Nested

A NATIONAL STUDY OF PERINATAL MENTAL HEALTH IN THE UNITED STATES

Missed Screenings, Missed Support

Parents are struggling and the system isn't catching it.

Every year, millions of parents experience Perinatal Mood and Anxiety Disorders (PMADs), but too few get the support they need. These aren't rare cases. PMADs are among the most common complications of childbirth, yet our systems are failing to recognize and respond.

We launched this study because maternal mental health is still not treated like the crisis it is. It's underfunded, under-researched, and too often dismissed. At Nested, we set out to change that with a national survey of over 1,000 caregivers and in-depth interviews that capture what parents are really going through.

The goal? To expose the cracks in how we screen, support, and care for families, and to turn that insight into action. Because when we listen to parents, the message is clear: the current system isn't working. We *can* do better. And we must.

This study was made possible by the generous support of our founding partners, who share our commitment to improving family well-being.

NYU

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bümo

APW ALL PARENTS WELCOME

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Meet Nested

We do the research that's chronically underfunded and desperately needed.

At Nested, we're committed to advancing family well-being through rigorous, impactful research. With deep expertise in child development, perinatal mental health, and parenting, **we are accelerating the research-to-action pipeline.**

As a specialized 501(c)(3) nonprofit research institute, we bring the expertise of top scholars while remaining agile, creative, and deeply attuned to the issues that matter most to families today.

Methodology

This study employed a mixed-methods approach to explore caregivers' experiences with perinatal mental health. Data were collected through an online survey, distributed via social media platforms, targeting birthing caregivers across the United States.

The 15-minute survey included questions about participants' experiences and mental health, incorporating selected items from the Edinburgh Postnatal Depression Scale (EPDS) to estimate PMAD experiences relative to an established measure.

Additionally, in-depth interviews lasting up to two hours each were conducted with Nested co-founder Dr. Erin O'Connor, providing rich qualitative insights into caregivers' narratives. The final analytic sample comprised 907 survey respondents and 17 interview participants. Analyses included qualitative coding of interview data and quantitative techniques such as multiple regression analyses and interaction analyses.

Executive Summary

PMADs affect at least 1 in 5 birthing caregivers

This study was born from the urgent need to address perinatal mood and anxiety disorders (PMADs), a widespread yet often overlooked public health crisis. PMADs are frequently misunderstood and underdiagnosed, leaving families to navigate profound challenges without adequate support.

Using a robust mixed-methods approach, our research provides fresh insights into the experiences of over 1,000 caregivers, uncovering systemic gaps in screening, treatment, and access to mental health care.

The findings shared in this report reveal critical gaps in perinatal mental health care that leave families vulnerable. Policymakers, healthcare providers, and funders must work together to:

Strengthen Training	Increase Access	Expand Paid Leave
Expand mental health training for providers, including pediatricians and OB/GYNs, who form a critical part of caregivers' care teams.	Ensure equitable access to telehealth services and peer-to-peer support networks.	Advocate for inclusive, extended paid leave policies that support birthing and non-birthing caregivers alike.

By addressing these systemic barriers, we can create a future where no caregiver navigates PMADs in isolation and every family has access to the support they need to thrive.

Key Findings

The findings reveal critical gaps in perinatal mental health care that leave families vulnerable.

FEAR

48% of caregivers who were screened felt they could not answer the questions truthfully, citing fears of judgment or custody loss.

SCREENING

40% of caregivers who experienced a PMAD were never screened during a follow-up obstetric or pediatric appointment.

98% of non-birthing caregivers (including fathers, adoptive parents, and same-sex partners) were never screened for PMADs, despite many reporting symptoms.

PROVIDERS

Only 24% of caregivers felt comfortable discussing mental health concerns with their healthcare providers.

Providers often felt unprepared to address PMADs, with limited training on pharmacological treatments and inadequate referral networks.

FAMILIES AS SYSTEMS

22% of caregivers reported feeling comfortable speaking openly with their partners about mental health struggles.

Caregivers frequently described a ripple effect, where PMADs in one partner strained the entire family dynamic.

NICU

Parents of infants who spend time in the NICU due to prematurity or health complications were 73.5% more likely to experience a PMAD than those whose babies did not require intensive care.

NICU parents were also more likely to report wanting more support from their own parents, friends, and a parent group.

PAID LEAVE

Families with more than 12 weeks of paid leave were 80% less likely to leave their jobs.

87.5% of caregivers who experienced PMADs and ultimately left their jobs wished they had access to longer paid leave.

Expanding paid leave to include grandparents could help close critical gaps in perinatal support. Birthing parents with supportive grandparents were significantly less likely to report PMADs (40%) than those without (60%).

BARRIERS TO CARE

Many caregivers reported difficulty connecting with specialists, especially in rural or underserved areas, due to a fragmented referral system.

Telehealth services and comprehensive care models may be a potential solution but remain underutilized in many regions.

The Stories That Bring the Data to Life

Each case study is based on an in-depth interview with a caregiver. Click on their profiles to hear their stories.

LISA

Navigating new parenthood while serving in a system with few resources for **military families.**

TINA

Navigating the **journey from foster to biological mom,** with unexpected relief from a partner doula.

ALICIA

Juggling classes, deadlines, and diapers. The toll of being a **student and new mother** on mental health.

MICHELLE

When **your partner is struggling,** and you find your own anxiety rising alongside theirs.

CAROLINE

Trying to keep **career momentum** while wrestling with postpartum mental health challenges.

MAYA

The racing thoughts, sleepless nights, and invisible weight of **perinatal anxiety.**

KEIKO

Comparing what it means to **give birth in the U.S. versus in Japan,** a country with stronger supports.

MONICA

Doing “everything right” in preparation and still feeling **blindsided by the reality.**

AMANDA

Pursuing a doctorate while navigating the emotional and physical demands of new parenthood.

OLIVIA

Confronting the quiet ache of **loneliness and grief** during the first months with a baby.

INTRODUCTION

Perinatal Mood and Anxiety Disorders: A Widespread Crisis

PMADs affect at least 1 in 5 birthing parents and often go unrecognized and untreated. These disorders are compounded by cultural myths about parenthood that frame mental health struggles as personal failures rather than normal responses to immense life changes.

MATERNAL MORTALITY

- Suicide accounts for up to 20% of maternal deaths, surpassing postpartum hemorrhage and hypertensive disorders as a leading cause of mortality during this period (Campbell et al., 2021).

- Maternal mortality rates in the USA are the highest among developed countries (Hoyert, 2025; MacDorman et al., 2016), and suicide is a leading cause of maternal mortality (Trost et al., 2021).

FINANCIAL BURDEN ON FAMILIES AND SOCIETY

- For families with Medicaid, perinatal depression results in over $5,000 in additional annual healthcare costs per individual (Pollack et al., 2022), while households with private insurance incur an average of 22% higher medical and pharmaceutical expenses in the year following childbirth (Epperson et al., 2020).

FINANCIAL BURDEN ON FAMILIES AND SOCIETY (CONTINUED)

- Medicaid, which covers 42% of U.S. births, only guarantees postpartum coverage for 60 days in some states, leaving many birthing individuals without continued mental health care when PMAD symptoms often peak (KFF, 2025).
- Unlike nations with built-in public resources, U.S. parents rely heavily on private, often costly services, limiting access for low-income families (OECD, 2019).
- Countries like Japan and Germany provide government-funded postpartum home visits by midwives, ensuring routine mental health check-ins, while the U.S. has no equivalent federal program.

> **In countries like the UK, midwives visit new moms multiple times in the first few months. Here, I had one rushed checkup at six weeks, and that was it.**
>
> Maya's Case Study

BARRIERS TO CARE AND SYSTEMIC GAPS

Lack of Access to Paid Leave

- Only 27% of private-sector workers in the U.S. have access to paid family leave through their employer. For low-wage workers who are predominantly women and people of color, 95% lack paid family leave entirely (Women's Bureau, 2024).
- Only 43% of private-sector workers have access to short-term disability coverage, leaving many without options to recover physically or mentally postpartum (Women's Bureau, 2024).

Maternal Mental Health Shortages

- 96% of birthing-aged women live in areas with insufficient maternal mental health providers (Policy Center for Maternal Mental Health, 2023).
- While initiatives like the TRIUMPH for New Moms Act aim to improve maternal mental health programs, they lack comprehensive funding and enforcement mechanisms (H.R.4217 - 117th Congress, 2021-2022).
- PMAD care is often siloed from routine postpartum medical care, leaving many parents without access to holistic, continuous mental health support (ACOG, 2018).
- Nearly 700 U.S. counties face high risks for maternal mental health conditions due to resource deficits, with Texas, Michigan, and Louisiana among the most affected (Policy Center for Maternal Mental Health, 2023).

Untreated PMADs

- 75% of those impacted by maternal mental health conditions remain untreated, increasing risks for long-term negative outcomes for families (Byatt et al., 2015).
- Untreated PMADs can lead to long-term impacts on physical and emotional health, including chronic anxiety, difficulties maintaining employment, and strained family relationships. Children of parents with untreated PMADs face greater risks for delayed emotional regulation, cognitive issues, and behavioral challenges.

CURRENT POLICY LANDSCAPE

The landscape of PMADs in the United States is shaped by longstanding policy gaps and systemic barriers that leave many birthing individuals without adequate support. While national guidelines, such as those from the U.S. Preventive Services Task Force (USPSTF), have recommended depression screening during and after pregnancy, implementation remains inconsistent. More recently, the 2022 TRIUMPH for New Moms Act sought to improve maternal mental health outcomes, yet gaps persist in screening, postpartum support, and long-term mental health care. Unlike other high-income nations, the U.S. lacks a comprehensive, publicly funded postpartum care system, forcing many new parents to navigate commercialized healthcare services without sufficient structural support.

International comparisons highlight where the U.S. falls short. In Japan, for example, postpartum care is embedded within a communal approach to child-rearing. As Keiko, a participant in our interviews, noted,

> **In Japan, we have a sense of shared responsibility for raising children. The city, the village, the town - they take responsibility for child care. There are public programs, spaces for mothers to gather, and actual support systems. Here in the U.S., it's the opposite. You're expected to pay for everything. Everything is so commercialized.**
>
> Keiko's Case Study

Similarly, Monica, another participant, recounted how her best friend in Germany received routine home visits from a midwife postpartum, while she herself was left to navigate early motherhood alone. These disparities underscore the urgent need for legislative action in the U.S., including universal mandatory PMAD screening, expanded paid leave policies, and greater integration of maternal mental health into routine perinatal care. Without systemic changes, many parents will continue to fall through the cracks, enduring preventable struggles that could be mitigated through more comprehensive policy interventions.

REFERENCES

ACOG Committee Opinion No. 757: Screening for Perinatal Depression (2018). *Obstetrics & Gynecology, 132*(5), e208–e212. https://doi.org/10.1097/AOG.0000000000002927

Campbell, J., Matoff-Stepp, S., Velez, M. L., Cox, H. H., & Laughon, K. (2021). Pregnancy-associated deaths from homicide, suicide, and drug overdose: Review of research and the intersection with intimate partner violence. *Journal of Women's Health, 30*(2), 236–244. https://doi.org/10.1089/jwh.2020.8875

Hoyert, D. (2025). Maternal Mortality, 2023. National Center for Health Statistics (U.S.). www.cdc.gov

H.R.4217 - 117th Congress (2021-2022): Triumph for New Moms Act of 2021 | Congress.gov | Library of Congress. (n.d.). https://www.congress.gov

Byatt, N., Biebel, K., Friedman, L., Debordes-Jackson, G., & Ziedonis, D. M. (2015). Enhancing participation in depression care in outpatient perinatal care settings. *Obstetrics & Gynecology, 126*(5), 1048–1058. https://doi.org/10.1097/AOG.0000000000001067

Epperson, C. N., Huang, M.-Y., Cook, K., Gupta, D., Chawla, A., Greenberg, P. E., & Eldar-Lissai, A. (2020). Healthcare resource utilization and costs associated with postpartum depression among commercially insured households. *Current Medical Research and Opinion, 36*(10), 1707–1716. https://doi.org/10.1080/03007995.2020.1799772

Kaiser Family Foundation (KFF) (2025). Medicaid Postpartum Coverage Extension Tracker. Retrieved from https://www.kff.org

Organisation for Economic Co-operation and Development (OECD) (2019). Family Database. Public spending on family benefits. Retrieved from https://www.oecd.org

Policy Center for Maternal Mental Health (2023, November 17). Maternal mental health provider shortages & population risk report. Retrieved from https://policycentermmh.org

Pollack, L. M., Chen, J., Cox, S., Luo, F., Robbins, C. L., Tevendale, H. D., Li, R., & Ko, J. Y. (2022). Healthcare utilization and costs associated with perinatal depression among Medicaid enrollees. *American Journal of Preventive Medicine, 62*(6), e333–e341. https://doi.org/10.1016/j.amepre.2021.12.008

Trost, S. L., Beauregard, J. L., Smoots, A. N., Ko, J. Y., Haight, S. C., Moore Simas, T. A., Byatt, N., Madni, S. A., & Goodman, D. (2021). Preventing pregnancy-related mental health deaths: Insights from 14 US maternal mortality review committees, 2008–17: Study examines maternal mortality and mental health. *Health Affairs, 40*(10), 1551–1559. https://doi.org/10.1377/hlthaff.2021.00615

US Preventive Services Task Force, Curry, S. J., Krist, A. H., Owens, D. K., Barry, M. J., Caughey, A. B., Davidson, K. W., Doubeni, C. A., Epling, J. W., Grossman, D. C., Kemper, A. R., Kubik, M., Landefeld, C. S., Mangione, C. M., Silverstein, M., Simon, M. A., Tseng, C.-W., & Wong, J. B. (2019). Interventions to prevent perinatal depression: US Preventive Services Task Force recommendation statement. *JAMA, 321*(6), 580. https://doi.org/10.1001/jama.2019.0007

Women's Bureau, U.S. Department of Labor (2024). Paid family and medical leave fact sheet. Retrieved from https://www.dol.gov/

KEY FINDINGS AND ANALYSIS: PART ONE

Gaming the Edinburgh: When Screening Feels Like a Test to Pass

CORE INSIGHT

Standardized screening tools are perceived as impersonal, intimidating, and disconnected from real caregiving experiences. Many caregivers hesitate to disclose PMAD symptoms due to fears of being judged, labeled "unstable," or even losing custody of their child.

For many caregivers, PMAD screenings don't feel like an opportunity for support. It feels like a test. And many parents quickly learn how to "pass" it. Maya and Olivia, two mothers who participated in this study, recalled during their interviews:

> **I knew how to answer so that they wouldn't flag me.**
>
> Maya's Case Study

> **I knew exactly how to answer to avoid raising red flags. But inside, I was really struggling.**
>
> Olivia's Case Study

The format of PMAD screenings itself can discourage honesty. The Edinburgh Postnatal Depression Scale is one of the most widely used tools. It is typically administered as a brief, standardized questionnaire at a hospital, obstetrician's office, or pediatrician's appointment. It is designed for efficiency, not connection.

To many caregivers, it feels more like a box-checking exercise than a genuine effort to understand their well-being. Their experiences reflect a broader issue: traditional screening methods often fail to capture the complexity of postpartum mental health (Letourneau et al., 2019). Mothers in our study explained:

> **The Edinburgh test feels incredibly shallow. I'd memorized which questions, and what score I needed to achieve to not raise eyebrows.**
>
> **It also lacks nuance, and never once did a doctor dive deeper into any of the answers. At best, a nurse practitioner would glance at the sheet and sweep it up into her clipboard.**
>
> **It feels like a trap instead of a tool to provide help.**

> **I was so anxious I was afraid if I was honest, they'd think I wasn't a good mom, so I just checked all 4's with one or two 3's so it didn't seem fake.**

Many new parents feel torn between protecting their mental health and protecting their family unit.

> **No one prepared me for this and that was the hardest part. I felt so alone and scared for me and my baby, but also scared to seek help out of fear of my baby being taken away.**

> **I was afraid if anyone knew how I really felt, they would take my baby away from me, no matter how irrational that sounds.**

> **It took until my third child's postpartum to be honest. I thought they would separate me and my baby.**
>
> Tina's Case Study

> **I felt ashamed. I didn't answer screening questions honestly because I thought the doctor didn't care.**

> **I didn't tell anyone... It felt selfish to talk about my struggles when everything was supposed to be about the baby.**

> **I felt so alone and scared for me and my baby, but also scared to seek help.**
>
> Olivia's Case Study

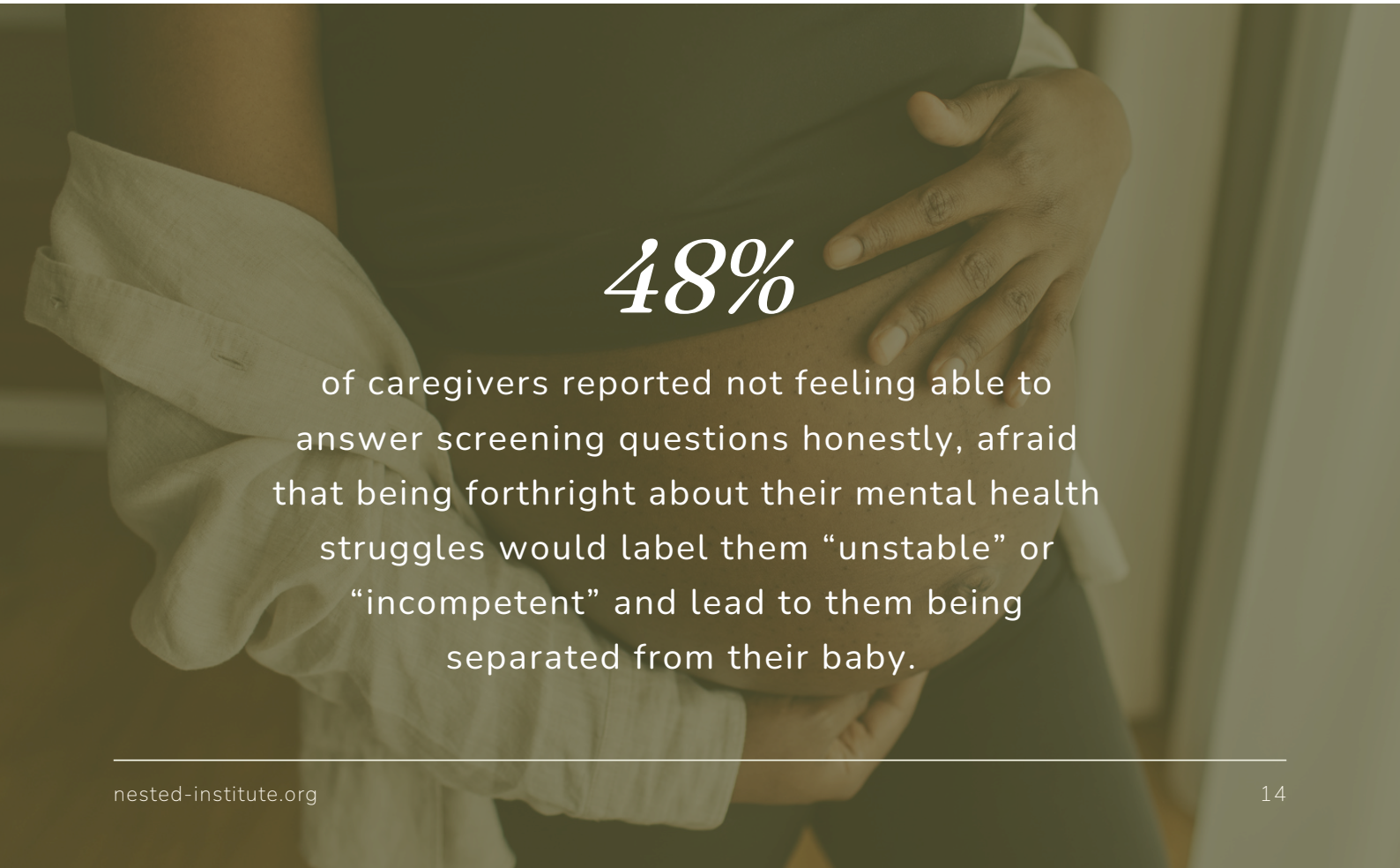
> **My biggest fear was that my child would be taken away from me if I was honest about how crazy I felt.**

This choice to stay silent, while understandable, can deepen suffering and block the path to crucial support for caregivers and infants. Every interaction in peripartum care should be an opportunity to listen and provide real resources, not a moment that heightens shame or stokes fear. Caregivers should feel safe disclosing mental health struggles, confident that honesty will lead to compassion, not condemnation.

Addressing these barriers starts with acknowledging the flaws in our current systems that perpetuate a culture of fear and dishonest disclosure, which may only inhibit help-seeking behavior. Only then can we hope to create a culture in which peripartum caregivers are genuinely supported, without fearing the loss of the very connection that matters most: the bond with their child.

Fear of Child Protective Services (CPS) involvement discourages many caregivers from honestly disclosing PMAD symptoms during screenings, particularly those from marginalized communities. Parents, especially low-income, Black, Indigenous, and other caregivers of color, often worry that admitting to struggles like postpartum depression or anxiety could lead to accusations of neglect or even child removal.

This fear is not unfounded, as reports have shown disproportionate CPS surveillance and intervention in communities of color, further eroding trust in healthcare and social service systems. As a result, many parents suffer in silence, avoiding critical mental health care to protect their families from potential state intervention.



48%

of caregivers reported not feeling able to answer screening questions honestly, afraid that being forthright about their mental health struggles would label them “unstable” or “incompetent” and lead to them being separated from their baby.

Follow-Up Screenings Are Scarce

Another critical flaw in the current approach to screening is that many caregivers fall through the cracks due to a lack of screening at follow-up appointments. PMADs don't always show up in the early weeks or months postpartum. Many parents describe the newborn phase as pure survival mode, running on adrenaline, barely sleeping, and just trying to get through each day. It's only later, sometimes after stopping breastfeeding or returning to work, that the reality of their mental health struggles sets in.

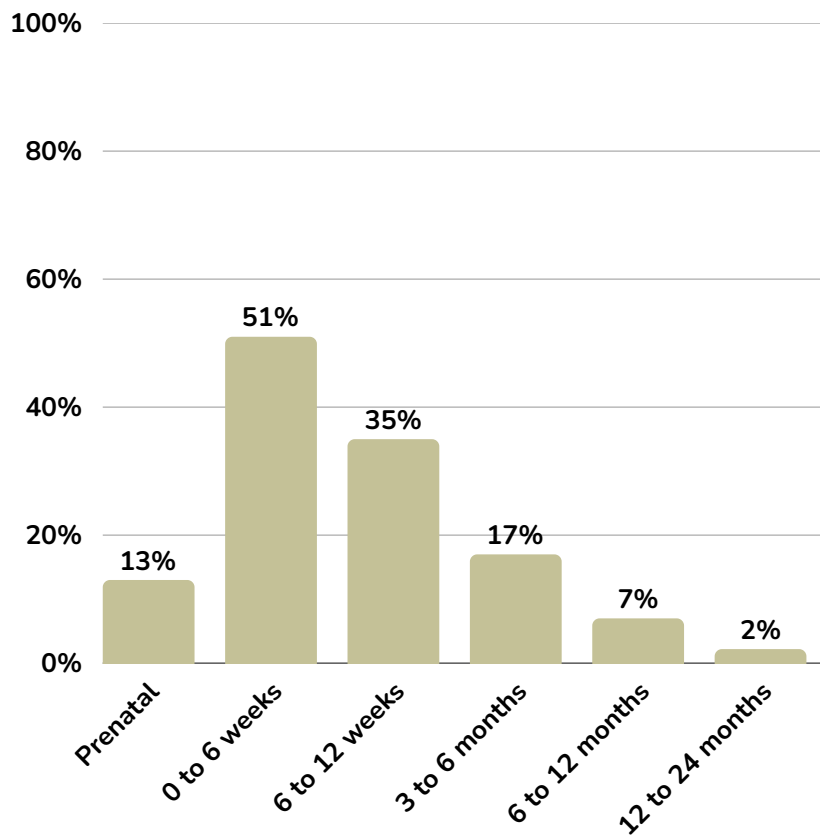
14% 14% of those who experienced a PMAD didn't notice symptoms until more than a year postpartum.

60% 60% of those who experienced a PMAD were screened during a follow-up obstetric or pediatric appointment.

This raises serious questions about how long and how often we should be screening parents. Currently, most screenings happen at the six-week postpartum checkup, and that's if they happen at all. But this data suggests that a single check-in is nowhere near enough.

When are caregivers being screened?

Percentage of Birthing Caregivers Screened by Timepoint



Around 1 in 4 birthing caregivers were never screened for PMADs, and only 40% were screened more than once.

For some, logistical barriers like short hospital stays, unsupportive care, or restrictive policies meant they never had the opportunity to be screened. One mother described how a cascade of obstacles left her without care:

> **I received no screening and extremely little care postpartum. I was out of the hospital in a day due to it being overcrowded and not having a proper room for us. I didn't feel comfortable sharing anything in the hospital anyway, since the nurses were really judgmental about the fact that I wasn't breastfeeding.**
>
> **No family was able to come help because they live across the country, and I almost couldn't go to my 6-week postpartum appointment because I wasn't allowed to bring my baby. And that was the last time I went to the doctor - almost 3 years ago.**

KEY FINDINGS AND ANALYSIS: PART TWO

Families Work as Systems: When One Struggles, Everyone Does

CORE INSIGHT

Caregivers are more likely to experience PMADs when their partner also struggles with mental health and they rely on that partner as their primary source of emotional support.

Families operate as interconnected systems where the well-being of one member directly affects others. When one caregiver experiences perinatal mood and anxiety disorders (PMADs), their struggles often ripple through the entire family. For families where partners serve as each other's primary or sole source of emotional support, this dynamic can become particularly challenging. Further, **only 24% of caregivers felt completely comfortable speaking openly with their partner about mental health struggles.**

When both partners are navigating mental health difficulties, it creates a cycle of strain. Without outside support, this reliance can lead to exhaustion, miscommunication, and a lack of emotional resources to meet the needs of the family. Caregivers shared:

> **My husband only got two weeks of paternity leave, so I was mostly alone.**
>
> Lisa's Case Study

> **When my husband went back to work after three weeks, I was alone and overwhelmed. It felt like everything was on me.**

NICU Families Face Unique Emotional Costs

Caregivers whose infants spent time in the Neonatal Intensive Care Unit (NICU) due to prematurity or health complications faced particularly elevated mental health risks. **Parents in our study whose babies required NICU care were 74% more likely to experience a PMAD** than those whose infants did not require such care. These caregivers were also significantly more likely to report wishing for greater support from their own parents, friends, and from parent support groups. Their heightened emotional vulnerability underscores how medical complications in infancy can amplify stress and isolation during the postpartum period, compounding the need for robust, tailored mental health interventions. As one NICU parent shared:

> **I wasn't prepared for the trauma. We survived, but I don't feel like I did emotionally. I just shut down.**

74%

Parents whose babies required NICU care were 74% more likely to experience a PMAD than those whose infants did not require such care.

SUPPORTING NICU FAMILIES

Parents with infants in the NICU face uniquely high emotional, physical, and financial demands. Medical complexity, prolonged hospital stays, and uncertainty about their baby's health can intensify the risk of PMADs. Targeted policies and supports are essential to reduce stress, strengthen family bonds, and ensure a smoother transition from hospital to home.

Recommendations for supporting NICU families:

1. **Extended Leave:** Families with infants in the NICU often require more time to recover, bond, and stabilize at home. Extending FMLA protections and providing paid family leave beyond standard durations ensures parents can focus on their baby's health without risking their jobs or income.

2. **Family-Centered Care:** Implement NICU models that actively include parents in care planning, decision-making, and daily caregiving tasks, strengthening parent–infant attachment and confidence.

3. **Peer Support Networks:** Provide access to peer mentors and support groups both in the NICU and after discharge to address the emotional toll of NICU stays, reduce isolation, and connect families to resources during the transition home.

KEY FINDINGS AND ANALYSIS: PART THREE

Non-Birthing Caregivers Are Overlooked

CORE INSIGHT

98% of non-birthing caregivers were never screened for PMADs.

While PMADs have long been associated with birthing parents, the reality is that a wide spectrum of non-birthing caregivers are vulnerable. This includes fathers, adoptive parents, same-sex parents, and other caregivers who step into parental roles. These individuals face unique challenges, from navigating new family dynamics to feeling isolated from traditional conversations about caregiving and postpartum mental health. Yet they are often excluded from screenings, interventions, and support systems.

For instance, fathers experience PMADs at rates of approximately 10%, but this is just the tip of the iceberg. Same-sex parents may feel additional stress due to societal stigma, a lack of resources tailored to their experiences, and heightened financial and emotional burdens (Soled et al., 2024). Adoptive parents may also experience anxiety or depression as they adjust to their new roles while often grappling with feelings of inadequacy or imposter syndrome.

> **I would bet all the money in the world that he had postpartum anxiety...**
>
> **Nobody ever expressed to him that fathers get it too. For about three weeks after we brought our daughter home from the hospital, he didn't sleep at night.**
>
> **He couldn't even shower or get ready for work unless our babysitter was there. He just couldn't put her down, even in a safe space.**

Michelle's Case Study

THE IMPORTANCE OF RECOGNIZING ALL CAREGIVERS

The mental health of non-birthing caregivers profoundly shapes the family dynamic. When one partner struggles, their ability to provide emotional and practical support diminishes, whether they are a father, adoptive parent, or non-gestational same-sex partner. This leaves the birthing parent shouldering more of the burden, which can exacerbate PMADs for everyone in the family.

> **Nobody talked about what his health would do or how it would change once I gave birth.**

> **Men go through physiological, neurological, chemical changes when their partners have children. Why aren't we talking to them?**

ADDRESSING THE GAP IN CARE

Including non-birthing caregivers in discussions about mental health ensures they receive the tools they need to thrive in their roles. These tools include access to education about PMADs, inclusive counseling options, and policies that validate their experiences.

To close the gap, systems need to adapt to meet the diverse needs of all caregivers. Key strategies include:

1. **Inclusive Screening Protocols:** Extend PMAD screenings to all caregivers, including fathers, adoptive parents, and non-gestational partners, during prenatal care, postpartum checkups, and pediatric visits.

2. **Expanded Definitions of Family:** Ensure support programs and workplace policies are inclusive of all parental structures, recognizing diverse family dynamics.

3. **Tailored Resources:** Develop educational materials, peer support groups, and therapy options specifically designed for adoptive parents and LGBTQ+ caregivers.

4. **Policy Innovation:** Advocate for comprehensive family leave policies that recognize and support the mental health needs of non-birthing caregivers.

REFERENCE

Soled, K. R., McKetta, S., Chakraborty, P., Reynolds, C. A., Austin, S. B., Chavarro, J. E., Eliassen, A. H., Wang, S., Haneuse, S., & Charlton, B. M. (2024). Sexual orientation-related disparities in perinatal mental health among a prospective cohort study. SSM - Mental Health, 5, 100301. https://doi.org/10.1016/j.ssmmh.2024.100301

KEY FINDINGS AND ANALYSIS: PART FOUR

Paid Leave Reduces PMAD Risk but Remains Inaccessible

CORE INSIGHT

Among caregivers who experienced PMADs and ultimately left their jobs, 88% wished for longer paid leave. Those with more than 12 weeks of paid leave were 80% less likely to quit their jobs.

Paid parental leave is an essential investment in the well-being of families, the economy, and society at large. Robust research demonstrates that having access to paid leave benefits parents, children, and employers alike, yet too many families are left without this critical support. Expanding paid leave policies to include flexibility across life stages, types of caregivers including adoptive parents and grandparents, could amplify these benefits and create healthier, more resilient family systems.

THE FAR-REACHING BENEFITS OF PAID LEAVE

Paid leave significantly reduces the risk of PMADs, improves parental mental health, supports postpartum recovery, and strengthens family bonds. The positive impacts of paid leave ripple outward to children's health and development. Research shows that infants benefit from the increased presence of caregivers, which fosters secure attachment and supports cognitive, emotional, and social growth. Studies also find that children whose fathers take leave are more likely to enjoy stronger paternal bonds and better developmental outcomes.

88% Among caregivers who experienced PMADs and ultimately left their jobs, 87.5% wished for longer paid leave.

80% Parents with more than 12 weeks of paid leave were 80% less likely to quit their jobs, protecting their career trajectories and reducing turnover costs for employers.

Every $1 invested in paid leave yields an estimated $2.57 return, thanks to increased employee retention and productivity, according to the National Partnership for Women and Families. Companies like Google, which extended paid leave from 12 to 18 weeks, saw a complete elimination of gender disparities in attrition rates. Before the shift, women were leaving their jobs at twice the rate of men. Google's senior VP of people operations, Laszlo Bock, commented:

> *"The attrition rate for women after childbirth was twice our average attrition rate . . . After making the change in leave, the difference in attrition rates vanished. And moms told us that they were often using the extra two months to transition slowly back to work, making them more effective and happier when the leave ended. When we eventually did the math, it turned out this program cost nothing. The cost of having a mom out of the office for an extra couple of months was more than offset by the value of retaining her expertise and avoiding the cost of finding and training a new hire."*

The benefits extend to the entire family system. When dads and non-birthing caregivers take leave, it eases the transition back to work for birthing parents and fosters shared parenting responsibilities. One mother explained:

> **"We also knew that my husband would be able to take 12 weeks at some point in our daughter's first year of life... Through the first year, we either had myself or my mother-in-law or my husband watching our daughter full-time.**

The Case for Grandparent Leave

Grandparents also play a critical role in family mental health, particularly during the perinatal period. Close relationships with grandparents are associated with fewer behavioral and emotional problems in children and a stronger sense of identity and belonging. By offering leave policies that include grandparents, we can unlock this vital support for families while preserving intergenerational wisdom and care.

Our research found that only **4 in 10** birthing parents with supportive grandparents reported PMADs, compared to **6 in 10** without such support. Unfortunately, many parents felt that work schedules and geographic distance limited their parents' ability to help. **A striking 63% of respondents wished for more support from their own parents.** One mother shared her experience:

> **My mom helped so much during those first few days, but she lives 5 hours away and works, and could only get a few days off. It would have been so helpful to have her stay longer to help out with the newborn but also my 4-year-old.**

Countries like Sweden provide a compelling model, allowing up to 480 days of paid leave to be shared among parents and grandparents. This flexibility strengthens family bonds and ensures crucial support during the early weeks and months of a

child's life. In the United States, companies like Booking.com have adopted **"grandternity" policies,** granting grandparents paid time off to care for their families. Employers report that these policies not only benefit families but also help retain workers who might otherwise retire early to support their grandchildren.

THE FAR-REACHING BENEFITS OF PAID LEAVE

Despite its benefits, paid leave remains inaccessible to many families. The U.S. is one of the few high-income countries without federally guaranteed paid parental leave. While the Family and Medical Leave Act (FMLA) provides 12 weeks of unpaid, job-protected leave for eligible employees, many workers do not qualify due to strict requirements or cannot afford to take unpaid time off.

To fully support families, paid leave policies must adapt to diverse caregiving needs across life stages. Grandparent leave, longer parental leave, and flexible return-to-work options can alleviate the strain on families and create stronger support networks. Flexible policies are particularly critical for caregivers balancing multiple responsibilities, such as foster parents or those with children of varying ages.

Workplace cultures also often discourage caregivers from taking advantage of leave policies. Many parents fear negative career repercussions or feel judged by colleagues and managers. As one mother explained:

> **"Many people saw my leave as a 'vacation.' It's exhausting to fight for what should be a basic right.**

Paid leave isn't just a benefit for individuals. It's a lifeline for families and a powerful tool for economic growth. **Employers benefit from lower turnover, higher morale, and a more resilient workforce.** A mother in our study summarized it well:

> **"Six months was amazing. Eight months was bliss. The fact that I had that amount of time with her made all the difference.**

KEY FINDINGS AND ANALYSIS: PART FIVE

Providers Need Support

CORE INSIGHT

Healthcare providers often lack training in PMAD care, making them hesitant to intervene or provide support.

Healthcare providers are often the first point of contact for caregivers experiencing PMADs, yet many feel unprepared to provide the necessary support. This gap leaves caregivers feeling isolated and providers feeling unsure of how to help. Research by Barkin et al. (2020) highlights the significant barriers faced by both pediatricians and OB/GYNs, two critical groups in perinatal care.

Pediatricians often find themselves caught in a difficult position. While they interact with new parents regularly, many see their role as solely focused on the child, not the caregiver. As one provider in Barkin et al.'s 2020 study noted:

> **"The mother isn't technically my patient, and I don't have access to her medical history.**

This lack of maternal mental health training means that many pediatricians feel ill-equipped to screen for PMADs, let alone provide follow-up care. The dual burden of addressing maternal mental health alongside their primary responsibilities further complicates matters, leaving mothers without the support they need.

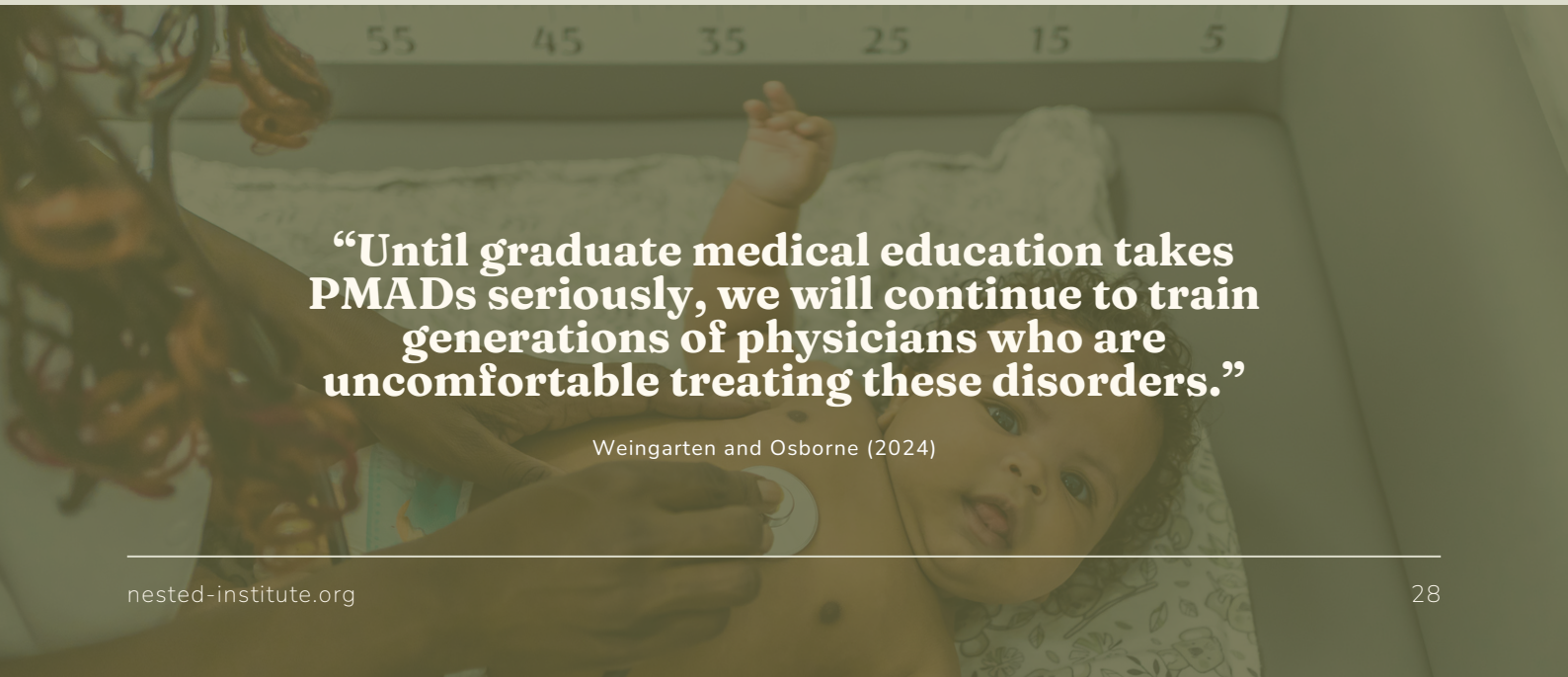
OB/GYNs face similar challenges. Many report inadequate training in PMAD-specific care, particularly when it comes to pharmacological treatments. One OB/GYN from Barkin's study shared:

> **The only drug I'm comfortable prescribing is Zoloft... I wasn't trained for this.**

The scarcity of perinatal mental health specialists compounds these challenges. In rural or underserved areas, providers frequently struggle to find appropriate referrals. As one OB/GYN asked:

> **If my patient screens positive, what do I do with them?**

A key reason for this gap is the lack of formal education on PMADs in medical training. A review by psychiatrists Weingarten and Osborne (2024) emphasized that both obstetrics and gynecology residents are required to learn about depression and anxiety in general, but no standardized curriculum ensures they receive PMAD-specific education. Psychiatry residents, meanwhile, are not required to study reproductive transitions at all. This creates a critical gap in expertise, leaving two of the primary specialties involved in perinatal care without adequate knowledge of PMADs. Without proper training, many providers hesitate to screen for or address the symptoms of PMADs.



"Until graduate medical education takes PMADs seriously, we will continue to train generations of physicians who are uncomfortable treating these disorders."

Weingarten and Osborne (2024)

THE NEED FOR TRAINING AND ACCESSIBLE SUPPORT NETWORKS

Closing the gap in perinatal mental health care starts with comprehensive training. While OB/GYNs and pediatricians are well-positioned to identify and support caregivers experiencing PMADs, many lack the formal education needed to do so effectively. A recent pilot study assessed the impact of a 10-hour virtual lecture series on PMADs for OB/GYN residents (Marty et al., 2024). Before the training, only 45% of residents were familiar with PMAD screening tools, and fewer than half felt comfortable diagnosing or providing resources for patients. After completing the lecture series, those numbers improved significantly. 86% were familiar with screening tools, and up to 78% felt comfortable diagnosing PMADs. However, confidence in actual treatment remained low, with only 22% of residents feeling comfortable managing cases. This study highlights the need for structured, standardized education on PMADs, particularly regarding treatment, to ensure providers are prepared to support their patients.

But this issue extends beyond OB/GYN training. Building a more robust perinatal mental health care system requires integrating PMAD education into medical schools, nursing programs, and training for physician assistants. Organizations like the **Seleni Institute** and **Postpartum Support International (PSI)** offer specialized programs to equip providers with essential PMAD knowledge. For example, PSI's training courses provide a practical foundation for pediatricians and OB/GYNs, helping them feel more confident in identifying and addressing PMADs. However, these resources are supplemental. There is still no universal requirement ensuring all providers receive adequate PMAD education before entering clinical practice.

Efforts by institutions like the **American College of Obstetricians and Gynecologists** (ACOG) to emphasize postpartum care during the "fourth trimester" are promising, but training alone isn't enough. Many caregivers, even those who are screened, lack access to mental health resources. The reality is that even when providers want to help, they often face a broken referral system. Specialists are in short supply, long waitlists are the norm, and providers are left without clear pathways to connect caregivers with timely, comprehensive support.

EXPANDING ACCESS THROUGH TELEHEALTH

One of the most promising ways to bridge the broken referral system is through telehealth. **96% of birthing-aged women in the U.S. live in areas with insufficient maternal mental health providers** (Policy Center for Maternal Mental Health, 2023). For many, telehealth could be the difference between receiving support and struggling in isolation.

Virtual mental health platforms like FamilyWell, Maven, and Phoenix Health provide caregivers with immediate access to specialists, therapy sessions, and tailored mental health care, without the barriers of travel, long wait times, or geographic restrictions. These platforms have the potential to increase equity in care, particularly for caregivers in rural or underserved communities who otherwise lack access to perinatal mental health specialists.

In addition to clinical care, telehealth networks can foster peer-to-peer support. Online support groups offer caregivers a space to connect, share experiences, and combat the isolation that often accompanies PMADs. These virtual communities are particularly valuable for caregivers who may not feel comfortable discussing their struggles in a clinical setting or who face logistical barriers to in-person support.

One inspiring example came from our interview with Alicia, a non-traditional student who struggled with isolation in academic settings while raising a young child. She took matters into her own hands, creating a peer-to-peer student parent support group at her university. The initiative helped her and other student parents navigate both academic and mental health challenges, highlighting the power of community-driven solutions.

PREPARING PROVIDERS & CREATING CONNECTION

The current system is failing both caregivers and providers. Caregivers often feel they cannot discuss their mental health struggles with healthcare providers, and providers feel unprepared to address these concerns. The result is a cycle of missed opportunities for early intervention.

To break this cycle, we must take a three-pronged approach:

1. **Expand Provider Training:** Ensure all healthcare professionals working with new parents receive PMAD-specific education.

2. **Improve Referral Networks:** Streamline pathways for caregivers to access specialized mental health care when they need it.

3. **Leverage Telehealth Solutions:** Invest in virtual mental health services to expand access, particularly for underserved communities.

With a more comprehensive approach, we can ensure that no caregiver feels alone in their journey and that providers are equipped with the tools they need to offer real support.

REFERENCES

Barkin, J. L., Osborne, L. M., Buoli, M., Bridges, C. C., Callands, T. A., & Ezeamama, A. E. (2020). Training frontline providers in the detection and management of perinatal mood and anxiety disorders. Journal of Women's Health, 29(7), 889.

Marty, L., Myrick, O., Perelman, A., Kotlyar, A., & Vernon, J. (2024). Filling a gap in OBGYN education: A pilot lecture series on perinatal mental health. Archives of Women's Mental Health, 27(1), 137–143.

Policy Center for Maternal Mental Health. (2023, November 17). Maternal mental health provider shortages & population risk report. Retrieved from https://policycentermmh.org/maternal-mental-health-provider-shortages-population-risk-report/

Weingarten, S. J., & Osborne, L. M. (2024). Review of the assessment and management of perinatal mood and anxiety disorders. Focus, 22(1).

RECOMMENDATIONS

Practical & Policy Solutions to Close the Gaps in Perinatal Mental Health

The findings from this study underscore the urgent need for systemic changes to better support caregivers. Addressing the gaps in perinatal mental health care requires coordinated efforts across multiple levels: workplaces, healthcare systems, and public policy. This final section details key recommendations.

Workplace Policies: Supporting Caregivers at Every Stage

FLEXIBLE PAID LEAVE ACROSS LIFE STAGES

- **Grandparent Leave:** Grandparents play a critical role in family mental health, particularly during the perinatal period. Our research found that 63% of parents wished for more support from their own parents, yet work schedules and geographic distance often limit their ability to help. Policies like "grandternity leave" can address this gap, ensuring grandparents have the flexibility to provide essential care during critical times.

- **Flexible Return-to-Work Programs:** Caregivers need flexible workplace policies to ease their transition back to work after parental leave. Gradual return-to-work options allow parents to adjust while balancing their mental health and caregiving responsibilities.

CREATE AN ADAPTIVE & EMPATHETIC WORK ENVIRONMENT

- **Manager Training:** Equip managers with training to foster empathy and understanding toward employees navigating parenthood. This includes recognizing the challenges of expecting parents and those returning to work after leave.

- **Ongoing Flexibility:** Policies should also extend beyond the initial postpartum transition to accommodate caregivers' needs during later stages, such as caring for sick children, managing childcare disruptions, or attending school-related activities.

The stories of our study participants underscore the difficulty of transitioning back to work.

> **"The expectation was you just figure it out, and if you struggle, then you're not as committed to your work. Institutions should proactively reach out to employees returning from parental leave to offer available resources.**
>
> Caroline's Case Study

> **"We hear women in the corporate sector say, 'I know that I can take six months paid leave, but I also know that when I come back, I'm going to be sidelined.'**
>
> Amanda's Case Study

Policy Reforms

FEDERAL PAID LEAVE

⟶ **Paid Leave:** The U.S. remains one of the only high-income countries without federally guaranteed paid parental leave. Currently, only 11 states and Washington, D.C., offer some form of paid family leave. This leaves millions of caregivers without access, disproportionately impacting low-income families and communities of color.

AFFORDABLE AND ACCESSIBLE CHILDCARE

⟶ **Childcare:** For many U.S. families, the high cost of childcare creates financial pressure that can exacerbate mental health challenges during the perinatal period. Addressing this requires actionable policy solutions, such as subsidies, tax credits, and expanded funding for childcare programs, to ensure that families can access affordable, high-quality care without compromising their mental health.

How much are families spending on childcare?

Families spent between 8.9% and 16% of their median income on full-day childcare for a single child, with annual costs ranging from **$6,552 to $15,600,** according to the latest data from the Department of Labor (2022).

Even before or after-school programs for school-aged children consumed 8.1% to 9.4% of median family income, costing between $5,943 and $9,211 annually. For context, **these expenses rival the median cost of rent, which was $15,216 that same year.**

MEDICAID EXPANSION FOR MENTAL HEALTH

⟶ **Expand Coverage:** Research indicates that expanding Medicaid to include comprehensive perinatal mental health services is likely to have significant long-term benefits, including more frequent postpartum care visits, stability in insurance coverage, and greater commitment from healthcare professionals (Centers for Medicare & Medicaid Services, 2021; Poyatzis and Livingston, 2024).

Innovations in Care

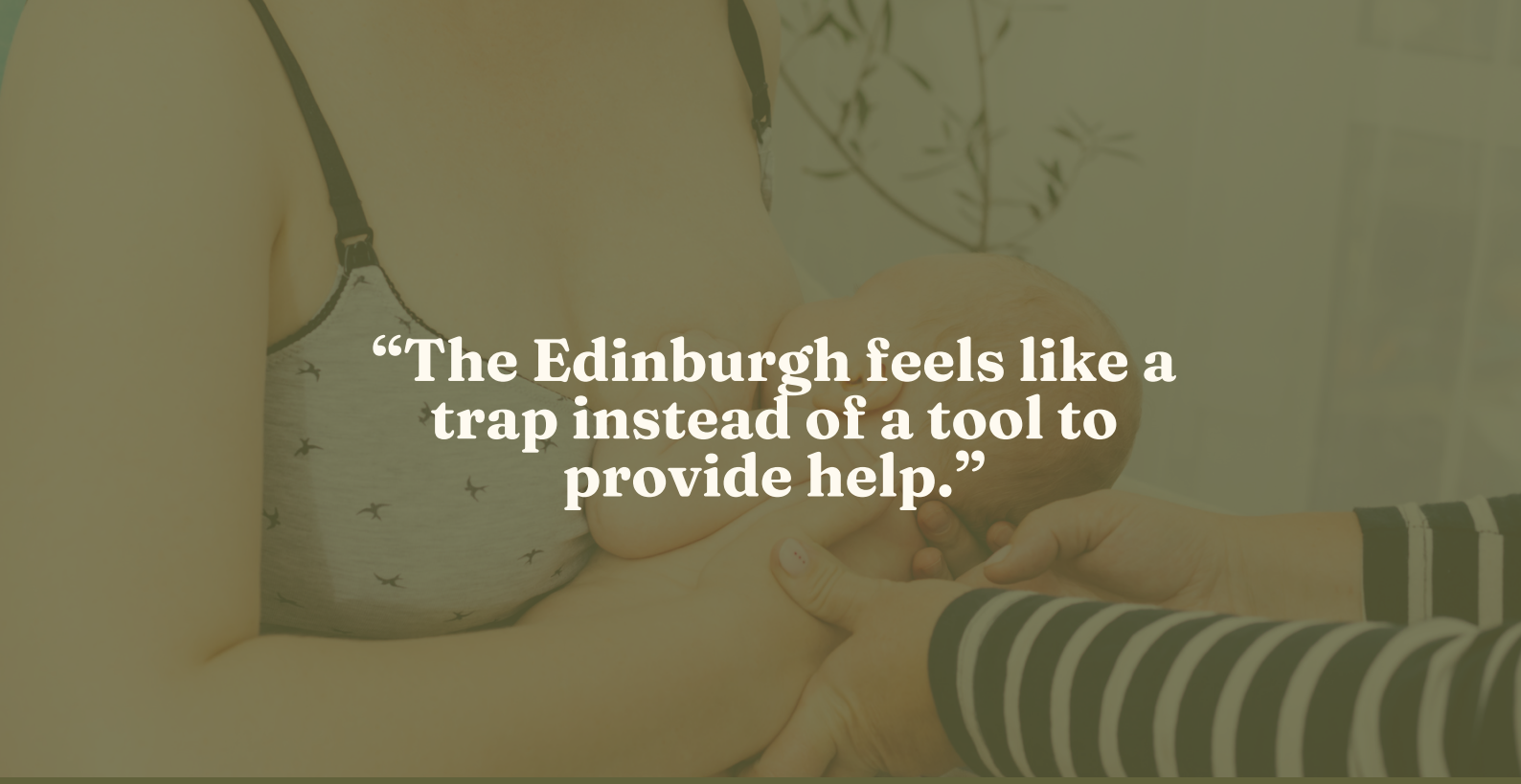
INITIATIVES & TRAINING

- **Training Healthcare Providers:** Healthcare providers are often the first point of contact for caregivers experiencing PMADs but frequently lack the training to identify and address symptoms. Expanding access to training and integrating PMAD education into medical school curricula could equip providers with the knowledge and confidence to offer effective support.

- **Collaborative Care Teams:** Together, teams of specialists can more effectively address the physical and emotional needs of caregivers. These networks can include OB-GYNs, mental health providers, physical and occupational therapists, doulas, lactation consultants, and other specialists. Connecting providers can also accelerate referrals and increase timely, comprehensive care for caregivers.

- **Telehealth Services:** Online platforms offer immediate access to mental health specialists. These can reduce financial and logistical barriers to accessing support, especially for families in rural or underserved areas.

- **Community:** Online and in-person support groups can be a lifeline for caregivers in combating isolation. Fathers in particular frequently struggle to find such communities.



> **“The Edinburgh feels like a trap instead of a tool to provide help.”**

ENHANCED SCREENING PROTOCOLS

- **Screening Tools:** Standardized screening tools like the Edinburgh Postnatal Depression Scale (EPDS) often feel impersonal or inadequate. Innovations in screening methods are necessary to help caregivers feel heard.
- **Extended Screening Period:** One screening at six weeks postpartum isn’t enough. The screening period needs to be extended to identify caregivers who experience symptoms later on, particularly during vulnerable transitions like the return to work.
- **Inclusive Screening:** Non-birthing caregivers, including fathers, adoptive parents, same-sex partners, and other caregivers, need to be screened for PMADs. This is vital for supporting the family as a system.
- **Increase Trust:** Transparency around the use of screening data is critical to building trust so that caregivers feel they can answer questions honestly and access the support they need.
- **Raise Awareness:** Greater awareness can reduce stigma and help caregivers recognize PMAD symptoms in themselves, their partners, and their peers.

REFERENCES

Centers for Medicare & Medicaid Services. (2021, December 7). SHO# 21-007 RE: Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP).https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf

Centers for Medicare & Medicaid Services. (2022, April 1). Thousands more people with Medicaid and CHIP coverage now eligible to access critical postpartum coverage thanks to the American Rescue Plan. https://www.cms.gov/newsroom/press-releases/thousands-more-people-medicaid-and-chip-coverage-now-eligible-access-critical-postpartum-coverage

National Academy for State Health Policy. (2023, March 17). Medicaid policies for caregiver and maternal depression screening during well-child visits, by state. https://nashp.org/state-tracker/maternal-depression-screening/

Poyatzis, G., & Livingston, G. (2024, November 19). New data: Childcare costs remain an almost prohibitive expense. U.S. Department of Labor Blog. Retrieved from https://blog.dol.gov/

Santhanam, L. (2022, April 8). How this Medicaid extension throws postpartum parents a lifeline.https://www.pbs.org/newshour/health/the-lifesaving-potential-of-extending-postpartum-medicaid

Conclusion

This white paper is part of a much larger effort. It builds on the vital work of other researchers who have been documenting these issues for decades, adding new data and stories that underscore what families have been telling us all along. **We now know more than enough to act, yet our system remains fragmented, leaving too many parents without support. We cannot go quiet in the face of this reality. We have to keep fighting, and we will.** At Nested, we are committed to keeping the conversation alive and pressing forward until there is tangible change for every caregiver and every family.

Get in Touch

If you're interested in partnering, sponsoring, or helping move this work forward, contact the Nested co-founders: **Erin O'Connor** (eoc2@nyu.edu) and **Robin Neuhaus** (rn1217@nyu.edu)