The National Association of NURSE PRACTITIONERS in WOMEN'S HEALTH

POSITION STATEMENT

Perinatal Mental Health

The National Association of Nurse Practitioners in Women's Health (NPWH) asserts that perinatal mental health is an essential component of women's and gender-related healthcare. Perinatal mental health has a powerful influence on overall maternal health and wellbeing. Unrecognized and untreated or undertreated perinatal mental health conditions (PMHCs) have a significant impact on maternal morbidity and mortality. PMHCs include depression, anxiety and anxiety-related disorders, bipolar disorder, and postpartum psychosis.[1,2]

Women's health nurse practitioners (WHNPs) and other advanced practice registered nurses (APRNs) who provide women's and gender-related healthcare are key to early identification and effective treatment of PMHCs for patients they see for routine well-visits and for perinatal care visits. NPWH affirms that board-certified WHNPs are well positioned through their expertise in women's and perinatal healthcare to be leaders in clinical, advocacy, and research initiatives in perinatal mental health.

NPWH promotes a person-centered approach to care based on current evidence and recognized guidelines on perinatal mental health screening, diagnosis, and treatment. Cultural background, socioeconomic status, health literacy, history of trauma, and overall health must be considered, as these factors influence perinatal mental health. Social determinants of health (SDOH)-mediated inequities in mental healthcare must be addressed through changes in healthcare systems, health professional education, and public health measures. NPWH is dedicated to providing resources that WHNPs and other APRNs can use to provide evidence-based, person-centered perinatal mental healthcare.

Further, NPWH is committed to raising public and healthcare provider awareness about perinatal mental health. NPWH advocates for federal, state, and local policies and funding that enhance perinatal mental health and increase the availability of resources needed by individuals with PMHCs. Public health campaigns, policies, and funding must be implemented with the understanding that effectively addressing perinatal mental health includes efforts maintained throughout the prepregnancy, prenatal, and postpartum continuum.

Finally, NPWH recognizes the need for ongoing research to improve strategies and best practices for the prevention of PMHCs, screening and early identification, and effective treatments. Persons from minority ethnic and racial populations, sexual minority women, transgender and gender-diverse individuals, and those with disabilities, comorbidities, and from other underrepresented and marginalized groups must be fully represented in research about perinatal mental health conditions, the findings of which constitute the basis for guidelines on best healthcare and best health outcomes.

BACKGROUND

Perinatal mental health conditions are those that occur in pregnancy or within the first 12 months after giving birth. Onset of the mental health condition may occur before pregnancy or during the perinatal period.[1] Perinatal depression affects approximately 1 in 7 women (14%). Over 1 in 4 of these women (27%) have depression before becoming pregnant. One third of affected women (33%) experience the onset of depression during pregnancy, while 40% experience the onset postpartum.[3] Generalized anxiety and anxiety-related disorders (ie, post-traumatic stress disorder, specific phobias, panic disorder) occur in up to 20% of women during pregnancy and postpartum.[4] A majority of individuals experiencing perinatal depression have comorbid generalized anxiety disorder.[4] Bipolar disorder occurs in 2.6% of pregnant and postpartum women, and postpartum psychosis occurs in 0.2% of women.[5]

Individuals with untreated mental health conditions experience symptoms detrimental to their quality of life and daily functioning. When these conditions occur in the perinatal period and are untreated, the sequelae can have significant negative short- and long-term effects on the maternal–infant dyad. Individuals with untreated PMHCs are at risk for behaviors such as untreated substance use and limited or no engagement in healthcare that can adversely impact perinatal outcomes.[6,7] Adverse outcomes for the fetus, neonate, and infant include fetal growth restriction, preterm birth, low birth weight, and stillbirth.[7,8] Infants are at risk for adverse neurodevelopment, impaired bonding, and early breastfeeding cessation. Further, there is a potential for long-term mental health effects for the offspring.[7–9]

Severe, untreated PMHCs are the most common underlying contributors to pregnancy-related death (23%), with suicide and overdose related to substance use disorders as the major causes. Maternal mortality review committees in the United States have determined that 100% of mental health condition-related deaths in the perinatal period are preventable.[10–12] The prevalence and potentially severe consequences of untreated PMHCs highlight the need for attention to mental health for all patients of reproductive age in all clinical settings.

The US Preventive Services Task Force recommends depression and anxiety screening for all adults, including pregnant and postpartum individuals, regardless of risk factors.[13,14] The American College of Obstetricians and Gynecologists (ACOG) recommends that all persons receiving well-woman, prepregnancy, prenatal, and postpartum care be screened for depression and anxiety using standardized, validated screening tools.[1]

Patients who are seeking pregnancy or who could become pregnant should be screened for mental health risks at well-visits and whenever else deemed appropriate. The Women's Preventive Services Initiative provides guidance for age- and risk-related screening, counseling, and anticipatory guidance that includes recommendations that correlate with mental health for reproductive-age women (See **Box**).[15]

BOX. Women's Preventive Services Initiative Wellness Visit Components for Reproductive-Age Women–Focus on Mental Health[15]

- **Alcohol use screening and counseling**
- **Anxiety screening**
- **Depression screening**
- **Intimate partner violence screening**
- **Substance use screening and counseling**

Screening for depression and anxiety should occur at multiple points throughout pregnancy. ACOG recommends screening at the initial prenatal visit, later in pregnancy, and at the postpartum visit.[1] ACOG further recommends that individuals be screened for bipolar disorder during pregnancy and postpartum. At the minimum, patients screening positive for depression or anxiety should be screened for bipolar disorder before initiating antidepressant pharmacotherapy.[1] Up to 1 in 4 women with perinatal depression have bipolar disorder.[5] Postpartum Support International recommends screening for depression and anxiety disorders at the first prenatal visit, at least once in the second trimester and third trimester, at the first postpartum visit, and at 6 and 12 months postpartum. Screening also can be implemented during pediatric visits at 1, 2, 4, and 6 months.[16] Commonly used validated screening tools for perinatal mental health include the Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire-9 (PHQ-9), Generalized Anxiety Scale-7 (GAD-7), and Mood Disorder Questionnaire (MDQ) for bipolar disorder.[1] The EPDS and PHQ-9 each include a self-harm question.[1] Any patient who answers affirmatively to a self-harm or suicide question requires further assessment, monitoring, and appropriate intervention.[17]

Universal screening for PMHCs in itself is valuable. This screening can decrease the stigma around PMHCs and provide opportunities for increased awareness and education.[1] However, screening that indicates a potential PMHC is insufficient without systems in place to include further assessment, diagnosis, and referrals when indicated and access to treatment and follow-up.[17–20] Fewer than half of patients with PMHCs are referred to treatment when indicated by screening or diagnoses.[19] Of women diagnosed with PMHCs, 75% remain untreated.[18]

Patient, provider, and systems level characteristics influence rates of screening, diagnosis, and treatment. More research is needed to understand disparities related to patient characteristics. although there is evidence that race, ethnicity, socioeconomics, language barriers, mental health history, and other health-related factors influence who is screened, diagnosed, and treated.[19] The stigma and misconceptions surrounding PMHCs can lead to feeling judged, feelings of shame, and fear of potential consequences such as custody issues that can hinder patient disclosure of risk factors and symptoms and reticence to seek treatment. Providers express lack of knowledge, confidence, and training about PMHC screening, diagnosis, and treatment. At the systems level, the lack of availability of appropriate and timely PHMC services, unclear workflow procedures, and lack of integration and collaboration create barriers to care.[20] Advocacy, policies, public awareness, provider education, and more research are essential to improve PMHC prevention, early identification, treatment, and follow-up.

IMPLICATIONS FOR PRACTICE

WHNPs play a critical role in delivering comprehensive care across the reproductive lifespan, with a growing emphasis on the mental health of patients during the perinatal period. As frontline providers, WHNPs are uniquely positioned to identify early signs of perinatal mental health conditions, such as postpartum depression, anxiety, and mood disorders. Their practice implications extend beyond physical health to encompass emotional wellbeing, requiring them to integrate mental health screenings, patient education, and referrals into routine prenatal and postnatal care. This holistic approach is vital for ensuring optimal outcomes for both mothers and infants.

The need for improved attention to perinatal mental health conditions is underscored by their high prevalence and significant consequences. Despite affecting up to 20% of birthing individuals, these conditions often go undiagnosed or untreated due to stigma, lack of awareness, or insufficient provider training. WHNPs therefore must be equipped with the skills and resources to conduct effective assessments and offer trauma-informed, culturally competent support. Operating within their scope to include perinatal mental healthcare can help bridge critical gaps in maternal healthcare systems and reduce the long-term effects of untreated mental health disorders on families.[21]

Ultimately, integrating perinatal mental health into WHNP practice has broader public health implications. Improved maternal mental health is linked to better child development, stronger family bonds, and decreased healthcare costs.[22] Policies and clinical guidelines should support WHNPs in receiving specialized training, accessing mental health consultation resources, and collaborating with interdisciplinary teams. As maternal mental health becomes a more prominent concern in healthcare policy and advocacy, WHNPs will continue to be vital advocates and providers in delivering compassionate, evidence-based care.

NPWH LEADERSHIP

NPWH will provide leadership to ensure the following:

- Continuing education programs and resources are available to support WHNPs and other APRNs who provide women's and gender-related healthcare in evidence-based, person-centered perinatal mental healthcare.
- WHNP educational programs have access to evidence-based information on perinatal mental health that can be incorporated into curricula.
- Collaborative engagement takes place with other organizations that support campaigns to increase public awareness about perinatal mental health.
- Advocacy for health policies addresses SDOH influencing perinatal mental health.
- Perinatal mental health research and quality improvement initiatives progress and include attention to diversity, equity, and inclusion.

REFERENCES

1. American College of Obstetricians and Gynecologists Committee on Clinical Practice Guidelines—Obstetrics. Screening and diagnosis of mental health conditions during pregnancy and postpartum. ACOG Clinical Practice Guideline No. 4. *Obstet Gynecol*. 2023;141(6):1232-1261. doi:10.1097/AOG.0000000000005200
2. American College of Obstetricians and Gynecologists. AIM patient safety bundle: perinatal mental health conditions. Alliance for Innovation on Maternal Health. 2022. https://saferbirth.org/psbs/perinatal-mental-health-conditions/. Accessed August 22, 2025.
3. Wisner KL, Sit DKY, McShea MC, et al. Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*. 2013;70(5):490-498. doi:10.1001/jamapsychiatry.2013.87
4. Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM. The prevalence of anxiety disorders during pregnancy and the postpartum period: a multivariate Bayesian meta-analysis. *J Clin Psychiatry*. 2019;80(4):18r12527. doi:10.4088/JCP.18r12527
5. Masters GA, Hugunin J, Xu L, et al. Prevalence of bipolar disorder in perinatal women: a systematic review and meta-analysis. *J Clin Psychiatry*. 2022;83(5):21r14045. doi:10.4088/JCP.21r14045
6. McKee K, Admon LK, Winkelman TNA, et al. Perinatal mood and anxiety disorders, serious mental illness, and delivery-related health outcomes, United States, 2006–2015. *BMC Womens Health*. 2020;20(1):150-156. doi:10.1186/s12905-020-00996-6
7. Jahan N, Went TR, Sultan W, et al. Untreated depression during pregnancy and its effect on pregnancy outcomes: a systematic review. *Cureus*. 2021;13(8):e17251. doi:10.7759/cureus.17251
8. Simonovich SD, Nidey NL, Gavin AR, et al. Meta-analysis of antenatal depression and adverse birth outcomes in US populations, 2010-20. *Health Aff*. 2021;40(10):1560-1565. doi:10.1377/hlthaff.2021.00801
9. Aktar E, Qu J, Lawrence PJ, et al. Fetal and infant outcomes in the offspring of parents with perinatal mental disorders: earliest influences. *Front Psychiatry*. 2019;10:391. doi:10.3389/fpsyt.2019.00391
10. Trost SL, Beauregard JL, Smoots AN, et al. Preventing pregnancy-related mental health deaths: insights from 14 US Maternal Mortality Review Committees, 2008–17. *Health Aff*. 2021;40(10):1551-1559. doi:10.1377/hlthaff.2021.00615
11. Trost S, Beauregard J, Chandra G, Njie F, et al. Pregnancy-related deaths: data from maternal mortality review committees in 36 US states, 2017–2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022.
12. Davis NL, Smoots AN, Goodman DA. Pregnancy-related deaths: data from 14 U.S. maternal mortality review committees, 2008–2017. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2019. archive.cdc.gov. MMR-Data-Brief_2019-h.
13. US Preventive Services Task Force. Screening for depression and suicide risk in adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2023;329(23):2057-2067. doi:10.1001/jama.2023.9297
14. US Preventive Services Task Force; Barry MJ, Nicholson WK, Silverstein M, et al. Screening for anxiety disorders in adults: US Preventive Services Task Force recommendation statement. *JAMA*. 2023;329(24):2163-2170. doi:10.1001/jama.2023.9301
15. Women's Preventive Services Initiative. Recommendations for well-woman care. Clinical Summary Table. Washington, DC: ACOG Foundation; 2025. https://www.womenspreventivehealth.org/wellwomanchart/. Accessed September 23, 2025.
16. Postpartum Support International. Screening Recommendations. https://www.postpartum.net/professionals/screening/?gad_source=1&gclid=Cj0KCQiAwtu9BhC8ARIsAI9JHamw8jsXJ-NUYlrd0Um0S4pmxHj_HCnGOZulR8AAOh0XiwiQ-aeBSHMaAi7sEALw_wcB. Accessed August 22, 2025.
17. American College of Obstetricians and Gynecologists Committee on Clinical Practice Guidelines—Obstetrics. Treatment and management of mental health conditions during pregnancy and postpartum. ACOG Clinical Practice Guideline No. 5. *Obstet Gynecol*. 2023;141(6):1262-1288. doi:10.1097/AOG.0000000000005202
18. Byatt N, Xu W, Levin LL, Moore Simas TA. Perinatal depression care pathway for obstetric settings. *Int Rev Psychiatry*. 2019;31(3):210-228. doi:10.1080/09540261.2018.1534725
19. Eakley R, Lyndon A. Disparities in screening and treatment patterns for depression and anxiety during pregnancy: an integrative review. *J Midwifery Womens Health*. 2024;69(6):847-862. doi:10.1111/jmwh.13679
20. Webb R, Uddin N, Ford E, et al; MATRIx study team. Barriers and facilitators to implementing perinatal mental health care and social care settings: a systematic review. *Lancet Psychiatry*. 2021;8(6):521-534. doi:10.1016/S2215-0366(20)30467-3
21. Kiraly C, Boyle-Duke B, Shklarski L. The role of maternal and child healthcare providers in identifying and supporting perinatal mental health disorders. *PLoS One*. 2024;19(7):e0306265. doi:10.1371/journal.pone.0306265
22. Ko JY, Haight SC. Addressing perinatal mental health and opportunities for public health. *Am J Public Health*. 2020;110(6):765-767. doi:10.2105/AJPH.2020.305663

NPWH GRATEFULLY ACKNOWLEDGES

Danielle Grimm, MPH, MSN, CNP, WHNP-BC, MSCP (Lead Writer);
Kristin Gianelis, DNP, APRN, WHNP-BC, ANP-BC, MSCP, PMH-C;
Lauren Hansen, DNP, WHNP-BC, PMHNP-BC, PMH-C;
Stephanie Jacobs, PhD, DNP, FNP-C, CNM;
Beth Kelsey, EdD, APRN, WHNP-BC; and
Terrie Platt, DNP, WHNP-BC

for their contributions as writing group members of this position statement.

Approved by NPWH Board of Directors:
January 22, 2026