UCSF Center for Health Equity

Maternal mental health screening in California: progress and opportunities

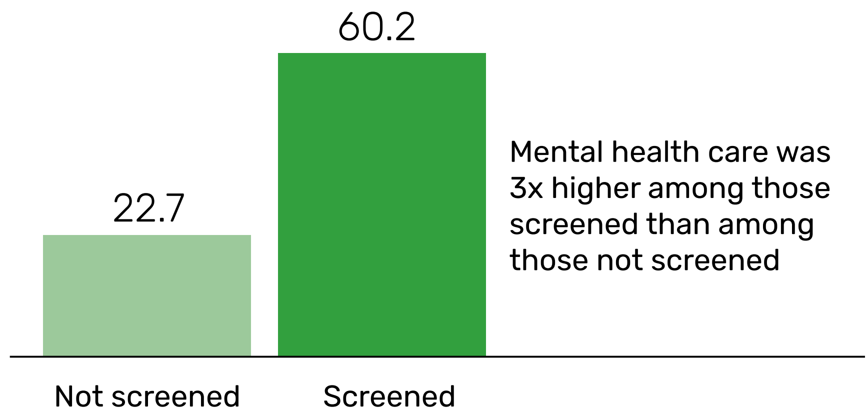
Maternal and Infant Health Assessment Data Brief

Maternal mental health plays a critical role in shaping the overall health and well-being of mothers and their infants. In 2024, over one-third of people giving birth in California experienced symptoms of the most common mental health conditions, depression and anxiety. While mental health conditions are an important contributor to maternal morbidity and mortality, research has shown that timely and adequate care is effective in treating them.

Universal screening is a key strategy for connecting individuals to mental health services. People giving birth in California who had depression or anxiety symptoms were more likely to receive mental health care if they were screened than if they were not screened.

RECEIPT OF MENTAL HEALTH CARE WAS HIGHER AMONG WOMEN WHO WERE SCREENED

Percent of women and other birthing people with postpartum depression or anxiety symptoms who received mental health care, by mental health screening, 2024



The process of screening with a questionnaire to detect maternal mental health conditions provides an opportunity to educate women about the signs and symptoms of mental health conditions and increases their recognition of the need for mental health care. It reduces stigma and shame associated with seeking mental health support and normalizes incorporating an assessment of mental health in overall care provision. Providers should refer those who screen positive for diagnosis and for treatment, such as therapy, medication, and support services. This brief describes the prevalence of screening for mental health conditions among people giving birth in California during 2020-2024 as measured in the Maternal and Infant Health Assessment (MIHA).

MEDICAL ORGANIZATIONS SPECIFY OPTIMAL TIMING AND FREQUENCY OF RECOMMENDED SCREENING

Women may enter pregnancy with undiagnosed mental health conditions or may develop them at any point during pregnancy or in the first two years postpartum. Therefore, medical organizations recommend routine screening for mental health conditions using a validated tool with follow-up to ensure appropriate diagnosis and treatment. The American College of Obstetricians and Gynecologists (ACOG) and the American Psychiatric Association recommend screening at multiple time points during and after pregnancy, such as at the initial prenatal visit, a second time later in pregnancy, and at the comprehensive postpartum visit.[1,2] The American Academy of Pediatrics recommends screening mothers at pediatric visits during the first six months postpartum.[3]

"The doctors need to ask the ladies who just had a baby about their mental health. Some of us don't have support and they are scared to speak up." -MIHA participant, 2024

CALIFORNIA LEGISLATION AIMS TO INCREASE MATERNAL MENTAL HEALTH SCREENING

In the past five years, several pieces of legislation have been enacted to increase screening rates and improve maternal mental health in California.

2019
AB 2193
Requires health care providers to offer mental health screening at least once during or after pregnancy.

2023
SB 1207
Requires health plans to include quality measures to encourage screening.

2025
AB 1936
Requires health plans to cover at least one mental health screening during pregnancy, one during the first six months postpartum, and additional screenings as necessary.

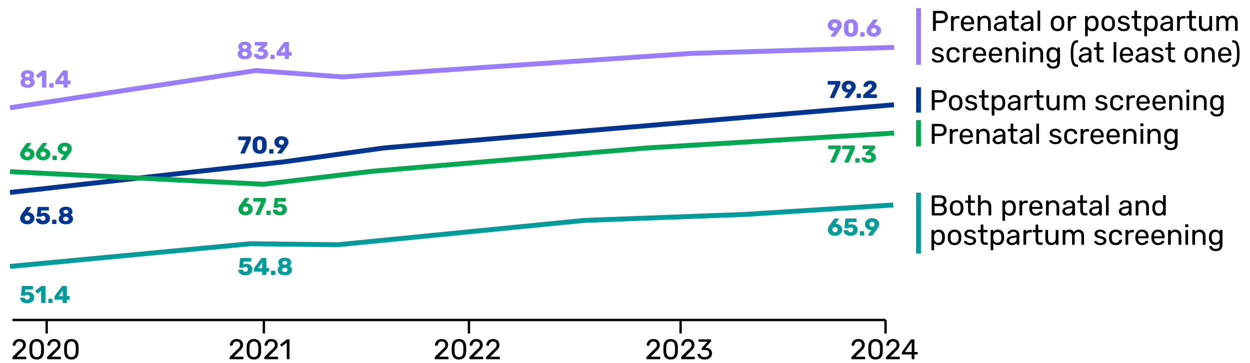
SB 626
Recently proposed legislation would require health care providers to screen, diagnose, and treat birthing people both during and after pregnancy (or refer) in accordance with ACOG guidelines.

WHILE SCREENING HAS IMPROVED, MANY WOMEN AND OTHER BIRTHING PEOPLE DO NOT RECEIVE MENTAL HEALTH SCREENINGS BOTH DURING AND AFTER PREGNANCY

From 2019-2024, California law required universal maternal mental health screening by obstetric providers *at least once* in the prenatal or postpartum period. MIHA self-reported data show that between 2020 and 2024, California made progress in increasing the percentage of women who received at least one maternal mental health screening during or after pregnancy from 81.4% to 90.6%.

In contrast to almost universal screening *at least once* during or after pregnancy, the percentage of women who received recommended screening *both* during *and* after pregnancy in 2024 was much lower, 65.9%. There are opportunities to align maternal mental health screening with the timing and frequency recommended by leading professional organizations. Starting in 2025, California legislation requires health plans to cover screening *both* during and after pregnancy.

MATERNAL MENTAL HEALTH SCREENING HAS INCREASED IN THE PAST SEVERAL YEARS, YET THERE'S ROOM FOR IMPROVEMENT



Percent of women and other birthing people who received mental health screening during pregnancy and postpartum, 2020-2024

"I would really love to see more information on postpartum depression. After leaving the hospital with a newborn we are basically 'booted' and off we go with no real knowledge of all the mental changes we just went through and will go through. Moms need the same attention and care babies get. Information on mental support after birth is very important." -MIHA participant, 2024

DESPITE UNIVERSAL SCREENING REQUIREMENTS, CERTAIN GROUPS ARE LESS LIKELY TO BE SCREENED ACCORDING TO RECOMMENDATIONS

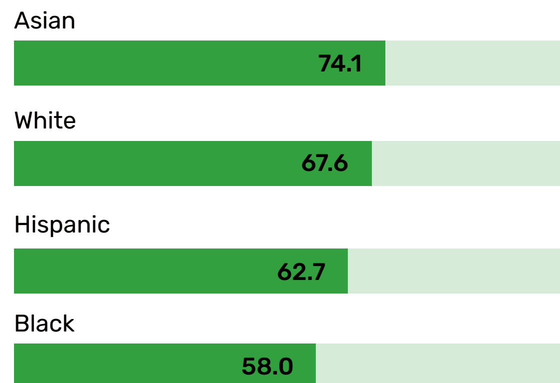
Not all individuals in California benefit equally from recent improvements in maternal mental health screening. Some groups were less likely to be screened *both* during *and* after pregnancy than others.

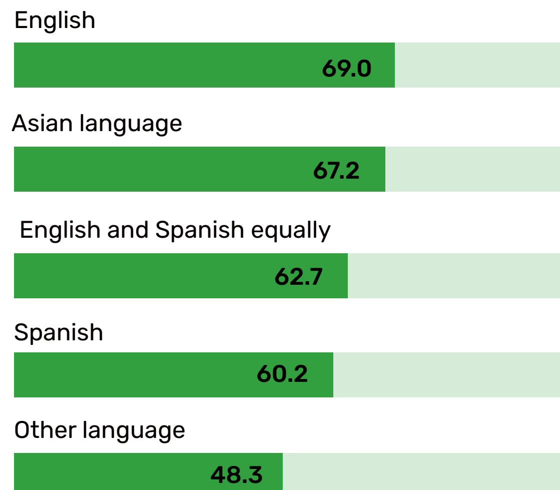
In 2024, Black and Hispanic people giving birth had lower levels of maternal mental health screening when compared to those who are Asian and White. For Black women, who have a higher rate of depression or anxiety symptoms than other groups, less frequent screening may contribute to overall mental health inequities, such as delay of care or worsening of symptoms.

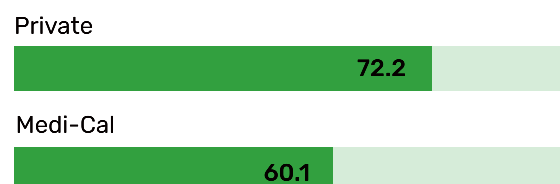
English and Asian-language speakers were the most likely to receive screening, while those who spoke Spanish or other languages at home were less likely to receive screening. Language barriers may drive inequities in screening, and therefore access to care, for non-English speakers.

Women who had Medi-Cal for prenatal care were screened less often than those with private insurance. Universal screening by Medi-Cal providers would increase the likelihood that more participants benefit from recent improvements in Medi-Cal coverage for mental health services.

WOMEN WHO ARE BLACK OR HISPANIC, SPEAK SPANISH OR OTHER LANGUAGES, OR HAVE MEDI-CAL WERE LESS LIKELY TO BE SCREENED







Percent of women and other birthing people who received mental health screening both during and after pregnancy, 2024

STRATEGIES TO INCREASE MATERNAL MENTAL HEALTH SCREENING

Universal screening at the timing and frequency recommended by ACOG is critical to improving maternal mental health and is most effective when it occurs within systems that support timely referral, care coordination, and access to appropriate treatment. Health care systems, providers, public health agencies, insurers, legislators, and researchers can apply multiple approaches to increase screening rates in California such as:

Reduce systems barriers to screening experienced by obstetric care providers

- Promote and implement the *AIM Perinatal Mental Health Conditions* safety bundle in health care systems to standardize screening, education, referral, and treatment.[4]
- Implement Department of Health Care Services (DHCS) California Birthing Care Pathway policy solutions to incentivize mental health screening and treatment across delivery systems serving Medi-Cal members.[5]
- Utilize private insurance payment strategies to incentivize screening and follow-up, including the coverage and provision of specific billing codes for these activities.[6]
- Increase access to behavioral health consultation programs and qualified providers, strengthen care coordination for patients with behavioral health needs, and simplify behavioral health insurance navigation.[7]
- Improve provider training around screening and diagnosis through organizations such as the Maternal Mental Health Leadership Alliance or the Policy Center for Maternal Mental Health.

Eliminate barriers to equitable screening for California's diverse maternity population

- Support policy solutions that improve screening, diagnosis, and treatment of birthing people for mental health conditions in accordance with ACOG guidelines.
- Restructure health systems screening processes in collaboration with impacted communities to ensure equitable outcomes for birthing people who are Black or Hispanic, do not speak English, or are Medi-Cal members.
- Incorporate translated screening tools into standard processes or offer interpreting services for every language spoken in each service population.[8,9]
- Conduct research to assess validity of current screening tools among California's diverse cultures and languages; adapt or develop culturally sensitive screening tools.[10]

Improve the transparency and quality of monitoring data.

- Require mandatory reporting of the HEDIS prenatal and postpartum depression screening and follow-up measures by health care plans for National Committee for Quality Assurance accreditation and promote disaggregated reporting of data.
- Allow health care plans to use claims data to meet reporting requirements.[11,12]

RESOURCES

Resources for health care systems and providers

Alliance for Innovation on Maternal Health (AIM) Perinatal Mental Health Conditions Bundle: A toolkit that provides actionable steps that can be adapted to a variety of facilities and resource levels to improve quality of care and outcomes for patients with perinatal mental health conditions.

California Department of Health Care Services Birthing Care Pathway: A strategic roadmap with the aim to reduce maternal morbidity and mortality and address racial and ethnic disparities that disproportionately affect Black, American Indian/Alaska Native, and Pacific Islander individuals.

Perinatal Psychiatric Consult Line: A consultation program for medical professionals who are prescribers and have questions about mental health care related to pregnant and postpartum patients and pre-conception planning.

Postpartum Support International (PSI): An organization providing advocacy, training opportunities for providers, and free support to parents.

Partner organizations

The California Perinatal Wellness Alliance: A survivor- and community-led coalition advancing perinatal mental health and justice in California and beyond; includes advocacy resources.

Maternal Mental Health Leadership Alliance: A non-profit organization dedicated to promoting the mental health of women and childbearing people in the United States; includes resources for advocacy work.

Policy Center for Maternal Mental Health: A national maternal mental health non-profit organization focused on improving maternal mental health care; includes screening tools, policies, and other resources for screening.

Information about maternal mental health

California Department of Public Health, Maternal, Child and Adolescent Health Division: Links to maternal mental health partners, print materials, videos, a social media library, and a data dashboard showing the latest data from the Maternal and Infant Health Assessment (MIHA).

DATA TABLES

DEPRESSION AND ANXIETY SYMPTOMS, 2024

	Prevalence (%)	95% Confidence Interval	Annual Population Estimate
Depression symptoms, prenatal or postpartum	25.8	24.2 - 27.4	101,200
Prenatal	16.4	15.0 - 17.8	64,800
Postpartum	16.8	15.4 - 18.2	65,700
Anxiety symptoms, prenatal or postpartum	29.9	28.2 - 31.7	116,700
Prenatal	20.8	19.3 - 22.3	81,800
Postpartum	20.5	19.0 - 22.0	80,000
Depression or anxiety symptoms, prenatal or postpartum	37.4	35.6 - 39.2	145,800

RECEIPT OF MENTAL HEALTH CARE BY SCREENING, AMONG WOMEN AND OTHER BIRTHING PEOPLE WITH DEPRESSION OR ANXIETY SYMPTOMS, 2024

	Prevalence (%)	95% Confidence Interval	Annual Population Estimate
Receipt of mental health care, prenatal			
Screened	48.1	44.1 - 52.2	37,600
Not screened	38.6	31.2 - 46.1	10,000
Receipt of mental health care, postpartum			
Screened	60.2	56.1 - 64.2	47,700
Not screened	22.7	15.5 - 29.9	4,000

TRENDS IN MENTAL HEALTH SCREENING, 2020, 2021, 2024

	Prevalence (%)	95% Confidence Interval	Annual Population Estimate
Prenatal mental health screening			
2020	66.9	65.4 - 68.5	275,500
2021	67.5	65.9 - 69.0	276,600
2024	77.3	75.7 - 78.9	305,100
Postpartum mental health screening			
2020	65.8	64.2 - 67.4	270,400
2021	70.9	69.4 - 72.4	290,700
2024	79.2	77.7 - 80.8	311,000
Either prenatal or postpartum mental health screening			
2020	81.4	80.0 - 82.7	334,800
2021	83.4	82.2 - 84.7	343,000
2024	90.6	89.5 - 91.7	357,600
Both prenatal and postpartum mental health screening			
2020	51.4	49.7 - 53.0	211,100
2021	54.8	53.2 - 56.5	224,400
2024	65.9	64.1 - 67.6	258,400

RECEIPT OF BOTH PRENATAL AND POSTPARTUM MENTAL HEALTH SCREENING, 2024

	Prevalence (%)	95% Confidence Interval	Annual Population Estimate
Race and ethnicity			
American Indian/Alaska Native	--		
Asian	74.1	69.6 - 78.6	42,400
Black	58.0	53.3 - 62.7	10,800
Hispanic	62.7	60.1 - 65.2	120,800
Pacific Islander	--		
White	67.6	64.0 - 71.2	70,800
Language usually spoken at home			
Asian language	67.2	60.0 - 74.5	17,800
English	69.0	66.8 - 71.2	162,400
English and Spanish equally	62.7	57.6 - 67.7	29,700
Spanish	60.2	55.8 - 64.6	37,600
Other language	48.3	37.8 - 58.7	7,000
Age			
15-24 years	62.7	58.1 - 67.2	38,200
25-29 years	63.0	59.4 - 66.7	57,800
30+ years	67.8	65.5 - 70.0	162,400
Prenatal health insurance			
Medi-Cal	60.1	57.6 - 62.7	114,300
Private	72.2	69.6 - 74.7	129,000
Uninsured	53.8	37.7 - 69.8	3,400
Other, including military	70.1	60.9 - 79.4	11,300
Household income			
0-100% of poverty	57.4	54.1 - 60.8	62,900
101-200% of poverty	66.9	62.7 - 71.2	48,600
201-400% of poverty	71.0	66.7 - 75.3	45,000
> 400% of poverty	74.2	71.0 - 77.4	78,500

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	Prevalence (%)	95% Confidence Interval	Annual Population Estimate
Total live births			
First birth	69.3	66.6 - 72.1	113,100
Second birth or more	63.4	61.0 - 65.7	145,200
Region			
Central Coast Area	64.7	59.5 - 69.9	15,200
Greater Sacramento Area	71.4	66.2- 76.7	18,900
Los Angeles County	59.4	54.9 - 63.9	52,300
North/Mountain	78.9	72.8 - 84.9	8,300
Orange County	69.2	61.4 - 76.9	20,600
San Diego County	77.0	71.0 - 83.0	27,300
San Francisco Bay Area	73.3	70.1 - 76.5	51,700
San Joaquin Valley	61.1	57.3 - 64.9	33,500
Southeastern CA	57.6	52.0 - 63.1	30,600

-- Estimate not shown because the relative standard error (RSE) is greater than 50% or fewer than 5 birthing individuals reported.

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TECHNICAL NOTES

SUGGESTED CITATION

Maternal mental health screening in California: progress and opportunities. San Francisco, CA: UCSF Center for Health Equity, 2026.

ABOUT THE SURVEY

The California Maternal and Infant Health Assessment (MIHA) is an annual representative survey of California residents with a recent live birth. MIHA had 6,363 respondents in 2020, 6,093 in 2021, and 5,435 in 2024.

MIHA participants were sampled from the California Monthly Birth File. Prevalence (%), 95% confidence interval (95% CI), and estimated number of birthing individuals in the population with a health indicator/characteristic are weighted to represent all individuals with a live birth who resided in California each year. Data were prepared by the University of California, San Francisco (UCSF) Center for Health Equity. MIHA is led by the Maternal, Child and Adolescent Health Division of the California Department of Public Health in collaboration with the UCSF Center for Health Equity. Visit the MIHA website at www.cdph.ca.gov/MIHA.

MIHA SURVEY MENTAL HEALTH SCREENING QUESTIONS

Prenatal: “During your pregnancy, did you fill out a form or were you asked a series of questions from a doctor, nurse, social worker, or other professional about feeling down, depressed, anxious, or irritable?”

Postpartum: “Since your most recent birth, have you filled out a form or have you been asked a series of questions from a doctor, nurse, social worker, or other professional about feeling down, depressed, anxious, or irritable?”

LIMITATIONS

The MIHA survey is administered only in English and Spanish; results may be less representative of individuals who speak Asian or other languages.

Results from self-reported screening data including MIHA may differ from sources such as HEDIS which rely on medical records reported by the health care provider.

The MIHA survey does not ask exact timing of mental health symptoms, screening, or treatment, so it is not possible using these data to assess the causal relationship between screening and treatment. A causal role is plausible in many cases, however, based on the role of screening in increasing recognition of symptoms and facilitating navigation of the health care system.

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Language used in this brief

Not every person who experiences pregnancy and gives birth identifies as a woman or a mother, but gender identification data are not available for MIHA survey participants. Therefore, the words "birthing people" and "women" are used to describe the population experiencing pregnancy, birth, and parenthood.

The terms "prenatal" and "during pregnancy" and the terms "after pregnancy" and "postpartum" are used interchangeably.

Acknowledgments

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Funding for the questions on mental health screening and the development of this brief was generously provided by the California Health Care Foundation.