Sarcouncil Journal of Internal Medicine and Public Health

ISSN(Online): 2945-3674

Volume- 05| Issue- 02| 2026

Research Article **Received:** 10-02-2026| **Accepted:** 05-03-2026 | **Published:** 20-03-2026

Healthcare Provider Perspectives on Barriers to Delivering Perinatal Mental Health Care in the U.S.

***Michael Appiah Frimpong*[1] *and Freda Frimpongmaa Botwe*[2]**

[1]*Washington University in St. Louis, St. Louis, MO, USA*
[2]*School of Public Health, Kwame Nkrumah University of Science and Technology, Ghana*

Abstract: Perinatal mood and anxiety disorders affect approximately one in five women in the United States and are major contributors to maternal morbidity and mortality, including suicide and substance-related deaths in the postpartum period. Although national professional organizations are encouraging universal screening of the populations during pregnancy and in the postpartum period, there are still gaps that lead to missing the screening and proper medication. This critical review considers the attitudes of healthcare providers concerning obstacles to the provision of perinatal mental healthcare in the United States and places these experiences into the context of the larger structural organization of the health system. Policy, health services, and workforce literature synthesis show that the causes of provider-reported difficulties lie in financing fragmentation, such as Medicaid coverage discontinuity and behavioral health carve-outs; regulatory heterogeneity across states; and long-term underinvestment in the behavioral health workforce. The timely referral and follow-up are further restricted by geographic maldistribution of specialists, administrative complexity, and organizational productivity pressures. Structural racism is intertwined with the instability of insurance and surveillance policy-oriented approaches to address access and outcome inequities. Combined, these results imply that provider-identified barriers are systemic indications of policy misfit and not individual reluctance or lack of training. To eliminate disparities in perinatal mental health care, there is a need to coordinate reform, such as nationally standardizing postpartum Medicaid coverage, universal maternity behavioral health reimbursement, investing in workforce perinatal psychiatry, aligning across states, and equity-focused policy interventions. It is also necessary to reframe perinatal mental health care as a structural-level issue of the system so that the providers can render guideline-concordant and equitable care.

Keywords: Perinatal mental health; Postpartum depression; Healthcare provider perspectives.

INTRODUCTION

Perinatal mood and anxiety disorders (PMADs) are one of the most widespread postpartum and pregnancy complications in the United States, occurring among one out of five women (ACOG, 2018; Byatt *et al.,* 2015). There is a correlation between depression and anxiety in the perinatal period and such adverse maternal, obstetric, and infant outcomes as preterm birth, lack of maternal-infant bonding, and long-term developmental risks (Howard *et al.,* 2014; Meltzer-Brody *et al.,* 2018). Over the last few years, maternal mental health has acquired increased urgency in the context of the overall maternal mortality crisis in the United States. The data on national surveillance of suicide and drug overdose show that they are the main causes of death in the first year after childbirth, which leads to the centrality of untreated mental health and substance use disorders in maternal mortality (Trost *et al.,* 2022; Nortey et al, 2025). Importantly, these burdens are not distributed equitably across racial and socioeconomic groups. Racial and structural inequities in the U.S. health system lead to unequally high rates of maternal morbidity and maternal mortality among Black women, Indigenous women, and low socioeconomic status women (Howell, 2018; Petersen *et al.,* 2019). Therefore, perinatal mental health is not a clinical but a public health and equity issue.

As a reaction, professional and policy-related bodies have placed emphasis on systematic detection and treatment of perinatal mental disorders. According to the American College of Obstetricians and Gynecologists (ACOG), depression and anxiety should be screened at least once throughout the perinatal period, and it proposes that systems be in place to guarantee the follow-up and treatment (ACOG, 2018). The same recommendation is made by the U.S. Preventive Services Task Force (USPSTF) in the case of the depression screening of adults, including pregnant and postpartum individuals, when it is supported by sufficient systems to diagnose, treat, and follow up (Siu *et al.,* 2016). Screening represents only one dimension of broader policy efforts to address perinatal mental health. As of 2021, the possibility to add 12 months to the 60-day postpartum period of Medicaid coverage is implemented by most states to help avoid coverage loss during a period of high risk of mental health issues (Centers for Medicare and Medicaid Services [CMS], 2023). The federal programs and legislative plans have also aimed to extend maternal mental health care and integrated care, and to bridge the disparities.

***Corresponding Author:** Michael Appiah Frimpong

DOI- https://doi.org/10.5281/zenodo.19138065

Collectively, these activities depict a transition into universal screening demands and greater acknowledgment of perinatal mental health as a routine part of obstetric care.

Despite these efforts, implementation gaps still exist. The perinatal depression rates have indeed increased tremendously in many settings, but even identification does not necessarily result in treatment attendance (Byatt *et al.,* 2018; Kozhimannil *et al.,* 2011). Most women who screen positive are not getting timely mental health care, and even those who do can only few undergo evidence-based treatment (Kozhimannil *et al.,* 2011). Such structural problems as insurance lapses, in particular, those of Medicaid beneficiaries, also impair continuity of care at the postpartum phase (Daw *et al.,* 2020). This is a common "defect but cannot treat" dilemma in which clinical requirements to screen are not accompanied by available, reimbursed, and integrated treatment (Byatt *et al.,* 2018). Consequently, screening becomes normalized as a policy environment, and therapeutic capacity is uneven and insufficient.

In this context, the views of healthcare providers are the key to explaining the insistent gaps within care. An obstetrician/gynecologist commonly forms the initial or the only health care provider for women in pregnancy and early postpartum and thus becomes a de facto gatekeeper in mental health identification and referral (ACOG, 2018; Byatt *et al.,* 2015). Simultaneously, perinatal mental health care in the United States is still disjointed between the obstetrics, primary care, psychiatry, and behavioral health systems that are frequently funded and administered independently. The environment in which providers work is one of productivity; there are different scopes of practice regulations in different states, and providers can be exposed to medico-legal and mandatory reporting demands, which influence screening and documentation practices. In line with this, barriers identified by the providers cannot be understood only as the lack of knowledge or attitude. Instead, they are structural products of care systems that are constrained by financing fragmentation, regulatory heterogeneity, maldistribution of workforces, and structural racism. Thus, a critical analysis of healthcare provider views offers a lens through which to interpret the system-wide constraints of U.S. perinatal mental health care. Critical analysis of healthcare provider views offers a lens through which to interpret the system-wide constraints of U.S. perinatal mental health care.

CONCEPTUAL FRAMEWORK

Structural Constraints in U.S. Perinatal Mental Health Care

To derive insights into healthcare providers' perceptions of the obstacles to perinatal mental health care in the United States, an analytical set of variables must be focused on more than individual clinician behavior. Although the knowledge, attitudes, and comfort of providers in relation to screening are frequently addressed in the literature, these proximal variables act in the context of bigger structural circumstances, which define clinical decision-making and access to care. Structural competency is the main framework that this review has taken. Structural competency insists on the fact that the health outcomes and clinical interactions are influenced by the upstream economic, political, and institutional forces instead of individual behavior alone (Metzl and Hansen, 2014). In this sense, the obstacles mentioned by the providers, including the lack of referral choices, payment issues, and documentation, are related to how the health system is organized.

To put the concept of structural competency within the United States, this review incorporates a health financing architecture model that preempts the roles of insurance design, reimbursement mechanisms, and regulatory oversight. The health system in the U.S. is marked by the stratified federal and state system of governance, where Medicaid, employer-based insurance, and individual market plans do not follow the same stipulatory regulations and reimbursement rates (Griffen *et al.,* 2021). This stratified framework creates inconsistencies in the coverage period for postpartum care, reimbursement for mental health services, telehealth policies, and regulations regarding the scope of practice. This means that providers operate in somewhat very different policies across states and payers, which adds to the disparate application of screening and treatment pathways.

Implementation science also elaborates on the disconnection between policy recommendations and practice. The Consolidated Framework of Implementation Research emphasizes the interaction of outer setting elements like policy incentives and financing and inner organization structures in order to affect practice change (Damschroder *et al.,* 2009). Depression screening is recommended by professional guidelines

Publisher: SARC Publisher

published by the American College of Obstetricians and Gynecologists and the U.S. Preventive Services Task Force in cases where there are sufficient systems to provide follow-up and treatment (ACOG, 2018; USPSTF, 2019). Nevertheless, there is evidence that screening programs tend to be more advanced than the creation of combined referral systems and reimbursement options (Byatt *et al.,* 2018). Here, provider-identified barriers are failures in the implementation of organizations and policies, instead of lack of professional motivation.

A provider is placed in layers of influence with an ecological systems perspective. The federal laws determine Medicaid eligibility regulations and mental health parity. The laws observed by state governments in the scope of practice and postpartum coverage extensions. It is the healthcare organizations that define the expectations of productivity, referral networks, and behavioral health integration models. The boundaries of professional roles are affected by training, liability issues, and institutional regulations, which affect clinicians to operate within professional role boundaries. At these levels, racial and socioeconomic inequalities are embedded to affect access to screening, referral, and treatment (Howell, 2018; Petersen *et al.*, 2019). These frameworks combined are a coherent prism within which the experiences of providers can be viewed in terms of reactions to structurally stratified systems instead of unique clinical constraints.

FINANCING ARCHITECTURE AND INSURANCE FRAGMENTATION

Perinatal mental health care provider experience barriers are largely determined by the organization of health financing in the United States. The combination of Medicaid, employer-sponsored insurance, and individual market plans provides obstetric and behavioral health services with separate rules on reimbursement and administration regulations. This disintegration creates variation in coverage, administrative complexity, and fragmented care delivery systems that have a direct impact on the providers in terms of coordinating mental health treatment (Griffen *et al.,* 2021). Structurally, a great number of the obstacles discussed by clinicians can be related to how the insurance systems are designed and not the unwillingness to provide mothers with access to mental health care or the unwillingness to remain committed.

Medicaid Discontinuity and Churn in Coverage.

In the past, Medicaid eligibility due to pregnancy was terminated sixty days after childbirth in most states. It was a policy that led to the sudden loss of insurance at a time when depressive and anxiety symptoms may manifest or aggravate (Daw *et al.*, 2020). The insurance churn that involves the transition from Medicaid to private insurance or the lack of insurance has also been shown to disrupt outpatient care and reduce continuity of care (Daw *et al.,* 2020). Even though federal policy currently allows states to expand Medicaid to twelve months of postpartum care, not all states are doing so, which has geographic inequities in terms of access to continuing mental health care (Centers for Medicare & Medicaid Services, 2023). These conditions introduce administrative burden and uncertainty into referral planning and medication management. Depression risk screening in late pregnancy can be effective, although coverage loss in the future is likely to constrain realistic treatment.

The Misalignment of Reimbursements.

The reimbursement policies are often seen to focus on screening rather than on the treatment infrastructure. The cost of screening for depression at obstetric visits is reimbursable in many states, but the cost of integrated behavioral health or a psychiatric appointment involves more billing systems and administrative resources (Byatt *et al.*, 2018). The Collaborative Care Model has defined billing codes in Medicare and in certain commercial plans; however, it requires coordination between obstetric practices, care managers, and consulting psychiatrists. Smaller or resource-limited practices might be unable to support these models with the administrative support they require. Behavioral health carve-outs also lead to more difficulties when it comes to coordination, as they divide mental health benefits and general medical benefits. There is a high likelihood that providers have to go through different authorization systems, provider networks, and documentation requirements that create more administrative workload and delay referral completion.

Behavioral Health Segmentation and Parity Restraints.

Despite the aim of federal parity laws to guarantee similar coverage of mental and physical health care, it is not applicable and implemented at the same rate in the insurance markets. The lack of access to timely psychiatric care is still a problem

Publisher: SARC Publisher

due to narrow behavioral health networks and reimbursement differences (Griffen *et al.,* 2021). The obstetric providers often complain of long queues for psychiatric visits and the inability to find therapists within the network. It can also result in a lack of communication between obstetric and behavioral health clinicians, which can be caused by managed care fragmentation and lack of continuity and shared care planning. In turn, some obstetric providers might seek to treat depression pharmacologically without professional assistance, whereas others might be reluctant to treat patients because of the lack of information about the available follow-up measures.

This Medicaid discontinuity, misaligned reimbursement, and behavioral health segmentation come together, highlighting how financing architecture is a key determinant of the behavior of providers and perceived barriers. Clinicians are also motivated and frequently obligated to screen against perinatal depression, but the systems that cover access to treatment are disjointed and state-specific. In this regard, the obstacles to providing perinatal mental health care in the United States exist at the insurance design and reimbursement framework level but not in the reluctance of the providers to act.

Workforce Scarcity and Geographic Maldistribution

One of the most repeatedly mentioned structural constraints to the provision of perinatal mental health care in the United States is workforce limitation. The country's workforce statistics show that there have been chronic shortages of psychiatrists, especially in reproductive and perinatal subspecialties. Large areas of the country have been declared Mental Health Professional Shortage Areas by the Health Resources and Services Administration and apply to both the underserved communities in cities and the rural areas (Health Resources and Services Administration [HRSA], 2023). Amidst this overall scarcity, those clinicians who have specialty training in perinatal psychiatry are even more constrained and limit access to consultations and specialty referral. Obstetric providers often complain that they are unable to find psychiatrists willing to prescribe during pregnancy and lactation, which complicates treatment planning and intensifies the use of informal networks of consultation (Byatt *et al.,* 2015).

The result of these shortages is extended waiting periods for psychiatric assessment and psychotherapy services. Access to outpatient psychiatry Empirical research on the subject has reported long delays in accessing the appointment, which may take several weeks to months, especially with patients with publicly funded insurance (Andrilla *et al.,* 2018; Nortey et al, 2025). In pregnant and postpartum women with depression, anxiety, or substance use disorders, delayed access may worsen the symptoms and risk factors of the conditions and place them at a time of increased vulnerability. The obstetric setting providers might thus be in a dilemma of need being identified through screening, but the referral pathways being limited due to the provision of limited specialists. This deficit supports a trend where obstetric clinicians provide mental health care without specialty assistance or referral on account of the uncertainty about post-discharge resources.

The geographic maldistribution also makes the shortage of workforce even more complicated. There is an unequal distribution of obstetric and behavioral health providers in rural communities. The literature has reported the shutdown of rural hospital obstetric departments in the last ten years, making maternity services less accessible to the community and making the commute to prenatal and postpartum care more difficult (Kozhimannil *et al.,* 2016). At the same time, the rural counties are much less likely to employ practicing psychiatrists, psychologists, or licensed clinical social workers than metropolitan areas (Andrilla *et al.,* 2018). The overlap between behavioral health workforce shortages and obstetric service closures is what some scholars refer to as maternal health deserts, where physical and mental health services are geographically unavailable. The transportation barriers, low availability of broadband infrastructure, and socioeconomic factors further restrict the possibility of traveling to specialty appointments, especially among low-income and publicly insured groups.

To address these gaps, there are psychiatric access programs instituted by a number of states to assist frontline clinicians. One of the most established models that has been studied extensively is the Massachusetts Child Psychiatry Access Program to Moms, which offers real-time psychiatry consultation, care coordination, and referral services to obstetric providers (Byatt *et al.,* 2016). According to the assessment of this model, it led to a better provider confidence level and more patients becoming engaged in the treatment (Byatt *et al.,* 2018). Other states have followed suit with

Publisher: SARC Publisher

similar programs, as it is acknowledged that it is the system level that has to be supported in order to alleviate workforce shortages, not only extended screening requirements. Such programs show that the shortage of specialists can be partially addressed through the active involvement of psychiatric specialists in obstetric care with the help of organized consultation networks.

Telepsychiatry growth has also been encouraged as one of the solutions to geographic inequities. There are also signs that telehealth can improve access to behavioral health services in underserved and rural populations, especially when remote care delivery is paid with reimbursement policies (Mehrotra *et al.,* 2017). On the one hand, temporary regulatory flexibilities boosted the adoption of telehealth in most states during the COVID-19 pandemic. Nonetheless, the practice of telepsychiatry is not evenly spread throughout, and it depends on the state licensure regulations, the policies of payers to provide reimbursement, and the lack of broadband infrastructure. In addition, telehealth fails to address the root causes of workforce shortages if the number of clinical providers is still insufficient.

The combination of workforce shortage and geographic maldistribution is a symptom of long-term underinvestment against behavioral healthcare infrastructure in the United States. The shortage of perinatal psychiatrists, unequal distribution of mental health care providers, the shutdown of rural obstetric services, and transportation barriers all limit the provider capacity to provide guideline-concordant care. Although consultation programs and telepsychiatry present a valuable mitigation strategy, they operate in a larger system that is typified by a lack of proper planning of the behavioral health workforce and disjointed funding. The identified provider barriers in this area thus indicate a multisystemic problem with resource allocation and not a single clinical resistance.

Regulatory Heterogeneity and Variation of Scope of Practice.

An important structural determinant influencing the provider attitude toward providing perinatal mental health care in the United States is regulatory dissimilarity among states. The laws that govern the practice of psychiatry are called scope-of-practice laws and define who has the right to diagnose, prescribe, and independently treat mental health issues. Such regulations vary greatly by state and type of profession, which makes the power and responsibility of obstetricians, family physicians, nurse practitioners, and certified nurse midwives uneven. Perinatal depression and anxiety are two instances of such variability that affect the screening to turn into pharmacologic therapy, referral, or delayed care. The issue of discomfort in prescribing selective serotonin reuptake inhibitors during pregnancy by the providers frequently intersects the boundaries of regulation and training, which supports the ambiguity of treatment decision-making (Byatt *et al.,* 2015). Prescription of selective serotonin reuptake inhibitors may also be a source of uncertainty during pregnancy, as many providers are either not specially trained or fear regulatory and liability issues (Byatt *et al.,* 2015).

According to research, obstetrician-gynecologists differ in their level of ease and confidence in the pharmacologic treatment of perinatal depression. It is also reported that they are hesitant because they lack formal training in psychiatry and fear exposing the fetus to medications, especially when there are no available psychiatric consultations (ACOG, 2018; Byatt *et al.,* 2015). Conversely, family physicians, with widely dissimilar training in lifespan psychopharmacology, might report being more confident starting antidepressant therapy at the time of pregnancy and postpartum (Siu *et al.,* 2016). These variations represent the training avenues as well as guidelines of professional identity. Obstetric clinicians may delay or fragment care when they screen, and they feel limited to prescribing, or they do not have access to timely specialist support.

Midwives and advanced practice clinicians are a poorly studied yet potentially essential workforce in perinatal mental health practice. The certified nurse midwives can give longitudinal prenatal and postpartum care and be in a good place to detect the onset of depressive symptoms. The prescription of controlled substances and some psychotropic drugs is, however, state-specific and might involve physician collaboration agreements in certain states (Ortiz *et al.,* 2018). In the same way, the scope of practice of nurse practitioners is fully independent in certain states and limited or reduced in other states, necessitating supervisory or collaborative work with physicians. It has been proven that states where nurse practitioners have full practice authority are linked to high access to primary care services, especially in underserved regions (Xue *et al.,* 2019). The ability of advanced practice clinicians to provide direct responses to

Publisher: SARC Publisher

positive mental health screenings may, therefore, be constrained by regulatory restrictions.

Whether or not a state has heterogeneity in licensure, prescribing authority, and telehealth practice rules only adds to continuity of care (Ismail and Nortey, 2025). In the COVID-19 pandemic, state lines have been opened to telehealth prescribing waivers, most of which are open to state-specific renewal or cancellation. The diversity of these policies determines the ability of patients to continue psychiatric treatment in case of a change in residence or the absence of local specialists. To providers, the administrative complexity and uncertainty associated with meeting various regulations in practice locations or patient insurance plans can be presented. Such heterogeneity can be disproportionally distributed among rural and low-income communities where advanced practice clinicians tend to provide primary care and where psychiatric specialists are not abundant.

Fragmentation in regulation thereby increases inequity and discontinuity of care in perinatal mental health service. The prescriptive authority and supervisory needs differ depending on the requirements of the provider, who may independently initiate or proceed with the treatment after the screening. In case of limitation of scope of practice, even simple cases of depression might require referral to psychiatrists, further increasing delays in the already underserved areas. Instead of individual provider aversion as the cause of observed differences in treatment patterns, regulatory systems tend to distribute power unevenly among professions and states. By doing so, the variation in scope of practice acts as a structural determinant of access to the overall financing/workforce context of U.S. perinatal mental health care.

Liability, Surveillance, and Risk Management Culture.

The United States' medico-legal environment is a unique structural factor that affects the provision of perinatal mental health care. It is well known that obstetric practice is a high-liability specialty, and malpractice premiums and litigation issues are influencing clinical decision-making (Studdert *et al.,* 2005). Even though most litigation in the obstetrics field focuses on the birth outcomes, a wider malpractice anxiety leads to defensive documentation and increased sensitivity to the issue of risk management. Within the framework of perinatal mental health, providers might experience depression, suicidality, or substance use screening to increase their medico-legal liability, especially in instances where the resources needed to facilitate a referral are scarce. The anticipation to detect mental health risk in the absence of assured services can make the issue of professional responsibility even more pressing in case of negative outcomes.

Another area where liability affects documentation practices is through documentation practices. The studies conducted in the obstetric and primary care environments indicate that the clinicians might feel tension between complete documentation and the interests of the medical record being used in the legal or the child welfare process (Angelotta *et al.,* 2016). Suicidal ideation, substance use, or interpersonal violence may be clinically indicated to be recorded in detail, but the providers might be concerned about the unwanted effects on patients, such as forcing them to report the issue or bringing Child Protective Services. The result of this dynamic can be the influence of the framing of the screening questions and the recording of the responses, especially in those communities where there is mistrust of an institutional system.

Perinatal mental health screening is also complicated by mandatory reporting laws. The state statutes differ in terms of reporting with respect to prenatal substance use, suspected child neglect, and imminent risk of self-harm. Under civil law, some states consider prenatal substance exposure as child abuse, whereas some only report when the harm is evident (Guttmacher Institute, 2023). Such legal provisions provide confusion to the provider on the levels of declaration and the possible legal implications against patients. There is evidence that the fear of incurring punitive action may discourage pregnant women from providing information about substance use or mental health issues, especially among marginalized populations (Angelotta *et al.,* 2016). The providers can thus face ethical conflict between the requirements of common health and patient trust.

The aspect of criminalizing substance use during pregnancy is one of the most relevant illustrations of the overlap of surveillance structures and clinical care. Prosecutions and civil interventions of pregnant women due to substance use have been reported by legal scholarship and population health research, though Black women and low-income people were disproportionately affected (Paltrow and Flavin, 2013). It is in this environment that

Publisher: SARC Publisher

clinicians might view the screening of substance use or severe psychiatric symptoms as potentially exposing patients to the investigation of the law. Providers may be affected by such concerns about whether they will directly inquire about suicidality or substance use and how openly they will discuss psychosocial stressors. Indifference may not demonstrate the lack of care towards mental health risk, but it is an understanding of the larger surveillance system where the disclosures are inculcated.

These issues of liability pressures, documentation anxiety, compulsory reporting regulations, and punitive substance use policies in aggregate demonstrate how the medico-legal environment influences clinical communication in perinatal environments. Providers work in a system that connects mental health disclosure with possible legal risks, professional responsibility, and reporting requirements at the institution. Such structural conditions not only affect whether screening takes place or not but also affect the discussion and recording of sensitive issues in an open way. Structurally, the choice of provider to ask about suicidality or take notes on suicidality is more about getting used to the culture of risk management instead of being merely a training or empathy lapse. The medico-legal environment is thus an upstream factor of perinatal mental health screening and referrals in the United States.

Organizational Constraints: Productivity Metrics and Clinical Time

Organizational design in the U.S. healthcare systems, in addition to the funding and regulatory frameworks, influences the experiences of providers in offering perinatal mental health care. The obstetric practice is often organized according to productivity goals tied to relative value units, which encourage high patient volume and procedure-based practices. In this model, prenatal and postpartum visit time is usually minimal, especially in high-volume practices and safety net environments. A study of outpatient patterns of care reveals that the duration of visits in an obstetric setting is typically between 10 and 20 minutes, based on the payer mix and the practice setting (Rayburn, 2011). Providers in these limited encounters have to deal with biomedical evaluations, fetal measurements, laboratory evaluations, patient education, and documentation necessities, leaving minimal time to engage in in-depth mental health discussions.

The quality of perinatal mental health screening and the subsequent follow-up are directly influenced by time scarcity. But despite the ability to deliver standardized instruments, like the Edinburgh Postnatal Depression Scale, within a short period of time, to share meaningful dialogue on positive events, safety assessment, and joint care planning is required. The implementation studies of depression screening have discovered that providers occasionally view screening as an extra burden on already pressured visits, especially when the referral systems are not readily available (Byatt *et al.*, 2015). In productivity metrics that give priority to throughput, screening will likely be procedural, not relational, and will have little time to investigate contextual issues such as trauma history, intimate partner violence, or substance use.

The clinical workflow and communication are also influenced by electronic health record systems. Although integration with EHR can support standardized documentation of screening, it also creates a burden on administration that competes with direct interaction with patients. The physicians working in various specialties claim that documentation requirements are among the causes of time pressure and burnout, which often leads to working after clinic hours (Sinsky *et al.*, 2016). Structured templates have the potential to decrease narrative space in subtle psychosocial assessments during perinatal care settings. The providers can thus be at a crossroads of filling out necessary forms and having an open-ended, trauma-informed conversation. The virtual infrastructure upon which billing and compliance depend is unintentionally limiting the richness of the conversation.

The organizational productivity norms are established within the wider market-oriented health system logics. Models of payment that compensate volume rather than longitudinal developmental care could undermine the long-term engagement that is usually required in dealing with depression and anxiety. Safety, trust, collaboration, and empowerment, which are the elements of the trauma-informed care frameworks, are time-consuming and continue to develop (Substance Abuse and Mental Health Services Administration, 2014). Clinicians might not have enough time to develop rapport or review mental health issues during multiple visits, and thus, they might make decisions to postpone further inquiry or just provide some quick assurance. The trend is more relevant to patients with complicated psychosocial

Publisher: SARC Publisher

requirements that might necessitate extended visits that are under-compensated.

Combined, productivity pressures, short prenatal visits, and EHR documentation demands provide organizational settings that restrict relational mental health care. The screening can be performed with high rates, but the level and quality of follow-up discussions are based on the time and the support used by the institution. Structurally, these constraints can be seen as a wider neoliberal setup in the health system, which favors efficiency and quantifiable output. Identified barriers by providers in this area thus enlighten the role of organizational productivity models in influencing the provision of perinatal mental health services in a manner that is more than the intention of the individual clinician.

Integrated and Collaborative Care Models: Promise and Structural Limits

Attempts at implementing behavioral health into obstetric and primary care facilities have arisen due to the historical failure to address the gaps in perinatal mental health care provision. Embedded behavioral health models make social workers, psychologists, or care managers stationed at the obstetric clinics to enable screening follow-up, brief intervention, and referral coordination. Integrated perinatal care programs have been evaluated and found to increase screening rates, treatment initiation, and patient engagement in cases when behavioral health services were co-located in a maternity environment (Byatt *et al.*, 2016). Such models minimize the use of external referrals and eliminate the barriers of logistics, including transport and scheduling. As a provider, embedded services can enhance trust in the process of dealing with depression and anxiety through providing instant consultation and shared care planning.

Another program that can be adopted to expand the scope of specialists without having to engage full-time on-site psychiatrists is psychiatric consultation programs. The Massachusetts Child Psychiatry Access Program to Moms is one of the most analyzed examples and fits the criteria of real-time telephone consultation, resource and referral assistance, and care coordination offered to obstetric clinicians (Byatt *et al.,* 2018). The same perinatal psychiatric access programs have been extended to various states, which indicates the national awareness of the workforce shortage. Some evidence shows that these programs enhance provider self-efficacy and can even improve uptake of treatment among patients (Byatt *et al.*, 2016). Nevertheless, these programs do not eradicate the underlying deficits: instead, they reallocate scarce psychiatric knowledge to greater geographical regions.

The collaborative care model provides a more formalized structure of integrating mental health in medical environments. This model entails structured screening, behavioral health care management, psychiatric assessment, and measurement-based treatment to focus on (Archer *et al.,* 2012). Collaborative care has shown to be effective in enhancing the results of depression relative to usual care in general adult populations (Archer *et al.,* 2012). Adaptations of collaborative care for perinatal populations have shown promising outcomes, especially when adopted with an adequately staffed and financially operational obstetric practice (Byatt *et al.,* 2018). Collaborative care is reimbursed by Medicare and a few commercial payers under particular billing codes. Nonetheless, these codes do have operationalization needs of administration ability, documentation, and payer alignment, which might be challenging in small or resource-limited practices.

The state-level heterogeneity plays a major role in determining the viability of integrated models. The policies of Medicaid reimbursement, telehealth, and behavioral health carve-outs vary by state, and they can influence the financial viability of collaborative care services. Other states have funded maternal mental health programs using specific fund streams, but some other states use time-limited grants or pilot funds. Programs that rely on federal or philanthropic grants will have an appearance of success in the short term but will have difficult staffing once the funding cycles run out. Such instability may cause provider mistrust of referral systems, as well as inhibit the growth of long-term infrastructure.

Even though integrated and collaborative care models indicate the practicality of discussing perinatal mental health in an obstetric care setting, they are still incorporated in a discontinuous financing and regulatory framework. It has been observed that successful programs may entail consistency among reimbursement policies, workforce capacity, and organizational leadership. In the case where alignment does not occur, the integration can be limited by administrative overhead, insufficient reimbursement, or staffing. Structurally, these models underscore the

Publisher: SARC Publisher

possibility of system redesign, as well as the constraints of the decentralized and market-based health financing. Integration will help reduce part of the barriers faced by the providers, but its sustainability relies on more comprehensive reforms that tackle financing fragmentation and policy variability among the states.

Critical Systems Level Synthesis

The above sections all point towards the fact that the perinatal mental health care provider-identified barriers in the United States are most effectively seen as characteristics of a health system that is structurally constrained rather than as the professional failures of an individual. To begin with, the provider agency is caught up in financing fragmentation. Obstetric clinicians are actively encouraged and even mandated to screen for depression and anxiety, but Medicaid discontinuity, behavioral health carve-outs, and reimbursement misalignment restrict access to timely and sustained treatment methods (Daw *et al.,* 2020; Griffen *et al.,* 2021). In the case of unstable insurance coverage or where integrated care billing arrangements are administratively complicated, providers may feel that they have minimal capacity to provide follow-up. Professional judgment is not the only way clinical decision-making is formed in this environment, as it is influenced by the expected barriers to access.

Second, regulatory inequality creates inequalities in the standards of care within and across states and professional groups. SOP laws define the people who can prescribe antidepressants or continue with mental health management on their own, in their own environment, and these laws differ significantly in jurisdictions (Xue *et al.,* 2019). Similarly, telehealth policies and Medicaid reimbursement policies vary by state, affecting the practicability of psychiatric consultation and collaboration care models. Consequently, the services provided to a pregnant or postpartum person might largely rely on the physical location. Providers who work in a restrictive regulation setting might be presented with extra referral procedures or supervisory demands that postpone the commencement of treatment. This heterogeneity makes national screening recommendations difficult to implement and distorts consistent standards of perinatal mental health care.

Furthermore, maldistribution of the workforce characterizes an underinvestment in behavioral health infrastructure by the system. Many communities have a low referral capacity due to a constant shortage of psychiatrists, especially with perinatal experience, and the overconcentration of mental health professionals in most urban communities (Andrilla *et al.,* 2018; HRSA, 2023). The decision to close rural hospital obstetric units also contributes to geographic inequities of physical as well as mental health services (Kozhimannil *et al.,* 2016). The programs of psychiatric access and telehealth show partial measures of mitigation, but they are implemented in the workforce environment with historical funding gaps and training pipeline limitations. Providers who report difficulty securing prompt psychiatric appointments are addressing systemic workforce issues and describing themselves as willing to coordinate care.

Moreover, structural racism cuts across the lines of care delivery, collides with financing, control, and staffing. The racial and ethnic differences in maternal morbidity and mortality indicate the larger inequities between access to high-quality care (Howell, 2018; Petersen *et al.,* 2019). The women of color and low-income groups are the most affected by the issue of insurance instability, aggravating the effects of Medicaid churn and narrow behavioral health networks. Geographic lopsidedness of providers is often in line with the residential segregation and disinvestment patterns. Moreover, the policies of criminalization of substance usage and the mandatory reporting have disproportionately influenced Black women as well, which can affect the practices of patient disclosure and provider communication (Paltrow and Flavin, 2013). This is due to these structural dynamics, which imply the provider experienced barriers that do not exist uniformly but within historically stratified systems.

This analysis reframes provider perspectives as reflections of structural constraints. The decentralized, market-oriented, and racially stratified health system of obstetricians, family physicians, midwives, and advanced practice clinicians. Fragmentation of financing, regulatory heterogeneity, imminent workforce underinvestment, and underlying inequities have influenced their reported problems in screening, prescribing, documenting, and referring. Providers also operate within a structurally constrained ecosystem that restricts their ability to provide guideline-concordant perinatal mental health services. Reform at the policy and systems level is needed to tackle these barriers rather than singly

Publisher: SARC Publisher

targeting the issues of individual clinician training or behavior change.

Policy and Practice Implications

The structural review introduced in the current review indicates that the clinical interventions in this area are unlikely to become so advanced that the existing gaps in the field of perinatal mental health care would be bridged without more comprehensive policy changes. Funding redesign is one of the key priorities. The national expansion of postpartum Medicaid coverage to twelve months in all states would help decrease geographic imbalances in insurance and churning at a time of increased vulnerability (Daw *et al.*, 2020). Moreover, there is a need to coordinate reimbursement to integrate maternity and behavioral health services. We should also subject sustainable payment and care coordination, psychotherapy, and psychiatric consultation to screening requirements. Making collaborative care billing needs less complex and uniform across payers may help ease administrative pressure and boost its adoption in smaller obstetric practices (Byatt *et al.*, 2018). Without financing reform, providers will continue to face structural barriers that impede care continuity.

Investment in the workforce is also vital. The capacity of specialists in the long term could be enhanced through federal funding to increase training in perinatal psychiatry and reproductive mental health. Potential levers include allocations of graduate medical education and incentives of loan repayment restricted to maternal mental health. Since shortages in rural and underserved areas are documented, incentive programs that develop behavioral health clinicians to work in Health Professional Shortage Areas can enhance geographic distribution (Andrilla *et al.*, 2018; HRSA, 2023). Programs of psychiatric access and telehealth programs prove to be feasible, yet their sustainability relies on the stable funding and workforce pipelines. There should be structural underinvestment in behavioral health training to avoid further dependence on the temporary or grant-dependent solutions.

Inter-state regulatory congruence is also a matter of concern. Diversity in the scope of practice legislation determines the clinicians that have the freedom to handle perinatal depression and anxiety independently. There is an indication that the authority of nurse practitioners to practice is linked with better access to primary care, especially in underserved locations (Xue *et al.*, 2019). Reconciling prescriptive authority and decreasing supervision barriers that are suitable may enlarge the number of clinicians who may offer prompt treatment after screening. Equally, more uniformity in telehealth policies and reimbursement would enable the continuity of psychiatric care across state lines. A decrease in regulatory heterogeneity would help implement the national screening and treatment recommendations more uniformly.

Equity-based reform needs to be incorporated into the financing, labor, and regulatory programs. The combination of structural racism and insurance instability, geographic disinvestment, and punitive substance use policies influences maternal mental health outcomes (Howell, 2018; Petersen *et al.*, 2019). The interventions that can be made to address anti-racist policy are strengthening the performance of mental health parity laws, investing in community-based perinatal mental health programs in historically marginalized communities, and supporting culturally responsive care models. Local organizations can be involved in improving engagement, and community health centers, home visiting programs, and integrated models of maternity care can be used to tackle mistrust. In the absence of explicit equity focus, structural reforms will recreate the existing inequalities. Interventions on policy and practices should then focus on systems integration as well as racial justice to empower providers to provide guideline-concordant and equitable perinatal mental health care.

CONCLUSION

In the United States, clinician-level interventions cannot be sufficient to comprehend and enhance perinatal mental health care. Even though obstetricians, family physicians, midwives, and advanced practice clinicians are the key players in the screening and referral procedures, their barriers as reported are indicative of the greater structural constraints initiated in the health system. The conditions in which care is provided are influenced by financing fragmentation, insurance churn, regulatory heterogeneity, workforce shortages, liability pressures, and organizational productivity demands, which are all factors that drive the problem. The restructuring of perinatal mental health as a structural problem at the systems level changes the focus on the shortcomings of individual providers and places the emphasis on the structure of policy and reimbursement regulation of clinical practice. In this context, the

Publisher: SARC Publisher

providers' views are not employed as an indication of reluctance or lack of training, but these views are diagnostic of policy misalignment at a larger scale.

The longevity of the discrepancy between the treatment capacity and the screening requirements is an example of the impact of decentralized and asymmetrical reform. Federal recommendations provide that universal screening should be encouraged, but through a state-dependent financing environment where there are both inconsistencies in Medicaid coverage, laws of scope of practice, and behavioral health integration infrastructure. Maldistribution of the workforce and inadequate investments in behavioral health also limit timely referrals, and structural racism overlaps with these processes to result in unequal access and outcomes. The absence of coordination in terms of financing, regulation, and workforce development leaves providers in a system where a provider cannot provide guideline-concordant and equitable care.

The policy action, which is coordinated and entails reimbursement reform, workforce expansion, regulatory harmonization, and equity-focused investment, will be required to achieve sustainable improvement in perinatal mental health outcomes. Standardizing postpartum coverage, balancing maternity and behavioral health funding, creating more perinatal psychiatric training pipelines, and decreasing the state-level regulatory discontinuity are key building blocks to system coherence. Finally, to change the perinatal mental health care in the United States, it is essential to acknowledge that provider-experienced barriers are a symptom of structural design. It does not just require meaningful improvements on clinical practice but redefines the institutional and policy environment within which it is defined.

Limitation

This review is limited by its narrative design and does not employ a formal systematic search strategy; therefore, it may not capture all relevant empirical studies or quantify the relative strength of evidence across domains. In addition, the analysis is confined to the United States, and the structural dynamics described may not be generalizable to health systems organized under different financing and regulatory models. Rapidly evolving state-level policy reforms may also alter aspects of the landscape outlined.

REFERENCES

1. Abuse, S. "SAMHSA's concept of trauma and guidance for a trauma-informed approach." (2014).
2. American College of Obstetricians and Gynecologists. "Screening for perinatal depression." *Obstetrics & Gynecology* 132.5 (2018): e208–e212.
3. Andrilla, C. H. A., Patterson, D. G., Garberson, L. A., Coulthard, C., & Larson, E. H. "Geographic variation in the supply of selected behavioral health providers." *American Journal of Preventive Medicine* 54.6 Suppl 3 (2018): S199–S207.
4. Angelotta, C., Weiss, C. J., Angelotta, J. W., & Friedman, S. "A moral or medical problem? The relationship between legal penalties and treatment practices for opioid use disorder in pregnancy." *Women's Health Issues* 26.6 (2016): 595–601.
5. Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., et al. "Collaborative care for depression and anxiety problems." *Cochrane Database of Systematic Reviews* 10 (2012).
6. Byatt, N., Biebel, K., Lundquist, R. S., Moore Simas, T. A., Debordes-Jackson, G., Allison, J., & Ziedonis, D. "Patient, provider, and system-level barriers and facilitators to addressing perinatal depression." *Journal of Reproductive and Infant Psychology* 30.5 (2012): 436–449.
7. Byatt, N., Biebel, K., Simas, T. A. M., Sarvet, B., Ravech, M., Allison, J., & Straus, J. "Improving perinatal depression care: The Massachusetts child psychiatry access project for moms." *General Hospital Psychiatry* 40 (2016): 12–17.
8. Byatt, N., Levin, L. L., Ziedonis, D., Moore Simas, T. A., & Allison, J. "Enhancing participation in depression care in outpatient perinatal care settings: A systematic review." *Obstetrics & Gynecology* 126.5 (2015): 1048–1058.
9. Byatt, N., Straus, J., & Biebel, K. "Improving perinatal depression care: The Massachusetts Child Psychiatry Access Program for Moms." *General Hospital Psychiatry* 51 (2018): 12–17.
10. Centers for Medicare & Medicaid Services. "Medicaid and CHIP postpartum coverage extension." (2023).
11. Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. "Fostering implementation of health services

Publisher: SARC Publisher

research findings into practice: A consolidated framework for advancing implementation science." *Implementation Science* 4.1 (2009): 50.
12. Daw, J. R., Winkelman, T. N. A., Dalton, V. K., Kozhimannil, K. B., & Admon, L. K. "Medicaid expansion improved perinatal insurance continuity for low-income women." *Health Affairs* 39.9 (2020): 1531–1539.
13. Griffen, A., McIntyre, L., Belsito, J. Z., & Burkhard, J. "Perinatal mental health care in the United States." *Health Affairs* 40.10 (2021): 1543–1551.
14. Guttmacher Institute. "Substance use during pregnancy." (2023).
15. Health Resources and Services Administration. "Designated Health Professional Shortage Areas statistics." (2023).
16. Howard, L. M., Molyneaux, E., Dennis, C.-L., Rochat, T., Stein, A., & Milgrom, J. "Non-psychotic mental disorders in the perinatal period." *The Lancet* 384.9956 (2014): 1775–1788.
17. Howell, E. A. "Reducing disparities in severe maternal morbidity and mortality." *Clinical Obstetrics and Gynecology* 61.2 (2018): 387–399.
18. Kozhimannil, K. B., Adams, A. S., Soumerai, S. B., Busch, A. B., & Huskamp, H. A. "New Jersey's efforts to improve postpartum depression care did not change treatment patterns." *Health Affairs* 30.2 (2011): 293–301.
19. Mehrotra, A., Huskamp, H. A., Souza, J., Uscher-Pines, L., Rose, S., Landon, B. E., et al. "Rapid growth in mental health telemedicine use among rural Medicare beneficiaries, wide variation across states." *Health Affairs* 36.5 (2017): 909–917.
20. Is-mail, M., & Nortey, R. T. "Economic impact of social support on reducing hospital readmissions in older hypertensive adults." *World Journal of Advanced Research and Reviews* 28.1 (2025): 2122–2127.
21. Nortey, R. T., Egbunu, A. S., & Oware, E. "Barriers to social support access in urban vs. rural older adults U.S populations: A scoping review." *Sarcouncil Journal of Medicine and Surgery* 4.11 (2025): 1–10.
22. Nortey, R. T., Korang, A., Ansah, R. S., & Kaiser, F. "Telehealth and digital platforms for delivering social support to rural older adults with hypertension: A systematic review with U.S. policy and global health implications." *Sarcouncil Journal of Internal Medicine and Public Health* 4.6 (2025): 1–15.
23. Ortiz, J., Hofler, R., Bushy, A., Lin, Y. L., Khanijahani, A., & Bitney, A. "Impact of nurse practitioner scope of practice regulations on rural population health outcomes." *Nursing Outlook* 66.2 (2018): 199–206.
24. Paltrow, L. M., & Flavin, J. "Arrests of and forced interventions on pregnant women in the United States, 1973–2005." *Journal of Health Politics, Policy and Law* 38.2 (2013): 299–343.
25. Petersen, E. E. "Racial/ethnic disparities in pregnancy-related deaths—United States, 2007–2016." *Morbidity and Mortality Weekly Report* 68 (2019).
26. Petersen, E. E., Davis, N. L., Goodman, D., et al. "Racial/ethnic disparities in pregnancy-related deaths—United States, 2007–2016." *Morbidity and Mortality Weekly Report* 68.35 (2019): 762–765.
27. Rayburn, W. F. *The obstetrician/gynecologist workforce in the United States: Facts, figures, and implications 2011*. Washington, DC: American Congress of Obstetricians and Gynecologists, 2011.
28. Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., et al. "Allocation of physician time in ambulatory practice: A time and motion study in 4 specialties." *Annals of Internal Medicine* 165.11 (2016): 753–760.
29. Siu, A. L., US Preventive Services Task Force (USPSTF), Bibbins-Domingo, K., Grossman, D. C., Baumann, L. C., Davidson, K. W., et al. "Screening for depression in adults: US Preventive Services Task Force recommendation statement." *JAMA* 315.4 (2016): 380–387.
30. Studdert, D. M., Mello, M. M., Gawande, A. A., et al. "Defensive medicine among high-risk specialist physicians in a volatile malpractice environment." *JAMA* 293.21 (2005): 2609–2617.
31. Trost, S., Beauregard, J., Chandra, G., Njie, F., Berry, J., Harvey, A., & Goodman, D. A. "Pregnancy-related deaths: Data from maternal mortality review committees in 36 US states, 2017–2019." *Education* 45.10 (2022): 1–10.
32. U.S. Preventive Services Task Force. "Screening for depression in adults." *JAMA* 322.6 (2019): 518–524.
33. Xue, Y., Smith, J. A., & Spetz, J. "Primary care nurse practitioners and physicians in low-income and rural areas, 2010–2016." *JAMA* 321.1 (2019): 102–105.

Publisher: SARC Publisher

Source of support: Nil; **Conflict of interest:** Nil.

Cite this article as:
Frimpong, M. A. and Botwe, F. F. " Healthcare Provider Perspectives on Barriers to Delivering Perinatal Mental Health Care in the U.S.." *Sarcouncil Journal of Internal Medicine and Public Health* 5.2 (2026): pp 21-33.

Publisher: SARC Publisher