February 8, 2024

Dear Honorable Admiral Levine, MD and Secretary Dr. Miriam Delphin-Rittmon,

The below-signed organizations, leaders in maternal and child health, mental health, and maternal mental health, are pleased to provide the following responses to the questions in the Maternal Mental Health Task Force's request for information. This information was culled from various sources, including reports and multiple years working with providers, community leaders, and those with lived experience.

1. **Data Research and Quality Improvement**

1A. What are the priority outcomes for pregnant and postpartum individuals with substance use disorder and/or mental health conditions?

Response: Priority outcomes include safe and supported pregnancies, births, and postpartum periods which include women/families not being set back financially.

Inputs necessary include:

A. **Healthcare System Inputs**
There should be infrastructure for maternity care services just as there is for postal services, motor vehicles/roads, elementary schools, and libraries - within reasonable distances and with wait times, including:

Facilities

a. Obstetric clinics staffed with maternal health care teams
b. Birthing facilities, including birthing centers/birthing hospitals
c. Outpatient and inpatient mother and baby maternal mental health and substance use disorder treatment/recovery centers

Workforce/Care Teams

d. Obstetric providers: Midwives/ObGyns ("OBs")
e. Reproductive psychiatrists and nurse practitioners (prescribers and experts in women's health and mental health specialties)
f. Maternal mental health providers (PMH-C), including but not limited to PsyDs, LCSWs, counselors, certified peer support specialists, and other licensed/certified providers
g. Alcohol, opioid, and other substance addiction providers, including but not limited to addiction medicine providers (MDs)

and certified peer specialists who are competent in treating pregnant/breastfeeding mothers

h. Doulas, to support women/birthing people with frequent interactions through pregnancy, birth, and the postpartum period
i. Community health workers to serve as
    - care extenders (assisting obstetric care providers/patients with screening and treatment plan development) and
    - patient care coordinators

Care

j. Standardized delivery/timeliness of screening/detection and care:
    - Implementation of the Alliance for Innovation in Maternal Health (AIM) outpatient perinatal mental health bundle by obstetric care providers (midwives, Ob/Gyns and Family Practice Providers who deliver babies - "OBs") and their supporting provider teams
    - Implementation of the AIM outpatient/inpatient perinatal SUD bundle by OBs and their supporting provider teams, as well as birthing facility providers in an inpatient setting as needed (when care is not already being managed by the OB and/or an addiction medicine specialist) and to support the infant.
    - SUD care is gender-based and includes a range of level-of-care settings, including residential treatment which allows infants/children.
    - MMH disorder care includes a range of level-of-care settings, including outpatient visits, day treatment programs such as IOPs/PHPs, inpatient mother-baby treatment, and residential treatment, including infants/children.
    - Implementation/availability of a range of evidence-based support and prevention interventions and treatments.
    - General MH/SUD education is provided in group settings to expand social networks and learn from one another. Groups facilitated by a workforce such as doulas/CHWs and nurse practitioners.

k. Respectful care from obstetric care providers, labor and delivery RNs, and other medical providers. Respectful care includes:
    - Care provided without discrimination (based on race, ethnicity, ability/disability, religion, age, marital status, socioeconomic status, or insurance coverage)
    - OBs who develop relationships with patients

- Care provided acknowledging many women/birthing people fear referral to child protective services/child welfare, acknowledging this should not/will not happen simply because a mother may need or is receiving support and treatment for MMH/SU disorders (harm reduction)
- Standardization of implementation of Plans of Safe Care and Requirements/Guidelines for Child Welfare involvement that protect and support mothers seeking care.

B. <u>Support System</u>

- Community-based group pregnancy support services (including nutrition, stress management, and social driver support) offered in partnership with community-based organizations/WIC aligned with obstetric clinics noted in 1. A.
- Affordable/free childcare for infants and toddlers based on income in settings that consider family needs and preferences.
- Paid leave that is equivalent to the benefit offered through the Federal employee paid leave program, including time off for prenatal and postpartum care through the postpartum period.
- Child-tax credits that are sufficient to address the cost of housing, and cost of living, with specific support for single parents.

1B. How would you define quality care for pregnant and postpartum individuals with substance use disorders and/or mental health conditions?

Response: As noted above in 1., AIM bundles have been developed for perinatal mental health and perinatal substance abuse; at a minimum, quality care is defined as standardized and routine screening through obstetric care providers and standardized services provided for every woman/birthing person identified as at risk or suffering from an MMH or SUD disorder.

Care teams should include integrated certified peer support specialists/community health workers/recovery doulas with lived experience to provide empathetic professional care and extend obstetric provider/facility capacity.

Access to alcohol dependence, opioid use disorder, and other addiction medications and medications specific to maternal mental health disorders on plan/insurer formularies without burdensome restrictions.

Obstetric care providers should all be aligned to a state or national psychiatric provider-to-provider consultation program to receive training/support in addressing MMH disorder and Maternal SUD diagnostic assessment and treatment plan development/deployment, including support in prescribing given the need to understand research and risk regarding drug treatment during pregnancy/lactation.

Suicide and overdose risk should be assessed among those with identified MMH disorders and SUD and/or sub-groups most at risk should be identified, and these patients/people should be prioritized.

Further, group prenatal and postpartum care should be provided. As described by the Prenatal to Three Policy Impact Center, "integrating family members and peer support into prenatal care and education can be a protective factor for a pregnant person's psychosocial health."

Care should be provided in partnership with and with linkages to community-based organizations (CBOs) when possible. For mild-moderate maternal mental health disorders, care should always include a referral to a local or online Postpartum Support International support group. CBOs should be made whole for their time to sustain meaningful services. This could look like holding contracts with local OB clinics/birthing facilities, including hospitals. CBOs that provide paraprofessional-led support groups should be supported in becoming contracted with and billing Medicaid plans and private insurance.

Successful treatment programs combine evidence-based practices with best-in-practice clinical professionals—with a 'whole person' approach that offers opportunities for patients to stay highly engaged. This is especially important with SUD because symptoms often return.

Care should be measured consistently across obstetric and MH/SUD settings and reported publicly. Though not perfect (screening measurement is not focused solely on clinical care, and outcomes are not monitored, the new HEDIS perinatal and postpartum depression measures could be used as a starting point. Rewards should be provided to those clinics performing well -including bonuses provided to staff through incentives like pay-for-performance (P4P) payments.

Finally, seeking care for both MMH disorders and SUD should be rewarded, not punitive. Systemically, this includes addressing how the federal Child Abuse Prevention and Treatment Act (CAPTA) and its implementation can serve as a barrier to treatment and healing.

1C. What are the priority research questions and gaps related to maternal substance use disorder and/or mental health conditions that must be addressed to improve services and outcomes for individuals while pregnant and postpartum?

Response:

A. **Diagnosis and Treatment**

Regarding clinical diagnosis and treatment for maternal depression and other MMH disorders with onset in pregnancy/postpartum, there are opportunities for further research related to improved diagnostics - using saliva/blood tests, for example, to understand biomarkers for MMH and biomarkers for SUD and risk for MMH (risk for SUD may be better understood/documented). Understanding biomarkers and risk can support prevention and also destigmatize these disorders. It's time to move beyond the simple use of screening questionnaires to diagnose these disorders, particularly mental health disorders.

Precision treatment ("precision medicine") for mental illness and substance use disorder must be further explored. Precision medicine is a therapeutic approach tailored to a person's genetic profile, symptoms, and strength. Currently, patients are prescribed medications without consideration of these nuances leading to longer suffering and higher utilization of psychiatric care that is in short supply.

Further research is needed to understand the means for increasing perinatal/postpartum SUD treatment engagement and retention.

B. **Implementation Science**

The types of care, including diagnosis, interventions, and treatments, that are effective are generally well-researched. The gaps lie in implementing such research and clinical recommendations/clinical practice guidelines. Research and related policy must address systemizing care delivery with proper quality management monitoring and reimbursement/incentives.

2. Prevention Screening and Diagnosis

2A. What is lacking and what is working to support maternal emotional health, substance use, and well-being during pregnancy and after?

Regarding what is lacking -the healthcare system is rarely delivering recommended maternal mental health and substance use care. Addressing these life-threatening gaps must be a priority. Further, it's equally concerning that families and taxpayers are paying for healthcare benefits that include these services, yet services are rarely delivered.

A body of evidence exists that highlights the importance of addressing structural drivers of health, such as transportation, when considering maternal mental health and substance use treatment needs. Research confirms that gender-specific barriers exist. Such factors are not only drivers of poor health but also barriers to accessing care and treatment. Specifically, factors like a lack of stable housing are associated with maternal mental health disorders, and without addressing these factors, clinical interventions may fall short.

Further research has found that the lack of context-specific interventions for pregnant and parenting women with substance use disorder creates health inequities. This is exacerbated by experiences of disrespectful maternity care and racism in the medical system at large. Stigma and judgment within practice create preventable gaps in access to care, as pregnant women's health is further harmed by mistreatment by medical providers.

There is general consensus on the value of peer support, including by CMS and SAMHSA). This is generally the case with the use of certified peer support specialists supporting maternal SUD recovery and healing from maternal mental health disorders. A recent study addressing community-based peer support noted mothers could have positive perceptions of peers offering empathetic and non-judgemental acceptance outside of their personal social group and primary health providers, as well as offering culturally congruent perspectives on mental health and professional support. However, there is also an acknowledgment of the additional considerations regarding implementing peer services to be effective. Further, recovery doulas are recognized as a positive addition to interdisciplinary teams addressing substance use challenges among those who are pregnant.

State governments can play a role in collating treatment resources and developing awareness campaigns like Colorado has. Further state departments of insurance can conduct network adequacy assessments of OB and MMH disorder/SUD providers.

State public health departments can lead public awareness campaigns. For example, the OK Maternal Mental Health Workgroup comprises individuals throughout the state, including family advocates, mental health

clinicians, social workers, providers, and others. The workgroup focuses on increasing the capacity of mental health providers trained in perinatal mental health services in OK and the percentage of medical providers screening for perinatal depression and anxiety. The group also engages in a media campaign to raise awareness of perinatal anxiety and mood disorders.

Much more can/must be done to prevent SUD addiction -most notably, alcohol addiction. Public awareness campaigns to educate women on what alcohol does to their bodies should be deployed in novel ways, including on social media platforms with appealing and relatable spokespeople. Taxes on alcohol makers, similar to so-called "soda taxes," could potentially fund these programs.

2B. What can be done to help pregnant and postpartum individuals feel more comfortable to open up about how they are feeling? Who, where, and how might pregnant and postpartum individuals feel safest about disclosing their experience?

Response:
Patients are more comfortable sharing their struggles through conversations or screening tools when obstetric care and other maternity providers are proactive about explaining how common MMH/SU disorders are and routinely screening. These protocols work to destigmatize these disorders. This must also be met with non-punitive/non-carceral actions and appropriate and approachable care. The lack of standardized screening protocols, as MMH remains undetected and untreated, disproportionately impacts low-income and BIPOC populations, particularly Black and Native mothers, who are at higher risk of these disorders,

Likewise, efforts to address stigma and proactively engage patients in maternal mental healthcare treatment must recognize that punitive measures have historically and presently disproportionately impacted the BIPOC community and low-income communities. Thus, help-seeking attitudes and intentions would be lower as the perceived risk of getting help from a care provider is greater.

Provider competency and decreased stigmatization must be promoted by the integration of maternal mental health disorders and maternal SUD training in medical/nursing schools, residency programs, and other provider education programs.

Patients also feel comfortable if the workforce is similar in race and culture. The workforce must be diversified to mirror the communities served, and all

providers trained in recognizing their own potential biases and in providing culturally relevant care to diverse populations. As noted above, diversifying the workforce must include nonmedical professionals such as community health workers, doulas, and certified peer support specialists. There are promising models for training through community colleges offered at zero cost to trainees.

Further, strategies must ensure birthing facilities do not restrict doulas, as trusted intermediaries and providers, from attending births and other care visits with the patients/their clients.

Community-based organizations (CBOs), including non-profit organizations like the Shades of Blue Project in Houston, providing support like diapers and maternal mental health support groups, and more, are critical trusted resources. The Policy Center for Maternal Mental Health has begun to collect the location of these CBOs through a map referred to as the maternal mental health non-profit nation.

Further, preschools, elementary schools, churches,, and even nail and hair salons can also be valuable partners in raising awareness of these disorders for mothers and "meeting them where they are." (A toolkit to provide services in preschool settings is linked below).

3. Evidence-Based Intervention and Treatment

3A. What are key evidence-based intervention and treatment models that should be broadly implemented to address maternal mental health and substance use?

Response:

Regarding maternal mental health disorders, a menu of prevention/treatment options (drug and non-drug treatments, including non-clinical alternative practices) was developed by the Policy Center for Maternal Mental Health to document the range of evidence-based care, from exercise to referrals for Cognitive Behavioral Therapy to inpatient care. An FDA-approved fast-acting postpartum depression (PPD) specific drug should also be among the treatments obstetric providers discuss with patients, particularly those with a history of PPD who have risk factors or need immediate relief that standard drug treatment and talk therapy do not provide. It is critical that state Medicaid and private insurers should cover this treatment. Prior authorization is reasonable to verify a patient is in the postpartum period, and any greater restrictions are viewed as interfering with access.

A range of treatment and prevention options should be offered to the perinatal population allowing patients to select what is most appealing given personal and cultural preferences and needs.

Evidence-based treatment for SUD varies based on the type of substance a mother is seeking treatment for and includes a variety of strategies, including medication-assisted treatment that suppresses cravings and withdrawal symptoms, peer support (sometimes referred to as "Recovery Doulas"), peer-based support groups, intensive outpatient programs, and residential treatment. Motivational interviewing and brief intervention (SBIRT) in a non-judgemental manner are important interventions for mothers who screen positive and are believed to have SUD disorders. Obstetric care providers should be positioned to screen, and deliver and/or facilitate SUD treatment.

3B. What are the barriers/gaps to evidence-based intervention for maternal mental health and substance use among reproductive-age individuals? How do access and engagement differ between people who have already received mental health and/or substance use treatment prior to pregnancy versus those who never have?

The largest barrier is that there is no uniform delivery of services in healthcare or community programs in the U.S. An obstetric care "system" with standard protocol for education, screening, and treatment is foundational to addressing maternal mental health in the U.S. The perinatal population deserves holistic standardized care from multidisciplinary, collaborative obstetric teams (doulas, psychiatrists, etc.), inclusive of medical care, as well as substance use and mental health care. This same holistic care should also be available to all childbearing-aged people (and others) starting in primary care settings.

The largest gap in maternal and maternal mental health care is the lack of obstetric care infrastructure to provide holistic care. Women, babies, families, and communities deserve access to these critical life-saving services in their own backyards just as they have access to post offices, elementary schools, and libraries. Standardized treatment, as described in 6. above, could then be deployed universally.

With regard to maternal mental health treatment, those with pre-existing mental health disorders, like depression, who are in treatment before pregnancy generally have had less difficulty accessing care. However, many women on drug therapy have been directed by psychiatrists and obstetric care providers to stop medication once becoming pregnant rather than examining the inherent risks of stopping medication. It's critical that

psychiatrists and other prescribers are educated about the risks before treating/advising patients.

Reproductive psychiatry recognizes the need for specialized women's mental health over the life course, including the perinatal period. As noted in response 1B, policies/systems should be instituted that enable these specialists to train and consult with obstetric care providers in every state and/or through a national clinical consultation program to build their capacity and knowledge about drug treatment (as well as the range of treatments and best practices in screening and assessment). Treatment-resistant depression, clients with multiple disorders, and those with severe mental illness, including acute postpartum psychosis, should be managed directly by reproductive psychiatrists. Severe shortages of such specialists, however exist.

Further severe shortages of other maternal mental health providers exist as well, and often extreme shortages exist in counties with high-risk perinatal populations.

Regarding SUD, research and those with lived experience suggest that becoming pregnant is generally the impetus for seeking treatment so less may be known about how care differs for those in SUD treatment before becoming pregnant. Further, with regard to treatment shortages for SUD, it's imperative that Obstetric care providers have ready access to addiction medicine consultation and care teams and intensive treatments when necessary.

3C. Are underserved populations represented in the research and subsequent guidelines developed from the research for screening and treatment? What evidence is still needed to inform guidelines for screening and treatment, including for underrepresented, underserved populations?

There has been recent discussion among the community and researchers in the field of maternal mental health questioning the validity of current screening tools, such as the EPDS and PHQ, in detecting MMH disorders in Black and BIPOC populations. Further detail is provided in the Policy Center for Maternal Mental Health's Black Maternal Mental Health Issue Brief:

"Despite having an elevated risk for depression due to increased stress due to the high prevalence of cardiometabolic conditions, research shows that depressive symptoms in Black women may not be detected via standard depression screening tools. As screening tools were historically created and informed by White research participants, there has been increased discussion as to whether maternal depression screening tools such as the Patient Health

Questionnaire 9 (PHQ-9) and Edinburgh Postnatal Depression Scale (EPDS) are valid or sensitive to the cultural nuances of non-White women, specifically Black women. Until more validated screening tools are developed to specifically address the maternal mental health screening needs of Black women and other persons of color, it has been recommended that a lower screening score cut-off be used for Black women.

It is important to consider how acculturation, cultural stigmas, or immigration status may skew self-reported rates of maternal mental health disorders, creating further need for screening protocols within healthcare settings. The Policy Center for Maternal Mental Health addressed this concern in the 2022 issue brief *Universal Screening for Maternal Mental Health Disorders:*

Dr. Alfiee Breland-Noble conducts research on health disparities in mental health screening, diagnosis, and treatment. She found the EPDS/PHQ screening tools are often less relevant for mothers of color. These screening tools were developed and tested with mostly white research participants and did not take cultural differences into account. In an interview with National Public Radio (NPR), Dr. Breland-Noble said Black people are less likely to use the term “depression,” rather they may say that they “do not feel like themselves.” She also notes that ethnically and racially diverse people suffering from mental illness often experience symptoms as physical symptoms, such as stomach aches and migraines. Research has found that these screening tools are not catching as many mothers as they should, particularly when looking at moms of color or those who are low-income.

Also noted in the Policy Center for Maternal Mental Health’s Universal Screening for Maternal Mental Health Disorders brief are several tools that are culturally appropriate and validated for the detection of maternal mental health challenges in the Black population. The Healthy Pregnancy Stress Scale (HPSS) offers a pregnancy-specific stress scale validated in a population of low-income African-American women but designed for use in diverse populations. This is important for understanding the relationship between structural inequities, pregnancy stress, and pregnancy health. This internally validated tool has the potential to function as a quick assessment of the pregnancy environment. Additional tools include the Perceived Prenatal Maternal Stress Scale (PPNMSS), the Tilburg Pregnancy Distress Scale (TPDS), and the Brief Pregnancy Experience Scale (PES). Learn more about these tools here.

Screening, even if successful in the identification of disorders, must be followed up to initiate treatment. While follow-up is a crucial part of treating

maternal mental health disorders, it is especially paramount to focus on follow-ups for Black women to maximize their chances for a successful recovery.

4. Evidence-based Community Practices

4A. What strategies have been the most successful, transformative, and/or sustainable in addressing maternal mental health and maternal substance use needs in your community? What strategies have been the least successful, transformative, and/or sustainable, and why?

Though local communities shouldn't have to address maternal mental health/SUD on their own, it would be preferred that a responsive healthcare system be in place, some communities and states have formed new or employed existing coalitions to address MMH, including addressing local treatment shortages/referral pathways through training of existing providers, structuring support groups and disseminating educational materials and leading awareness campaigns.

There are limited *scalable/sustainable* programs addressing maternal mental health within the health delivery system, as noted above. Payors must play a role in defining their reimbursement strategy for obstetric care providers for screening, treatment plan development, care coordination, and follow-up. There are many technology-enabled solutions that can streamline screening and delivery of interventions (Mammah, FamilyWell, Canopie, and others). Reimbursement to obstetric care providers must be sufficient to include these resources, account for additional staffing needs, and include pay for performance incentives for improved screening scores over time (measurement-based care).

Medicaid plans should also define the role of the pediatrician in supporting care (including collaborating with the Obstetrician), given state Medicaid agencies must also cover any medically necessary treatment for the child as part of the Early and Periodic. Screening, Diagnostic, and Treatment (EPSDT) benefits, which could include dyadic care for postpartum MMH disorders. This is addressed in the 2023 CMS postpartum care toolkit.

At the same time, public health and community-based programs also can play an important role in education, prevention, and healing. There are promising programs that have been developed in community and public health settings.

A Robert Wood Johnson Foundation Clinical Scholars team produced a program and toolkit to support maternal mental health in preschool settings.

The toolkit can be used to guide the development and implementation of interventions to promote mental health in community settings and specifically to prevent maternal depression in preschools.

Regarding SUD services, the federal government's gender-specific Pregnant and Parenting Women (PPW) program (administered through SAMHSA) offers grants to states to develop residential treatment for women experiencing SUD and their children for up to 6 months. These programs are model programs in that they provide whole-person and relationship-based care as well as support addressing drivers of health (SDoH) NJ example, AZ example.

Medicaid-covered Special Women's Programs (SWPs) provide gender-specific SUD outpatient and intensive outpatient providers, which provide free or low-cost services and community-based resources. Many of these programs also provide employment services, affordable housing, and access to other maternal healthcare services. Programs should provide support/housing for children and address co-occurring medical and mental health disorders. State departments of health can standardize these policies and ensure that individuals who are pregnant and in the postpartum are a priority group for admission for treatment.

Examples of meaningful state legislation include:

California AB 2193 (2018), SB 1207 (2022): These bill(s) require obstetric providers to screen for maternal mental health disorders and address the establishment of maternal mental health programs among health insurers and health plans, including incentivized training opportunities for contracting obstetric providers, and educate enrollees and insureds about the program and include quality measures to encourage screening, diagnosis, treatment, and referral.

Florida Code § 383.14 (2018): To help ensure access to the maternal and child health care system (Florida's Healthy Start Program), required the Department of Health to address screening and identification for maternal mental health (MMH) disorders of all newborns and their families for environmental risk factors. In addition to MMH disorders such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity provide early intervention, remediation, and prevention services, including but not limited to, parent support and training

programs, home visitation, and case management. Any mother who screens positive for maternal mental health disorders is eligible for these programs.

Illinois HB 2438 (2019) & HB 3511 (2019): Required mental health conditions occurring during pregnancy or during the postpartum period, including postpartum depression, be covered by insurers and that licensed physicians, advanced practice registered nurses, and physician's assistants who provide prenatal and postpartum care for a patient ensure that the mother is offered screening or is appropriately screened for mental health conditions. Established the Maternal Mental Health Conditions, Education, Early Diagnosis, and Treatment Act and required the Department of Human Services to develop educational materials for healthcare professionals and patients about maternal mental health conditions and require birthing hospitals to supplement the materials with relevant resources to the region or community in which they are located.

Oklahoma SB 419 (2019): Requires licensed healthcare professionals that provide pre- and post-natal care to women and infants and hospitals that provide labor and delivery services to educate women and, if possible, their families about perinatal mental health disorders. Requires licensed health care professionals providing prenatal, postnatal, and pediatric care to invite each pregnant and postpartum patient to complete a questionnaire to detect perinatal mental health disorders. Requires health care professionals to review the completed questionnaire in accordance with the formal opinions and recommendations of the American College of Obstetricians and Gynecologists.

Texas HB 253 (2018): Requires the Health and Human Services Commission to develop and implement a five-year strategic plan to improve access to postpartum depression screening, referral, treatment, and support services. The strategic plan must include: strategies to increase awareness among providers about the effects of postpartum depression on outcomes for women and children; establish a referral network of community-based mental health providers and support services; increase access to formal and informal peer support services; raise public awareness and reduce stigma related to postpartum depression; and leverage sources of funding to support community-based screening, referral, treatment, and support services. **The strategic plan was released in 2021.**

Further, several states have begun to address screening reimbursement by Medicaid agencies.

Examples of Medicaid Coverage Policies Relevant to MMH and Obstetric Care

State Medicaid Program	Policy Document	MMH Guidance
California Medi-Cal	CA Medi-Cal Obstetric Provider Workbook, May 2023	"Providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum. The combined total claims for screening pregnant or postpartum recipients using HCPCS codes G8431 and/or G8510 may not exceed two per year per recipient by any provider of prenatal or postpartum care. Providers must include a pregnancy or postpartum diagnosis code on all claims. Claims submitted without a pregnancy or postpartum diagnosis code may be denied. Depression Screening Billing Codes Modifier HD is used with G8431 and G8510 when billing for either a positive or negative depression screening for pregnant or postpartum recipients."
Arizona Health Care Cost Contain-ment System	Medical Policy for Maternal Child Health, Chapter 4, Section 410, January 2023	16. Identification of postpartum depression for referral of members to the appropriate health care providers. The Contractor shall require the use of any norm-criterion referenced validated screening tool to assist the provider in assessing the postpartum needs of members regarding depression and decisions regarding health care services provided by the maternity care provider or subsequent referral to the plan/entity responsible for the provision of behavioral health services if clinically indicated. 17. Process for monitoring provider compliance for perinatal and postpartum depression screenings being conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made if a positive screening is obtained.

These efforts are generally reflected in improved outcomes in the Policy Center's Maternal Mental Health state report cards.

5. Communications and Community Engagement

5A. What do ideal services and resources look like for a pregnant or postpartum individual in your community? And what are the barriers to access to these services?

See responses to question 1A and all other conditions above.

5B. What steps should be taken to ensure that approaches to detecting maternal emotional health issues and substance use challenges are culturally appropriate?

See response to questions 2B and 4A above.

5C. What can be done to help mothers and pregnant and postpartum people feel more comfortable to open up about how they are feeling? Who, where, and how might mothers and pregnant and postpartum people feel safest about disclosing their experience?

See response to question 4A above.

In closing, we again thank the Task Force leaders for the opportunity to comment and share these important insights. We welcome further dialogue. Should you have questions or comments, we strongly encourage you to contact Joy Burkhard, Joy.Burkhard@PolicyCenterMMH.org.

With hope,

Policy Center for Maternal Mental Health

Alabama Department of Mental Health
American Foundation for Suicide Prevention
American Psychological Association
Arbit Counseling
Baby Blues Connection
Babyscripts
Behavioral Wellness for Women
Birth In Color
Buffalo Prenatal Perinatal Network
California Chapter of Postpartum Support International
California Council of Community Behavioral Health Agencies
Candlelit Care
Center for Law and Social Policy (CLASP)
Center for Population Health

Chrysalis Collective LLC
Cummings Graduate Institute for Behavioral Health Studies
Flourish Counseling & Wellness
Georgetown Center for Children and Families
H&L Psychological Services
Healing Our Hearts Foundation
Healthy Mothers, Healthy Babies- The MT Coalition
HealthyWomen
Hopeful Beginnings of St Mary's
International OCD Foundation
Lifeline for Families Center and Lifeline for Moms Program at UMass Chan Medical School
March for Moms
Mental Health America
Mental Health America of Ohio
Micronesian Islander Community
Mission: Motherhood
Mom Congress
Moms Mental Health Initiative
MomsRising
Monterey County Supervisor Wendy Root Askew
National Alliance on Mental Illness
National Association of Pediatric Nurse Practitioners
National League for Nursing
New Futures
No Health Without Mental Health (NHMH)
Partners in Women's Mental Health
Postpartum Health & Harmony
Postpartum Resource Center of New York
Postpartum Support International
Postpartum Support International - Alaska Chapter
Postpartum Support International - Arizona Chapter
Postpartum Support International - Georgia Chapter
Postpartum Support International - West Virginia Chapter
Postpartum Support - Virginia
Reproductive Mental Health Consultants
Return to Zero: HOPE
Seleni Institute
The Center for Postpartum Health
The Lovely Little Lotus
Triangle Area Parenting Support
United Women’s Healthcare of The Carolinas
Women's Mental Health Program at the Icahn School of Medicine at Mount Sinai