Focus Area	Citation	Findings
Background Information (Not a specific focus area)	Howard LM, Khalifeh H. Perinatal mental health: a review of progress and challenges. World Psychiatry. 2020 Oct;19(3):313-327. doi: 10.1002/wps.20769. PMID: 32931106; PMCID: PMC7491613.	Perinatal mental health has become a significant focus of interest in recent years, with investment in new specialist mental health services in some high-income countries, and inpatient psychiatric mother and baby units in diverse settings. In this paper, we summarize and critically examine the epidemiology and impact of perinatal mental disorders, including emerging evidence of an increase of their prevalence in young pregnant women. We conclude with research and clinical implications, which, we argue, highlight the need for an extension of generic psychiatric services to include preconception care, and further investment into public health interventions, in addition to perinatal mental health services, potentially for women and men, to reduce maternal and child morbidity and mortality.
Clinical Screening and Referral	Reilly N, Kingston D, Loxton D, Talcevska K, Austin MP. A narrative review of studies addressing the clinical effectiveness of perinatal depression screening programs. Women Birth. 2020 Feb;33(1):51-59. doi: 10.1016/j.wombi.2019.03.004. Epub 2019 Apr 4. PMID: 30954483.	Majority of studies on depression screening during maternity care increases referral rates and service usage, associated with positive emotional health outcomes.
	Screening for perinatal depression. ACOG Committee Opinion No. 757. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e208–12.	The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool
	Myers ER, Aubuchon-Endsley N, Bastian LA, Gierisch JM, Kemper AR, Swamy GK, Wald MF, McBroom AJ, Lallinger KR, Gray RN, Green C, Sanders GD. Efficacy and Safety of Screening for Postpartum Depression. Comparative Effectiveness Review 106. (Prepared by the Duke Evidence-based Practice Center under Contract No. 290-2007-10066-I.) AHRQ Publication No. 13-EHC064-EF. Rockville, MD: Agency for Healthcare Research and Quality; April 2013. www.effectivehealthcare.ahrq.gov/reports/final.cfm.	Potential effectiveness of screening for postpartum depression appears to be related to the availability of systems to ensure adequate follow-up.
	Waqas, A., Koukab, A., Meraj, H. *et al.* Screening programs for common maternal mental health disorders among perinatal women: report of the systematic review of evidence. *BMC Psychiatry* **22**, 54 (2022). https://doi.org/10.1186/s12888-022-03694-9	Meta-analysis indicates a positive impact in favor of the intervention group (screening for perinatal depression and anxiety). Screening appears to lead to improved outcomes, with a significant improvement in symptoms of anxiety among perinatal women.

	O'Connor E, Senger CA, Henninger ML, Coppola E, Gaynes BN. Interventions to Prevent Perinatal Depression: Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA.* 2019;321(6):588–601. doi:10.1001/jama.2018.20865	Reviewed multiple interventions for perinatal mood disorders. Counseling interventions associated with lower likelihood of onset of perinatal depression. Some other interventions, including health system interventions, showed some evidence of effectiveness but lacked robust evidence base.
	Johnson A, Stevenson E, Moeller L, McMillian-Bohler J. Systematic Screening for Perinatal Mood and Anxiety Disorders to Promote Onsite Mental Health Consultations: A Quality Improvement Report. J Midwifery Womens Health. 2021 Jul;66(4):534-539. doi: 10.1111/jmwh.13215. Epub 2021 May 24. PMID: 34032002.	Measured the effects of a quality improvement project that developed systematic screening guidelines including the administration of the PHQ-9 and onsite mental health consultations for eligible women. Screening rates and mental health consultations significantly increased.
	Declercq E, Feinberg E, Belanoff C. Racial inequities in the course of treating perinatal mental health challenges: Results from listening to mothers in California. Birth. 2022 Mar;49(1):132-140. doi: 10.1111/birt.12584. Epub 2021 Aug 30. PMID: 34459012; PMCID: PMC9292331.	Non-Latina Black women experienced higher rates of prenatal depressive symptoms and significantly lower use of postpartum counseling and medications. Those asked by a practitioner about their mental health status were almost six times more likely to report counseling.
	English CMC. Screening Isn't Enough: A Call to Integrate Behavioral Health Providers in Women's Health and Perinatal Care Settings. Int J Integr Care. 2020 Nov 18;20(4):12. doi: 10.5334/ijic.5640. PMID: 33262679; PMCID: PMC7678558.	This paper describes the creation of integrated behavioral health in a midwife practice in Arizona, with a special focus on the financial barriers that may hinder integrated models.
	Topiwala A, Hothi G, Ebmeier KP. Identifying patients at risk of perinatal mood disorders. Practitioner. 2012 May;256(1751):15-8, 2. PMID: 22774377.	The most efficient strategy to identify patients at risk relies on focusing on clinically vulnerable subgroups: enquiries about depressive symptoms should be made at the usual screening visits. Attention should be paid to any sign of poor self-care, avoidance of eye contact, overactivity or underactivity, or abnormalities in the rate of speech.
	Meltzer-Brody S, Jones I. Optimizing the treatment of mood disorders in the perinatal period. Dialogues Clin Neurosci. 2015 Jun;17(2):207-18. doi: 10.31887/DCNS.2015.17.2/smeltzerbrody. PMID: 26246794; PMCID: PMC4518703	Treatment of perinatal mood disorders requires a collaborative care approach between obstetrics practitioners and mental health providers, to ensure that a thoughtful risk : benefit analysis is conducted. It is vital to consider the risks of the underlying illness versus risks of medication exposure during pregnancy or lactation.
	Henshaw, C. (2014). Screening and Risk Assessment for Perinatal Mood Disorders. In: Barnes, D. (eds) Women's Reproductive Mental Health Across the Lifespan. Springer, Cham. https://doi.org/10.1007/978-3-319-05116-1_5	Preconceptual counselling, in addition to screening for mood disorders during pregnancy and in the postpartum period, can reduce the risks associated with perinatal illness by identifying mothers who need intervention
	Dempsey, Allison G. and others (eds), 'Screening for Perinatal Mood and Anxiety Disorders Across Settings', *Behavioral Health Services with High-Risk Infants and Families: Meeting the Needs of Patients, Families, and Providers in Fetal, Neonatal Intensive Care Unit, and Neonatal Follow-Up Settings* (New York, 2022; online edn, Oxford Academic, 1 Aug.	Screening can be challenging for NICU providers due to constraints in time and resources. Screening protocols must include well-validated measures, trained staff to administer, and clear plans for addressing elevated risk. This highlights the need for the integration of mental health professionals into perinatal settings to help foster resilience in families during this vulnerable time

	2022), https://doi.org/10.1093/med-psych/9780197545027.003.0010, accessed 8 May 2023.	
	Murthy S, Haeusslein L, Bent S, Fitelson E, Franck LS, Mangurian C. Feasibility of universal screening for postpartum mood and anxiety disorders among caregivers of infants hospitalized in NICUs: a systematic review. J Perinatol. 2021 Aug;41(8):1811-1824. doi: 10.1038/s41372-021-01005-w. Epub 2021 Mar 10. PMID: 33692474; PMCID: PMC8349842.	Common facilitators included engaging multidisciplinary staff in program development and implementation, partnering with program champions, and incorporating screening into routine clinical practice. Referral to mental health treatment was the most significant barrier.
	Lanuza KK, Butler JM. Implementing a Safety Bundle to Improve Screening and Care for Perinatal Mood and Anxiety Disorders. Nurs Womens Health. 2021 Aug;25(4):264-271. doi: 10.1016/j.nwh.2021.05.004. Epub 2021 Jun 16. PMID: 34146523.	Use of the SBIRT model to implement a safety bundle may contribute to improved mental health outcomes for individuals receiving perinatal care in a private-practice outpatient health care setting. Education and engagement among clinicians, staff, and patients are key to successful implementation of a safety bundle.
	Sidebottom, A., Vacquier, M., LaRusso, E. *et al.* Perinatal depression screening practices in a large health system: identifying current state and assessing opportunities to provide more equitable care. *Arch Womens Ment Health* **24**, 133–144 (2021). https://doi.org/10.1007/s00737-020-01035-x	There were no disparities identified with regard to prenatal screening. However, several disparities were identified for postpartum screening. After adjusting for clinic, women who were African American, Asian, and otherwise non-white were less likely to be screened postpartum than white women. Women insured by Medicaid/Medicare, a proxy for low-income, were less likely to be screened postpartum than women who were privately insured. National guidelines support universal depression screening of pregnant and postpartum women. The current study found opportunities for improvement in order to achieve universal screening and to deliver equitable care.
	Rafferty J, Mattson G, Earls MF, Yogman MW; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH. Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. Pediatrics. 2019 Jan;143(1):e20183260. doi: 10.1542/peds.2018-3260. PMID: 30559118.	This committee opinion agrees with the US Preventive Services Task Force, Centers for Medicare and Medicaid Services, and other agencies that recommend routine universal screening for perinatal depression. Current evidence suggests a minority of pediatricians routinely screen for postpartum depression, and advocate for using pediatric primary care clinicians to increase screening and referral activities.
	Puryear LJ, Nong YH, Correa NP, Cox K, Greeley CS. Outcomes of Implementing Routine Screening and Referrals for Perinatal Mood Disorders in an Integrated Multi-site Pediatric and Obstetric Setting. Matern Child Health J. 2019 Oct;23(10):1292-1298. doi: 10.1007/s10995-019-02780-x. PMID: 31222600.	A case study of a successful quality improvement project in integrated obstetric/pediatric care in Houston Texas. The pediatric practice screened parents at 2 week and 2, 4, and 6- month well-baby visits using the EPDS. 6.3% of women screening positive, with about half of these being referred to treatment. The more integrated the system was with behavioral health, the more likely the parent would complete follow-up. The authors conclude that high screening and referral rates can be achieved.
	Gilbert AL, Balio C, Bauer NS. Making the Legal and Ethical Case for Universal Screening for Postpartum Mood and Anxiety Disorders in Pediatric Primary Care. Curr Probl Pediatr Adolesc Health Care. 2017	This article seeks to move the needle toward universal screening for PPD using validated tools in pediatric primary care settings for new caregivers by making the legal and ethical case for this course of action in a manner that is both

	Oct;47(10):267-277. doi: 10.1016/j.cppeds.2017.08.001. Epub 2017 Sep 12. PMID: 28916453.	compelling and accessible for clinicians. Toward this end, we summarize current literature as it applies to provider responsibilities, liabilities and perspectives; and caregiver autonomy, confidentiality, and privacy. We conclude that there is a strong ethical case for universal screening for PPD in pediatric primary care settings using validated tools when informed consent can be obtained and appropriate follow-up services are available and accessible
	Puspitasari AJ, Heredia D, Weber E, Betcher HK, Coombes BJ, Brodrick EM, Skinner SM, Tomlinson AL, Salik SS, Allen SV, O'Grady JS, Johnson EK, L'amoureux TM, Moore KM. Perinatal Mood and Anxiety Disorder Management in Multicenter Community Practices: Clinicians' Training, Current Practices and Perceived Strategies to Improve Future Implementation. J Prim Care Community Health. 2021 Jan-Dec;12:2150132721996888. doi: 10.1177/2150132721996888. PMID: 33618558; PMCID: PMC7905716.	Cross-sectional, descriptive design. Focused on clinician perspectives and sufficient training to adequately support perinatal mood disorders. Results suggest that even when PMAD screening is implemented, clinicians need better training to fully capitalize on successes. Top three facilitators to PMAD screening include: better physician training, clear/updated list of behavioral health providers for referrals, and integrated behavioral health.
	Smith T, Kipnis G. Implementing a perinatal mood and anxiety disorders program. MCN Am J Matern Child Nurs. 2012 Mar-Apr;37(2):80-5; quiz 86-7. doi: 10.1097/NMC.0b013e3182446401. Erratum in: MCN Am J Matern Child Nurs. 2012 May-Jun;37(3):199. PMID: 22270180.	The authors detail a case study of a universal PMAD screening program in rural Northern Arizona, using a nurse-led interdisciplinary program.
	Lieb K, Reinstein S, Xie X, Bernstein PS, Karkowsky CE. Adding perinatal anxiety screening to depression screening: is it worth it? Am J Obstet Gynecol MFM. 2020 May;2(2):100099. doi: 10.1016/j.ajogmf.2020.100099. Epub 2020 Mar 13. PMID: 33345965.	Case study of a clinic that added the Generalized Anxiety Disorder 2 question to the PHQ-2 during pregnancy. The clinic found that screening for both anxiety and depression increased referral rates and almost as many pregnant people screened positive for anxiety as depression.
Patient-Provider Interactions	Vedam S, Stoll K, Taiwo TK, Rubashkin N, Cheyney M, Strauss N, McLemore M, Cadena M, Nethery E, Rushton E, Schummers L, Declercq E; GVtM-US Steering Council. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reprod Health. 2019 Jun 11;16(1):77. doi: 10.1186/s12978-019-0729-2. PMID: 31182118; PMCID: PMC6558766.	One in six women (17.3%) reported experiencing one or more types of mistreatment such as: loss of autonomy; being shouted at, scolded, or threatened; and being ignored, refused, or receiving no response to requests for help. Context of care (e.g. mode of birth; transfer; difference of opinion) correlated with increased reports of mistreatment. Rates of mistreatment for women of colour were consistently higher even when examining interactions between race and other maternal characteristics.
	Okpa A, Buxton M, O'Neill M. Association Between Provider-Patient Racial Concordance and the Maternal Health Experience During Pregnancy. J Patient Exp. 2022 Feb 8;9:23743735221077522. doi: 10.1177/23743735221077522. PMID: 35155750; PMCID: PMC8829722.	Due to limited sample size, we did not see statistically significant associations between racial concordance and our variables of interest. However, the open-ended comments that we received reveal nuances and concerns in the maternal health field, including the value of support and guidance from other women who have been pregnant, and patients' increasing comfort with self-advocacy with the provider over time.
	Attanasio L, Kozhimannil KB. Patient-reported Communication Quality and Perceived Discrimination in Maternity Care. Med Care. 2015	Over 40% of women reported communication problems in prenatal care, and 24% perceived discrimination during their hospitalization for birth. Having hypertension or diabetes was associated with higher levels of reluctance to ask

	Oct;53(10):863-71. doi: 10.1097/MLR.0000000000000411. PMID: 26340663; PMCID: PMC4570858.	questions and higher odds of reporting each type of perceived discrimination. Black and Hispanic (vs. white) women had higher odds of perceived discrimination due to race/ethnicity.
	Munch S, McCoyd JLM, Curran L, Harmon C. Medically high-risk pregnancy: Women's perceptions of their relationships with health care providers. Soc Work Health Care. 2020 Jan;59(1):20-45. doi: 10.1080/00981389.2019.1683786. Epub 2019 Nov 12. PMID: 31714182.	We found that beyond normative stress related to managing physical aspects of MHRP (medically high risk pregnancy), women reported added emotional stressors associated with navigating the fragmented health care environment. This study suggests that improved care coordination and systematic integration of psychosocial professionals within the perinatal interdisciplinary health care team are vital to reduce care-related stressors on this vulnerable patient group.
	Sperlich M, Seng JS, Li Y, Taylor J, Bradbury-Jones C. Integrating Trauma-Informed Care Into Maternity Care Practice: Conceptual and Practical Issues. J Midwifery Womens Health. 2017 Nov;62(6):661-672. doi: 10.1111/jmwh.12674. Epub 2017 Nov 28. PMID: 29193613.	This article presents an overview of traumatic stress sequelae of childhood maltreatment and adversity, the impact of traumatic stress on childbearing, and technical assistance that is available from the National Center for Trauma-Informed Care (NCTIC) before articulating some steps to conceptualizing and implementing trauma-informed care into midwifery and other maternity care practices.
	Drexler KA, Quist-Nelson J, Weil AB. Intimate partner violence and trauma-informed care in pregnancy. Am J Obstet Gynecol MFM. 2022 Mar;4(2):100542. doi: 10.1016/j.ajogmf.2021.100542. Epub 2021 Dec 3. PMID: 34864269.	Intimate partner violence is defined as any behavior within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship. Universal screening at the first prenatal visit and subsequently every trimester is recommended, with either written or verbal validated tools. Pregnant persons experiencing intimate partner violence need nonjudgmental, compassionate, confidential, and trauma-informed care.
	Vogel TM, Coffin E. Trauma-Informed Care on Labor and Delivery. Anesthesiol Clin. 2021 Dec;39(4):779-791. doi: 10.1016/j.anclin.2021.08.007. PMID: 34776109.	System-based changes to policies, protocols, and practices are needed to achieve sustainable change. Maternal morbidity and mortality that result from trauma-related and other mental health conditions in the peripartum period are significant. Innovative approaches to the prevention of negative birth experiences and retraumatization during labor and delivery are needed.
	Hall S, White A, Ballas J, Saxton SN, Dempsey A, Saxer K. Education in Trauma-Informed Care in Maternity Settings Can Promote Mental Health During the COVID-19 Pandemic. J Obstet Gynecol Neonatal Nurs. 2021 May;50(3):340-351. doi: 10.1016/j.jogn.2020.12.005. Epub 2021 Jan 9. PMID: 33493462; PMCID: PMC7836903.	The purpose of this article is to highlight the pressing need for perinatal clinicians, including nurses, midwives, physicians, doulas, nurse leaders, and nurse administrators, to be educated about the principles of trauma-informed care so that they can support the mental health of pregnant women, themselves, and members of the care team during the pandemic.
	White A, Saxer K, Raja S, Hall SL. A Trauma-informed Approach to Postpartum Care. Clin Obstet Gynecol. 2022 Sep 1;65(3):550-562. doi: 10.1097/GRF.0000000000000730. Epub 2022 Jun 17. PMID: 35708976.	We propose practical communication, behavioral, and procedural considerations for integrating trauma-informed care principles into routine postpartum care, with attention to populations that have been marginalized. We see postpartum care as a critical component of holistic patient recovery and an opportunity to facilitate posttraumatic growth so that all families can thrive.

	Kendig S, Keats JP, Hoffman MC, Kay LB, Miller ES, Moore Simas TA, Frieder A, Hackley B, Indman P, Raines C, Semenuk K, Wisner KL, Lemieux LA. Consensus Bundle on Maternal Mental Health: Perinatal Depression and Anxiety. Obstet Gynecol. 2017 Mar;129(3):422-430. doi: 10.1097/AOG.0000000000001902. Erratum in: Obstet Gynecol. 2019 Jun;133(6):1288. PMID: 28178041; PMCID: PMC5957550.	The focus of this bundle is perinatal mood and anxiety disorders. The bundle is modeled after other bundles released by the Council on Patient Safety in Women's Health Care and provides broad direction for incorporating perinatal mood and anxiety disorder screening, intervention, referral, and follow-up into maternity care practice across health care settings.
	Hernandez ND, Francis S, Allen M, Bellamy E, Sims OT, Oh H, Guillaume D, Parker A, Chandler R. Prevalence and predictors of symptoms of Perinatal Mood and anxiety Disorders among a sample of Urban Black Women in the South. Matern Child Health J. 2022 Apr;26(4):770-777. doi: 10.1007/s10995-022-03425-2. Epub 2022 Mar 27. PMID: 35344149; PMCID: PMC9054427.	The prevalence of symptoms of PMADs was 56%. A higher proportion of women with PMADs had experienced depression (16% vs. 32%, p = 0.006); physical (18% vs. 31%, p = 0.030), emotional (35% vs. 61%, p = 0.000), or sexual abuse (12% vs. 29%, p = 0.002); and symptoms of depression or anxiety before pregnancy (18% vs. 46%, p = 0.000). After adjusting for socio-demographics in multivariate analysis, experiencing symptoms of depression or anxiety before pregnancy (adjusted odds ratio [aOR] = 3.445, p = 0.001) was positively associated with experiencing symptoms of PMADs, whereas higher levels of self-esteem (aOR = 0.837, p = 0.000) were negatively associated with experiencing symptoms of perinatal mood and anxiety disorders.
	Nicoloro-SantaBarbara J, Rosenthal L, Auerbach MV, Kocis C, Busso C, Lobel M. Patient-provider communication, maternal anxiety, and self-care in pregnancy. Soc Sci Med. 2017 Oct;190:133-140. doi: 10.1016/j.socscimed.2017.08.011. Epub 2017 Aug 18. PMID: 28863336.	Women's perceptions of better communication, collaboration, and empowerment from their midwives were associated with more frequent salutary health behavior practices in late pregnancy. Controlling for mid-pregnancy anxiety, lower anxiety in late pregnancy mediated associations of communication and collaboration with health behavior practices, indicating that these associations were attributable to reductions in anxiety from mid- to late pregnancy.
	Haley, J, Benatar S. Improving Patient and Provider Experiences to Advance Maternal Health Equity: Strategies to Address Inequity During the COVID-19 Pandemic and Beyond. Robert Wood Johnson Foundation. 2020. urban.org/sites/default/files/publication/103311/improving-patient-and-provider-experiences-to-advance-maternal-health-equity_0.pdf	This report draws on literature reviews and interviews with maternal care stakeholders to explore how the pandemic is contributing to inequitable patient and provider experiences with maternal health care during the prenatal, delivery, and postpartum periods. We also explore the following promising strategies to consider.
	Jennifer Nicoloro-SantaBarbara, Lisa Rosenthal, Melissa V. Auerbach, Christina Kocis, Cheyanne Busso, Marci Lobel, Patient-provider communication, maternal anxiety, and self-care in pregnancy. Social Science & Medicine. Volume 190, 2017. Pages 133-140. ISSN 0277-9536. https://doi.org/10.1016/j.socscimed.2017.08.011.	Women's perceptions of better communication, collaboration, and empowerment from their midwives were associated with more frequent salutary health behavior practices in late pregnancy. Controlling for mid-pregnancy anxiety, lower anxiety in late pregnancy mediated associations of communication and collaboration with health behavior practices, indicating that these associations were attributable to reductions in anxiety from mid- to late pregnancy.
	Okpa, A, Buxton, M, O'Neill M. Association between provider-patient racial concordance and the maternal health experience during	The survey collected information from 14 mothers, of whom 9 had a racially discordant relationship with their physician and 5 had a racially concordant

	pregnancy. Journal of Patient Experience. 2022. 9(1-6). https://journals.sagepub.com/doi/pdf/10.1177/23743735221077522	relationship. Due to the small sample size for evaluating the patient-provider relationship, we cannot draw quantitative conclusions surrounding the patient experience. However, this area of research does not have much readily available data connecting patient race with provider race and how that racial concordance affects the patient's experience.
	Josefsson A, Angelsiöö L, Berg G, Ekström CM, Gunnervik C, Nordin C, Sydsjö G. Obstetric, somatic, and demographic risk factors for postpartum depressive symptoms. Obstet Gynecol. 2002 Feb;99(2):223-8. doi: 10.1016/s0029-7844(01)01722-7. PMID: 11814501.	The strongest risk factors for postpartum depressive symptoms were sick leave during pregnancy and a high number of visits to the antenatal care clinic. Complications during pregnancy, such as hyperemesis, premature contractions, and psychiatric disorder were more common in the postpartum depressed group of women.
	Jeffers NK, Canty L, Drew M, Grayson N, Amani J, Marcelle E, Amore AD. Beyond "patient-provider race matching." Black midwives clarify a vision for race-concordant care to achieve equity in Black perinatal health: A commentary on "Do Black birthing persons prefer a Black health care provider during birth? Race concordance in birth". Birth. 2023 Jun;50(2):267-272. doi: 10.1111/birt.12720. Epub 2023 Apr 23. PMID: 37088917.	The authors (Black midwives) respond to a recent article that surveyed black women about race and gender concordance. The authors offer a vision for race-concordant care that additionally encompasses cultural safety and care provided in a community-based setting.
	Falade E, Cornely RM, Ezekwesili C, Musabeyezu J, Amutah-Onukagha N, Ferguson T, Gebel C, Peprah-Wilson S, Larson E. Perspectives on cultural competency and race concordance from perinatal patients and community-based doulas. Birth. 2023 Jun;50(2):319-328. doi: 10.1111/birt.12673. Epub 2022 Aug 26. PMID: 36017646.	Focus group discussions that highlight the doula-client relationship. Highlight the importance of cultural competency in doula care, specifically cultural humility and structural competency. Highlights the importance of listening and learning, and building trust between doulas and clients.
	Kemet S, Yang Y, Nseyo O, Bell F, Gordon AY, Mays M, Fowler M, Jackson A. "When I think of mental healthcare, I think of no care." Mental Health Services as a Vital Component of Prenatal Care for Black Women. Matern Child Health J. 2022 Apr;26(4):778-787. doi: 10.1007/s10995-021-03226-z. Epub 2021 Sep 14. PMID: 34519952; PMCID: PMC8438651.	This study sought the opinions of Black peripartum women on group prenatal care. Participants consistently expressed the need for access to mental health care, and focused on mental health integration into group perinatal care. The evidence suggests that group prenatal care can address health disparities for Black women, especially when the group care involves providers who are racially conscious.
	Altman MR, McLemore MR, Oseguera T, Lyndon A, Franck LS. Listening to Women: Recommendations from Women of Color to Improve Experiences in Pregnancy and Birth Care. J Midwifery Womens Health. 2020 Jul;65(4):466-473. doi: 10.1111/jmwh.13102. Epub 2020 Jun 18. PMID: 32558179.	A qualitative study of women of color in San Francisco. Participants shared practical ways to improve care for women of color, focusing on person-centered care, relationship-building, and implicit bias training. The authors recommend that providers listen to and understand women of color during pregnancy.
	Hunte R, Klawetter S, Paul S. "Black Nurses in the Home is Working": Advocacy, Naming, and Processing Racism to Improve Black Maternal and Infant Health. Matern Child Health J. 2022 Apr;26(4):933-940. doi: 10.1007/s10995-021-03283-4. Epub 2021 Nov 24. PMID: 34817758; PMCID: PMC10027493.	This qualitative study used focus groups of clients and staff of a culturally-specific perinatal care program. The main themes include: shared identities (between providers and clients/patients) facilitate trust and healing, racism impacts mental health, and advocacy is a vital service. The authors recommend

		culturally-specific approaches to perinatal care, and stronger mental health support.
	Chambers BD, Taylor B, Nelson T, Harrison J, Bell A, O'Leary A, Arega HA, Hashemi S, McKenzie-Sampson S, Scott KA, Raine-Bennett T, Jackson AV, Kuppermann M, McLemore MR. Clinicians' Perspectives on Racism and Black Women's Maternal Health. Womens Health Rep (New Rochelle). 2022 May 4;3(1):476-482. doi: 10.1089/whr.2021.0148. PMID: 35651994; PMCID: PMC9148644.	This qualitative study focused on providers who serve racially diverse clients. Most participants were OBGYNs or nurse midwives (76% total) and most identified as white (64%). Three themes include: provision of inequitable care, excessive surveillance of Black women, and structural care issues. Authors conclude that racism/inequitable care is currently happening, and more racial equity training is needed, especially for perinatal care clinicians.
	Russell S. Eradicating Racism From Maternity Care Begins With Addressing Implicit Bias. Nurs Womens Health. 2021 Jun;25(3):167-169. doi: 10.1016/j.nwh.2021.03.005. Epub 2021 Apr 24. PMID: 33905673.	This commentary highlights the experience of racism for Black women, and the vulnerability that occurs during pregnancy. The author concludes that training nurses and other health care providers about implicit bias is one step toward eradicating racism from maternity care.
	Kalata M, Zeineddine S, Lentino A, Finnegan B. Addressing Racial Disparities in Maternal and Infant Health Outcomes Through an Anti-Racism Curriculum. Obstet Gynecol. 2023 May 5. doi: 10.1097/AOG.0000000000005187. Epub ahead of print. PMID: 37141588.	This article detailed an anti-racism curriculum for current and future healthcare professionals. Although many participants were aware of anti-racism training, there was a lack of knowledge about structural context contributing to disparities. This training is especially important for health care professionals working with pregnant people.
Clinical Structure and Services	Hans SL, Edwards RC, Zhang Y. Randomized Controlled Trial of Doula-Home-Visiting Services: Impact on Maternal and Infant Health. Matern Child Health J. 2018 Oct;22(Suppl 1):105-113. doi: 10.1007/s10995-018-2537-7. Erratum in: Matern Child Health J. 2018 Aug 20;: PMID: 29855838; PMCID: PMC6153776.	This RCT examined home-visits from doulas and the impact on childbirth preparation class attendance, breastfeeding, and other infant safety measures. Mental health outcomes were not measured. Conclusions for practices The doula-home-visiting intervention was associated with positive infant-care behaviors
	Yonemoto N, Dowswell T, Nagai S, Mori R. Schedules for home visits in the early postpartum period. Cochrane Database Syst Rev. 2017 Aug 2;8(8):CD009326. doi: 10.1002/14651858.CD009326.pub3. Update in: Cochrane Database Syst Rev. 2021 Jul 21;7:CD009326. PMID: 28770973; PMCID: PMC6483560.	Increasing the number of postnatal home visits may promote infant health and maternal satisfaction and more individualised care may improve outcomes for women, although overall findings in different studies were not consistent. The frequency, timing, duration and intensity of such postnatal care visits should be based upon local and individual needs.
	Yonemoto N, Nagai S, Mori R. Schedules for home visits in the early postpartum period. Cochrane Database Syst Rev. 2021 Jul 21;7(7):CD009326. doi: 10.1002/14651858.CD009326.pub4. PMID: 34286512; PMCID: PMC8407336.	The evidence is very uncertain about the effect of home visits on maternal and neonatal mortality. Individualised care as part of a package of home visits probably improves depression scores at four months and increasing the frequency of home visits may improve exclusive breastfeeding rates and infant healthcare utilisation. Maternal satisfaction may also be better with home visits compared to hospital check-ups. Overall, the certainty of evidence was found to be low and findings were not consistent among studies and comparisons.
	McNaughton DB. Nurse home visits to maternal-child clients: a review of intervention research. Public Health Nurs. 2004 May-Jun;21(3):207-19. doi: 10.1111/j.0737-1209.2004.021303.x. PMID: 15144365.	Findings indicate that a wide range of client problems are addressed during home visits using a variety of nursing interventions. Missing from most of the reports is a clear theoretical link between the client problem addressed, the

		nursing intervention, and target outcomes. About half of the studies were successful in achieving desired outcomes.
	Dennis CL, Dowswell T. Psychosocial and psychological interventions for preventing postpartum depression. Cochrane Database Syst Rev. 2013 Feb 28;(2):CD001134. doi: 10.1002/14651858.CD001134.pub3. PMID: 23450532.	Overall, psychosocial and psychological interventions significantly reduce the number of women who develop postpartum depression. Promising interventions include the provision of intensive, professionally-based postpartum home visits, telephone-based peer support, and interpersonal psychotherapy.
	Lomonaco-Haycraft KC, Hyer J, Tibbits B, Grote J, Stainback-Tracy K, Ulrickson C, Lieberman A, van Bekkum L, Hoffman MC. Integrated perinatal mental health care: a national model of perinatal primary care in vulnerable populations. Prim Health Care Res Dev. 2018 Jun 18;20:e77. doi: 10.1017/S1463423618000348. PMID: 29911521; PMCID: PMC6567896.	Implementation of a universal screening process for PMADs alongside the development of an IBH (integrated behavioral health) model in perinatal care has led to the creation of a program that is feasible and has the capacity to serve as a national model for improving perinatal mental health in vulnerable populations.
	Cassidy JM, Boyle VA, Lawrence HC. Behavioral health care integration in obstetrics and gynecology. MedGenMed. 2003 May 14;5(2):41. PMID: 14603140.	This article, from 2003, describes the need for integrated behavioral health in obstetrical care, especially as many patients treat OB care as their only primary care physician. The authors conclude that barriers to integrated care must be addressed.
	Tubay AT, Mansalis KA, Simpson MJ, Armitage NH, Briscoe G, Potts V. The Effects of Group Prenatal Care on Infant Birthweight and Maternal Well-Being: A Randomized Controlled Trial. Mil Med. 2019 May 1;184(5-6):e440-e446. doi: 10.1093/milmed/usy361. PMID: 30535396.	This randomized control trial on group perinatal care found that babies from pregnant parents participating in group care were more likely to be appropriate for gestational age, although there were similar levels of depression and anxiety for pregnant parents.
	Crockett AH, Chen L, Heberlein EC, Britt JL, Covington-Kolb S, Witrick B, Doherty E, Zhang L, Borders A, Keenan-Devlin L, Smart B, Heo M. Group vs traditional prenatal care for improving racial equity in preterm birth and low birthweight: the Centering and Racial Disparities randomized clinical trial study. Am J Obstet Gynecol. 2022 Dec;227(6):893.e1-893.e15. doi: 10.1016/j.ajog.2022.06.066. Epub 2022 Sep 13. PMID: 36113576; PMCID: PMC9729420.	This large randomized control trial on group perinatal care found no difference in overall rates of preterm birth or low birthweight between group and individual prenatal care. However, the authors did find that among Black participants with increased participation in group prenatal care, lower rates of preterm birth and low birthweight were observed, potentially helping to reduce racial disparities.
	Heberlein EC, Smith JC, Marton J, Otekunrin A, LaBoy A, Britt JL, Crockett AH. Well Child Visit Attendance for Group Prenatal Care Participants. Acad Pediatr. 2023 Mar;23(2):296-303. doi: 10.1016/j.acap.2022.09.022. Epub 2022 Oct 8. PMID: 36220619.	This study on Medicaid patients in South Carolina examined the effect of group prenatal care on future well-child visits for pediatric care. The study found a modest increase in well-child visits for those in group prenatal care, although gaps in well-child visits persist regardless of prenatal care model.
	Heberlein EC, Picklesimer AH, Billings DL, Covington-Kolb S, Farber N, Frongillo EA. The comparative effects of group prenatal care on psychosocial outcomes. Arch Womens Ment Health. 2016 Apr;19(2):259-69. doi: 10.1007/s00737-015-0564-6. Epub 2015 Aug 11. PMID: 26260037.	This prospective cohort model examines the psychosocial outcomes of group prenatal care. The study determined that group prenatal care demonstrated an increase in prenatal planning-preparation coping strategies, but no significant greater positive outcomes in other measures. However, women who were at greater psychosocial risk benefitted from group prenatal care, as they

		experienced a decrease in pregnancy-specific stress, higher mean maternal functioning scores postpartum, and a decrease in postpartum depressive symptom scores.
	Rowley RA, Phillips LE, O'Dell L, Husseini RE, Carpino S, Hartman S. Group Prenatal Care: A Financial Perspective. Matern Child Health J. 2016 Jan;20(1):1-10. doi: 10.1007/s10995-015-1802-2. PMID: 26227738.	This mathematical cost-benefit modeling found that group prenatal care could be cost effective as long as an average of 10.652 pregnant parents are enrolled with enriched staff or 4.801 women are enrolled with a single staff member.
	Byerley BM, Haas DM. A systematic overview of the literature regarding group prenatal care for high-risk pregnant women. BMC Pregnancy Childbirth. 2017 Sep 29;17(1):329. doi: 10.1186/s12884-017-1522-2. PMID: 28962601; PMCID: PMC5622470.	This systematic review identified 37 reports about group prenatal care to determine the outcomes for women enrolled in group prenatal care. Important findings include that preterm birth decreased among low-income and African American women, and attendance at prenatal visits was shown to increase among women in GPC. However, authors caution that there is not sufficient high-quality, well-controlled studies to draw conclusions.
	Grant JH, Handwerk K, Baker K, Milling V, Barlow S, Vladutiu CJ. Implementing Group Prenatal Care in Southwest Georgia Through Public-Private Partnerships. Matern Child Health J. 2018 Nov;22(11):1535-1542. doi: 10.1007/s10995-018-2576-0. PMID: 30047079.	A case study of implanting group prenatal care in Georgia's Southwest Public Health district. They found positive outcomes for preterm birth and low-birth weight as well as increased breastfeeding. Additionally, the program was able to enroll mostly medically underserved women. No comments on behavioral health outcomes.
	Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. Cochrane Database Syst Rev. 2016 Apr 28;4(4):CD004667. doi: 10.1002/14651858.CD004667.pub5. PMID: 27121907; PMCID: PMC8663203.	The authors searched the Cochrane Pregnancy and Childbirth Group's Trials Register to determine all published and unpublished trails in which pregnant women were randomly assigned to midwife-led continuity models of care versus other traditional models of care. The authors conclude that midwife-led continuity model of care leads to improved outcomes.
Access	Stanley AY, Wallace JB. Telehealth to Improve Perinatal Care Access. MCN Am J Matern Child Nurs. 2022 Sep-Oct 01;47(5):281-287. doi: 10.1097/NMC.0000000000000841. PMID: 35960218.	The United States has the worst maternal mortality rate of peer countries. Since 1935, the maternal mortality risk among Black women has remained three to four times higher than that of White women. Telehealth allows health care providers to communicate directly with patients that cannot physically be seen in a clinic or hospital. Telehealth is endorsed by the American College of Obstetricians and Gynecologists as an alternate mode to deliver prenatal and postpartum services.
	Blair A, Cao J, Wilson A, Homer C. Access to, and experiences of, maternity care for women with physical disabilities: A scoping review. Midwifery. 2022 Apr;107:103273. doi: 10.1016/j.midw.2022.103273. Epub 2022 Feb 4. PMID: 35158123.	This review found that for women with physical disabilities access to, and experiences of, maternity care is suboptimal. Improving maternity providers disability knowledge and awareness, increasing the availability of support services for women, and increasing person-centred care through organisational policies and provider training may help to address the inequities women with disabilities face in accessing high-quality maternity care.

	Shah JS, Revere FL, Toy EC. Improving Rates of Early Entry Prenatal Care in an Underserved Population. Matern Child Health J. 2018 Dec;22(12):1738-1742. doi: 10.1007/s10995-018-2569-z. PMID: 29992373.	Introduction Early prenatal care can improve pregnancy outcomes, reduce complications, and ensure a healthier pregnancy. Unfortunately, many pregnant women do not seek early care. This research provides a framework for improving prenatal care in a low income community-based obstetrics clinic. Methods A multi-disciplinary quality improvement initiative was implemented at a large federally qualified health clinic in Houston, Texas to improve the rate of early entry into prenatal care by identifying barriers through patient surveys, focus groups, stakeholder feedback, and improving processes to reduce these barriers. Patients with early prenatal care had better obstetrical and neonatal outcomes; however, the results were not statistically significant likely due to the small sample size.
	McClanahan P. Improving access to and use of prenatal care. J Obstet Gynecol Neonatal Nurs. 1992 Jul-Aug;21(4):280-4. doi: 10.1111/j.1552-6909.1992.tb01738.x. PMID: 1494970.	Many women do not seek prenatal care early, and some obtain no prenatal care. The history of prenatal care, the impact of inadequate prenatal care, and the many factors involved in access to and use of prenatal care are discussed. Nursing implications aimed at exploring ways of reducing these factors are examined.
	Phillippi JC. Women's perceptions of access to prenatal care in the United States: a literature review. J Midwifery Womens Health. 2009 May-Jun;54(3):219-25. doi: 10.1016/j.jmwh.2009.01.002. PMID: 19410214.	Women report many barriers to accessing prenatal care. This article reviews the literature from 1990 to the present on women's perceptions of access to prenatal care within the United States. Barriers can be classified into societal, maternal, and structural dimensions.
	York R, Grant C, Gibeau A, Beecham J, Kessler J. A review of problems of universal access to prenatal care. Nurs Clin North Am. 1996 Jun;31(2):279-92. PMID: 8637805.	Despite the preponderance of evidence that points to the advantages of prenatal care, the number of women who receive adequate prenatal care has remained at a plateau or actually decreased since 1980. Over the past decades, many demographic and structural barriers to receiving prenatal care have been identified; financial obstacles have been cited as the major barrier. Recent appreciation of the significance of nonfinancial barriers to prenatal care has resulted in recognition that even if all financial barriers were removed, there would still be access problems.
	Masters GA, Asipenko E, Bergman AL, Person SD, Brenckle L, Moore Simas TA, Ko JY, Robbins CL, Byatt N. Impact of the COVID-19 pandemic on mental health, access to care, and health disparities in the perinatal period. J Psychiatr Res. 2021 May;137:126-130. doi: 10.1016/j.jpsychires.2021.02.056. Epub 2021 Mar 1. PMID: 33677216; PMCID: PMC8084993.	The pandemic has increased symptoms of perinatal depression and anxiety and impacted perceived access to care. Self-reported increases in depression and anxiety and changes to healthcare access varied by education, race/ethnicity, income, and positive screens. Understanding these differences is important to address perinatal mental health and provide equitable care.
	Hussain-Shamsy N, Shah A, Vigod SN, Zaheer J, Seto E. Mobile Health for Perinatal Depression and Anxiety: Scoping Review. J Med Internet Res. 2020 Apr 13;22(4):e17011. doi: 10.2196/17011. PMID: 32281939; PMCID: PMC7186872.	This study aimed to understand the extent, range, and nature of mobile health (mHealth) tools for prevention, screening, and treatment of perinatal depression and anxiety in order to identify gaps and inform opportunities for future work. A total of 26 publications describing 22 unique studies were

		included (77% published after 2017). mHealth apps were slightly more common than texting-based interventions (12/22, 54% vs 10/22, 45%). Most tools were for either depression (12/22, 54%) or anxiety and depression (9/22, 41%); 1 tool was for anxiety only (1/22, 4%). Interventions starting in pregnancy and continuing into the postpartum period were rare (2/22, 9%). Tools were for prevention (10/22, 45%), screening (6/22, 27%), and treatment (6/22, 27%). Interventions delivered included psychoeducation (16/22, 73%), peer support (4/22, 18%), and psychological therapy (4/22, 18%). Cost was measured in 14% (3/22) studies.
	Tilden EL, Holmes LR, Vasquez Guzman CE, Orzech CP, Seghete KM, Eyo V, Supahan N, Rogers GR, Caughey AB, Starr D, DiPietro JL, Fisher PA, Graham AM. Adapting Mindfulness-Based Cognitive Therapy for Perinatal Depression to Improve Access and Appeal of Preventive Care. J Midwifery Womens Health. 2022 Nov;67(6):707-713. doi: 10.1111/jmwh.13444. PMID: 36527394; PMCID: PMC10015792.	Existing and emerging evidence indicates that perinatal depression is a key contributor to preventable morbidity and mortality during and after childbearing. Despite this, there are few effective options for prevention and treatment that are readily accessible for and appealing to pregnant people. In this article, we briefly summarize key systems barriers to delivering preventive care for perinatal depression in standard prenatal care clinics. We then describe Mindfulness-Based Cognitive Therapy for Perinatal Depression and outline our adaptation of this intervention, Center M. Finally, we identify next steps, challenges, and opportunities for this recent innovation.
	Gopalan P, Spada ML, Shenai N, Brockman I, Keil M, Livingston S, Moses-Kolko E, Nichols N, O'Toole K, Quinn B, Glance JB. Postpartum Depression-Identifying Risk and Access to Intervention. Curr Psychiatry Rep. 2022 Dec;24(12):889-896. doi: 10.1007/s11920-022-01392-7. Epub 2022 Nov 23. PMID: 36422834; PMCID: PMC9702784.	Recent research suggests that identifying risk for perinatal depression including historical diagnoses of depression, anxiety, trauma, and comorbid substance use and intimate partner violence may move the field to focus on preventive care in peripartum populations. Emerging data shows stark health inequities in racial and ethnic minority populations historically marginalized by the health system and in other vulnerable groups such as LGBTQ+ individuals and those with severe mental illness. Innovative models of care using systems-level approaches can provide opportunities for identification and risk analyses of vulnerable peripartum patients and facilitate access to therapeutic or preventive interventions. Utilizing intergenerational approaches and leveraging multidisciplinary teams that thoughtfully target high-risk women and other birthing individuals could promote significant changes to population-level care in maternal health.
	Susser LC, Wilkins VM, Sternberg LH. Perinatal Planning Guide: Mitigating Perinatal Mood and Anxiety Disorders During the COVID-19 Pandemic. Prim Care Companion CNS Disord. 2021 Sep 23;23(5):21nr02953. doi: 10.4088/PCC.21nr02953. PMID: 34559484.	Women are at high risk for and more vulnerable to perinatal mood and anxiety disorders (PMADs) during the coronavirus disease 2019 (COVID-19) pandemic. While access to specialized perinatal mental health services is limited, clinicians with whom women have ongoing relationships are in a unique position to counsel about prevention of PMADs. These clinicians include primary care, obstetric, and general mental health clinicians. By providing a woman with practical guidance and psychoeducation for perinatal planning (eg, about sleep,

		exercise, nutrition, and the importance of social supports), clinicians can mitigate a woman's risk of PMADs. This practical guidance must be modified to fit the social context of the COVID-19 pandemic. This guidance can prevent or attenuate unnecessary suffering on the part of the mother and have a long-lasting impact on her child. This review provides a perinatal planning guide that outlines important topics to discuss and problem solve with women in the context of the COVID-19 pandemic.
	Rodriguez AN, Holcomb D, Fleming E, Faucher MA, Dominguez J, Corona R, McIntire D, Nelson DB. Improving access to perinatal mental health services: the value of on-site resources. Am J Obstet Gynecol MFM. 2021 Nov;3(6):100456. doi: 10.1016/j.ajogmf.2021.100456. Epub 2021 Aug 10. PMID: 34384907.	This was a retrospective cohort study of women undergoing universal postpartum depression screening with deliveries from January 2017 to December 2019 who were compared with a historic cohort from the same population from June 2008 to March 2010. Utilization of mental health services following a positive depression screen more than doubled following the implementation of colocated services.historic cohort from the same population from June 2008 to March 2010
	Roberson DN, Roussos-Ross D, Goodin AJ. Impact of an on-site perinatal mood disorders clinic in the diagnosis and management of perinatal mood disorders. J Perinat Med. 2020 Oct 25;48(8):837-843. doi: 10.1515/jpm-2020-0036. PMID: 32764166.	Women treated at the Perinatal mood disorder clinic (on-site) showed improved EPDS scores when receiving at least two separate care visits. Therefore, the clinic may be filling a gap in access to timely care for women with perinatal mood disorders.
	Deichen Hansen ME, Londoño Tobón A, Kamal Haider U, Moore Simas TA, Newsome M, Finelli J, Boama-Nyarko E, Mittal L, Tabb KM, Nápoles AM, Schaefer AJ, Davis WN, Mackie TI, Flynn HA, Byatt N. The role of perinatal psychiatry access programs in advancing mental health equity. Gen Hosp Psychiatry. 2023 May-Jun;82:75-85. doi: 10.1016/j.genhosppsych.2023.03.001. Epub 2023 Mar 12. PMID: 36989766.	This editorial presents: 1) a review of Perinatal Psychiatry Access Programs as an integrated care model with potential for promoting perinatal mental health equity; and 2) a summary of how the model has been and can be further adapted to help achieve perinatal mental health equity in geographically diverse settings.
	Sobowale K, Richards M, Dixon LB. Perinatal Psychiatry: Improving Access to Perinatal Mental Health Care. Psychiatr Serv. 2022 Jan 1;73(1):116-117. doi: 10.1176/appi.ps.2021.73102. PMID: 34974744. (This is not a single article, but a full Edition of the journal Pyschiatric Services, which includes several articles on perinatal mental health access and concerns)	This Editor’s Choice collection builds on the April 2019 perinatal psychiatry collection and highlights innovative service models across the care continuum, from screening to longitudinal treatment. The first set of articles details the large treatment gap for perinatal mental illness despite its association with pregnancy complications. The second set of articles discusses digital health tools (e.g., mobile apps and telepsychiatry) to support perinatal mental health screening and integrated care. The last group of articles discusses the benefits of perinatal collaborative care models in controlled trials and real-world settings in socioeconomically, racially, ethnically, and geographically diverse populations. It is incumbent upon mental health clinicians to build upon the innovations in this collection to expand access to perinatal mental health care with the goal of reversing the concerning rise in maternal morbidity and mortality.

	Tyokighir D, Hervey AM, Schunn C, Clifford D, Ahlers-Schmidt CR. Qualitative Assessment of Access to Perinatal Mental Health Care: A Social-Ecological Framework of Barriers. Kans J Med. 2022 Feb 9;15:48-54. doi: 10.17161/kjm.vol15.15853. PMID: 35371389; PMCID: PMC8942588.	Thirty-three interviews were conducted with 12 (36%) pregnant or postpartum women, 15 (45%) PCPs, and 6 (18%) mental health care providers. Barriers were categorized into three levels: individual, social, and society. Individual level barriers, including cost or lack of insurance and transportation, were consistent across groups, however, women identified barriers only at this level. Provider groups identified barriers at all levels, including lack of support, poor communication between providers, and Medicaid limitations.
Care Team and Coordination	Perrella SL, Miraudo J, Rea A, Geddes DT, Prosser SA. Maternal Evaluation of a Team-Based Maternity Care Model for Women of Low Obstetric Risk. J Patient Exp. 2022 Apr 11;9:23743735221092606. doi: 10.1177/23743735221092606. PMID: 35434293; PMCID: PMC9006366.	A multidisciplinary team-based maternity care service led by general practitioners with obstetric training (GPOs) and midwives was established for women of low obstetric risk. Proportions of participants that were very satisfied with their overall pregnancy, hospital stay, and postpartum care were 91%, <50%, and 85%, respectively. Both survey and qualitative data identified high satisfaction with emotional care and time afforded to discuss concerns during appointments. High levels of satisfaction can be achieved in women of low obstetric risk through the provision of GPO-midwife led multidisciplinary care throughout the maternity journey.
	Grote N, Katon W, Russo J, Lohr M, Curran M, Galvin E, Carson K. Collaborative Care for Perinatal Depression in Socioeconomically disadvantaged women: a randomized trial. Depression and Anxiety. 2015. 32:821-834. DOI: 10.1002/da.22405	Compared to public health maternity support services (MSS-Plus), the authors implemented "MOM-Care," a culturally relevant, collaborative care intervention model. The model showed significant improvement in quality of care, depression severity, and remission rates, especially for socioeconomically disadvantaged women.
Incentives	Sudhof L, Shah NT. In Pursuit of Value-Based Maternity Care. Obstet Gynecol. 2019 Mar;133(3):541-551. doi: 10.1097/AOG.0000000000003113. PMID: 30801455.	Improving the value of maternity services will require public policies that measure and pay for quality rather than quantity of care. Equally important, clinicians will need to employ new strategies to deliver value, including considering prices, individualizing the use of new technologies, prioritizing team-based approaches to care, bridging pregnancy and contraception counseling, and engaging expecting families in new ways.
Community Initiatives	The Perigree Fund: https://perigeefund.org/	Perigee Fund partners with organizations whose initiatives support the infant-caregiver relationship and increase the capacity for all families to experience healthy, joyful connections. We focus our funding and resources on two key areas – Mental Health and Family Supports for Well-Being – particularly initiatives that center communities of color.
	Oregon Health Authority: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/MATERNALMENTALHEALTH/Pages/CommunityStrategies.aspx	Maternal mental health disorders are a major public health problem, affecting thousands of women, children, and families. Communities all around the country are mobilizing to identify and address perinatal depression and anxiety, and to support pregnant and parenting families. Use this page to learn more

		about how to engage partners, raise awareness, and develop networks in your community.
	Washington DOH: MaMHA: https://waportal.org/partners/home/mamha	Washington Maternal Mental Health Access (MaMHA) in the Department of Psychiatry and Behavioral Sciences, University of Washington (UW), is a funded program through the Perinatal Unit of the Office of Family and Community Health Improvement, Washington State Department of Health (DOH), to train and support members of WA primary care clinics to decrease perinatal suicide risk and accidental opioid overdose.
	Raising the Bar for Health Equity and Excellence: https://rtbhealthcare.org/maternal-health-launch/	The guidance is organized into four core roles that healthcare provider institutions play, as: • Providers: Provide whole-person care to achieve maternal health equity • Employers: Employ and support a diverse maternal health workforce • Community Partners: Engage with individuals and organizations in the community to achieve maternal health equity • Advocates: Advocate for and invest in maternal health equity
	US Department of Health and Human Services: Mom's Mental Health Matters: https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms/action-plan	Use this action plan to see if what you are feeling is depression and anxiety during pregnancy or after birth, and if you should seek help. This action plan is designed to help you understand the signs of depression and anxiety and to take steps to feel better
	The Blue Dot Project: https://www.thebluedotproject.org/	The Purpose of TheBlueDotProject is to: Raise awareness of maternal mental health disorders, Proliferate the blue dot as the symbol of solidarity and support, Combat stigma and shame
	HRSA: Black Maternal Health Week - https://mchb.hrsa.gov/programs-impact/focus-areas/maternal-health/black-maternal-health#:~:text=Black%20Maternal%20Health%20Week%20is,an%20urgent%20call%20for%20action. And	Black Maternal Health Week is recognized each year from April 11-17. This year, President Biden issued his third White House Proclamation on Black Maternal Health Week. He declared this week as an urgent call for action. Due to the alarming state of Black maternal health, he wants all Americans to know: That prejudices within our systems cause the problem, How big the problem is, Why we need to solve it quickly, He asks that everyone raise the voices and experiences of Black women, families, and communities.
	Black Mamas Matter Alliance: https://blackmamasmatter.org/	The Black Mamas Matter Alliance (BMMA) is a Black women-led cross-sectoral alliance that centers Black mamas and birthing people to advocate, drive research, build power, and shift culture for Black maternal health, rights, and justice
	Black Birth Empowerment Initiative (Swedish): https://www.swedish.org/services/doula-services/black-birth-empowerment-initiative	BBEI (pronounced "Bay") is a component of the Swedish Doula Program that seeks to honor Black lives by centering and uplifting the Black birth experience with culturally congruent doula care. The Black Birth Empowerment Initiative

		provides doula care created for us by us to empower Black/African American clients for delivery and after their baby arrives.
	Perinatal Support Washington: https://perinatalsupport.org/	Perinatal Support Washington (PS-WA) is a statewide non-profit committed to shining a light on perinatal mental health to support all families and communities. We support people in the emotional transition to parenthood, including those experiencing depression, anxiety, loss, infertility, trauma, and more. Our toll-free telephone support line, the "Warm Line", has been operating since 1991, providing peer support to parents in need. We also offer mental health therapy, free and low-cost new parent support groups, culturally-matched peer support in King County, training and consultation for health care providers, and education and advocacy. We do all of this with the help of our dedicated staff, board members, and dozens of volunteers.