November 5, 2021

The Honorable Chris Murphy
United States Senate
136 Hart Senate Office Building
Washington DC, 20510

The Honorable Bill Cassidy, M.D.
United States Senate
520 Hart Senate Office Building
Washington DC, 20510

Dear Senators Murphy and Cassidy,

The Maternal Mental Health Leadership Alliance would like to express our gratitude for your commitment to addressing the United States' growing mental health crisis with the "Request for Information" solicited on October 5th and your work over the past decade on mental health and substance use disorder programs. As you consider updates and reauthorization for many of the programs in your *Mental Health Reform Act*, passed through the *21st Century Cures Act*, we value the opportunity to provide input on how Congress can best support the specific mental health needs of our nation's mothers.

Congress must continue to invest in the screening, identification, treatment of, and referral for MMH conditions, which are the most common complications of pregnancy and childbirth and affect 1 in 5 women (800,000 families each year in the United States).[1] Recent studies show that suicide and overdose combined are the leading cause of postpartum death for new mothers, contributing to the distressingly high maternal mortality rate in the United States.[2,3] Sadly, 75% of those experiencing MMH conditions are never treated, increasing the risk of multigenerational, long-term impacts on both mother and child.[4,5] The cost of not treating MMH conditions is $32,000 per mother-infant pair, or $14.2 billion nationally each year.[6] COVID-19 has exacerbated MMH conditions, with a recent study showing that pregnant women and new mothers are experiencing anxiety and depression at 3-4 times the rate prior to the pandemic.[7,8] Women of color, low-income women, and other populations disproportionately served by Medicaid programs are also impacted at greater rates by both the pandemic[9] and MMH conditions, experiencing maternal mental health and substance use disorders at rates as high as 28%.[10,11,12,13,14]

[1] Luca, D., et al (2019). Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States. *Mathematic Policy Research.*
[2] Metz, t., et al (2016). Maternal Deaths From Suicide and Overdose in Colorado, 2004-2012. *Obstetrics Gynecol.*
[3] Davis N., et al (2019). Pregnancy-Related Deaths: Data From 14 U.S. Maternal Mortality Review Committees, 2008-2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.
[4] Center for Disease Control and Prevention website. www.cdc.gov/reproductivehealth/depression/index.
[5] Luca, et al.
[6] Luca, et al.
[7] Berthelot N., et al (2020). Uptrend in Distress and Psychiatric Symptomatology in Pregnant Women During the Coronavirus Disease 2019 Pandemic. *Acta Obstetricia et Gynecologica Scandinavica*.
[8] Lebel, C., et al (2020). Elevated Depression and Anxiety Among Pregnant Individuals During COVID-19c. *Journal of Affective Disorders.*
[9] Society for Research in Women's Health website. https://swhr.org/the-disproportionate-impact-of-covid-19-on-women-of-color/
[10] Howell, E., et al. (2005). Racial and Ethnic Differences in Factors Associated With Early Postpartum Depressive Symptoms. *Obstet Gynecol.*
[11] Goldman-Mellor, S. and C.E. Margerison, *Maternal drug-related death and suicide are leading causes of postpartum death in California.* Am J Obstet Gynecol, 2019. **221**(5): p. 489.e1-489.e9.
[12] Lindahl, V., J.L. Pearson, and L. Colpe, *Prevalence of suicidality during pregnancy and the postpartum.* Arch Womens Ment Health, 2005. **8**(2): p. 77-87.
[13] Davis, N.L., A.N. Smoots, and D.A. Goodman, *Pregnancy-Related Deaths: Data from 14 US Maternal Mortality Review Committees.* Education, 2019. **40**(36): p. 8-2.
[14] Gavin, N.I., et al., *Perinatal depression: a systematic review of prevalence and incidence.* Obstetrics & Gynecology, 2005. **106**(5 Part 1): p. 1071-1083.

Professional societies and policy-makers recommend universal screening for perinatal mental health and substance use disorders[15,16,17,18,19,20] and many states mandate universal screening.[21] Although screening is well accepted by patients and obstetric providers[22,23], screening alone is not enough. Less than 20% of pregnant individuals who screen positive for depression receive initial treatment and as little as 0-2% receive any follow-up treatment.[24] Regrettably, the care pathway for mental health and substance use disorders– screening, assessment, and treatment until symptom remission – is laden with barriers and gaps in care. These barriers are magnified for women who are Medicaid-insured.[17,25] Federal and state policy-makers, researchers, and our patient and provider partners all identify the need to improve the capacity of front-line obstetric providers to address perinatal mental health and substance use disorders. Doing so is critical to securing access to quality mental healthcare for perinatal women.

Our comments focus specifically on **reauthorizing and expanding the Bringing Postpartum Depression out of the Shadows Act, which first passed as Section 10005 of the 21st Century Cures Act**. The reauthorization effort has been led by Senators Gillibrand, Capito, and Baldwin. This bipartisan provision authorized $5 million annually for states grants to train health care providers to screen and treat for maternal depression and create psychiatric access programs for maternal mental health (MMH) conditions under HRSA. Since this authorization, HRSA created the "Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program", funding seven states out of thirty-two that applied to create and maintain these programs.

Demand for and success of these grant programs – including in the state of Louisiana, which currently receives funds through the authorization – demonstrates the critical need to reauthorize this program. Additionally, there exists a huge opportunity to expand the program's reach and positive impact on maternal mental health in the following ways:

Expanding HRSA Screening and Treatment for Maternal Depression and Related Behavioral Disorders Grants

Pregnant and postpartum patients see a healthcare provider an average of 25 times during the two-year timeframe from conception through the first year following pregnancy. Psychiatric access line programs and healthcare provider MMH trainings therefore function within existing systems of care to give providers necessary tools to identify and successfully interrupt MMH conditions. Existing HRSA "Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program" are

[15] Felitti, V.J., et al., *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study.* American journal of preventive medicine, 1998. **14**(4): p. 245-258.
[16] Edge, D., *Falling through the net—Black and minority ethnic women and perinatal mental healthcare: health professionals' views.* General hospital psychiatry, 2010. **32**(1): p. 17-25.
[17] Dennis, C.L. and L. Chung-Lee, *Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review.* Birth, 2006. **33**(4): p. 323-331.
[18] Bennett, I.M., et al., *"One end has nothing to do with the other:" Patient attitudes regarding help seeking intention for depression in gynecologic and obstetric settings.* Archives of women's mental health, 2009. **12**(5): p. 301-308.
[19] Taylor, K.J. and S. Benatar, *The pandemic has increased demand for data and accountability to decrease maternal health inequity.* Urban Institute, 2020.
[20] Siu, A.L., et al., *Screening for depression in adults: US Preventive Services Task Force recommendation statement.* Jama, 2016. **315**(4): p. 380-387.
[21] Rowan, P.J., S.A. Duckett, and J.E. Wang, *State mandates regarding postpartum depression.* Psychiatric Services, 2015. **66**(3): p. 324-328.
[22] LaRocco-Cockburn, A., et al., *Depression screening attitudes and practices among obstetrician–gynecologists.* Obstetrics & Gynecology, 2003. **101**(5): p. 892-898.
[23] Byatt, N., et al., *Strategies for improving perinatal depression treatment in North American outpatient obstetric settings.* Journal of Psychosomatic Obstetrics & Gynecology, 2012. **33**(4): p. 143-161.
[24] Byatt, N., et al., *Enhancing participation in depression care in outpatient perinatal care settings: a systematic review.* Obstetrics and gynecology, 2015. **126**(5): p. 1048.
[25] Palladino, C.L., et al., *OB CARES—The Obstetric Clinics and Resources Study: providers' perceptions of addressing perinatal depression—a qualitative study.* General hospital psychiatry, 2011. **33**(3): p. 267-278.

effective at strengthening the maternal health workforce by training frontline providers, such as obstetricians and pediatricians, to educate and screen women for MMH conditions; providing real-time psychiatric consultation; and offering resources and referrals. Nearly 120 million Americans (including 3.4 million Louisianans and 1.1 million Nutmeggers) live in a Mental Health Professional Shortage Area – defined by the Bureau of Health Workforce as an area with fewer than 1 psychiatrist for every 30,000 people.[26] Given these gaps, many individuals impacted by MMH conditions are unlikely to ever receive psychiatric treatment. Psychiatric access programs instead leverage available highly-trained psychiatrists to educate community-embedded frontline providers so they can meet the needs of their patients where they are.

The Massachusetts Child Psychiatry Access Program (MCPAP for Moms), which serves as a national model for psychiatric access programs, has been found to improve treatment initiation and sustainment rates and depression outcomes among pregnant and postpartum individuals.[27] They are being implemented in 19 states across the United States, with seven currently funded by HRSA through the Screening and Treatment Grants program.[28] Collectively, these programs cover more than 2 million (55%) of the 3.7 million US births each year. The widespread adoption and growth of Perinatal Psychiatry Access Programs reflects demonstrated evidence of effectiveness and creates an unprecedented opportunity for federal investment to support further expansion, evaluation, and sustainability. When the funding opportunity was first announced in 2018, thirty states, along with Washington, D.C., and Puerto Rico, applied for HRSA Screening and Treatment Grant funding. However, due to budget limitations, only seven applicant states ultimately received grants. We therefore recommend the reauthorization and expansion of these grants to nationwide availability – including all states, the District of Columbia, and United States territories – so that every mother can receive these supports regardless of where she lives. Secondly, funding is required to support psychiatric access programs in developing the evaluative approaches needed to leverage available data and inform ongoing quality improvement initiatives. Thirdly, funding is required to sustain programs that received initial investments through HRSA. The original seven grantees report facing a funding cliff, jeopardizing the sustainability of their respective programs. Federal initiatives to support the sustainability of these existing programs are critical, especially given evidence that the MCPAP for Moms model improves treatment rates and depression outcomes. Finally, we propose the inclusion of culturally congruent care trainings for providers and HRSA-provided technical assistance to grantee and non-grantee states to help with program implementation and other MMH efforts.

Summary of our Recommendations:

Expand existing HRSA Screening and Treatment for Maternal Depression and Related Behavioral Disorders program capacity from 7 states to all 50 states, D.C., and Puerto Rico.

1. Add culturally and linguistically appropriate care trainings for providers;
2. Assist mothers to receive treatment, including patient consultation, care coordination, and navigation for treatment;
3. Conduct outreach and awareness around the state's programs;
4. Support the development of evaluative approaches to leverage data and inform quality improvement of psychiatric access lines;
5. Sustain previous grantees to ensure program sustainability;
6. Coordinate with state and local government agencies' maternal and child health programs,

[26] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport
[27] Byatt, N., et al., *Program In Support of Moms (PRISM): a pilot group randomized controlled trial of two approaches to improving depression among perinatal women.* Journal of Psychosomatic Obstetrics & Gynecology, 2018. **39**(4): p. 297-306.
[28] Health Resources and Services Administration. *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program* 2021 [cited 2021 October 25]; Available from: https://mchb.hrsa.gov/maternal-child-health-initiatives/mental-behavioral-health/mdrbd.

including child psychiatric access lines; and

7. Include HRSA-provided technical assistance to support grantee and non-grantee states with the creation, implementation, and improvement of state-based MMH psychiatric access lines as well as screening and treatment training programs.

Permanently Authorizing the Maternal Mental Health Hotline

The Maternal Mental Health Hotline, originally passed through the Fiscal Year 2021 Consolidated Appropriations Act, works as an extension of HRSA Screening and Treatment Grants to get mothers support and treatment as soon as possible. MMHLA recommends the permanent authorization of this 24/7 real-time voice and text support for mothers and families, so that it can continue to offer a lifeline to struggling mothers. The MMH Hotline immediately connects callers to highly-trained individuals who provide real-time emotional support, information, brief intervention, and resources and referrals for individuals affected by maternal mental health conditions. We further recommend the addition of culturally and linguistically appropriate supports to the hotline to improve access and equity.

Summary of our Recommendations:

Authorize and improve the existing HRSA Maternal Mental Health Hotline, allowing for a nationally-operated 24/7 real-time voice and text access resource for individuals affected by MMH conditions, including the following improvements to the hotline:

1. Add culturally and linguistically appropriate supports to improve access and equity;
2. Consult and coordinate with the other federal hotlines including the Domestic Violence Hotline and National Suicide Prevention Lifeline to ensure pregnant and postpartum women are connected in real time to appropriate specialized hotline services, when applicable;
3. Conduct a public awareness campaign for mothers and their loved ones; and
4. Coordinate with federal departments and agencies, including SAMHSA's Centers of Excellence and Technical Assistance Centers

We thank the Committee for its ongoing attention to issues of mental health in our country, and especially for addressing MMH conditions. New mothers need support: they are the heart and soul of the family. When a mother thrives, so does her child, her family, and her community.

Sincerely,

Adrienne Griffen, MPP
Executive Director