MARSHALL | CENTER OF EXCELLENCE FOR RECOVERY

West Virginia Perinatal PARTNERSHIP

PERINATAL BEHAVIORAL HEALTH IN WEST VIRGINIA

February 2026

Amy M. Saunders
Sarah J. Surber

This report was supported by funding from the Health Resources and Services Administration (HRSA) through the WV Department of Human Services, Bureau for Behavioral Health. The report was prepared by Marshall University's Center of Excellence for Recovery in collaboration with the West Virginia Perinatal Partnership.

Contents

01	Background and Purpose
03	History and Existing Resources in West Virginia
06	Demographic Information
12	Training
15	Screening and Treatment
42	Recommendations
53	References

Background and Purpose

The West Virginia Perinatal Partnership (WVPP) collaborated with Marshall University's Center of Excellence for Recovery to conduct a needs assessment on perinatal behavioral health in West Virginia. This initiative was supported through a grant from the federal Health Resources and Services Administration (HRSA) to the WV Department of Human Services, Bureau for Behavioral Health (WV DoHS, BBH). The West Virginia Perinatal Partnership is a subrecipient, with an award of $458,750. This report was supported through the WVPP's funding.

The purpose of the needs assessment was to better understand health care providers' capacity to screen, assess, treat, and refer pregnant and postpartum individuals for maternal mental health and substance use disorders. Specific areas of focus included examining existing screening practices, assessing training needs in perinatal behavioral health, identifying behavioral health conditions, evaluating referral capacity within the state, and understanding the barriers that perinatal individuals face when seeking treatment and support services. The research team began this process by administering a review of surveys conducted on engagement with perinatal individuals related to perinatal behavioral health services and assessments on the behavioral health systems (Ayres A., et al., 2019; Bailey, E., et al., 2022; Hick, L., et al., 2022).

Based on this review, two anonymous surveys were developed. One survey was tailored and administered to providers who serve perinatal and postpartum individuals, while the second survey was tailored and administered to perinatal and postpartum individuals. After the questions were developed, the team piloted the surveys with members of the Maternal Mental Health Advisory Council and other stakeholders in the perinatal behavioral health field.

The Marshall University Institutional Review Board (IRB) determined that this project was exempt from human subject research review.

The final anonymous surveys were administered online via the Qualtrics platform. To ensure a broad and diverse sample, a snowball sampling technique was used to recruit participants through email and social media. Participants were offered to be entered into a drawing for $30 gift cards as an incentive to participate. A total of 154 providers responded to the survey. To qualify, providers had to be at least 18 years old and currently practice or work within West Virginia or serve West Virginia perinatal individuals. A total of 131 perinatal individuals responded to the survey. Eligible participants were at least 18 years old, West Virginia residents, and either currently pregnant or having been pregnant within the past two years. Of these respondents, 42 were currently pregnant, and 89 had been pregnant within the last two years.

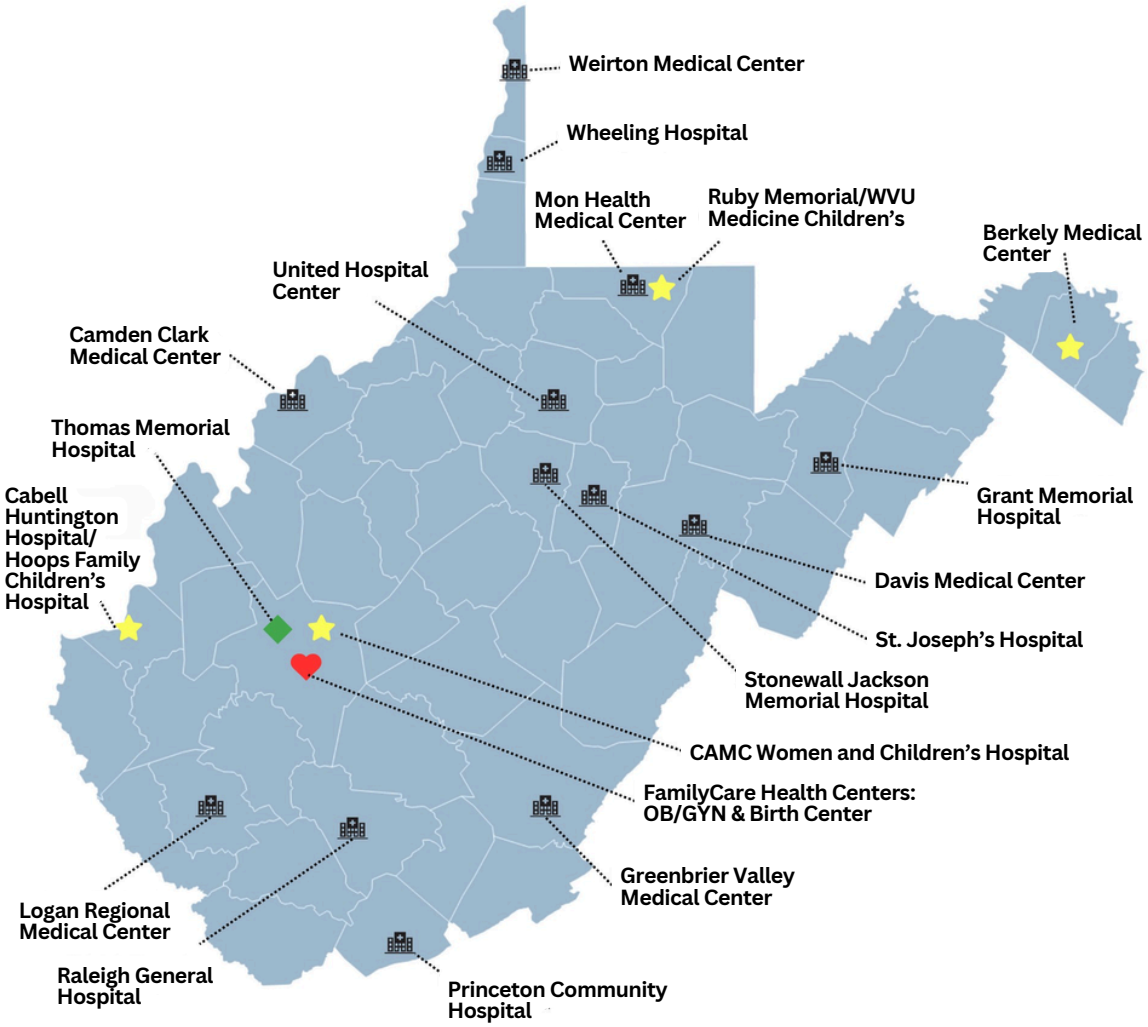
History and Existing Resources in West Virginia

The West Virginia Perinatal Partnership (WVPP) was established to improve the health outcomes of mothers and babies across West Virginia by bringing together hospitals, public health agencies, clinicians and community organizations to focus on this mission. It was initially created to address high rates of infant mortality, preterm birth, and limited access to perinatal care in the state.

The WVPP now leads statewide quality-improvement initiatives, training programs, and collaborative projects such as those addressing maternity access and care for individuals with substance-use concerns during pregnancy. West Virginia faces significant challenges in maternity care with fewer than one-third of its counties housing a birthing facility. Currently there are 18 birthing hospitals and one freestanding birthing center in the state. One of the current birthing hospitals, Greenbrier Valley Medical Center, will cease labor and deliver services April 30, 2026. Access to specialized services for high-risk pregnant and postpartum patients is limited, further exacerbating poor maternal health outcomes across the state (see Figure 1).

Figure 1

West Virginia Birthing Facilities December 2025



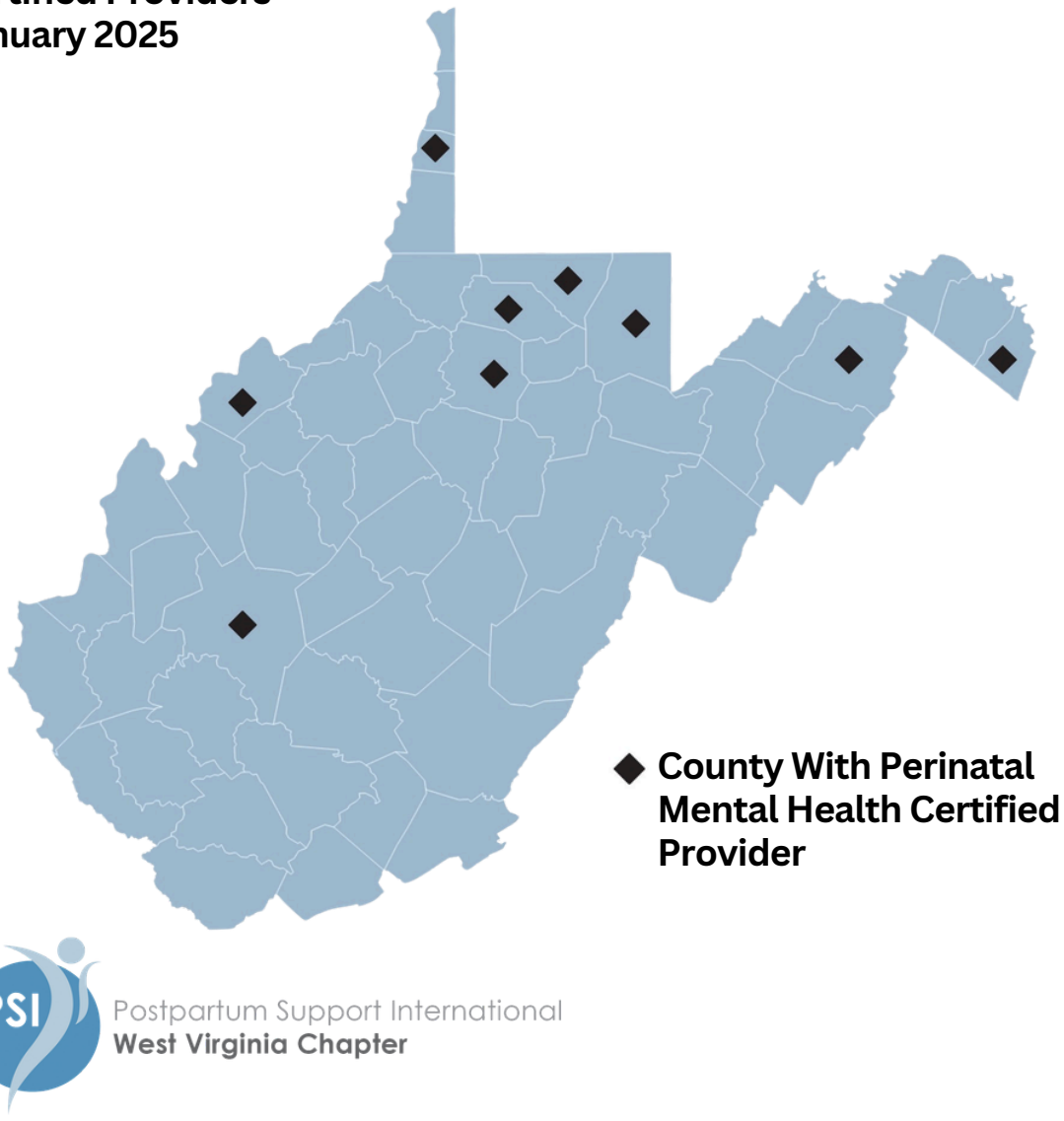
West Virginia Perinatal PARTNERSHIP

Map Provided by WV Perinatal Partnership

The WVPP has worked to increase the number of providers trained and certified in perinatal mental health through Postpartum Support International (PSI), which offers evidence-based trainings as well as more advanced training in specialty areas. The WV Chapter of PSI maintains a list of counties with certified providers in perinatal mental health (PMH). Currently, there are nine counties with certified providers that include Wood, Kanawha, Marion, Monongalia, Preston, Harrison, Hampshire, Jefferson, and Brooke.

Figure 2

West Virginia Counties with Perinatal Mental Health Certified Providers
January 2025



Map Provided by WV Chapter of Postpartum Support International

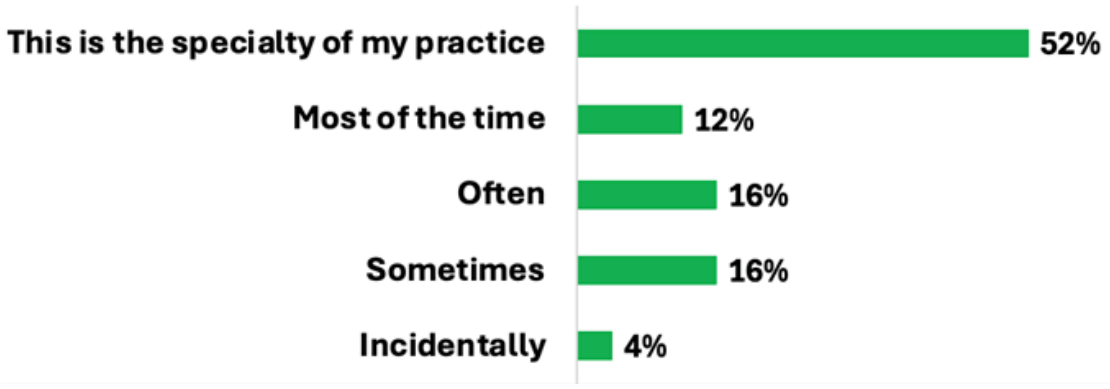
Demographic Information

Background on Providers

The majority (52%) of the respondents were health care providers who specialize in treating perinatal patients.

Figure 3

How Often Do You Treat Perinatal Patients?
n=154



The provider respondents came from a variety of professions, with the top respondents identifying as nurses (general), obstetrician/gynecologists (OB/GYNs), social workers, and therapists. Selections for the “Other” category (18%) included project coordinator, nurse midwife student, lactation consultant, case manager, pregnancy resource center, community health worker, primary care, occupational therapist, osteopathic doctor, childbirth educator, midwife, and breastfeeding peer counselor (see Table 1).

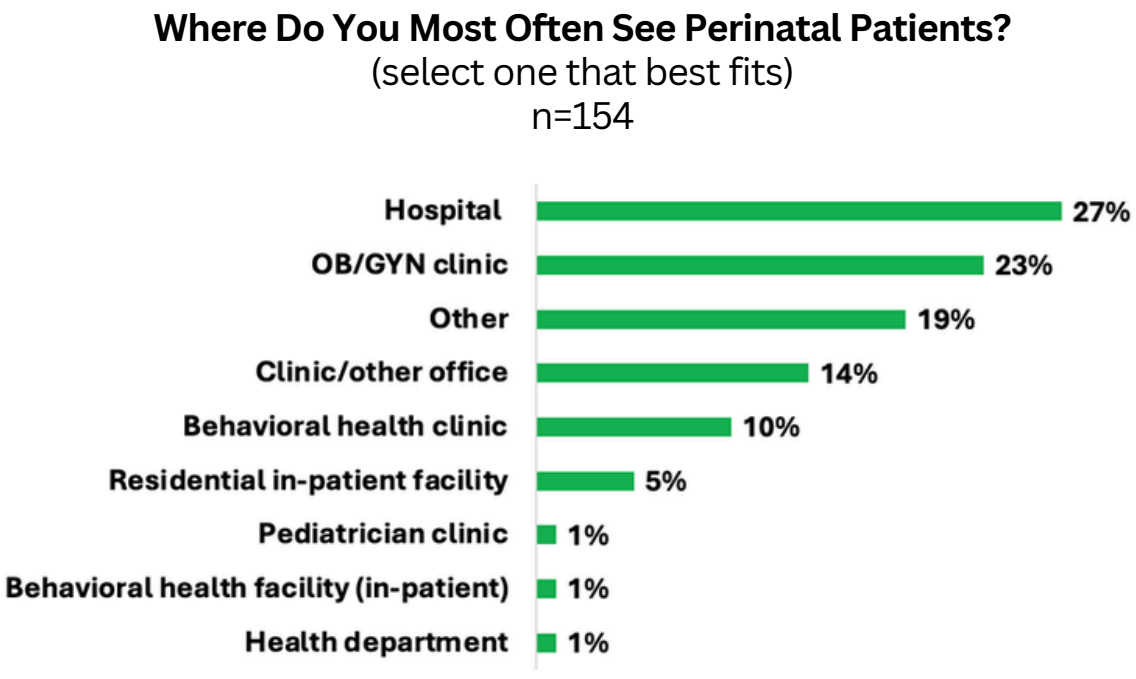
Table 1

Healthcare Professions of Provider Respondents (Respondents selected all that applied) n=154	
Nurse (general)	23%
Other	18%
OB/GYN	16%
Social Worker	12%
Nurse Practitioner	6%
Substance Use Disorder Provider	6%
Family Medicine	5%
Nurse Midwife	5%
Home Visitor	5%
Doula	4%
Psychologist	4%
Emergency Department	3%
Psychiatrist	3%
Peer Recovery Coach or Peer Recovery Support Specialist	3%
Counselor	3%
Pediatrician	2%

Emergency Responder (EMT, EMS, etc.)	1%
Physician Assistant	1%
Resident Physician	1%

The respondents interact with perinatal individuals in a variety of settings, with the top responses being hospitals (27%), OB/GYN clinics (23%), other types of clinics (14%), and behavioral health clinics (10%). Selections for the “Other” category (19%) included home visits, recovery residence, pregnancy resource center facility, phone/telehealth, virtually, and emergency shelter.

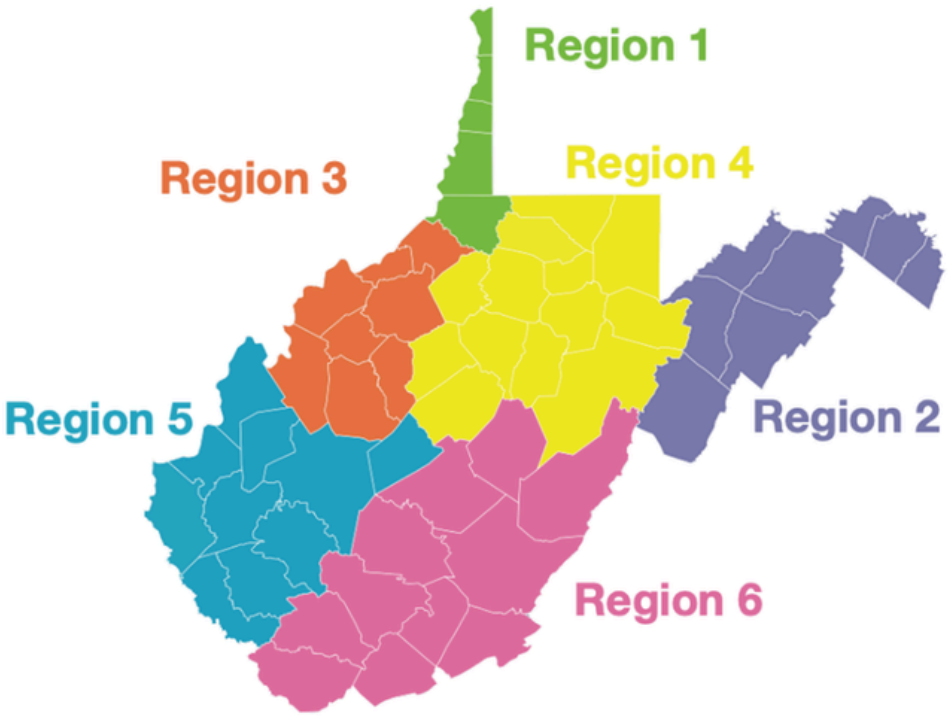
Figure 4



The provider respondents were located throughout the state, with an additional 3% outside the state but providing services to West Virginia residents. In addition, information was collected on respondents' location by the West Virginia Department of Human Services, Bureau for Behavioral Health (BBH) regions. There are six designated regions in the state.

Figure 5

West Virginia Bureau of Behavioral Health Regions



Map from West Virginia Prevention First Alliance
https://helpandhopewv.org/docs/2023%20Prevention%20First%20Flyer.pdf

All regions were represented in the survey with the greatest representation from Region 5 (25%), Region 4 (21%), and Region 1 (20%). Respondents were distributed across regions as shown in Table 2.

Table 2

Region 1	Brooke, Hancock, Marshall, Ohio, Wetzel	20%
Region 2	Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, Pendelton	13%
Region 3	Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt, Wood	5%
Region 4	Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, Upshur	21%
Region 5	Boone, Cabell, Clay, Kanawha, Lincoln, Logan, Mason, Mingo, Putnam, Wayne	25%
Region 6	Fayette, Greenbrier, McDowell, Mercer, Monroe, Nicholas, Pocahontas, Raleigh, Summers, Webster, Wyoming	13%

It is important to note that both the populations and resources for healthcare and perinatal healthcare in the six geographic regions are not evenly distributed.

Background on Perinatal Individuals

The majority of perinatal respondents (72%) were between the ages of 25 and 34, while 22% were 35 or older and 6% were between 18 and 24. Most respondents (91%) identified as White, 5% as Black or African American, and 1% as Native American or Alaska Native. Regarding ethnicity, 93% identified as not Hispanic or Latinx, 6% identified as Hispanic or Latinx, and 2% preferred not to respond.

Types of Health Care Received by Perinatal Individuals

The majority of perinatal individuals (88%) reported receiving care from an OB/GYN. Additional providers identified included midwives (30%), pediatricians (28%), and nurse practitioners (27%). Selections for the "Other" category (5%) included maternal fetal medicine specialist and other medical provider specialists.

Table 3

Health Care Received by Perinatal Individuals (Respondents selected all that applied) n=131	
OB/GYN	88%
Midwife	30%
Pediatrician	28%
Nurse practitioner	27%
Primary care physician	21%
Behavioral health provider	8%
Other	5%

Training

Perinatal Provider Respondent Trainings

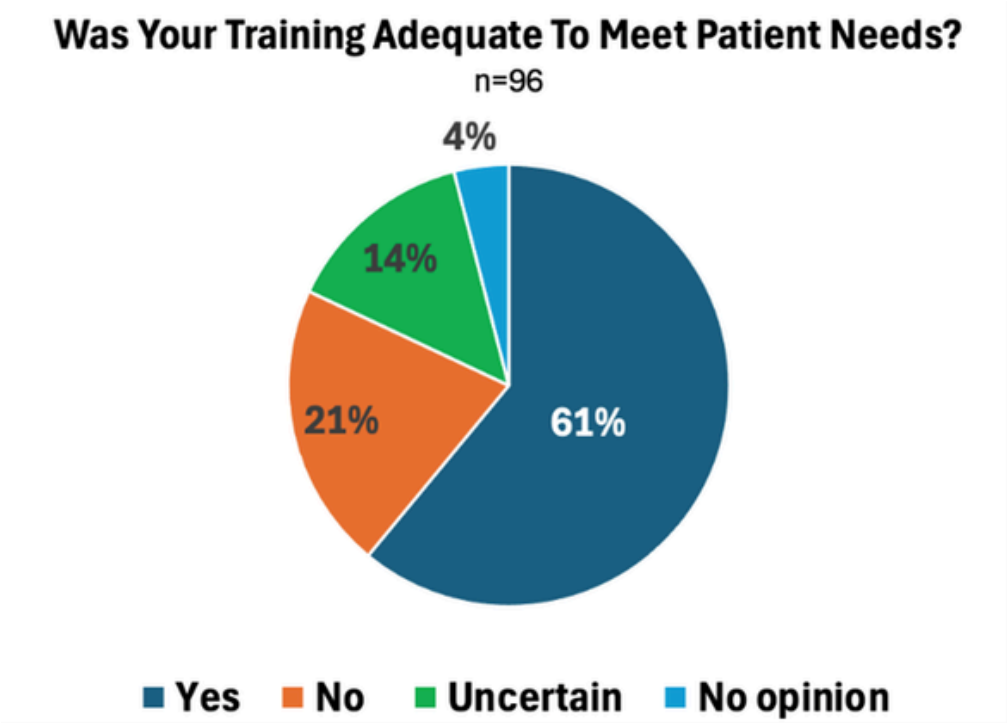
The majority of respondents (63%) reported receiving training in perinatal behavioral health, while 37% indicated they had not. Of those who received training, nearly three-quarter (73%) had completed continuing education focused specifically on perinatal behavioral health. Selections for the “Other” category (5%) included patient safety bundles (Alliance for Innovation on Maternal Health), peer-led training, and the WV Perinatal Partnership Summit.

Table 4

What Types of Training Have You Had in Perinatal Behavioral Health? (Select all that apply) n=97	
Continuing education specific to perinatal behavioral health	73%
School/educational program	27%
Residency or practicum	27%
Postpartum Support International (certification or course)	26%
Self-trained	23%
Other	5%

The majority (61%) responded that their training was adequate, while 35% responded that their training was either not adequate or that they were uncertain of its adequacy.

Figure 6



Providers were given a list of potential training topics and asked to identify the areas in which they would like to receive additional training. More than half of the providers selected perinatal substance use disorder (SUD) and the signs and symptoms of perinatal anxiety as priority topics. The responses reflect broad interest across multiple areas and highlight significant opportunities to strengthen perinatal behavioral health workforce capacity within the state. Selections for the "Other" category (4%) included topics such as pregnancy and bipolar management, engaging in conversations about maternal mental health, complex medication regimens during pregnancy and the postpartum period, and refresher courses on the topics listed (see Table 5).

Table 5

Requested Perinatal Behavioral Health Training Topics (Respondents selected all that applied) n=145	
Perinatal substance use disorder	56%
Signs and symptoms of perinatal anxiety	54%
Perinatal psychosis	48%
Signs and symptoms of perinatal obsessive-compulsive disorder	44%
Trauma informed care	37%
Domestic violence or intimate partner violence	34%
A training for understanding and knowing how to assess and utilize behavioral health screening tools	33%
Polysubstance use disorder	32%
Medications for opioid use disorder and medication assisted treatment	30%
Cannabis use disorder	28%
Mental health 101	28%
Methamphetamine use disorder	26%
Suicide risk	26%
Social determinants of health	26%
Opioid use disorder	24%

Human trafficking	23%
Signs and symptoms of suicide	23%
Alcohol use disorder	19%
Substance use coercion	18%
Other	4%

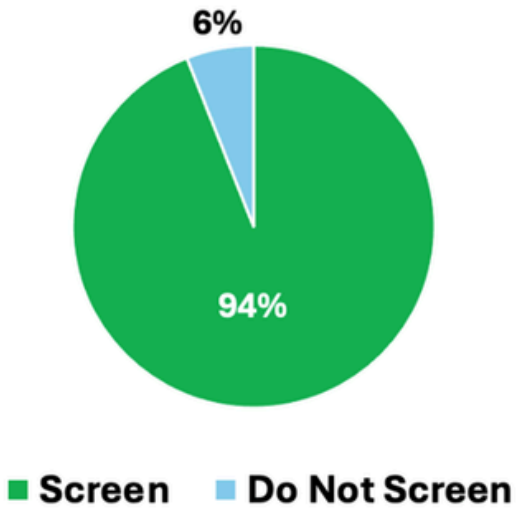
Screening and Treatment

Screening Tools for Perinatal Behavioral Health

Among respondents, most perinatal providers (94%) reported routinely using a screening tool to assess behavioral health concerns in perinatal patients, while only 6% indicated that they do not conduct screenings.

Figure 7

Percent of Providers Who Routinely Use a Screening Tool for Perinatal Behavioral Health
n=153



Respondents were asked to identify all screening tools they routinely use. The majority reported using the Edinburgh Postnatal Depression Scale (EPDS) (67%) and the Patient Health Questionnaire-9 (PHQ-9) (56%). Additionally, one-third of respondents indicated that they screen for basic needs assistance, such as housing, food, clothing, and utilities.

Table 6

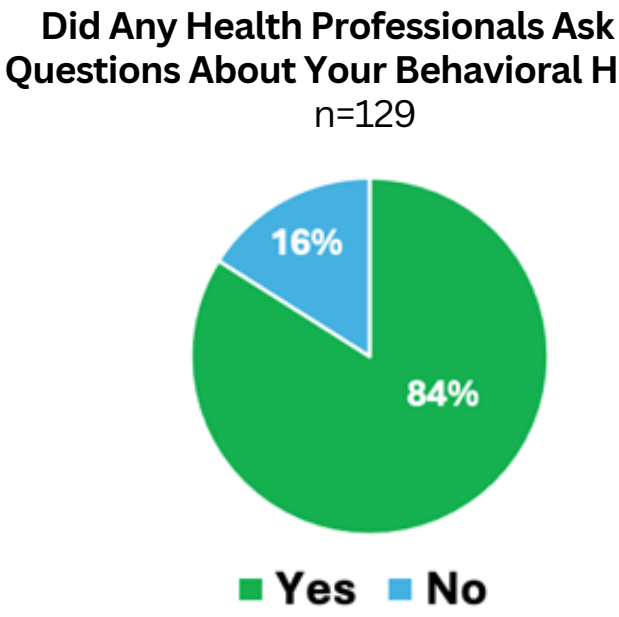
Screening Tools Routinely Used for Perinatal Behavioral Health (Respondents selected all that applied) n=153	
Edinburgh Postnatal Depression Scale (EPDS)	67%
Patient Health Questionnaire-9 (PHQ-9)	56%
Basic needs assistance (no specific tool looking at housing, food, clothing, utilities, etc.)	33%
General Anxiety Disorders-7 (GAD-7)	31%
Diagnostic interview (no tool)	20%
Domestic violence/intimate violence screening	18%
Columbia Suicide Severity Risk Scale	11%
Prenatal Risk Screening Instrument (PRSI)	10%
Mood Disorder Questionnaire (MDQ)	10%
CAGE Assessment (alcohol use disorder screening tool—Concern, Apparent, Grave, Evidence)	8%
Postpartum Depression Screening Scale	8%
Posttraumatic Stress Disorder (PC-PTSD)	7%
The healthcare system I work for has its own tool/questionnaire	6%

I do not screen	6%
Other	3%
Postpartum Depression Predictions Inventory	2%

Perinatal Individuals' Experiences with Screening

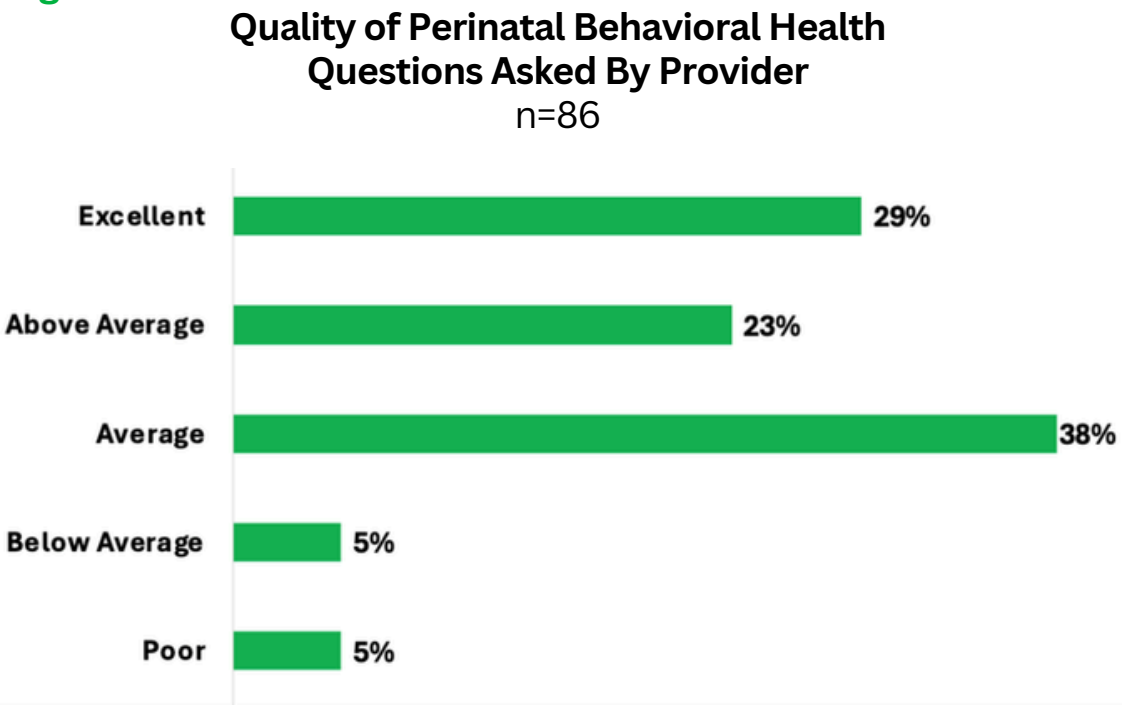
The experiences of perinatal respondents were largely consistent with those of providers, as most agreed that behavioral health screenings occur routinely. When asked whether a health professional had asked about their behavioral health, the majority of perinatal individuals (84%) responded yes, while 16% responded no.

Figure 8



Perinatal individuals were divided in their perceptions of the quality of behavioral health screening questions. Just over half (52%) rated the questions asked by their health professionals as above average or excellent, while 38% rated them as average and 10% as below average or poor.

Figure 9



Provider Ability to Identify and Treat Perinatal Behavioral Health Needs

When asked about their personal ability to meet the behavioral health needs of their patients, providers identified three areas of strength and three areas needing improvement. The areas of strength were those directly within the providers' control, such as being able to use their professional skills to treat behavioral health. In contrast, the areas needing improvement involved referral consultations and access to further treatment for behavioral health needs.

- Only half (50%) of the providers felt they could ensure that their perinatal patients received substance use disorder treatment in a timely manner, while 37% were neutral on this issue and 13% disagreed.

- Less than half (45%) of the providers agreed that they were able to ensure timely access to mental health treatment for their patients, with 37% neutral and 19% disagreeing.

- Only 40% agreed that they could obtain psychiatric consultations for perinatal patients in a timely manner, while 36% were neutral and 24% disagreed.

- Over half (58%) of providers agreed they were able to meet the behavioral health needs of their perinatal patients, compared to 31% who were neutral and 11% who disagreed.

- Over half (62%) of providers agreed that they consistently screen behavioral health concerns at appropriate set time points for perinatal patients, while 21% were neutral and 15% disagreed.

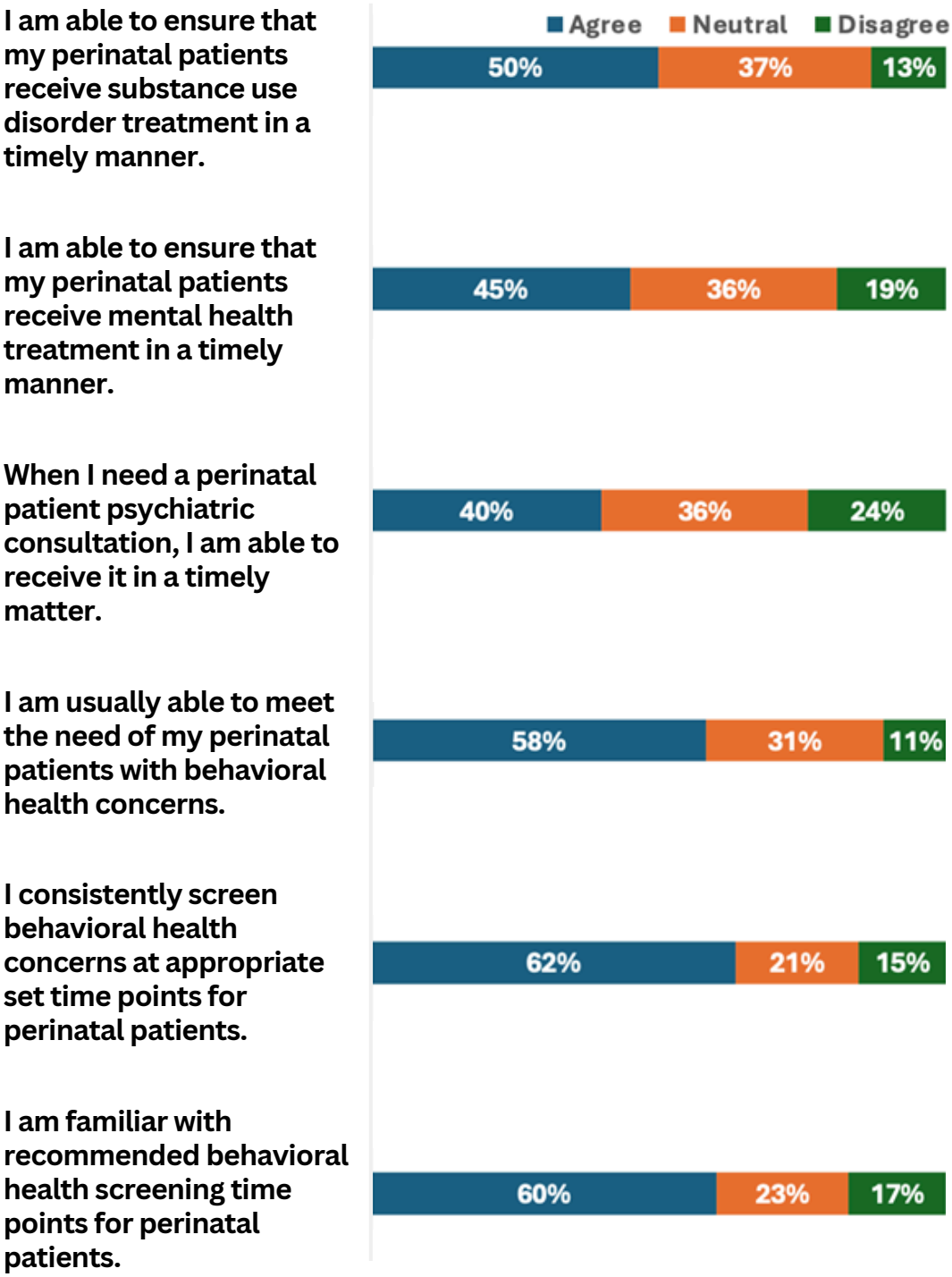
- Finally, 60% of providers agreed that they are familiar with recommended behavioral health screening schedules for perinatal patients, with 23% neutral and 17% disagreeing.

*See Figure 10

Figure 10

Self-Assessed Personal Ability to Identify and Treat Behavioral Health Needs

n=149



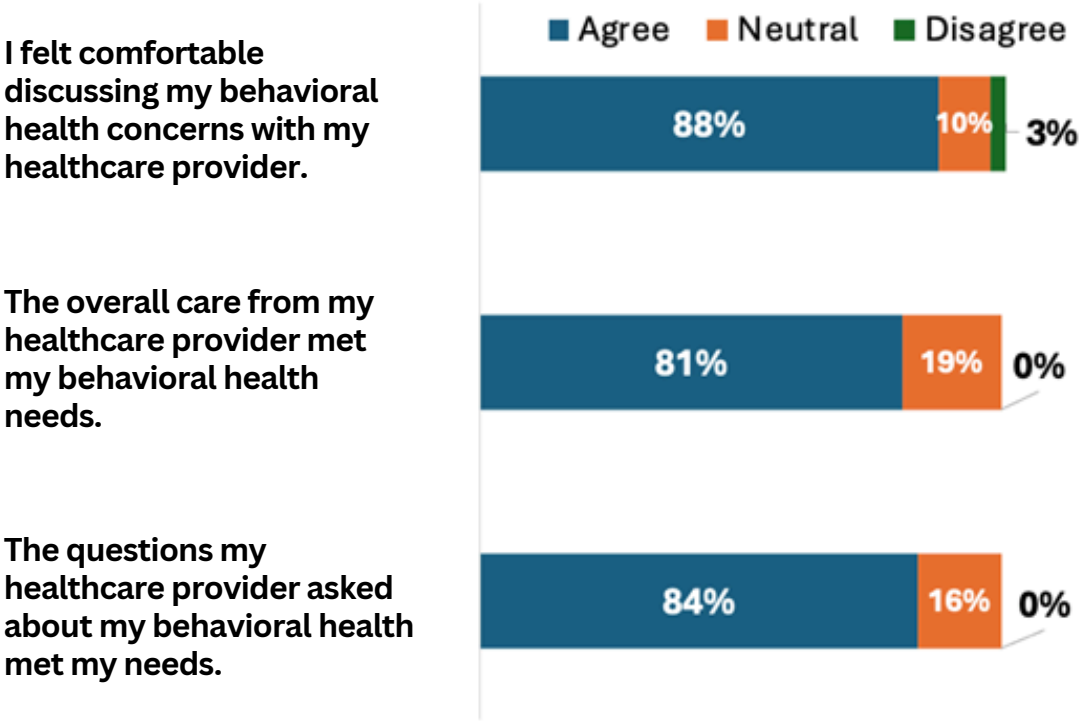
Satisfaction with Providers by Perinatal Individuals

Perinatal individuals reported positive experiences with their providers regarding behavioral health care and having their needs met. The majority felt comfortable discussing their concerns (88%) and said the questions providers asked met their needs (84%). Similarly, 81% agreed that their overall care met their behavioral health needs.

It is important to note that only 32 respondents answered this question. While the reason for the low response rate is unclear, some individuals may have chosen not to respond because they did not perceive a need for behavioral health support or had not discussed these concerns with their provider.

Figure 11

Perinatal Individual's Satisfaction with Provider Care for Behavioral Health Needs
n=32



Provider Confidence in Identifying and Treating Perinatal Behavioral Health Needs

Providers expressed confidence in their ability to identify and refer patients with perinatal behavioral health concerns across several areas. Most agreed that they could appropriately refer patients for substance use disorder concerns (73%) and mental health concerns (72%), as well as identify or assess substance use disorders (70%) and mental health (65%) issues.

However, confidence was lower when it came to treating these conditions directly. Only 38% of providers felt confident in treating substance use concerns, and 42% felt confident in treating other mental health concerns. This may reflect the scope of practice for certain organizations or professions that may focus on identification and referral rather than direct treatment. It may also highlight an opportunity for future training and professional development (see Figure 12).

Figure 12

Provider Confidence in Treatment of Perinatal Behavioral Health

n=144

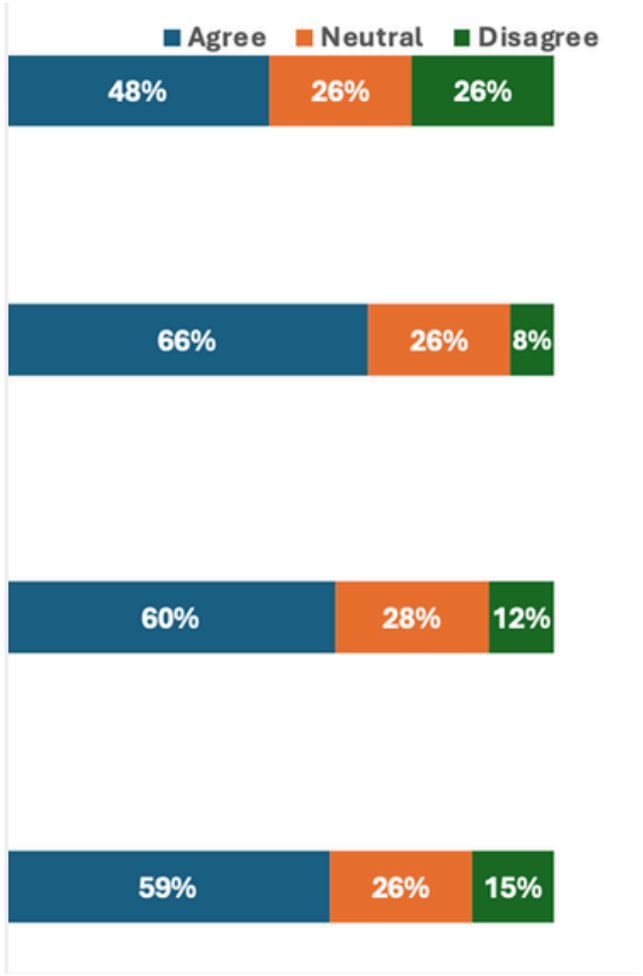
Provider Practice Care and Processes to Address Basic Needs of Patients

The majority of the perinatal providers reported having standard processes in place for connecting perinatal patients to basic needs assistance (66%), substance use disorder resources (60%), and mental health resources (59%). Less than half (48%) indicated that their practices include integrated care teams with behavioral health professionals who support perinatal patients.

Figure 13

Practice Care for Patients to Identify and Treat Behavioral Health Needs

n=149

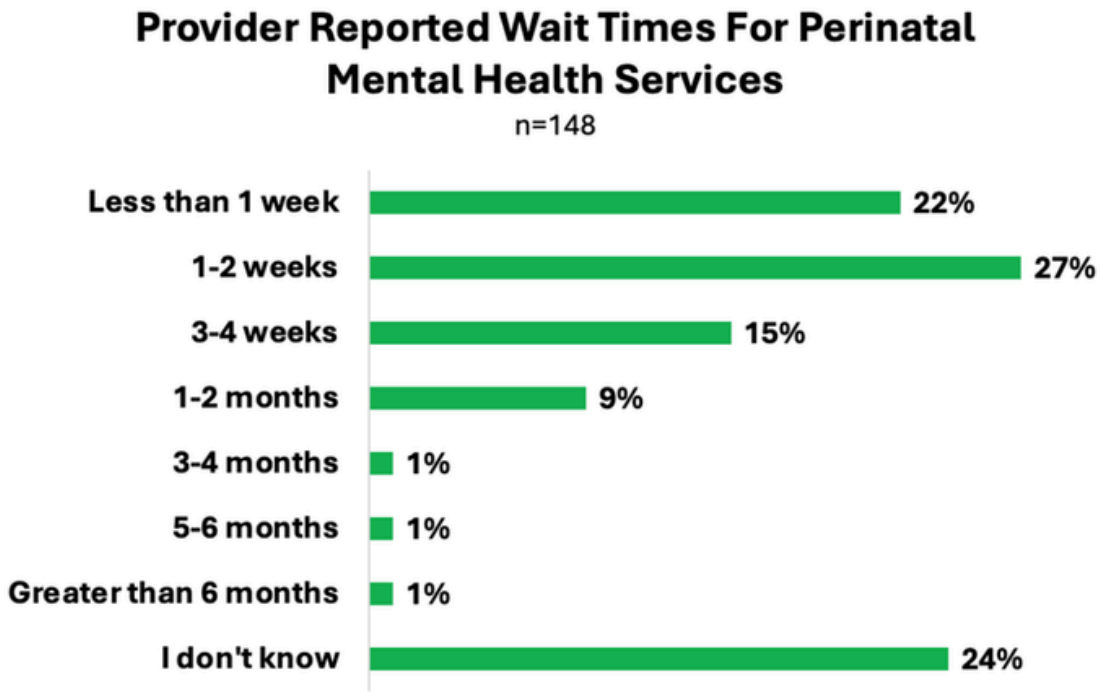


Availability of Services for Perinatal Behavioral Health

Since service availability has been identified as a barrier for perinatal individuals seeking behavioral health care, both providers and perinatal individuals were asked about wait times for appointments.

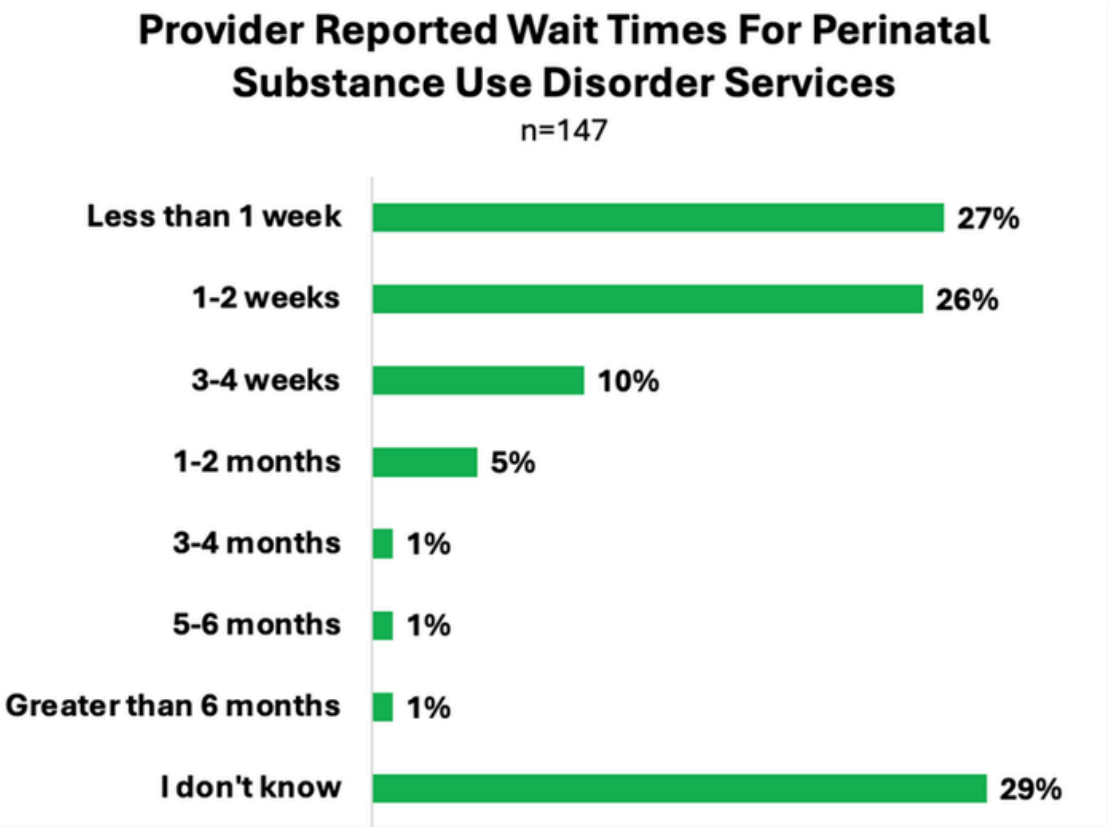
The majority of both groups reported wait times of two weeks or less for behavioral health services. Nearly half (49%) of providers indicated that wait times for perinatal mental health services were two weeks or less, with 22% reporting less than one week and 27% reporting one to two weeks. Approximately one-fourth (24%) of providers did not know the appointment wait times for perinatal mental health services.

Figure 14



Similarly, more than half (53%) reported wait times of two weeks or less for perinatal substance use disorder services, with 27% indicating less than one week and 26% indicating one to two weeks. Over one-fourth (29%) of providers did not know how long their patients would have to wait for substance use disorder treatment.

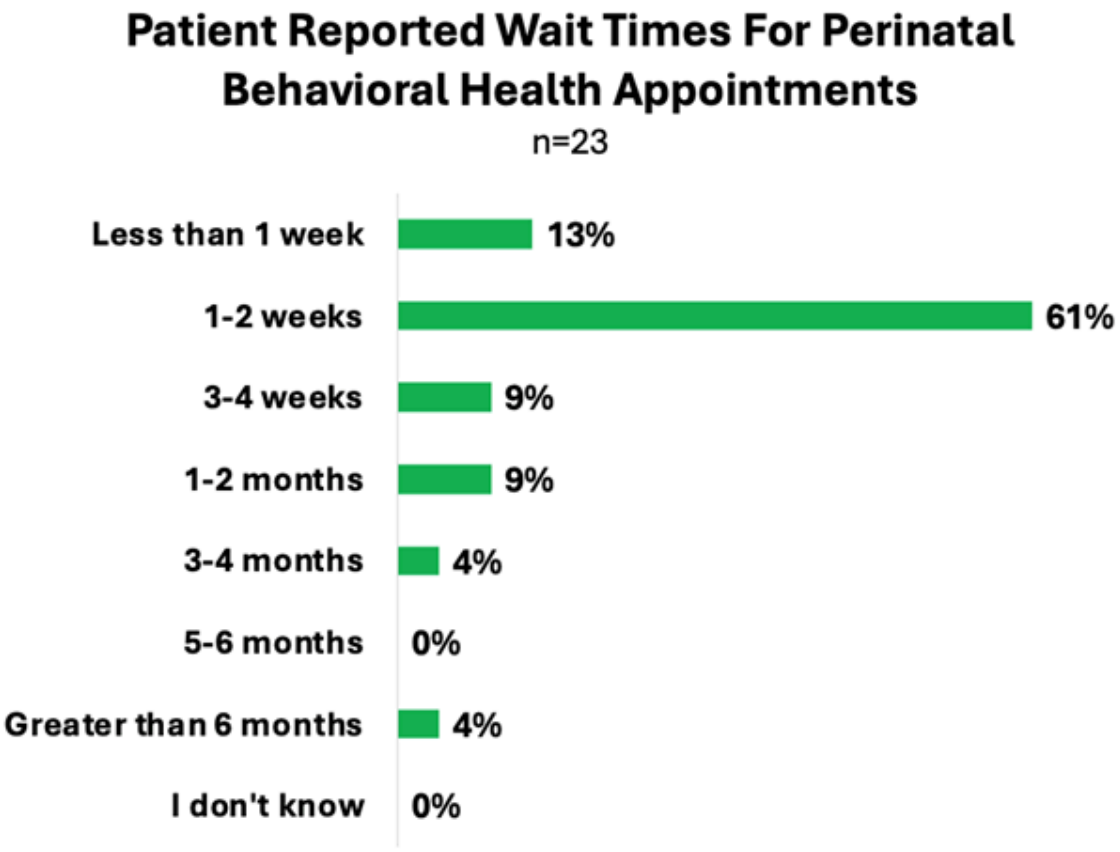
Figure 15



Of the total 131 perinatal respondents, 45% reported receiving a referral to a perinatal behavioral health service, and 18% responded to the question about wait times.

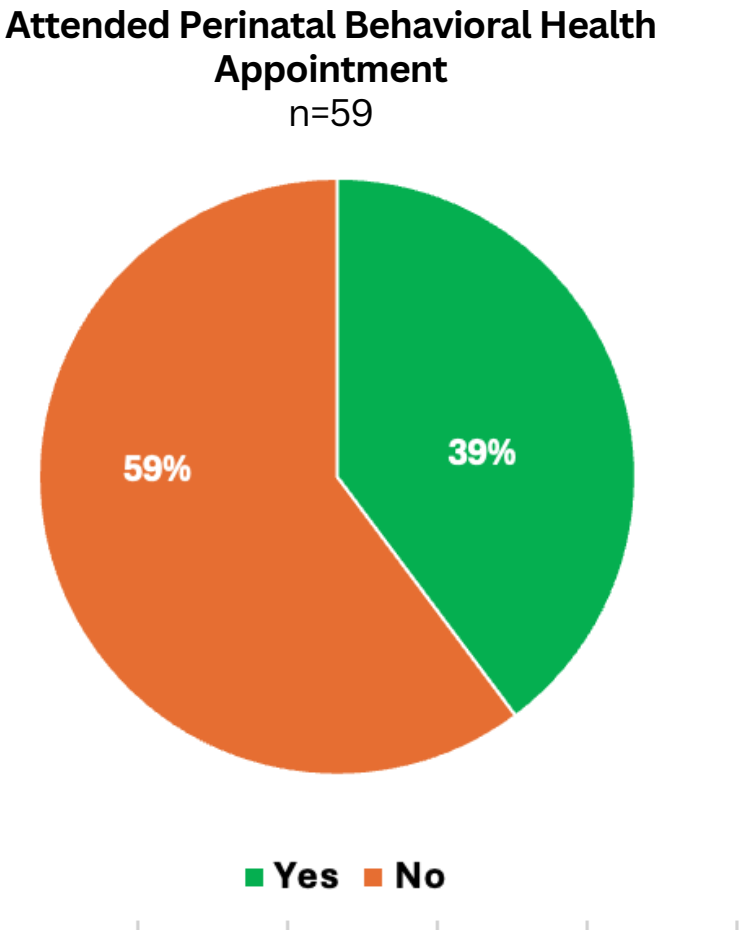
Among those who did receive a referral for behavioral health care, 23 individuals provided information about wait times. Nearly three-quarters (74%) reported wait times of two weeks or less for perinatal mental health services, with most (61%) indicating one to two weeks and 13% indicating less than one week.

Figure 16



Respondents who reported receiving a referral for behavioral health services were also asked whether they attended a perinatal behavioral health appointment (n=59). Among those offered services, over half (59%) indicated that they did not attend an appointment. It is not clear why this occurred, but it represents an area that should be explored in future assessments.

Figure 17



Provider Perceptions on System Limitations for Perinatal Individuals to Receive Behavioral Health Care

To better understand system capacity for improving perinatal behavioral health, the research team examined potential limitations within the health care system that may affect whether perinatal individuals receive needed behavioral health care. A majority of respondents (60%) indicated that providers are unsure how to appropriately treat perinatal individuals with behavioral health needs. Other reported limitations included stigma (59%), lack of basic resources such as housing, food, clothing, and utilities (54%), and lack of insurance or adequate coverage (42%). Selections for the “Other” category (9%) included perceptions of behavioral health referrals as negative experiences; lack of standardized processes for private providers; limited communication and coordination between hospitals and private providers; an overall shortage of providers, particularly behavioral health specialists; long travel times due to limited provider availability; closure or absence of facilities offering family behavioral support; and insufficient training on perinatal behavioral health (see Table 7).

Table 7

Provider Perceptions of Limitations for Perinatal Individuals to Receive Behavioral Health Care (Respondents selected all that applied) n=147	
Providers are unsure how to appropriately treat perinatal individuals with behavioral health care needs	60%
Stigma about behavioral health	59%
Lack of resources for the pregnant individual (housing, food, clothing, utilities, etc.)	54%
Lack of insurance or adequate coverage	42%
Lack of providers accepting Medicaid	37%
Workforce capacity	33%
Developmental or cognitive disabilities	18%
Language	10%
Other	9%
Other disabilities	6%

Provider Viewpoints on Perinatal Behavioral Health in West Virginia

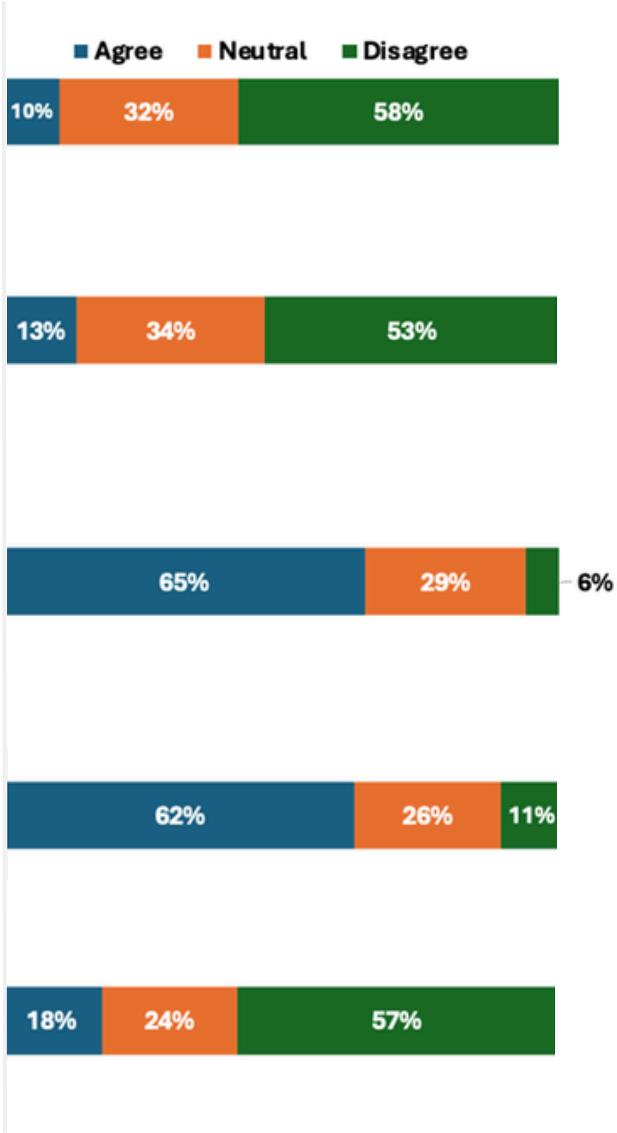
To better understand perinatal providers' perceptions of issues related to perinatal behavioral health in West Virginia, respondents were presented with a series of statements to assess their viewpoints. The majority of providers did not believe that the West Virginia health care system is adequately addressing perinatal behavioral health needs. Specifically, 58% disagreed that mental health concerns are adequately treated, and 53% disagreed that substance use disorder (SUD) concerns are adequately treated. Sixty-five percent agreed that perinatal individuals were not receiving sufficient mental health treatment, and 62% agreed that they were not receiving adequate substance use disorder treatment.

Provider burnout also emerged as a concern that could further reduce the state's behavioral health workforce. When asked to respond to the statement, "I feel professionally burned out to the degree that I may leave the profession of treating perinatal individuals in West Virginia in the near future," 18% agreed, 24% were neutral, and 57% disagreed. Given the state's existing workforce limitations, the number of respondents expressing burnout or uncertainty raises concerns about potential future shortages in provider capacity and highlights an area for improvement with initiatives that promote workforce support, retention, and well-being (see Figure 18).

Figure 18

Provider Viewpoints on Perinatal Behavioral Health in West Virginia

n=144



Provider and Individuals' Perceived Barriers to Perinatal Individuals Receiving Behavioral Health Care

To better understand the barriers that perinatal individuals face in accessing behavioral health care, both perinatal providers and perinatal individuals were asked to select from the same list of potential issues that may limit care.

Perinatal providers identified fear or anxiety about Child Protective Services (CPS) or child welfare involvement (83%) and a lack of available health professionals in the area (82%) as the most common barriers. Other frequently cited barriers included transportation challenges (72%), self-stigma (65%), overall stigma (60%) and appointment wait times (59%) (see Table 8).

Table 8

Provider Viewpoints on Perceived Barriers to Perinatal Individuals Receiving Behavioral Health Care (Respondents selected all that applied) n=144	
There is a fear or anxiety of CPS/child welfare involvement	83%
Lack of available health professionals in the area	82%
Transportation issues	72%
Pregnant people may feel ashamed or guilty (self-stigma)	65%
There is negative judgment about behavioral health (stigma)	60%
It takes too long to receive an appointment	59%
It is difficult to attend appointments	52%
Not being appropriately screened or asked the right questions by healthcare professionals to assess/diagnose behavioral health issues	49%
Domestic violence or intimate partner violence	40%
People cannot take time off from work	40%
Cost	42%
Lack of support from healthcare professionals to receive behavioral health services	38%
No problems exist to keep people from receiving behavioral health care	3%

Perinatal individuals identified difficulties attending appointments as the most common type of barrier to receiving behavioral health care. The top three specific barriers were cost (64%), lack of available health professionals in the area (58%), and inability to take time off from work (52%). Stigma is also ranked among the top five barriers, with self-stigma reported by 52% of respondents and overall stigma by 46%.

Table 9

Individual Perinatal Individuals Viewpoints on Perceived Barriers to Receiving Behavioral Health Care (Respondents selected all that applied) n=124	
Cost	64%
Lack of available health professionals in the area	58%
People cannot take time off from work	52%
Pregnant people may feel ashamed or guilty (self-stigma)	52%
There is negative judgment about behavioral health (stigma)	46%
Not being appropriately screened or asked the right questions by healthcare professionals to assess/diagnose behavioral health issues	43%
There is a fear or anxiety of CPS/child welfare involvement	43%
It takes too long to receive an appointment	40%
It is difficult to attend appointments	39%
Transportation issues	25%

Lack of support from healthcare professionals to receive behavioral health services	23%
Domestic violence or intimate partner violence	15%
No problems exist to keep people from receiving behavioral health care	5%

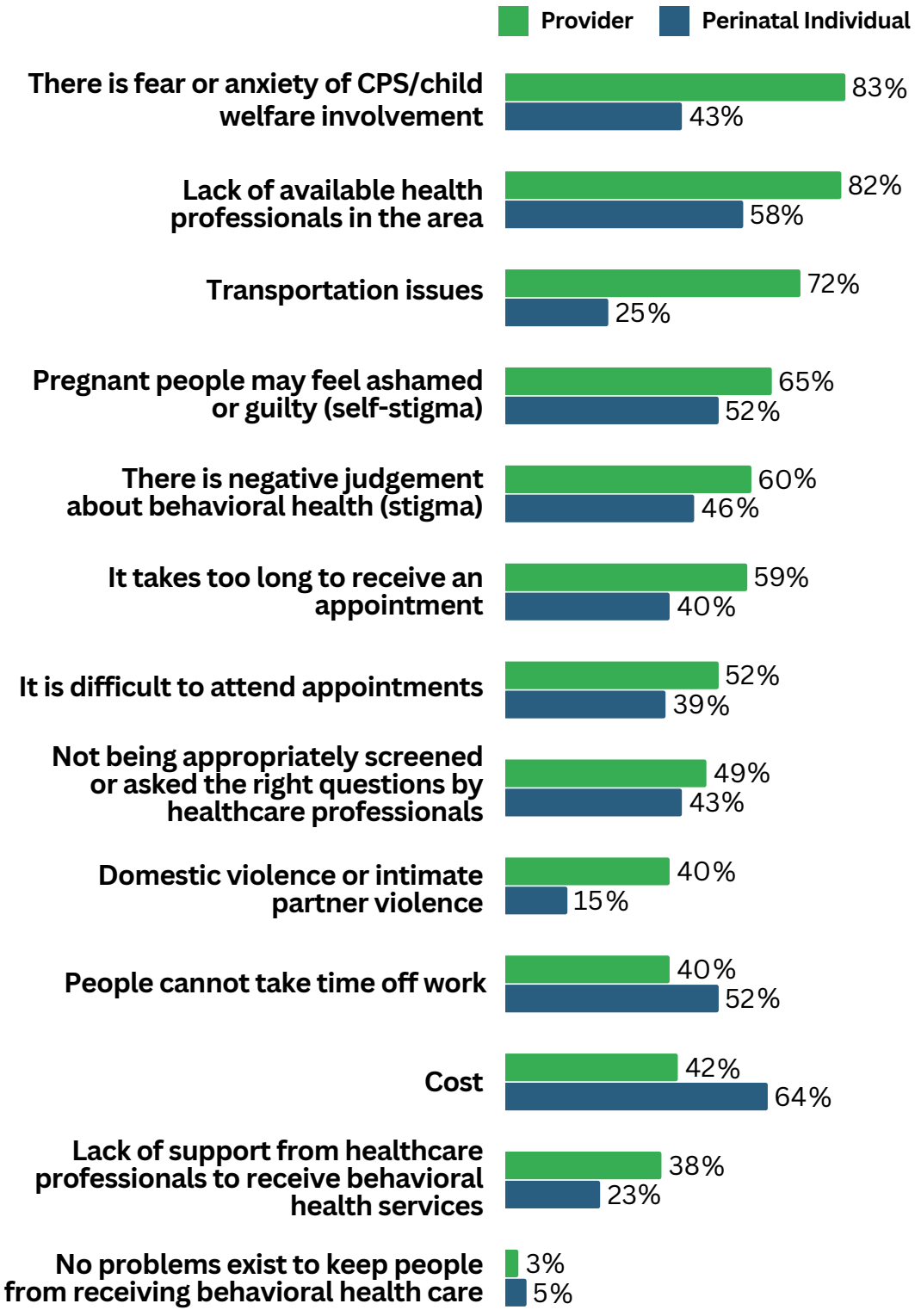
Perceived barriers differed significantly between providers and perinatal individuals as seen in Figure 19. Providers most frequently identified fear or anxiety about CPS involvement as a barrier (83%), while fewer than half of perinatal individuals (43%) viewed it as a concern. Conversely, only 42% of providers identified cost as a barrier, yet it was the most frequently selected barrier among perinatal individuals (64%).

Perceptions of barriers vary greatly depending on perspective, underscoring the importance of understanding the viewpoints and giving voice to all participants in the healthcare system. For example, cost is a relative concept. Some perinatal individuals may be financially unable to afford behavioral health care, while others may simply perceive behavioral health care services as unaffordable. Even a small copay may pose a significant challenge for some families. Recognizing these perceptions is critical for providers, particularly given that fewer than half identified cost as a barrier.

Figure 19

Differences Between Perceptions of Barriers for Receiving Perinatal Behavioral Health Care

n=144



Viewpoints on Ways to Improve Perinatal Behavioral Health Care in West Virginia

When asked how services could be improved for perinatal behavioral health in West Virginia, providers reported the following areas:

- Increase the number of providers (highest number of responses were related to this theme)
- Increase training opportunities (second highest number of responses were related to this theme)
- Better collaboration between providers of different specialties
- Increased screening from the very first perinatal appointment to normalize the process to reduce the perinatal individual's feelings of stigma
- Increase screening in the pediatrician's office, as well as WIC and lactation appointments—break down the silos of care
- Increase time spent with perinatal patients during appointments
- More transportation options for rural areas
- More streamlined referral systems and plans of care for timely patient care
- More providers who accept Medicaid
- Anti-stigma campaigns
- Increase referrals for in-home supports
- Increase public awareness to perinatal individuals on access to care
- Increase support groups
- Family members and partner education on screening
- Increase education on behavioral health medication management
- Expand telehealth programs

When asked how services could be improved for perinatal behavioral health in West Virginia, perinatal individuals reported the following areas:

- Offer more postpartum services than just a 6-week checkup appointment—appointments feel rushed at 6-week checkup (highest number of responses were related to this theme)
- Increase providers, availability, and services—improve accessibility (second highest number of responses were related to this theme)
- Increase providers accepting a broader range of insurance plans
- More screenings throughout pregnancy and postpartum
- Increase education on perinatal behavioral health in order to normalize screening on a regular basis throughout pregnancy and postpartum
- Screen/check-in with perinatal patients when they are alone (not when partners/family members are present) so that they can speak freely
- Remove copays for behavioral health services
- Increase awareness
- Increased access to telehealth and increase virtual options that insurance will cover—face-to-face can feel embarrassing to some patients
- More personalized healthcare—patients feel that their providers do not know who they are—improve doctor-patient relationship
- Grief care for those who have miscarriages
- Talk about perinatal behavioral health more—reduce stigma

Perceived Strengths and Areas for Improvement for Perinatal Behavioral Health Care in West Virginia

When asked what strengths exist for support of perinatal behavioral health in West Virginia, providers reported the following areas:

- Growing and increased awareness, as well as recognition of needs—increased discussions have moved the issues forward
- Telehealth has expanded and is used more
- Some health systems have increased the number of perinatal behavioral health providers
- Providers have increased their comfort level in treating SUD due to the opioid epidemic
- Resources have improved for recognizing perinatal behavioral health and family supports
- Right From the Start, Birth to Three, and Drug Free Moms and Babies programs
- The health care workforce is motivated and wants what is best for families; the workforce is caring, passionate, and dedicated; support has increased
- Peers (with lived experience) working in the field and advocating
- Stigma is more recognized and starting to decrease

When asked how services could be improved for perinatal behavioral health in West Virginia, perinatal individuals reported the following areas:

- Screenings occur regularly during appointments; screenings have increased over the years; and pediatrician screenings have increased and helped
- Strong town/community to rely on
- Telehealth/virtual appointments are available in some health systems
- Resources exist, but accessibility is the remaining issue
- Right From the Start, Birth To Three, Drug Free Moms and Babies, and Helping Appalachian Parents and Infants (HAPI) projects
- Therapy groups

Recommendations

The survey identified several issues that can help guide efforts to strengthen West Virginia's perinatal behavioral health system, including screening, assessment, treatment, and referral for maternal mental health and substance use disorders.

Support and Train the Workforce

Building a strong and well-trained workforce is essential to improving perinatal behavioral health care across West Virginia. The WVPP can work to increase the number of counties with certified providers in perinatal mental health since there are currently only nine counties. This focus could concentrate on expanding the certification training to the current counties with birthing facilities. The WVPP can provide the certification training for free and explore offering incentives to providers to complete the training.

This survey further identified several training priorities for continuing education opportunities for all professionals serving pregnant and postpartum populations. The top three topics requested by providers were perinatal substance use disorders, signs and symptoms of perinatal anxiety, and perinatal psychosis. Providers also expressed interest in additional topics, including trauma-informed care, medication safety, and the use of screening tools for perinatal mood and anxiety disorders. It is important to note that some learners may require more basic instruction while others may need advanced skill development to meet provider's needs. Offering hands on training, such as screening for perinatal mood and anxiety disorders or the Screening Brief Intervention and Referral to Treatment + (SBIRT +) model, to demonstrate how to integrate screening and referral processes into everyday practice can make implementation more effective and boost provider confidence.

These applied trainings would help translate knowledge into action and promote meaningful change within a variety of healthcare settings. The WVPP can collaborate with statewide subject matter experts and other training partners, such as the WV Behavioral Health Training Center to ensure these topics are addressed in the upcoming year. When possible, trainings should be recorded and hosted on a website so that participants can attend the training on demand.

Promote Organizational Wellness and Workforce Well-Being

To sustain long-term improvements in perinatal behavioral health, West Virginia partners could promote organizational wellness policies that support the well-being of both providers and the workforce serving perinatal populations. Compassion fatigue, burnout, and secondary trauma are common among professionals in healthcare, behavioral health, and social services, especially those working with families experiencing perinatal mental health or substance use challenges.

Developing comprehensive wellness policies within organizations can help address these issues by fostering healthier work environments, improving staff retention, and enhancing the quality of care. These policies may include:

- Regular wellness and resilience training for staff and leadership.
- Reflective supervision and peer consultation models to support emotional health and prevent burnout.
- Flexible scheduling and workload management strategies that balance service demands with staff well-being.
- Access to employee assistance programs (EAPs), mindfulness or stress reduction resources, and wellness initiatives tailored to the perinatal workforce.

- Organizational self-assessment tools to help agencies identify strengths, stressors, and areas for improvement in workforce wellness (AHA, 2023).

Statewide partners could provide training to help organizations develop, implement, and evaluate these policies. Incorporating wellness as a core component of organizational practice can create more resilient systems, reduce staff turnover, and strengthen continuity and quality of care for perinatal individuals and families.

Make Screening and Follow-up Routine

Develop a statewide plan to ensure that every pregnant and postpartum individual receives multiple screenings for depression and anxiety. Screenings should be conducted early in pregnancy, later in pregnancy, and after childbirth. The plans can adopt a standardized screening schedule aligned with the American College of Obstetricians and Gynecologists (ACOG, 2023) recommendations, using validated tools such as the Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire-9 (PHQ-9), and Generalized Anxiety Disorder-7 (GAD-7). Training webinars have been provided on this topic in the past, but training needs to be provided continuously for current and new providers, and it should be expanded to other provider groups.

These tools could be embedded within electronic health record (EHR) systems to prompt screenings at the appropriate intervals and automatically generate referrals for behavioral health services when results indicate concern. Pair screening with a closed-loop referral process that includes warm handoffs to behavioral health providers, scheduling follow-up appointments before discharge, and ensuring a check-in within 7–14 days. This check-in is critical to the success of the screening and referral process, helping prevent individuals from

falling through the cracks and promoting early engagement in treatment.

West Virginia could collaborate with partners to assess clinics capacity and needs related to electronic health record (EHR) integration and provide targeted assistance for sites lacking built-in screening templates or automated referral processes. Partners could offer support and funding for EHR customization, staff training, and data tracking can help ensure consistency and sustainability across diverse practice settings. The partners could explore collaboration and funding through a variety of groups, including the West Virginia First Foundation and the Rural Health Transformation (RHT) Program.

Finally, the state could examine establishing a statewide tracking system to monitor screening rates, referral completion, and follow-up outcomes. This coordinated approach would promote consistent and data-driven care for perinatal mental health across West Virginia. The state is already advancing this effort through the Alliance for Innovation on Maternal Health (AIM) program in hospitals, which could be further expanded in partnership with Medicaid and Managed Care Organizations (MCOs) to strengthen care across all settings.

Offer Preventive Support Before a Crisis Happens

Provide early mental health support for individuals who may be at higher risk of developing depression or anxiety during or after pregnancy. Stakeholders can review and implement the US Preventative Services Task Force (USPSTF, 2019) guidance for referring at risk pregnant and postpartum individuals to evidence-based counseling, which has been shown to improve the health outcomes in those at increased risk of depression.

Prioritize low-barrier options such as telehealth programs to increase access for those in rural or underserved areas. The stakeholders can work with payers, such as Managed Care Organizations (MCOs), to remove prior authorization requirements and ensure that brief, evidence-based preventive interventions are fully covered. These efforts can help reduce the severity of symptoms, improve overall well-being, and prevent the need for more intensive treatment later. Furthermore, West Virginia is the recipient of funding from the Rural Health Transformation (RHT) opportunity. Through this initiative, the state will improve outcomes by focusing on a variety of areas, including prevention, disease management for chronic issues, behavioral health, and prenatal care. Collaboration between the WVPP and other partners will be essential to align efforts, strengthen implementation, and improve health outcomes statewide.

Establish a West Virginia Perinatal Psychiatry Access Program (P-PAP)

The WV Perinatal Partnership is working to develop a Perinatal Psychiatry Access Program (P-PAP) in West Virginia to help frontline providers, such as doctors, nurses, midwives, pediatricians, and home visitors, quickly access expert consultation and support for patients with perinatal mental health or substance use concerns.

These types of programs, such as the Massachusetts Child Psychiatry Access Program (MCPAP) for moms in Massachusetts (Commonwealth of Massachusetts, 2024) and the Project Training and Education for Adolescent and Children's Health (Project TEACH) in New York (New York State Department of Health, 2024), have been proven effective in increasing provider confidence and expanding access to behavioral health care. These models offer psychiatric consultation, aid in care coordination, and provide education to clinicians serving perinatal populations.

The WV P-PAP program can serve as a hub-and-spoke network to provide clinician consultation lines staffed by behavioral health experts; care plans for common perinatal behavioral health conditions, such as use of medications during pregnancy, medication for opioid use disorder (MOUD), and lactation safety guidance; and referral directories to connect patients and providers to local services if applicable. Establishing this model in the state will strengthen provider capacity across the state, ensure access to expert guidance, and create a system of support for perinatal behavioral health care in West Virginia.

Increase Access to Crisis and Support Services

Expand access to crisis response and support resources so that individuals and families can easily find perinatal-specific help at any time. Promote the HRSA (2024) National Maternal Mental Health Hotline (1-833-TLC-MAMA), which is available 24/7 by including it in prenatal packets, hospital discharge folders, Women, Infants, and Children (WIC) clinics, newborn screening materials, and electronic health record after-visit summaries. Work with partners to establish a statewide “no wrong door” network to ensure that any parent seeking help is connected to appropriate services, regardless of where they enter the care system. Train designated champions across hospitals, birthing centers, and community sites to raise awareness and about the referral support. The WVPP should serve on the state 988 workgroup with other state agencies to integrate the national hotline, 988, the WV Perinatal WV Perinatal Psychiatry Access Program and other local crisis teams into a unified support pathway that includes warm transfers to West Virginia providers and peer support specialists. Coordinating these systems will ensure timely care for parents experiencing perinatal mental health or substance use challenges.

Improve Funding and Remove or Reduce Cost Barriers for Integrated Care

Leveraging the established success and infrastructure of the Drug Free Moms and Babies (DFMB) program, the WVPP and partners should strengthen integrated care and coordination by expanding comprehensive behavioral health services at sites where such services are currently lacking. The team can work to secure funding to provide start-up stipends and technical assistance to practices interested in building integrated mental health services.

Building on the Transforming Maternal Health (TMaH) grant received in 2025, West Virginia can explore the feasibility of implementing a Collaborative Care Model (CoCM), a team-based approach in which OB/GYNs, family physicians, and behavioral health providers work together to address perinatal mental health and substance use concerns. As part of this assessment, the state can also explore the adoption of the Psychiatric Collaborative Care Model (CoCM) by enabling and promoting billing under existing Medicaid (Centers for Medicare & Medicaid Services, 2024).

To further improve affordability for families, continue implementing and promoting the 12-month postpartum Medicaid coverage (National Academy for State Health Policy, 2023). By working with the West Virginia Perinatal Payors Workgroup, stakeholders can explore ways to remove financial barriers, such as copays for behavioral health visits, psychotherapy, and prescription medications. Even small out-of-pocket costs can discourage families from seeking care.

These efforts together will make it easier for providers to deliver integrated behavioral health care and ensure that all families, regardless of income or geographic location, can access timely, and affordable behavioral health support.

Use Data to Improve Services

Strengthen and expand a statewide data system to track how well perinatal behavioral health care is working across West Virginia. Utilizing the Alliance for Innovation on Maternal Health (AIM) bundle, the state can explore ways, such as a statewide perinatal health registry or data platform, to collect and monitor key metrics such as screening rates, positive screens, time to first appointment, and treatment participation. Such a registry or platform, with the ability to track screening rates, referrals, and treatment outcomes and to generate regular reports for health care agencies, would align with CDC (2023) and HRSA (2024) recommendations for maternal mental health data systems. These reports can support learning collaboratives, guide quality improvement efforts, and help identify where additional resources or training are needed. The state should also explore ways to collaborate with the West Virginia Health Information Network (WVHIN), which provides a secure site for providers to share health information and improve coordination.

Furthermore, data measures should be aligned with established national standards, including the American College of Obstetricians and Gynecologists (ACOG) toolkits and the Collaborative Care Model (CoCM) quality indicators (American College of Obstetricians and Gynecologists, 2023; Centers for Medicare & Medicaid Services, 2024). Using data in this way will promote transparency and continuous improvement in perinatal behavioral health outcomes statewide.

Strengthen System Coordination, Access and Community Support

A coordinated and connected perinatal behavioral health system is key to improving access, affordability, and outcomes for families across West Virginia. To expand collaboration, West Virginia can strengthen provider networks through a centralized directory of perinatal behavioral health providers. This directory could include contact information, service types, provider-insurance acceptance and geographic coverage, helping connect both professionals and patients to the right resources. Since cost was identified as a barrier most often by perinatal individuals, identifying and collecting inventory on available financial assistance programs, grants, and funding support for maternal health services could help reduce that barrier. Providers making referrals could have information available prior to referring the patient, and patients could be able to make informed decisions regarding whether insurance will cover those providers. Further establishing these networks could also foster mentorship, professional collaboration, and quicker referrals across professionals.

West Virginia should also consider establishing a statewide referral and resource network with real-time data sharing to ensure that patients, providers, and community organizations can easily locate and connect with services. Ongoing data collection and mapping of perinatal behavioral health resources will help identify gaps, track service availability, and guide targeted investments in underserved regions.

To reduce barriers to care, the state should expand telehealth services and flexible appointment scheduling, including evening and weekend hours, to better accommodate barriers for families. Strengthening transportation options for rural populations and

increasing awareness of financial assistance programs, including Medicaid and other public supports, will help make care more accessible.

West Virginia should also prioritize public awareness and stigma reduction by launching a statewide campaign to normalize discussions about maternal mental health. Embedding behavioral health conversations into routine prenatal and postpartum visits and offering education for partners and families on recognizing early warning signs.

Finally, expanding community-based and family supports is essential to sustaining recovery and resilience. This includes increasing access to peer recovery programs, support groups, and in-home services, as well as providing specialized post-loss and postpartum grief support. Strengthening cross-sector collaboration among healthcare, behavioral health, social services, and community organizations will ensure families receive coordinated, compassionate care wherever they seek help.

Conclusion

These recommendations can help foster a culture of openness and support. The 2025 data reaffirms that West Virginia has made significant progress in screening and awareness, but there are still needs related to access, training and workforce capacity, and system coordination. Implementing these updated recommendations can significantly improve the quality of perinatal behavioral health services statewide.

References

American College of Obstetricians and Gynecologists. (2023). Screening for perinatal depression (Committee Opinion No. 757). Obstetrics & Gynecology.

American Hospital Association. (2023). Behavioral health integration in obstetrics: Best practices for collaborative care. AHA Maternal Health Learning Series.

Ayres, A., et al. (2019). Engagement with perinatal mental health services: A ross-sectional questionnaire survey. BMC Pregnancy and Childbirth, 19(170). https://doi.org/10.1186/s12884-019-2320-9

Bailey, E., et al. (2022). Results of a statewide survey of obstetric clinical depression practices. Journal of Womens Health, 31(5): 675-681.

Byatt, N., Mittal, L., Brenckle, L., Logan, D., Masters, G., Bergman, A., & Moore Simas, T. (2025, April). Perinatal mental health and substance use toolkit. ACCESS Mental Health and Substance Use for Moms. https://www.accessmhct.com/moms/wp-content/uploads/sites/3/ACCESS-Mental-Health-and-Substance-Use-for-Moms-Provider-Toolkit-Final-Spring-2025.pdf

Centers for Disease Control and Prevention. (2023). Maternal mental health surveillance and data systems overview. CDC Division of Reproductive Health.

Centers for Medicare & Medicaid Services. (2024). Psychiatric collaborative care model (CoCM) billing codes: 99492–99494 and 99484. https://www.cms.gov

Commonwealth of Massachusetts. (2024). MCPAP for Moms: Massachusetts Child

Health Resources and Services Administration. (2024). Maternal Mental Health Blueprint for Action. U.S. Department of Health and Human Services.

Health Resources and Services Administration. (2024). National Maternal Mental Health Hotline: 1-833-TLC-MAMA https://mchb.hrsa.gov/national-maternal-mental- health-hotline

Hick, L., et al. (2022). Assessment of Canadian perinatal mental health services from the provider perspective: Where can we improve?, Frontiers Psychiatry, 13. https://doi.org/10.3389/fpsyt.2022.929496

National Academy for State Health Policy. (2023). Postpartum Medicaid coverage extensions: State implementation tracker. https://nashp.org

New York State Department of Health. (2024). Project TEACH: Training and Education for the Advancement of Children's Health. https://projectteachny.org

Psychiatry Access Program for Moms. https://www.mcpapformoms.org

U.S. Preventive Services Task Force. (2019). Interventions to prevent perinatal depression: Recommendation statement. JAMA, 321(6), 580–587.

West Virginia Perinatal Partnership. (2025). West Virginia Birthing Facilities.

West Virginia Perinatal Partnership. (2025). West Virginia Counties with Perinatal Mental Health Certified Providers.

West Virginia Prevention First Alliance. (2025). West Virginia Bureau of Behavioral Health Regions. https://helpandhopewv.org/docs/2023%20Prevention%20First%20Flyer.pdf