



Working together to improve health care quality, outcomes, and affordability in Washington State.

Perinatal Behavioral Health Report and Guidelines

TBD 2024

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Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous health care quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying health care services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix H** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid, and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

Bree Collaborative members identified perinatal behavioral health as a priority improvement area and convened a workgroup to develop evidence-informed standards. The workgroup met from January 2022 to January 2023.

See **Appendix I** for the workgroup charter and a list of members.

Background

The perinatal period, **defined here as including the time from conception until the end of the first year after birth, involves significant physiological and psychosocial change**¹. Pregnancy and parenting are life altering events that may result in new or increased behavioral health symptoms for the person who gave birth (i.e., gestational parent). Behavioral health diagnoses can be disruptive and concerning to the person experiencing them and have a negative impact on the fetus and newborn, as a strong predictor of infant health is the wellbeing of the parent². **The term behavioral health includes both mental health and alcohol or other substance misuse (e.g., opioids).**

Postpartum depression is common, impacting 10-15% of gestational parents with symptoms ranging from minimal to severely disruptive in self and infant care.^{2,3} In some more rare cases, postpartum depression can include psychosis.^{3,4} Rates of postpartum depression are higher among those with a pre-pregnancy depression diagnosis, who are American Indian/Alaska Native, who smoked during or after pregnancy, who experienced intimate partner violence before or during pregnancy, or whose infant died since birth.⁵ Postpartum anxiety disorders are also very common and estimated to occur in 21% of gestational parents postpartum.⁵ Mental health concerns in the perinatal period can increase risk for minimal or absent prenatal care, and depression, anxiety and other mood disorder symptoms may increase in prevalence or severity postpartum.⁶ When not addressed, there is an increased incidence of adverse outcomes including preterm birth, low birth weight for neonates, impaired bonding, and difficulty with mood regulation for offspring later in childhood.⁷

Pregnant and postpartum individuals with mental health concerns are at greater risk for substance use and abuse.⁸ Alcohol and substance use during the perinatal period, especially during pregnancy, is likely underreported and can cause psychological harm to the fetus.⁹ Survey data shows about 6% of pregnant people using drugs other than those prescribed, 8.5% drinking alcohol, 16% smoking, and about 2.5% receiving at least one opioid prescription.^{10,11} Perinatal opioid use has increased as in the general population.¹²

Pregnant and postpartum individuals have more frequent interactions with the healthcare system but are less likely to receive adequate care for behavioral health conditions compared with the general population.¹³ To adequately meet patient needs and population health goals, behavioral healthcare should be integrated into all settings where perinatal people interact with the healthcare system and providers. Perinatal behavioral health screening effectiveness is contingent on availability of adequate follow up and treatment options for those who screen positive.¹⁴ Behavioral health integration improves efficacy of referrals, reduce barriers to treatment and improve outcomes for perinatal individuals.^{15 16 17} When full integration is not possible, at a minimum perinatal providers should have a follow Screening, Brief Intervention and Referral to Treatment (SBIRT) protocols that provide early identification and intervention.

This guideline was informed by Agency for Healthcare Research and Quality (AHRQ) topic brief on [Pregnant and Postpartum Behavioral Health Integration](#) and draws on and supplements the Bree Collaborative's report on [Behavioral Health Integration](#) into primary care. These guidelines also draw from the Collaborative Care Model, developed by the UW AIMS Center, that has had significant success identifying and treating depression in perinatal clinics, decreasing racial disparities in screening and referral to treatment, and can be adapted for use in rural settings.¹⁸ The AIMS Center uses five principles to define Collaborative Care, see more [here](#). This guideline also supplements The American College of

Obstetricians and Gynecologist (ACOG) and [American Academy of Pediatrics](#) screening guidance for perinatal behavioral health, and [The American College of Obstetricians and Gynecologists \(ACOG\) consensus bundle](#) on maternal mental health for perinatal depression and anxiety including general guidance for onsite screening, intervention, referral, and follow-up.^{19, 20}

Behavioral health treatment in the perinatal period should be informed by symptom severity and patient preference. In most cases, mild to moderate depression and anxiety can be managed in the perinatal setting while patients with more severe symptoms or diagnoses may require a referral to specialty behavioral health. For individuals with opioid use disorder (OUD), most pregnant individuals should remain on medications for OUD (MOUD) as it prevents relapse and potential further harm to parent and child.²¹ If prenatal providers opt to refer patients out for specialty mental health treatment, attempts should be made to track these referrals as evidence suggests that less than 20% of patients follow up on specialty behavioral health referrals.²² For patients with opioid use disorder, providers should follow the Committee on Obstetric Practice and American Society of Addiction Medicine joint opinion [Opioid Use and Opioid Use Disorder in Pregnancy](#) and the most updated Bree Collaborative Report on [Opioid Use Disorder Treatment](#).

The Perinatal Behavioral Health topic was selected by Bree Collaborative members in September 2022 and a workgroup of clinical and community experts met from January 2022 to January 2023. The Bree recommendation focus areas are organized around identifying a person with or at risk for perinatal behavioral health needs and ensuring they receive appropriate treatment and follow-up care. To identify focus areas, the workgroup relied on existing guidelines from ACOG, American Academy of Pediatrics (AAP), Agency for Healthcare Research and Quality, available evidence, and expert opinion.

Focus Areas (informed by AHRQ guidelines)²³

Focus Area	Action Steps
Education and communication	<ul style="list-style-type: none">• Communication between patient and provider• Patient education• Public health education
Integrated behavioral health	<ul style="list-style-type: none">• Universal Screening, Brief Intervention, and Referral to Treatment protocols.• Integration of behavioral health (e.g., collaborative care), co-located care, referral systems and/or community linkages to higher levels of behavioral health care• Coordinated treatment for pregnant and postpartum individuals experiencing substance use disorders.
Care coordination	<ul style="list-style-type: none">• Operational systems for quick coordination and triage.• Care coordinators'/peer navigators' role and integration
Community linkages to social programs	<ul style="list-style-type: none">• Referral pathways to community-based resources and organizations• Partnerships with community.
Expanded team roles	<ul style="list-style-type: none">• Roles of community-based/additional perinatal providers in supporting perinatal behavioral health.• Expanded reimbursement

These focus areas were synthesized into guidelines for each of the following audiences: Perinatal Care Providers, Providers and Clinics working with pediatric patients, Outpatient Perinatal Care Clinics and Facilities, Birthing Hospitals, Health Plans, Purchasers, Public Health Agencies, and the Washington State Legislature.

Guidelines

Perinatal Care Providers

- ☐ Consistently provide trauma-informed, patient-centered, and culturally humble perinatal care. Provide care in alignment with harm reduction principles. See **Appendix A: Culturally Humble Care**
 - Inquire about patient's mental health, life stressors and well-being, and ongoing healthcare in the postpartum period through trauma-informed, culturally humble care during each visit. Inquire about connection to community resources and birthing support, such as doulas. Connect to resources if wanted. See **Appendices B and C** for a non-exhaustive list.
- ☐ Explain the purpose of screening for depression, anxiety, suicidality, alcohol misuse, and substance use including the safety and security of the information to patients.
- ☐ Be aware of community and culturally aligned resources available to perinatal individuals. Educate patients on benefits that these resources can provide. See **Appendices B and C** for a non-exhaustive list.
- ☐ Screen every pregnant person for and/or review prior diagnoses of depression, anxiety, suicidality, and tobacco, marijuana, alcohol, and other substance use **at intake, at least every trimester, and at routine postpartum visits** using a **validated instrument(s)**, as recommended by the American Academy of Obstetricians and Gynecologists (ACOG) and the US Preventive Services Task Force (USPSTF); document in the medical record using structured data fields. Screening can be performed by another care team member as part of team-based care.
 - **Depression** (e.g., Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire-2, -3, or-9)
 - **Anxiety** (e.g., Generalized Anxiety Disorder-2, -7)
 - **Suicidality:** (e.g., if positive on PHQ-9 or EPDS use C-SSRS, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), or the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
 - **Bipolar Disorder:** (e.g., MDQ, CIDI or other validated instrument) at a minimum screen at **intake**. Ensure screening for bipolar disorder is completed before beginning pharmacological therapy for depression or anxiety.
 - **Tobacco, marijuana, alcohol** (e.g., AUDIT-C), **opioid use disorder** and **other substance use** (e.g., single-item screener, ASSIST, DAST-10, single item cannabis and other drug use questions.)

- ☐ If someone is undergoing active treatment for a behavioral health diagnosis, check for any contraindicated medication in pregnancy, coordinate with other providers, and do not unnecessarily stop treatment.
- ☐ If positive on screening, tailor brief intervention and treatment to screening results (see below). Provide warm handoff to specialty behavioral health if warranted based on results. Coordinate care with other providers.
 - **Depression and anxiety:** For mild depression and anxiety (depending on scale used), provide education and referral to therapy; for moderate-severe depression, provide therapy and/or medication management.
 - For clinical providers, follow the [American College of Obstetrician and Gynecologists' Guideline on the Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum](#).
 - Ensure patient is connected to evidence-based follow-up treatment using warm-handoff and direct follow-up if same-day treatment is not possible.
 - Prior to beginning pharmacotherapy for depression, screen for bipolar disorder using a validated instrument.
 - Provide contact and support during transitions of care.
 - **Bipolar Disorder:** do not unnecessarily discontinue mood stabilizers during pregnancy unless medication is contraindicated.
 - For clinical providers, follow the [American College of Obstetrician and Gynecologists' Guideline on the Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum](#).
 - Ensure patient is connected to evidence-based follow-up treatment using warm-handoff and direct follow-up if same-day treatment is not possible.
 - Provide contact and support during transitions of care.
 - **Suicide:** If suicide risk is detected, make [a suicide safety plan](#) and follow guidelines within the 2018 Bree Collaborative [Suicide Care Report and Recommendations](#), or more recent guidance if available. See **Appendix G** for an Example Suicide Safety Plan.
 - Ensure individuals at risk of suicide have pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment).
 - Keep patients in an acute suicidal crisis in an observed, safe environment.
 - Address lethal means safety (e.g., guns, medications).
 - Engage patients in collaborative safety planning.
 - If possible, involve family members or other key support people in suicide risk management.
 - Use effective evidence-based treatments provided onsite that directly target suicidal thoughts and behaviors (rather than focusing primarily on specific

- mental health diagnoses) through integrated behavioral health or off-site with a supported referral.
- Document patient information related to suicide care and referrals.
- Provide contact and support during transition from inpatient to outpatient sites, and from out-patient to no behavioral health treatment.
- Provide numbers for crisis resources (e.g., [988](#), [Native and Strong Lifeline](#), Maternal Mental Health Hotline 1-833-TLC-MAMA (1-833-852-6262), see **Appendix B** for more information)
- **Alcohol:** Educate on the risks of any alcohol exposure on the developing fetus. Use the Frequently Asked Questions from ACOG for assistance having a conversation about fetal alcohol spectrum disorders [here](#). No amount of alcohol is safe during pregnancy.
- **Tobacco:** Educate on the risks of tobacco use when pregnant. Counsel patient on benefit of smoking cessation. Follow ACOG guidance [here](#).
- **Other non-opioid drugs:** Follow ACOG's [Substance Use Disorder in Pregnancy](#) guidelines. Opioid use is covered separately and, in more detail, due to the availability of opioid agonist therapy.
- **Opioid use:** Provide counseling and education on pharmacotherapy for opioid use disorder, continued use of legal and illicit substances while pregnant, withdrawal from opioids while pregnant, and risks for pregnant person-baby dyad if relapse occurs.
 - **Start patients on opioid maintenance therapy** as early as possible in pregnancy to help reduce the severity of neonatal abstinence syndrome.
 - After a positive screen for opioid use disorder, medical examination and psychosocial assessment should be performed by a qualified provider.
 - Co-manage care for patients who are pregnant with opioid use disorder with a prenatal care provider and an addiction specialist as available.
 - Use a supported referral or warm handoff, such as reviewing the care plan in person or over the phone during handoff, to a setting offering methadone or buprenorphine and harm reduction related services rather than withdrawal management or abstinence. Hospitalization during initiation may be advisable.
 - Consider partial hospitalization or outpatient intensive programs such as the [PCAP program](#) as clinically appropriate.
 - For patients in need of hospitalization, consider a supported referral to Substance Using Pregnant People (SUPP) Program for individuals who are pregnant, covered through WA Apple Health and have a substance use history. See more details [here](#).
 - Follow SAMSHA's [Clinical Guidance for Treating Pregnant and Parenting Person With Opioid Use Disorder and Their Infants](#)

- ☐ Screen every pregnant or postpartum person at **initial prenatal visit, later in pregnancy, and postpartum visits** for Intimate Partner Violence (IPV), and social needs. Consider screening for adverse childhood experiences (ACEs). Educate the patient and support system on the purpose of screening for social determinants of health (SDOH), IPV and ACEs.
 - **IPV:** (e.g., [USPSTF referenced tools](#)) Follow [ACOGs recommendations](#) on framing statements, screening location, and patient education.
 - **Social Determinants of Health** (e.g., PRAPARE) Screen pregnant or postpartum person for SDOH needs utilizing a validated tool. Follow the Foundation for Health Care Quality's [Social Need Screening Report](#).
- ☐ **If positive**, tailor the care plan to results:
 - IPV: Follow [USPSTF recommendations](#) for components of effective ongoing support for IPV
 - SDOH: Follow Foundation for Health Care Quality's [Social Need Screening Report](#) and [Social Need Interventions Report](#) to support a person with identified SDOH needs.
- ☐ Identify and facilitate inclusion of external/community-based care coordinators or case managers in care planning.
 - For patients on **Medicaid (Apple Health)**, refer to Maternity Support Services (MSS) in the appropriate county for support, education, resources, and care coordination. See **Appendix C: Additional Support Services** for more information on MSS and other resources available.
- ☐ Educate patients on signs and symptoms of mental health concerns that may arise during pregnancy and after, the importance of integrated behavioral health care and how they can participate in care planning and shared decision-making. See the Center for Disease Control's (CDC) [Hear Her Campaign](#) for resources to support conversations.
- ☐ Consider sharing your identities in your professional bios to facilitate patients' ability to choose a racially and/or culturally concordant provider.
- ☐ Provide educational and community resources to patients to support perinatal and postpartum needs as appropriate. A non-exhaustive list is included in **Appendix E: Additional Support Services**

Providers and Clinics working with Pediatric Patients

- ☐ Consistently provide trauma-informed, patient-centered, and culturally humble perinatal care. Provide care in alignment with harm reduction principles. See **Appendix A: Culturally Humble Care**
 - Inquire about patient's mental health, life stressors and well-being, and ongoing healthcare in the postpartum period through trauma-informed, culturally humble care during each visit. Inquire about connection to community resources and support. Connect to resources if wanted. See **Appendix A for Culturally Humble Care** and **Appendices B and C** for a non-exhaustive list of resources.

- ☐ Explain the purpose of screening for depression, anxiety, suicidality, alcohol misuse, and substance use including the safety and security of the information to patients.
- ☐ Screen postpartum people for behavioral health concerns according to AAP, USPSTF, and Bright Futures guidelines of 1-, 2-, 4-, and 6-month well-child visit; continue screening through all 1-year well-child visits and consider continuing screening throughout all well-child visits after 1-year. Consider incorporating routine screenings for the Social Determinants of Health (SDOH), Intimate partner violence (IPV) and Adverse Childhood Experiences (ACEs) into well-child visits. Incorporate screenings into routine workflows. Example workflow for postpartum depression screening [here](#).
- ☐ If screenings are **negative**, provide education to pregnant or postpartum people and support system on signs and symptoms of behavioral health concerns that may arise after birth.
- ☐ If screenings are **positive**, develop a plan on the same day for intervention when perinatal mood disorders or other behavioral health concerns are identified AND provide education on signs and symptoms of behavioral health concerns that may arise after birth.
 - Inform and educate patients on findings, diagnosis, and resources to support them.
 - Consider and develop pathways to coordinate care with parent's postpartum clinician (e.g., obstetrician, family medicine, primary care provider).
 - Depression, anxiety and substance use can impact the relationship between child and caregiver: Assess relationship between child and caregiver and refer to [infant mental health specialist](#) for dyad treatment if necessary.
 - Connect the patient and parent with other care team members to support their referral to interventions for the further assessment and treatment of the parent, and community resources to the support of the parent-child dyad. Follow up with the parent within two weeks to ensure connection to appropriate treatment and resources.
- ☐ Track system-level data regarding screening for behavioral health and follow up. If system goals are not met, use quality improvement efforts to achieve screening and follow up goals and outcome standards

Outpatient Perinatal Care Clinics/Facilities

- ☐ Consistently provide trauma-informed, patient-centered, and culturally humble perinatal care from all staff (e.g., obstetricians, midwives, other clinicians, and other community service supporters of pregnant and postpartum people.) Provide care in alignment with harm reduction principles. See **Appendix A: Culturally Humble Care**
- ☐ Ensure that all staff who interact or treat pregnant and postpartum people understand and/or have received training on: (**see Appendix D: Provider and Allied Professionals Trainings for Training Resources**)
 - Trauma-informed care principles.
 - Harm reduction techniques.
 - Implicit bias and antiracism training.
 - Patient-centered care.
 - Gender-neutral/gender-inclusivity.
 - Mental health and substance use disorder among individuals who are pregnant and postpartum, and treatment protocols for individuals identified as experiencing these behavioral health concerns.
 - Protocols and procedures related to integration of behavioral health into perinatal care at their facility.
- ☐ Offer to connect perinatal patients to a racial, cultural or gender-identity concordant provider when possible.
- ☐ Educate patients on the role of doulas and other community birth supports. Facilitate doulas' inclusion in the care team when applicable and/or chosen by the patient.
- ☐ Develop a perinatal patient registry with the ability to track individuals from intake through 12 months postpartum. Use registry to track system level behavioral health screening, intervention and referrals. Consider stratifying the registry by interoperable REaL data, SOGI data and payer status to identify and track inequities. If system goals are not met, use quality improvement efforts to achieve screening and follow up goals and outcome standards.
- ☐ Integrate behavioral health into routine perinatal care. This can include integration of perinatal care into behavioral health settings, such as substance use disorder clinics, the full Collaborative Care Model that includes telehealth or virtual modalities for consultation and use of the registry, or other models of integrated care.
 - As resources allow, co-locate behavioral healthcare with perinatal care providers to allow for same-day interventions for behavioral health.
- ☐ Enable perinatal providers to provide care for mild behavioral health concerns by supporting training and continuing education on perinatal behavioral health.
- ☐ Facilitate communication and inclusion in care planning across members of the care team, including perinatal clinicians, community services, and behavioral health providers.
- ☐ Prior to implementing perinatal behavioral health screening, engage with multidisciplinary staff members and partner with program champions.

- ☐ Offer an easy-to-access specialty behavioral health referral list for perinatal providers to conduct a warm handoff.
- ☐ Establish protocols for screening, treatment and referral that follow most up-to-date clinical guidelines, align with onsite available resources and/or known community resources, and incorporate protocols into routine clinical practices during routine visits. Ensure screening is universally and equitably administered.
 - Include protocols and procedures for all prescribers to be empowered to prescribe medications for opioid use disorder, as an x waiver is no longer required to prescribe.
 - Consider including resources such as the [Perinatal Psychiatry Consultation Line](#) in protocols.
- ☐ Provide screening and educational materials in multiple languages at a 6th grade reading level.. Have screening accessible to complete online via patient portals prior to visits.
- ☐ Create systems for supported referrals to a setting offering methadone or buprenorphine rather than withdrawal management or abstinence. Hospitalization during initiation may be advisable.
- ☐ Develop pathways to address and consider individual social needs, such as transportation to and from clinics, connection to resources for food insecurity and housing instability. Follow Foundation for Health Care Quality Guidance on [Social Needs Intervention](#)
- ☐ Develop pathways to connect patients to existing public health resources such as First Steps through your local health jurisdiction.
- ☐ Develop protocols and procedures to support care team screening for intimate partner violence (IPV) according to [ACOG guidance](#), including providing private and safe setting for the birth parent alone for screening, integrating screening into routine protocols and providing available resources for providers and patients.
- ☐ Connect medical residents to providers currently providing perinatal behavioral health care.
- ☐ Change clinic/facility policy to address structural barriers in care.
 - Increase clinic hours to accommodate late or early appointments.
 - Create child-friendly waiting and examination rooms.
 - Adopt telehealth modalities of delivering care.
 - Provide translation and/or interpretation services to all patients.
- ☐ Develop capabilities to measure and track a set of performance measures related to behavioral health in the perinatal period.
 - Patient-reported outcome measures on perceived discrimination and mistreatment during pregnancy (e.g., PREM-OB).
 - Inequities in screening, treatment progress, referrals and outcomes by socioeconomic status and race/ethnicity.

Birthing hospitals

- ☐ Consistently provide trauma-informed, patient-centered, and culturally humble perinatal care from all staff (e.g., obstetricians, midwives, other clinicians, and other community service

supporters of pregnant and postpartum people.) Provide care in alignment with harm reduction principles. See **Appendix A: Culturally Humble Care**

- ☐ Ensure that all staff who interact or treat pregnant and postpartum people understand and/or have received training on: (**see Appendix D: Provider and Allied Professionals Trainings for Training Resources**)
 - Trauma-informed care principles.
 - Harm reduction techniques.
 - Implicit bias and antiracism training.
 - Patient-centered care.
 - Gender-neutral/gender-inclusivity.
 - Mental health and substance use disorder among individuals who are pregnant and postpartum, and treatment protocols for individuals identified as experiencing these behavioral health concerns.
 - Protocols and procedures related to integration of behavioral health into perinatal care at their facility.
- ☐ Align with requirements to become a [Birthing Center of Excellence from the DOH](#). Criteria are below:
 - Screen every person giving birth for substance use disorder with a validated screening tool upon admission.
 - Screen every person giving birth for perinatal mood and anxiety disorders (PMADS) with a validated screening tool upon admission (validated with the perinatal population)
 - Have a provider on-site with skills and scope to begin maintenance medications that treat OUD and/or adjust maintenance medications that treat OUD during labor and delivery and postpartum.
 - If the hospital does not have an on-site/on-call provider, there is a procedure in place to consult with a provider to initiate/adjust maintenance medications.
 - Allow birth parent and infant to room together, unless parent is in ICU or medical reasons other than neonatal abstinence syndrome for the infant to be in the neonatal intensive care unit (NICU).
- ☐ Consider participating in the Washington Health Care Authority's **Substance Using Pregnant People (SUPP) Program** for individuals who are pregnant, covered through Apple Health and have a substance use history. See more details [here](#).
- ☐ Connect medical residents to providers currently providing perinatal behavioral health care.
- ☐ Offer an easy-to-access specialty behavioral health referral list for providers to conduct a warm handoff at discharge.

Health Plans

- ☐ Include Certified Nurse Midwives (CNM) in network in addition to obstetricians and family medicine as perinatal care providers.
- ☐ Cover Licensed Midwives (LM) in addition to obstetricians and family medicine as perinatal care providers for low-risk pregnancies.
- ☐ Increase coverage for perinatal behavioral health services to reduce financial barriers to care, such as Medicaid programs offering behavioral health consultations.
- ☐ Increase availability and reimbursement for perinatal behavioral health services within OB and Pediatric clinics for improved access to services.
- ☐ Reimburse for
 - Doula support during the perinatal period.
 - Telehealth services
 - Perinatal providers and/or care teams to perform warm handoffs and shared referrals, including to settings offering methadone or buprenorphine.
- ☐ Consider pathways to reimburse for care coordination and warm handoffs between pediatricians and obstetrical care/primary care providers for identified behavioral health concerns or needs.
- ☐ Cover prescription naloxone at no cost-sharing.
- ☐ Consider and reimburse diverse models of perinatal care delivery to address perinatal behavioral health concerns. Potential models include:
 - Integrated Behavioral within Perinatal healthcare, including co-location of behavioral health services and Collaborative Care.
 - Home visits by nurse for perinatal care.
 - Group prenatal care
 - Telehealth modalities of care.
 - Community midwives
 - Community health workers
- ☐ Have a system to track behavioral health screening and referral rates of pregnant and postpartum members through 12 months postpartum, and track inequities in screening and referral by interoperable REaL data. Analyze the information to identify disparities and develop processes to address those disparities.
- ☐ Ensure an adequate provider network, including behavioral health professionals with expertise in perinatal behavioral health. Analyze utilization numbers to periodically verify network adequacy.
- ☐ Make provider biographical data easily accessible in provider directory to perinatal patients.
- ☐ Provide patient navigation services to support perinatal members finding perinatal and behavioral health care.
- ☐ Educate members on:
 - Signs and symptoms of behavioral health disorders including during the perinatal period.

- All options to manage the perinatal episode including the postpartum period, including an obstetrician, a certified nurse midwife, nurse midwives, family medicine and doulas. Appendix
- Patient navigation services to support perinatal members finding perinatal and behavioral healthcare, and other perinatal support services that are covered and/or free and available to them during the perinatal period.

- ☐ Develop pathways to address or consider individual social needs, such as transportation to and from clinics, food insecurity and housing instability. Follow [Foundation for Health Care Quality's recommendations](#) for developing and/or supporting resources for social needs.

Purchasers

- ☐ The Washington Health Care Authority (HCA) should work across systems, health professionals and agencies to increase access to perinatal integrated behavioral health, including facilitating care coordination between behavioral health providers, perinatal providers, and other members of the care team.
- ☐ Cover behavioral health consultation as part of perinatal health care and post-delivery in recognition of pregnancy being a significant life event.
- ☐ Cover diverse options for individuals to receive perinatal care so the member may choose care that best aligns with them and their desired birthing process, including individual providers (e.g., licensed midwives, certified nurse midwives, family practice, OB/Gyns, maternal fetal medicine specialists), care and delivery settings (hospital, freestanding birthing centers, home birth) and other
 - Educate members on the options available to them.
 - Expand coverage for community-based pregnancy and maternity care (e.g., midwives, home visits, group visits, community-based doulas)

Department of Health, Public Health Agencies and Urban Indian Health Organizations

- ☐ Increase education around perinatal behavioral health to reduce stigma and increase awareness of existing services.
 - Increase community education through partnerships with community organizations and public health agencies to reduce stigma and increase awareness.
- ☐ Increase access to community programs to support perinatal people with behavioral health conditions.
- ☐ Create education campaigns for the public on signs and symptoms of perinatal behavioral health concerns and where to go to receive care if a concern arises.
 - Collaborate across all public health care and social needs agencies (i.e. DSHS, DCYF, HCA, DOH, ESD, Commerce) in unified educational messaging
- ☐ Develop and support programs to address and consider individual social needs, such as transportation to and from clinics, food insecurity and housing instability. Follow [Foundation for Health Care Quality's recommendations](#) for developing and/or supporting resources for social needs.
 - Support or partner with community-based organizations to provide these services.

Washington State Legislature

- ☐ Fund the initial prenatal visit separately, including requiring behavioral health screening, social determinants of health (SDOH) screening and clinician face-to-face time in the initial obstetrical visit.

Bree Perinatal Behavioral Health Workgroup

Updated: November 13, 2023

Evidence Table		
Focus Area	Citation	Findings
General: Background and Resources	Howard LM, Khalifeh H. Perinatal mental health: a review of progress and challenges. <i>World Psychiatry</i> . 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.
	American College of Obstetricians and Gynecologists. Perinatal Mental Health Toolkit. https://www.acog.org/programs/perinatal-mental-health	ACOG provides resources related to patient screening, assessment and treatment, patient/provider education, and even a guide to integrating mental health care into obstetrical practice.
	HealthAffairs October 2021 Issue on Perinatal Mental Health. https://www.healthaffairs.org/maternal-health-and-perinatal-mental-health	The October 2021 issue of HealthAffairs offers several Perinatal Mental Health articles, including some focusing on policy and programs to expand access to care.
	Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma18-5054.pdf	SAMHSA provides clinical guidance for treating Pregnant and Postpartum women with Opioid Use Disorder and their Infants
	The Academy - Agency for Healthcare Research and Quality (AHRQ). (n.d.). Teaching Patients: Integrated Ambulatory Care. Retrieved from https://integrationacademy.ahrq.gov/playbooks/behavioral-health-and-primary-care/implementing-plan/educate-patients-and-families-about-integrated-ambulatory-care	The AHRQ provides guidance on educating patients and families on integrated behavioral and primary care.
	Harm Reduction Coalition. (2023). Pregnancy and Substance Use: A Harm Reduction Toolkit. Retrieved from https://harmreduction.org/issues/pregnancy-and-substance-use-a-harm-reduction-toolkit/#section2	The Harm Reduction Coalition partnered with the Academy of Perinatal Harm Reduction to develop a harm reduction toolkit for pregnant and parenting people that use drugs, their families and their service providers.
Integrated Behavioral Health – Universal Screening	Reilly N, Kingston D, Loxton D, Talcevska K, Austin MP. A narrative review of studies addressing the clinical effectiveness of perinatal depression screening programs. <i>Women Birth</i> . 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. <i>Obstet Gynecol</i> 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. <i>et al.</i> Screening programs for common maternal mental health disorders among perinatal women: report of the systematic review of evidence. <i>BMC Psychiatry</i> 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. <i>JAMA</i> . 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. <i>J Midwifery Womens Health</i> . 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.

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Declercq E, Feinberg E, Belanoff C. Racial inequities in the course of treating perinatal mental health challenges: Results from listening to mothers in California. <i>Birth</i> . 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. <i>Int J Integr Care</i> . 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. <i>Practitioner</i> . 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. <i>Dialogues Clin Neurosci</i> . 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) <i>Women's Reproductive Mental Health Across the Lifespan</i> . 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', <i>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</i> (New York, 2022; online edn, Oxford Academic, 1 Aug. 2022), https://doi.org/10.1093/med-psych/9780197545027.003.0010 , accessed 8 May 2023.	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
Murthy S, Hausslein 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. <i>J Perinatol</i> . 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. <i>Nurs Womens Health</i> . 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. <i>et al.</i> Perinatal depression screening practices in a large health system: identifying current state and assessing opportunities to provide more equitable care. <i>Arch Womens Ment Health</i> 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. <i>Pediatrics</i> . 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. <i>Matern Child Health J</i> . 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. <i>Curr Probl Pediatr Adolesc Health Care</i> . 2017 Oct;47(10):267-277. doi: 10.1016/j.cppeds.2017.08.001. Epub 2017 Sep 12. PMID: 28916453.	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 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	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

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	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.	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.
	Wright T, Terplan M, Ondersma S, Boyce C, Yonkers K, Chang C, Creanga A. 2016. The role of screening, brief intervention, and referral to treatment in the perinatal period. American Journal of Obstetrics and Gynecology. DOI: http://dx.doi.org/10.1016/j.ajog.2016.06.038	Substance use during pregnancy is at least as common as many of the medical conditions screened for and managed during pregnancy. While harmful and costly, it is often ignored or managed poorly. Screening, brief intervention, and referral to treatment is an evidence-based approach to manage substance use. In September 2012, the US Centers for Disease Control and Prevention convened an Expert Meeting on Perinatal Illicit Drug Abuse to help address key issues around drug use in pregnancy in the United States. This article reflects the formal conclusions of the expert panel that discussed the use of screening, brief intervention, and referral to treatment during pregnancy. Screening for substance use during pregnancy should be universal. It allows stratification of women into zones of risk given their pattern of use. Lowrisk women should receive brief advice, those classified as moderate risk should receive a brief intervention, whereas those who are high risk need referral to specialty care. A brief intervention is a patient-centered form of counseling using the principles of motivational interviewing. Screening, brief intervention, and referral to treatment has the potential to reduce the burden of substance use in pregnancy and should be integrated into prenatal care.
	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.
	Association of Maternal and Child Health Programs. 2020. Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Pregnant and Postpartum Women. AMCHP, NASADAD. Accessed June 21, 2023. https://amchp.org/wp-content/uploads/2022/01/AMCHP-NASADAD-SBIRT-Issue-Brief-October-2020.pdf	Screening for substance use during perinatal health care visits provides a unique opportunity to intervene in a positive way with women who use substances. During the perinatal period, pregnant women are highly motivated to stop using substances and deliver healthy babies.1, 2, 3A The significant life changes that occur during the postpartum period can cause depression and an increased risk of substance use.4 Studies show that early detection through screening can prevent the progression of substance use disorders and decrease the likelihood of serious consequences of substance use.5, 6, 7
	Allen C, Van C, Mossburg S. 2023. Maternal Safety and Perinatal Mental Health. Agency for Healthcare Research and Quality Patient Safety Network. Accessed June 21, 2023. https://psnet.ahrq.gov/perspective/maternal-safety-and-perinatal-mental-health	Perinatal mental health refers to the mental health of individuals during pregnancy and the first year after giving birth. It is an essential aspect of maternal healthcare.1 Maternal safety considerations for perinatal mental health are important because untreated mental health problems can have serious consequences for both the mother and the child. Reports of the prevalence and incidence of these conditions vary; one study estimates that roughly 9% of pregnant individuals experience a perinatal mental health condition though this may be lower than actual values given the challenges with access to data.2 These conditions include a wide range of mood and anxiety disorders, including depression, anxiety, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, and postpartum psychosis. If not addressed, perinatal mood and anxiety disorders can lead to significant negative outcomes for both patients and their children.
Education and Communication	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 color 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 Oct;53(10):863-71. doi: 10.1097/MLR.0000000000000411. PMID: 26340663; PMCID: PMC4570858.	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 questions and

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		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, McCoy JLM, Curran L, Harmon C. Medically high-risk pregnancy: Women's perceptions of their relationships with health care providers. <i>Soc Work Health Care</i> . 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. <i>J Midwifery Womens Health</i> . 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. <i>Am J Obstet Gynecol MFM</i> . 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. <i>Anesthesiol Clin</i> . 2021 Dec;39(4):779-791. doi: 10.1016/j.andclin.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. <i>J Obstet Gynecol Neonatal Nurs</i> . 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. <i>Clin Obstet Gynecol</i> . 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. <i>Obstet Gynecol</i> . 2017 Mar;129(3):422-430. doi: 10.1097/AOG.0000000000001902. Erratum in: <i>Obstet Gynecol</i> . 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. <i>Matern Child Health J</i> . 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. <i>Soc Sci Med</i> . 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. <i>Social Science & Medicine</i> . 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 pregnancy. <i>Journal of Patient</i>	The survey collected information from 14 mothers, of whom 9 had a racially discordant relationship with their physician and 5 had a racially concordant relationship. Due to the small sample size for evaluating the patient-provider relationship, we cannot

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	Experience. 2022. 9(1-6). https://journals.sagepub.com/doi/pdf/10.1177/23743735221077522	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, Angelsjö L, Berg G, Ekström CM, Gunnervik C, Nordin C, Sydsjö G. Obstetric, somatic, and demographic risk factors for postpartum depressive symptoms. <i>Obstet Gynecol</i> . 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". <i>Birth</i> . 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, Pephrah-Wilson S, Larson E. Perspectives on cultural competency and race concordance from perinatal patients and community-based doulas. <i>Birth</i> . 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. <i>Matern Child Health J</i> . 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, McEmore MR, Oseguera T, Lyndon A, Franck LS. Listening to Women: Recommendations from Women of Color to Improve Experiences in Pregnancy and Birth Care. <i>J Midwifery Womens Health</i> . 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. <i>Matern Child Health J</i> . 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, McEmore MR. Clinicians' Perspectives on Racism and Black Women's Maternal Health. <i>Womens Health Rep (New Rochelle)</i> . 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. <i>Nurs Womens Health</i> . 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. <i>Obstet Gynecol</i> . 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.
Integrated Behavioral Health	Hans SL, Edwards RC, Zhang Y. Randomized Controlled Trial of Doula-Home-Visiting Services: Impact on Maternal and Infant Health. <i>Matern Child Health J</i> . 2018 Oct;22(Suppl 1):105-113. doi: 10.1007/s10995-018-2537-7. Erratum in: <i>Matern Child Health J</i> . 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. <i>Cochrane Database Syst Rev</i> . 2017 Aug 2;8(8):CD009326. doi: 10.1002/14651858.CD009326.pub3. Update in: <i>Cochrane Database Syst Rev</i> . 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 individualized 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. <i>Cochrane Database Syst Rev</i> . 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. Individualized 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 utilization. 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.

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McNaughton DB. Nurse home visits to maternal-child clients: a review of intervention research. <i>Public Health Nurs.</i> 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, Dowsell T. Psychosocial and psychological interventions for preventing postpartum depression. <i>Cochrane Database Syst Rev.</i> 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. <i>Prim Health Care Res Dev.</i> 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. <i>MedGenMed.</i> 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. <i>Mil Med.</i> 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. <i>Am J Obstet Gynecol.</i> 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, Otekinrin A, LaBoy A, Britt JL, Crockett AH. Well Child Visit Attendance for Group Prenatal Care Participants. <i>Acad Pediatr.</i> 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. <i>Arch Womens Ment Health.</i> 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, Hussein RE, Carpino S, Hartman S. Group Prenatal Care: A Financial Perspective. <i>Matern Child Health J.</i> 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. <i>BMC Pregnancy Childbirth.</i> 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. <i>Matern Child Health J.</i> 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. <i>Cochrane Database Syst Rev.</i> 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 trials 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.
Perrella SL, Mirauda J, Rea A, Geddes DT, Prosser SA. Maternal Evaluation of a Team-Based Maternity Care Model for Women of Low Obstetric Risk. <i>J Patient Exp.</i> 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.

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	Melville et al; Improving Care for Depression in Obstetrics and Gynecology: A Randomized Controlled Trial	Two-site randomized controlled trial included screen-positive women (Patient Health Questionnaire-9 of at least 10) who then met criteria for major depression, dysthymia or both (Mini-International Neuropsychiatric Interview). Women were randomized to 12 months of collaborative depression management or usual care; 6, 12 and 18-month outcomes were compared. The primary outcomes were change from baseline to 12-months on depression symptoms and functional status. Secondary outcomes included at least 50% decrease and remission in depressive symptoms, global improvement, treatment satisfaction, and quality of care. RESULTS—Participants were on average 39 years old, 44% were non-white and 56% had posttraumatic stress disorder. Intervention (n= 102) compared to usual care (n=103) patients had greater improvement in depressive symptoms at 12 months (P< .001) and 18 months (P=.004). The intervention group compared with usual care had improved functioning over 18 months (P< .05), were more likely to have an at least 50% decrease in depressive symptoms at 12 months (relative risk [RR]=1.74, 95% confidence interval [CI] 1.11–2.73), greater likelihood of at least 4 specialty mental health visits (6 month RR=2.70, 95% CI 1.73–4.20; 12 month RR=2.53, 95% CI 1.63–3.94), adequate dose of antidepressant (6-month RR=1.64, 95% CI 1.03–2.60; 12-month, RR=1.71, 95% CI 1.08 2.73), and greater satisfaction with care (6-month RR=1.70, 95% CI 1.19–2.44; 12-month RR=2.26, 95% CI 1.52–3.36). CONCLUSION—Collaborative depression care adapted to women’s health settings improved depressive and functional outcomes and quality of depression care.
	Delivering perinatal depression care in a rural obstetric setting: a mixed methods study of feasibility, acceptability and effectiveness	Objectives: Universal screening for depression during pregnancy and postpartum is recommended, yet mental health treatment and follow-up rates among screen-positive women in rural settings are low. We studied the feasibility, acceptability and effectiveness of perinatal depression treatment integrated into a rural obstetric setting. Methods: We conducted an open treatment study of a screening and intervention program modified from the Depression Attention for Women Now (DAWN) Collaborative Care model in a rural obstetric clinic. Depression screen-positive pregnant and postpartum women received problem-solving therapy (PST) with or without antidepressants. A care manager coordinated communication between patient, obstetrician and psychiatric consultant. We measured change in the Patient Health Questionnaire 9 (PHQ-9) score. We used surveys and focus groups to measure patient and provider satisfaction and analyzed focus groups using qualitative analysis. Results: The intervention was well accepted by providers and patients, based on survey and focus group data. Feasibility was also evidenced by recruitment (87.1%) and retention (92.6%) rates and depression outcomes (64% with >50% improvement in PHQ 9) which were comparable to clinical trials in similar urban populations. Conclusions for practice: DAWN Collaborative Care modified for treatment of perinatal depression in a rural obstetric setting is feasible and acceptable. Behavioral health services integrated into rural obstetric settings could improve care for perinatal depression
	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.
	Miller ES, Jensen R, Hoffman MC, Osborne LM, McEvoy K, Grote N, Moses-Kolko EL. (2020) Implementation of perinatal collaborative care: a health services approach to perinatal depression care. Primary Health Care Research & Development 21(e30): 1–9. doi: 10.1017/S1463423620000110	Aim: Our objective was to integrate lessons learned from perinatal collaborative care programs across the United States, recognizing the diversity of practice settings and patient populations, to provide guidance on successful implementation. Background: Collaborative care is a health services delivery system that integrates behavioral health care into primary care. While efficacious, effectiveness requires rigorous attention to implementation to ensure adherence to the core evidence base. Methods: Implementation strategies are divided into three pragmatic stages: preparation, program launch, and program growth and sustainment; however, these steps are non-linear and dynamic. Findings: The discussion that follows is not meant to be prescriptive; rather, all implementation tasks should be thoughtfully tailored to the unique needs and setting of the obstetric community and patient population. In particular, we are aware that implementation on the level described here assumes commitment of both effort and money on the part of clinicians, administrators, and the health system, and that such financial resources are not always available. We conclude with synthesis of a survey of existing collaborative care programs to identify implementation practices of existing programs
	Increased Depression Screening and Treatment Recommendations After Implementation of a Perinatal Collaborative Care Program	Objective: The study evaluated whether implementation of perinatal collaborative care is associated with improvements in screening and treatment recommendations for perinatal depression by obstetric clinicians. Methods: This cohort study, conducted from January 2015 to January 2019, included all women who received prenatal care in five obstetric clinics and delivered at a single quaternary care hospital in Chicago. In January 2017, a perinatal collaborative care program (COMPASS) was implemented. Completion of depression screening and recommendations for treatment following a positive depression screen were compared before and after COMPASS implementation. Adjusted analyses included inverse probability weighting by using propensity scores to impose control over imbalance between exposure groups with respect to prespecified covariates. Results: A total of 7,028 women were included in these analyses: 3,227 (46%) before and 3,801 (54%) after COMPASS implementation. Women who received obstetric care after implementation were significantly more likely than those who received care before implementation to receive antenatal screening for depression (81% versus 33%; adjusted odds ratio [aOR] 58.5, 95% confidence interval [CI] 57.6–9.5). After implementation, women with a positive antenatal screen for depression were more likely to receive a

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		treatment recommendation (61% versus 44%; aOR52.1, 95% CI51.2–3.7). After implementation of perinatal collaborative care, combined psychotherapy and pharmacotherapy were more frequently recommended, compared with before implementation. Conclusions: Implementation of a perinatal collaborative care program was associated with improvements in perinatal depression screening and recommendations for treatment by obstetric clinicians
	Associations Between Implementation of the Collaborative Care Model and Disparities in Perinatal Depression Car	OBJECTIVE: To evaluate whether perinatal collaborative care model implementation was associated with a reduction in racial disparities in depression care. METHODS: This retrospective cohort study included pregnant and postpartum people who self-identified as either Black or White, and received prenatal care at academic faculty offices affiliated with an urban quaternary medical center. Individuals were divided into two cohorts to reflect the epochs of implementation. The primary outcome was the frequency of depression screening. The secondary outcome was the frequency of provision of a treatment recommendation for those with a positive depression screen. Antenatal and postpartum care were analyzed separately. A propensity score was used in multivariable models to control for confounders chosen a priori across implementation epoch. Interaction terms were created between race and implementation epoch to identify whether effect modification was present. Subgroup analyses were performed for outcomes with significant race-by-epoch interaction terms. RESULTS: Of the 4,710 individuals included in these analyses, 4,135 (87.8%) self-identified as White and 575 (12.2%) self-identified as Black. Before implementation, Black individuals were more likely to receive screening (adjusted odds ratio [aOR] 2.44) but less likely to have a treatment recommended when a positive screen was identified (aOR 0.05). In multivariable models, race-by-epoch interaction terms were significant for both antenatal screening (P.001) and antenatal treatment recommendation (P5.045), demonstrating that implementation of the perinatal collaborative care model was associated with reductions in extant racial disparities. After implementation, there were no significant differences by race (referent5White) in screening for antenatal depression (aOR 1.22, 95% CI 0.89–1.68) or treatment recommendations for those who screened positive (aOR 0.64, 95% CI 0.27– 1.53). Race-by-epoch interaction terms were not significant in multivariable models for either postpartum screening or treatment recommendation. CONCLUSION: Implementation of the perinatal collaborative care model is associated with a mitigation of racial disparities in antenatal depression care and may be an equity-promoting intervention for maternal health.
	A Systematic Review of Integrated Care Interventions Addressing Perinatal Depression Care in Ambulatory Obstetric Care Settings	This systematic review searched 4 databases (PubMed/MEDLINE, Scopus, CINAHL, and PsychINFO) and identified 21 articles eligible to evaluate the extent to which interventions that integrate depression care into outpatient obstetric practice are feasible, effective, acceptable, and sustainable. Despite limitations among the available studies including marked heterogeneity, there is evidence supporting feasibility, effectiveness, and acceptability. In general, this is an emerging field with promise that requires additional research. Critical to its real-world success will be consideration for practice workflow and logistics, and sustainability through novel reimbursement mechanisms
	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-centered care through organizational 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.

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		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. <i>J Psychiatr Res.</i> 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. <i>J Med Internet Res.</i> 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. <i>J Midwifery Womens Health.</i> 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. <i>Curr Psychiatry Rep.</i> 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. <i>Prim Care Companion CNS Disord.</i> 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. <i>Am J Obstet Gynecol MFM.</i> 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. <i>J Perinat Med.</i> 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. <i>Gen Hosp Psychiatry.</i> 2023 May-Jun;82:75-85. doi: 10.1016/j.genhosppsy.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. <i>Psychiatr Serv.</i> 2022 Jan 1;73(1):116-117. doi: 10.1176/appi.ps.2021.73102. PMID: 34974744.	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

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	(This is not a single article, but a full Edition of the journal Psychiatric Services, which includes several articles on perinatal mental health access and concerns)	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. <i>Kans J Med</i> . 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.
	Phan J, Liu HH, Yasui M, Liu CH. Psychosocial and healthcare experiences among women with pre-pregnancy mental health concerns. <i>Arch Psychiatr Nurs</i> . 2019 Apr;33(2):196-202. doi: 10.1016/j.apnu.2019.01.007. Epub 2019 Jan 24. PMID: 30927990; PMCID: PMC6668341.	The lifetime prevalence of major depressive disorder in women is approximately 20% within the U.S., with its onset occurring most among women of childbearing age (20–40 years) (Marcus & Heringhausen, 2009). It is well established that a history of mental illness is a risk factor for mental health concerns during and after pregnancy (Beck, 2001; Bina & Harrington, 2017; Marcus, Flynn, Blow, & Barry, 2003; Robertson, Grace, Wallington, & Stewart, 2004). However, only a small number of women who meet criteria for major depressive disorders seek treatment with many women remaining undiagnosed and untreated (Ko, Farr, Dietz, & Robbins, 2012). Thus, there is a need to better understand whether a history of depression prior to pregnancy is related to a variety of negative outcomes in the prenatal and postpartum periods such as increased psychiatric attention during the prenatal period.
	Lee-Carbon L, Nath S, Trevillion K, Byford S, Howard LM, Challacombe FL, Heslin M. Mental health service use among pregnant and early postpartum women. <i>Soc Psychiatry Psychiatr Epidemiol</i> . 2022 Nov;57(11):2229-2240. doi: 10.1007/s00127-022-02331-w. Epub 2022 Jul 29. PMID: 35902425; PMCID: PMC9636080.	Only a third of women with a diagnosable mental disorder at their first antenatal appointment had any contact with mental health services during pregnancy or up to 3 months postpartum. Further research is warranted to elicit perinatal women's views about the potential barriers to accessing professional mental health care.
	Washington State Health Care Authority: Maternal Care and Medicaid https://www.hca.wa.gov/about-hca/programs-and-initiatives/clinical-collaboration-and-initiatives/maternal-care-model	
	Sudhof L, Shah NT. In Pursuit of Value-Based Maternity Care. <i>Obstet Gynecol</i> . 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.
	Foster VA, Harrison JM, Williams CR, Asiodu IV, Ayala S, Getrouw-Moore J, Davis NK, Davis W, Mahdi IK, Nedhari A, Niles PM, Peprah S, Perritt JB, McLemore MR, Mask Jackson F. Reimagining Perinatal Mental Health: An Expansive Vision For Structural Change. <i>Health Aff (Millwood)</i> . 2021 Oct;40(10):1592-1596. doi: 10.1377/hlthaff.2021.00805. PMID: 34606355; PMCID: PMC9107292.	Developing relevant policies for perinatal mental health thus requires attending to the intersecting effects of racism, poverty, lack of child care, inadequate postpartum support, and other structural violence on health. To fully understand and address this issue, we use a human rights framework to articulate how and why policy makers must take progressive action toward this goal. This commentary, written by an interdisciplinary and intergenerational team, employs personal and professional expertise to disrupt underlying assumptions about psychosocial aspects of the perinatal experience and reimagines a new way forward to facilitate well-being in the perinatal period.
	Mind the Gap: A Strategic Roadmap to Address America's Silent Health Crisis: Untreated and Unaddressed Perinatal Mental Health Disorders, Led by Postpartum Support International. Accessed June 21, 2023. Retrieved from Mind the Gap National Report	There is significant evidence that Perinatal Mental Health is a national public health issue seriously impacting the health and well-being of mothers, infants, fathers, partners, families and the broader community. Leading national organizations have issued guidance and statements on screening and follow-up care, national groups have convened in dialogue to discuss critical areas resulting in reports, and some key states have issued recommendations that are paving the way for change. However, still absent from these important efforts is a national framework and strategic action plan. In 2019, Postpartum Support International and The Reilly Group conducted an in-depth analysis of the available data and reports to begin the process of framing a collective response
	Griffen A, McIntyre L, Belsito JZ, Burkhard J, Davis W, Kimmel M, Stuebe A, Clark C, Meltzer-Brody S. 2021. Perinatal Mental Health Care in the United States: An Overview of Policies and Programs. <i>HealthAffairs</i> . 40(10). DOI: https://doi.org/10.1377/hlthaff.2021.00796	In the United States, mental health conditions are the most common complications of pregnancy and childbirth, and suicide and overdose combined are the leading cause of death for new mothers. Although awareness of and action on perinatal mental health is increasing, significant gaps remain. Screening and treatment are widely recommended but unevenly implemented, and policies and funding do not adequately support the mental health of childbearing people. As a result, treatable perinatal mental health conditions can have long-term, multigenerational negative consequences. This article provides an overview of the perinatal mental health landscape in the United States by identifying serious gaps in screening, education, and treatment; describing recent federal and state policy efforts; highlighting successful models of care; and offering recommendations for robust and integrated perinatal mental health care.
	Counts NZ, Kuklinski MR, Wong V, Feinberg ME, Creedon TB. Comparison of Estimated Incentives for Preventing Postpartum Depression in Value-Based Payment Models Using the Net Present Value of Care vs Total Cost of Care. <i>JAMA Netw Open</i> . 2022;5(4):e229401. doi:10.1001/jamanetworkopen.2022.9401	In this decision analytical model with a simulated cohort of 1000 pregnant individuals enrolled in Medicaid, sharing estimated savings offered more than double the financial incentives for clinicians to prevent postpartum depression than traditional VBP models, assuming continuous health insurance coverage (ie, no churn). This incentive decreased as rates of annual health insurance churn increased. These findings suggest that VBP models that share expected future savings may offer greater

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		incentives for implementing interventions that prevent postpartum depression, but additional policy action is needed to address challenges posed by health insurance churn.
	Medicaid.gov Maternal and Infant Health Initiative Value-Based Payment. https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/functional-areas/value-based-payment/maternal-infant-health-initiative-value-based-payment/index.html	Medicaid offered technical assistance to state agencies (Colorado, Maine, Mississippi, and Nevada) to implement value-based payments in maternal and infant health. This site provides more information about their resources and assistance.
	Institute for Medicaid Innovation. 2023. Innovation in Perinatal and Child Health in Medicaid: Investing in the Prenatal-to-Three Framework to Support Communities and Advance Equity. Institute for Medicaid Improvement. Accessed June 21, 2023. https://medicaidinnovation.org/wp-content/uploads/2023/04/IMI-2023-Innovation-in-Perinatal-and-Child-Health-in-Medicaid-FINAL.pdf	IMI conducted a national review of practices and policies implemented to effectively leverage Medicaid to improve prenatal, perinatal, neonatal, and 12-month postpartum outcomes. The goal was to elevate examples of innovation, particularly partnerships between Medicaid health plans with community-based organizations (CBOs) to inform comprehensive and sustainable models and policies grounded in health equity. The prenatal-to-age-three framework provides the backdrop for the report, followed by a grounding in the policy landscape for perinatal and child health in Medicaid.
	Maternal Mental Health and State Medicaid Agencies (various links)	California: AB 3032/AB 2193 Washington: During Pregnancy , After Pregnancy
	National Academy for State Health Policy. 2019. State Medicaid Policies for Identifying Maternal Depression During Well-Child Visits. Accessed June 22, 2023. https://nashp.org/wp-content/uploads/2019/01/Maternal-Depression-Fact-Sheet.pdf	This (now slightly outdated) sheet contains information ONLY about states requiring perinatal depression screening in fee for service and whether or not those organizations require or recommend specific screening tools.
	Rosenbaum S, Markus AR, Murphy C, Morris R, Casoni M, Johnson K. 2023. The Road to Maternal Health Runs Through Medicaid Managed Care. The Commonwealth Fund. Accessed June 22, 2023. https://www.commonwealthfund.org/blog/2023/road-maternal-health-runs-through-medicaid-managed-care	To address the maternal health crisis, state Medicaid programs must work with managed care plans to adopt a “continuum” approach to maternal health. Medicaid covered 42% of all US births in 2020 and must play a central role in any redesign of maternal health care delivery.
	White House. 2022. White House Blueprint for Addressing the Maternal Health Crisis. Published June 2022. Accessed June 22, 2023. https://www.whitehouse.gov/wp-content/uploads/2022/06/Maternal-Health-Blueprint.pdf	Congress should also require all states to provide continuous Medicaid coverage for 12 months postpartum (currently, states are only required to provide pregnancy-related Medicaid coverage for 60 days postpartum) and make significant investments in other efforts that reduce maternal morbidity and mortality, including the \$470 million in the Fiscal Year (FY) 2023 President’s Budget. This funding will expand maternal health initiatives in rural communities; implement implicit bias training for health care providers; create pregnancy medical home demonstration projects; address the highest rates of perinatal health disparities, including by supporting the perinatal health workforce; strengthen data collection and evaluation; and address behavioral health disorders.
	Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care	Integrating behavioral health into primary care is an important way to increase access to effective behavioral health treatment while maximizing the capacity of our very limited behavioral health workforce. There are many approaches to integration, but the Collaborative Care Model (CoCM) has the most robust evidence base, especially for anxiety and depression. ¹ Compared to the usual primary care approach to managing behavioral health needs, in which a provider either refers the patient to a specialist or manages needs on their own, CoCM offers supports for the providers and delivers superior clinical outcomes for common, less complex behavioral health conditions
Community Linkages and Expanded Team Roles	The Perigee 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: <ul style="list-style-type: none"> • 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

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	US Department of Health and Human Services: Mom's Mental Health Matters: https://www.nichd.nih.gov/ncmhhep/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.

Appendix A Culturally Humble Care

Culturally humble care is an essential component of providing effective, patient-centered perinatal care. Cultural humility in healthcare emphasizes the importance of acknowledging power imbalances, practicing self-reflection and developing partnerships in healthcare delivery, as opposed to cultural competence which emphasizes the acquisition of knowledge and skills related to different cultures. It, “incorporates elements of self-questioning, immersion into an individual patient’s point of view, active listening and flexibility, which all serve to confront and address personal and cultural biases or assumptions.”²⁴ When healthcare providers approach patient care in this way, the professional nurtures communication between them and their patients, allowing for the development of shared goals and patient-centeredness in all interactions and activities. Cultural humility relies on a life-long learning process in which a provider is “flexible and humble enough to assess anew the cultural dimensions of the experiences of each [person].”³⁰ Rather than having a static endpoint, self-questioning and self-critique, and active listening become part of the process.²⁵

Person-centered care starts with the use of non-stigmatizing language in written materials and in personal encounters. The University of California San Francisco offers the resource for HIV #LanguageMatters: Addressing Stigma by Using Preferred Language available [here](#). Example: *Person living with HIV* rather than *HIV infected person*.²⁶

Abuse, violence, and other forms of trauma are widespread. The landmark 1998 study on adverse childhood experiences (ACEs) shows the high prevalence of ACEs across populations and links these experiences to a lifetime risk of poor health outcomes such as alcoholism, depression, heart disease, cancer, and obesity.²⁷ While children are highly sensitive to trauma, as seen through these later health impacts, trauma is also impactful for adults. Trauma-informed care is built on understanding a person’s individual life experiences (e.g., asking what has happened to you) and the need for clinical encounters to empower rather than re-traumatize a person.²⁸ The term was developed to integrate an understanding and strategies to mitigate trauma into delivery of behavioral health care and has since been adapted to physical health services and to delivery of integrated physical and behavioral health services.²⁹ Many of the individual elements have been regularly used in the delivery of care for decades including addressing a person’s distress, providing emotional support, encourages positive coping, but practice is ahead of literature and no best-practice guideline or widely used metric to track practitioner adherence to trauma-informed care exists.³⁰

Integrating trauma-related issues into counseling has had positive effects for survivors of physical and sexual abuse and shown reductions in mental health symptoms.³¹ In many cases, providers operate under the assumption that someone has experienced trauma without directly asking whether this is so, a universal precautions approach.³² Key aspects include fostering a person’s feeling of safety in the clinical encounter and developing a positive, trusting person-provider relationship. Trust is based in one party being vulnerable, such as through having an illness or a lower level of knowledge and believing the other party will care for their interests.³³ Fidelity, competency, honesty, and confidentiality are also dimensions of trust.³⁹

This workgroup does not endorse a single guideline for trauma-informed care as this care philosophy cannot be operationalized through a checklist, although checklists can serve as a starting point.

Many organizations have developed toolkits to support trauma-informed care. The Centers for Disease Control and Prevention lists six principles to a trauma-informed approach: ³⁴

- **Safety:** Staff and people receiving care feel physically and psychologically safe
- **Trustworthiness and transparency**
- **Peer support:** Those with lived experience of trauma as allies in recovery or using stories
- **Collaboration and mutuality:** Decision making is shared, power differentials among staff or between providers and people receiving care are reduced
- **Choice:** Empowerment and self-advocacy
- **Cultural, historical and gender issues:** Recognizing and addressing historical trauma, removing provider bias, care that is responsive to cultural background

Moving to a trauma-informed approach in a clinical setting starts with being trauma-aware, as the Substance Abuse and Mental Health Services Association (SAMHSA) does through their four Rs: ³⁵

- **Realization** that anyone may have experienced trauma and behavior can be understood as a coping strategy to address past trauma
- **Recognize** the signs of trauma
- **Respond** to the above through using a universal precautions approach (e.g., all people are approached as though they have experienced trauma)
- **Resist Re-traumatization** by seeking to not create toxic or stressful environments

While a universal trauma precautions approach negates the need for explicit trauma screening, some practices, such as pediatric practices, have found screening to be helpful. The American Academy of Pediatrics offers clinical assessment tools for people who have been exposed to violence [here](#), including adverse childhood experiences. The signs of trauma are diverse, varying from person to person, include emotional, physical, cognitive, and behavioral signs, and may change over time. ³⁶ A non-exhaustive list includes:

- Emotional: Emotional dysregulation anger, anxiety, sadness, and shame, numbing or detachment
- Physical: sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders
- Cognitive: Cognitive errors, misinterpreting situations as dangerous, excessive or inappropriate guilt, idealization, rationalization, delusions, intrusive thoughts or memories
- Behavioral: reenactments, self-harm or self-destructive behaviors

For individuals that use substances, harm reduction approaches are critical and evidence-based to improve outcomes and save lives. ³⁷ Harm reduction is, “a practical and transformative approach that incorporates community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives.” Harm reduction focuses on comprehensive prevention and continuity of care, emphasizing overdose education, and distribution of reversal medications.

The [Academy of Perinatal Harm Reduction](#) published a patient-facing [toolkit](#) on Pregnancy and Substance Use, updated in 2022, that provides education to parents on harm reduction while using

various substances, input on navigating the healthcare and legal systems, and considerations from prenatal through postpartum care periods.

Appendix B Behavioral Health Support Services

Pregnant people, their children and families may require supportive services to align person-centered pregnant person-dyad care with their social and physical needs, goals, values, capacities, and preferences. This section focuses primarily on support services related to behavioral health for pregnant and postpartum patients. These support services should be integrated into the birth plan and perinatal clinical care plan.

Partnership Access Line (PAL) for Moms: University of Washington (UW) Partnership Access Line for Moms (PAL for Moms) is a free telephone consultation service for health care providers caring for patients with mental health problems who are pregnant, postpartum, or planning pregnancy. Any health care provider in Washington State can receive consultation, recommendations, and referrals to community resources from a UW psychiatrist with expertise in perinatal mental health.

Psychiatrists provide consultation on any mental health-related question for patients who are pregnant, in the first year postpartum, who are planning pregnancy, or who have pregnancy-related complications (e.g. pregnancy loss, infertility). Topics may include depression, anxiety, or other psychiatric disorders; adjustment to pregnancy loss, complications, or difficult life events; risks of psychiatric medications; non-medication treatments; and consulting about women on psychotropic medications who are wanting to or thinking about getting pregnant.

Perinatal psychiatrists are also available to help any practice thinking about instituting routine screening for depression. They can come to a clinic and provide a broad overview of best practices for depression screening and follow-up in the perinatal period.

The phone line **877-725-4666 (PAL4MOM)**, is staffed weekdays from **9 AM to 5 PM**. Providers can call at any time and receive a call back within one working day. Providers can also e-mail with any questions or to set up a consultation at ppcl@uw.edu.

View their [Perinatal Mental Health Care Guide 2023](#) which provides general guidance and workflows for behavioral health and other concerns in the pregnant and postpartum period.

Perinatal Support Washington Warm Line: Perinatal Support Washington is a state-wide non-profit that aims to support efforts to address perinatal mental health. Their **warm line** is a toll-free telephone peer support line for parents in need.

Parents can call or text **1-888-404-7763** to speak to a parent who has experience with perinatal mood and/or anxiety disorders and can connect them with licensed therapists trained in perinatal mental health. Patient-facing flyers can be found [here](#)

They maintain a [directory](#) with various kinds of support for all over the state that helps parents find the kinds of support they need, including doulas, lactation consultants, midwifery, primary care, and support groups. Learn more [here](#)

Parent-Child Assistance Program (PCAP): PCAP is an evidence-based home visitation case-management model for birthing parents on Apple Health who abuse alcohol or drugs during pregnancy. Its goals are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs. A client who is pregnant or postpartum, self-reports heavy substance use during the current or recent pregnancy and has not successfully accessed community resources for substance use treatment and long-term recovery is eligible for PCAP.

More information about the PCAP program can be found [here](#).

988: (call, [text or chat](#) 988) 9-8-8 is a suicide & crisis lifeline that is confidential, free and available 24/7 all year. Anyone can contact to get support for thoughts of suicide, mental health crises, substance use concerns or any kind of emotional distress. Partners or loved ones can also call about someone they are concerned about. Services are available in Spanish and over 240 languages and dialects through interpretation.

For more information, click [here](#).

If you use American Sign Language, you can get crisis support in ASL by visiting [988lifeline.org](#), selecting the “[For Deaf & Hard of Hearing](#)” link and selecting “[ASL Now](#)” on the next page

Native and Strong Lifeline: Native and Strong is a crisis line specifically for native and/or indigenous peoples in Washington state. Anyone can call it by dialing 988 and selecting option 4. Callers will be connected to Native counselors who can support Native people experiencing a mental health crisis, thinking about suicide or seeking emotional support. You can also call if you are concerned about a loved one. Conversations are kept confidential, and counselors consider culture and tradition as they connect with people in crisis.

Visit their website [here](#), or call 866-491-1683

211: 2-1-1 is an easy-to-remember phone number for people to call for health and human service information and referrals and other assistance to meet their needs. Pregnant and postpartum patients can call 2-1-1 (or 1-877-211-9274) to get connected with **mental health providers** within their area.

Click [here](#) for more information.

Maternal Mental Health Hotline: The Maternal Mental Health Hotline is a national 24/7 free confidential support line for individuals before, during or after pregnancy. They offer phone or text access, real-time support, information and referrals to resources, providers and support groups in the area. They also offer counselors who speak English and Spanish, and have interpreter services for over 60 languages.

Call or text **1-833-TLC-MAMA (1-833-852-6262)**. TTY users can use a preferred relay service or dial **711** and then **1-833-852-6262**. To see more information, click [here](#).

Crisis Line: Patients thinking of suicide or are in crisis can call 1-866-427-4747.

Appendix C Additional Support Services

While this report focuses on perinatal behavioral health, holistic person-centered care cannot separate behavioral from medical wellness. Many support services across the state provide both behavioral health support and other forms of support needed to have a healthy pregnancy and postpartum period. Therefore, providers should consider all resources available to support the parent-child dyad through the perinatal period. The following section focuses primarily on support services for Apple Health moms and babies. To support the birthing parent's choices and goals, support services should be integrated into the birth plan and clinical care plan.

Commercial health plans may provide support services using maternity case management, lactation consulting, breastfeeding support, or other services during the maternity and newborn episode. Gestational parents may also self-pay for support services, such as doulas, that follow their birth plan and pregnancy and delivery goals. Clinicians and their teams can learn more about support services for birthing parents and babies with commercial health plan coverage by contacting the birthing parent's health plan.

Apple Health Member Support Services

First Steps Maternity Support Services (MSS): Any pregnant or up to 60 days postpartum Medicaid Enrollees are eligible for MSS. MSS is an optional, enhanced service which is reimbursed fee for service. The services provided may take place in an office setting, the client's home or an alternate location. The purpose of MSS is to improve and promote healthy birth outcomes using an interdisciplinary team consisting of a registered nurse, behavioral health specialist, and registered dietitian. Some MSS providers also have community health workers as part of the team. MSS helps clients access prenatal care as early as possible and obtain health care for eligible infants. MSS covered services consist of screening for risk factors, interventions for identified risk factors, brief counseling, education related to pregnancy and infant health, basic health messages, breastfeeding support, referrals to community resources, case management, and care coordination.

For more information and to find an MSS provider in your area, check the MSS Provider Directory, click [here](#) or call the Help Me Grow Washington Hotline at 1-800-322-2588.

First Steps Childbirth Education (CBE): Any pregnant client covered by Washington Medicaid is eligible for at least six hours of education provided by a Health Care Authority-approved CBE educator who accepts Apple Health. Education must include topics related to pregnancy, labor and birth, and newborn care.

For more information and to find a HCA-approved CBE educators, click [here](#) or call the Help Me Grow Washington Hotline at 1-800-322-2588.

Doula: The goal of doula services is to reduce disparities in birth outcomes among racial, ethnic, and geographic populations; improve birth outcomes by reducing preterm birth, low birth rate, cesarean sections; shorten labor time; reduce the need for pain medications; reduce consequences associated with morbidities such as severe lacerations and hemorrhage; and improve rates of breastfeeding and length of time babies are breastfed. Legislation requires the Health Care Authority to implement doula services through the **First Steps Maternity Support Services (MSS) program**. HCA is collaborating with

partner agencies, doula advocates, and MSS providers to determine cost savings and how best to implement. HCA is also working with the Centers for Medicare and Medicaid Services (CMS) to add doulas as an allowable provider in the Medicaid State Plan to reimburse for services.

Please sign up for [HCA's doula listserv](#) to stay informed as HCA works to implement doula services.

Women, Infants and Children (WIC) Nutrition Program: WIC is a federal assistance program benefitting pregnant individuals, new and breastfeeding birth parents and children under 5 years of age by supplementing their diet with healthy foods, promoting and supporting breastfeeding and other healthy habits, and referring families to healthcare. Participating in WIC does not affect immigration status.

For more information on finding WIC services in your area, Call the Help Me Grow WA Hotline **1-800-322-2588** or Text "WIC" to **96859**. Healthcare providers, click [here](#) to learn more.

Additional Support Services

Home Visiting for Families (DCYF): This program provides voluntary services in the home to expecting parents and families with infants and young children. Visits focus on linking families to health care and other community resources, promoting strong parent-child attachment, and coaching parents on learning activities to help their child's development. Visits also include regular screenings to help parents identify possible health and developmental issues.

Find a local home visiting program by calling the Help Me Grow Washington Hotline at **1-800-322-2588**.

Nurse-Family Partnership (NFP): NFP is a unique community health home visiting program that pairs nurse home visits with specialized training with parents to provide education, support and confidence in their ability to succeed. Extensive research has shown improvement in childhood outcomes like a reduction in behavioral health and intellectual problems at age 6, reduction in likelihood of experiencing child abuse and neglect, and reduction in ER visits for accidents and poisonings. They have locations across Washington State and serve thousands of families every year.

For more information and to find an NFP program in Washington, click [here](#).

WithinReach: A not-for-profit organization that provides multiple ways for people to access support in person, over the phone and online to find resources in their community. WithinReach is a leader and coalition builder for programs such as Basic Food education, Medicaid outreach and immunization action in Washington State. WithinReach's [ParentHelp123](#) website assists pregnant patients and families in finding resources like food banks, play and learn groups, free or low-cost health clinics by entering their zip code.

Patients can also call WithinReach's Help Me Grow Hotline at **1-800-322-2588** to apply for Medicaid online or be referred to other resources.

Native Resource Hub by Volunteers of America Tribal Services: The Native Resource Hub is a resource specifically for individuals who identify as Native American and/or Alaska Native. The hub supports native resources like follow up on calls to the Native and Strong Lifeline, care coordination, contact for

tribal DCRs, and provide light case management. The hub was developed in partnership with the Tribal Centric Behavioral Health Advisory Board, the American Indian Health Commission, The WA State Health Care Authority and the Washington Department of Health.

Learn more [here](#) or call 1-866-491-1683 to get connected.

211: 211 is a confidential, free community service hotline that connects individuals to local services including utility assistance, food, housing, healthcare, childcare, afterschool programs, crisis intervention and more. Individuals can call from anywhere in Washington state and reach a referral specialist to assist in assessing needs and finding services that address them. Referrals can be initiated via phone, email or text, TTY for people with deafness or hard of hearing and interpreters are available for over 140 languages.

Call **2-1-1** for assistance, or click [here](#) to learn more.

Appendix D Provider and Allied Professionals Trainings

To provide equitable and effective care to pregnant and postpartum individuals experiencing behavioral health concerns or conditions, providers and allied professionals need training to that provides information on evidence-based/evidence-informed approaches to treatment and support. This section focuses on training opportunities for providers, other members of the care team and allied birthing professionals.

Perinatal Support Washington: Perinatal Support Washington offers provider trainings and events focused on perinatal mental health. Trainings focus on best practices in prevention, identification and treatment of PMADs, Birth trauma for therapists and allied birth professionals and special topics in perinatal mental health. Trainings often provide CEUs/CMEs for licensed providers. They locate trainings in different areas of the state and offer customized training for staff.

Learn more about and see upcoming trainings [here](#)

Contact Perinatal Support WA about custom trainings [here](#)

Mom's Access Project (MAP) ECHO: MAP ECHO is a 10-session CME accredited program for providers that care for perinatal patients in Washington can participate in to improve provider capacity to care for perinatal behavioral health. Perinatal psychiatrists, obstetrician-gynecologists, maternal fetal medicine experts, ARNPs, therapists and social workers from the University of Washington School of Medicine facilitate the conference series, and providers from across the state are welcome to register.

For more information, please click [here](#).

Marce Society of North America: The International Marce Society for Perinatal Mental Health is an international organization focused on the prevention and treatment of mental illness in childbearing. They aim to promote the spread of research into all aspects of mental health for birthing parents, their infants, and partners around the time of childbirth. Past virtual workshops have included prescription considerations for depression during pregnancy, and the prevention of perinatal depression.

To find out for about MONA and their resources, click [here](#).

Appendix E Patient Educational Resources

Lactation Guidance for Healthcare Professionals: The Department of Health generated guidance on lactation and substance use in June 2023. This resource outlines concerns and guidance related to lactation and parental substance use, detailing specific safety concerns, adverse effects, considerations, and monitoring suggestions for specific substances such as opioids, benzodiazepines, stimulants, alcohol, cannabis, and tobacco/nicotine. They also offer screening tools for use during lactation support.

Link [here](#).

Perinatal Support Washington: Perinatal Support Washington has resource guides and toolkits for parents, including resources in multiple languages and resources specific to families of color. Providers and health delivery systems can order warm line educational flyers on the website.

Link here for [resources](#) for parents and children

Appendix F Pregnancy and Post-partum Care Providers

Title	Role	Can Deliver the Baby?	Prescribe Medications?	Licensed/ Certified	Notes
OB Physician	Obstetricians are physicians that specialize in caring for people during preconception, pregnancy, childbirth and several weeks postpartum (after childbirth).	Y	Y	Y	
Family Medicine Physician	Family medicine physicians can provide comprehensive care for low to high risk pregnancies from preconception through postpartum.	Y	Y	Y	
Primary Care Clinician	Like Family Medicine Physicians, can provide comprehensive care for low to high-risk pregnancies from preconception through postpartum care. Primary care clinicians can include Nurse Practitioners, Physician Assistants and other Advanced Practice Providers (APPs), whose scope of practice may vary from physicians.	Y/N	Y	Y	
Certified Nurse Midwife	Advanced practice nurse practitioners who specialize in pregnancy, childbirth, and postpartum care. They can also provide gynecological care, family planning and primary care services.	Y	Y	Y	
Licensed Midwife	Healthcare providers specializing in pregnancy, childbirth, and postpartum care. However, under Washington law they do not have full prescriptive power	Y	N	Y	

Registered Nurse	Registered nurses perform many functions across the healthcare system. Perinatal nurses specialize in caring for individuals during pregnancy, childbirth and postpartum, providing education, support and monitoring.	N	N	Y	Registered nurses are typically found in hospital labor and delivery units, antenatal units, postpartum units and newborn units
Doula	In Washington state, birth doulas are defined as, <i>“a person that is a nonmedical birth coach or support person trained to provide physical, emotional, and informational support to birthing persons during pregnancy, antepartum, labor, birth, and the postpartum period. Birth doulas advocate for and support birthing people and families to self-advocate by helping them to know their rights and make informed decisions. Birth doulas do not provide medical care.”</i>	N	N	Y/N	Washington State recently implemented a voluntary certification process, but individuals can practice as a birth doula without obtaining certification.
Lactation Specialist/Consultant	Lactation Specialists/Consultants are professionals that specialize in breastfeeding and chestfeeding. They offer support, advice, and guidance on common nursing problems.	N	N	Y	Certified through the International Board of Lactation Consultant Examiners (IBLCE)
Perinatal Psychologist	Mental health professionals that specialize in providing diagnosing mental health conditions, developing and implementing treatment plans and providing therapy to pregnant and postpartum individuals.	N	N	Y	
Psychiatrist	Medical physicians that specialize in the diagnosis, treatment and management of behavioral health	N	Y	Y	

	conditions. They can prescribe medication, assist in coordinating care plans, provide psychosocial interventions and collaborate with other care team members.				
MAT-Provider	Clinicians authorized to prescribe buprenorphine for opioid use disorder treatment, including physicians and advanced practice providers.	Y/N	Y	N	The X Waiver requirement was recently removed, so all Washington physicians and advanced practice providers now can prescribe buprenorphine
Substance Use Disorder Specialist	Behavioral health professionals that specialize in providing evidence-based practices around screening and interventions for individuals with substance use disorder, including pregnant and postpartum individuals.	N	N (generally)	Y	They can be certified. The National Certification Commission for Addiction Professionals has three foundational credentials for addiction counselors
Behavioral Health Therapist	Licensed mental health professional who works with clients to provide support, guidance, and therapeutic interventions to assist with behavioral health conditions. In Washington state they must have a masters or doctoral degree in counseling, or field related to mental health counseling.	N	N	Y	
Certified Peer Counselor	In Washington, they work with individuals and parents of children receiving behavioral health services, assist in identifying services and activities that promote recovery, assist in developing goals and serve as advocates.	N	N	Y	In Washington, certified peer counselors must go through an HCA approved CPC training and pass oral and written exams, and often their employer requires them to become credentialed through the Department of Health as an agency affiliated counselor. ³⁸

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Licensed Clinical Social Worker	Can specialize in perinatal behavioral health, aiding in diagnosis, treatment and management of perinatal patients with behavioral health conditions	N	N	Y	Trained to provide a range of services like individual and group therapy, case management, advocacy and crisis intervention
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Appendix G Example Suicide Safety Plan

The following Suicide Safety Plan is provided from UW Valley Medical Center in 2023. The Suicide Safety Plan is initiated when an individual answers 'Yes' to Question 10 on the EPDS and then is assessed with the CRSS. Regardless of suicide risk, a safety plan is made the same day.

Safety Plan

Name: Date:

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity):

Step 3: People and social settings that provide distraction (name & number, place):

Step 4: People whom I can ask for help (name & number):

Step 5: Making the environment safer (plan for lethal means safety):

The one thing that is most important to me and worth living for is:

Step 6: Professionals or agencies I can contact during a crisis:

Clinician Name: ***

Phone: ***

Emergency Services: Call 911

VMC Emergency Room Intervention Team (ERIT): 425-690-6466

Psychiatric Emergency Services:

- **National Suicide Prevention Lifeline: 1-800-273-8255**
The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals in the United States.
- **Warm Line Phone: 1-877-500-9276 (1-877-500-WARM)**
WA Warm Line is a peer support help line for people living with emotional and mental health challenges. Calls are answered by specially trained volunteers who have lived experience with mental health challenges. They have a deep understanding of what you are going through and are here to provide emotional support, comfort, and information. All calls are confidential. Available Monday – Sunday, 12:30pm – 9pm.
- **24-Hour Crisis Line: 988**
Provides immediate help to individuals, families, and friends of people in emotional crisis and can link to the appropriate services.
- **Teen Link: 1-866-833-6546 (1-866-TEENLINK)**

Confidential and anonymous help line for teens, specialists are available to talk by phone from 6-10pm and chat or text from 6-9:30pm every night

- **Washington Recovery Help Line: 1-866-789-1511**
24-Hour help for substance abuse, problem gambling and mental health
- **The Trevor Project: 1-866-488-7386**
LGBTQ crisis line for young people in crisis, open 24/7. Also available by text (Text START to 678-678) or chat at [thetrevorproject.org](https://www.thetrevorproject.org)

Appendix H Bree Collaborative Members

MEMBER	TITLE	ORGANIZATION
JUNE ALTARAS, MN, NEA-BC, RN	Executive Vice President, Chief Quality, Safety and Nursing Officer	Multicare Health System
SUSIE DADE, MS	Patient Advocate	
DAVID DUGDALE, MD, MS	Medical Director, Value Based Care	University of Washington Medicine
PATRICIA EGWUATU, DO	Family Medicine Physician	Kaiser Permanente
GARY FRANKLIN, MD, MPH	Medical Director	Washington State Department of Labor and Industries
COLIN FIELDS, MD, AAHIVS	Medical Director, Government Relations & Public Policy	Kaiser Permanente
JASON LAKE, MD	Chief Medical Officer	Confluence Health
MARK HAUGEN, MD	Family Medicine	Walla Walla Clinic
DARY JAFFE, MN, ARNP, NE-BC, FACHE	Senior Vice President Safety and Quality	Washington State Hospital Association
SHARON ELORANTA, MD	Medical Director, Performance Measurement and Care Transformation	Washington Health Alliance
NORIFUMI KAMO, MD, MPP	Internal Medicine	Virginia Mason Franciscan Health
ANGIE SPARKS, MD	Chief Medical Officer, Community Plan	UnitedHealthcare
GREG MARCHAND	Director, Benefits, Policy and Strategy	The Boeing Company
KIMBERLY MOORE, MD	Associate Chief Medical Officer	Franciscan Health System
CARL OLDEN, MD	Family Physician	Pacific Crest Family Medicine, Yakima
NICOLE SAINT CLAIR, MD	Executive Medical Director	Regence BlueShield
MARY KAY O'NEILL, MD, MBA	Partner	Mercer
KEVIN PIEPER, MD	Chief Medical Officer	Kadlac Medical Center
SUSANNE QUISTGAARD, MD	Medical Director, Provider Strategies	Premiera Blue Cross
EMILY TRANSUE, MD (CHAIR)	Chief Clinical Officer	Comagine Health
JUDY ZERXAN-THUL, MD	Medical Director	Washington State Health Care Authority

Appendix I The Bree Collaborative: Perinatal Behavioral Health Charter and Roster

Problem Statement

Perinatal depression is one of the most common pregnancy complications, affecting one in seven women,¹ and may contribute to adverse neonatal, infant, and child outcomes.² Both the US Preventative Services Task Force and the American College of Obstetrics and Gynecology recommend screening for depression and anxiety during pregnancy and the post-partum period, as well as initiating treatment or referring to mental health care providers for maximum benefit.^{1,3} Despite these recommendations, stigma around mental illness, lack of insurance coverage for behavioral health, and structural barriers all prevent access to quality mental health care.⁴

Aim

To improve the mental health care continuum in Washington State along the reproductive or family building journey including the perinatal and postpartum period.

Purpose

To propose practical and evidence-informed recommendations to the full Bree Collaborative on reducing the burden of perinatal/maternal mental health including:

- Defining topic area and scope.
- Expand inclusive definitions and services.
- Advancing equity and addressing inequities in perinatal/maternal mental health prevention, treatment, resources, and supports.
- Uplift culturally, relevant, and linguistically appropriate care.
- Acknowledge the impact of interpersonal and structural racism on people's perinatal mental health and overall health.
- Identifying at-risk populations and increasing screening activities.
- Identifying mechanisms for following-up with brief interventions, treatment, or referrals to mental health services.
- Improving access to quality mental health services.
- Addressing structural determinants and other barriers to perinatal/maternal mental health.

Duties & Functions

The workgroup will:

- Research evidence-informed and expert-opinion informed guidelines and best practices (emerging and established).
- Make recommendations for inclusive care and language.
- Acknowledge how current structures contribute to inequality.
- Identify current barriers and future opportunities for implementing interventions.
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.

¹ American College of Obstetrics and Gynecology. 2018. ACOG Committee Opinion No. 757: Screening for Perinatal Depression. 132:5(208-212). doi: 10.1097/AOG.0000000000002927

² Howard L & Khalifeh H. 2020. Perinatal mental health: a review of progress and challenges. World Psychiatry. 19:3(213-327).

³ US Preventive Services Task Force. 2019. Interventions to Prevent Perinatal Depression: US Preventive Services Task Force Recommendation Statement. JAMA. 321(6):580-587. doi:10.1001/jama.2019.0007

⁴ Shuffrey L, Thomason M, & Brito, H. 2022. Improving Perinatal Maternal Mental Health Starts With Addressing Structural Inequities. JAMA Psychiatry. 79(5):387-388. doi:10.1001/jamapsychiatry.2022.0097

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- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies including metrics or a process for measurement.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative. The Bree Collaborative director and program coordinator will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. Bree Collaborative staff will conduct meetings, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the Bree Collaborative director.

NAME	TITLE	ORGANIZATION
COLLEEN DALY, PHD (CHAIR)	Director, Global Occupational Health, Safety and Research	Microsoft
TRISH ANDERSON, MBA, BSN	Senior Director, Safety and Quality	Washington State Hospital Association
APHRODYI ANTOINE, MPH, MBA	Deputy Regional Administrator	Health Related Services Administration
CHRISTINE COLE, LCSW	Infant and Early Childhood Mental Health Program Manager	WA Health Care Authority
MELISSA COVARRUBIAS		Community Health Plan of Washington
BILLIE DICKINSON	Associate Director, Policy	Washington State Medical Association
ANDREA ESTES, MBA	Sexual and Reproductive Health Programs Innovation Manager	WA Health Care Authority
CINDY GAMBLE, MPH	Tribal Public Health Consultant	American Indian Health Commission
KRISTIN HAYES, MSW	Perinatal Mental Health Counselor	Evergreen Health
LIBBY HEIN, LHMC	Community Director	Children's Home Society of Washington
MANDY HERREID, MN	Maternal Health Program Manager	United Healthcare

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KAY JACKSON, CNM, ARNP	Midwife	Off the Grid Midwifery and Health
ELLEN KAUFFMAN, MD, FACOG	Obstetrician	
JILLIAN KING, DNPC		University of Washington
GINA LEGAZ, MPH	National Director, Prematurity Collaborative	March of Dimes
JENNIFER LINSTAD, CNM	Midwife	Center for Birth
MARYELLEN MACCIO, MD	Family Medicine	Valley Medical Center
PATRICIA MORGAN, ARNP	Psychiatric Nurse Practitioner	Evergreen Health
SHERYL PICKERING	Health Services Consultant/WIC Tribal Liaison	WA Department of Health, WIC
ASHLEY PINA		WA Health Care Authority
SARAH PINE	Behavioral Health Program Manager	WA Health Care Authority
KATIE PRICE, LICSW	Clinical Social Worker	Katie Price Therapy
BRIANNE PROBASCO	Reproductive Health Coordinator	WA Association of Community Health
MONICA SALGAONKAR, MHA	Program Manager, Continuing Medical Education	Washington State Medical Association
NICOLE SAINT CLAIR, MD	Executive Medical Director	Regence
CAROLINE SEDANO, MPH	Perinatal Unit Supervisor	WA Department of Health
LEWISSA SWANSON, MPH	Regional Maternal and Child Health Consultant	Health Related Services Administration
BETH TINKER, PHD, MPH, MN, RN	Nursing Consultation Advisor, Clinical Quality Care Transformation	WA Health Care Authority
JANMARIE WARD, MPA	Private Consultant	American Indian Health Commission
JOSEPHINE YOUNG, MD, MPH, MBA	Medical Director, Commercial Markets	Premera

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