October 2022

Dear Community Partners, Leaders, Service Providers, and Families,

It is with much enthusiasm that the Association of Infant Mental Health in TN (AIMHiTN) and Postpartum Support International Tennessee (PSI-TN) announce that we have created a public service announcement (PSA) in English and Spanish that aims to:

1. Raise public awareness of mental health challenges during pregnancy and postpartum including greater understanding of the importance of prevention, recognition, and treatment, and how to seek help and support for mothers and families;
2. Raise awareness about the importance of safe, stable, and nurturing relationships in promoting healthy child, family, and community development;
3. Reduce stigma around perinatal mental health challenges;
4. Raise awareness about health disparities and adverse childhood experiences (ACEs) and advocacy based resources;
5. Raise awareness of state-based resources to support caregivers of infants and young children (e.g., CHANT)

We are asking for your help to help share this PSA with as many families and providers across the state of Tennessee.

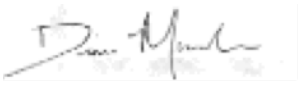
Ways you can help:

- Share this PSA on social media, with your staff/colleagues, and with any families you serve
    - Bonus: Please fill out this brief survey to let us know how you shared it
        - This will help us apply for future funding related to this cause
        - It will also help us identify gaps in reach
- Invite one of our team members to offer a brief presentation that shares the PSA and dissemination tool kit in your class, meeting, agency, etc
    - Contact Keena Friday-Gilbert at keenafg@aimhitn.org
- Make a small donation to AIMHiTN in exchange for printed promotional posters, flyers and/or postcards to let families know about this PSA
    - Contact Keena Friday-Gilbert at keenafg@aimhitn.org
    - Digital posters, flyers, and/or postcards are available at no cost
- Share any of the resources in the dissemination tool kit below with anyone who might benefit from resources related to perinatal (surrounding pregnancy) mental health and/or infant/early childhood mental health

Below you will find a resource toolkit. Please share as you see fit.

This project is funded by a Postpartum Support International Community Engagement Grant and through the support of AIMhiTN and PSI-TN.

Thank you for helping us help children and families across Tennessee!



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ASSOCIATION OF INFANT MENTAL HEALTH IN TENNESSEE

Infant And Early Childhood Mental Health

What Is Infant and Early Childhood Mental Health (IECMH)?

Infant and early childhood mental health refers to the social-emotional well-being of children ages birth to 5 years.

Secure attachments which are formed through sensitive and responsive caregiving are the foundation for all infant and early childhood development. These early relationships shape infant brain development and influence how infants understand themselves, others, and the world. Through secure attachments, infants learn emotional regulation, and with emotional regulation and trust that adults will care for them, they are able to explore their world and learn.

Why Focus on Infant and Early Childhood Mental Health?

Infants are born ready to relate, communicate, and learn. The early years are an especially important time for brain development as more than a million neural connections are made each second. The nature and strength of these connections are determined by an infant's experience with their primary caregivers and environment.

Early exposure to trauma and toxic stress is especially harmful to development. The good news is that infants and young children are also more able to repair, learn, and grow from positive experiences than older children and adults. Early, evidence-informed intervention can improve lifelong functioning.

> "In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last and always."
>
> —Urie Bronfenbrenner

In the context of family, community, and cultural expectations for young children, those who have healthy social/emotional development learn to:

1. ***Experience, regulate, and express emotions***
2. ***Form close and secure interpersonal relationships***
3. ***Explore the environment and learn***

How To Support Infant and Early Childhood Mental Health:

- Creating physically and psychologically safe and nurturing environments
- Being sensitive and responsive to children's needs
- Seeking to understand children's cues and the meaning of their behavior
- Validating children's emotions and being with them when they have big feelings
- Remaining calm and comforting children when they are dysregulated
- Taking time to talk with, have fun with, play with, laugh with, sing with, and delight in children
- Noticing what children notice, getting on children's levels, allowing children to lead play
- Celebrating children's cultures
- Creating routines, consistency, and predictability
- Helping children feel safe by setting limits and using developmentally-appropriate discipline
- Having age-appropriate expectations
- Providing opportunities for children to explore and learn
- Engaging in reflective practice and self-care to better support children
- Recognizing that children are impacted by adverse experiences such as domestic violence and community violence
- Ensuring caregivers have what they need physically and psychologically in order to thrive and care for their children
- Supporting policies and programs that recognize the needs of young children

Infant and Early Childhood Mental Health "values early developing relationships between parents and young children as the foundation for optimal growth and change; directs all services to nurture early developing relationships within families; values the working relationship between parents and professionals as the instrument for therapeutic change; values all relationship experiences, past and present, as significant to one's capacity to nurture and support others."

—www.mi-aimh.org/for-imh-professionals/glossary

Strong Foundations. Healthy Relationships. Bright Futures.

AIMHiTN

Assocation of Infant Mental Health in Tennessee is a professional membership organization. We welcome all those who are part of the early childhood workforce to join us as we make a lasting impact on infants, toddlers, their families, and the future of Tennessee.

www.AIMHiTN.org
info@aimhitn.org

https://aimhitn.org/

https://aimhitn.org/about-early-experiences/what-is-infant-mental-health

National Maternal Mental Health Hotline




1-833-9-HELP4MOMS 1-833-943-5746

https://mchb.hrsa.gov/national-maternal-mental-health-hotline

Free, 24/7, Confidential Hotline for Pregnant and New Moms

Voice and Text in English and Spanish

The National Maternal Mental Health Hotline provides FREE 24/7 confidential support before, during, and after pregnancy.

The Hotline offers helpseekers:

- Phone or text access to professional counselors
- Real-time support and information
- Response within a few minutes, 24 hours a day, 7 days a week
- Resources
- Referrals to local and telehealth providers and support groups
- Culturally sensitive support
- Counselors who speak English and Spanish
- Interpreter services in 60 languages

HOTLINE COUNSELORS

- Licensed health care providers such as nurses or doctors
- Licensed mental health clinicians
- Certified doulas or childbirth educators
- Certified peer support specialists

HOTLINE SERVICES

- Real-time emotional support, encouragement, information, and resources
- Referrals to local or telehealth providers
- Culturally appropriate and trauma-informed support

The Health Resources and Services Administration (HRSA), which is part of the U.S. Department of Health and Human Services, funds the National Maternal Mental Health Hotline under contract number HRS280162. HRSA awarded the contract to Postpartum Support International in September 2021. Congress authorized the Maternal Mental Health Hotline in the Consolidated Appropriations Act of 2021.

This Fact Sheet was prepared by Maternal Mental Health Leadership Alliance (www.mmhla.org) for advocacy purposes and is not an official HRSA publication.

All information is available at **https://mchb.hrsa.gov/national-maternal-mental-health-hotline**, including promotional materials in English and Spanish.

TENNESSEE STATEWIDE CRISIS LINE

There is hope.

855-CRISIS-1 (855-274-7471)

Do you feel like you are experiencing a mental health crisis?

Our Statewide Crisis Line is here to help individuals struggling with a mental health emergency.

This phone line is free and operated by caring, trained mental health professionals, 24 hours a day, 7 days a week.

Confidential help from anywhere in Tennessee is only a phone call away.

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tn.gov/behavioral-health/crisis-services

Tennessee Department of Mental Health and Substance Abuse, Authorization No. 339517, June 2018, 1,000 copies. This public document was promulgated at a cost of $.16 per copy.

TN Department of Mental Health & Substance Abuse Services

CHANT

Community Health Access and Navigation in Tennessee

What is CHANT?

Navigating the complex system of health and social services can be challenging for many individuals and families, and depending on individual needs and medical diagnoses, care may involve several programs, providers, and personnel. To overcome these challenges, the Tennessee Department of Health recently streamlined three public health programs, Help Us Grow Successfully (HUGS), Children's Special Services (CSS) and TennCare Kids Community Outreach into one integrated model of care coordination called the Community Health Access and Navigation in Tennessee (CHANT). CHANT is a voluntary care coordination service through the Local Health Departments to assist families with coordinating medical and social service needs. Through screening and assessments CHANT determines the needs of families and begins the process of connecting them to resources. Individuals may also qualify for services that provide reimbursement for medical services and assistance with co-pays, deductibles and co-insurance for children with physical disabilities from birth to 21 years of age. CHANT teams aim to provide enhanced patient-centered ***engagement*** through ***navigation*** of medical and social service referrals and make a positive ***impact*** on child and maternal health outcomes.

Who is eligible?

Individuals eligible for CHANT include:

- Pregnant and postpartum adolescents and women
- Children (Birth – 21 years)
- Children and Youth with Special Health Care Needs (Birth – 21 years)

Have a referral?

CHANT Care Coordination teams are in each of the 95 Tennessee counties within local health departments. Referrals are accepted from all medical providers and social service agencies. Self-referrals to CHANT are also accepted. Referral forms, instructions and a listing of local CHANT teams are available by accessing the website at www.tn.gov/health/health-program-areas/fhw/early-childhood-program/chant.html or by contacting the CHANT Program Director, brittney.stewart@tn.gov or (615) 532-8192

Comprehensive Screening and Assessment

Each member of the family unit is screened for the following:

- Social services needs
- Mental /behavioral health risk
- Child health and development milestones
- Special health care needs
- Medical risk
- Health insurance
- Medical and dental services

Pathways of Care

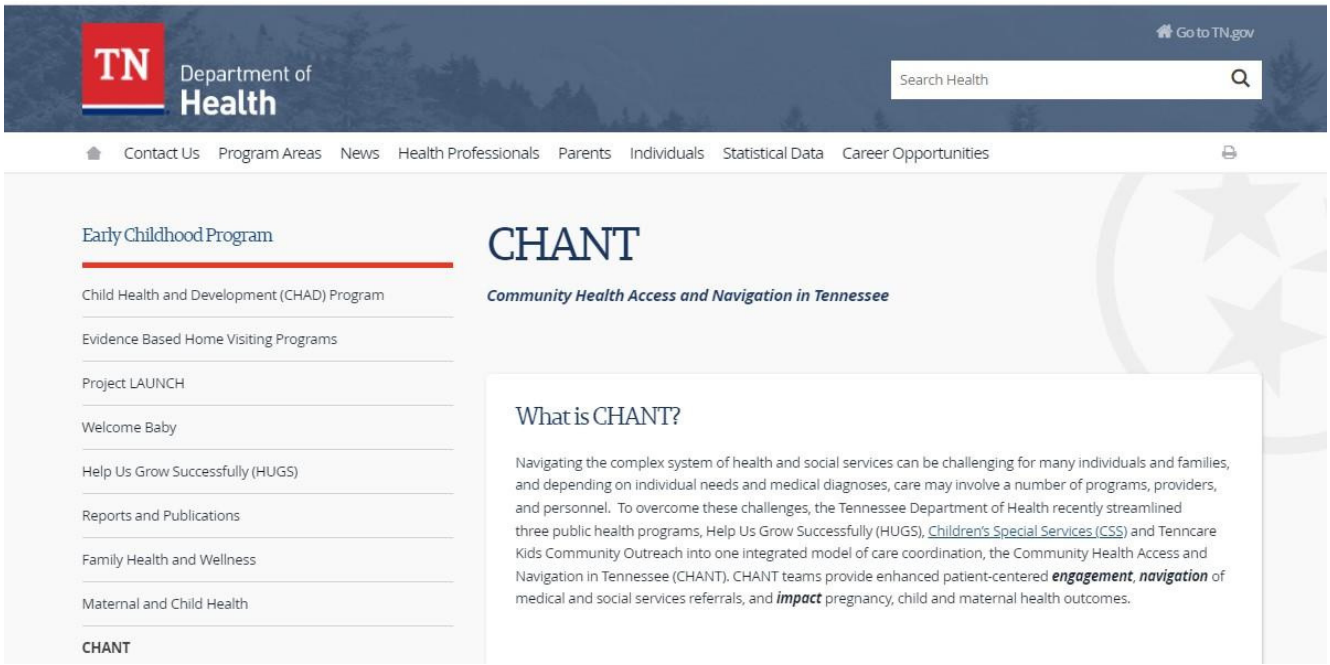
- Behavioral Health
- Child Health and Development Education
- Children and Youth with Special Health Care Needs (CYSHCN)
- Dental Home/Referral
- Developmental Screening/ Referral
- Employment
- Family Planning
- Health Insurance
- Housing
- Immunization Screening/ Referral
- Maternal Loss
- Medical Home/Referral
- Pregnancy/ Postpartum
- Perinatal Loss
- Smoking Cessation
- Social Service Referral
- Transition of CYSHCN 14+ yrs.

Care Coordination

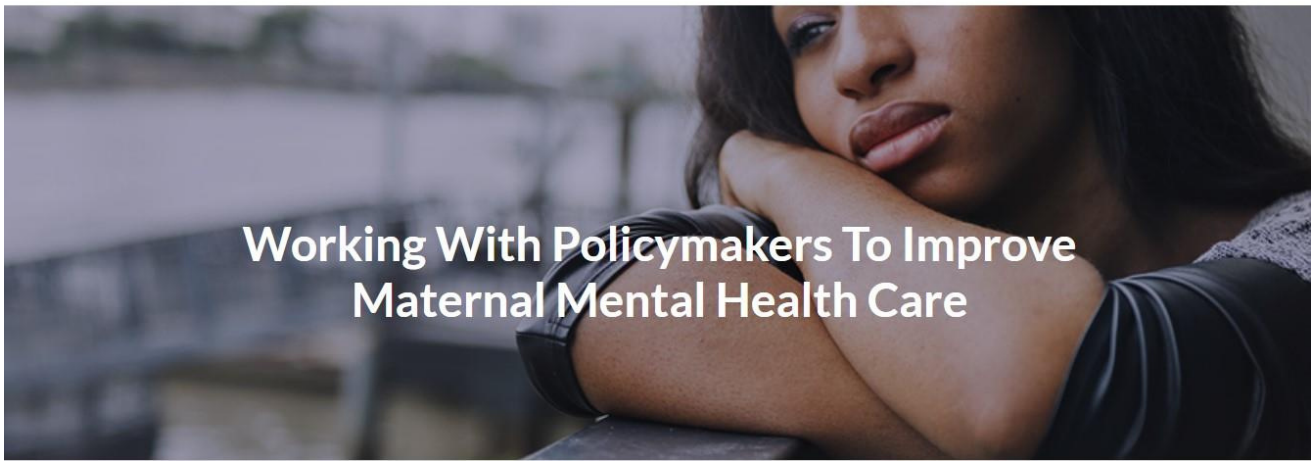
- Link patients and families with resources to facilitate referrals and respond to medical and social service needs
- Communicate Care plans and goals and proactively track patients as they go to and from clinical care to communities
- Identify and refer eligible high risk patients to available EBHV Programs

CHANT

Community Health Access and Navigation in Tennessee



https://www.tn.gov/health/health-program-areas/fhw/earlychildhood-program/chant.html



https://www.mmhla.org/

https://www.mmhla.org/factsheets/

JULY 2020

MMHLA
Maternal Mental Health Leadership Alliance

FACT SHEET
Maternal Mental Health (MMH)

KEY POINTS

- Maternal mental health (MMH) conditions are the most common complications of pregnancy and childbirth, affecting 1 in 5 women (800,000 women each year in the United States).[1-3]
- MMH conditions include depression, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, bipolar illness (which may include psychotic symptoms), and substance use disorders.[1-3]
- The "baby blues" are a normal period of transition affecting up to 85% of new mothers in the first 2-3 weeks after baby is born. Baby blues typically include emotional sensitivity, weepiness, and/or feeling overwhelmed. Baby blues resolve without treatment.[4]
- MMH conditions are caused by a combination of changes in biology, psychology, and environment.[4]
- Women at increased risk of MMH conditions are those who have a personal or family history of mental illness; lack social support, especially from their partner; experienced a traumatic birth or previous trauma in their lives; or have a baby in the neonatal intensive care unit.[1,4]
- Suicide and overdose are the leading causes of death in the first year postpartum, with 100% of these deaths deemed preventable.[5-7]
- All parents — including fathers, partners, and adoptive parents — can experience changes in mood when there is a new baby in the household.[8,9]

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women will experience MMH conditions during pregnancy or first year following pregnancy[1-3]

of women who experience MMH symptoms go untreated[10]

Cost of not treating MMH conditions

is $32,000 per mother-infant pair (adding up to $14 billion nationally)[11]

SIGNS & SYMPTOMS

DEPRESSION	ANXIETY
• Feeling hopeless, helpless, or worthless • Lacking motivation, concentration, or energy • Loss of interest or pleasure in activities • Feelings of anger, guilt, irritability, rage, or regret	• Feeling easily stressed, worried, or overwhelmed • Being hypervigilant with baby • Having scary, intrusive, or racing thoughts • Feeling keyed up, on edge, restless, or panicked

Women experiencing MMH conditions might say...

Having a baby was a mistake.
I'm not bonding with my baby.
I'm afraid to be alone with my baby.
I'm exhausted, but I can't sleep, even when my baby sleeps.
I'm such a bad mother; my baby would be better off without me.

WOMEN AT INCREASED RISK

Women living in poverty and women of color are MORE likely to experience MMH conditions and LESS likely to get help due to:[12, 13]

- Lack of access to healthcare, including culturally appropriate mental health care
- Cultural and racial biases in the healthcare system
- More barriers to care, such as lack of transportation or childcare
- Fear that child protective services or immigration agencies will become involved

TERMINOLOGY

Perinatal: ~2-year timeframe from conception to baby's first birthday

Antenatal or Prenatal: During pregnancy

Postpartum or Postnatal: First year following pregnancy

The following terms are used interchangeably to describe the mental health conditions women experience during pregnancy and the first year following pregnancy:

- Postpartum depression (PPD) has long been used as an umbrella term encompassing mood changes following childbirth
- Antenatal / prenatal / perinatal / postnatal depression and anxiety
- Perinatal mood disorders (PMDs) or perinatal mood and anxiety disorders (PMADs)
- Maternal mental health (MMH) challenges / complications / conditions / disorders / illnesses / issues

CONSEQUENCES OF UNTREATED MMH CONDITIONS

Untreated MMH conditions can have long-term negative impact on mother, baby, and entire family.

MOTHER

Women with untreated MMH conditions are more likely to:[4, 14-17]

- Not manage their own health
- Have poor nutrition
- Use substances such as alcohol, tobacco, or drugs
- Experience physical, emotional, or sexual abuse
- Be less responsive to baby's cues
- Have fewer positive interactions with baby
- Experience breastfeeding challenges
- Question their competence as mothers

CHILD

Children born to mothers with untreated MMH conditions are at higher risk for:[12, 16-19]

- Low birth weight or small head size
- Pre-term birth
- Longer stay in the NICU
- Excessive crying
- Impaired parent-child interactions
- Behavioral, cognitive, or emotional delays

Untreated mental health issues in the home may result in an Adverse Childhood Experience, which can impact the long-term health of the child.[20]

Parents who are depressed or anxious are more likely to:[15,16]

> Make more trips to the emergency department or doctor's office
> Find it particularly challenging to manage their child's chronic health conditions
> Not follow guidance for safe infant sleep and car seat usage

Most maternal mental health conditions are temporary & treatable.

STEPS TO WELLNESS[17]

LOWER COST
LOWER BARRIER

Self-Care
sleep, nutrition, exercise, time off

Social Support
from friends, family, doulas, home-visiting programs, or support groups

Therapy/Counseling

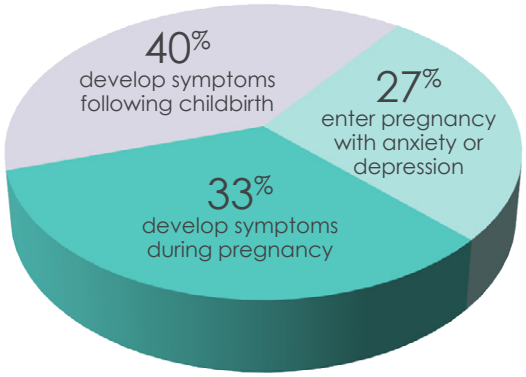
Medication

HIGHER COST
HIGHER BARRIER

Editorial Team

A multidisciplinary editorial team provided input for this Fact Sheet representing the fields of obstetrics, pediatrics, nursing, psychiatry, psychology, and public health. Team members from MMHLA are Adrienne Griffen, MPP; Pooja Lakshmin, MD; Kelly Sheppard, PhD; and Terri Wright, PhD, MPH. Additional editorial team members include Nancy Byatt, DO, MBA; Wendy Davis, PhD; Sue Kendig, JD, WHNP; Tiffany Moore Simas, MD, MPH; and Debra Waldron, MD, MPH.

Of women who experience anxiety or depression during pregnancy or first year of baby's life[21]



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OCTOBER 2020

MMHLA
Maternal Mental Health Leadership Alliance

Lifeline4Moms

FACT SHEET
Perinatal Psychiatry Access Programs

KEY POINTS

- Perinatal mental health (PMH) conditions are the most common complications of pregnancy and the year following pregnancy, affecting 1 in 5 perinatal individuals (800,000 people each year in the United States).[1-3]
- PMH conditions include mood, anxiety, trauma-related, and substance use disorders.[1-3]
- Perinatal individuals will see a frontline healthcare provider (obstetric, pediatric, or primary care provider) 20-25 times during a routine pregnancy and first year of baby's life, providing ample opportunity for these providers to detect and address PMH conditions.
- Frontline healthcare providers, however, do not always have the training, knowledge, or resources to address PMH conditions, nor are they typically reimbursed for doing so.[5]
- There are not enough psychiatric providers to care for individuals experiencing PMH conditions.[5]
- Perinatal Psychiatry Access Programs provide education, consultation, and resource and referral to increase the capacity of frontline healthcare providers to address PMH, thereby leveraging scarce psychiatric resources and increasing access to timely and evidence-based care.[5]

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perinatal individuals will experience a PMH condition during pregnancy or the first year following pregnancy.[1-3]

75% **of those who experience PMH symptoms go untreated**[4]

perinatal individuals will see a healthcare provider up to 25 times during the two-year timeframe from conception to baby's first birthday

HOW PERINATAL PSYCHIATRY ACCESS PROGRAMS WORK

ACCESS PROGRAMS TRAIN FRONTLINE PROVIDERS TO
- Screen for PMH conditions with validated tools
- Assess and treat mild to moderate PMH conditions

FRONTLINE PROVIDERS CONTACT THE ACCESS PROGRAM FOR
- Consultation for expert clinical guidance and support
- Mental health resources and referrals

SOME ACCESS PROGRAM PSYCHIATRISTS CAN PROVIDE FACE-TO-FACE CONSULTATION FOR THE MOST COMPLEX CASES

BUILDING CAPACITY

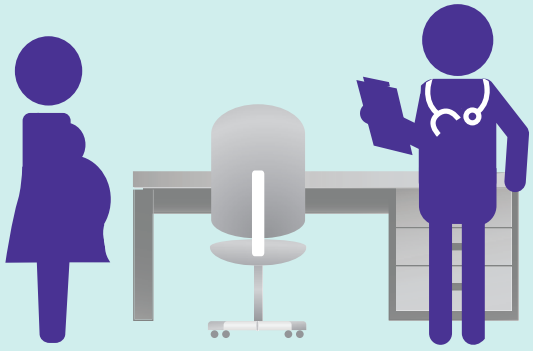
Perinatal Psychiatry Access Programs build the capacity of frontline providers to address PMH conditions through:

EDUCATION
Trainings and toolkits for providers and staff on evidence-based guidelines for screening, triage, and referral; risks and benefits of treatment; and discussion of screening results and treatment options.

CONSULTATION
Real-time psychiatric consultation for frontline providers serving perinatal individuals including obstetric, pediatric, primary care, and psychiatric providers

RESOURCES & REFERRALS
Linkages with community-based mental health resources including individual and group therapy, support groups, and other resources to support the well-being of perinatal individuals.

Perinatal Psychiatry Access Programs address a critical public health issue through an innovative, creative, cost-effective approach to address mental health in frontline healthcare settings.



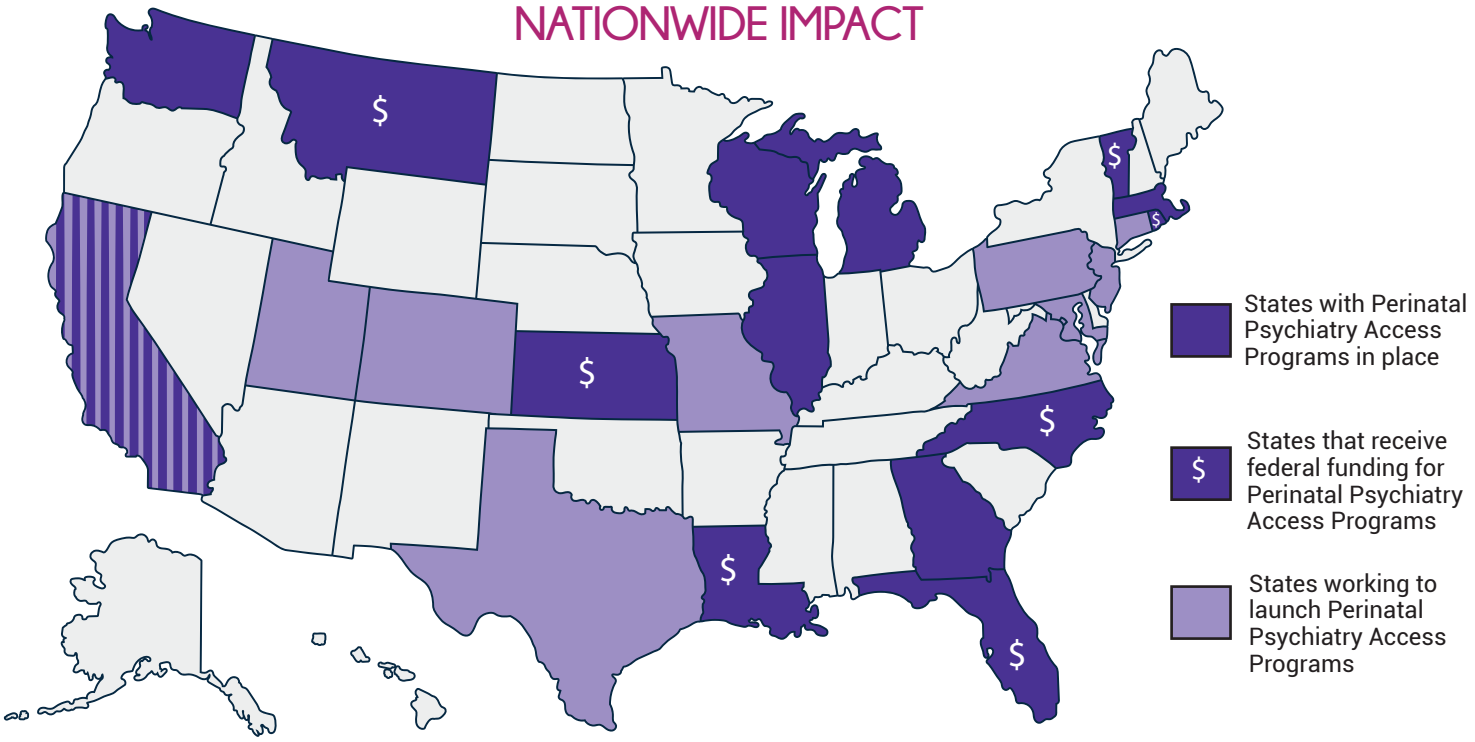
PERINATAL PSYCHIATRY ACCESS PROGRAMS & RESOURCES

Massachusetts Child Psychiatry Access Program MCPAP For Moms	MCPAP for Moms launched in 2014 as the first Perinatal Psychiatry Access Program in the U.S. MCPAP for Moms builds upon the successful Massachusetts Child Psychiatry Access Program (MCPAP), which leverages psychiatric experts to assist pediatric providers in managing the mental health of their child and adolescent patients. Learn more at **mcpapformoms.org**
Lifeline4Moms	The Lifeline4Moms National Network of Perinatal Psychiatry Access Programs is a learning community that brings together Perinatal Psychiatry Access Programs from across the country to • Evaluate, inform, and share best practices • Build community, engage partners and collaborators, evaluate programs, facilitate peer learning • Identify policies and funding to replicate successful cost-effective models Learn more at **umassmed.edu/lifeline4moms**
pcori	The Patient-Centered Outcomes Research Institute (PCORI) has funded a 3-year study to assess the effectiveness of Perinatal Psychiatry Access Programs. The study will assess which program components work best (education, consultation, resource and referral). Results will be shared in scientific journals and at national webinars and meetings. Learn more at **bit.ly/pcoristudy**

BRINGING POSTPARTUM DEPRESSION OUT OF THE SHADOWS ACT

This federal legislation provides funding to states to create Perinatal Psychiatry Access Programs based on the MCPAP for Moms model. In 2018, 30 states and the District of Columbia applied for funding for Perinatal Psychiatry Access Programs; 7 states were each awarded 5-year grants (totaling $3.2 million per state over the lifetime of the program). This is the first-ever federal funding to address maternal mental health in the United States.

NATIONWIDE IMPACT



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Learn more at bit.ly/mcpap-pmh

NOVEMBER 2021

MMHLA
Maternal Mental Health Leadership Alliance

FACT SHEET
Maternal Mental Health: Black Women & Birthing People

KEY POINTS

- Maternal mental health (MMH) conditions are the most common complications of pregnancy and childbirth, affecting 1 in 5 women or birthing people during pregnancy or postpartum.[1-3]
- MMH conditions include depression, anxiety disorders, obsessive-compulsive disorder, post-traumatic stress disorder, bipolar illness (which may include psychotic symptoms), substance use disorders, and postpartum psychosis in rare cases.[1-3]
- Untreated MMH conditions can have long-term negative impact on parent, baby, family, and society.[4, 6, 7, 10]
- Almost 40% of Black mothers and birthing people experience MMH conditions.[4,7]
- Compared to white women, Black women are twice as likely to experience MMH conditions but half as likely to receive treatment.[7, 10]
- Black women experience maternal mortality rates 3-4 times the rate of white women.[5, 9]

CONTRIBUTING FACTORS

Factors that may increase the risk of MMH among Black women[4-7]

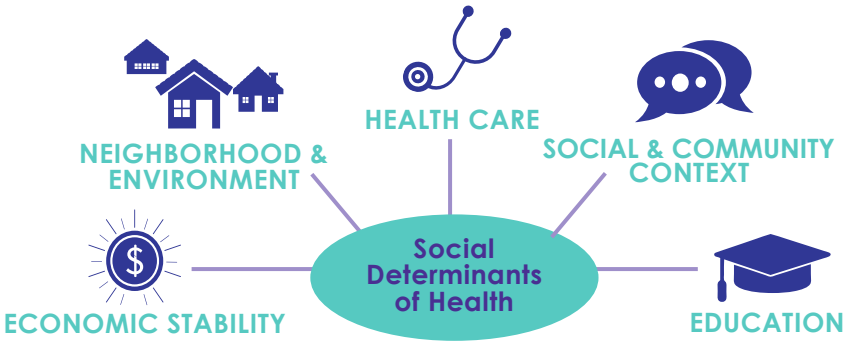
- Systemic racism
- Unemployment
- Exposure to violence
- Gaps in medical insurance
- Adverse Childhood Experiences
- Lack of access to high-quality medical and mental health care
- Lack of representation in the medical system
- Higher risk of pregnancy and childbirth complications

Black women are one of the most undertreated groups for depression in the U.S.[5]
Over 50% cases of postpartum depression in women of color go unreported.[4]

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age. SDOH affect a wide range of health, functioning, and quality-of-life outcomes. Black people are disproportionately impacted by SDOH, which may include:

- Safe housing, transportation, neighborhoods
- Racism, discrimination, violence
- Education, job opportunities, income
- Access to nutritious foods and physical activity opportunities
- Language and literacy skills



Learn more at bit.ly/SDOH-HHS

ADVOCACY OPPORTUNITIES

Black Maternal Health Week

Sponsored by the Black Mamas Matter Alliance.

- Expands the national conversation about Black maternal health.
- Amplifies community-driven solutions.
- Centers the voices of Black people.

Black Maternal Mental Health Week

Sponsored by the Shades of Blue Project.

- Raises awareness and highlights disparities.
- Shares stories and builds communities.
- Breaks down cultural barriers in MMH.

BLACK MATERNAL HEALTH MOMNIBUS ACT OF 2021

The Momnibus consists of 12 separate pieces of legislation that comprehensively address every dimension of maternal health. One provision—The Moms Matter Act—would provide funding to address MMH with a specific focus on racial and ethnic minority groups.

The intersection of race, gender, physical and mental health, and socioeconomic status creates cumulative harms that are associated with poorer outcomes for Black mothers. Thus, Black communities often develop an entire social service sector, with church leaders, sociologists, nurses, and home visitors providing care in the home, neighborhood, churches, and other community-based organizations.[7] This type of care helps build resilience in Black women and birthing people.

BARRIERS FACED BY BLACK BIRTHING PEOPLE

Systemic and interpersonal racism. The cumulative effect of systemic and interpersonal racism takes a toll on the physical and emotional health of Black people. Stress, anxiety, and fear all increase the likelihood of developing MMH conditions.[6-9]

Distrust of the healthcare system. Historically, many Black people have been mistreated and harmed by medical providers, creating deep mistrust of the health care system.[4, 6]

Shame and stigma. The pressure of social stigma encourages Black people to keep their problems private to avoid appearing crazy, weak, or lacking faith. Having to be a "strong Black women" prevents many women from seeking help.[6, 7, 10]

Fear of child protective services. Child welfare workers deem Black mothers unfit at a higher rate than white mothers, even when controlling for factors such as education and income.[7, 11]

Logistical barriers. Issues such as transportation, time off from work, and childcare can prevent women from seeking care.[7, 10]

Screening tools. Most mental health screening tools were developed based on primarily white research participants. These tools do not assess for beliefs and attitudes that are grounded in culture and religion, nor do they assess for physical symptoms, which Black people often use to describe their feelings of depression.[11]

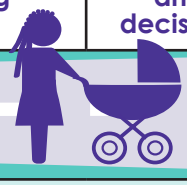
Strategies to remove these barriers[7-9]

- ✓ Acknowledge the role of racism and cultural oppression.
- ✓ Build long-term, respectful relationships with community organizations and leaders.
- ✓ Embed diversity in the maternal and mental health care teams.
- ✓ Retrain and educate current health care professionals to recognize inherent biases in the delivery of care and on culturally responsive mental health care.
- ✓ Provide social support for pregnant and postpartum people.
- ✓ Create mental health screenings that are designed for people of color.
- ✓ Support political and economic policies that empower communities.
- ✓ Create services informed by cultural humility and holistic care.

Reimagining the maternal mental health care landscape is essential to addressing the Black maternal health crisis[8]

PATHWAYS TO IMPROVE & EXPAND MMH CARE FOR BLACK BIRTHING PEOPLE[8]

Educating and training practitioners	Investing in the Black women mental health workforce	Investing in Black women-led community-based organizations	Valuing, honoring, investing in community, traditional healing practices	Promoting integrated care and shared decision making



LEARN MORE FROM THESE BLACK WOMEN-LED ORGANIZATIONS

pmhapoc.org

sistersong.net

birthequity.org

bwhi.org

soysom.com

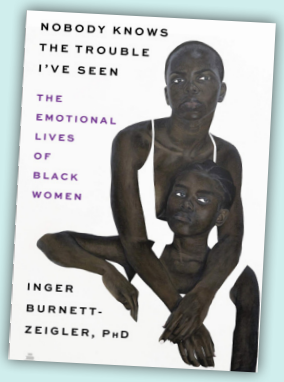
shadesofblueproject.org

blackmamasmatter.org

birthcenterequity.org

RECOMMENDED READING

Nobody Knows the Trouble I've Seen
Esteemed clinical psychologist Dr. Inger Burnett-Zeigler praises the strength of Black women while exploring how racism, trauma, and adversity have led to deep emotional and physical pain which can lead to chronic health issues, some of which have intergenerational effects.



This fact sheet was supported by a grant from the California Health Care Foundation.

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1 ACOG Committee Opinion No. 757: Screening for perinatal depression. (2018).

2 O'Hara and Wisner (2014). Perinatal Mental Illness: Definition, Description and Aetiology.

3 Fawcett et al (2019). The Prevalence of Anxiety Disorders During Pregnancy and the Postpartum Period.

4 UPMC Health Beat (2020). Black Maternal Mental Health: The Challenges Facing Black Mothers.

5 Martin and Montagne (2017). Lost Mothers: Maternal Care and Preventable Deaths.

6 Parker (2021). Reframing the Narrative: Black Maternal Mental Health and Culturally Meaningful Support for Wellness.

7 Taylor and Gamble (2017). Suffering in Silence: Mood Disorders Among Pregnant and Postpartum Women of Color.

8 Matthews et al (2021). Pathways to Equitable and Antiracist Maternal Mental Health Care: Insights From Black Women Stakeholders.

9 CLASP (2020). Advancing Racial Equity in Maternal Mental Health Policy.

10 Kozhimanill et al (2011), Racial and Ethnic Disparities in Postpartum Depression Care Among Low-Income Women.

11 Feldman and Pattani (2019). Black Mothers Get Less Treatment for Postpartum Depression.

JUNE 2021

MMHLA
Maternal Mental Health Leadership Alliance

FACT SHEET
Dads & Depression

KEY POINTS

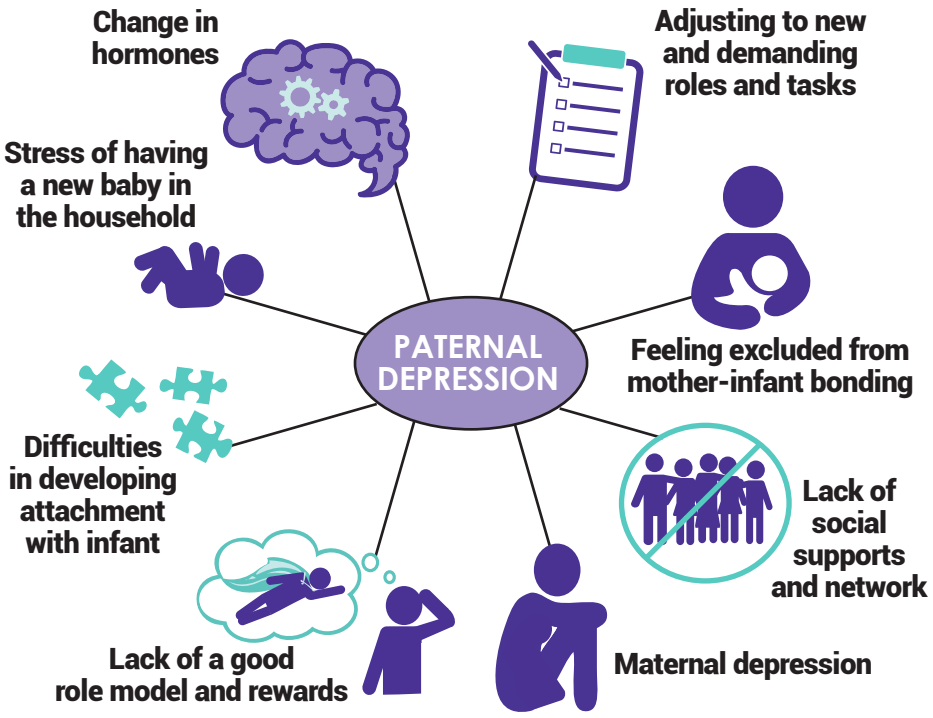
- One in 10 fathers will experience postpartum depression or anxiety.[2, 3, 4, 5, 7]
- Depression and anxiety are two times as common in expecting and new fathers, compared with global estimates in men.[5]
- The peak incidence of postpartum depression in fathers is 3-6 months.[5]
- The Edinburgh Postnatal Depression Scale (EPDS) has been validated for detecting paternal depression, but with lower cut-off scores.[3]
- Men suffering depression often exhibit higher levels of irritability and anger.[6]
- Fathers suffering postpartum depression report lower levels of affection and higher levels of criticism both toward and from their partner.[6]

Learn more: **postpartum.net/news/ifmhd**
Follow: **facebook.com/dadsMHday**

Society views men as stoic, self-sacrificing, and above all, strong. When men feel none of those things as new fathers, it might be hard to admit it or seek help. The stigma in experiencing difficulties as a new parent is even greater for men than for women.

MATERNAL DEPRESSION IS THE MOST IMPORTANT RISK FACTOR FOR PATERNAL DEPRESSION [4, 5, 7]

CAUSES AND RISK FACTORS[4, 5, 7]



IMPACTS OF PATERNAL DEPRESSION

INCREASES	DECREASES
Negative parenting[2], including harsh discipline practices (such as spanking or corporal punishment)	Positive parenting[2], including sensitivity or warmth, and practices such as reading to children.
Hostility and conflict in the home, particularly with spouse/partner [1, 6]	
Children's behavioral and conduct problems[4, 6]	

Higher levels of positive parenting by a non-depressed adult can lessen the impact of parental depression on the child.[1]

TREATMENT

To treat paternal depression, recommendations include:

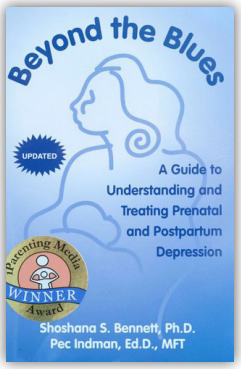
- Adequate sleep, exercise, nutrition
- Social support
- Talk therapy
- Medication

Citations

1 Chang et al. (2007). *Arch Pediatr Adolesc Med*, 161(7): 697-703.
2 Davis et al. (2011). *Pediatrics*, 127: 612-618.
3 Edmondson et al (2010). *Journal of Affective Disorders*, 125(1-3): 365-368.
4 Kim and Swain (2007). *Psychiatry, February*: 36-47.
5 Paulson and Bazemore (2010). *JAMA*, 303(19): 1961-1969.
6 Ramchandani et al. (2011) *Depression and Anxiety*, 28: 471-477.
7 Thiel et al. (2020). *Frontiers in Psychiatry*, 11: 1-14.

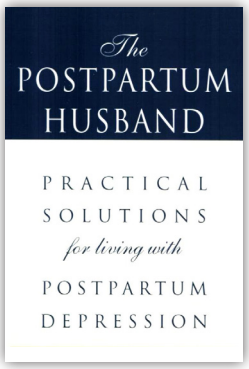
This fact sheet was supported by a grant from the California Health Care Foundation

SUPPORT FOR DADS/PARTNERS



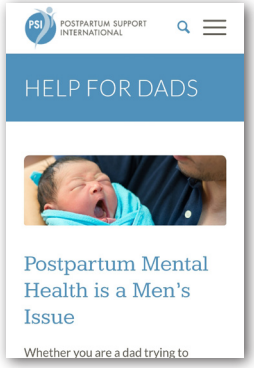
Beyond The Blues (by Shoshanna Bennet, PhD, and Pec Indman, EdD, MFT) devotes an entire chapter to supporting partners. Text of the chapter is available at:

bit.ly/beyond-blues



The Postpartum Husband (by Karen Kleiman, MSW). This concise book provides insights for fathers / partners / spouses who are also experiencing depression or anxiety.

bit.ly/postpartumhub



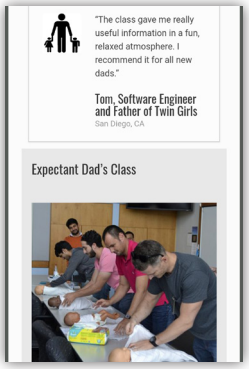
Postpartum Support International has a full page of resources for dads and partners, including:

- Dads Coordinator
- Weekly chats for dads
- Monthly support group for fathers

bit.ly/dad-support

Boot Camp for New Dads is a father-to-father, community-based website that equips men to engage with their infants, support their mates and navigate their transformation into dads.

bootcampfornewdads.org



Basic Training for New Dads offers virtual classes where participants connect with other expectant dads and talk with a "veteran dad" who has been through the class.

bit.ly/menexcel

Postpartum Men is is a place for men with concerns about depression, anxiety or other problems with mood after the birth of a child. It includes a self-assessment for postpartum depression and an online forum for dads.

postpartummen.com

AUSTRALIA'S PROGRAM FOR NEW DADS

SMS4dads is a program in Australia that provides new and soon-to-be-dads with useful messages and tips matched to their baby's age. SMS4dads sends three texts per week with tips and information about infant development to fathers' phones from 16 weeks into the pregnancy until the baby is 12 months old.

SMS4dads

How it works: SMS4dads uses the 'voice' of the baby to deliver messages that are synchronised with the development of the fetus and baby. The messages—which focus on interacting with a new baby, supporting mothers, and staying healthy—are brief but have links to further online information.

Success rate: Over 90% of fathers report that the messages helped in their transition to becoming a father. Here's what fathers say about this program:

When other people tell me what to do, that doesn't really work for me, but when the message came from my baby asking me to read to her—well, what could I do?

The texts were a great conversation starter with my wife, I forwarded quite a few through to her.

The way the messages would pop up and sometimes the timing was just right to give you a boost or a smile amidst everything—like a mate tapping you on the shoulder.

Just wanted to say "thanks" for this project. The text messages have been invaluable and I couldn't have known just how important and how much I needed to receive these short and helpful messages.

Learn more at sms4dads.com

MARCH 2021

MMHLA
Maternal Mental Health Leadership Alliance

FACT SHEET
Medicaid & Maternal Mental Health

KEY POINTS: MEDICAID

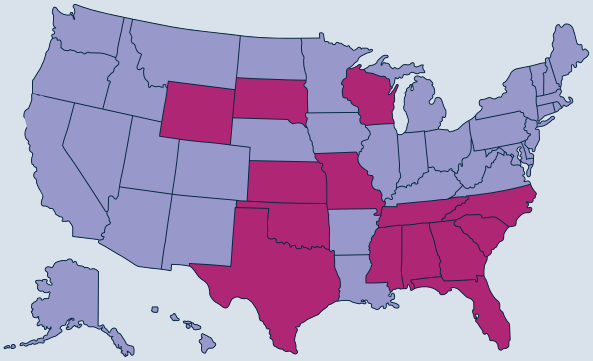
- Medicaid was created in 1965 as a public insurance program to help with medical costs for people with limited income and resources.
- Medicaid is administered by states according to federal requirements and is jointly funded by states and the federal government.
- States can tailor their Medicaid programs to best serve their state's needs resulting in wide variation in eligibility requirements, services offered, and reimbursement for providers.
- Since 2010, states have been able to expand Medicaid eligibility to those whose incomes are at or below 138% of the federal poverty level (FPL), thereby providing medical insurance to thousands of additional low-income individuals.

KEY POINTS: MEDICAID & PREGNANCY

- Since 1989, federal law requires Medicaid coverage for eligible pregnant women and includes
  - Prenatal care
  - Labor and delivery
  - Care for the mother for 60 days postpartum
  - Care for the infant for the first year of life
- Many new mothers—primarily in states that have not expanded Medicaid—lose Medicaid coverage at 60 days postpartum because the income eligibility limit is lower for parents than for pregnant women.

MEDICAID EXPANSION

Current Status of Medicaid Expansion as of March 2021.
For interactive map: bit.ly/medicaidmap



Source: Kaiser Family Foundation's State Health Facts

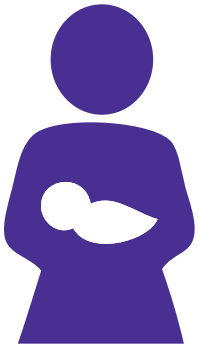
Expansion states: 36 states (and DC) have expanded Medicaid

Non-expansion states: 14 states have not expanded Medicaid, thereby maintaining stricter income eligibility requirements

INCREASED RISK

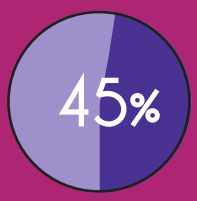
Women who lose their Medicaid coverage at 60 days postpartum are left uninsured at a medically vulnerable time in their lives.

AT RISK



In the postpartum period, women are at increased risk of experiencing life-threatening conditions including

- Eclampsia
- Infection
- Hemorrhage
- Hypertension
- Cardiovascular disorders
- Mental health conditions
- Suicide
- Overdose



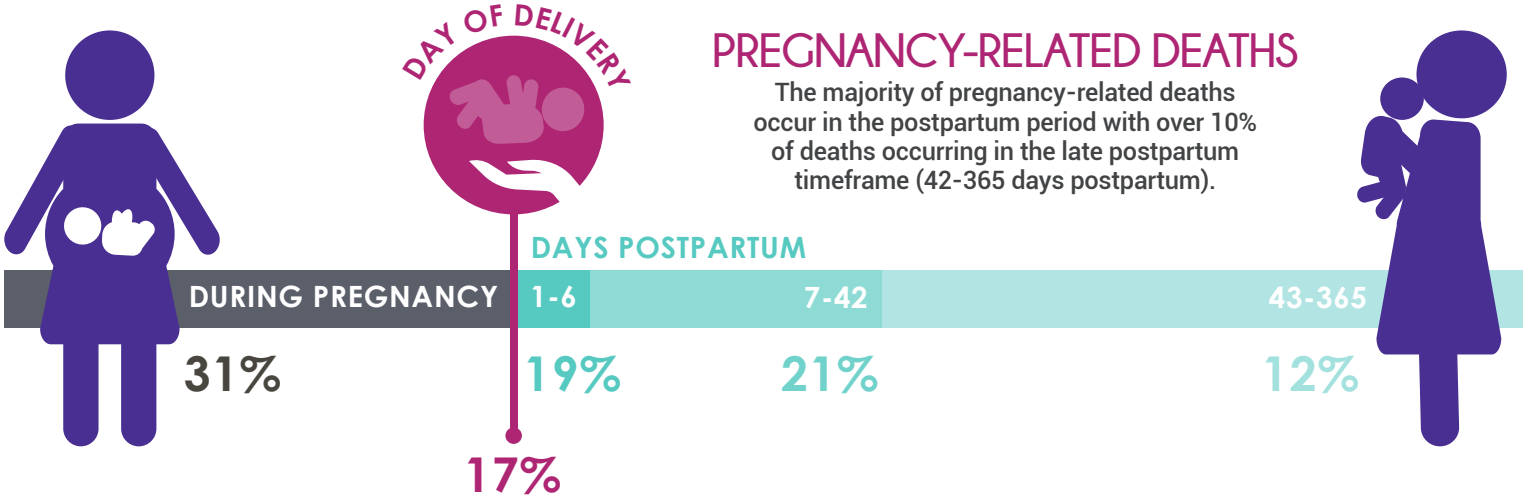
OF BIRTHS IN THE U.S. ARE COVERED BY MEDICAID

TERMINOLOGY

Federal Poverty Level (FPL): A measure of income issued every year by the U.S. Department of Health and Human Services. FPL is used to determine financial eligibility for federal programs and benefits such as Medicaid.

Expansion states: 36 states (and DC) have chosen to expand Medicaid, in some cases up to 380% of FPL.

Non-expansion states: 14 states have not expanded Medicaid, maintaining more restrictive income eligibility requirements (11 states set Medicaid income eligibility for parents at less than 50% FPL; the lowest is Texas, at 17% FPL).



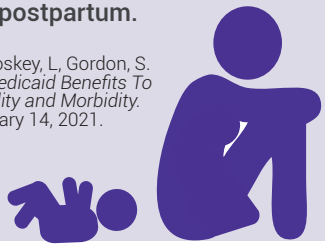
PREGNANCY-RELATED DEATHS

The majority of pregnancy-related deaths occur in the postpartum period with over 10% of deaths occurring in the late postpartum timeframe (42-365 days postpartum).

WHY IS EXTENDING MEDICAID COVERAGE FOR A FULL YEAR important in terms of maternal mental health?

- Women of color are over-represented in Medicaid enrollment and disproportionately impacted by MMH: almost 50% of low-income mothers report depressive symptoms, and women of color are only half as likely to receive care for postpartum depression as white women.
- The relatively short 60-day window of Medicaid coverage means that many women neither attend a postpartum visit with their obstetric provider nor are screened or treated for MMH conditions following pregnancy.
- Even if a new mother starts treatment for postpartum depression, Medicaid rarely covers treatment after 60 days. (Health Affairs article).
- Many women experience mental health issues far beyond the Medicaid mandatory coverage of 60 days postpartum:
  - The peak incidence of postpartum depression is 3-6 months postpartum.
  - The peak incidence of self-harm is 9-12 months postpartum.
  - Some women experience mood changes upon cessation of breastfeeding or return of menses, often late in the first year postpartum.

SOURCE: Babbs, G, McCloskey, L, Gordon, S. *Expanding Postpartum Medicaid Benefits To Combat Maternal Mortality and Morbidity.* Health Affairs, January 14, 2021.



MATERNAL MENTAL HEALTH (MMH) FACTS

- Mental health conditions are the MOST COMMON complication of pregnancy and childbirth, affecting up to 1 in 5 women.
- Left untreated, maternal mental health issues can have long-term negative impact on mother, baby, and entire family.
- Suicide and overdose combined are the leading cause of death for women in the first year following pregnancy.

AMERICAN RESCUE PLAN ACT OF 2021

The American Rescue Plan Act (March 11, 2021) gives states the option to extend Medicaid coverage for a full year postpartum (learn more at bit.ly/rescueplan21). In addition, Medicaid has created policies, including reimbursement, for screening new mothers for PMH during well-child visits. (Learn more at bit.ly/wellchild21). Important details to note:

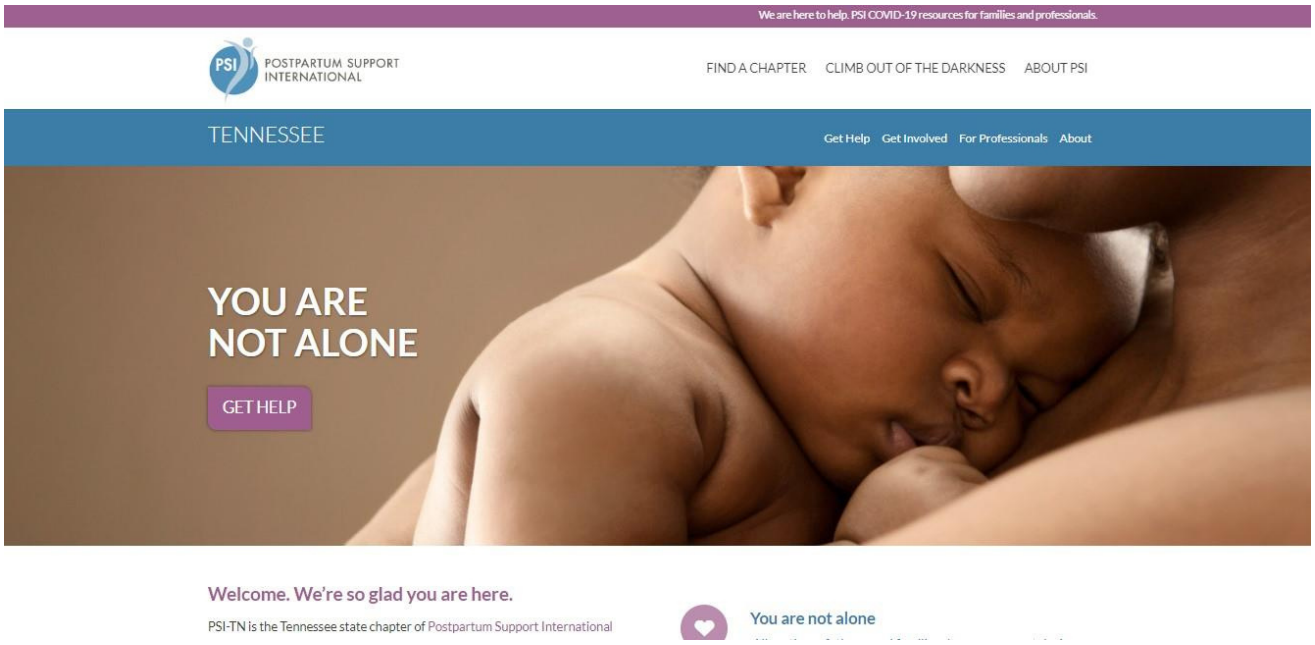
MEDICAID

States would have a new option to cover women in pregnancy-related Medicaid and CHIP coverage for one year after the end of pregnancy, extending their coverage well beyond the current cutoff of 60 days.

Currently, states can only receive federal matching funds to extend postpartum coverage beyond 60 days through a Section 1115 waiver, and though six states have applied to the Centers for Medicare and Medicaid Services (CMS), none have yet received approval.

States that opt to extend postpartum coverage must do so for both Medicaid and CHIP (if they cover pregnant women through CHIP). The option will be available to states for five years, beginning with the start of the first calendar year quarter one year after enactment.

SOURCE: Park, E. American Rescue Plan Act Would Spur Medicaid Expansion and Promote Maternal Health. Georgetown University Health Policy Institute. March 2, 2021



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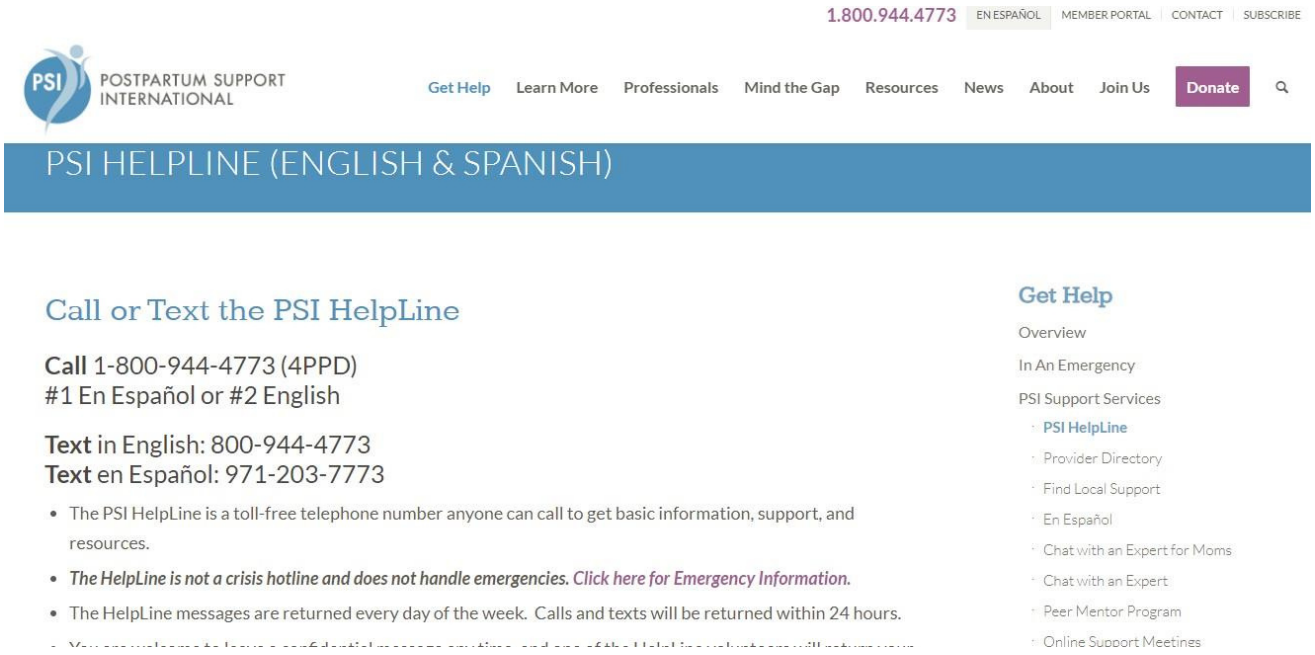
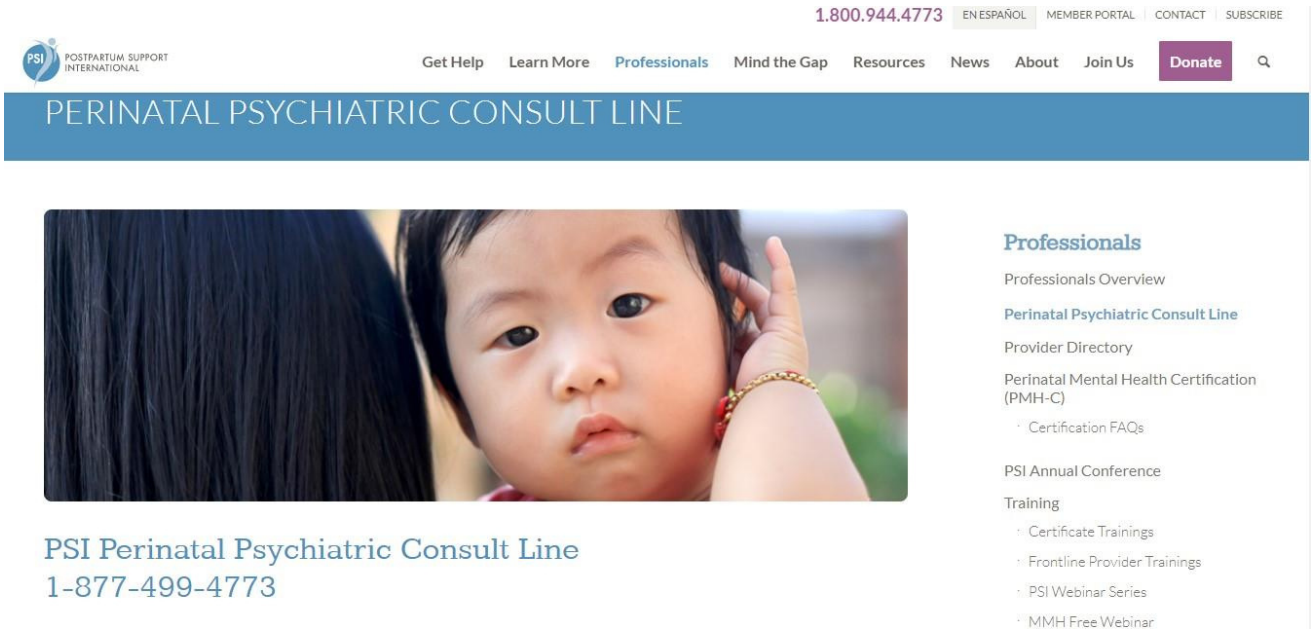
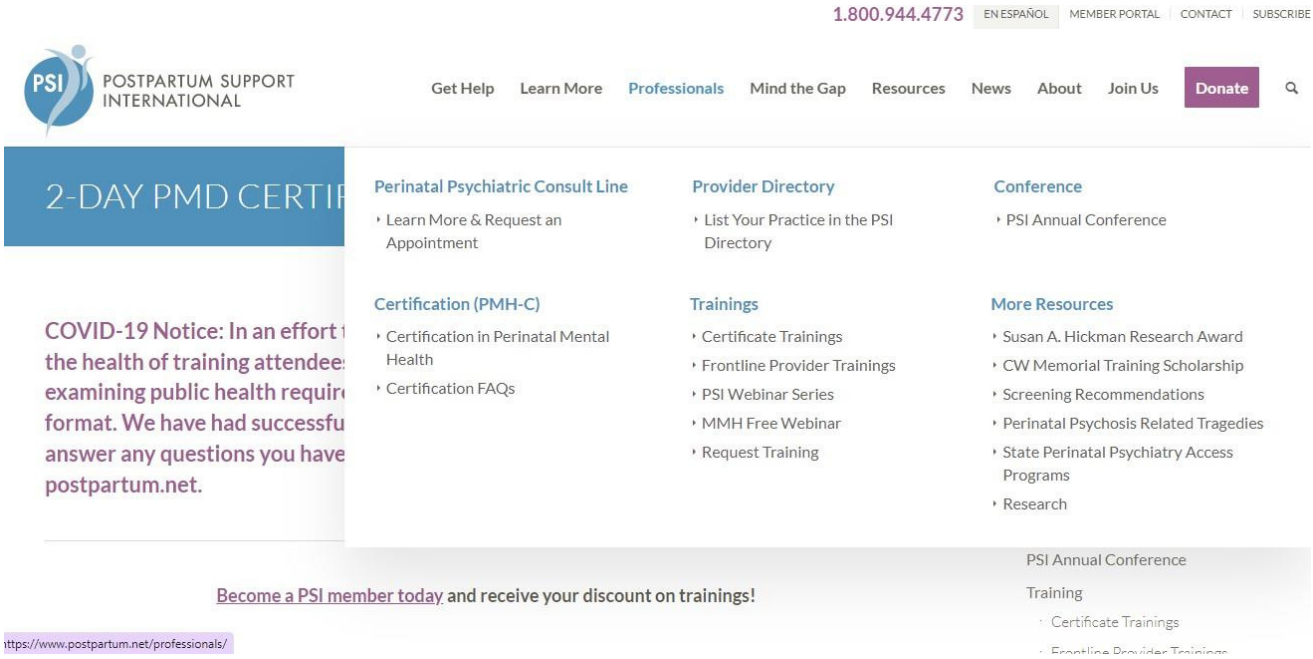


https://www.postpartum.net/get-help/psi-helpline/

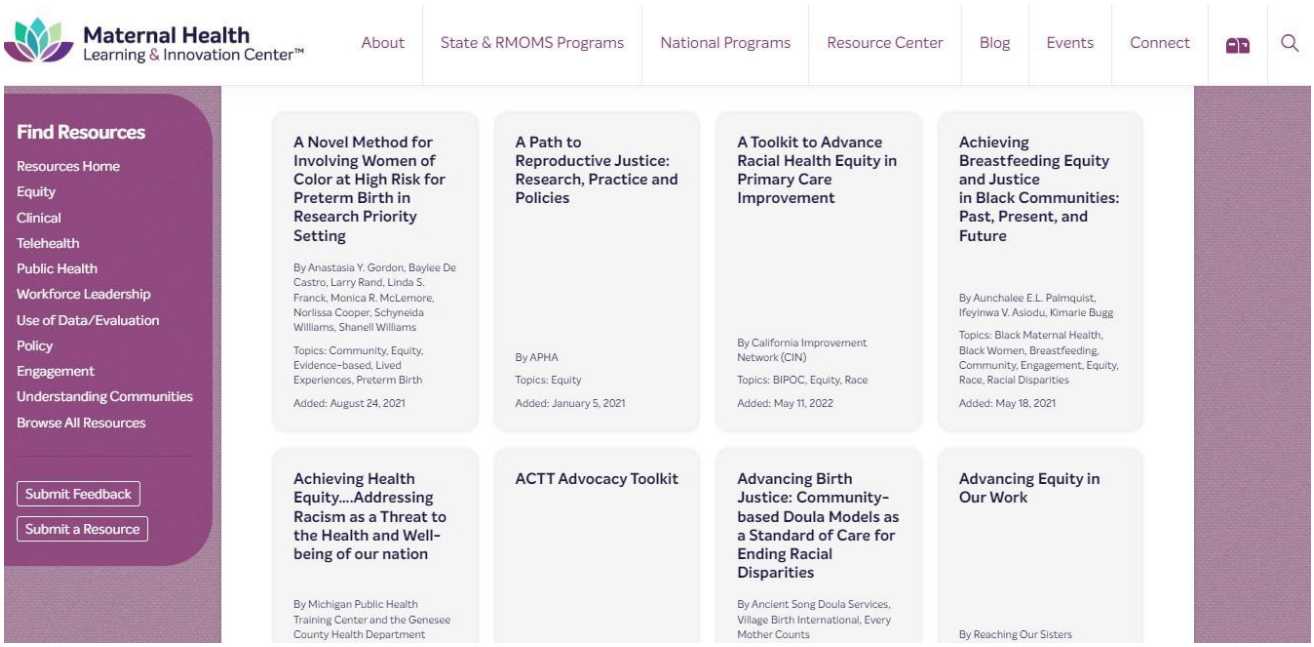


https://www.postpartum.net/professionals/perinatal-psychiatricconsult-line/



https://www.postpartum.net/professionals/certificate-trainings/psi-certificate-training/

https://blackmamasmatter.org/



https://maternalhealthlearning.org/equity-resources/