months—a finding that underscores the importance of attending to maternal mental health throughout the year after giving birth (Robbins et al., 2023). Extending pregnancy coverage ensures continuity of care, warm handoffs, and referrals and linkages to primary care or mental health support systems.

How?

- This recommendation calls for the integration of mental health care and substance use care across all relevant perinatal settings, such as obstetricians' offices, primary care offices, pediatric outpatient settings, emergency rooms, inpatient settings (including medical units), labor and delivery settings, postpartum units, and neonatal intensive care units (NICUs).
- Services embedded in these integrated care models should include evidence-based screening, prevention, assessment, treatment, referral, and follow-up services; evidence-based dyadic (parent–child) treatment services to address both the parental mental health conditions and SUDs and associated early childhood mental health concerns when they are present; nonclinical support personnel—such as community health workers, doulas, and peer support specialists—to facilitate culturally responsive linkages to services in the community and assist with screening and providing resources to address SDOH; guidance on how atypical locations for care and services (such as jails, prisons, and Special Supplemental Nutrition Program for Women, Infants, and Children [WIC] offices) can integrate mental health and SUD treatment into their service provision; screening, patient education, and services for gender-based violence [GBV] and other trauma; and coordination with community-based organizations to provide at least 1 year of follow-up support in the community.
- All components of the integrated care models should be embedded in a practice's electronic health records or equivalent documentation systems and be accounted for when billing.
- There should be incentives established and support provided to states for offering increased reimbursement for screening and treatment services related to perinatal mental health and substance use conditions (Agency for Healthcare Research and Quality, n.d.).
- Established guidelines on integration—such as those in the American College of Obstetricians and Gynecologists' (ACOG) [*Guide for Integrating Mental Health Care into Obstetric Practice*](#), the World Health Organization's (WHO) [*Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services*](#), and the Agency for Healthcare Research and Quality's (AHRQ) [information on behavioral health integration for pregnant and postpartum women](#)—should be followed.
- Federal policies and incentives should be established and expanded to encourage all states to promote and sustain permanency of pregnancy-related Medicaid coverage.
- Congress and the executive branch should enact laws that do the following:
 - Require (versus only offer an option to) all states, all territories, and D.C. to expand Medicaid and Children's Health Insurance Program (CHIP) coverage from 60 days to 1 year after pregnancy, as well as providing information on how to use these benefits to providers, patients, and communities (MOMMIES Act, 2023).
 - Require all states, D.C., and all territories to provide Medicaid coverage of nonclinical support staff members, such as community health workers, doulas, health navigators, peer support specialists, lactation consultants, and GBV counselors/specialists.
 - Require all states, D.C., and all territories to provide Medicaid coverage for dyadic family mental health and SUD services. Ensure that providers can bill for services provided to both the mother and the baby during the same visit (i.e., not having just one of them be the identified patient).
- There should be incentives and support for states and private payers to implement the same coverage as outlined above.
- In the absence of federal law, federal agencies should encourage more states to opt in to Medicaid benefits for services provided by nonclinical support personnel, such as community health workers, doulas, and peer support specialists. As of July 1, 2022, 29 states that had responded to KFF's 22nd annual Medicaid Budget Survey reported allowing Medicaid payment for the services of community health workers (Halder & Hinton, 2023).

- Models that have worked, including the following, should be funded, scaled up, and disseminated:
 - The [Integrated Maternal Health Services \(IMHS\) program](#) fosters the development and demonstration of integrated maternal health service models, such as the Maternity Medical Home, with a focus on advancing equity and supporting comprehensive care for pregnant and postpartum people from under-resourced communities.
 - The AIMS Center at the University of Washington offers a [comprehensive implementation guide for the Collaborative Care Model](#), which is an evidence-based model demonstrating positive outcomes in the primary care setting (Melek et al., 2018) and has also been shown to reduce racial disparities in care (American Psychiatric Association Committee on Integrated Care, n.d.). The behavioral care manager serves as the linchpin of the Collaborative Care Model. Care managers (often clinical social workers, psychologists, or nurses by training) act as the primary point of contact for both patients and obstetricians.
 - The [Integrated Behavioral Health Academy at Denver Health](#) uses existing mental health and substance use treatment systems and staffing to create a universal screen-to-treat process for perinatal mood and anxiety disorders in obstetric clinics (Lomonaco-Haycraft et al., 2019).
 - The [New Jersey Birth Equity Funders Alliance](#) has an effective model for providing grants to community-based organizations that focus on reducing disparities.
- Training should be incorporated into federal technical assistance programs, and training programs that have been effective should be disseminated (e.g., the training programs for integrated care managers identified by Miller and colleagues [2020]).
- Maternity care centers (MCCs) could be created to address the problems of having a limited workforce and maternity care deserts and provide integrated care (modeled on certified community behavioral health clinics [CCBHCs] and federally qualified health centers [FQHCs]), which includes psychiatry access programs, peer navigators, doulas, community health workers, and licensed substance use and mental health care providers. This should include a robust program and process for workforce projection, monitoring, development, and deployment.

Recommendation 1.1.2

Enact federal laws that require the implementation of 6 months of paid family and medical leave and universal child care in all states, the District of Columbia, and all U.S. territories.

Why?

Federal paid family and medical leave. The benefits that federal paid family and medical leave would have on perinatal mental health emerged as an overarching theme of task force discussions, listening sessions, and public comments. Countries that provide paid family and medical leave by law have better maternal and infant health and well-being outcomes (National Partnership for Women and Families, 2021). Among 41 countries examined in one analysis, the United States was alone in offering no national paid family or medical leave of any kind (Livingston & Thomas, 2019). Without a federal paid family and medical leave policy, about a quarter of new mothers return to work within 2 weeks of giving birth. Research suggests that state-level policies that make it easier for people to extend paid family and medical leave may improve maternal mental health outcomes (Coombs et al., 2022). As of February 2024, federal employees are offered 12 weeks of paid family and medical leave. The U.S. Department of Defense has also extended paid family and medical leave to 12 weeks for service members and offers convalescent leave for recovery from pregnancy and birth (Vergun, 2023). Only 13 states plus the

“I didn’t want to go back to work, but America isn’t really set up for moms to stay at home and live on one income, so that wasn’t something we could do.”
- K.L., mother of two

District of Columbia have mandatory paid family and medical leave systems. In states with paid family and medical leave, many parents need education and assistance around completing documentation for the leave. Additionally, the lag time in receiving the initial payment can be a challenge for those with low incomes.

Paid family and medical leave can have a direct and lasting positive impact on the mental health and well-being of both parents and children (Herrick, 2023). For example, parental leave can help alleviate mental health symptoms by preventing or reducing stress associated with childbirth and infancy and increase bonding time between parent and child. There is some evidence that paid family and medical leave reduces household financial instability—decreasing poverty and stress that could lead to mental health symptoms and other negative outcomes, such as family violence (Bullinger et al., 2024).

Universal child care. Affordable high-quality child care can offer tremendous benefits to families and the overall economy (Herrick, 2023). Currently, more than 3 million families lack access to child care, and most families are challenged by the cost of child care (Herrick, 2023). Additionally, individuals in the child care workforce are often paid substandard wages. It is crucial for our nation to build the infrastructure for a robust child care system—including increasing wages for child care workers—to support the mental health and well-being of parents, children, and families.

How?

Paid family and medical leave.

- The federal government should identify ways to support the [House Bipartisan Paid Family Leave Working Group](#) (launched in January 2023).
 - The task force suggests a duration for paid family and medical leave of at least 6 months (Earle & Heymann, 2019).
- For states where it may prove challenging to implement this legislation in a timely manner, the federal government should offer support and technical assistance around implementation.

Universal child care.

- Congress and the executive branch should implement a series of actions, including the following:
 - Expansion of relevant tax credits, such as child tax credits and employer tax credits for providing child care. (For example, the Internal Revenue Service's Employer-Provided Child Care Credit "offers employers a tax credit up to \$150,000 per year to offset 25 percent of qualified child care facility expenditures and 10 percent of qualified child care resource and referral expenditures" [26 U.S. Code 45F].)
 - Establishing policies that provide child care subsidies and expanding current federal child care subsidy programs.
 - Consideration of universal federal incomes during the postpartum period.
 - Enacting laws that mandate a universal minimum wage and health benefits for all child care workers.
- The federal government should establish incentives and support for state and local governments to leverage a variety of different funding sources to increase early childhood education (ECE) workforce wages and benefits.
- The federal government should work with state and local governments to improve consumer education efforts so they are culturally and linguistically responsive to reach more families and improve their access to early care and education programs and services.
- The federal government should facilitate partnerships among state and local governments and institutions of higher education to improve professional pathways and professional development opportunities for the ECE workforce.

Administration for Children and Families (ACF) Resources That Support Increased Wages for Child Care Workers and Support the Mental Health and Well-Being of Parents and Children

- The Office of Child Care released sub-regulatory guidance that supports lead agencies in [using the Child Care and Development Fund to improve compensation for the child care workforce](#).
- ACF hosted a webinar titled “Helping Early Childhood Educators Thrive: Promoting ECE Staff Mental Health and Well-Being.” Slides for the webinar are available [here](#).
- The Office of Early Childhood Development released a “dear colleagues” letter titled “[Dear Colleague on New Federal Opportunities to Bolster the Early Care and Education Workforce](#).” The letter outlines new federal opportunities for states, local programs, and communities to sustain and build on their efforts to strengthen the ECE workforce.
- The Office of Early Childhood Development regularly updates the [Resources to Support Early Care and Education Workforce Strategies](#) webpage. The resources address [compensation and benefits](#), [pathways for career advancement](#), and information about [working conditions](#) that demonstrate the value of the early childhood workforce.
- The Office of Early Childhood Development also regularly updates the [Behavioral Health Resources for Children and Families](#) webpage. This page includes resources related to supporting the mental health and well-being of parents, other caregivers, and the ECE workforce.
- The [National Early Care & Education Workforce Center](#) is a joint research and technical assistance center. “This center builds on broader efforts of [ACF] to support the early childhood workforce by identifying effective policies and strategies through research and evaluation, translating lessons from research for practice, and supporting innovations in states and communities through technical assistance.”

Recommendation 1.1.3

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

Why?

Stigma and punitive approaches against people with mental health conditions and SUDs have negative effects on perinatal well-being and can be strong deterrents to seeking help. Substance use is considered child abuse under civil child-welfare statutes of 24 states and the District of Columbia (Weber et al., 2021). In 25 states and the District of Columbia, health care professionals are mandated to report suspected prenatal drug use, with eight states requiring the testing of infants for prenatal drug exposure when maternal substance use is suspected (Weber et al., 2021). These policies are often implemented in discriminatory ways (Jarlenski et al., 2023).

Women are understandably concerned about mandatory referrals to child welfare services and the possibility of their children being removed from their homes by child protective services and placed in foster care, and this concern is a barrier to their seeking SUD treatment (Office of National Drug Control Policy, 2022). In addition to seeing this issue in their professional experience, members of the task force heard this concern in state and local listening sessions and the public comments. Evidence indicates that the criminalization of SUD during pregnancy is ineffective at deterring substance use and may actually lead to worse maternal and child health outcomes (American College of Obstetricians and Gynecologists, 2020; Office of National Drug Control Policy, 2022). These fears can be further amplified in the context of IPV, in which abusive partners threaten to leverage punitive policies as a tactic of control (Office of the Assistant Secretary for Planning and Evaluation & Family & Youth Services Bureau, 2020; Phillips et al., 2021; Warshaw & Tinnon, 2018). In addition to the Office of National Drug Control Policy (ONDCP), major medical and professional societies have supported non-punitive approaches to screening and care, including the American Medical Association (AMA), ACOG (the American College of Obstetricians and

Gynecologists), and the American Society of Addiction Medicine (ASAM). ASAM “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).

Women with mental health conditions may also be concerned about the removal of their children, especially if they experience intrusive thoughts about harming their babies, which can occur with perinatal obsessive-compulsive disorder (Byatt et al., 2019). As noted in the task force’s report to Congress, women experiencing perinatal mental health problems in the United Kingdom reported that stigma and fear (including losing custody of children) were significant barriers to seeking treatment (Ford et al., 2019). Other qualitative research on individuals with perinatal mental health conditions indicated their 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).

How?

- The federal government should work with states, D.C., and U.S. territories to implement guidelines, recommendations, and actions from:
 - ASAM’s [*Public Policy Statement on Substance Use and Substance Use Disorder Among Pregnant and Postpartum People*](#), in the section titled “Federal and State Policy Changes and Reimagining Support”;
 - ONDCP’s report titled [*Substance Use Disorder in Pregnancy: Improving Outcomes for Families*](#);
 - ACOG’s policy statement titled “[*Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period*](#)”;
 - AMA’s report titled [*Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers*](#); and
 - The National Center on Domestic Violence, Trauma, and Mental Health’s research and policy brief titled “[*Saving Lives: Meeting the Needs of Intimate Partner Violence Survivors Who Use Opioids*](#),” specifically sections that make recommendations for federal and state policymakers.
- Training and technical assistance activities should be developed for the field to reduce overreporting, and other incentives should be established that support implementation of the above recommendations on non-stigmatizing and non-punitive approaches to maternal substance use, SUDs, and mental health conditions (Roberts et al., 2024).
- The federal government should work with states, hospitals, licensing bodies, professional societies, and training programs to establish notification pathways to resources without reporting pathways.
- The federal government should scale up, enhance, and fund successful models that promote non-punitive approaches and offer medications for opioid use disorder (MOUD) and medications for alcohol use disorder (MAUD).
 - The [*Maternal Opioid Misuse \(MOM\) Model*](#), funded through the Center for Medicare and Medicaid Innovation, offers states the ability to integrate maternal health, mental health, and SUD treatment to help alleviate psychosocial stressors and stigma around seeking help.
 - The Substance Abuse and Mental Health Services Administration’s (SAMHSA) [*Services Program for Residential Treatment for Pregnant and Postpartum Women*](#) and [*State Pilot Program for Treatment for Pregnant and Postpartum Women*](#) support comprehensive family-centered and dyadic care for mothers with primary diagnoses of SUDs and their infants.

- The federal government should ensure states are in compliance with the [SUPPORT for Patients and Communities Act \(Public Law 115–271\)](#), which requires state Medicaid programs to cover all Food and Drug Administration–approved forms of MOUD, as well as counseling.

Recommendation 1.1.4

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

Why?

In December 2021, President Joe Biden signed [Executive Order 14058](#), focused on improving customer experience when it comes to interacting with federal services—including maternity care and the WIC program. Parents who visit a health care facility, mental health care setting, or SUD treatment program in person often need to bring their children with them because they lack other options for child care (Waters et al., 2022). It can be stressful for parents to manage long wait times, filling out forms, and consultations with young children in tow. The lack of child care is a key reason many people are unable to attend office visits and do not complete their treatment programs during the postpartum period (Choi et al., 2022).

Specialized inpatient care in the form of psychiatric mother–baby units is considered the gold standard of care in other countries, and some have argued for expansion of these facilities in the United States (Dembosky, 2021; Posmontier et al., 2022). The low number of residential SUD treatment programs that include child care or restrictions on the children that mothers can bring with them is considered a structural barrier (Substance Abuse and Mental Health Services Administration, 2009). Therefore, provision of child care is considered one way to engage women in SUD treatment (Substance Abuse and Mental Health Services Administration, 2009).

How?

- The federal government should establish incentives and support for states, hospitals, and outpatient clinics to create family-friendly spaces and free embedded child care in facilities that include outpatient SUD treatment, mother–baby mental health units, SUD residential treatment centers, maternal/perinatal intensive outpatient programs, and partial hospitalization programs.
- Federal health care facilities, physical health and mental health care service programs, and SUD treatment programs should be required to establish a designated child-friendly play area (equipped with toys and age-appropriate activities) with supervision from dedicated staff members or volunteers on-site.
- The federal government should scale up, enhance, and increase funding for model programs:
 - SAMHSA's [State Pilot Program for Treatment for Pregnant and Postpartum Women](#) and [Services Program for Residential Treatment for Pregnant and Postpartum Women](#) make child care services at the treatment centers mandatory as part of wraparound and recovery support services.
- The federal government should provide technical assistance support for establishing family-friendly spaces—such as sample plans, budget templates, and volunteer schedules.

Recommendation 1.1.5

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

Why?

The American Academy of Family Physicians defines clinical practice guidelines as “statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options” (American Academy of Family Physicians, 2017). Clinical practice guidelines help practitioners understand the risks, benefits, and potential harms of a treatment so that they can engage in shared decision-making with patients (American Academy of Family Physicians, 2017). Although best practices and resources that could improve maternal mental health exist, providers may not be unaware of them, may not have the time and resources to learn and implement them, or may not be implementing them because of systemic barriers, which can lead to suboptimal care and in some cases cause harm to patients.

Selected Recommendations and Practice Guidelines

Various medical and professional societies have released well-deliberated, clinically sound recommendations and practice guidelines relevant to providing care for maternal mental health and SUDs, including the following:

- ACOG’s [guidelines for screening and diagnosis](#);
- ACOG’s [guidelines for treatment](#);
- The American Society of Addiction Medicine’s [guidelines for opioid use disorder treatment](#);
- The Society for Maternal-Fetal Medicine’s [guidelines](#);
- The American Psychiatric Association’s [Perinatal Mental Health Toolkit](#);
- The U.S. departments of Veterans Affairs and Defense’s [Clinical Practice Guidelines for the Management of Pregnancy](#);
- SAMHSA’s [Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants](#);
- The [ACCESS Mental Health for Moms Perinatal Mental Health Toolkit](#);
- The [HRSA-Supported Women’s Preventive Services Guidelines](#);
- The Agency for Healthcare Research and Quality’s [Safety Program in Perinatal Care](#); and
- The Alliance for Innovation on Maternal Health’s (AIM) [patient safety bundles](#) (discussed below).
 - [Perinatal mental health conditions](#)
 - [Pregnant/postpartum SUD](#)
 - [Institute for Healthcare Improvement \(IHI\)–AIM change packages](#)

AIM has developed patient safety bundles—collections of evidence-informed best practices that address specific conditions in pregnant people and postpartum individuals. The bundles offer a structured way to improve the processes of care and patient outcomes. Each one includes actionable steps that can be adapted to a variety of facilities and resource levels. AIM has produced perinatal mental health and SUD safety bundles, along with IHI–AIM change packages. AIM patient safety bundles include multidisciplinary resources and implementable changes for organizations, as well as trainings and drills. Additionally, clinical providers can extend their capacity in the area of maternal mental health conditions and SUDs by linking with community-based services. These efforts are related to the work of perinatal quality collaboratives (PQCs)—state or multistate networks of teams working to improve the quality of maternal and infant care—which are addressed in a separate recommendation (3.2.2) of this national strategy (Centers for Disease Control and Prevention, 2023a).

“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

How?

- The federal government should leverage existing expertise, evidence, teamwork, and communication science to increase the access to and implementation of evidence-based practices and clinical practice guidelines for the treatment of perinatal mental health conditions and SUDs through training and technical assistance to the workforce.
 - Examples of existing federal programs include HRSA's portfolio of [activities that support AIM](#)—the AIM Technical Assistance Center, AIM's state capacity grants, and AIM's Community Care Initiative.
 - Grantees, contractors, hospitals, and community organizations need programmatic support in choosing and implementing evidence-based practices and the most up-to-date clinical guidelines.
- Providers in federally funded programs should be required to adhere to guidelines, and the requirements should be added to relevant notices of funding opportunities and contracts, along with guidance for contracting officers' representatives (CORs) and government program officers (GPOs) on how to oversee compliance.
- The federal government should work with ACOG and The Joint Commission to ensure that mental health and SUD care is incorporated into their Advanced Certification in Perinatal Care, which requires that hospitals rely on evidence-based literature and practice guidelines to design and implement their policies and improve clinical outcomes (The Joint Commission, n.d.). This could be the gold standard by which federal programs look at hospitals, inpatient care settings, and their delivery of care.
- The National Committee for Quality Assurance (NCQA) might consider how Healthcare Effectiveness Data and Information Set (HEDIS) and Medicaid measures, which are addressing implementation to a degree, could be further leveraged.
- Federal agencies should use incentives, quality measures, and quality improvement measures (e.g., measures from HEDIS and the Medicaid Core Set) to increase adherence.
- The federal government should create a national technical assistance center for perinatal mental health and SUD that provides consultation for the health workforce and focuses on implementation strategies for evidence-based practices related to maternal mental health conditions and SUDs. It should also assist with dissemination of research findings and communicating them in plain language. Finally, it should have an advisory board with members representing various communities, cultures, practice settings, types of practitioners, and types of researchers.
- Federal agencies should partner with appropriate medical societies or other relevant organizations to create AIM patient safety bundles on addressing GBV in perinatal populations, as well as bundles that focus on maternal mental health in special settings, such as NICUs.
- The federal government should consult an evidence review for additional information on policy and programmatic changes needed to improve maternal mental health (Wisner et al., 2024).

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

Recommendation 1.2.1

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

Why?

SAMHSA, HRSA, AHRQ, and other federal agencies engage populations at high risk for maternal mental health conditions and SUDs in services through existing programs. However, these programs are not always required to incorporate care for maternal mental health conditions and SUDs. Agencies could readily expand them to include maternal mental health screening and linkage to intervention. Such programs (e.g., Healthy Start) are discussed in the “Existing Federal Programs and Coordination” chapter of the report to Congress. Community-based programs include evidence- and research-based models, some of which are discussed in the “Best Practices” chapter of the report to Congress (e.g., CenteringPregnancy, Expect With Me, MAMA’s Neighborhood, Mothers and Babies, the ROSE Program, the CUB Clinic, Practical Resources for Effective Postpartum Parenting [PREPP], Family Spirit, Healthy Families America, the Nurse-Family Partnership, HealthySteps, and Parents as Teachers).

How?

- The relevant federal programs for which to consider expansion include—but are not limited to—the following:
 - [CCBHCs](#);
 - [Healthy Start](#);
 - [FQHCs](#) and HRSA-funded health centers;
 - [Maternal Infant and Early Childhood Home Visiting \(MIECHV\)](#) and [Tribal MIECHV](#);
 - The [Services Program for Residential Treatment for Pregnant and Postpartum Women](#);
 - The [Maternal Opioid Misuse \(MOM\) Model](#);
 - The [Continuum of Care Program](#);
 - [State, local, territorial, and tribal partnership programs to reduce the number of maternal deaths caused by violence](#); and
 - The [Rural Maternity and Obstetrics Management Strategies \(RMOMS\) program](#).
- Federal agencies should make training in perinatal mental health, SUD, and GBV screening, assessment, treatment, and recovery supports mandatory for relevant federal programs, ensuring a focus on trauma-informed, culturally relevant approaches.
- The federal government should work with private payers and offer incentives to enhance coverage of maternal mental health services and SUD screening and intervention.
- Congress and the executive branch should enact laws to add a specific set-aside requirement to enhance perinatal mental health training, screening, intervention, and treatment services, as well as the perinatal mental health workforce, within existing state block grant funding for maternal and child health, SUD, and mental health. Additionally, these funds should cover partnerships with community-based services for GBV, substance use treatment, housing, and legal assistance.

Recommendation 1.2.2

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

Why?

The task force’s report to Congress discusses the intersection of SDOH—e.g., race, ethnicity, educational attainment, income level, and geographic location—as well as their relationships with the marked health disparities and inequities in our country (Puka et al., 2022). Data indicate that Black, Hispanic, and American Indian/Alaska Native (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). The report to Congress also describes how negative SDOH (e.g., experiences of racism and discrimination and food insecurity) are stressors that are associated with a higher likelihood of maternal mental health conditions and SUDs (Linares et al., 2020; Weeks et al., 2022). These research findings are

aligned with the broad understanding of SDOH as reflected in the definition from CDC. This definition says SDOH encompass “the wider set of forces and systems shaping the conditions of daily life” and adds that those forces “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.-h).

Crear-Perry and colleagues (2021) applied a theoretical framework that focuses on “structural determinants of health” to analyze the higher overall maternal mortality rate among Black women in the United States. Their analysis outlines how structural determinants of health—such as slavery, the Jim Crow era, and residential segregation—have influenced interacting SDOH (e.g., income, housing, educational opportunities, and access to care) (Crear-Perry et al., 2021). Those SDOH in turn affect the higher rate of maternal mortality among Black women (Hoyert, 2024). The theoretical framework applied by Crear-Perry and colleagues (2021) contributes to the identification of the “root causes of inequities” and extends the understanding of how social and political structures and policies have influenced the distribution of unfavorable SDOH for particular U.S. subgroups (Crear-Perry et al., 2021). The authors also suggest how practice and policies might be changed to reduce inequities in maternal health.

Access to high-quality maternity care is uneven in the United States and intersects with multiple health, societal, and economic factors that contribute to higher rates of maternal and infant health complications (March of Dimes, 2023). 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 AI/AN people disproportionately affected (Policy Center for Maternal Mental Health, 2023a, 2023b). The ongoing effects of structural racism influence inequities in access to diagnostic and treatment services for maternal mental health conditions and SUDs (Matthews et al., 2021). Qualitative research suggests the need to center equity in the education and training of practitioners, mental health workforce investments, and funding of community-based organizations. Additionally, this research highlights the importance of investing in all communities, recognizing traditional healing practices, promoting integrated care, and supporting shared decision-making (Matthews et al., 2021).

How?

- Federal agencies should include best practices for screening and treating mental health conditions, substance use, and SUDs as domains in respectful care guidelines (Cantor et al., 2024) and incorporate them into trainings for nonclinical and clinical providers and others who work with pregnant and postpartum individuals.
- The federal government should increase funding and focus for research in this area, such as new funding opportunities, notices of special interest, and inclusion of this topic in special research initiatives, such as the [Office of the Secretary Patient-Centered Outcomes Research Trust Fund](#).
- Federal agencies should develop metrics and enhance collection of data on racial disparities. For example, the government should incentivize health plans and hospitals across the country to report disaggregated data on maternal mental health to their states, ensuring a focus on these outcomes and allowing for tailored approaches for improvement.
- There should be federal advisories with guidance to the nation’s health care centers and providers on how to address structural racism in practice and improve patient outcomes.
- Trainings on implicit bias and structural racism should be incorporated into federal technical assistance programs.
- The federal government should follow the HHS Office of Minority Health’s [National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice](#) and make the implementation of the National CLAS Standards mandatory in all relevant federal programs serving perinatal populations and their families.

Recommendation 1.2.3

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

Why?

As described in *The Task Force on Maternal Mental Health's Report to Congress*, the federal government supports many programs, initiatives, and activities related to promoting maternal mental health and addressing maternal mental health conditions and SUDs. Continuing the work of this task force would provide the coordination needed to implement this national strategy.

“My midwife checked in with me periodically. She was one of my providers. She was support for me. And I was honest with her about where I was mentally, but there was only so much support she could provide me.”

- F.P., pregnant mother of one

How?

- Congress should consider changing the name of the group from a “task force” to a “coordinating committee.”
- Congress should consider replicating the Advisory Committee on Immunization Practices (ACIP), a highly influential FACA committee whose recommendations are reviewed directly by the CDC Director and, if approved, published as official HHS recommendations in the *Morbidity and Mortality Weekly Report (MMWR)* (Centers for Disease Control and Prevention, 2022).
- Congress should identify the federal agencies that should be represented on the permanent Coordinating Committee on Maternal Mental Health. This might include HRSA, SAMHSA, CDC, NIH, VA, DOD, DHS, ACF (including the Office of Family Violence Prevention and Services), ASPE, CMS, IHS, DOJ, AHRQ, OASH, and DOL (including the Employee Benefits Security Administration).
- Congress should identify nonfederal organizations and stakeholders to be represented on the permanent Coordinating Committee on Maternal Mental Health. This might include providers, medical/professional societies, people with lived experience, industry representatives, payers, advocates and nonprofit groups, states, local agencies, and private groups.
- The federal government should call for the implementation of this national strategy and update it regularly.
- Federal agencies might create a consortium of key stakeholders to help guide and support implementation of this national strategy so it is aligned with [the U.S. National Plan to End Gender-Based Violence: Strategies for Action](#).
- Congress should consider modeling the [Health in All Policies \(HiAP\)](#) approach in future legislation for this work.
- The HHS Office of Disease Prevention and Health Promotion should bolster the [Healthy People 2030](#) goals related to pregnancy and the postpartum period by including all perinatal mood and anxiety disorders (PMADs) and SUDs, as well as their treatment (i.e., go beyond screening). Similarly, the government should review the U.S. Preventive Services Task Force’s (USPSTF) recommendations on prevention for perinatal depression and consider expanding them to all PMADs and SUDs and including a mechanism for enforcement and monitoring. The government should use the Healthy People 2030 goals, USPSTF’s recommendations, the CMS “Birthing-Friendly” designation, and the Child and Adult Core Sets to guide an interagency approach to effecting change.

Pillar 2: Make Care and Services Accessible, Affordable, and Equitable

Individuals experiencing maternal mental health conditions and SUDs face many barriers in accessing care that is equitable and affordable. Many factors contribute to these challenges, including workforce shortages (both clinical and nonclinical), the fact that systems of care can be fragmented and non-holistic, challenges with reimbursement and payment, and the fact that care is not always linguistically and culturally relevant. As a result, the majority (up to 75 percent) of individuals experiencing maternal mental health conditions and SUDs do not get the care they need, potentially leading to long-term negative effects on mothers, infants, and families (Byatt et al., 2015; Mughal et al., 2019). Recommendations supporting Pillar 2 include addressing issues of diagnosis, reimbursement, access, continuity of care, and workforce shortages.

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

Recommendation 2.1.1

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

Why?

Despite the high prevalence of maternal mental health conditions and SUDs, screening rates remain low. For example, only about 20 percent of individuals are screened for perinatal depression, according to data from HEDIS (Burkhard & Britt, 2022). Without screening and appropriate follow-up, women experiencing these conditions do not receive the care they need. Although many validated screening tools exist (these are noted in the task force's report to Congress), they are not universally implemented. In the

“[I experienced] anxiety around the birth, feeling uncertain, nervous, trying to do the right thing to keep myself and my family healthy.”

- R.R., mother

case of perinatal depression, researchers have shown that a collaborative care model improves rates of screening and treatment recommendations (Miller et al., 2021). Health care systems should support asking patients questions about their histories of maternal mental health conditions and SUDs as much as they support the consideration of gestational diabetes and preeclampsia in previous pregnancies. Screening is not the sole responsibility of the provider; health care systems and

infrastructure often leave little support, resources, and time for providers to screen in a culturally relevant, trauma-informed way. Nor is there typically support for providers to engage subsequently in dialogue with patients to provide education regarding the screening results and provide linkages to follow-up resources and care. Other barriers to screening include a lack of reimbursement and a lack of support for the provision of holistic care coordination and referral resources. In order for this recommendation to come to fruition, providers need the adequate support, infrastructure, and practice personnel.

IPV and Screening for Perinatal Mental Health Conditions and SUDs

It is important to understand the links among IPV, maternal mental health conditions, and SUDs when screening for these conditions. Experiencing IPV has a significant impact on maternal mental health and substance use and is a major contributor to maternal mortality, suicide, overdose, and homicide. People who experience IPV often face additional barriers to care by abusive partners who prevent them from accessing treatment, control their medications, sabotage their recovery efforts, and then leverage stigma-related policies against them (e.g., child custody loss) as part of broader patterns of abuse and control (Phillips et al., 2021; Warshaw et al., 2014). Women who experience IPV are 7.5 times likelier to have a partner interfere with their care than those who do not experience this form of violence (McCloskey et al., 2007). Despite the finding in one study that 3.5 percent of the women studied had experienced perinatal IPV, many reported that they had not been asked about IPV before (58.7 percent), during (26.9 percent), or after pregnancy (48.3 percent) (Kozhimannil et al., 2023).

How?

The federal government should expand training and implementation of education, screening, and preventive services for all health systems and providers.

- **Training:**

- Federal agencies should provide technical assistance and training on issues such as (1) reducing stigma, creating safe spaces, and implementing screening tools with fidelity and in culturally relevant, trauma-informed manners, including how to raise and discuss sensitive issues (e.g., GBV and other trauma); (2) clinical workflow and reducing provider burden; and (3) communication of screening results (including for those with disabilities).
- Federal agencies should encourage the provision of patient education as part of a broader continuum of care that begins with screening. Approaches to educating pregnant and postpartum individuals and their providers, promoting maternal mental health, and preventing SUDs should attempt to eliminate stigma and shame, ensure knowledge about these complications of pregnancy and childbirth and empower people to access services, and create safe opportunities for people to discuss experiences of violence or other life circumstances that affect their mental health, well-being, and access to care. Education and screening approaches also should provide information and resources as early in pregnancy as possible, thereby potentially preventing and/or mitigating negative effects.
- Federal agencies should provide training on trauma-informed responses to people experiencing GBV and other trauma, including incorporation of conversations about IPV and other trauma into routine assessments and clinical care; information, resources, and ongoing support; warm handoffs and/or on-site GBV services; access to trauma treatment; and attention to issues of safety, confidentiality, and coercive control (e.g., treatment interference, recovery sabotage, telehealth and electronic medical record safety, and custody-related threats).
- Federal agencies should offer training and technical assistance on the identification of military/veteran status, screening for these individuals, and the resources and treatment needed to best support service members and veterans.

- **Implementation:**

- The federal government should work with states and health systems to embed screening for mental health conditions, substance use, and SDOH into provider electronic medical record platforms, along with prompts for asking and responding appropriately and addressing safety.
- Evidence-based recommendations about preventive services (such as screening) for pregnant people, postpartum people, and all women of reproductive age (including adolescents) should be incorporated into all federal maternal, pediatric, and primary care

- programs and recommendations serving perinatal populations, such as recommendations from the [U.S. Preventive Services Task Force \(USPSTF\)](#) and the Maternal Mental Health Leadership Alliance's framework that has an equal emphasis on patient education and screening (the [Perinatal Mental Health Education and Screening Project](#)).
- The federal government should fund, model, and scale up interventions that work well—for example:
 - SAMHSA's community-based provider education on screening, brief intervention, and referral to treatment (SBIRT) and the expansion of SBIRT implementation (Substance Abuse and Mental Health Services Administration, 2022). This should include ways to incorporate assessment of GBV, other trauma, and SDOH into SBIRT.
 - Federal agencies should support task-shifted workforce practices for implementing screening and assessments related to GBV and SDOH. Interdisciplinary teams should include members (clinical or nonclinical) who have the time to talk with patients about sensitive issues.
 - The VA's national [maternity care coordination program](#) includes trained care coordinators who contact patients via phone and administer some screenings (e.g., for trauma and SDOH) and refer patients to care as appropriate. This removes the burden from direct clinical care providers while ensuring that patients are supported.
 - Federal agencies should consider incentives, partnerships, and technical assistance to facilitate state oversight to ensure that laws and regulations around screening are carried out—for example:
 - The [Women's Preventive Services Guidelines](#) (supported by HRSA), which require that the following preventive services be covered in most health plans for patients without their having to pay a copayment, coinsurance, or deductible:
 - Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum; and
 - Screening adolescents and women for interpersonal and domestic violence at least annually and, when needed, providing or referring them for initial intervention services.
 - [California's legislation mandating maternal mental health screening](#) in the prenatal, birthing, and postpartum periods (California A.B. 2193, 2018).
 - Federal agencies should work with experts, communities, and research bodies to lead efforts to adapt and validate screening tools for perinatal mental health conditions, substance use, and SUDs for various cultures, various languages, and people with various disabilities.

Recommendation 2.1.2

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

Why?

Research indicates that for about 75 percent of women who screen positive for maternal mental health conditions, symptoms emerge during pregnancy or the postpartum period (Moore Simas et al., 2023; Wisner et al., 2013). The clinical nuances of these conditions require perinatal specifiers at a minimum, if not a new category for perinatal mental illness. Clarification or standardization of language in

“Make me feel like I am actually being listened to. Ask about me as a person. I am still a person. I am still a female, a woman. Sometimes you get that feeling of the doctor doesn't really want to hear you.”

- J.N., pregnant mother of one

the field is needed for diagnostic and coding purposes and to improve research and surveillance (e.g., have more accurate prevalence rates). Currently, studies use different definitions of “maternal,” “perinatal,” and “postpartum.” As a result of these different definitions, estimates of mortality and morbidity and their causes vary considerably (Nguyen & Wilcox, 2005). This national strategy represents an opportunity for the federal government, in partnership with the American Psychiatric Association and other relevant professional societies, to encourage the development of a universal set of criteria that may, in turn, support payer–provider policies related to coverage and reimbursement.

How?

- The federal government should facilitate convenings, discussions, and partnerships among relevant stakeholders—such as medical, mental health, and research organizations and professional societies, as well as payers, health care providers, and people with lived experience.
- Federal agencies should align definitions and diagnostic criteria through partnerships and/or research support to build an evidence base that could be incorporated into diagnostic criteria development.
- Federal agencies should collaborate with such relevant stakeholders to survey the literature in order to:
 - Identify perinatal-specific conditions that have large evidence bases and are currently not included in diagnostic criteria;
 - Determine a standardized time period that captures the majority of adverse outcomes related to maternal morbidity and mortality;
 - Standardize the definitions of relevant terminology—such as “maternal,” “perinatal,” and “postpartum”—across health and research disciplines; and
 - Propose perinatal specifiers with unique perinatal presentations supported by the literature.

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

Recommendation 2.2.1

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

Why?

Traditional models of care by appointment and other barriers related to SODH (e.g., lack of access to transportation and child care) discussed in the Background section of this national strategy contribute to missed appointments and difficulties accessing perinatal care. Improving flexibility in how pregnant and postpartum individuals access services (e.g., expanding hours, home visiting, community outreach, and innovative technology options such as telehealth) is essential to improving equitable access to care (Burak & Wachino, 2023; Goldfeld et al., 2021; Hanach et al., 2021; Stentzel et al., 2023).

“It was going to take 3 to 6 months to find someone, and I ended up just giving up.”

- C.S., pregnant mother of two

Research suggests that mobile health (mHealth)—including mobile applications and text messaging—has 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 might offer opportunities for outreach and engagement. There are more than 250 apps related to pregnancy, according to a systematic review published in 2024. These apps provide

entertainment, information, and maternal health monitoring (Mazaheri Habibi et al., 2024). Their use could be expanded to provide education, awareness, and connections with mental health services. Some apps are used in clinical care. For example, the VA's 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).

How?

- The federal government should establish (and bolster existing) programs that include/strengthen the following:
 - Requirements to incorporate innovative patient-centered care delivery, including flexible scheduling; culturally relevant services, such as the inclusion of *promotoras de salud*, community health workers, or cultural brokers; coordinated appointments (e.g., therapy and medication treatment visits); integrated and co-located care for the mother and baby (as well as elementary-age children); and the creation of mobile mental health teams;
 - Home visiting programs that can provide home-based care in the perinatal period—for example, leveraging the HRSA-funded [Maternal, Infant, and Early Childhood Home Visiting \(MIECHV\) program](#), which provides evidence-based voluntary home visiting services to pregnant people and parents of young children to improve their health and well-being and focuses on enhancing early childhood development, preventing child abuse and neglect, increasing children's readiness for school, and connecting families to community resources to address SDOH (e.g., WIC, Medicaid, and housing support);
 - Access to technology and telecommunications, such as affordable and accessible broadband and government-subsidized data plans that allow for video-based health visits; infrastructure support, including improving and funding telehealth access; innovative methods to reach and support people during the perinatal period, particularly in medically underserved areas; sustained support for telehealth reimbursement (including telephone care); and telehealth options with protections for the safety of individuals experiencing IPV;
 - Co-created app content with maternal mental health experts, individuals with lived experience, storytellers, and other stakeholders;
 - The use of text messaging among community-based organizations to enhance engagement and tailor the content of interventions/support;
 - Digital solutions within community-based settings to help in closing the access gap to support services, such as [Health Evolve](#); and
 - Training and technical assistance support on how to implement, monitor, and sustain all of the above interventions.

Recommendation 2.2.2

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

Why?

Pregnant and postpartum people experiencing a mental health crisis need integrated intervention services to prevent self-harm. The task force's report to Congress provides detailed information on pregnancy-related deaths from suicide. An analysis of pregnancy-related deaths in 14 states found that 63 percent of deaths determined by a maternal mortality review committee (MMRC) to be related to a mental health

condition were by suicide (Trost et al., 2021). Among people with pregnancy-related mental health deaths (i.e., deaths from suicide, deaths from overdose or poisoning related to SUD, and other deaths that an MMRC deemed related to a mental health condition or SUD), more than a fifth (22 percent) had a documented previous suicide attempt or attempts, and 72 percent had a history of depression (Trost et al., 2021). This study also found that nearly two-thirds (63 percent) of pregnancy-related deaths from causes associated with mental health occurred 43–365 days postpartum (Trost et al., 2021). This finding aligns with the results of research from the Canadian province of Ontario between 1994 and 2008, which found that these deaths most often occurred after 6 months postpartum (Grigoriadis et al., 2017). Other research has found that both depression and suicidal ideation during the year prior to pregnancy increased between 2008 and 2018—with the sharpest rises occurring among Black women (Tabb et al., 2023).

In the context of these and other findings on perinatal suicidal behavior, researchers have pointed out the lack of studies to inform evidence-based strategies for prevention and emphasized the need to elevate it as a public health imperative (Kobylski et al., 2023). The task force adds that currently, there are no thorough, comprehensive evidence-based guidelines for emergency department providers on care for individuals experiencing a mental health crisis during the perinatal period (Pluym et al., 2021). The task force's report to Congress discusses the intersection of GBV, particularly trauma from IPV, with perinatal mental health conditions, SUDs, and pregnancy-related deaths. The task force asserts that the integrated crisis intervention services for perinatal populations should take a trauma-informed approach and provide culturally relevant support.

How?

- The federal government should establish programs that will implement crisis intervention services, training, and infrastructure support for addressing mental health, SUD, and GBV-related crises in perinatal populations, and it should incorporate that type of support into existing integrated service programs.
- All crisis intervention should be paired with program-specific technical assistance and training on how to implement best practices in crisis support for perinatal populations. Examples of ways to accomplish that include the following:
 - Expanding current technical assistance grants, such as SAMHSA's [Crisis Systems Response Training and Technical Assistance Center](#) and [Suicide Prevention Resource Center](#), to incorporate technical assistance on this topic;
 - Working with SAMHSA's 988 team and HRSA's National Maternal Mental Health Hotline team to ensure that content specific to maternal mental health conditions and SUDs (such as suicidality risk and postpartum psychosis) is incorporated into all crisis and mental health response team trainings; and
 - Providing training and technical assistance for first responders in the community on how to manage perinatal crises.
- The federal government should fund the development and dissemination of evidence-based guidelines for emergency room providers on how to assess, provisionally diagnose, and treat perinatal mental health crises.

Recommendation 2.2.3

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

Why?

When seeking mental health care, many people have difficulty finding in-network mental health providers that accept new patients (U.S. Government Accountability Office, 2022). Limited access to in-network providers and low reimbursement for Medicaid patients drive this problem. Low provider reimbursement

“The financial cost of paying someone [for mental health counseling] out of pocket is not in the budget.”

- F.P., pregnant mother of one who didn't have a therapist after 6 months

rates for psychological, psychiatric, and substance use treatment also contribute to this problem. Mental health parity laws require that health plans and insurers offer mental health and SUD benefits that are comparable to their coverage for general medical and surgical care. Preauthorization and referral requirements for services related to perinatal mental health conditions and SUDs are barriers to treatment. Removing these barriers would support

maternal mental health and facilitate timely treatment access. Incentivizing states to increase reimbursement for their Medicaid programs represents another way that the federal government could support enhanced access and equity in maternal mental health. More than two-fifths (41 percent) of women who gave birth in the United States in 2021 were covered by Medicaid (Valenzuela & Osterman, 2023).

States might benefit from assistance with encouraging insurance companies to improve reimbursement for and coverage of midwives and other perinatal supports, as well as services provided by community-based workers (The White House, 2022). The number of state Medicaid programs that reimburse the services of peer support specialists, community health workers, and doulas is growing. Community-based workforce roles provide meaningful career pathways for people with lived experience; such workers understand the people they serve. The Policy Center for Maternal Mental Health (2023c) and others have argued that peer support specialists are well positioned to address maternal mental health, as their services are reimbursed by most state Medicaid programs (Fallin-Bennett et al., 2020; McLeish et al., 2023). Reforms should strive for a system in which all in-network providers who care for perinatal patients can bill for the services of certified peer support specialists.

Alternative payment models (APMs) are another way to incentivize states in ways that align with positive outcomes in perinatal mental health and substance use care. According to CMS, an APM “is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population” (Centers for Medicare & Medicaid Services, n.d.). APMs can serve as a vehicle to provide more flexible prevention, early intervention, or care that is not traditionally viewed as medical (e.g., linkage to a housing provider or support for people experiencing IPV) that reduces the risk for negative maternal and child outcomes. APMs might specifically address equitable access to care during the perinatal period (Stone et al., 2023).

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

- J.N., pregnant mother of one

How?

- The federal government should work with states and private payers to increase financial incentives and reimbursement for services that demonstrate positive outcomes. The following are some ways to do this:
 - CMS could support states with creative proposals to change maternal health payment methodologies, including APMs—especially those that incentivize upstream care and support to prevent substance use and health and family crises.
 - CMS could increase awareness of its [new regulation](#) that requires states to compare their fee-for-service payment rates for primary care, obstetric and gynecological care, and outpatient mental health and SUD services with Medicare rates and publish their analyses every two years.
 - The U.S. Department of Labor's [Employee Benefits Security Administration](#) could be involved in conversations about reimbursement of perinatal maternal mental health and

SUD services in [Employee Retirement Income Security Act of 1974 \(ERISA\)](#)— and employer-provided insurance.

- The federal government could incentivize public–private partnerships in efforts to reduce administrative burden and encourage insurance companies to remove preauthorization and referral requirements for services related to perinatal mental health conditions and SUDs.
- The federal government could work with all payers to encourage increasing reimbursement rates for the following:
 - State Medicaid programs. For example, the government should consider providing funding to state Medicaid programs for a maternity care and/or mental health/SUD incentive payment that could supplement current rates. This would help to increase the number of patients with Medicaid who are accepted into mental health and SUD care. The government should call attention to the need to factor reimbursement and billing administration into the direct and indirect work of service providers.
 - Nonclinical support personnel, such as community health workers, doulas, and peer support specialists. The government should encourage more states to opt in to the community health worker Medicaid benefit (currently available in 29 states) (Halдар & Hinton, 2023).
 - Developing and scaling perinatal collaborative care models in settings such as OB-GYN, pediatrics, and primary care (Miller et al., 2020). Collaborative care models are evidence-based, patient-centered models of care that traditionally integrate primary care and mental health care and have been shown to [reduce stigma](#) (American Psychiatric Association, n.d.) and [reduce disparities](#) (American Psychiatric Association Committee on Integrated Care, n.d.). These models can provide many lessons that apply to perinatal populations. Specific attention to reimbursement in perinatal collaborative care is vital, as reimbursement and insurance coverage vary across disciplines and providers.

Note: This might entail creating forums—such as learning communities, policy academies, or technical expert panels—to encourage peer learning of successful models and discuss the benefits of increased reimbursement, including cost savings, improved patient outcomes and engagement, expansion of the workforce, and support for clinical providers that are often overburdened and understaffed.

- The federal government should implement and sustain APMs for Medicaid perinatal care that account for integrated mental health and substance use screening and treatment.
 - One example is the new CMS [Transforming Maternal Health \(TMaH\) Model](#). The TMaH Model will include an APM for participating states. It is a new 10-year payment and care delivery model with a goal of improving maternal health and birth outcomes for women and their infants. The TMaH Model focuses on improving maternal health care for people enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

Recommendation 2.2.4

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

Why?

Efforts to enhance community-based perinatal services, supports, and resources should ensure that they are culturally responsive. In the experience of task force members and participants in listening sessions, strengthening links to community-based services is particularly important for under-resourced populations because those populations are less likely to seek care in health care systems. Public comments and feedback from listening sessions mentioned the need to adapt evidence-based practices to ensure cultural sensitivity. These comments highlighted issues with trust, stigma, and systemic racism as challenges that might be addressed by integrating community-based workers—including peer support specialists, doulas, community health workers, navigators, and lactation consultants—into perinatal services. As described in the task force's report to Congress, these workers typically serve people in their communities, have similar lived experience, and are familiar with local resources. They are well positioned to provide culturally relevant multigenerational support for mothers, infants, and families. Throughout the task force discussions, listening sessions, and public comments, participants emphasized the important roles community-based services and workers play in supporting maternal mental health.

How?

- There should be collaboration among federally funded programs that support mental and behavioral health, including the National Maternal Mental Health Hotline, the Community Mental Health Centers Grant Program, the VA's mental health services, the Family Violence Prevention and Services Act program, and the Pediatric Mental Health Care Access Program.
- Federally funded programs should develop and enhance partnerships to expand treatment and recovery support service options and coordinate services and activities to achieve program goals. That should be completed by doing the following:
 - Developing partnerships across a state, tribe, or region and then connecting these partners to a broad range of community-based mental health and substance use treatment and recovery providers;
 - Ensuring that partnerships increase access to such services for pregnant and postpartum people and their families; and
 - Ensuring that partnerships are established with entities that receive funding for other federal programs to facilitate referrals for comprehensive services for pregnant and postpartum individuals.
- Federally funded programs (e.g., FQHCs, CCBHCs, Healthy Start, the MOM Model, MIECHV, and HRSA home visiting) should specify the categories of partnerships that they require in funding opportunities as a condition of funding to ensure community linkages.

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

Recommendation 2.3.1

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

Why?

Providers are at the heart of the envisioned maternal mental health infrastructure but must be supported themselves. For example, both clinical and nonclinical providers require the appropriate training and education on maternal mental health conditions, substance use, and SUDs (including non-stigmatizing, respectful, and culturally appropriate care). Appropriate provider training helps build trust with pregnant and postpartum individuals. Task force discussions, listening sessions, and public comments all pointed to the need for specific training in the area of maternal mental health. Frontline providers—including

"I didn't go [to therapy] for months. There were wait lists. The other piece was, I was starting to go back to work and find a day care. [Making a mental health care] appointment ... felt [like] too much, another thing [for me to do]."

- S.B., mother of two

nonphysician providers (e.g., midwives, doulas, community health workers, and consultants)—need specific training on how to address perinatal mental health conditions and SUDs. In the experience of the task force, specific training on perinatal mental health conditions and SUDs is needed among health care providers (e.g., in obstetrics, pediatrics, and family medicine) of all levels (e.g., advanced practice

nurses, other nurses, physicians, and physician assistants). Mental health care providers (e.g., psychiatrists, psychologists, social workers, counselors, and therapists) and SUD treatment specialists also need specific training in perinatal conditions. Part of provider training should cover the risk factors for and subgroups most affected by perinatal mental health conditions and SUDs. Providers also need ongoing support and supervision.

The field needs increased opportunities for training in interdisciplinary care (including mental health care) and requirements for cultural competence and knowledge of SDOH. Medical school and residency training for obstetrician-gynecologists (ob-gyns) in maternal mental health is insufficient. Major transformations in provider trainings—such as requirements, certifications/accreditations, and changes to curricula—may require alterations to laws, policies, regulations, and standards set by medical and educational bodies. A specific training need relates to the reluctance among many health care providers to prescribe (or continue) medications for mental health conditions and SUDs to patients during the perinatal period (American Psychiatric Association, 2022; Kalfoglou, 2016). Continuing education and training and technical assistance initiatives have the potential to increase providers' knowledge about that. Although difficult to implement, these changes would most likely have a high impact on overall access to services and individual care encounters.

How?

- In order to effect this recommendation, federal agencies should:
 - Incorporate implementation of specialty training efforts by federal agencies and experts in the field of perinatal mental health and SUD, such as those below, into all relevant federal training and technical assistance programs:
 - The [National Curriculum in Reproductive Psychiatry](#), which provides reproductive mental health information to both mental health and maternal–child health providers and includes the 5-Hour Essentials Mini-Curriculum, designed for students who have limited time to devote to reproductive psychiatry;
 - Programs supported by HRSA's Maternal and Child Health Bureau (e.g., the [Maternal and Child Environmental Health Network: MotherToBaby](#));
 - SAMHSA's [Providers Clinical Support System \(PCSS\)](#) and [SMI Advisor](#); and
 - Postpartum Support International's [training opportunities](#).
 - Partner with professional associations, societies, providers, and national technical assistance centers to enhance training and technical assistance, including the creation of guidance through publications and advisories;
 - Include opportunities for clinicians to access free training toward the Postpartum Support International Certification in Perinatal Mental Health;
 - Ensure that training and technical assistance are targeting all health care disciplines, including pediatrics, internal medicine, family medicine, emergency medicine, obstetrics and gynecology, mental health and SUD care, and nursing; and
 - Incentivize and offer technical assistance to support anti-stigmatizing and nondiscriminatory patient interaction training for health care providers and all personnel (e.g., assistants, front desk staff members, and others).

Recommendation 2.3.2

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

Why?

As discussed above, there is insufficient training and education provided for perinatal mental health, SUDs, and GBV, and more collaborative and comprehensive efforts need to be made to improve curricula in school and in continuing education for practicing providers. Workforce shortages must be offset by increasing the number of new providers entering fields who are trained from the outset to provide care for patients with maternal mental health conditions and SUDs (including those who have experienced GBV).

How?

- Federal agencies should work with medical professional societies, clinical training programs, and other relevant institutions to help support the adjustment of training and educational curricula and certification to include perinatal mental health conditions, substance use, SUDs, GBV, and SDOH and ensure that assessments reflect current practice guidelines for pregnant and postpartum individuals. Agencies should encourage inclusion and expansion of these topics in all examinations required for relevant professional licensure, such as the United States Medical Licensing Examination (USMLE) for physicians, the American Board of Psychiatry and Neurology's (ABPN) certification exam for psychiatrists, and the American Board of Obstetrics & Gynecology's (ABOG) qualifying exam.
- Federal training and technical assistance programs should provide continuing education units (CEUs) and continuing medical education (CME) for clinicians.
- Federal agencies should work with licensing bodies to create a requirement to complete a minimum number of education credits on perinatal mental health, SUDs, and GBV for initial license approval and subsequent license renewals in all professions serving pregnant and postpartum individuals.

Recommendation 2.3.3

Allocate long-term funding to establish, expand, and sustain perinatal mental health, substance use, and GBV consultation programs for medical, mental health and substance use, nursing, allied health, and nonclinical community-based workers.

Why?

Given the shortage of obstetricians and psychiatrists who specialize in treating mental health conditions during pregnancy and the postpartum period, [perinatal psychiatry access programs](#) can help meet the need for care. Perinatal psychiatry access programs (which include professional consultation lines) are typically state-based resources that support ob-gyns in improving access to high-quality mental health care. These programs also help mental health care providers who would like to enhance their training or competency in reproductive health care. Providing consultations with perinatal mental health specialists

"I was looking for a Latina [provider], someone who has had a home birth experience, an experience they could share with me."

- F.P., pregnant mother of one

(e.g., reproductive psychiatrists and perinatal psychiatrists) via telehealth can increase access to services, such as the diagnosis of mental health conditions and SUDs. Perinatal psychiatry access programs also can serve as a means of training and education for providers—particularly in rural areas and other medically underserved areas. Scaling up these programs emerged as an important way to increase

access and address the workforce shortage in task force deliberations, listening sessions, and public comments. In the experience of the task force, scale-up will require increasing the number of specialists who are knowledgeable about perinatal mental health conditions and SUDs to staff these programs.

How?

- The HRSA-funded State Perinatal Psychiatry Access Programs, provided through the [Screening and Treatment for Maternal Mental Health and Substance Use Disorders program](#), should be expanded to cover all states, D.C., and all territories. These programs should provide specific culturally appropriate supports for tribes and territories.
- The federal government should encourage states to adopt recent [Medicaid guidance on interprofessional consultation](#), which allows for reimbursement of interprofessional consultation. This would enable obstetric care providers to be reimbursed for their services when they consult with a specialist but do not have a face-to-face interaction with the patient.
- Federal agencies should develop and scale up consultation-based technical assistance programs, such as SMI Adviser, the [Refugee and Migrant Behavioral Health Technical Assistance Center](#) (both of which include addressing perinatal mental health, SUDs, or GBV), and the [VA Reproductive Mental Health Consultation program](#).
- Federal agencies should increase the awareness of and engagement with these psychiatry access programs among perinatal care providers—including primary care, mental health/SUD clinicians, and allied health providers.
- The federal government should clarify messaging on the purpose and target population for each consultation line.
- Federal agencies should consider ways to engage relevant clinical and nonclinical providers directly to increase use of consultation lines.
- Support programs such as [Lifeline for Moms](#), which provides training and technical assistance for providers that want to implement perinatal psychiatry access lines, should be scaled up and modeled.

Recommendation 2.3.4

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

Why?

Drastic workforce shortages and under-resourcing drive the lack of access to services for perinatal mental health conditions and SUDs, as well as general support for pregnant women, postpartum people, and parents. This is particularly true in maternal health care deserts. The workforce shortage—as well as a lack of representation among communities most affected by maternal mental health conditions and SUDs—was a major theme of task force discussions, listening sessions, and public comments. Our nation faces a shortage of obstetricians, licensed midwives, family physicians, and mental health care and SUD treatment providers (Counts, 2023; Health Resources & Services Administration, 2024a; The White House, 2022). These professions lack diversity and have limited pathways for people from underrepresented communities to enter these roles, which contributes to gaps in culturally appropriate care (Counts, 2023; The White House, 2022). Nonclinical community-based professionals who provide perinatal services and support for mental health and SUD recovery are also in short supply—a problem that is integrally related to low reimbursement rates and lack of coverage from insurers (Counts, 2023; The White House, 2022). States need guidance on how they might expand access to licensed midwives, doulas, peer support workers, community health workers, and freestanding birth centers.

Spotlight on Programs That Incorporate Doulas

Doulas are at the heart of [Hummingbird Indigenous BirthKeepers](#), a program that integrates evidence-based care, culturally appropriate care, and social connections. Indigenous BirthKeepers provide holistic support during the perinatal period. This Seattle Indian Health Board program received a maternal health grant from the HHS Quality Improvement Fund. Oregon was the first state to launch Medicaid reimbursement for “traditional health workers,” such as doulas, in 2012 (Oregon State Legislature House Bill 3311, 2012). Oregon’s [Community Doula Program](#) has cross-trained doulas as peer wellness specialists. The training allows peer support doulas to assist pregnant women affected by substance use during pregnancy and up to 3 years postpartum. Collaboration between the Oregon Community Doula Program and a peer support program for individuals working toward recovery has enabled 90 percent of clients to retain custody of their children (Institute for Medicaid Innovation, 2023).

How?

- The federal government should invest in and bolster existing initiatives that train and certify nonclinical community-based workers—such as peer support specialists, doulas, community health workers, *promotoras de salud*, navigators, and lactation consultants—to expand and diversify the perinatal workforce and improve perinatal mental health, particularly in under-resourced areas.
 - For example, Healthy Start includes support for training and supporting doulas as part of the care team for pregnant and postpartum individuals (Health Resources & Services Administration, 2024b).
- Federal agencies should require training in maternal mental health and SUD care as part of the certification of peer support specialists, doulas, and community health workers.
- Federal agencies should facilitate the implementation of the “care extender” model—which expands the health care workforce, builds capacity for maternal health teams, and offers culturally congruent care—with peer navigators. In the short term, the government should publish and disseminate guidance on how to recruit, train, and implement models that include peer navigators as part of a holistic care team. In the long term, it should change payment policies and models to incorporate peer navigator services as part of payment bundles or fee-for-service schedules.
- Federal agencies should apply lessons learned from the [Accountable Health Communities Model](#), developed by CMS, to bridge the gap between clinical care and community services. This model used screening, referral, and community navigation services to address SDOH needs. The development of trainings might be based on this model, which was [evaluated](#) in May 2023.
- The government should expand funding for and incorporate mandatory training around perinatal mental health and SUD care in federal workforce programs, including but not limited to the following:
 - [SAMHSA’s Minority Fellowship Program](#);
 - [SAMHSA’s Historically Black Colleges and Universities Center of Excellence in Behavioral Health program](#); and
 - [The Bureau of Health Workforce’s \(BHW\)](#) more than 60 programs aimed at strengthening the health workforce and bolstering the maternal health workforce by increasing the supply, distribution, and quality of clinicians who can advance maternal health, including family medicine and OB-GYN providers, nurses, and certified nurse midwives. Relevant investments include the following:
 - The Maternity Care Nursing Workforce Expansion (MatCare) program, which is focused on the training of nurse-midwives and has a goal of enhancing maternal health training to better address maternal mental health, maternal mortality, and morbidity risk factors;

- The Primary Care Training and Enhancement-Community Prevention and Maternal Health program, which trains primary care physicians to provide maternal health care, with a focus on improving outcomes for the perinatal population;
 - Integrated behavioral health programs that expand the number of providers who are trained to provide integrated services for SUDs in community-based settings, including programs such as the Addiction Medicine Fellowship, the Integrated Substance Use Disorder Training Program, and the Opioid-Impacted Family Support Program; and
 - The Behavioral Health Workforce Education and Training Program for Paraprofessionals grants, which aim to increase the number and enhance the quality of mental health and SUD professionals.
- SAMHSA, HRSA, and related agencies should fund clinical and nonclinical internships in federally funded programs serving perinatal populations to increase recruitment into the field.
 - Federal agencies should incentivize students and trainees in high school, college, and graduate education to choose careers in areas of need through pipeline development programs that spark interest and develop knowledge about mental health care professions. Opportunities include internships, summer programs, and education for high school career counselors.

Pillar 3: Use Data and Research to Improve Outcomes and Accountability

Gathering, evaluating, and disseminating data is necessary to ensure that policies and programs are effective. As noted in the task force's report to Congress, our nation currently faces many challenges related to maternal health data overall, including data related to maternal mental health conditions and SUDs. Recommendations supporting Pillar 3 address ways that the United States could enhance the quality of data collection, interpretation, measurement, analysis, and dissemination—including ensuring that maternal mortality review committees and perinatal quality collaboratives are in place nationwide. The task force also identified two primary areas in which data and research could drive positive change in maternal mental health. First, data and research could be leveraged to support strategies and spur innovations in care across the spectrum of care—prevention, screening, diagnosis, intervention, and treatment—to improve outcomes for individuals with perinatal mental health conditions and SUDs. Second, data and research are foundational for helping health systems and providers improve the quality of care across the spectrum of services and increase access and equity.

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

Recommendation 3.1.1

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

Why?

Research and data collection are lacking in some areas relevant to perinatal mental health (e.g., effects of medications and other treatments on under-resourced populations of pregnant people, children, partners, and families). Federal agencies support research and data collection on many different topics, and a

coordinating expert panel could help prioritize these efforts to ensure maximum impact. Dedicated funding and a long-term strategic plan are needed.

How?

- The expert panel would help in carrying out this national research agenda and promote research that supports the development, implementation, and evaluation of an array of comprehensive holistic approaches to improving maternal mental health, including the approaches recommended in this strategy. The research agenda would:
 - Support perinatal longitudinal research, surveillance, and data collection (including the qualitative lived experiences of families) to examine the effects of mental health conditions, substance use, and SUDs and the need for ongoing support for women, children, partners, and other family members.
 - Examine the interplay between maternal mental health conditions, SUDs, and comorbidities (e.g., hypertension, cardiac disease, renal disease, and birth defects) to ensure that these topics are embedded in the research, surveillance, and care models.
 - Augment research on modifiable and nonmodifiable risk factors (e.g., genetics, sleep deprivation, social supports, and ACEs, as well as their effects on neuroplasticity), GBV, and SDOH (e.g., the built and social environment, food access, education access and quality, employment and economic stability, and health care access and quality) that affect maternal mental health conditions and SUDs.
 - Support studies that include greater engagement of pregnant, postpartum, and parenting individuals across the research life cycle (e.g., development, implementation, and dissemination) to inform policy, practice, and person-centered care across the lifespan, as opposed to studies that focus on specific time periods (e.g., the postpartum period).
 - Fund dedicated research to investigate sex-based differences and ensure the representation of under-resourced groups and mother–child dyads.
 - Support the systematic analysis of value-based payment and new delivery models (e.g., collaborative care) to assess the cost-effectiveness of investing in these types of care for maternal mental health conditions and SUDs.
 - Promote ongoing systematic data capture efforts to assess unmet needs for perinatal mental health and SUD care at multiple levels (e.g., national, state, jurisdictional, county, local, and health system). Focus on reducing pregnancy-related deaths by suicide.
 - Enhance perinatal mental health and substance use research to investigate maternal and infant outcomes associated with specific treatment approaches and models of care, including implementation research. In addition, examine maternal and infant outcomes associated with infant feeding.
 - Support research on ways to prevent treatment from being punitive, especially for under-resourced communities.

Recommendation 3.1.2

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

Why?

Research on maternal health that includes the subpopulations most affected is crucial to advancing knowledge, as well as equity and access. Furthermore, the exclusion of pregnant people in studies and surveillance efforts results in an extremely limited evidence base, which curtails the ability to provide tailored research-supported interventions for maternal mental health conditions and SUDs. Currently, individuals from under-resourced communities are often not represented in data collection (2022). Investments in building trust and partnerships that support the participation of under-resourced communities would facilitate translational research and the implementation of interventions in community-based settings. Greater inclusion of individuals from under-resourced communities in research would help advance implementation and dissemination research to improve outcomes related to maternal mental health conditions and SUDs.

Members of under-resourced communities that have experienced historical abuses may lack trust in the health and medical research enterprise. Understanding their perspectives requires an appreciation of some abusive experiences related to race, ethnicity, socioeconomic status, and other factors in the context of medical research. Historically, some have used the pretext of scientific research to perpetuate racist beliefs (e.g., eugenics) and to support ongoing disparities without evidence (Bergeron, 2021). Under-resourced groups have historically not been represented in the taxpayer-funded evidence base, nor have findings always been applied to improve the lives of people from these communities (Bergeron, 2021). Here are examples of historical research abuses:

- Cells from Henrietta Lacks, an impoverished Black woman who sought treatment at an academically affiliated hospital in the 1950s, were used for research purposes without informed consent. Ms. Lacks received treatment for her symptoms but ultimately died from cervical cancer at the age of 31. Use of her cell line has been widespread in research and continues, yet her descendants have not received compensation despite legal action (Baptiste et al., 2022).
- In the 1930s, researchers in Tuskegee, Alabama, began a study of untreated syphilis with Black men without informed consent. These men did not receive the treatment researchers promised, but the study continued into the 1960s despite multiple opportunities for government agencies to stop it. Some men in the study became infected during the research project but remained untreated and died from syphilis. The wives of these men also developed this sexually transmitted infection, and some of their children acquired congenital syphilis (McVean, 2019).
- The Havasupai Tribe took legal action against a research university in 2004 for using DNA samples in studies for which members of the tribe had not provided informed consent. Members of the tribe had participated in a study on Type 2 diabetes, providing blood samples for genetic analysis, but had not consented for their use in other investigations (Garrison, 2013). The university paid financial compensation to settle legal claims in 2010 (Mello & Wolf, 2010).

Current health research initiatives—such as NIH's [All of Us Research Program](#)—emphasize wide participation that is representative of the diversity of the United States. Still, the trauma of past events reverberates today and contributes to a reluctance to participate in health research among people from under-resourced groups.

Currently, data collection is not standardized across all of the domains relevant to maternal mental health. This limits our understanding of the impact of mental health conditions and SUDs on the lives of individuals and subpopulations. The field must go beyond the medical model to address the impact of these conditions on all aspects of life—for both parents and children. Data collection should encompass the risk factors and SDOH (e.g., food insecurity, stress, and housing insecurity) associated with these conditions. Thorough data collection helps build intervention strategies that take into consideration a community's lived experience and socioeconomic conditions. These factors affect access and health-seeking behaviors, as well as maternal mental health outcomes. Data are lacking on some emergent maternal mental health issues that warrant investigation (e.g., safe sleep environments, opioid use during pregnancy, and rates of postpartum depression screening). To promote health equity, data collection—

both quantitative and qualitative—should focus on understanding and meeting the needs of underserved communities. Although data are routinely collected in the provision of care to women and their infants (e.g., birth and death certificates and hospital billing data) and many public programs (e.g., the Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]), this information is infrequently combined for evaluation or research. Improved linkage of existing data systems and leveraging the data could reduce the burden on researchers and provide a more holistic evaluation of maternal and infant outcomes. Ultimately, policymakers and community leaders must be able to use the data to create intervention strategies that improve health outcomes and equity.

How?

- The [National Vaccine Injury Compensation Program](#) should be a model for the inclusion of pregnant and postpartum individuals in research related to the use of pharmaceutical or device-based treatments.
- The federal government should work with tribal epidemiology centers across the country to support the collection, analysis, and reporting of data on maternal mental health. For example, the Albuquerque Area Southwest Tribal Epidemiology Center conducted a tribal Pregnancy Risk Assessment Monitoring System (PRAMS) survey. However, this was for a limited time, and the survey was not able to be continued because of a lack of funding. PRAMS has collaborated with 10 jurisdictions that include tribal populations to promote maternal and child health priorities and activities (e.g., mental health, prenatal care, breastfeeding, and nutrition). Dedicated funding could ensure routine inclusion of tribal communities in the PRAMS survey.
- The federal government should disseminate and implement the recommendations from the [Task Force on Research Specific to Pregnant Women and Lactating Women \(PRGLAC\)](#), which has advocated for the inclusion of pregnant people in research and clinical trials and advises the HHS Secretary on research gaps regarding whether therapies are safe and effective for use among pregnant women and lactating women.
- Federal agencies should support community-based participatory research, which engages the subpopulations of interest. Examples include:
 - The [NIH Community Engagement Alliance](#);
 - The [Eugene Washington PCORI Engagement Award Program](#); and
 - The National Institute on Disability, Independent Living, and Rehabilitation Research's [2024–2028 Long-Range Plan](#).
- Federal agencies should encourage use of the GAP-REACH checklist, which provides guidance on standard reporting of race and ethnicity for research.
- There should be a federally sponsored series of facilitated focus groups with people who have lived experience of perinatal mental health conditions and SUDs and are representative of the populations most affected by these problems, and their feedback should be incorporated into the national research agenda mentioned above.
- Federal agencies should review case studies of research efforts that have built the trust of under-resourced communities that have experienced abuses in the past.

Recommendation 3.1.3

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

Why?

There are two primary reasons for data sharing. One is for clinicians to be able to coordinate care, which in many cases can be lifesaving; the second is for analysis of systems-level innovations with an eye to improvement and equity. As the nation modernizes data collection and linkages across data repositories, it is crucial to invest in data standards, data linkages, data architecture and infrastructure, and data sharing agreements. These elements are needed to permit the combination, comparison, and analysis of medical data and other data at the national, jurisdictional, and local levels. The task force recognizes that the federal government controls only particular data systems and that integration of these systems may be limited. The task force also acknowledges the different barriers for sharing and linking health record systems. In all data system linkage efforts, best practices for coordination of data and developing standards for allowing research should be followed.

Data relevant to an individual's health are often stored in multiple sources (e.g., the administrative records of insurance companies, databases from clinical trials or other research, and service agencies). The technique of data linkage—combining information on an individual from various sources—provides a rich resource that researchers can tap to understand complex health conditions across the population (Harron, 2022). The task force asserts that to support optimal maternal mental health, our nation needs sustainable data linkages—that is, systems that are maintained and remain linked over time. Current federal data linkages should be leveraged, strengthened, and used as a foundation for these activities.

How?

- The federal government should invest in systems that integrate data from municipalities, counties, states, U.S. territories, U.S.-affiliated Pacific islands, and federal agencies.
- Federal agencies should seek legal and ethical guidance on how to integrate data systems in a way that respects patient privacy and confidentiality. They should include patients' rights groups (e.g., the National Alliance on Mental Illness and Mental Health America) as co-collaborators in this process.
- It should be determined which federal data systems require linkages.
- Contextual language should be developed to indicate the standard for which all surveillance data sharing will be used, noting the intent is to improve the health and well-being of birthing parents.
- Any current linkages at the federal level should be leveraged and strengthened.
- Experts in data modernization should be engaged to develop the necessary data standards and pipelines, create data warehouses and repositories, and link data. Suggested models include:
 - The [Trusted Exchange Framework and Common Agreement \(TEFCA\)](#), which establishes an agreement on technical matters that support nationwide interoperability, makes it easier for health and social service agencies to improve care, and allows patients to access their own health care information (HealthIT.gov, n.d.).
 - The [Observational Medical Outcomes Partnership \(OMOP\)](#), which was designed to provide a standardized structure for observational data and analysis to produce high-quality medical and health evidence.
 - CDC's MAT-LINK team (with the assistance of an implementation partner team at Johns Hopkins University) is focusing on data modernization in its clinical-focused surveillance model to improve data quality and completeness before the data arrive at CDC. The team is working to map variables to OMOP at the clinical sites to increase interoperability, introduce more data quality tools, and standardize extraction of data from electronic health records. The team is also working to increase efficiencies in gathering abstracted data into the common data model by integrating electronic health records with REDCap (software that supports research databases).

- Activities of the [Observational Health Data Sciences and Informatics program](#).
- Federal agencies should engage with the Office of the National Coordinator for Health Information Technology to examine options from electronic health records.
- Federal agencies should model and scale programs such as the [Public Health Data Warehouse](#) in Massachusetts, which combines health care and social service data to address SDOH for women living with mental health conditions and SUDs. The warehouse links the records of mothers and their children and collects the outcomes of pregnant women through 1 year postpartum. (Connecting these systems might require legislative approval.)
- Data coordination and linkages should be a requirement in existing federal grant programs such as the [Screening and Treatment for Maternal Mental Health and Substance Use Disorders program](#), and there should be technical assistance and funding provided for it.
- The federal government should use consistent criteria to define relevant conditions for public health reporting to ensure that standardized data are collected, which would permit comparisons across geographic areas and the development of targeted strategies. See the examples in “[State Approaches to Leveraging Neonatal Abstinence Syndrome Data to Inform Policymaking](#)” and “[Evaluation of State-Led Surveillance of Neonatal Abstinence Syndrome — Six U.S. States, 2018–2021](#).”
- The federal government should enhance the linkage of data as part of CDC’s [data modernization efforts](#) and the use of big data.
- Federal agencies should consider the HHS Assistant Secretary for Planning and Evaluation’s report titled [Linking State Medicaid Data and Birth Certificates for Maternal Health Research](#).

Recommendation 3.1.4

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

Why?

Although the federal government supports perinatal health data resources and best practices, many researchers are unaware of their availability. Heightening awareness of these resources among the public health and scientific community would most likely increase the number of researchers studying perinatal conditions and expand the evidence base. Enhancements in the evidence base in the areas of prevention, intervention, treatment, and implementation science would contribute to improved maternal health outcomes.

How?

- The federal government should continue to fund the [MATernaL and Infant NetworK to Understand Outcomes Associated with Medication for Opioid Use Disorder during Pregnancy \(MAT-LINK\)](#) (managed by CDC), which collects surveillance data related to pregnancy and opioid use disorder from 11 clinical sites—capturing information on mothers and children through 6 years of age (e.g., comorbidities, risk factors, and SDOH).
- The federal government should continue to fund and enhance the [Pregnancy Risk Assessment Monitoring System \(PRAMS\)](#). PRAMS provides jurisdiction-specific population-based perinatal health data on maternal attitudes, experiences, and behaviors before, during, and shortly after pregnancy. The births in the 50 jurisdictions that participate in PRAMS are 81 percent of all live births in the United States. Increased investments are critically needed to maintain high-quality data, including high survey participation, as well as expansion of the PRAMS survey in territorial and tribal communities.

Recommendation 3.1.5

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

Why?

Scientific findings and surveillance data are published in research and scientific literature but not necessarily used to support specific, direct public health actions. Moreover, the majority of this information is not translated into public-facing, easy-to-understand, and actionable materials. Given the high prevalence of maternal mental health conditions and SUDs, it is critical that individuals, families, and providers have access to information as they make choices about health care and treatment.

How?

- Federal agencies should ensure that research and surveillance findings on perinatal mental health conditions and SUDs are disseminated beyond the scientific community so that they reach community partners, practitioners, individuals experiencing or at risk for these conditions, and policymakers.
- Federal agencies should share research in accessible formats to diverse audiences to inform policy, practice, and patient-centered care.
- Evidence-based materials—including information on perinatal mental health conditions and SUDs—should be translated and disseminated appropriately to patients (at each perinatal visit), providers, and families. These materials help patients make informed health care choices.
- Federal agencies should implement CDC plain language guidance (including using the [Single Overriding Communication Objective Worksheet](#)) and use [related resources](#).
- Federal agencies should draw upon expert guidance on [trauma-informed communication](#) and [practical guidance for implementing a trauma-informed approach](#).
- The federal government should offer materials and resources that are written in multiple languages and are reflective of cultural preferences. For example, Minnesota created [materials in multiple languages](#) for parents and families to learn about depression and anxiety during and after pregnancy.

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

Recommendation 3.2.1

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

Why?

When evidence-based interventions are developed, high-fidelity implementation is required to ensure that improvements reach frontline environments. Because environments differ, quality improvement (QI) science is necessary to monitor effectiveness in various settings, sustain good practice, and adjust to unique conditions. Systematic and meaningful quality metrics ensure that implementation proceeds with optimal efficiency, ineffective strategies are tailored to fit new environments, and processes can be adapted to evolving conditions.

How?

- For this effort, there should be a collaborative model in which multiple operating divisions can engage.
- Federal agencies should create the necessary billing codes, incentives for provider/community intervention, and QI programs and monitoring to ensure that evidence-based programs are adopted more widely.
 - One strategy is to establish HEDIS measures focused on maternal mental health and SUD outcomes at least through the first year after pregnancy (e.g., suicide and substance use).
- Congress and the executive branch should enact laws to require states to report on the entire [Medicaid Adult Core Set](#) (reporting on all behavioral health measures and the Child Core Set is already mandatory).
- CMS should ensure the Overall Hospital Quality Star Rating system includes measures that track outcomes for maternal mental health and substance use care.
- CMS should consider enhancing the “Birthing-Friendly” designation to ensure future iterations include stronger quality measures (including for maternal mental health and substance use). CMS should include a variety of stakeholders, such as perinatal quality collaboratives, to help determine the designation criteria.

Recommendation 3.2.2

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

Why?

PQCs are state or multistate networks of teams that work to improve the quality of maternal and infant care. PQC members focus on identifying health care processes that need to be improved and using the best available methods to make changes as quickly as possible (Centers for Disease Control and Prevention, n.d.-e). PQCs have made important contributions to improving maternal and infant health care and outcomes (e.g., reductions in severe pregnancy complications) (Centers for Disease Control and Prevention, n.d.-e).

How?

- CDC’s Division of Reproductive Health is currently providing support for PQCs in 36 states (Centers for Disease Control and Prevention, 2023b). This support should be expanded to all 50 states and all jurisdictions.
- Each relevant federal agency should be establishing monitoring mechanisms that can oversee the incorporation of maternal mental health conditions and SUDs as components of its major accountability efforts and align them to indicators of success.
- The federal government should continue funding the [National Network of Perinatal Quality Collaboratives \(NNPQC\)](#). NNPQC is a platform that facilitates wide sharing of effective improvement strategies.

Recommendation 3.2.3

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

Why?

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.-b). MMRCs make recommendations for preventing maternal mortality, and CDC works with MMRCs to enhance their review processes. Currently, CDC’s [Enhancing](#)

[Reviews and Surveillance to Eliminate Maternal Mortality \(ERASE MM\) program](#) supports 44 states and two U.S. territories. Through a congressional appropriation, CDC published a funding opportunity (CDC-RFA-DP-24-0053) in March 2024 to support an MMRC in every state, the District of Columbia, every U.S. territory, and every freely associated state. With support from CDC, the organizations that coordinate and manage MMRCs are able to identify the factors contributing to pregnancy-related deaths and recommend ways to prevent them. ERASE MM funding also enhances the understanding and reduction of disparities in maternal mortality. As noted in the task force's report to Congress, PQC and other initiatives that address maternal health utilize findings and recommendations from MMRCs to inform their efforts.

How?

- CDC should continue to invest in the [ERASE MM](#) program so that it covers all 50 states, D.C., and all U.S. territories.
- The federal government should expand support for MMRCs to address injuries and violence (e.g., overdoses, suicide, and homicide) as causes of pregnancy-related deaths.

Pillar 4: Promote Prevention and Engage, Educate, and Partner with Communities

The federal government's work will be most successful if carried out in collaboration with states, public-private entities, industry, advocates, medical and professional societies, communities, and individuals with lived experience and their families. Recommendations supporting Pillar 4 identify opportunities to bring partners together to promote and fund community-based prevention strategies that have a focus on empowerment and resilience, as well as elevating education about maternal mental health conditions and SUDs.

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

Recommendation 4.1.1

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

Why?

As described in the task force's report to Congress, evidence-based best practices and programs are available to prevent perinatal mental health conditions and SUDs. However, they are not widely implemented—particularly in under-resourced populations. The perinatal period offers a unique opportunity to engage individuals in discussions about their mental health and substance use, as well as additional risk factors that affect health and well-being. Pregnant and postpartum individuals need support from care systems and providers to optimize their overall health, as well as their mental health and well-being. This engagement—which could change the life courses of the parent and child—should include patient education and connection to resources and referrals. The federal government could lead prevention efforts that are culturally relevant, linguistically appropriate, and sensitive to the needs of pregnant and postpartum individuals—particularly those from under-resourced communities who are at high risk for maternal mental health conditions and SUDs.

How?

- The federal government should fund, model, and scale up prevention programs, tools, and initiatives in line with this recommendation. That should include implementation of best practices for the prevention of mental health conditions and SUDs among people who are in the conception phase and individuals who have experienced miscarriages, stillbirths, having children be in NICUs, or other traumatic perinatal events.
- Examples include:
 - [CenteringPregnancy](#);
 - [PREPP](#) (which stands for “Practical Resources for Effective Postpartum Parenting”);
 - The [ROSE \(which stands for “reach out, stay strong, essentials for mothers of newborns”\) program](#);
 - The [Health Advocates In-Reach and Research \(HAIR\) program](#) for perinatal populations, which brings health screening, services, and community support to the community in a culturally relevant way that has built trust and rapport with the community;
 - The [Community Informant Detection Tool \(CIDT\)](#), which promotes help seeking for those with perinatal mental health conditions and SUDs; and
 - Opportunities for communities to develop, implement, and evaluate culturally responsive and empowerment-focused interventions for maternal mental health conditions and SUDs.
- The federal government should enhance and promote harm reduction programs. According to SAMHSA, “harm reduction is an evidence-based approach that is critical to engaging with people who use drugs and equipping them with life-saving tools and information to create positive change in their lives and potentially save their lives” (Substance Abuse and Mental Health Services Administration, 2023a), and it is a primary pillar of the [HHS Overdose Prevention Strategy](#).
- Federal initiatives such as the [Federal Plan for Equitable Long-Term Recovery and Resilience](#)—which works to empower and bolster the resilience of individuals, families, and communities—should be elevated.

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

Recommendation 4.2.1

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

Why?

Currently, several warmlines and hotlines exist to serve the public. Although each of these lines provides critically needed services, the number of lines and the separation by topic areas, authority, and target population may cause confusion and decrease their potential impact. Coordination and clarifying messaging on these resources would facilitate an environment in which there is “no wrong door” for all pregnant and postpartum individuals and their families when it comes to warmlines and hotlines.

Public-Facing Hotlines That Support Perinatal Mental Health

Currently available hotlines include the following:

- HRSA’s [National Maternal Mental Health Hotline](#);
- Postpartum Support International’s [HelpLine](#);
- SAMHSA’s [National Helpline](#);
- SAMHSA’s [988 Suicide & Crisis Lifeline](#);
- The [National Domestic Violence Hotline](#);
- The [National Sexual Assault Telephone Hotline](#); and
- The [National Human Trafficking Hotline](#).

Information about warmlines is available [here](#).

How?

- There should be a federal central clearinghouse for information about warmlines and hotlines, and the federal government should provide appropriate guidance on what the lines help with and whom they are for. The clearinghouse should contain state and national resources and be disseminated to the community and existing warmline/hotline workers so they can transfer callers to the most appropriate resources.
- Federal agencies should encourage cross-training and cross-referral between maternal mental health and GBV warmlines and hotlines.
- The federal government should provide technical assistance and training on supporting specific subgroups (including perinatal populations) and relevant topics (e.g., best practices for supporting people experiencing GBV) for warmline and hotline workers.

Recommendation 4.2.2

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

Why?

Despite the high prevalence of perinatal mental health conditions and SUDs, many people require education about these conditions and their effects—including members of families, personal support networks, under-resourced communities, and law enforcement agencies. For pregnant people who live in a safe family system, it is essential to engage members of their personal networks and educate them about ways they could support maternal mental health. Family members can listen to their loved one's concerns, offer to go with them to medical care appointments, help them ask questions, take notes, and provide support throughout pregnancy and follow-up care (Centers for Disease Control and Prevention, n.d.-d). Family members' involvement is critical in promoting maternal mental health regardless of where they live. Support from one's personal network is important because too often the care focus is on babies

"If my husband had been more equipped to understand all the hormonal shifts you go through or the signs of postpartum depression, if he were more educated, he could have been more of a support to me."
- A mother

rather than mothers (Megnin-Viggars et al., 2015). Engaged family members who are educated about maternal mental health can support mothers in these areas and help providers meet their needs. Policies, infrastructure, and systems (e.g., those that facilitate attending a partner's perinatal care appointments) are needed so that family and personal network members can support a loved one's maternal mental health.

As described in *The Task Force on Maternal Mental Health's Report to Congress*, IPV and other forms of GBV are directly related to mental health, substance use, and SUDs for pregnant and postpartum individuals. Additionally, pregnancy and the postpartum period have been linked with a higher risk for IPV (Campbell et al., 2021; Noursi et al., 2020). Therefore, communications and community engagement must also consider GBV more broadly and recognize that many pregnant and postpartum individuals have ongoing concerns about safety, confidentiality, and coercive control. Messaging on maternal mental health should therefore be culturally relevant, non-objectifying, and non-retraumatizing. Messaging should also provide information on the impact that GBV can have on maternal mental health conditions, substance use, and SUDs and how people experiencing them can access resources and supports.

Community involvement in efforts is essential, so federal agencies need to engage and listen to community leaders, members of faith communities, pregnant and postpartum individuals, family members, and people with lived experience. Engaging community-identified trusted messengers in federal government efforts to address maternal mental health conditions and SUDs ensures that the

messaging is relevant, relatable, and credible to audiences. Community-identified trusted messengers are best positioned to understand the needs, preferences, and communication styles of their peers—increasing the effectiveness of outreach efforts. They can help convey this information to federal partners and service agencies. Community-identified trusted messengers (e.g., community leaders, health care providers, peer supporters, those with lived experience, and members of faith communities) enhance the credibility of communication materials and outreach efforts. They are well positioned to encourage individuals to seek support when needed and help link people to care. They also can help disseminate messages and materials to individuals and organizations in the community.

How?

- The government should create new (and incorporate into existing) federal programs (e.g., contracts, task orders, grants) focused on providing community education, messaging, and engagement.
 - *Regarding education and messaging:*
 - Consider incorporating the following topics into communications and messaging: addressing common misconceptions about maternal mental health conditions and SUDs, providing research-based information, enhancing engagement in care, reducing stigma, ways for parents to obtain financial assistance, and understanding the link between IPV and maternal mental health conditions and SUDs. All messaging should feature a one-step call to action through concise, repeatable, simple, and memorable language. Messages and materials should be accessible to individuals of all education levels, ages, and ethnicities. People with lived experience should be involved in the co-creation and review of messages and materials that connect individuals with resources, provide education, and reduce stigma. Materials should leverage powerful storytelling that features individuals who have faced challenges with maternal health conditions and SUDs. At the same time, messages should amplify the voices of supportive family members. Communication campaigns should specifically address maternal mental health and workers' rights under the Family and Medical Leave Act. Campaigns should dispel common misconceptions about maternal mental health conditions and SUDs through strategic outreach in schools, houses of worship, hospitals, and public health clinics. Materials should use a trauma-informed approach to create supportive environments, acknowledge the impact of trauma on people's lives, and promote healing and resilience. Messages and materials should resonate with the cultural values, beliefs, and practices of specific communities, which is essential for reducing stigma and increasing help-seeking behaviors. Intended populations in the community include patients, partners, families, providers, and law enforcement agencies.
 - Base communications on research, including audience preferences for receipt of information and engagement, so that messaging can be adapted for different community preferences.
 - Ensure that consumers are aware of their rights and of ways to access [free or low-cost treatment or support options related to mental health or substance use](#). Partner with providers and make pregnant people and postpartum individuals aware that these resources are available.
 - *Regarding engagement:*
 - These outreach and engagement efforts should be flexible in their approaches—listening to community needs and building on their assets—and work closely with trusted community-identified leaders as a primary source of knowledge. Partner with community-identified trusted messengers in communication and outreach efforts related to perinatal mental health and substance use. Involve

- these individuals in the development or adaptation of messages and materials as the needs of the community evolve.
- Leverage the social media channels of federal agencies and trusted partners (e.g., medical and professional societies) to increase the dissemination of information on maternal mental health.
 - Consider regularly engaging community-based organizations in listening sessions to gain insight on the needs of participants and community members related to support for people with mental health conditions and SUDs.
 - Engage community advisory boards (CABs), which consist of trusted, established leaders who are involved in uplifting and advocating for their communities. Members of CABs can play a crucial role in reaching under-resourced communities, as they already serve as local experts and facilitators. They understand policy and have mechanisms to disseminate information to a wide audience. CAB members can also provide feedback on programs, improving their effectiveness, especially in response to shifting community needs.
 - Work with community-based organizations that serve pregnant, postpartum, and/or parenting individuals, as they are 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 also can conduct listening sessions with members of the intended audience to obtain insight into their top-of-mind issues.
 - Consider engaging communities in asset mapping. Asset mapping involves identifying and leveraging existing resources, strengths, and networks within the community. When a community is engaged in asset mapping, it ensures that everyone feels connected to a common cause and that communication materials are localized, effective, and sustainable.
 - Consider using available tools for asset-based community development (ABCD)—e.g., the [ABCD Toolkit, by the Collaborative for Neighborhood Transformation, and Module 2 of “The Practice of Hope.”](#)
 - Align materials development with the principles of cultural competence, community-based participatory research, and collaborative care.
 - Work with state and local organizations to connect people to perinatal support services and to disseminate materials.
- The federal government should launch a public health campaign to counter stigma toward people with maternal mental health conditions and SUDs.
 - Good examples include CDC’s [Hear Her campaign](#) and [resources for American Indian/Alaska Native communities](#), the [Tough as a Mother campaign](#), and [The Blue Dot Project](#).
 - Federal agencies should work with states to enhance their role in communication and outreach efforts.
 - The federal government should promote its resources and practices that facilitate culturally responsive and sensitive communications and community engagement, including but not limited to the following:
 - SAMHSA offers [resources on how to talk about mental health](#) from different perspectives (Substance Abuse and Mental Health Services Administration, 2023b). Normalizing conversations about mental health helps people seek the help they need.
 - 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 peripartum individuals.

- Because violence (including IPV and GBV more broadly) is a cross-cutting issue for communities that requires ongoing supportive and sensitive messaging, communications should incorporate the principles of a [trauma-informed approach](#). Resources in this area include the [U.S. National Plan to End Gender-Based Violence: Strategies for Action](#) and CDC's [Intimate Partner Violence Prevention Resource for Action](#).
- Many tools are available to support community outreach and engagement, including CDC's [Advancing Health Equity in Chronic Disease Prevention and Management](#) and Engage the Community.
- The federal government has [guidance on clear communication and plain language](#).

Pillar 5: Lift Up Lived Experience

The information provided in Pillar 5 of this national strategy reflects the findings of the U.S. Digital Service (USDS), which conducted a 6-week research sprint in January 2024 to inform the work of the Task Force on Maternal Mental Health. The goal of the research sprint was to **capture information on the lived experiences of people who have had perinatal mental health journeys and the providers who work with them**. The resulting report, titled *Maternal Mental Health: Lived Experience*, presents the findings of interviews with 11 individuals from different backgrounds to provide a personal perspective on the issues considered by the Task Force on Maternal Mental Health.

Notably, any gaps in recommendations in Pillar 5 have been carefully considered by the task force. The task force has addressed these gaps by making additional and reinforcing recommendations in the other four pillars, drawing on the public comments and input from the many members with lived experience. As **the research sprint was not a formal study with a representative sample**, the task force notes the importance of considering the lived experiences of all populations, including members of the racial and ethnic subgroups and under-resourced communities highlighted in the “Language Used in This National Strategy” feature box, active-duty service members and veterans, migrants and refugees, individuals with disabilities, those with unintended pregnancies, those who have experienced GBV, and those who have been incarcerated. The task force also suggests consideration of the lived experiences of health care and service providers, including their perspectives on workforce shortages, burnout, demands to do more without supportive systems of care, the stresses of time-limited visits, and reimbursement and billing issues. Finally, the task force recognizes the need to consider the lived experiences of partners and others in the personal support networks of pregnant and postpartum individuals with mental health conditions and SUDs.

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

The information in this section summarizes the findings described in *Maternal Mental Health: Lived Experience*.

Provide More Information About Pregnancy and the Postpartum Period

Many mothers said that they and their partners **needed more information about the range of mental health experiences that can occur during pregnancy and the postpartum period**. They particularly wanted to know what mental health experiences to expect, how to recognize signs and symptoms of conditions, and where to seek treatment. Mothers noted that including mental health in the perinatal and parenting materials provided during primary care visits would have been helpful to them, their partners, and members of their personal networks. In some cases, mothers were aware of but ignored mental health warning signs.

Mothers worried about how they would be perceived by family members, friends, and health care providers—mentioning concerns such as social comparisons and leaving the house for postpartum appointments. Women often felt burdened by the pressure to be “good” moms, which affected their mental health and was sometimes a barrier to their seeking care. Societal expectations, pressure from

providers, and perinatal mental health often intersected when deciding whether to breastfeed. Mothers with mental health conditions voiced the concern that while they felt added pressure by providers to breastfeed, they did not know the benefits and trade-offs of alternatives.

Continue to Focus on and Care for Mothers

A common perspective among mothers was that after pregnancy, medical attention tends to be focused on the baby—leaving them to feel devalued rather than supported. Women shared that as the primary caregivers of their babies, they felt vulnerable during the transition to motherhood. With fewer appointments available to them postpartum, they did not feel supported by health care providers and perceived that the focus was on their babies' wellness. This experience reduced women's trust in the health care system and diminished their sense that new mothers are supported by a larger community. This may have contributed to the expressed desire to connect with other mothers who share their lived experience with perinatal mental health conditions. However, many did not know how or where to connect with others. **They felt that mothers who had recently gone through similar experiences would have expertise and be able to provide supportive guidance, a shared culture, and a sense of community.** With the responsibility of having to make important decisions about the care of their babies, mothers who did not have others with lived experience to support and guide them felt anxious, lonely, and isolated during the postpartum period. Individuals who lived farther from friends and family members tended to feel more isolated.

Build Trust

Mothers' trust in the health care system was sometimes undermined by mental health screening tools, which created more anxiety when delivered without context or a conversation about why they were given. Mothers described situations in which they were given a paper questionnaire during a prenatal, postpartum, or pediatrician appointment with no explanation about why they were given the screening tool or what would happen afterward if they scored too high. Women discussed their feelings of anxiety about answering the questions truthfully. For almost all mothers who participated in the interviews, their mental health challenges were identified in ways other than standard screening tools. Mothers mentioned other issues with screening tools, including that (1) the timing of their mental health challenges fell outside the single-point screen during 6-week postpartum appointments, (2) the questions tended not to match their experiences, (3) their responses were influenced by their fears of being perceived as "bad" mothers, and (4) they had a misperception that support is not needed without a current crisis. Women from under-resourced communities expressed a heightened sense of fear about screening, as they perceived pressure to show more competence as mothers.

From the provider perspective, screening can be difficult. Providers noted that they lack time and do not have specific education or training on screening for perinatal mental health conditions, substance use, or experiences that intersect with them (e.g., IPV and SDOH). Many mentioned that they do not screen because perinatal mental health is outside their specialty areas. Other reasons for not screening included a lack of reimbursement for performing this service and not knowing about appropriate resources for referral.

Understand Mothers as People and What Is Happening in Their Lives

Negative situational factors in a woman's life compound to influence her perinatal mental health. The experiences of health and financial stress, physical challenges and pain during pregnancy and postpartum, and a lack of sleep compounded the risk for developing mental health conditions—especially for people without immediate support. Women who had limited insurance coverage or changed their living situations experienced greater stress. Mothers who had experienced health scares during labor and delivery and mothers who had experienced longer recovery also noted negative effects on their mental health. **Returning to work too soon can be a trigger for perinatal health challenges.** Mothers who

participated in the interviews had different financial situations. Many needed to return to work and had to put aside their own recovery, as well as the needs of their babies (e.g., discontinuing breastfeeding).

Barriers to seeking and receiving mental health treatment—including the financial costs, workforce shortages, and problems accessing services—were often insurmountable for the mothers who participated in the interviews. Women spoke about difficulties finding a mental health provider who is affordable, available, and able to form a connection. Finding the right match was important to the women, who felt that they were solely responsible for determining whether they needed help, how to access care, and having insurance coverage. The burdensome process of seeking treatment—on top of having a newborn to care for—was often so overwhelming that many mothers stopped trying. Those who persisted waited months to receive care, with delays sometimes worsening perinatal mental health. Individuals with Medicaid had particularly difficult experiences finding timely care from available high-quality providers who accepted their coverage (i.e., lower reimbursement rates).

Respond to the Needs of Mothers and Their Families

Mothers underscored that clinical and nonclinical providers—including doctors, nurses, midwives, and doulas—noticing and responding to their needs changed their mental health trajectories toward wellness. For example, providers who took time to ask mothers about their mental health and/or connected them to care coordinators improved the likelihood of correct diagnosis and appropriate services. Mothers highlighted that check-ins by telephone calls or home visits by a midwife, nurse, and/or doula immediately postpartum made them feel supported. Women noted that the check-ins were beneficial because they could speak more frankly without being dismissed and did not have to wait for the 6-week postpartum appointment to discuss mental health concerns. During interviews, individuals also mentioned that having preexisting relationships with providers who understood their mental health histories facilitated correct diagnosis and supported continued care. Mothers mentioned that having continuity of care with their providers decreased anxiety and increased the speed of treatment and recovery.

Priority 5.2: Prioritize the Recommendations from People with Lived Experience

The information in this section summarizes the findings described in *Maternal Mental Health: Lived Experience*. During USDS interviews, people who have lived experience of perinatal mental health conditions voiced opinions on changes that would have improved their situations during pregnancy and the postpartum period. They mentioned the following:

- Opportunities to connect with experienced mothers to build community;
- Information, preparation, and community connections during early pregnancy;
- Access to high-quality care for everyone;
- Perinatal mental health check-ins with providers (having conversations about mental health early and often);
- Education about available medications that benefit people with mental health conditions and using them during the perinatal period;
- Clear information on continuing medications for mental health conditions during pregnancy and during breastfeeding;
- Recognition that breastfeeding can greatly affect perinatal mental health;
- Services that meet mothers and babies where they are;
- Sleep strategies and support during early pregnancy;
- Acknowledgment that screening alone is not enough, including the need for providers to make time for personal connection and explanations;
- Recognition that care for perinatal mental health is health care;

- Acknowledgment that paid family and medical leave improves outcomes for the entire family; and
- Specialty training in perinatal mental health support for members of the workforce who come from under-resourced populations.

Maternal Mental Health: Lived Experience highlighted key opportunities for change that would improve the experiences of and outcomes for mothers. The recommendations in the report address overall gaps and challenges in perinatal mental health at all levels of government—offering pathways for legislative bodies, federal agencies, and state agencies to consider pursuing. Changing the trajectory early in the motherhood experience would lead to positive outcomes for whole families. These key opportunities are based on the qualitative interviews with mothers, providers, experts, and digital mental health companies, as well as other qualitative and quantitative studies. Quotations from participants are highlighted.

Opportunities for Change	What Was Heard During Interviews
<p>1. A national paid family and medical leave policy</p> <p>Task Force Recommendation 1.1.2</p>	<p><i>"I didn't want to go back to work, but America isn't really set up for moms to stay at home and live on one income, so that wasn't something we could do."</i> — K.L., mother of two</p> <p><i>"I definitely had some separation anxiety with both [my babies]. But of course, I have to work—I have to be able to survive—so I have to get over it."</i> — C.S., pregnant mother of two</p>
<p>2. A diverse, interdisciplinary, culturally competent perinatal health workforce</p> <p>Task Force Priority 2.3</p>	<p><i>"[I wish there were] more support from a midwife after 6 weeks that's already set up [for you]. You've been through such an ordeal with them, and then you never see them after 6 weeks. [You only see them at the 6-week appointment] to see if you can have sex again."</i> — S.B., mother of two</p> <p><i>"With my therapist and with my daughter [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."</i> — M.S., mother of two</p> <p><i>"I joined the Black women's center. They have a doula on staff to help. She makes me appointments, has child care. That's how I kept it together."</i> — J.N., pregnant mother of one</p> <p><i>"Doulas are good at introductions. Doulas often have access to the local resources that keep you engaged."</i> — A psychiatric nurse practitioner</p>
<p>3. Peer support and a group care model</p> <p>Task Force Priority 2.3, Recommendation 2.3.4</p>	<p><i>"For brand-new moms who have never had babies, a support group after for you to share your experiences [would be helpful/supportive]. It's harder than I thought, and that support would be nice. I should have gone to therapy a lot sooner and [gotten] a more in-depth mental health assessment. I would have been more likely to do it ... [and] wouldn't have struggled so much."</i> — J.S., mother of one</p> <p><i>"I needed somebody to see how I was feeling and not just hear and reflect back that it was familiar to them and they got through it—someone to commiserate with."</i> — S.B., mother of two</p> <p><i>"Having someone who I knew ... like my sister or a community of other mothers, more community."</i> — M.S., mother of two</p>

Opportunities for Change	What Was Heard During Interviews
<p>4. Measures of the quality of patients' experiences with maternity care, including mental health care</p> <p>Task Force Priority 3.2, Recommendation 3.2.1</p>	<p><i>"I scored in the middle, just above normal. They asked how I was but said it was something to keep an eye on. He said I was sad but adjusting to being a new mom. The doctor put 'no signs or symptoms' on my chart."</i> — J.S., mother of one</p> <p><i>"I felt very cared for all through pregnancy, and then I had the baby, and it was like, 'OK, you are done. We are done caring for you, and now it's all about the baby.' I was very confused by that dynamic."</i> — M.S., mother of two</p>
<p>5. Holistic care models that integrate treatment of both mothers and babies</p> <p>Task Force Priority 1.1, Recommendation 2.2.1</p>	<p><i>"If someone came to my house, I would have felt more seen, supported, and I could be my fuller self."</i> — M.S., mother of two</p> <p><i>"Would have been nice to have midwives or OB call to check in on how I was doing, not just at a baby well care appointment."</i> — S.B., mother of two</p> <p><i>"On my child's birth pediatrician visit, she asked if I was OK, [said], 'You don't look OK.' I said I was because I didn't feel like she could help me. We can have a little chat, but what can you offer me?"</i> — F.P., pregnant mother of one</p>
<p>6. Screenings for different types of perinatal mood and anxiety disorders (PMADs), such as anxiety, obsessive-compulsive disorder, and bipolar disorder</p> <p>Task Force Pillar 1, Pillar 2, Priority 2.1, Recommendation 2.1.1</p>	<p><i>"It's very hard to scrutinize people, to write down they're not doing well. It's easier to talk about it. Screeners are useful conversation starters."</i> — A psychiatric nurse practitioner</p> <p><i>"I had postpartum anxiety, different from depression. I was having intrusive thoughts, compulsions."</i> — S.B., mother of two</p> <p><i>"I felt good that someone noticed and I wasn't just sending these surveys out into the ether."</i> — R.R., mother of two</p>
<p>7. Human-centered training and implementation of PMAD screening</p> <p>Task Force Priority 2.3, Recommendation 2.3.1, Recommendation 2.3.2</p>	<p><i>"The survey at [the pediatrician's office that] connected me to someone was huge. We only get one postpartum appointment."</i> — E.L., mother of one</p> <p><i>"How the provider responds really matters. Could be a small thing that is very beneficial. Sometimes 'I see you; I hear you' is intervention itself."</i> — A mental health policy expert</p>
<p>8. Closed-loop referral systems for perinatal mental health</p> <p>Task Force Priority 2.1, Recommendation 2.1.1</p>	<p><i>"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."</i> — R.R., mother of two</p> <p><i>"Therapy should be included with Medicaid like you have dental and vision. You should have a therapy appointment, too."</i> — J.N., pregnant mother of one.</p> <p><i>"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."</i> — M.S., mother of two</p>

Opportunities for Change	What Was Heard During Interviews
9. Continuing education requirements for perinatal mental health providers, including medication management Task Force Priority 2.3	<i>“There is a lack of clarity on [substance use disorder] treatment. People are dying trying to manage their doses.” — T.Y., mother of one</i>

The recommendations of people with lived experience of maternal mental health conditions and SUDs offer the federal government and others potential pathways to improve the health care experiences and outcomes of mothers. Acting on these recommendations to address the policy, system, and structural challenges that mothers face will not only improve maternal mental health but also enhance the well-being of their families and communities.

Conclusion

In this national strategy, the Task Force on Maternal Mental Health outlines ways that the federal government could lead efforts to build a national infrastructure that supports maternal mental health and improves care for perinatal mental health conditions and SUDs. Recommendations encompass a whole-government approach to coordination and scale-up of federal programs, collaboration with a diverse group of public and private partners, and incentivization of states to implement effective models and best practices. However, the task force notes here that some important areas for national action are outside its scope per the authorizing legislation but nevertheless relevant for promoting maternal mental health and improving the care for maternal mental health conditions and SUDs. For example, researchers and public health practitioners should focus on the need to enhance the health of people before they become pregnant—particularly regarding the care for mental health conditions and SUDs.

This national strategy is a living document that the Task Force on Maternal Mental Health will update regularly until it sunsets in 2027. Updates will include a report that details steps for implementation of the recommendations and a document for the governors of states focused on opportunities for partnerships. Updates to this national strategy will inform Congress of the federal government's efforts and describe the current status of maternal mental health and the care for perinatal mental health conditions and SUDs in the United States.

Appendix A: Acronyms and Abbreviations

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
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
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
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
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
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
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
ODU	opioid use disorder
OWH	HHS 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
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
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
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 National Strategy

Prenatal, Perinatal, and Postpartum

Unless otherwise noted in this document, “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 document 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 document 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

The language used in the congressional authorization and the name of the task force include the phrase “maternal mental health.” Task force recommendations foreground 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 document, “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 document 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 and Intimate Partner Violence

Violence against pregnant and postpartum individuals can result in adverse outcomes for the mental and physical health of those individuals and their babies. This document 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 document 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 document 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 document 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 document predate the 2024 revisions and therefore reference the racial and ethnic categories set forth in 1997. In line with OMB’s definitions, this document 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 document notes when sources use categories or definitions of race and ethnicity that differ from those of OMB.

Under-Resourced and Underserved

In this document, 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 document 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 document 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: Task Force Roster

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