

From Policy to Practice: Administrative Solutions to Strengthen Maternal Mental Health Services

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Abstract

Maternal mental health issues, such as anxiety and depression during pregnancy and the postpartum period, impact many people and are not treated by the healthcare system. Maternal care has always focused primarily on physical results, leaving little opportunity for psychological assistance. Current policy developments, such as the Helping Moms Act and extended postpartum Medicaid coverage, are intended to increase access; nevertheless, administrative obstacles, such as a lack of workers and restricted access to reimbursement, continue to impede implementation. To enhance outcomes and promote health equity, this evaluation will look at the gaps between policy and practice and identify administrative solutions such as integrated care systems, workplace development, screening methods, and sustainable finance.

Keywords

Maternal mental health; Postpartum depression; Healthcare administration; Policy implementation; Medicaid expansion; Collaborative care; Health disparities; Integrated care; Telehealth; Workforce development.

Introduction

A critical yet often overlooked component of healthcare is maternal mental health, which takes place within clinical care, public health, and healthcare administration. Even though pregnancy and childbirth are closely monitored for the physical outcomes, most of the time, the psychological well-being of the mother receives much less attention. Maternal health conditions such as prenatal depression and

anxiety affect approximately 10-20% of individuals during pregnancy or within the first year of postpartum, which is worse among marginalized populations. These factors, which are influenced by things like social stressors, hormonal changes, and access to care, are often not taken seriously and made out to be temporary emotional experiences that everyone goes through, rather than being recognized as a serious health issue. Leaving maternal health issues untreated can cause damaged parent-infant relationships, poor maternal functioning, developmental challenges for children that can become long-term, and, in the worst-case scenario, maternal mortality due to suicide or substance-related causes. These outcomes put a spotlight on the fact that maternal mental health isn't just a clinical issue but a major concern for healthcare quality, safety, and equity.

Even though there is an increase in awareness and policy advancements, such as extended Medicaid postpartum coverage and initiatives to improve maternal health nationally, huge gaps remain to make these policies everyday practices. There are concepts such as prenatal mental health, screenings routinely with tools like the Edinburgh Postnatal Depression Scale that are key and supported in research, but the implementations in clinical settings are inconsistent due to barriers in administration, like limited reimbursements, lack of workforce personnel, and broken care coordination. This paper will investigate the policy and practice disconnecting and will argue that healthcare administrators play a central role in closing the gap. The guiding research question is: how can administrative strategies strengthen maternal mental health services and ensure equitable access to care? This paper will dive into the historical context of maternal health, review current articles, analyze existing policies and case examples, and provide recommendations focused on standardized screenings, integrated care models, workplace development, and adequate funding to improve outcomes for mothers and families.

Background and historical context

For a long time, the way we run healthcare had a huge blind spot. Doctors were great at tracking physical things like a baby's heartbeat or weight, but they often ignored how the person carrying the child was feeling. Maternal mental health was basically one of the most forgotten parts of the system. For most of the 1900s, if a new parent felt deep sadness or fear, it was usually brushed off as just the baby blues. That attitude did a lot of damage. It created a system where mental health was treated like a side issue, leaving many parents to struggle through their hardest moments completely alone.

The change from seeing these struggles as a private problem to seeing them as a major public health crisis has been very slow. We finally realize that only looking at the physical side of pregnancy is dangerous. Our hospitals and clinics were mostly built to handle the birth itself and not much else. Because of that, the rules for insurance and hospital policies rarely include mental health. Even if a mother was brave enough to say she was struggling, the system often had no real way to help her.

As more research came out, reality became impossible to ignore. Today, we know that between 10% and 20% of people deal with serious depression or anxiety during pregnancy or in the first year after birth [1]. In many communities, those numbers are even higher. One of the scariest facts is that mental health problems, like suicide or drug overdoses, cause a large number of deaths in the year after a baby is born (HHS, n.d.). These are real lives. It shows that mental health is not a small detail. It is a main part

of keeping mothers safe and alive.

We do have tools now like the Edinburgh Postnatal Depression Scale to find out who is at risk. Major medical groups now say every patient should be checked for these issues. But a suggestion is not the same thing as a rule. Many patients still leave their checkups without anyone asking about their emotions. This is a failure in how clinics are run. Without a clear plan or a way to get paid for the extra time, these screenings feel optional in a busy office. When that happens, patients get lost in a messy system and never get the care they need.

The data also shows a big problem with fairness. Research shows that Black mothers are three to four times more likely to die from pregnancy related issues than white mothers (HHS, n.d.). When you add the physical risks to the same people sometimes feel about mental health, it creates a huge wall that stops them from getting help. From a management view, these differences show that our funding and our systems for providing care are broken.

There have been some good changes lately. The Affordable Care Act made mental health care a basic requirement for insurance. Medicaid is also very important since it pays for about 42% of all births in the United States (HHS, n.d.). Many states are now extending Medicaid coverage from two months to a full year after birth [2]. This is a big deal because it recognizes that the hard parts of being a new parent last a lot longer than just a few weeks.

In clinics, new models of care are starting to work. Instead of just giving a patient a phone number and hoping they call, these clinics put mental health experts right in the same office. Some states even have programs where doctors can call an expert for advice while they are still in the room with a patient [2]. The government also has a new plan to make these services a normal part of healthcare and to hire more diverse workers [1].

Improving maternal mental health requires changing the system. We need fair pay for screenings, a workforce that understands the people they serve, and better technology to keep everyone connected. For the people running healthcare, the goal is to build a system that catches people before they fall. When we care about the mental health of parents, we make families stronger and kids healthier. This is more than just a job for administrators. It is a moral duty to make sure no parent has to suffer in silence.

Literature Review

For a long time, the people running our healthcare systems mostly just looked at the physical side of pregnancy. Doctors were incredibly careful about tracking things like weight gain and the baby's heartbeat, but they often completely missed how the person actually having the baby was doing emotionally. Maternal mental health was basically pushed to the side, and if someone was in real emotional pain, it was usually just dismissed as the baby blues. But things are finally starting to change. Experts are shifting the conversation and realizing that these struggles aren't just a private issue between a patient and their doctor. Instead, they are seeing them as major failures in how our healthcare systems are built in the first place. Even though we know more about these conditions than ever before, our clinics and hospitals are still lagging way behind. It is becoming clear that the way we

organize care is often what stands in the way of someone get better [4].

We now know that looking only at physical health can actually be dangerous. Statistics show that between 10% and 20% of people deal with serious depression or anxiety during or after pregnancy [1]. Even worse, mental health issues like suicide and drug overdoses are a major cause of deaths in the year after someone gives birth [5]. One of the most important things we have learned is that screening patients works. When clinics use official tools like the Edinburgh Postnatal Depression Scale, many more people get the help they need [6]. However, a survey on a piece of paper does not help if there is no plan for what to do next. If a clinic does not have a clear path for treatment, the patient still gets left behind. To fix this, many experts say we should put mental health workers right in the same office as the pregnancy doctors. This is called a collaborative care model. Instead of just giving a mother a phone number for a therapist and hoping she calls it, she can see someone in the same building where she gets her checkups. This makes it much less likely that she will fall through the cracks and leads to better health for both the mother and the baby [4]. But even if this works, it usually comes down to money and staff. If a clinic does not get paid fairly for the time it takes to do these screenings, they might stop doing them. Real progress requires the government to change how these services are funded, which is why many states are now letting people stay on Medicaid for a full year after birth instead of just two months (MACPAC, 2023). These changes are especially important for fixing unfair treatment based on race. Data shows that Black mothers are three times more likely to die from pregnancy issues than White mothers [6]. They also face many more walls when they try to get mental health support. These problems show that our outreach and our healthcare systems are weak in specific areas. Also, insurance is not enough if there are simply no doctors nearby who know how to help new parents. There is a huge shortage of these specialized workers [2]. To truly fix maternal mental health, we need better pay for doctors, more diverse staff, and better technology. The goal is to build a system that acts like a real safety net so that no parent has to suffer alone.

Current Approaches & Case Examples

One of the most familiar efforts of improving maternal mental health is the Helping MOMS Act, which focuses on increasing funding for maternal mental health programs, improving provider training, and increasing access to screening and treatment. The purpose of this act is to better the connection between practice and policy supporting healthcare systems and the state. The Health Resources and Services Administration (HRSA) Maternal Mental Health Hotline, also provides 24/7 free access for pregnant and postpartum individuals. The hotline connects moms to trained counselors who offer emotional support and direction to local resources if needed.

Medicaid programs have extended postpartum coverage from 60 days to 12 months under the Centers for Medicare & Medicaid Services (CMS). This policy change is significant because many maternal mental health conditions develop or worsen after the traditional 60-day postpartum period. By extending coverage, states are helping ensure that mothers can continue therapy, medication management, and follow-up visits without losing insurance. Hospitals and health systems have also implemented screening programs such as the Edinburgh Postnatal Depression Scale during prenatal and postpartum visits.

Healthcare organizations are responding by integrating mental health services into obstetric and primary care settings. Instead of referring patients to outside providers, some systems are using collaborative care models where behavioral health specialists work directly with OB-GYNs and family physicians. This reduces delays in treatment and improves communication between providers. Policy responses have also focused on workforce development. Federal and state funding has supported telehealth services, loan repayment programs, and training grants to increase the number of providers who specialize in maternal mental health. In addition, accreditation bodies such as The Joint Commission have emphasized the importance of screening for perinatal mood and anxiety disorders as part of quality improvement standards.

A real-world example is MCPAP for Moms in Massachusetts. This program supports obstetric, primary care, and pediatric providers by offering psychiatric consultation and care coordination for pregnant and postpartum patients. Instead of requiring every clinic to hire a psychiatrist, providers can call a consultation line for guidance on diagnosis, medication, and treatment planning. MCPAP for Moms has shown measurable results. Studies have found increased screening rates for postpartum depression and higher provider confidence in managing mental health conditions. Many women were able to begin treatment more quickly because their primary provider received immediate psychiatric support.

Several strategies appear to be effective. First, extending Medicaid coverage has helped reduce gaps in care during the postpartum period. Continuous insurance coverage increases the likelihood that women will attend follow-up visits and continue prescribed treatment. Second, integrating mental health screening into routine prenatal and postpartum care has normalized conversations about emotional well-being. This reduces stigma and increases early detection. Telehealth has also been successful in expanding access, especially in rural communities. Virtual therapy appointments make it easier for new mothers who may struggle with transportation, childcare, or work schedules.

Measured outcomes from various programs show improved screening rates, increased referrals to treatment, and higher patient satisfaction. Some states have reported reductions in severe maternal morbidity related to untreated mental health conditions, though long-term national data is still developing. Despite progress, gaps remain. Workforce shortages continue to limit access, particularly for low-income and minority populations. Even with extended Medicaid coverage, some women face long wait times to see a mental health provider. In addition, not all healthcare systems consistently follow screening guidelines. Stigma also remains a barrier. Some mothers may avoid disclosing symptoms due to fear of judgment or concerns about child protective services involvement. Language barriers and cultural differences can further limit engagement with services. Funding sustainability is another challenge. Many maternal mental health programs

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mothers may avoid disclosing symptoms due to fear of judgment or concerns about child protective services involvement. Language barriers and cultural differences can further limit engagement with services. Funding sustainability is another challenge. Many maternal mental health programs rely on grants rather than permanent funding streams. Without stable reimbursement models, it can be difficult for organizations to maintain long-term services.

Overall, progress has been made in moving maternal mental health policy into practice. Federal legislation, extended Medicaid coverage, hotline services, and collaborative care models are helping close long-standing gaps. Programs such as MCPAP for Moms show that practical, provider-focused solutions can improve screening and treatment rates. However, continued investment, workforce development, and culturally responsive care are needed to ensure that all mothers receive timely and effective mental health support.

Analysis, Recommendations & Conclusion

The research shown throughout the paper clearly stresses how maternal mental health isn't just a clinical problem, but that it also requires a lot of responsibility from healthcare administration to solve. Maternal mental health conditions like depression and anxiety affect so many pregnant and postpartum women, but there are still too many healthcare systems that don't seem to acknowledge or treat these conditions successfully. A lot of awareness has spread about these issues and have caused new policies to be introduced, but there are still barriers. Barriers like inconsistent screening practices, workforce shortages, and disparities in access set them back tremendously and hinder their overall progress. These patterns show that improving maternal mental health calls for a collaborative effort of administrative action and clinical care.

The impact of maternal mental health disorders is hard enough for the patients that experience them, but also negatively influences families and communities. Untreated depression and anxiety during pregnancy or the postpartum period can severely affect maternal functioning, parent infant bonding, and long-term child development. Research also shows that these conditions might last for years if they aren't taken care of in the ways that they need to be. Mothers who have higher risk pregnancies or a higher risk of having premature birth might experience emotional turmoil for a long time after they deliver. One study found that mothers of very preterm infants still reported symptoms of depression and anxiety five years after birth, stressing the lasting effects of maternal mental health challenges [7]. Evidence like this just reiterates how important it is for providers to offer mental health support that lasts instead of limiting their support to the immediate postpartum period.

A few current approaches to maternal mental health still show some strengths within the field. Policies like extending Medicaid postpartum coverage to twelve months have really helped to improve continuity of care and allowed more mothers to receive treatment beyond the traditional sixty-day coverage window. It has also been said that screening tools during prenatal and postpartum visits have helped doctors be able to see early signs of depression and anxiety. Care models that have placed behavioral health professionals into obstetric settings have helped communication between providers and made it a lot easier for patients to easily get treatment. Research indicates that integrating mental

health services within obstetric care can improve treatment engagement and reduce barriers to accessing specialized support [8]. Telehealth services have also increased access for women who might have transportation challenges or limited provider availability which helps increase access to care even more.

Even though there are improvements, some challenges still exist. Many healthcare systems still don't have standardized procedures for mental health screening and referrals. Patients who may need immediate support have to sit through long wait times or are having trouble with being able to access qualified providers. Workforce shortages in maternal mental health specialties are also continuing to limit availability of care, especially in rural and underserved communities.

Even though there are improvements, some challenges still exist. Many healthcare systems still don't have standardized procedures for mental health screening and referrals. Patients who may need immediate support have to sit through long wait times or are having trouble with being able to access qualified providers. Workforce shortages in maternal mental health specialties are also continuing to limit availability of care, especially in rural and underserved communities. Disparities are another big thing to think about because black mothers and other marginalized populations have much higher risks and struggle more when looking for mental health services. To fix these issues, healthcare systems have to do a better job of improving culturally responsive care and work their outreach.

There are a few things that can make maternal mental health services stronger. Healthcare organizations can start to use standardized screening protocols during prenatal and postpartum visits and make sure that patients who need treatment have access to referral pathways. Another thing is that administrators should use integrated care models as more of a tool to place mental health professionals throughout not only obstetric, but primary care settings. Workforce development initiatives can be reworked so that there is more of a priority in making sure that providers are trained in maternal mental health and culturally responsive care. Lastly, policymakers should create sustainable funding that allows successful programs to operate long term and improve data collection to track maternal mental health outcomes across populations [9].

Conclusion

Maternal mental health is an important part of safe and effective maternal care; things should go beyond the delivery period as giving birth comes with many different challenges. Even though policies and plans have been slightly changed over time and increased awareness, there are still many things to address. There are still issues with gaps in screening, treatment coordination, and limited workforce capacity. We can help work on these issues by creating strong administrative leadership, integrated care models, and sustaining policy support. By reworking healthcare systems and prioritizing equitable access to mental health services, healthcare organizations can make a true change and improve outcomes for all mothers, children, and families.

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