Improving Maternal Mental Health in Women With Serious Mental Illness

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Abstract

Mental health during pregnancy and the postpartum period plays a crucial role in the overall health of both the mother and the baby. Women with serious mental illness—such as schizophrenia, bipolar disorder, and major depressive disorder—are at increased risk for negative maternal health outcomes. Many pregnant or postpartum women develop symptoms of mental illness for the first time during the perinatal period. Mental health and/or substance use disorders are also leading causes of maternal mortality in the United States. More attention and resources are needed to address mental health in pregnant and postpartum women. This paper identifies gaps in current maternal mental health systems and proposes strategies for improvement, drawing on promising practices.

Highlights

- Addressing mental health among pregnant and postpartum women with serious mental illness (SMI) is vital to improving parent, child, and family outcomes.
- State mental health leaders report multiple gaps in their mental health systems that serve pregnant and postpartum women with SMI, including a limited workforce, a lack of adequate perinatal mental health training, unequal or limited access to quality services, and a lack of mother–baby treatment units.
- Opportunities to improve maternal mental health among pregnant and postpartum women with SMI include universal screening, training and consultation programs, integrated care, maternal mental health peer support, home-visiting programs, and expanded access to mother–baby treatment units.

Recommendations

1. State leaders should ensure that the responsibility for maternal mental health is clearly defined at the state executive level and should foster collaboration across relevant agencies, including behavioral health, public health, Medicaid, and others.
2. Policymakers should consider establishing perinatal care quality collaboratives that prioritize maternal mental health.
3. State leaders should consider establishing universal screening programs for maternal mental health and develop reimbursement models to support them.
4. States should facilitate specialized perinatal psychiatric consultation for ob-gyns, primary care providers, pediatricians, and other providers via telehealth to augment workforce capacity.
5. States should invest in mother–baby units and home-visiting programs that screen for and address mental health needs while strengthening the mother–child dynamic within the family's natural environment.

Introduction

Mental health is a critical component of overall maternal health, with far-reaching implications for both maternal and child physical and emotional well-being. The relationship between a mother's physical and mental health is bidirectional and deeply intertwined, especially during pregnancy and the postpartum period (**Figure 1**). When the well-being of the mother is supported, the benefits extend beyond the individual to the entire family. Although women with prepregnancy SMI are at heightened risk for symptom exacerbation or recurrence during pregnancy and throughout the perinatal period, many women will experience the onset of SMI symptoms for the first time during the perinatal period. Support is therefore needed for women with existing SMI who become pregnant as well as for those who develop a new onset of SMI symptoms during the perinatal period. This paper is intended to assist mental health policymakers and providers in supporting the mental health of pregnant and postpartum women, including those with and at risk for developing SMI, to improve holistic health outcomes for women and families.

Figure 1: Definitions of Terms

Maternal health: health of women during pregnancy, childbirth, and postnatal period

Perinatal period: time frame surrounding childbirth, including the pregnancy and postpartum periods

Postnatal period: time frame immediately after childbirth, typically considered 6–8 weeks after birth; also part of postpartum

Postpartum: time after childbirth, typically considered up to 1 year after birth

According to the Centers for Disease Control and Prevention, mental health conditions and substance use disorders (SUDs) account for approximately 23 percent of pregnancy-related deaths.[1] They are the leading cause of maternal mortality among non-Hispanic White women.[2] Common mental health conditions during pregnancy and the postpartum period include depression (affecting 26–29 percent of women),[3] anxiety disorders (21 percent),[4] and substance use (22 percent of women report using at least one substance, including alcohol, tobacco, or cannabis).[5] While new-onset SMI is less common in the perinatal population, with prevalence estimates ranging from 0.1 percent to 9 percent, studies indicate that rates of SMI during this period are increasing.[6,7] Definitions of SMI vary across studies, complicating prevalence estimates.[8,9] Pregnant women with preexisting SMI also have more than five times the odds of using multiple substances compared to those without mental illness.[10]

Women with SMI who become pregnant face significantly elevated risks of adverse pregnancy, delivery, and fetal outcomes, even after accounting for medical and substance use comorbidities. Examples of adverse outcomes include preeclampsia, preterm birth, fetal distress, and other conditions.[11,12] Women with SMI are more likely to experience chronic physical health conditions such as obesity, diabetes, and thyroid disease, all of which independently increase the risk of poor maternal and fetal health outcomes.[13] In turn, chronic physical illnesses can heighten the risk of developing perinatal mental illness, further underscoring the interconnected nature of mental and physical health among this population.[14]

Postpartum psychosis, though rare, is a serious and potentially life-threatening condition that demands prompt attention. Postpartum psychosis occurs in an estimated 0.9–2.6 per 1,000 births.[15] Though exceptionally rare, untreated postpartum psychosis is associated with an

increased incidence of infanticide.[16,17,18] Postpartum psychosis typically emerges rapidly, most often in the first month after childbirth, and can include symptoms such as mood instability, psychosis, and cognitive disorganization.[19,20,21] The risk of postpartum psychosis is higher in women with a history of bipolar disorder, previous postpartum psychosis, or a first-degree relative who has had postpartum psychosis.[22] Women with postpartum psychosis who do harm to their infants are likely to become involved with state mental health services as many, though not all, are found not guilty by reason of insanity and placed in either state hospitals or community-based treatment settings. Thus, it is important to understand this rare phenomenon when developing policies and processes for managing and treating the needs of women exhibiting these devastating behaviors.

Maternal substance use, whether or not in the context of co-occurring mental illness, is also an extremely difficult situation that warrants attention. The rate of children being removed from families as a result of maternal substance use is on the rise and is one of the leading drivers of removal.[23] This can have ripple effects across generations. An array of requirements and services are being developed to combat this, including ensuring plans of safe care when children and babies are allowed to return home with a mother who has been using substances.[24]

Early screening and treatment for perinatal mental health conditions, substance use, and co-occurring physical health conditions are essential to prevent crises, ensure early intervention, and facilitate coordinated care. Among perinatal women who screen positive for depression, less than 30 percent attend an initial or subsequent mental health visit, and fewer complete a course of treatment.[25] Therefore, integrated care—addressing physical, mental, and substance use needs in a unified setting—is especially important given the bidirectional relationship between mental and physical health. Integrated care models can improve access, reduce treatment delays, and support better outcomes.[26,27] Obstacles to continued mental health treatment include stigma, fear of negative consequences, limited transportation, lack of childcare, and financial hardship.[28]

Effective treatment of mental illness during the perinatal period requires a comprehensive biopsychosocial approach. This includes mental health care, substance use treatment, physical health care, and support for psychosocial needs. Continuous risk screening for suicidal ideation, emerging depression or psychosis, or SMI symptom recurrence or exacerbation is necessary to ensure prompt intervention.[29] Mental health treatment may involve medication, which should be carefully evaluated in terms of risk and benefit, particularly in the context of untreated SMI.[30] Psychotherapy and other therapeutic interventions, as well as continued treatment of comorbid substance use and/or physical health conditions, may also play a role in recovery.

The presence of an SMI during the perinatal period can significantly affect both parent and child outcomes. Key interventions may include psychoeducation, support for parents and the parent-child dyad, and consistent monitoring of both parent and child outcomes.[31] Community-based interventions and peer support services can also be valuable in promoting recovery and resilience.[32,33] This paper will outline strategies that policymakers, providers, and leaders in the mental health field can adopt to improve outcomes for women and families, including improving outcomes for women with existing SMI who become pregnant and preventing or intervening early in new-onset perinatal mental health conditions.

Landscape Analysis of Innovative Programs and Gaps in Systems for Maternal Mental Health in States

States vary in their prioritization of the mental health needs of pregnant and postpartum women with SMI. Women with existing SMI face disproportionate barriers to receiving adequate perinatal care, experience elevated rates of obstetric (OB) complications, and face increased risks of adverse maternal and child health outcomes.[34,35,36] State leaders play a pivotal role in shaping policies, financing services, building infrastructure, and coordinating across systems to improve outcomes.

The National Association of State Mental Health Program Directors conducted a brief survey of states to better understand the landscape of maternal mental health services, including the state structure and responsibility for maternal mental health, as well as gaps that state leaders perceive as the largest barriers to improving outcomes for this population. Eight states responded to the survey.

STRUCTURE AND RESPONSIBILITY FOR MATERNAL MENTAL HEALTH

The responsibility for maternal mental health within the state structure varies widely from one state to the next. For example, responsibility for maternal mental health can fall under the state's mental health authority; public health department; or children, youth, and family services. Some states have shared responsibility or have multiple departments that have programs dedicated to or related to maternal mental health—sometimes overlapping with coordination and sometimes with a lack of coordination. Shared responsibility or a lack of clear responsibility designated for policies and programs specifically focused on maternal mental health may contribute to a lack of ownership and accountability. Maternal mental health touches many different sectors, including primary care, Medicaid, hospitals, public health, mental health, children's health, and others. Without state or local leadership to bring partners together to address the mental health needs of pregnant or postpartum women with SMI, the systems caring for these women often remain siloed and do not adequately address maternal mental health needs.

Out of the eight state mental health leaders who responded to the listserv questions, three reported that responsibility for maternal mental health falls under the state mental health authority (SMHA). Only one state reported that responsibility for maternal mental health falls fully under the public health agency, and the other four states reported that responsibility falls under multiple state departments. These departments primarily include the SMHA and public health agency, with one state also reporting private and nonprofit partners and another state reporting that the Medicaid program includes some maternal mental health initiatives. State leaders may not have collectively gathered to map where maternal mental health initiatives exist. Doing so could create opportunities to identify gaps and needs and promote each agency's programs and offerings.

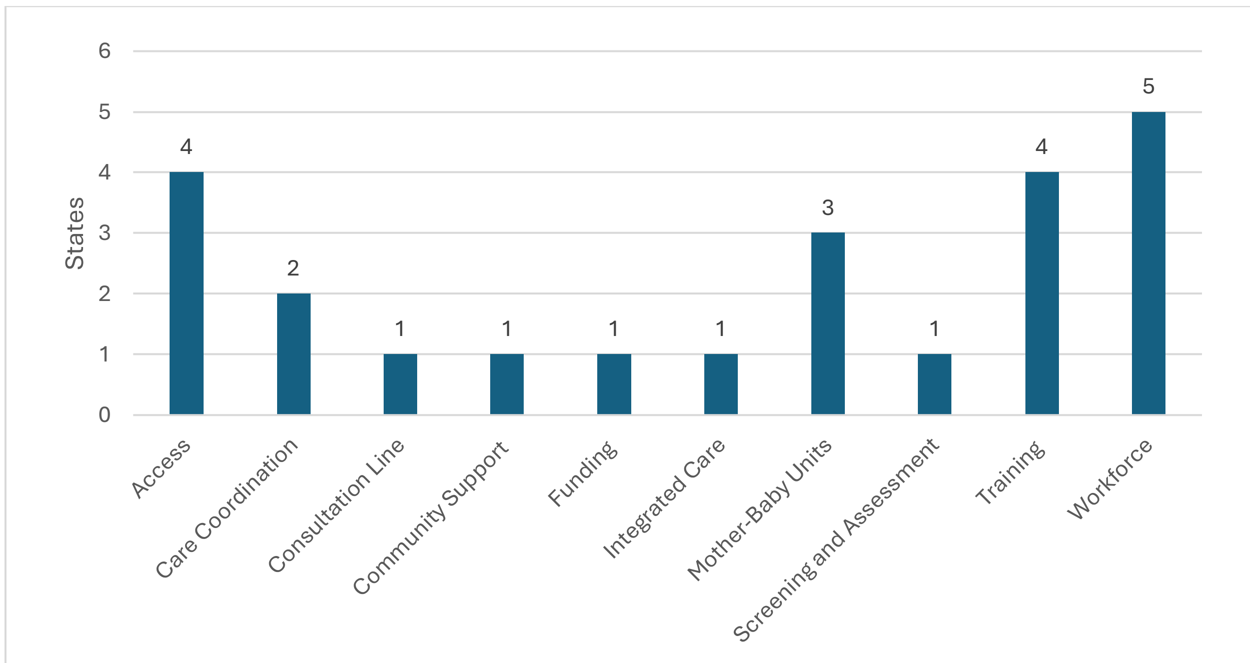
States may also have maternal mental health task forces, coalitions, or collaborations, which often are legislatively driven, with time-limited funding, or formed as a result of a governor's priorities. These task forces usually include state leaders, provider agencies, private-sector representatives, and others who form a committee that meets regularly to review current issues

and barriers to improved maternal mental health outcomes in the state and provide recommendations or develop strategic plans to guide future initiatives. Although the effectiveness of these task forces can vary, the presence of one generally indicates prioritization and leadership in this area. According to the Policy Center for Maternal Mental Health's 2025 state report cards, 13 states (Arizona; California; Washington, D.C.; Florida; Kentucky; Louisiana; Massachusetts; Maryland; New York; Ohio; Oregon; Texas; Utah) currently have or have had in the past 5 years a maternal mental health task force or strategic plan.[37] Additionally, 15 states (Colorado, Kansas, Kentucky, Louisiana, Massachusetts, Maine, Michigan, Missouri, Nevada, New Hampshire, Oklahoma, Virginia, Vermont, Utah, Washington) have a perinatal care quality collaborative that prioritizes addressing maternal mental health. These are state networks of multidisciplinary teams working to improve maternal and infant health outcomes.[38]

GAPS

States reported a variety of gaps in their systems for addressing mental health for perinatal women with SMI in their states (**Figure 2**).

Figure 2: Gaps or Barriers to Providing MMH Services to Women with SMI



Note: MMH = maternal mental health.

WORKFORCE

Maternal mental health workforce gaps—whether for preexisting SMI or new-onset mental illness—were the largest area of need identified by states. Workforce issues reported by states included a lack of availability of providers able to respond to and treat mental health issues in pregnant and postpartum women with SMI, including therapists and psychiatrists. This aligns with general workforce shortages across states, as there is a widespread lack of availability of most types of behavioral health providers.[39] According to the *2025 Maternal Mental Health State Report Cards* from the Policy Center for Maternal Mental Health, 40 states and DC meet the recommended ratio (1 per 5,000 births) of mental health prescribers with specialized perinatal training to the perinatal population.[40] However, only two states (Montana, Vermont) and DC meet the recommended ratio (5 per 1,000 births) of nonprescriber maternal mental health providers to the perinatal population.[41]

TRAINING

The lack of training of the current workforce, as well as the need for training resources for the future workforce, was the next most frequent gap mentioned by states in adequately addressing maternal mental health. Despite the high prevalence and significant risks associated with SMI during the perinatal period, many health care providers lack adequate training in maternal mental health.[42] Ob-gyns, primary care providers, and mental health professionals often report limited confidence in identifying and managing perinatal psychiatric disorders, especially postpartum psychosis.[43]

> “One need in our state is training and securing a more robust workforce to support maternal mental health for pregnant or postpartum women with serious mental illness. Currently, not enough providers are trained on the needs, symptoms of mental illness, and the system of care that is available for pregnant or postpartum women.”

ACCESS

Barriers to accessing treatment and supports for pregnant and postpartum women with SMI were the third most common gap reported by states. This was most often related to unequal access for different populations within the state, with cities and urban areas having better access to such specialized services and programming than do rural or frontier areas. For example, one frontier state reported that 40 percent of counties are maternity care deserts, without a hospital/birth center providing OB care and without any OB providers, making it less likely that perinatal individuals with or at risk for SMI will be able to access treatment and support. Additionally, 51 percent of counties do not have an active licensed addiction counselor, and 37 percent of counties don’t have a psychologist or psychiatrist working there.

MOTHER–BABY UNITS

In severe cases, hospitalization of the mother may be necessary. When psychiatric hospitalization is required, coordination with obstetrics-gynecology (OB-GYN) is critical. Many psychiatric inpatient units are reluctant to admit pregnant women, especially those close to delivery. In such cases, admission to the OB-GYN unit with close psychiatric monitoring may be needed. A conference of practitioners is recommended to determine what would be in the best interest of the mother and baby. Pregnancy should not be a barrier to accessing inpatient

psychiatric or OB-GYN care when needed, and policymakers should work to address any barriers to obtaining this care.

Mother–baby units can offer critical and supportive interventions for postpartum women with SMI who require inpatient hospitalization. These units provide comprehensive psychiatric care while allowing mothers to remain with their infants, but they are significantly lacking in the United States.[44] This co-admission model promotes mother–infant bonding, supports breastfeeding, and reduces the trauma of separation during a vulnerable period.[45] Research suggests that mother–baby units lead to improved maternal mental health outcomes, including reduced depressive symptoms and enhanced parenting confidence, while also promoting better developmental outcomes for infants.[46,47] The lack of availability of such programs to support postpartum women with SMI was a significant gap mentioned by states, with potential solutions described later in this paper.

> “Our state faces the challenge of not having an option for in-state care for perinatal women with serious mental illness who meet criteria for higher levels of care, where they can still be with their babies and need to travel to an out-of-state facility to receive such treatment.”

State Implementation of Promising Practices and Programs

SCREENING

Universal screening for maternal mental health conditions involves implementing standardized protocols within the healthcare system to screen all women who are pregnant or postpartum.[48] This approach has been widely adopted in many areas of health care to identify individuals at risk for, or in the early stages of, a condition to enable timely intervention, reduce symptoms, and lower healthcare costs.[49] Examples include newborn screenings for various diseases[50]; cancer screenings such as mammograms and colonoscopies; and routine monitoring of blood pressure, glucose, and cholesterol.[51]

Professional medical organizations have issued guidelines recommending screening at various points in maternal, medical, and psychiatric care. The American College of Obstetricians and Gynecologists recommends screening for depression and anxiety at the initial prenatal visit, later in pregnancy, and during postpartum visits.[52] Similarly, the American Academy of Pediatrics recommends screening for perinatal depression at the 1-, 2-, 4-, and 6-month well-child visits.[53]

Training providers on the appropriate use of screening tools is essential, especially across specialties and for specific mental health conditions. The American Psychiatric Association provides guidance on screening and recommended tools for conditions including perinatal depression, anxiety, trauma and post-traumatic stress disorder, bipolar disorder, obsessive–compulsive disorder, psychosis spectrum disorders, and SUDs.[54] At the state level, for example, the Ohio Perinatal Mental Health Task Force has prioritized screening promotion by identifying and distributing protocols and educational resources to equip providers with the knowledge and tools to screen effectively.[55]

Integrated or collaborative care models can further support universal screening efforts. Embedding mental health professionals within physical healthcare settings facilitates both screening and access to treatment for those who screen positive. This approach has been shown to improve outcomes for women with perinatal depression.[56] For example, the MOMCare Program within the Seattle–King County Public Health System uses a collaborative care approach that includes mental health professionals and the individual's OB provider. Pregnant women are screened using a patient health questionnaire to assess depression symptoms during visits with a Maternity Support Services social worker. Treatment and follow-up are then more easily provided in a coordinated and timely way.[57] Similarly, Montana's Meadowlark Initiative model of care includes universal screening for anxiety, depression, substance use, and social needs at all Initiative sites. In the event of a positive screening result, behavioral health care is generally available on-site in the same visit. Care coordinators are also available to follow up on any social needs identified.[58]

Policymakers can also leverage performance and monitoring standards to drive screening adoption and ensure connection to care. Health plan accreditation standards and state Medicaid managed care organization contracts often include quality improvement requirements that can encompass perinatal mental health screening rates. The National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set measures include Prenatal Depression Screening and Follow-Up[59] and Postpartum Depression Screening and Follow-Up metrics,[60] which track the percentage of pregnant and postpartum women screened during and after pregnancy as well as the percentage of those with positive results who receive follow-up care. In 2025, the Policy Center for Maternal Mental Health analyzed HEDIS perinatal screening rates of Medicaid enrollees by OB providers and identified Pennsylvania, California, Wisconsin, and Washington as top-performing states.[61] Additionally, Arizona, California, Oregon, and Virginia have incorporated perinatal screening requirements into their Medicaid managed care organization contracts.[62]

Ensuring reimbursement for screening through Medicaid and private insurance is also critical to achieving universal screening. Policymakers should work to ensure that screenings are reimbursable at both OB appointments and well-child pediatric visits. In Colorado, allowing Medicaid reimbursement for postpartum depression screening at well-child visits led to increased screening and treatment rates.[63] The Policy Center for Maternal Mental Health has also advocated for OB-provider screening to be reimbursed as preventive care, separately from bundled maternity services.[64]

Finally, many states are advancing universal screening through legislation. The Policy Center for Maternal Mental Health continues to track state-level bills related to maternal mental health, offering a valuable resource for policymakers seeking to promote universal screening.[65] To promote universal maternal mental health screening, policymakers can seek to establish standardized screening protocols, including when and where screening should occur; disseminate and train providers on the use of validated screening tools; promote integrated care models; and facilitate uptake through reimbursement mechanisms and performance standards.

TRAINING AND CONSULTATION

Behavioral health providers often lack formal training in perinatal mental health, leading to gaps in their ability and self-efficacy to recognize, assess, and treat such conditions effectively.[66,67,68,69] According to the Maternal Mental Health Leadership Alliance, there are fewer than 500 psychiatrists in the United States who specialize in perinatal mental health.[70] A 2017 survey found that only 36 percent of psychiatry residency program directors believed their residents required competencies in perinatal mental health.[71] In addition, behavioral health providers may have particular perceptions of barriers to providing psychopharmacological therapies for pregnant and breastfeeding women.[72]

Obstetricians, midwives, or primary care providers typically serve as the primary or sole point of contact to care for women during the perinatal period. A woman receiving routine perinatal care will see a physical health care provider (i.e., obstetrician, primary care provider, midwife, or pediatrician) 20–25 times during her pregnancy and the first year of her baby's life. These providers are therefore well positioned to screen for perinatal mental illness, treat where appropriate, and/or connect with the qualified provider. However, these providers may not feel equipped to screen for, refer for, or manage mental illness in their practices independently due to a lack of training and/or liability concerns.[73,74] Importantly, women receiving care from OB providers often perceive these providers to be inadequately trained in assessing and addressing mental health concerns as well.[75] Lack of training or willingness to screen for and address mental health concerns contributes to underdiagnosis and undertreatment as opportunities for timely intervention are often missed. Moreover, systemic barriers—including time constraints, stigma, fragmented care systems, and lack of integrated behavioral health services—further impede effective treatment.

Notably, women with preexisting SMI may receive their main health care through a mental health center and may not be accessing perinatal mental health care or OB care. Unfortunately, because people with SMI are at risk for criminal court involvement, women with SMI who are pregnant may be receiving care in carceral settings. Linkages to treatment and monitoring for these women, whether in the community or in other systems, are critical.

The implementation of perinatal psychiatry access programs (PPAPs) aims to close the gap in maternal mental health care by providing support to health care providers. PPAPs are designed to address the significant gap in maternal mental health services by supporting primary care providers, obstetricians, pediatricians, and other clinicians in managing mental health conditions among pregnant and postpartum women. These programs typically offer psychiatric consultation, care coordination, and provider education, allowing clinicians to receive expert advice on diagnosis, treatment planning, and medication management. The model helps integrate mental health care into routine perinatal care settings, making support more accessible for individuals being served.[76,77]

One of the key successes of this model lies in its ability to expand access to mental health care in a timely and cost-effective manner. Programs like the Massachusetts Child Psychiatry Access Program for Moms and Access Mental Health for Moms in Connecticut have shown that these services can significantly increase the number of providers equipped to identify and treat perinatal mood and anxiety disorders.[78,79] In Massachusetts, for example, Massachusetts Child Psychiatry Access Program for Moms has led to increased screening and treatment of perinatal

mental health conditions, with thousands of consultations provided annually to help clinicians manage care effectively.[80]

These programs typically operate through a centralized consultation line staffed by perinatal psychiatrists and care coordinators who are available during business hours to respond to clinicians' questions. In addition to offering real-time consultations, many PPAP programs offer referral support and resource directories, connecting individuals being served with local therapists, support groups, or higher levels of psychiatric care when needed. The flexibility of this model supports integration into a variety of clinical settings, including rural areas where access to specialized mental health care may be particularly limited.[81]

Successful implementation of PPAPs hinges on several key strategies. First, strong stakeholder engagement—including collaboration with state health departments, health systems, and professional organizations—ensures sustainability and reach. Second, continuous education for providers on the importance of maternal mental health and how to use the access program empowers them to engage confidently. Third, robust data collection and evaluation are crucial for demonstrating impact and securing funding. For instance, Vermont's expanding consult line is supported by training, measurement, and quality improvement efforts to ensure consistent delivery and outcomes.[82,83]

To further support these efforts, national organizations such as Postpartum Support International (PSI) have established a national psychiatric consultation line, providing additional infrastructure to replicate and scale the model.[84] As more states adopt this approach, a network of regionally tailored but nationally connected programs is emerging, helping to close critical gaps in maternal mental health care across the country. The National Network of Perinatal Psychiatric Access Programs is home to information on all existing state-level PPAPs in the United States.[85]

Women in the perinatal period may also interact with specialists and social service providers beyond obstetricians, midwives, or primary care providers. These may include perinatal doctors, nurses, home visitors, case workers, lactation consultants, behavioral health workers, and others. It is ideal, therefore, that all clinicians and service providers who may interact with women in the perinatal period have at least a basic capacity to recognize maternal mental health concerns and connect with perinatal behavioral health care. There are several strategies that state and other behavioral health system leaders can pursue to expand the capacity of behavioral health, physical health, and social service providers.

Providers of adult psychiatry training, as well as graduate programs in psychology, social work, and counseling, can be encouraged to incorporate perinatal mental health modules into their core curricula, and developing fellowships focused on perinatal mental health within psychiatry and clinical psychology can cultivate future leaders in the field. Health systems, academic institutions, and public health agencies can collaborate to create such programs, particularly in specific geographic areas lacking perinatal mental health specialists. Training programs rooted in community health centers and Federally Qualified Health Centers can strengthen client-centered and responsive care and build trust with high-risk populations. Behavioral health providers can be encouraged to pursue perinatal mental health training through financial incentives such as loan forgiveness programs, scholarships, or salary enhancements.

Certification programs provide structured pathways to acquiring expertise. Validated and evidence-based certification programs can be utilized by SMHAs and provider organizations to improve the capacity of their workforces. PSI offers evidence-based training curricula and validated certification exams for mental health providers, psychopharmacological prescribers, and affiliated professions (such as peer specialists, nurses, doulas, lactation consultants, community health workers, and others).[86] To enable providers to fulfill the base training requirements to pursue this certification, the Policy Center for Maternal Mental Health has created its Maternal Mental Health Certificate Training for Mental Health and Clinical Professionals in collaboration with PSI.[87] The National Curriculum in Reproductive Psychiatry is an online, interactive curriculum for mental health professionals. The curriculum can be pursued independently or integrated into an existing educational program such as psychiatric residency.[88] Funding access to these programs and integrating certification into professional development requirements would increase the number of trained providers.

Some state agencies have chosen to create or replicate their own, customized training modules in this space as part of their PPAPs or independent of these programs. Online training modules for OB providers have shown promise in improving knowledge and self-efficacy regarding perinatal depression. Studies have demonstrated that web-based training programs for OB providers can significantly improve knowledge, attitudes, and clinical confidence regarding perinatal depression.[89,90,91] Online modules ideally should incorporate case-based learning, simulated patient interactions, and embedded assessment tools to reinforce learning and translate knowledge into practice. Online training offers scalable and accessible educational opportunities, especially in resource-limited or rural settings where in-person training may not be feasible. Digital modules allow providers to learn at their own pace and revisit materials as needed, which can be crucial for sustained behavioral change. From a policy standpoint, integrating standardized online perinatal mental health training into licensure or continuing medical education requirements could promote consistent screening and management across systems.

MATERNAL MENTAL HEALTH PEER SUPPORT

Peer support services are an evidence-based practice in which qualified professionals with lived experience of mental health and/or substance use challenges, along with specialized training and often state certification, provide support to others facing similar issues. Peer support workers offer emotional, informational, and instrumental support grounded in empathy, shared understanding, and respect. These professionals fill a critical role in the behavioral health workforce, particularly amid ongoing workforce shortages that affect access to behavioral health care across the United States.

Research supports the effectiveness of peer support in improving maternal mental health outcomes for women with SMI. Peer support delivered by individuals with lived experience of perinatal mental health challenges has been shown to foster trust, reduce stigma, and increase engagement with services.[92] Mothers with SMI often face complex barriers to care, including fear of child welfare involvement, social isolation, and internalized stigma, barriers that peer support professionals are uniquely positioned to address.[93]

Perinatal peer support programs can also serve as a bridge to clinical mental health care and social services for women who may otherwise distrust or avoid clinical providers while helping women navigate the complex medical, pediatric, and social support systems. Evidence suggests that peer support is a cost-effective service model for individuals with perinatal mental health challenges by preventing hospitalization and lowering treatment costs.[94] Evidence also suggests that peer support can reduce service disengagement and improve continuity of care, especially among mothers with SMI.[95]

The Substance Abuse and Mental Health Services Administration s 2024 report, *Financing Peer Recovery Support: Opportunities to Enhance the Substance Use Disorder Peer Workforce,* offers challenges and opportunities to finance and strengthen the peer recovery support services workforce.

Perinatal peer support can be implemented in a state system in a variety of ways. The following are two examples for other states to consider:

Perinatal Outreach & Encouragement for Moms

Perinatal Outreach & Encouragement (POEM) for Moms is a peer support and care navigation program for moms with mental health challenges in Ohio. Under the direction of Mental Health America Ohio, the POEM program employs perinatal peers who provide phone-based support to pregnant and postpartum women with mental health needs. In addition to taking self-referrals, the POEM program takes referrals from any type of provider, including OB physicians, doulas, and midwives. Once a referral is made and consent is given to share contact information, a peer will reach out to the individual within 24 business hours. There is no intake or diagnosis assessment, and the peer will work with the individual for as long as she needs through the perinatal period. The average duration of support is 3–4 months. The program serves approximately 2,000 participants a year. Program administrators attribute its success to consistent, dependable, and rapid follow-up and strong relationships with referring providers.[96] Through the success of the program, the Policy Center for Maternal Mental Health has partnered with POEM to develop a national offering of a maternal mental health add-on training for peer support specialists. An evaluation conducted by the Cummings Graduate Institute for Behavioral Health Studies and published in December 2024 found that the majority of participants in the training demonstrated significant improvement in their knowledge of evidence-based perinatal mental health interventions.

Northeast Georgia Medical Center's Peer Recovery Support program

Through an innovative public–private partnership, a large hospital system in Northeast Georgia offers peer support services in its neonatal intensive care unit (NICU) and labor and delivery unit for mothers who are on a path to recovery from SUD via the Northeast Georgia Medical Center's Peer Recovery Support program. The model has great potential to be adapted to serve mothers with mental health needs, though it primarily focuses on substance use and co-occurring issues. Four to six peer coaches are employed and funded by the state at any given time. Introducing peer coaches helped to address stigma from staff surrounding mothers with SUD and/or mental health challenges. The program has evolved to best meet the needs of families. For instance, mothers are now roomed in with their babies, even when an infant requires extended NICU care. Peer coaches follow up with families after

discharge by phone, text, or in-person meetings. They also partner with child welfare to report on progress and support family preservation. The program has achieved significant success in improving outcomes for infants and families, reducing the average length of stay in the NICU for babies with neonatal abstinence syndrome from 30 days to 11.

INTEGRATED CARE DURING PREGNANCY AND POSTPARTUM PERIODS

Integrated care models either co-locate or coordinate treatment from both physical and mental health providers. For pregnant or postpartum women with SMI, integrated care can include behavioral health integration within OB-GYN outpatient clinics, labor and delivery units, or even pediatric settings. Frequently, these models also incorporate traditional social support services such as benefits or housing assistance as well as perinatal-specific services like lactation consulting or child development specialists.

Research has shown that alone is not enough to engage women with perinatal mental illness into treatment; integrating care into outpatient perinatal settings increases participation in treatment two- to fourfold.[97] Integrated care addresses the fragmented health system often experienced by pregnant and postpartum women, as birthing hospitals, OB-GYN clinics, and perinatal centers may be unaware of the community resources to support mothers.

Evidence supports the effectiveness of integrated care in improving maternal mental health both in the United States and internationally. For example, a study of mothers with infants in a NICU found that family-integrated care improved depression and post-traumatic stress disorder outcomes, particularly among mothers experiencing high stress.[98] An evaluation of a model embedding a psychiatrist and a case manager in an urban pediatric practice serving primarily low-income families found significant improvements in treatment engagement and maternal mental health symptoms.[99] The MOMCare program in Washington state reduced depression severity and was cost-effective.[100] Internationally, a postnatal integrated care program in Japan significantly reduced suicidal ideation at 3–4 months postpartum, a critical risk period for perinatal suicide.[101]

Despite these benefits, implementation barriers exist. OB and midwifery practices often have high volumes of individuals being served and short appointments, leaving little time for screenings for support services.[102] A qualitative study of clinicians' perspectives on integrating mental health into perinatal care found that nurse-midwives and OBs felt they did not have the time or bandwidth to adequately address mental health needs; therefore, conducting screenings or asking about mental health issues felt uncomfortable, or they felt as if they were doing a disservice to the individuals served by asking without being able to address the issues.[103] The only tool they felt that they had was to prescribe common psychiatric medications. In contrast, mental health clinicians participating in an integrated care model felt they were being pulled into

Multiple published guides exist for best practices on implementation of integrated care for pregnant and postpartum women:

- American College of Obstetricians and Gynecologists' *Guide for Integrating Mental Health Care Into Obstetric Practice*
- World Health Organization's *WHO Guide for Integration of Perinatal Mental Health in Maternal and Child Health Services*
- Agency for Healthcare Research and Quality's information about behavioral health integration for pregnant and postpartum women

various roles beyond their scope, disrupting their care of individuals being served. The study results also suggested that mental health and perinatal health clinicians had different ideas of what constituted mental health issues, which sometimes resulted in mental health clinicians' being consulted for individuals experiencing normal emotional swings during pregnancy and the postpartum period.[104]

Below are two examples of successful integrated perinatal care programs:

RHODE ISLAND COLLABORATIVE CARE MODEL FOR PERINATAL DEPRESSION SUPPORT SERVICES

The Rhode Island Collaborative Care Model for Perinatal Depression Support Services program, established in 2017 across five OB offices within a large academic medical center, serves approximately 3,500 women annually. A woman is referred to the program after a positive depression screening or by her OB clinician. A licensed clinical social worker care manager conducts a psychiatric diagnostic evaluation and develops an initial care plan with the individual being served and her OB clinician. Treatment decisions are made using a shared decision-making approach, and psychiatric consultation is provided if needed. Psychotherapy is available in-office, and referrals to higher levels of care, such as a partial hospitalization, are made while individuals being served continue to be monitored for up to 12 months postpartum through a web-based platform, with periodic screenings to monitor treatment response, relapse, and/or remission.[106] A cohort study comparing outcomes of before and after Collaborative Care Model for Perinatal Depression Support Services program participation found increased depression screening, higher treatment uptake for positive screens, and more frequent inclusion of psychotherapy compared with pharmacologic-only approaches.[107]

Collaborative care is a specific model of integrated care that is a health-systems approach to integrating mental health services into primary care. The core principles of collaborative care include [105]:

- Patient-centered team care
- Population-based care
- Measurement-based treatment to target remission
- Evidenced-based interventions

MATERNAL AND FAMILY CARE CENTER IN NEW JERSEY

CarePlus NJ, a certified community behavioral health clinic, operates the Maternal & Family Center, an integrated care model for women who are trying to conceive, are currently pregnant, are postpartum, or have experienced pregnancy or child loss. Services address maternal mental health needs for up to 2 years postpartum and support the whole family, including specialty services for young adult pregnancy. The program treats conditions such as postpartum psychosis, mood disorders, trauma, and SUD, coordinating with primary care, ob-gyns, or external mental health professionals as needed. Individual, family, and couples counseling is available, along with support groups for fathers, spouses, and individuals who have experienced pregnancy or infant loss. Online referrals provide direct access to care, with a telehealth intake being completed within 48 hours of contact.

MOTHER–BABY TREATMENT UNITS

As mentioned above, mother–baby units are inpatient or residential programs where the mother receives treatment for her mental health and/or SUD and the baby is allowed to be admitted with her. These programs allow mothers to receive treatment while protecting and strengthening the mother–infant bond and enabling breastfeeding. They prevent the trauma of separation in the critical 1st months after birth, while ensuring both mother and infant are safe. Mother–baby treatment programs are particularly designed to protect the mother–infant attachment, maternal functioning, and the mother's role in the family while addressing psychiatric needs.[108]

Mother–baby units and programs are particularly important for pregnant and postpartum women with SMI, who are at high risk for serious perinatal mental health issues such as postpartum depression or psychosis and may require intensive care. Postpartum psychosis can impair mother–infant interaction, with child custody involvement more likely among women with schizophrenia than first-time postpartum psychosis.[109] Women with bipolar disorder face a 30 percent increased risk of postpartum psychosis, making psychiatric treatment during pregnancy or soon after delivery crucial.[110] Additionally, 60 percent of women with postpartum psychosis will develop recurring symptoms, highlighting the need for long-term planning for maternal mental health, infant development, and parental functioning supports.[111]

A systematic review of 53 studies published from 2016 to 2024 found consistent evidence that mother–baby units improve maternal mental health and mother–infant attachment.[112] A 2017 review of 44 studies of individual mother–baby units had similar findings,[113] and a third review published in 2015 reported improved maternal mental health and mother–infant relationship and an absence of adverse effects on child development.[114] A study of mothers admitted to a mother–baby unit compared to a general psychiatric inpatient unit found no differences in hospital readmission rates within 12 months postdischarge.[115] Of 279 women in the study across 42 healthcare organizations in England and Wales, there were no differences in the cost-effectiveness of the intervention or perceived bonding between the mother and child. However, service satisfaction was significantly higher among women who received care in mother–baby units.

Descriptive studies of mothers in mother–baby units can also provide insights into implementation considerations. A study of women with psychotic disorders admitted to a mother–baby inpatient unit found that most (70 percent) did not require social services supervision or exhibit parenting issues, as judged by clinical staff, at time of discharge. However, women with schizophrenia were more likely to require social services supervision compared to those with psychotic depression.[116] Women with lower socioeconomic status or partners with psychiatric illness were also more likely to require social services supervision or have staff-rated challenges with practical baby care. These results suggest interventions addressing socioeconomic challenges, early psychosis treatment, and partner care could improve parenting outcomes.

A study in Australia of women with severe postpartum psychosis admitted to a mother–baby unit found most infants had appropriate development, with only a small minority showing concerns.[117] Most women were admitted involuntarily, but all infants were able to be discharged with their mothers after treatment. One-third of individuals served maintained some breastfeeding.

Mother–baby units are standard in the United Kingdom and many European countries but are rare in the United States. Those that do exist often serve privately insured individuals rather than Medicaid beneficiaries. In fact, one report noted that no psychiatric inpatient hospital in the United States allows for the infant to stay 24/7 with the mom, despite strong evidence that these programs improve maternal mental health, physical health, parenting outcomes, attachment, bonding, breastfeeding, and infant outcomes while ensuring safety.[118] State survey results cited mother–baby units as a top gap in meeting the mental health needs of pregnant and postpartum women with SMI. Significant barriers to implementation of mother–baby units exist in the United States, including legal regulations and insurance coverage restrictions, which policymakers should address.

Lessons for implementation in the United States can be learned from the 60-year history of mother–baby units' operation in the United Kingdom and elsewhere. The UK model emphasizes integration of mother–baby units within the perinatal community psychiatric team to ensure that the needs of mothers and their infants are met before, during, and after their inpatient stays.[119] They estimate that one mother–baby unit bed should be available for every 2,000 women who give birth.[120]

Below are three examples of U.S.-based mother–baby intensive psychiatric service programs:

UNIVERSITY OF NORTH CAROLINA PERINATAL PSYCHIATRIC INPATIENT UNIT

The University of North Carolina Department of Psychiatry, Center for Mood Disorders, operates a Perinatal Psychiatric Inpatient Unit in Chapel Hill. The locked five-bed inpatient unit serves perinatal women and allows infants for extended daytime visitation to support bonding, attachment, and breastfeeding if desired. The unit has specialty-trained perinatal mental health, lactation consultants, hospital-grade breast pumps, and storage options for breastmilk. Rooms are equipped with gliders, bassinets, and other baby products. OB-GYN consultation, nutritional counseling, and spiritual support from perinatal-trained chaplains are available. The average length of stay in the program is 7–10 days, and women are often connected to outpatient perinatal psychiatric programs after discharge. A program evaluation published in 2013 showed significant improvements in maternal depression, anxiety, suicidal ideation, and overall functioning following discharge.[121]

MICHIGAN MOTHER & BABY INTENSIVE DAY PROGRAM

Pine Rest in Michigan is a short-term, intensive, partial hospitalization day program for women with perinatal mental health issues. The program provides psychiatric treatment in a setting with a nursery for infants up to 8 months, supporting mother–baby bonding and eliminating childcare or breastfeeding barriers. For infants 9 months and older, childcare is provided through a partner agency. A specialty-trained, multidisciplinary team offers psychiatry, medication review, case management, and aftercare planning. Daily group therapy and education sessions allow mothers to bring their babies and provide peer support, skill building, and strategies for managing symptoms while caring for their children. Pregnancy and lactation considerations are prioritized, and the program can serve as a step-down after inpatient hospitalization. While privately funded and limited in availability, the program serves as a model for other states to consider. An evaluation of individuals served from 2019 to 2021 found large decreases in

depression and anxiety symptoms as well as clinically significant improvements in mother–baby bonding, with reductions in maternal rejection, anger, or anxiety toward the baby.[122] These results indicate that the program improves maternal mental health and enhances the child's neurobiological, social, emotional, and cognitive development through strengthened bonding.[123]

"The fact I could bring my son with me was really a blessing. It made the experience more positive, rather than adding more trauma by being apart. I was also able to continue breast feeding, which was really important to me."

—Pine Rest patient

MARYLAND RESIDENTIAL TREATMENT CENTERS FOR WOMEN AND THEIR CHILDREN

Maryland's SMHA supports multiple residential treatment programs for women with SUD and co-occurring mental illness throughout the state. In these residential programs, women can bring their children with them. Women admitted to these programs often are escaping domestic violence or abuse, have complex trauma, and may have a history of criminal justice involvement. Although not specifically focused on perinatal mental health concerns, the programs provide shelter and safety for the women and their children while working on keeping the families together and providing comprehensive mental health, substance use, and recovery services.

For example, Chrysalis House in Crownsville, Maryland, provides mental health and substance use treatment services as a residential treatment program, while allowing the women's children to live onsite. Family preservation, parenting skills, dual diagnosis services, and employability, in addition to recovery from SUD and mental illness, are the central focus of treatment services. Chrysalis has 50 beds for women and their children, and a child development center is onsite for childcare needs for younger children not in school. The program works closely with Child Protective Services in keeping families together, if possible, while providing comprehensive recovery services that empower women to build better lives for themselves and their children.

HOME VISITS

Home-visiting programs for maternal mental health support are implemented across the world to support women and their families with mental health screening, psychoeducation, case management, and social support in the home environment.[124] The structure of these programs can vary widely in frequency, duration, and type of provider, though there are some recognized programs including Parents as Teachers and Healthy Families America. While the primary intent of home-visiting programs is to lessen stressors of parenthood for women who have adverse social determinants of health like low socioeconomic status or who have histories of trauma, they can also address whole-person and whole-family health by providing services for physical, mental, and infant health, all in the home environment.[125]

Montana has created a statewide training curriculum and certification process for recovery doulas, who are doulas with specialized training in substance use treatment and recovery. The state is currently developing an additional training and certification process for recovery doulas working with tribal communities.

Evidence supports the implementation of home-visiting programs for supporting pregnant and postpartum women with SMI. A scoping review of literature published in 2022 found that home-visiting programs can provide treatment for perinatal depression and reduce the effects of depression for birthing women and that they are most effective when started before birth of the infant.[126] An evaluation of the national Parents as Teachers home-visiting program found that while mothers who had major depressive disorder or postpartum depression had fewer months participating in the program, those who accessed additional mental health services were able to engage in the home-visiting program more effectively.[127] A randomized controlled trial of a 1-year follow-up of a nurse home-visiting program for pregnant women experiencing adversity that comprises 25 home visits until the child is age 2 years found that women enrolled in the program had significantly improved mental health symptoms, including depression, anxiety, and stress, as well as improved self-efficacy.[128]

Although national models exist, funding is often a barrier to widespread implementation. Most insurers do not cover the care of doulas or perinatal community workers who provide home-visiting services, and as of 2024, only three state Medicaid programs provided coverage for these services.[129] About half the states provide Medicaid coverage for doula services.[130] This is despite the fact that home-visiting programs have been shown to be extremely cost-effective, with one study reporting that for every $1 invested in home visiting, $3 was saved in emergency department costs.[131]

INFANT MENTAL HEALTH HOME VISITING MODEL IN MICHIGAN

Michigan has a Medicaid-funded home-visiting program called the Infant Mental Health Home Visiting model. It is a home-based, dyadic, therapeutic intervention that supports maternal mental health and mother–baby attachment relationships. The services are provided by masters-level early childhood mental health professionals who also provide case management services and offer developmental guidance and emotional support to the family. The infants or toddlers and caregivers receiving these services are referred due to their exposure to a range of factors that could place the infant or toddler at risk for developing a variety of emotional, behavioral, social, and cognitive delays, including psychiatric illness in the mother. The program is focused on building and maintaining the important relationships between the infant, toddler, young child, and caregivers to ensure the needed foundation for growth and development throughout childhood. In 2022, the Infant Mental Health Home Visiting program provided services to more than 1,800 infants, toddlers, and their caregivers.

VERMONT DOULA PROJECT

The Vermont Doula Project is a community-based doula program in one county in the state. In addition to providing traditional doula care during pregnancy, labor, delivery, and/or the postpartum period, the community-based doulas offer patient advocacy, facilitation of community resources, collaboration with mental health services, and concrete needs like transportation to appointments. Noting the impact of doula care on reducing postpartum

depression and anxiety,[132] the Doula Project began in one county in Vermont with hopes that it will be implemented statewide with additional Medicaid funding. Vermont recently signed into law a bill developing a certification process for doulas as the state moves closer to providing Medicaid coverage to these services, all based on the success of the Doula Project in Washington County.

Conclusion

The mental health of pregnant and postpartum women—both those who develop symptoms of mental illness in the perinatal period and those with preexisting SMI—is an area of growing interest. Given the large unmet need for services and support and the potential pivotal role SMHAs can play in improving outcomes for mothers, babies, and families, it is imperative that there be continued focus on building services and supports that are uniquely tailored to this population. This work requires a commitment to collaboration with other agencies engaged in promoting maternal and family well-being. While fathers and other caregivers provide crucial supports that must also be fostered, the mother–child bond is paramount to promoting positive outcomes for children and families. Mental health symptoms or substance use in the perinatal period can disrupt youth development, and mothers can be at increased risk of serious sequelae that can also impact other children at home if their symptoms are not addressed. Looking upstream and supporting the mental well-being of mothers, therefore, is a key strategy to support the health and well-being of children and future generations. The information in this paper provides background and the positive research-based support that uniformly points to this work as a priority area of public mental health policy.

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