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TO: Task Force on Maternal Mental Health, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

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RE: Public Comment Solicitation on Maternal Mental Health Issues

The Task Force on Maternal Mental Health, a subcommittee under the Substance Abuse and Mental Health Services Administration (SAMHSA) Advisory Committee for Women's Services (ACWS), is soliciting public input on a series of questions related to the prevention and treatment of maternal mental health conditions and substance use disorders (SUD), including alcohol use, and their associated complications.

The Task Force actively seeks public comments from stakeholders to support the development of a comprehensive report on the state of Federal maternal mental health programs and best practices for maternal mental health and SUD. The Task Force will formulate a national strategy for improving maternal mental health with particular emphasis on recommendations applicable during pregnancy and the postpartum period (up to one year after birth) for individuals with or at risk for mental health and substance use conditions.

In response to the questions below, the Advancing Health Equity and Behavioral Health teams at the Commonwealth Fund have prepared the following:

Data, Research, and Quality Improvement

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

The primary goals for pregnant and postpartum individuals who are dealing with substance use and/or mental health conditions align with those for all pregnant individuals. These goals include ensuring a healthy pregnancy leading to a full-term live birth, preventing severe maternal health complications and mortality, and establishing a comprehensive health care plan. This plan should address not only general health needs but also provide specific resources and support for managing substance use and mental health issues. Recent research has shown that roughly two thirds of maternal deaths in the U.S. occur during the postpartum period,[i] and mental health conditions were the most represented underlying cause of maternal deaths, representing 22.7% of pregnancy-related deaths where a cause was identified (Trost et al., 2021).[ii] Furthermore, all the deaths attributed to mental health were deemed preventable by Maternal Mortality Review Committees, highlighting the urgent need to support maternal mental health.

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

Quality health care and mental health care includes addressing the structural drivers and social determinants of health that also contribute to perinatal health disparities among racialized minorities, including lack of housing, paid family leave, access to quality health care including doulas and midwifery support, adequate nutrition, and breastfeeding assistance. An integrated, systems-based, patient-centered approach is needed to support these individuals, their families, and communities. Tackling maternal mental health issues in racialized minority communities demands a comprehensive strategy that not only acknowledges the distinct challenges these groups face but also addresses the potential risks of stigma and inequitable punitive measures in these settings. Systemic issues such as racism, trauma, socioeconomic disparities, and limited culturally competent care play a significant role in mental health and wellbeing.

- For example, housing instability and poor housing quality are associated with poorer maternal mental health, which is a risk factor for maternal morbidity and mortality.
- Further, living in an unsafe community or social context can have physical and mental health consequences, which disproportionately impacts birthing people of color, who reside in these areas due to the legacy of redlining, systematically limiting quality housing for Black families.
- Evidence also highlights the profound negative impacts of interpersonal violence on maternal morbidity and mortality, including increased risk of pregnancy-associated homicide and suicide and other maternal mental health issues.
- Finally, life stressors including financial and relationship stress predicts high depressive symptoms postpartum, particularly among Black and Hispanic mothers[iii] (Liu et al., 2016)

Quality care for pregnant and postpartum individuals with substance use or mental health conditions should thus reflect a "continuum approach" to help ensure that health is optimized before pregnancy and that quality care is delivered throughout pregnancy, birth, and an extended postpartum period (a minimum of 12 months, which has been adopted as a Medicaid extension period in 40 states plus the District of Columbia).

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?

Resources that support maternal SUD and mental health conditions must be integrated into the social benefits and quality of care bundles for pregnant and postpartum people, from family planning and health before pregnancy, during pregnancy, and through the postpartum period of 12 months. Priority research questions should be:

1. What is the prevalence and prominent mental health conditions among pregnant and postpartum people? How do these differ when diagnosed pre-pregnancy (as a primary condition) or during pregnancy/postpartum (as a secondary condition)?
2. What is the burden of SUD among pregnant and postpartum people?
3. How are structural racism and the social drivers of health (e.g., housing, social support, employment access) affecting these conditions, and how can these be mitigated with current programming (Medicaid, screening, etc.), existing support (e.g., community-based models of care) and emerging innovations (e.g., home visits, telehealth) to address SUD/mental health conditions, and achieve mental health equity among pregnant and postpartum individuals at risk for maternal mortality and severe morbidity?
4. How are current evidence-based, community-engaged programs working to improve mental health well-being and SUD? What is working and what can be replicated at scale to maximize impact?
5. What state and local policies exist to support mental health, and what may be insufficient or resulting in worse mental health outcomes for pregnant and postpartum people with SUD or mental health conditions?

Prevention, Screening, and Diagnosis

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

Perinatal mood and anxiety disorders are associated with a range of adverse outcomes for pregnant and postpartum people, affecting up to one out of five birthing people, depending on the study population and the screening tool used.[iv] Substance use in pregnancy varies in prevalence, depending on the type of substance, with SAMHSA's 2022 National Survey on Drug Use and Health (NSDUH) report revealing that approximately 9.6% of pregnant women 15-44 reported illicit drug use in the past month, 11% reported alcohol use, and 5.5% used tobacco products. The report also noted increases seen in both illicit drug and alcohol use since 2021, while tobacco use was substantially reduced since 2021. Further research is essential to pinpoint specific risks among different racial groups and to explore opportunities for interventions that are effective across various cultural groups.

Research by the Commonwealth Fund and Urban Institute found that pregnant and postpartum people experience a lack of recognition for their birthing preferences, postpartum visits that appear perfunctory and unnecessary based on interactions with providers, and a lack of awareness of the breadth of community-based options and resources available to them (e.g., doulas, midwives, free standing birthing

centers) that can facilitate a healthy pregnancy and maternal outcomes. Aligning with the preferences of pregnant or postpartum individuals with SUD and mental health issues would be a first step in providing adequate services to screen, diagnose and support the mental health and emotional well-being of new moms.

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

According to the Commonwealth Fund's policy review, access to and engagement in treatment for perinatal mood and anxiety disorders and substance use in pregnancy remains challenging, with notable racial disparities.[v] Universal screening for perinatal depression and substance use are currently recommended, but there are significant barriers to implementation, including:[vi]

- An inability to conduct screening in languages other than English and Spanish, as well as issues with the cultural relevance of screening tools;
- Provider payment structures, which do not support screening;
- Referral requirements, particularly in areas where services are unavailable or scarce;
- Stigma of depression and SUD;
- Lack of privacy at many screening locations, which can deter people from seeking mental health screening;
- Lack of access to specialists in the field of reproductive mental health.

Perinatal mood and anxiety disorders and, especially, substance use in pregnancy have been used legally to criminalize pregnant and birthing people and can result in removal of children from birth parents, which may lead many to delay care or not seek help.[vii] Birthing people of color are especially likely to be criminalized for mental illness.[viii]

The removal of children and the arrest of parents does irreparable harm to many families; moreover, these actions can pose a barrier to getting evidence-based treatment and can lead individuals to avoid seeking prenatal care.[ix] Notably, criminalization does not increase access to treatment: people referred into substance use treatment through criminal justice agencies are in fact less likely to receive treatment.[x]

Community-based supports, and involvement of pregnant and postpartum people with SUD/mental health concerns are needed to drive change. Helping to identify and screen for both primary and secondary mental health conditions in pregnant and postpartum people can assist, while also acknowledging the life stressors that may be more prevalent among racialized minorities. Finally, working to identify, diagnose, and treat SUD before, during pregnancy and postpartum without penalty is key to supporting maternal mental health equity.

Reproductive Mental Health and Women Veterans. More than 50 percent of women Veterans seen at the VA have a mental health diagnosis.[xi] Given the mental health comorbidity in women Veterans, reproductive mental health is a major area of focus. Additional efforts leveraging the capacity of the Department of Defense and Department of Veterans Affairs in collaboration with SAMHSA and other agencies in the federal government can further support reproductive mental health initiatives to optimize the health and wellness of women Veterans.

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?

Trust in health care providers, diversity of providers (e.g., midwives, doulas, race concordant health care workers) and adequate training to personalize care, and addressing legal consequences for SUD and mental health conditions could contribute to more open communication and appropriate care and referrals for pregnant and postpartum individuals.

Evidence-based Intervention and Treatment

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

- Community-based care models and home visits;
- Extension of Medicaid benefits to include postpartum depression screening, coverage of treatment, and SUD benefits without legal penalty;
- Technological interventions for screening and monitoring maternal health, including telehealth;
- Diversification of the workforce to incorporate a mental health provider into the perinatal health team (e.g., exploring training specialized community health workers in maternal mental health tracking and monitoring).

What are the barriers/gaps to evidence-based intervention for maternal mental health and substance use among reproductive age individuals?

Key barriers/gaps include:

- Stigma for SUD and mental health conditions, either pre-pregnancy, during pregnancy, or postpartum;
- A lack of additional, context-specific information on the needs across racial and ethnic groups.
- Limited access to evidence-based programming, and to diverse mental health professionals
- Logistical hurdles and limited resources to access quality mental health care, such as referrals, and associated costs

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?

Our perspective as health care workers, funders, and policymakers is not enough. For community-engaged research to be effective, it needs to follow principles aligned with participatory research through all phases of guideline development and privilege the voices of those most directly affected. Ongoing, meaningful participation needs to be activated in the design of screening tools, their implementation guidelines, and application to screening, care, and treatment for diverse, underserved populations, including veterans and incarcerated women.

Evidence-based Community Practices

What are the most pressing needs related to maternal mental health and maternal substance use in your community? For the purposes of this question, please define "community" however it most resonates with you (e.g., geography, race, ethnicity, sexual orientation, and gender identity, disability status, American Indian/Alaska Native status, veteran status, etc.)

Through a study with the Urban Institute, the Commonwealth Fund has aligned with the community to identify a range of preferences that would support maternal health, and in turn, maternal mental health and well-being from pregnancy through the extended postpartum period. For example, women expressed preference for providers who can share information on their range of care options—including provider types and birthing locations—based on their risk level starting in the prenatal period. Women also desired a holistic maternity care model that includes screenings and support for the social drivers of health.

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?

The Commonwealth Fund has identified the following strategies that hold promise for transformative delivery of community-based perinatal care, some of which are also being offered through Medicaid, to improve mental health outcomes among pregnant and postpartum people:

- Incorporating diverse groups of health care providers, including community-based doulas and midwives;
- Offering non-hospital-based care, including freestanding birth centers and community health clinics;
- Exploring innovative models of maternity care, including group prenatal care and pregnancy medical homes and models optimizing digital health;
- Leveraging payment and delivery system reform by:
    - Expanding and improving reimbursement for diverse health care provider types (e.g., doulas, midwives) and maternal/reproductive mental health specialists;
    - Improving access to services (e.g., extending Medicaid coverage to at least one year postpartum, including more services that address medical, behavioral, and social health needs within Medicaid and other delivery system models). This may include clarifying that maternity care physicians may be reimbursed for maternal mental health screening under Medicaid;
    - Incentivizing health systems and providers to adopt evidence-based models of care that foster maternal health equity.

Communications and Community Engagement

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

What we're hearing from the community:

- Making critical investments to address social determinants of health that can exacerbate mental well-being and SUD, rather than a siloed approach solely focused on mental health;
- Training and diversifying the perinatal workforce—including doulas and midwives, who can respond to diverse pregnant and postpartum people with empathy and culturally-appropriate tools for mental health screening, diagnosis, care and treatment;
- Funding organizations that are working to improve maternal health outcomes holistically in Black communities and community-based models of care.

What we're hearing from health care providers:

- Investing in maternal mental health care and treatment for SUD. Stigma remains strong for mental health care and treatment, limiting access and options to pregnant and postpartum people;
- Expanding models for postpartum in-hospital withdrawal and treatment options for mom and baby,
- Requiring more research and focused, culturally competent interventions addressing communities of color;
- Improving data collection and quality measures to understand causes of the maternal health crisis, and the intersections with mental health and SUD, to ensure appropriate resource allocation and an integrated, systems-level approach;
- Investing in telehealth to improve maternal mental health outcomes in underserved areas, particularly in perinatal care deserts across the U.S. which disproportionately impact Native American populations. Recent research findings suggest that patients are receptive to routine verbal screening for substance use. Thus, investment in consultation hotlines, distance coaching for providers under collaborative care models, and telehealth may help to improve access to treatment for perinatal mental health and substance use.

What we're hearing from policymakers:

- Promoting payment models that incentivize high-value maternity care and continuous health coverage from pregnancy through one year postpartum, including mental health screening and SUD support;
- Supporting Medicaid expansion which provides continuous care for the postpartum period, when the majority of severe maternal morbidity and maternal mental health issues emerge;
- Increasing access to and coverage of comprehensive high-quality maternal health services, including behavioral health services (e.g., expanding the Rural Maternity and Obstetrics Management Strategies Program), as noted by the Health Resources and Services Administration in support of the White House Blueprint for Addressing the Maternal Health Crisis;
- Testing innovative models through the Centers for Medicare and Medicaid Services, such as the Innovation in Behavioral Health (IBH) model that supports community-based behavioral health practices to meet the behavioral, physical, and health-related social needs of people with moderate to severe behavioral health conditions. *NOTE- These models can and should be integrated with Models addressing maternal health.*

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

A community-led, continuum-based, integrated approach is critical to detect, treat and support pregnant and postpartum people with culturally sensitive and tailored mental health care, that acknowledges the social determinants of health.

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 above.

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