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Nurturing Development: Policy Strategies for Perinatal Mental Health to Enhance Early Childhood Well-being and Reduce Child Welfare Involvement

ZERO TO THREE
Early connections last a lifetime

INTRODUCTION

Infants, toddlers, and young children grow up in the context of relationships that contribute to their physical, emotional, and social well-being, and parental mental health is inextricably linked to early childhood health and development. Healthy parents and caregivers are better able to provide for the physical needs of their children and to establish strong, nurturing relationships with them. This social and emotional development during the first three to five years of life lays the foundation for all future development and is often referred to as infant and early childhood mental health (IECMH).[a,1]

Positive parental mental health also plays a key role in reducing child welfare involvement. Healthy parents are less likely to be reported for maltreatment and to otherwise come into contact with the child welfare system.[2] Some families, particularly Black and Indigenous families, face ongoing community violence and institutional racism that increase the risk of developing mental health conditions, while at the same time being less likely to receive care.[3] This can compound already elevated rates of child welfare reporting and removal.

Policies that support parent and caregiver mental health for families in and at risk of entering the child welfare system benefit all — children, families, and society. A growing spotlight on the perinatal period[b] presents an opportunity for early childhood systems to prioritize positive mental health for parents during this crucial window of time and in turn promote optimal infant and early childhood health.[c,4,5]

An early childhood system brings together health (holistically defined and for all members of the family); child welfare, including the dependency court; early care and education; other human services; and family support program partners — as well as community leaders, families, and other partners — to achieve agreed-upon goals for thriving children and families.

a IECMH is defined as the developing capacity of infants and young children to form close and secure relationships; experience, manage, and express a full range of emotions; and explore the environment and learn — all in the context of family, community, and culture.[1]

b This brief refers to the perinatal period as pregnancy through one year postpartum.

c For example, the Biden-Harris administration recently invested $103 million to address the maternal health crisis, including mental health conditions,[4] while more than 40 states have extended postpartum Medicaid coverage over the last four years.[5]

This brief discusses the importance of promoting parental and caregiver mental health during the perinatal period and explores policy levers related to both prevention and treatment of mental health conditions. These policy options provide examples of actions to strengthen families and prevent child welfare involvement at the community level and in state and federal policy. By creating conditions that nurture positive mental health for parents and children alike, states and communities can reduce experiences of trauma, as well as costs for the child welfare, mental health, education, and other family-serving systems.

Policy Levers to Promote Perinatal Mental Health

Economic Supports

(e.g., tax credits and paid leave)

Parent Supports

(e.g., peer support, doulas/birth workers, and home visiting)

Medicaid Coverage

(e.g., expansion and postpartum extension)

Screening and Support

(for all parents and for higher-risk populations)

Training and Capacity Building in Child Welfare and Court Systems

WHY IT MATTERS

Mental health refers to emotional, psychological, and social well-being, and mental health conditions are common and can affect anyone. About one in five U.S. adults live with a mental health disorder.[6] Many factors may contribute to an individual's risk for developing a mental health disorder, including family history; brain chemistry; chronic medical problems; stressful life experiences like trauma, abuse, neglect, isolation, economic hardship, and domestic violence; and environmental exposure such as experiencing racism and/or community violence.[7] Families are better positioned to experience mental well-being when they are well-supported with safe and healthy environments, have sufficient means to meet their basic needs, and receive early identification and access to needed services.

Promoting positive mental health benefits parents, babies, and society as a whole because mental health conditions affect all three in complex and intersecting ways. Parental mental health can impact how parents care for both themselves and their children. For example, parents coping with depression or anxiety report more difficulty providing for their children compared with those who describe their mental health as "good."[8] Furthermore, parents may face increased stressors when caring for their children when lacking such resources and support as stable housing and access to health care and appropriate treatments. The effect of these challenges can in turn greatly impact babies' mental health. Parents and children may also experience such shared risks as having a family history of mental health conditions, living in underfunded communities or unsafe environments, and/or facing discrimination.

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Many Parents and Caregivers Experience Mental Health Concerns

Across all families, one in 14 children has a caregiver with poor mental health.[9] Comparatively, families with child welfare involvement have much higher rates; one-half of all children with a maltreatment allegation have a mother with a mental health condition. While most available data examine maternal mental health in greater detail than paternal, fathers' mental health also has a significant effect on children's health and wellness.

Maternal mental health conditions are the most common complications of pregnancy and childbirth, affecting approximately one in five women during pregnancy and through one year postpartum.[10] These conditions include depression, anxiety, and substance use disorders. While this brief takes a closer look at mood and anxiety disorders, refer to ZERO TO THREE's previously published data brief for more on the intersection between parental substance use disorder and child welfare.

Mental health conditions among pregnant and postpartum women can lead to significant suffering and sometimes death, while access to care remains a challenge. State-level reviews reveal that mental health conditions are among the top causes of pregnancy-related death nationally, with suicide accounting for up to 20% of postpartum deaths.[11] Many more mothers experience both prenatal and postpartum depression and anxiety, but most[d] do not get the care they need.[12] Fathers also experience perinatal depression and anxiety.[e,13]

Generations of individual, community, and systemic violence and disenfranchisement have taken a toll on the mental health of Black and Native families. Black parents experience postpartum depression at rates 25–52% higher than those of the general population,[14] while American Indian/Alaska Native women have a higher prevalence of postpartum depression (14–30%) when compared with the U.S. average (11%).[15] In addition to the ongoing stressors Black and Native communities face, the same systemic injustices can also lead to higher levels of poverty and barriers to accessing quality care — compounding the risk for and prevalence of untreated mental health conditions.

Certain other populations also have significantly higher risk of perinatal mood and anxiety disorders due to traumatic and stressful experiences, with both teen/adolescent parents and people experiencing intimate partner violence more likely to experience perinatal mood and anxiety disorders[f] while also facing such barriers to care as isolation, stigma, and obstacles to seeking care.[16,17,18]

Economic hardship and poverty can lead to acute or chronic stress, which can increase the risk of poor mental health for pregnant people and parents with young children. These conditions can also make it harder to access care, whether due to lack of health coverage, financial resources, time, transportation, or trusted and culturally appropriate service providers.

Parental distress also increased during the COVID-19 pandemic. Figure 1 shows that while initial sharp rises in stress, anxiety, and depression during the first few months of the pandemic have since leveled out, they are still higher than pre-pandemic numbers.[9,19] Many of the risk factors discussed above may have contributed to pandemic-related mental distress, including medical problems (experienced by oneself or loved ones), trauma, isolation, discrimination, and economic hardship.

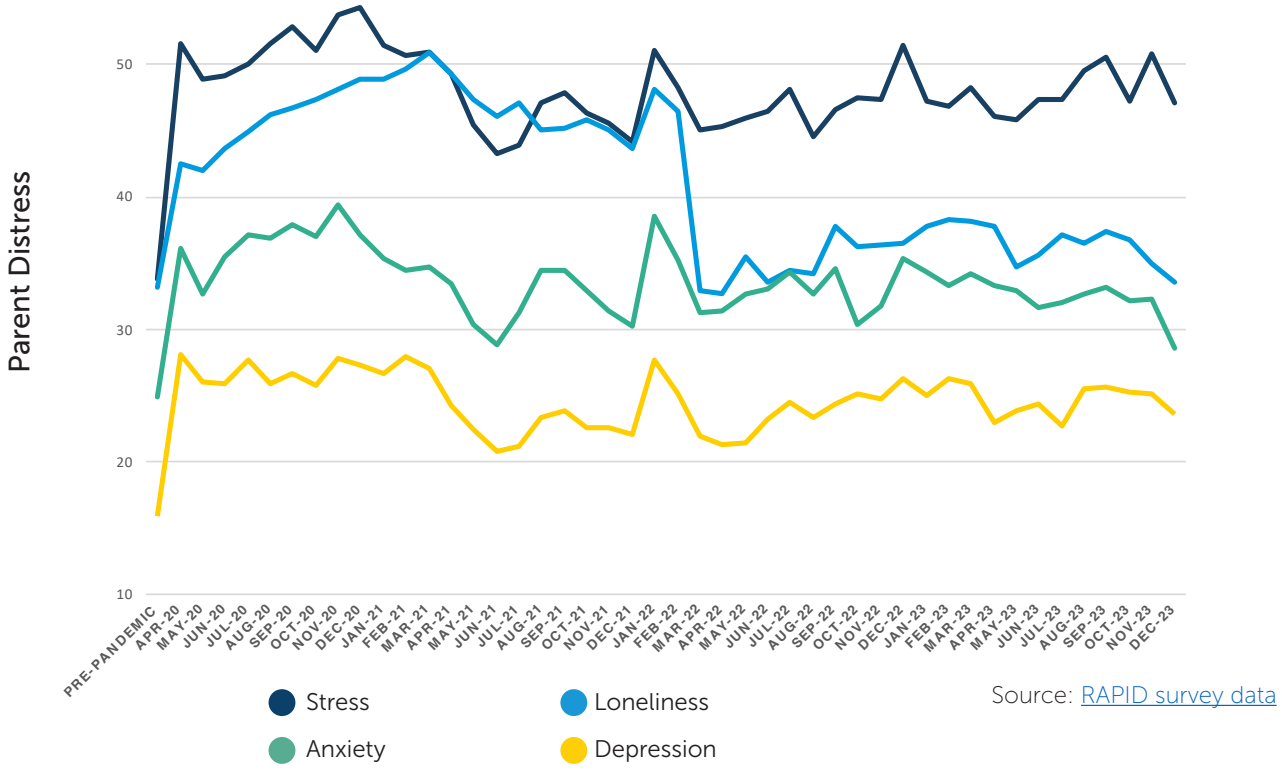
d Three out of four women experiencing perinatal depression and anxiety do not get the care they need.[12]

e Among fathers, about 5–10% experience perinatal depression and 5–15% experience perinatal anxiety.[13]

f In both groups, the prevalence of perinatal mental health conditions may be two to four times that of their counterparts (non-adolescent parents and pregnant people who do not experience intimate partner violence, respectively).[16,17,18]

g Among parents surveyed in July 2023, depression rates were 22.7% compared with 15.9% pre-COVID; anxiety rates were 32% compared with 24.9% before COVID; and stress rates were 47.3% compared to 33.8% prior to COVID.[19]

Figure 1. Parental Well-being Before and After the Start of the COVID-19 Pandemic



Source: RAPID survey data

Children Can Be Negatively Impacted in Numerous Ways by Parents or Caregivers with Mental Health Problems

The most immediate effects of poor mental health can manifest in higher-risk birth outcomes. For example, those with depression during pregnancy are more likely to deliver preterm or give birth to a low-birthweight baby.[20] Babies born early or with low birthweight are at comparatively higher risk for such complications as breathing problems, jaundice, infections, and developmental disabilities.[21]

When pregnant and postpartum parents and other caregivers suffer from untreated depression and/or anxiety, they can struggle to connect with their babies in healthy ways. Such difficulties with bonding and attachment can lead to increased anxiety and emotional problems for parents as well as emotional and developmental problems in their children.[22]

Numerous studies have highlighted the association between perinatal depression and anxiety and poorer social-emotional, cognitive, language, motor, and adaptive behavior development in children. Developmental outcomes extend beyond infancy, into childhood and adolescence.[23] Both mothers' and fathers' mental health play a large role in young children's health and development.[h,24] Healthy fathers who are able to fully engage during the perinatal period tend to raise children with comparatively higher rates of school readiness, social skills, and ability to regulate emotions.[25]

Unaddressed Parental Mental Health Challenges May Increase the Likelihood of Child Welfare Involvement

New parents may experience loneliness and social isolation, both as a result of and as a contributor to perinatal depression. This complicated relationship can lead to further self-isolation and hiding symptoms due to the stigma associated with perinatal depression, fear of judgment, and/or lack of support from one's partners, family, or community.[26] Parental mental health during the perinatal period may also affect child safety and well-being, as well as increase the risk of child welfare involvement, with or without maltreatment. Poor mental health can compromise parenting and increase the risk for neglect or abuse when parents are under stress and do not receive the supports they need.[27]

h Mothers with higher levels of depressive symptoms are 11% slower in responding to their children than mothers with low depression risk.[24]

A study of postnatal depression among women found that those with depressive symptoms engaged in significantly fewer well-child health visits than those without depression, were comparatively less likely to use home safety devices or place their infants in the preferred back-to-sleep position, and were less likely to complete recommended immunizations.[28] Other studies link parental stress and mental health conditions to dysfunctional discipline practices that can lead to abuse.[29]

> *Whether or not maltreatment has occurred, parents with poor mental health are more likely to receive allegations and reports of abuse and neglect.*

Whether or not maltreatment has occurred, parents with poor mental health are more likely to receive allegations and reports of abuse and neglect. Almost half of children associated with a maltreatment allegation had a mother with a mental health condition,[30] while 34.6% of infants born to mothers with a mental health disorder were reported to Child Protective Services within one year. A majority of those reports were made within the first month of life — 2.6 times the rate of those born to mothers without a mental health disorder.[31]

Rather than getting the support they need, these parents may end up experiencing even greater stress related to involvement in the child welfare system, feelings of guilt and loss of confidence in their parenting ability, and fear of having their children removed. Considering the additional stressors often faced by Black and Indigenous parents, as well as the higher rates of child welfare reporting due to individual prejudice and racist systems and processes, there is even greater need to address the multiple layers of risk for Black and Native families.

Increasing Access to Care Can Reduce Mental Health Stigma and Prevent the Trauma of Child Welfare Involvement

Parents may want to seek care but often face barriers such as lack of insurance coverage, availability of providers trained in perinatal mental health, access to child care for treatment, or ability to obtain culturally appropriate services. They may also face stigma associated with mental health care and fears of having their children removed. In severe cases, hospital stays to treat mental health conditions may have further implications for removal and reunification without a strong support system in place.

Understanding the prevalence of mental health problems, their effects on families and young children, and the barriers and facilitators to care are important first steps to identifying solutions. Policymakers can shift the focus to supporting families' positive mental health and overall well-being, helping to change the trajectory of these families' lives.

While funded programs and interventions are important in helping families navigate perinatal mental health, families often also rely on informal supports in their communities as a source of strength and to cope with stress.[32] Such support can include community leaders, parenting groups, social networks, and cultural traditions and practices. Policymakers can consider how to facilitate families' access to informal supports by removing systemic barriers and honoring the important role these supports play in building family resilience.

The next section will explore potential policy levers that can improve systems and supports to promote parental mental health during the perinatal period.

POLICY LEVERS TO PROMOTE PERINATAL MENTAL HEALTH

The perinatal period is an ideal time to provide additional support to families as many adults obtain health coverage for the first time through increased eligibility for pregnancy-related Medicaid. Additionally, there are more touchpoints with parents and infants during this period.

Early intervention with the right support and treatment can prevent or reverse negative health effects, while the promotion of protective factors can strengthen families to weather hardships. Further, upstream policies that address environmental risks can improve community health and promote equity. These combined efforts can promote healthy infant development and mental health, and prevent child maltreatment.

Across all of the policy levers discussed below, it is important to partner with parents and those with lived experience to design and implement programs. Depending on the policy, lived experience may be defined as having current or past perinatal mental health disorders, having previous involvement in the child welfare system, or having experienced intimate partner violence. Partnering with those with lived experience ensures that programs and policies are built around the needs and experiences of those most affected and are set up for success by identifying the real-world barriers and avenues to achieving mutually agreed upon outcomes.

The policy levers discussed in this data brief include options such as economic supports, parent peer support, access to health care, and workforce training, among others, with each lever including primary, secondary, and tertiary prevention strategies. Primary prevention policies promote mental health for all families to help them achieve optimal health. Secondary prevention policies provide additional support for families facing significant stressors, such as those experiencing poverty, young parental age, or behavioral health concerns. For families involved in the child welfare system, tertiary prevention policies can help achieve healing, improve parent-child bonding and attachment, and reduce the length of time that infants are removed from their families.

While policies at each level support perinatal mental health for all families served, they have the opportunity to make an even greater difference in the lives of those disproportionately impacted by racism and systemic oppression by addressing social drivers of health and providing additional, tailored support where needed.

Economic Supports

For primary prevention, states can implement economic supports that help ease burdens on families and promote positive mental health. These can include policies around income and food assistance, tax credits, cash payments, child care assistance, housing or rental assistance, and paid medical and parental leave. Because economic stress is a major risk factor for perinatal mental health disorders, policies that support families' concrete needs can improve parental mental health and in turn promote healthy infant development and mental health.

In particular, **paid medical and parental leave** is associated with beneficial effects on the mental health of parents, including a decrease in postpartum maternal depression and intimate partner violence.[33] Paid parental leave also helps mitigate the negative psychological effects of returning early to work after giving birth, even when extended leave is not possible.[34] When parents are able to care for themselves and their newborns, and have the time to bond and strengthen attachment without financial pressure to return to work, both their mental health and their children's mental health benefit. Such policies can also help prevent child abuse, neglect, and involvement in the child welfare system by nurturing the parent-infant bond.[35,36]

At least 13 states and the District of Columbia have state-paid family leave laws.[37] These vary widely in the length of covered time, qualifying reasons, eligibility, benefit amounts, and funding mechanisms, but all recognize bonding with a new child (through birth, adoption, or foster care placement) as a qualifying reason for paid leave. Maryland also includes kinship care[i] as a qualifying reason for up to 12 weeks of paid leave.[38]

i Kinship care is when children live with relatives or those known to the family.

Parent Supports

Peer Support

A key community-level policy lever to promote perinatal mental health that spans all levels of prevention is engaging peer support. **Parent peer support**, including parent mentors, are mothers and fathers with prior relevant experience (e.g., with perinatal mental health problems and/or the child welfare system, etc.) who have been trained to provide support and guidance to help parents currently experiencing hardship. Studies have shown that peer support can be effective in preventing postpartum depression, as well as in reducing the severity of perinatal mental health conditions once present.[j,39,40]

Similarly, **group prenatal care** employs a strong peer support and group-learning model for prenatal care that may help improve the mental health of participating parents. In cases where group prenatal care includes targeted education on mental health, researchers have seen significant reductions in depressive symptoms.[41]

These models can be particularly helpful for families in or at risk of involvement with the child welfare system, when peer support can be of even greater benefit. It can be daunting and stressful to navigate stressors that put families at risk of child maltreatment, as well as the child welfare system itself. Peer navigators in both the mental health and child welfare spaces can help center parents' perspectives and alleviate their uncertainties and fears, providing a trusted advocate who understands the system and can walk alongside parents.[42]

Doulas and Birth Workers

Increasing access to doulas or birth workers is another policy lever for improving postpartum depression or anxiety, especially in low-income communities and communities of color — particularly among Black women.[43,44] Doulas are professional labor assistants who provide physical, emotional, and educational support during pregnancy, childbirth, and the postpartum period. While doulas do not provide medical care or deliver the baby, they provide support and serve as advocates for the birthing parent. Studies have shown that continuous support from doulas during childbirth may be associated with decreases in the use of pain relief medication during labor, cesarean deliveries, the length of labor, and negative childbirth experiences.[45]

j In a clinical trial, mothers who received phone calls from their peers during the last three months of pregnancy until two months after delivery had lower postpartum depression scores than those who only had access to routine care.[39] A qualitative study found that mothers who used formal or informal peer support reported reduced mental health difficulties.[40]

The benefits of doulas are relevant because positive birth experiences support overall maternal mental health.[46] Having a trusted person who provides education and advocacy can help decrease anxiety during the birthing process and increase readiness for screening and treatment in cases where parents experience perinatal depression or anxiety.

In particular, **community-based doulas** can help reduce disparities by tapping into birth workers who come from the same community or share key cultural backgrounds with the communities they serve. Community-based doulas are highly recommended by maternal health experts to help improve birth outcomes among Black and Indigenous communities with significantly higher rates of maternal health complications.[47] In addition to providing emotional support, doulas help advocate for pregnant and postpartum parents with their providers, which can improve clinical outcomes.

At least 11 states and the District of Columbia are actively providing some level of Medicaid coverage for doula care to increase access for those who may not be able to pay out of pocket for services.[48] This strategy also allows communities with the highest need to obtain services for additional support during pregnancy, labor, and postpartum. At least nine other states are in some stage of implementing coverage, with an additional 14 states taking some related action such as studying the costs and benefits of this type of support, allowing for voluntary doula certification, or funding pilot programs.

Oregon, which first began covering doula benefits under state Medicaid coverage in 2014, has since expanded its program to provide higher reimbursement rates and serve non-English-speaking parents.[49] The program has been successful in supporting increasing deliveries and improving birth outcomes and experiences, which in turn improve perinatal mental health.[50] Rhode Island now requires both Medicaid and private insurers to cover doula services.[51]

Home Visiting

Voluntary home visiting is a service delivery strategy that connects expectant parents and parents of young children with a designated support person such as a trained nurse, social worker, or early childhood specialist. Services are tailored to meet the strengths and needs of individual families and offer information, guidance, and support directly in a family's home or other location of their choice. While home visiting programs vary in their goals and services, they generally provide assistance to families with such issues as parenting and health education, support for family well-being, early intervention and education services, and referrals to other professionals, all of which help build resiliency and promote the positive health and mental well-being of families. There are many home visiting programs and models across the United States, with research demonstrating their effectiveness in achieving healthy outcomes for families across a range of measures.[52]

Home visiting models that **target expecting parents and parents of newborns** can play a large role in improving perinatal mental health for families in or at risk of involvement with the child welfare system. Some home visiting programs identify families at higher risk for such adverse outcomes as infant mortality or child welfare involvement, while some states offer universal home visiting for all new families. For example, New Jersey passed legislation in 2021 to provide all families with newborns (including adoptive and resource parents, as well as those who experience stillbirths) with one to three postpartum home visits regardless of income, insurance coverage, or legal status.[53]

The Health Resources and Services Administration (HRSA) funds the voluntary Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program in all 50 states, the District of Columbia, and the U.S. territories.[54] MIECHV funds states, tribes, and territories in the implementation of evidence-based models to meet the needs of higher-risk communities and improve maternal and child health and development.[55]

Healthy Families America (HFA), the signature home visiting program of Prevent Child Abuse America, is one example of an evidence-based home visiting model that may be funded by MIECHV or privately funded. HFA provides personalized in-home support to families facing challenges such as single parenthood, low income, a childhood history of abuse, or current behavioral health issues.[56] A long-term, relationship-based program, HFA offers services for at least three years,[k] including family-centered, culturally respectful education, skills building, and connections to resources. Among the program's successes include self-reporting of higher parental confidence, the positive promotion of healthy child development, a one-third reduction in the recurrence of maltreatment, improved mental health, and reduced parenting stress.[57]

SafeCare is another example of an evidence-based home visiting model focused on creating positive relationships between caregivers and their children, ensuring homes are safe to reduce the risk of unintentional injury, and keeping children as healthy as possible.[58] Over 18 sessions, home visitors work with families with children under age 5[l] to promote health and safe, stable, nurturing relationships. The program's successes include significant reductions in child maltreatment recurrence and parental depression. Families also report increases in parenting skills, use of services and social support, and non-violent discipline.[59]

Recognizing the importance of fathers' involvement and mental health in babies' health and development, some home visiting models have found success with **enhanced services for fathers.** For example, a pilot study of Dads Matter[60] home visiting in Chicago found that families who received additional services involving fathers saw positive outcomes related to quality of the mother-father relationship, the perceived stress of both parents, fathers' involvement and verbalization with their children, and maltreatment indicators.[61]

Home visiting programs also strive to meet the unique **cultural and linguistic needs of families**, with some dedicating significant resources to specific populations. For example, the Tribal Maternal, Infant, and Early Childhood Home Visiting program provides grants to tribal organizations to offer American Indian and Alaska Native children and families with high-quality, culturally relevant services.[62] One particular model available to grantees is the Family Spirit Home Visiting Program.[m,63] Studies have found that families participating in the program reported increases in parenting knowledge, involvement, and home safety, and decreases in maternal depression and the emotional and behavioral problems of both mothers and their children.[64]

Home visitors can also provide **focused support on mental health** and the dyadic relationship between parent and child when equipped to do so. Some home visiting programs incorporate perinatal mental health consultation to support staff training and efficacy in assessing and addressing the mental health needs of parents and children.[65] For example, Perinatal Support Washington is a state-funded initiative that supports Washington's Start Early home visitors in improving and increasing caregiver depression screening, referral, and follow-up through a training and consultation model.[66] The state initiative's work has helped decrease stigma, provide accurate information about perinatal mental health to families, and support families in navigating complex mental health systems.

Alongside perinatal mental health consultation, home visiting programs may also benefit from IECMH consultation, given the reciprocal relationship between the mental health of parents and their young children. Providers with expertise in IECMH build

k HFA enrollment begins either during pregnancy or within three months of the child's birth and continues for at least three years. Families with a child up to 24 months old may enroll when referred through the child welfare system.

l SafeCare serves families with children from birth to age 5, with parents eligible for enrollment during pregnancy.

m The Family Spirit Core Curriculum consists of 63 lessons taught from pregnancy to age 3.

home visitors' knowledge and skills to successfully work with families that may have complex needs, helping improve social, emotional, and mental health to achieve successful outcomes for young children and their parents.[67]

For parents with young children who have become involved with the child welfare system, home visiting programs and infant-toddler court teams can effectively collaborate to provide mental health support for families.[68] Home visitors may also be able to attest to the protective capacity of parents and improvements in their knowledge and treatment.

Medicaid Coverage

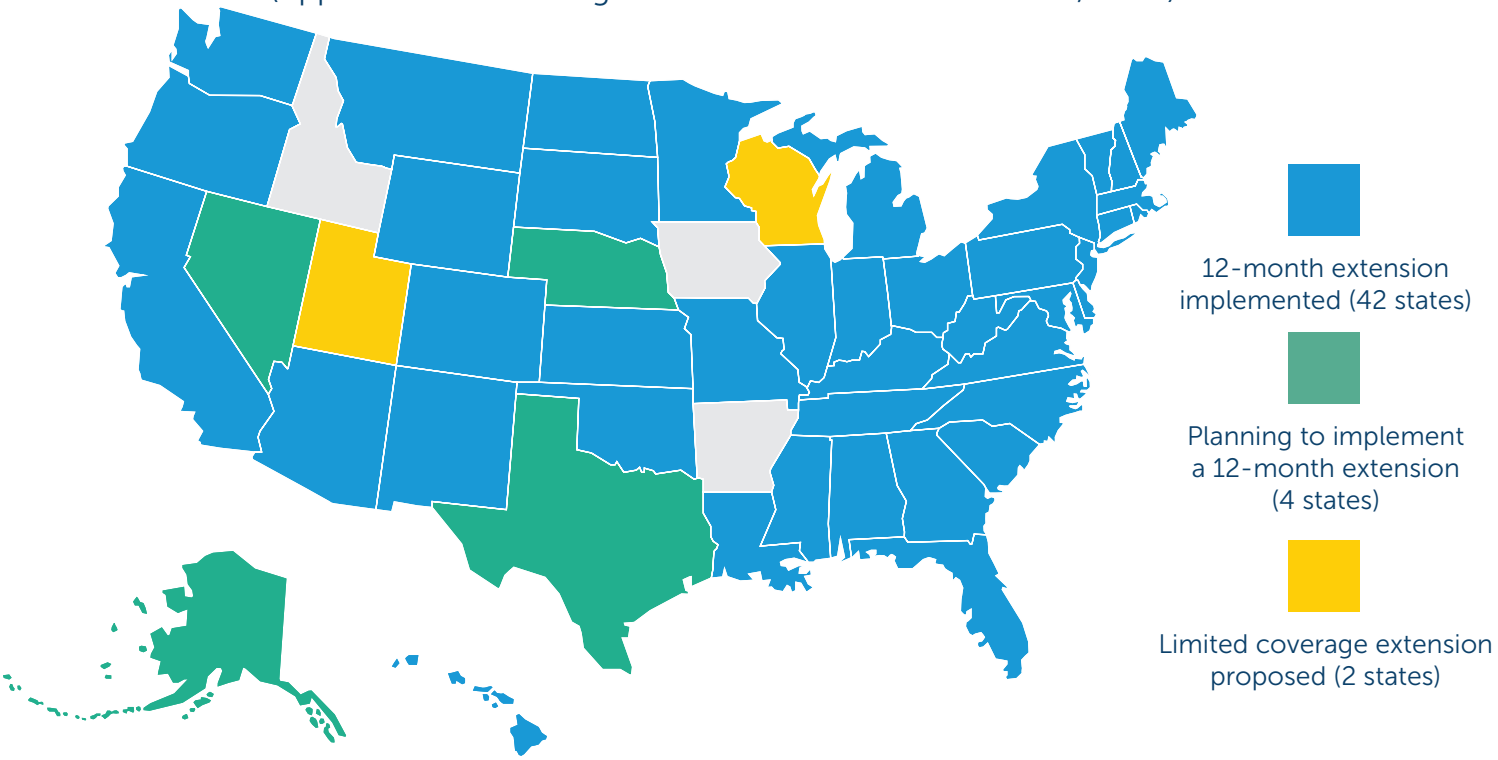
Medicaid offers a key opportunity for states to implement broad-reaching policy change to improve perinatal mental health.

Medicaid covers approximately 42% of births in the United States,[69] including a large share of births for Latine, Black, and American Indian/Alaska Native families. With Medicaid's role in covering births among communities with higher risk for perinatal mental health disorders, the program can provide opportunities to improve mental health and address disparities by ensuring coverage for and access to preventive and treatment services.

Medicaid expansion gives states the chance to provide Medicaid coverage to all people with incomes below a certain level.[70] Forty states and the District of Columbia have expanded Medicaid, providing coverage for nearly all adults with incomes up to 138% of the federal poverty level.[71] States that have adopted expansion are more likely to see improvements in perinatal mental health and pre-pregnancy mental health in particular.[72] This is important because access to screening and services before pregnancy can set people up for success and decrease gaps in care during pregnancy when risk for mental disorders increases. Medicaid expansion allows states to support more families' pre-pregnancy mental health and ensure continuity of care both during pregnancy and postpartum. In states that have not opted to expand Medicaid, the perinatal period may be the only time that those who fall within the income eligibility gap have health coverage because pregnancy-related coverage has higher income thresholds.

Before the American Rescue Plan Act of 2021,[73] federal policy required **postpartum Medicaid coverage** to end 60 days after childbirth; states that wanted to extend beyond this time had to take significant steps to receive an exception. States now have the option to extend their coverage through 12 months postpartum, reducing coverage loss and helping moms stay connected to care during this crucial time. If all states were to adopt such an extension, an estimated 720,000 moms would gain coverage unavailable to them prior to 2021.[74]

Figure 2. Medicaid Postpartum Coverage Extensions
(Approved and Pending State Action as of December 14, 2023)



Source: Kaiser Family Foundation Medicaid Postpartum Coverage Extension Tracker

To date, 41 states and the District of Columbia have implemented 12 months of postpartum Medicaid coverage, with pending action in six other states (Figure 2).[75] Maine also increased the income eligibility limit for pregnancy-related coverage to 214% of the federal poverty level to cover more families.[76]

Extended coverage could help identify postpartum depression and anxiety that may manifest during or after the limited coverage period of 60 days. Once identified, there would be significantly more time to access covered mental health services. Given the reciprocal nature of parent and infant mental health, this would be an opportunity to align and integrate services and streamline whole family care.

> *Extending coverage alone does not guarantee positive mental health outcomes. States and Medicaid agencies can work with families and communities to identify gaps in accessing care and explore opportunities to take advantage of coverage. The National Academy for State Health Policy offers considerations for states to optimize postpartum coverage extension.[77] For the majority of states that have already approved extended coverage, there are several key considerations for implementing the policy to help meet their goals. For example, states and community providers can conduct outreach and education to ensure that pregnant people are aware that they have extended coverage. States can maximize the reach of extension by engaging with health plans, providers, and home visiting programs to ensure early identification and follow-up on postpartum needs; building workforce capacity through the training of maternal health providers in mental health screening and referrals and increasing the number of mental health providers; and ensuring that services are accessible in terms of distance, availability, and culturally appropriate care. State plans may also consider covering multigenerational mental health therapies for babies and caregivers based on children's eligibility.*

Screening and Support

Screening and Support for All Parents

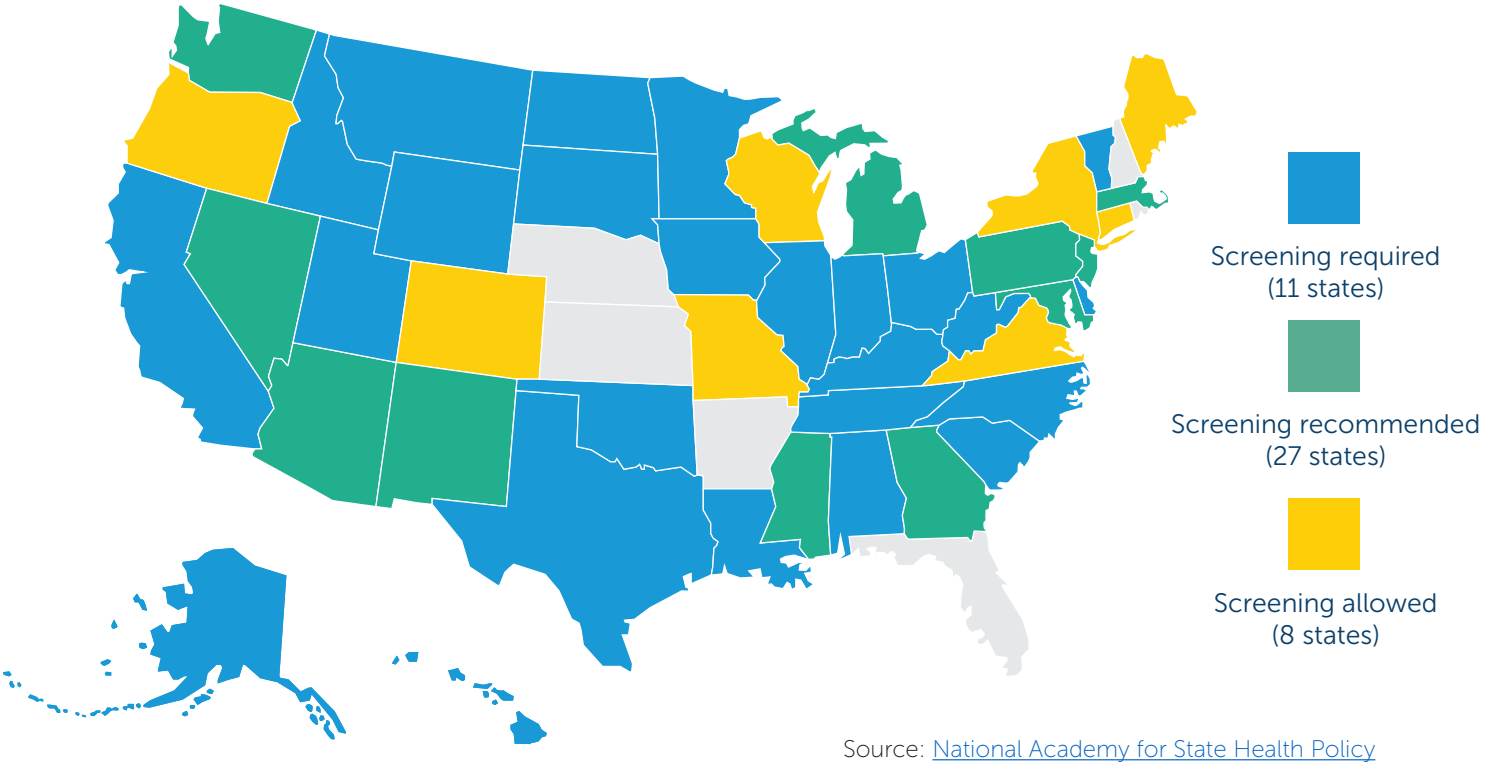
Along with private insurers, Medicaid can be leveraged in **integrated care models** such as patient-centered medical homes, which offer comprehensive and coordinated care that centers the whole person beyond just episodic or condition-based treatment.[78] A central medical home that houses accessible services across multiple disciplines and care teams — serving both medical and social needs — can help ensure that parents and children alike receive coordinated health care that encompasses the entire family. Pregnancy medical homes, such as those in North Carolina[79] and Wisconsin,[80] have found success in improved birth outcomes like fewer low-birthweight babies,[81] increased postpartum care visits, and delivery of timely behavioral health care.[82] This model of integrated, whole-person care can play a crucial role in bridging gaps in the identification and treatment of perinatal mental health conditions.[83]

Another key primary prevention policy option at the provider level is **universal screening for perinatal mental health disorders during OB-GYN and pediatric well-child visits** — for all caregivers. Studies reveal reduced perinatal depression and anxiety among women who have participated in screening programs.[84] Engagement in mental health services increased twofold to fourfold with additional interventions such as training perinatal providers in mental health, employing teleconsultation programs, and providing resources to patients screened.[85]

> *HealthySteps, a program of ZERO TO THREE, helps identify family needs early and successfully connects families with services.[86] Under the model, a child development specialist joins the pediatric primary care team to help families and providers foster healthy child development and well-being. This includes universal screening for family needs, leading to impressive outcomes for maternal depression screening and referral to services. Mothers are significantly more likely to discuss their depressive symptoms and pediatric providers are significantly more likely to discuss postpartum depression with mothers. Some participating practices have doubled maternal depression screening rates, increased referral follow-up rates, and achieved successful referral rates of up to 87%.[87]*

The American Academy of Pediatrics recommends routine screening for postpartum depression during well-child visits at 1, 2, 4, and 6 months of age.[88] Medicaid guidance allows states to provide coverage of maternal and/or caregiver depression screening during well-child visits under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, with most states taking advantage of this option to some extent. As of March 2023, 11 states require screening, 27 recommend screening, and eight allow screening under this coverage (Figure 3).[89]

Figure 3. Medicaid Policies for Caregiver and Maternal Depression Screening During Well-Child Visits, by State (March 2023)



Source: National Academy for State Health Policy

While many current practices center around maternal depression screening, pilot studies indicate that paternal postpartum depression screening can be an effective tool to identify depression in fathers and increase their engagement in health care.[90] There is a growing call to action among pediatricians to provide consistent screening, referral, and follow-up for all new parents, including fathers, at well-child visits.[91]

When parents or caregivers experience a mental health disorder, providers should also evaluate their children. Given the reciprocal nature of parent and infant mental health, both parents and their babies should receive assessment and treatment to support the dyad's individual and joint health.

Another policy lever to increase screening and access to services is the use of **teleconsultation for mental health**. This lever aims to serve more patients by connecting providers with perinatal mental health specialists via a telephone service to eliminate such barriers as distance in rural areas, limited specialist availability, and knowledge gaps. Providers, such as those in OB-GYN or pediatric practices, have access to perinatal mental health specialists like psychiatrists who can quickly consult on specific cases, direct telehealth assessments, and provide follow-up care or connections to follow-up. Another key component of mental health teleconsultation programs is care coordination, whereby parents identified with perinatal mental health conditions can be connected to additional needed services.

The benefits of mental health teleconsultation include increased early identification of perinatal mental health conditions, improved access to treatment in service gap areas, and expanded training and capacity for providers to assess and treat perinatal mental health conditions. Studies show that perinatal psychiatric teleconsultation programs have high levels of both provider engagement and provider satisfaction.[92]

The HRSA-funded Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) supports teleconsultation programs in seven states.[93] In Louisiana, perinatal and pediatric providers can access a real-time consultation line for guidance on treating their patients' mental health concerns.[94] Providers also have access to on-site consultation in certain regions, as well as on-site and online training. The program helps providers expand early identification of perinatal risks and mental health symptoms, serve as the first line of management for these conditions, and make effective referrals to additional services.

Other virtual consultation and training models include Project ECHO, which creates opportunities for provider-to-provider consultation, training, and case review.[95] In Montana, providers are able to connect with interdisciplinary specialist teams for mentoring

and knowledge sharing, which can particularly benefit rural and underserved areas by equipping providers with support to manage perinatal mental health conditions when local provider access is limited.[96]

> *At a national level, HRSA administers the National Maternal Mental Health Hotline, which provides free, confidential support, resources, and referrals to local and telehealth providers and support groups.[97] The hotline is available 24/7 by phone or text nationwide, connecting those with perinatal mental health concerns to professional counselors trained in culturally sensitive support.*

In addition to universal screening, programs that provide broader education and support can help parents manage stress and prevent postpartum depression. For example, the Mothers and Babies[n] program is an evidence-based intervention designed to prevent perinatal depression by helping pregnant people and new parents learn how to manage stress within the context of parenting a baby.[98] Studies have found that Mothers and Babies leads to fewer new cases of postpartum depression, reductions n depressive symptoms, and improved mood management.[99]

Screening and Support for Higher-Risk Populations

When looking at secondary and tertiary prevention strategies for increasing screening and access to services for higher-risk groups, states can consider several policy options to provide enhanced and targeted services and supports.

For example, system responses to survivors of intimate partner violence should **screen for mental health and refer to services once safe**. Services targeted toward teen and adolescent parents should include mental health screening, education, and connection to services.

Teen parents in foster care need additional support to navigate pregnancy, parenthood, and their mental health needs. They are more likely than teens not in foster care to suffer from mental health disorders, unemployment, and homelessness. Many teen parents have experienced maltreatment, multiple placements, and separation from family, resulting in significant trauma that, if left untreated, could impact their mental health and ability to form lasting relationships with trusted and caring adults, and even their own children.

One effective program for pregnant and parenting teens in foster care is the Inwood House at The Children's Village in Queens, New York.[100] Teen mothers and their babies have a stable place to live in small, **community-based group homes** that help them to become independent and to parent. Residents have access to education and services for parenting, child development, life skills, job preparation, education, and financial support, as well as receive mental health support to deal with trauma and help safely parent their children. An evaluation of the program found that one year after participation, almost 100% of teen mothers had custody of their children with the fathers being regular participants and almost 100% had health insurance with high levels of babies receiving well-baby visits.

Other programs that provide comprehensive care for teens, parenting education, and knowledge of early development through group meetings and personal visits, such as Parents as Teachers[101] and the Family and Youth Services Bureau's Maternity Group Homes program,[102] can also be good options for supporting teen parents both in and outside of foster care.

Training and Capacity Building in Child Welfare and Court Systems

Policies within child welfare or dependency court systems can promote positive parental mental health through professional training, funding for treatment, and modified practices when working with families with parental mental health conditions, particularly during the perinatal period and early childhood.

Child welfare agency and dependency court professionals should be **trained in perinatal mental health** — to understand the conditions and interplay between parental mental health and infant health, and recommended care practices; to provide trauma-responsive services; and to reduce bias and reporting in favor of referring to treatment. One way to do this would be to include lived experience testimonials in professional training due to the emotional connection and empathy reaction these testimonials can invoke.

ZERO TO THREE's Safe Babies Program provides an example of how states and communities can help child welfare and dependency court professionals understand the weight that economic, social, and health hardships; domestic violence; and mental health disorders have on families, and how that can affect the early relationship parents develop with their babies

n Mothers and Babies can be implemented one-on-one over the course of nine brief sessions or in a group setting over the course of six 90- to 120-minute sessions.

and toddlers.[103] The program further partners with families, providers, and other early childhood professionals to build a continuum of care that focuses on protective factors for families while connecting those who need additional support to services.

For families at risk of having a child removed, the Family First Prevention Services Act (FFPSA) allows Title IV-E Prevention Program dollars to fund certain models of treatment that may be suitable for perinatal mental health. These include Eye Movement Desensitization and Reprocessing Therapy (EMDR),[104] a treatment for conditions caused by experiencing trauma, and Interpersonal Psychotherapy[105] and Mindfulness-Based Cognitive Therapy,[106] treatments for depression. Additionally, Child-Parent Psychotherapy can be used to address the reciprocal relationship between the mental health of caregivers and their babies, as well as help caregivers with their individual trauma.

For families with active child welfare cases, Mental Health America offers recommendations to help promote positive mental health for parents and thus support families in preventing removals or in reunifying quickly. In addition to the recommendation above to train workers to better understand parental mental health, the child welfare workforce can advocate for parents as service plans are developed; assist parents in developing their own self-care plans to strengthen their parenting skills and manage their disorders; enable parent-child visitation during psychiatric hospitalization to maintain the parent-child bond; and advocate for increased specialized services for parents with serious mental health conditions available through the court system.[107]

CONCLUSION

With increased rates of perinatal mental health challenges, states have explored different avenues to promote the perinatal mental health of parents and caregivers through an array of family-focused policy changes that strengthen families, prevent child abuse and neglect, encourage positive parenting, and promote child development. The policy levers discussed in this brief offer a broad array of services and supports and tap into the inherent strengths and resources within families and communities.

RELATED RESOURCES

National Maternal Mental Health Hotline Partner Toolkit

What The Data on Infants and Toddlers Tell Us: The Intersection of Parental Substance Use and Child Welfare

The Infant-Toddler Court Program National Resource Center's *Strengthening Families with Infants and Toddlers: A Policy Framework* lays out a menu of options for state and local policymakers to develop policies that meet the basic components of what it takes for young children and families to thrive. By providing supports from the start, communities can enable families to nurture their children and promote positive outcomes for the entire family.

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