

# GOAL 1 Action 1.14

WHITE HOUSE  
BLUEPRINT  
EVIDENCE TO  
ACTION BRIEFS



Expand capacity to screen, assess, treat, and refer for maternal depression and related behavioral disorders



**Maternal Health**  
Learning & Innovation Center™  
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**THE WHITE HOUSE BLUEPRINT  
FOR ADDRESSING THE  
MATERNAL HEALTH CRISIS**

The [White House Blueprint for Addressing the Maternal Health Crisis](#) (White House Blueprint) has identified goals and actions to reduce the rates of maternal mortality and morbidity, eliminate disparities in maternal health outcomes, and improve the experience of pregnancy, birth, and the postpartum period for people across the United States.

The following Evidence to Action Brief highlights Action 1.14 in an effort to increase access to and coverage of comprehensive high-quality maternal health services, including behavioral health services (Goal 1 in the White House Blueprint).

### **Maternal Health Action 1.14**

Expand capacity to screen, assess, treat, and refer for maternal depression and related behavioral disorders by providing real-time psychiatric consultation, care coordination support, and training for frontline health care providers.

### **Contribution to Quality of Life**

The [White House Blueprint](#)<sup>1</sup> is a “whole-of-government approach to combating maternal mortality and morbidity” so that all people in the United States who are capable of becoming pregnant and giving birth are healthy and safe.

Maternal mental health affects not only the health and well-being of mothers but also has long-lasting effects on the physical, intellectual, and emotional development of their children.<sup>2</sup> Expanding the capacity of health care providers to screen, assess, treat, and refer for maternal depression and related behavioral disorders can mitigate the impact of untreated behavioral health conditions.

### **Basic Facts**

Perinatal depression can affect a mother’s ability to bond with and care for her baby, as well as lead to negative health outcomes for both mother and baby.<sup>3</sup> In 2020 in the United States, 1 in 8 women with a recent live birth reported symptoms of postpartum depression, yet health providers miss critical opportunities to ask pregnant and postpartum women about depression. Around 1 in 5 women reported not being asked about depression during a prenatal visit; half of pregnant women who reported depressive symptoms were not treated.

When left untreated, perinatal depression can affect a mother’s health as well as cause sleeping, eating, and behavioral problems for the baby.<sup>3</sup> Infants born to women suffering from psychiatric or perinatal behavioral issues, such as depression, are at increased risk for poor birth outcomes—such as low birth weight and preterm birth—and demonstrate poorer cognitive performance, behavioral problems, increased anger, and lower rates of breastfeeding.<sup>4</sup> Untreated behavioral health conditions are also a leading underlying cause of pregnancy-associated deaths in the US, including suicides.<sup>5</sup>

Evidence-supported interventions to address perinatal depression and other behavioral concerns include maternity care coordination, universal screenings for depression, the application of validated screening tools, and the dissemination of local mental health resources and referral information. Maternity care coordination programs are associated with increased healthy outcomes for perinatal women and their infants, especially for those from groups that have been historically marginalized and those experiencing pregnancy-related or preexisting comorbidities, including mental and behavioral health challenges.<sup>6</sup> In addition, evidence supports the critical importance of having real-time psychiatric support for perinatal populations as well as health care providers trained in behavioral or mental health.<sup>4</sup>



Evidence-based screening programs (coupled with treatment resources) for common mental health disorders (i.e., depression and anxiety) have been shown to improve perinatal maternal mental health.<sup>7</sup> The adaptation of screening tools and the training and supervision of health providers to perform screening and subsequent management (whether referral or provision of psychosocial/psychological interventions) is critical to the success of a program. The American College of Obstetricians and Gynecologists recommends that all providers screen for depression and anxiety at least three times during the perinatal period, including at the first obstetric care visit, once during the third trimester, and at the postpartum visit(s), using a validated screening tool.<sup>8</sup>

The United States Preventive Services Task Force (USPSTF) recommends that all adults be screened for depression, including during the prenatal and postpartum period, and that clinicians provide or refer to counseling interventions those pregnant and postpartum women who are at increased risk for perinatal depression.<sup>9</sup> A review for the USPSTF that synthesized 33 studies found that “screening women during the perinatal period reduced the prevalence of depression.”<sup>4</sup> In addition, screening during the first six months of the postpartum period is recommended by the American Association of Pediatricians.<sup>10</sup>

To increase access to and coverage of comprehensive high-quality maternal health services, including behavioral health services, the [White House Blueprint](#) commits the federal government to expanding health care providers’ capacity to screen, assess, treat, and refer for maternal depression and related behavioral disorders (including training frontline health care providers in rural and underserved areas), and to expanding maternal care coordination support.<sup>1</sup> To fulfill this commitment, the Department of Health and Human Services will double its reach, increasing access to treatment and recovery services as well as to health care providers in an additional seven states. In addition, the Department of Defense’s Military Health System (MHS) will pilot a partnership with the Department of Veterans Affairs to support a reproductive behavioral health consultation service that gives MHS providers access to no-cost support from behavioral health experts on reproductive mental health issues.<sup>1</sup>

### How are we doing?

Below we highlight selected data related to Action 1.14. Racial, ethnic, geographic, and socioeconomic disparities emphasize where efforts should be focused to improve health outcomes related to the action.

**Table 1: Prevalence of Self-reported Postpartum Depressive Symptoms Among Women with a Recent Live Birth, by Health Insurance Status at Delivery—Pregnancy Risk Assessment Monitoring System (PRAMS), 2018**

Health Insurance at Delivery	
	% (95% CI)
Private	10.1 (9.5-10.8)
Medicaid	17.2 (16.3-18.2)
None	13.2 (10.0-16.3)

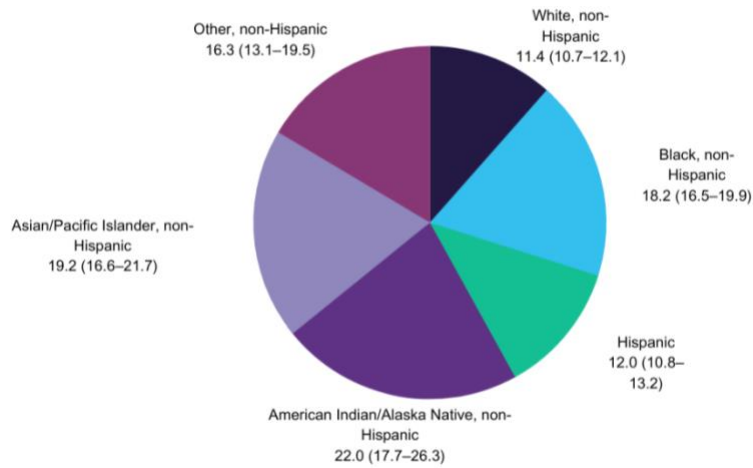
P<0.05 from a chi-square test of independence with a 95% confidence interval

The 2018 PRAMS data comes from 31 states (n = 32,656) in the US. Among those with a recent live birth, women with Medicaid health insurance had the highest rates of depressive symptoms at the time of delivery, compared with those with private health insurance and those without any type of health insurance.

Source: [CDC Pregnancy Risk Assessment Monitoring System Survey, 2018](#)



**Figure 1: Percentage of Prevalence of Self-reported Postpartum Depressive Symptoms Among Women with a Recent Live Birth, by Race/Ethnicity—Pregnancy Risk Assessment Monitoring System (PRAMS), 2018**

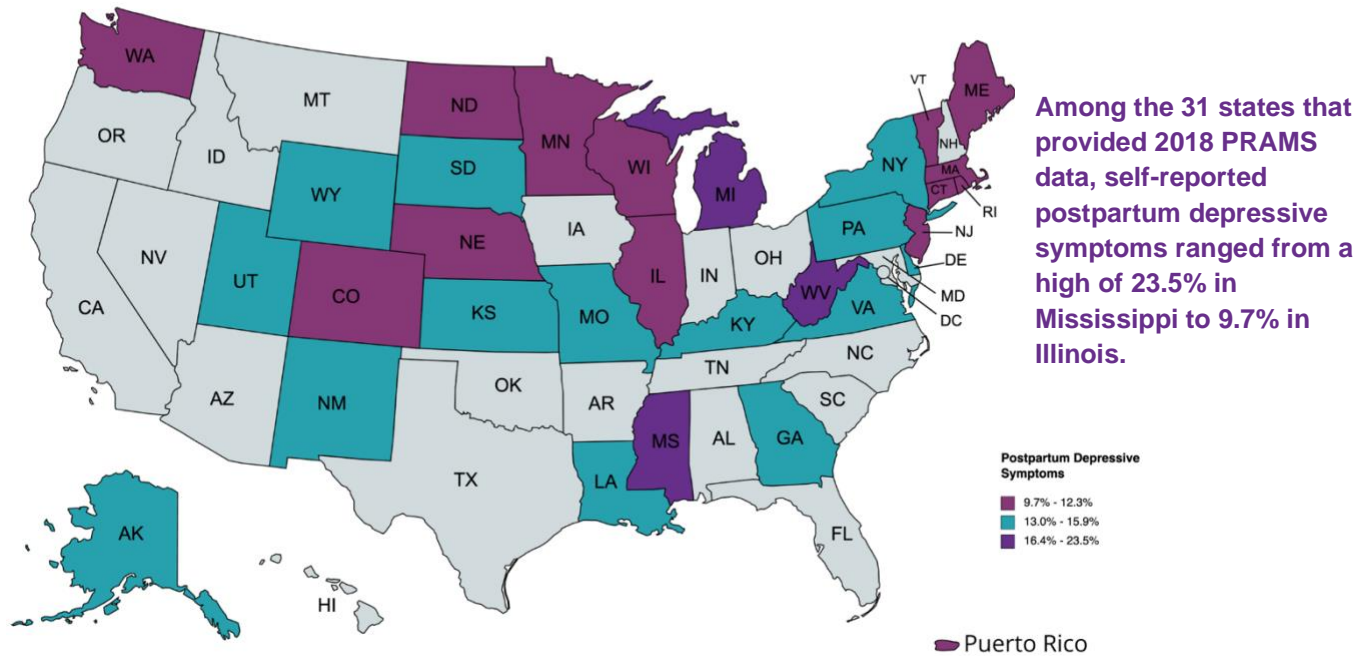


The 2018 PRAMS data comes from 31 states (n = 32,656) in the US. American Indian/Alaska Native women have the highest self-reported rate of postpartum depressive symptoms (22.0%), compared with non-Hispanic Asian/Pacific Islander (19.2%) and non-Hispanic Black (18.2%) women.

Source: [CDC Pregnancy Risk Assessment Monitoring System Survey, 2018](#)

P<0.05 from a chi-square test of independence with a 95% confidence interval

**Figure 2: Geographic Distribution of Self-reported Postpartum Depression, 2018**



Source: [CDC Pregnancy Risk Assessment Monitoring System Survey, 2018](#)



## Story Behind the Data: Factors Affecting Progress

Maternal mental health needs often go untreated or undertreated for several reasons. One challenge is a lack of research available on treatment regimens using psychiatric medications during pregnancy; another is a lack of information on how to prevent the onset of psychiatric illness during the perinatal period.<sup>11</sup> It also can be difficult for individuals and especially new parents to schedule, initiate, and sustain psychotherapy. Missed opportunities for screening and diagnosis by an obstetric care clinician could also lead to a failure to identify a mental health condition.<sup>11</sup> A pregnant patient's reluctance to divulge symptoms or mental health history can make screening and diagnosis even more difficult.<sup>11</sup>

According to data in the 2018 Pregnancy Risk Assessment Monitoring Systems (PRAMS) report from the Centers for Disease Control and Prevention, almost 80% of women who received prenatal care stated that they were asked about depression during pregnancy; however, this varied by race, ethnicity, geographic location, and socioeconomic status. People were more likely to report being screened for depression during a prenatal visit if they were younger ( $\leq 19$  and age 20 to 24), identified as non-Hispanic Black, Hispanic, American Indian/Alaska Native, or non-Hispanic Other; had received less education ( $\leq 12$  years); were not married; received WIC; were covered by Medicaid; smoked cigarettes during the last trimester; or had self-reported depression before or during pregnancy.<sup>9</sup> Puerto Rico (51.3%) and Mississippi (69.4%) had the lowest rates of prenatal depression screening in the US, while Minnesota (90.6%) and Alaska (90.7%) had some of the highest rates in the country.<sup>9</sup>

There also are racial, ethnic, geographic, and socioeconomic differences among those who receive screening during the postpartum period. The reported percentage of having a health care provider ask about depression during a postpartum visit was higher among women age  $\leq 19$  years who were White, American Indian/Alaska Native, or Other, and among those who self-reported depression before or during pregnancy.<sup>9</sup> Women in Puerto Rico (50.7%) and New York City (73.1%) had some of the lowest rates of being asked about depression during their postpartum visits compared with Minnesota (95.9%) and Vermont (96.2%).<sup>9</sup> Among the 87.0% of women who reported being screened for depression during their postpartum visit, 13.0% reported experiencing symptoms of depression.<sup>12</sup>

Health insurance coverage is another factor affecting progress in improving maternal mental health. Many individuals with health insurance coverage for mental health care experience challenges finding in-network providers; this can lead to higher costs, delays in receiving care, or avoidance of care altogether.<sup>12</sup> Low reimbursement rates for mental health care is at the root of this problem, along with restrictive health plan approval processes and plan coverage limitations, including restrictions on coverage of inpatient care under Medicaid and loss of Medicaid coverage 60 days after the end of a pregnancy for many low-income pregnant women. Other obstacles are a shortage of workers in the mental health workforce and a lack of community-based mental health care programs to meet community needs.<sup>12</sup>

Perinatal maternal mental health for veterans of reproductive age requires special attention because of women veterans' lower overall health status. Female veterans are more likely than non-veteran females to be overweight or obese, have painful musculoskeletal issues, be diagnosed with depression and/or post-traumatic stress disorder, engage in smoking, have

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### CALL TO ACTION

Undiagnosed and untreated perinatal mental health disorders negatively impact mothers, their babies, families, and communities. Policymakers and health care leaders should expand awareness of and access to evidence-based mental health education, screening, treatment, and support services. Frontline health care workers should be trained to screen, treat, or refer women for mental health care during the perinatal period, and those in need should be provided with care coordination and psychiatric support.



poorer self-reported physical and mental health, and have lower social support.<sup>5</sup> Women veterans see non-VA health care providers for perinatal care and then continue regular care with their primary VA provider. This system can result in compartmentalized care, especially when behavioral or mental health issues arise or exist.<sup>6</sup>

### What can be done to address the issue?

The [White House Blueprint](#) identifies actionable steps to address Action 1.14. In addition, experts from the maternal and child health field have identified innovative, evidence-informed strategies from several databases and national repositories.

### Maternal & Child Health (MCH) Innovations

*MCH experts selected the following resources for action after a review that included: the [MCHbest Database](#), a database developed to aggregate evidence-based strategies that can be used as is or adapted to fit local and state-level contexts; the [Association of Maternal & Child Health Program's Innovation Hub \(AMCHP\)](#), a searchable repository of local and state practices, policies, and community-based innovations considered to be “what’s working” in the MCH field; the [Robert Wood Johnson Foundation's What Works for Health \(RWJ\)](#) database, a tool that helps local communities to identify policies and programs that fit within their context and match their priorities; the [Maternal Health Learning & Innovation Center](#), a national resource for improving maternal health inequities; and a search of leading organizations and agencies working in this field.*

- [Anxiety and Depression Association of America](#). This organization offers reviews and ratings of 19 mental health apps, considering ease of use, effectiveness, personalization, availability of feedback, and strength of research evidence.
- [HRSA Strategy to Address Intimate Partner Violence](#). This initiative is an updated 2023–2025 strategic plan from HRSA to reduce intimate partner violence in the US.
- [Mind the Gap](#). A national collective impact coalition of women, families, and leading organizations addresses the US perinatal mental health crisis.
- [Mobile Mental Health](#). There is some evidence that mobile mental health services—known as mHealth and including text messaging and applications on digital devices—can be effective in addressing depression, anxiety, post-traumatic stress disorder, and substance abuse. mHealth has also been shown to reduce such barriers as transportation, insurance, and time. More research is needed to understand the effects of telemental health services during the perinatal period. (RWJ)
- [Moving Beyond Depression](#). A best practice from AMCHP’s Innovation Hub, this Ohio program evaluates mothers for depression who are participating in a home visit or another early childhood program. Coordination between the home visitor and therapist is crucial to the program. All program participants are regularly screened for depression. (AMCHP)
- [Nurse-Family Partnership](#). A scientifically supported home visiting program to support first-time mothers, NFP has been found to reduce maternal and infant mortality and morbidity, decrease substance abuse in mothers, and decrease unstable partner relationships. NFP nurses can be trained on factors related to perinatal depression, including assessment, referrals, and care coordination. (RWJ)
- [Perinatal Continuum of Care](#). Identified by AMCPH’s Innovation Hub as a cutting-edge practice from Colorado, this tool was developed to illustrate the myriad services that new

[National Maternal Mental Health Hotline](#). The 24-7 free hotline is a confidential tool for pregnant, postpartum, and new parents. It is available in English and Spanish (1-833-852-6262) and TTY (dial 711, then 1-833-852-6262).



and expectant families frequently encounter and describes opportunities to address perinatal mental health across these service sectors. (AMCHP)

- [Perinatal Depression Screening and Referral Project](#). Identified by AMCHP's Innovation Hub as an emerging practice, this project from the Connecticut Department of Public Health tested the feasibility of screening and establishing a referral system during prenatal, postpartum, and well-baby visits among women receiving services in Federally Qualified Health Centers. (AMCHP)
- [Postpartum Progress](#). This website and blog dedicated to maternal mental illness are widely recognized for their resources for perinatal women with depression or other behavioral conditions.
- [Postpartum Support International](#). PSI offers information for health care providers about depression and perinatal mental health disorders. PSI works to support people with perinatal mental health disorders during and after pregnancy and addresses postpartum depression through advocacy, policy, practice, and partnerships.
- [Telemental Health Services](#). There is some evidence that utilization of telemental health can improve mental health and may positively affect substance abuse, depression, suicide, and anxiety, and improve quality of life in multiple populations. More research is needed to understand the effects of telemental health services during the perinatal period. (RWJ)

### **State Maternal Health Innovations from the Health Resources & Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) Grantees**

The [State Maternal Health Innovations](#) (MHI) initiative, funded by [HRSA's MCHB](#), currently provides funding to 18 states to develop, implement, and evaluate state-level equity-centered innovations. Below we highlight innovations from the MHI cohorts (2019–2024) that address Action 1.14:

- [Illinois](#). The Illinois MHI, I PROMOTE-IL, developed and implemented [DocAssist](#), a free, statewide consultation and training that provides phone consultation services to primary care providers, nurses, nurse practitioners, and other health professionals to screen, diagnose, and treat the mental health problems of women during the perinatal period, including complications that can occur within the family. DocAssist also provides CME-eligible educational trainings for primary care clinicians, onsite practice consultations (where psychiatrists help providers develop ways to integrate regular perinatal mental health screenings into the practice routine), referral resources, and screening tools.
- [Montana](#). The Montana Obstetrics & Maternal Support initiative (MOMS) and Frontier Psychiatry are partnering to provide a free, statewide psychiatric consultation line for any clinician caring for the mental health of patients who are pregnant or in the postpartum period. The Psychiatric Referrals, Intervention, and Support in Montana (PRISM) line helps to increase providers' capacity to screen, assess, treat, and refer those experiencing maternal depression, anxiety, substance use, and related behavioral health disorders in rural and medically underserved areas of the state.

### **Evidence-based Strategy Measures from the [MCH Evidence Center](#) Related to Action 1.14**

Throughout the country, state-level [Title V MCH](#) agencies develop measures to help track their efforts around improving the health and well-being of women, children, and families. Below are selected measures related to improving equitable maternal and child outcomes that can support Action 1.14.



- Percentage of women who received a depression screening after delivery. ([American Samoa](#))
- Percentage of postpartum women with positive screenings for depression (using a validated screening tool) who will receive resources/education or referrals for professional services. ([TN](#))
- Number of local health departments that use the North Carolina Psychiatry Access Line (NC-PAL). ([NC](#))
- Percentage of Medicaid prenatal care providers who screen pregnant women for smoking, alcohol and drug use, domestic violence, and depression using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) tool. ([SC](#))
- Percentage of perinatal patients screened for depression. ([RI](#))
- Percentage of women screened in pediatric clinics at clinics. ([ND](#))
- Percentage of women receiving postpartum follow-up health care services within the first 4 to 6 weeks after delivery. ([IN](#) and [Marshall Islands](#))
- Number of women referred for an annual well-woman visit by a perinatal program. ([District of Columbia](#))

### Resources from the [MCH Evidence Center's Digital Library](#)

The [MCH Digital Library](#) is a digital repository of evidence-based and -informed toolkits, briefs, white papers, and more with seminal and historic resources. The following may support Action 1.14.

- Byatt N, et al. [Lifeline for Moms Perinatal Mental Health Toolkit](#). University of Massachusetts Medical School. 2019.
- Earls M. [Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice](#). The Committee on Psychosocial Aspects of Child and Family Health. *Pediatrics*. 2010;126(5):1032-1039.
- Maternal Mental Health NOW. [Perinatal Mental Health Integration Guide](#). 2018. Accessed September 27, 2023.

### Strategy Development Criteria to Consider for State and Local Implementation

To select impactful strategies for local implementation, an organization may consider using the following criteria, based on the Results-Based Accountability framework outlined in the book *Trying Hard Is Not Good Enough* by Mark Friedman.

- **Specificity:** Ensure strategies are clearly defined, including responsible parties and timelines.
- **Leverage:** Evaluate how strategies can improve data quality and reliability.
- **Values:** Assess alignment with community and organizational values.
- **Reach:** Consider feasibility and affordability at the required scale.

Using these criteria can aid in developing feasible and impactful strategies. Visit [maternalhealthlearning.org/Blueprint](https://maternalhealthlearning.org/Blueprint) for more details.





## References

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9. Bauman BL, et al. [Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression—United States, 2018](#). Morbidity and Mortality Weekly (MMWR) Rep 2020;69:575–581.
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11. American College of Obstetricians and Gynecologists. [Clinical Guidance 2023](#). Last updated 2023. Accessed August 11, 2023.
12. GAO Highlights. [Mental Health Care—Access Challenges for Covered Consumers and Relevant Federal Efforts](#). United States Government Accountability Office. March 2022. Accessed August 11, 2023.





The MHLIC is available for consultation, coaching, and technical assistance to support your implementation of any innovations to improve maternal mortality and morbidity. For more information, visit

<https://maternalhealthlearning.org/connect>.

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