

MOMS & BABIES SERIES

THE MATERNAL MENTAL HEALTH CRISIS UNDERMINES MOMS' AND BABIES' HEALTH

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THE PROBLEM: UNTREATED MATERNAL MENTAL HEALTH MEANS WORSE HEALTH OUTCOMES FOR MOMS AND BABIES

The mental health of mothers in the United States is in crisis. This harms not only their own health, but also that of their infants. Maternal mental health (MMH) conditions are relatively common, affecting one in five women.¹ When left undiagnosed and untreated, MMH conditions can lead to long-term adverse health consequences for the birthing person,[†] their infant, and family. Preventing and consistently treating MMH conditions is a crucial component in fighting the larger maternal mortality and morbidity crisis in the United States, and in promoting healthier communities overall.

MMH conditions are generally defined as those that appear during pregnancy or up to one year after giving birth. Depression is the most common, followed by generalized anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), bipolar disorder, and postpartum psychosis.²

Though hormonal changes during pregnancy and the postpartum period can cause mood disorders or anxiety to surface, MMH conditions are not exclusively driven by neurochemical causes; other key factors, including racism and low socioeconomic status, can increase the risk and severity.³ Centuries-long systemic racism, discrimination, and social inequities have inflicted multi-generational trauma on Black, Indigenous, and other people of color (BIPOC) in this country.⁴ In addition, structural racism and discrimination have created barriers to affordable and culturally appropriate mental health care.⁵ While this racial trauma can contribute to the development of mental health conditions,⁶ research and disaggregated data on BIPOC communities' mental health prior to becoming pregnant is needed. These external stressors can have significant effects on pregnancy, maternal health, and a child's development.⁷

During national crises, pregnant women have significantly higher rates of mood disorders than the general population.⁸ In addition, racism and other structural disadvantages result in people of color being disproportionately affected by national crises, which also exacerbates MMH conditions among pregnant and birthing people of color.⁹ The COVID-19 pandemic has disproportionately harmed the health and economic well-being of Black and Latinx^{††}

† We recognize and respect that pregnant, birthing, postpartum, and parenting people have a range of gender identities, and do not always identify as “women” or “mothers.” In recognition of the diversity of identities, this series prioritizes the use of non-gendered language where possible.

†† To be more inclusive of diverse gender identities this bulletin uses “Latinx” to describe people who trace their roots to Latin America, except where the research uses “Latino/a” or “Hispanic,” to ensure fidelity to the data.

ABOUT THE SERIES:

Our maternity care system often fails to provide equitable, respectful, culturally centered, safe, effective, and affordable care. It spectacularly fails communities struggling with the burden of structural racism and other forms of inequity, including: Black, Indigenous, and other People of Color (BIPOC); rural communities; and people with low incomes. The multiple crises of the COVID pandemic, economic downturn, and national reckoning on racism have underscored the need to address the social influencers of health. This series identifies ways to improve maternal and infant health by tackling some of these factors. Topics were chosen based on importance and urgency, and availability of systematic reviews and complementary research.



communities, who have suffered a higher risk of hospitalization and death due to the disease.¹⁰ An important driver of these inequities is that people of color are more likely to be essential workers in industries that are not amenable to working from home, putting them at greater risk of contracting COVID-19.¹¹ Moreover, communities of color are more likely to face food insecurity, unstable housing, and loss of income and health insurance. The stress of these additional burdens placed on pregnant and birthing people of color has caused symptoms of MMH conditions to skyrocket.¹²

MATERNAL MENTAL HEALTH CONDITIONS RISK THE HEALTH OF PREGNANT PEOPLE AND THEIR INFANTS

Systematic reviews (rigorous reviews that collect, assess, and synthesize the best available evidence from existing studies) have found:

- According to one meta-analysis, women experiencing depression or anxiety at any time during their pregnancy are 40 percent more likely to have hypertension than those who do not.¹³
- Women with untreated bipolar disorder are more likely to experience adverse pregnancy outcomes, such as gestational hypertension and hemorrhaging,¹⁴ and are nearly twice as likely to have a preterm birth compared to women without mental health challenges.¹⁵
- Pregnant women with untreated anxiety have a higher risk of preterm birth, lower birth weight, and their infants have a higher risk of being small for their gestational age.¹⁶
- Infants of women with untreated postpartum depression can experience long-term negative impacts on their weight, length, head circumference, motor development, cognitive development, and sleep patterns.¹⁷
- Women who experience PTSD during pregnancy have a higher risk of preterm birth and poor fetal growth.¹⁸

Other individual studies have found:

- Undiagnosed and untreated psychiatric disorders, such as depression, are a risk factor for suicide in new mothers,¹⁹ a leading cause of maternal mortality in the United States.²⁰
- If left untreated, postpartum psychosis can lead to an increased risk of infanticide.²¹

COMPARED TO WHITE MOTHERS, NEW MOTHERS OF COLOR HAVE NEARLY DOUBLE THE RATE OF POSTPARTUM DEPRESSION.¹




MATERNAL MENTAL HEALTH INEQUITIES DISPROPORTIONATELY BURDEN PEOPLE OF COLOR AND THOSE WITH LOW INCOMES

Birthing Black, Indigenous, and other people of color, and those with low incomes bear a heavier burden of MMH conditions. Intersecting structures of disadvantage, grounded in racism, have systematically denied communities of color resources that would prevent, mitigate, and treat MMH conditions.

Studies show:

- Women of low socioeconomic status – including income, marital status, employment, education level – are 11 times more likely to develop postpartum depression symptoms than women of higher socioeconomic status.²²
- More than half of infants in low-income households live with a mother experiencing some form of depression.²³
- New mothers of color have rates of postpartum depression close to 38 percent, almost twice the rate of white new mothers.²⁴
- Nearly 60 percent of Black and Latina mothers do not receive any treatment or support services for prenatal and postpartum emotional complications. Reasons include lack of insurance coverage, social and cultural stigma related to mental health needs, logistical barriers to services, and lack of culturally appropriate care.²⁵
- Nearly 30 percent of American Indian and Alaskan Native (AI/AN) mothers experience postpartum depression.²⁶ One study found that postpartum depression in the AI/AN communities is correlated to stressful life events such as financial and housing instability.²⁷
- Postpartum depression is 40 percent greater in Latina mothers and 80 percent greater in Black mothers living in small cities and rural communities compared to their white counterparts.²⁸



“ AFTER BIRTH, I CRIED FOR WEEKS. I FELT SO DOWN I HAD NO SUPPORT FROM MY OB DOCTOR. I DIDN'T GET TO SEE HER AFTER SIX WEEKS. IT WOULD BE NICE IF THERE WERE MORE SUPPORT FOR NEW MOMMIES. ”



THE MATERNAL MENTAL HEALTH CRISIS UNDERMINES MOMS' AND BABIES' HEALTH

RECOMMENDATIONS

1. Congress must make extending Medicaid for an entire year postpartum permanent and mandatory. The American Rescue Plan included a state option to extend Medicaid postpartum coverage from the standard 60 days to up to 12 months following delivery. However, this provision will expire in 2026 and offers few incentives to states to expand to 12 months. Congress should pass MOMMA's Act to extend Medicaid to 12 months postpartum nationwide. By doing so, states can ensure that tens of thousands of new parents have access to mental health care services during a medically vulnerable period for BIPOC birthing people and new parents.
2. Congress must pass the Moms Matter Act (H.R. 909/S. 484), the Kira Johnson Act (H.R. 1212), and the Tech to Save Moms Act (H.R. 937/S. 893), all part of the Black Maternal Health Omnibus. Together, these bills include funding for local initiatives that address MMH conditions among communities of color and grow and diversify the maternal mental and behavioral health workforce, as well as instituting best practices in screening for and treating MMH conditions.
3. Congress should increase funding for Alliance for Innovation on Maternal Health (AIM) Maternity Care Safety Bundles. State lawmakers and health care systems should support widespread implementation of AIM safety bundles. The AIM safety bundle provides recommendations to effectively implement standardized screening, intervention, referral, and follow-up for MMH conditions in maternity care, as well as pairing them with resources to aid in effective utilization.
4. Decisionmakers must work with and fund initiatives spearheaded by BIPOC-led birthing justice organizations. We must support the work that birthing justice organizations lead in advocating for quality mental health services that center the concerns and lived experiences of BIPOC communities.



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