By Emily C. Dossett, Alison Stuebe, Twylla Dillion, and Karen M. Tabb

DOI: 10.1377/hlthaff.2023.01455
HEALTH AFFAIRS 43,
NO. 4 (2024): 462–469

COMMENTARY

Perinatal Mental Health: The Need For Broader Understanding And Policies That Meet The Challenges

Emily C. Dossett, University of Southern California, Los Angeles, California.

Alison Stuebe, University of North at Carolina Chapel Hill, Chapel Hill, North Carolina.

Twylla Dillion, HealthConnect One, Chicago, Illinois.

Karen M. Tabb (ktabb@illinois.edu), University of Illinois at Urbana-Champaign, Urbana, Illinois.

ABSTRACT Perinatal mental health is gaining recognition as a key antecedent of adverse maternal and child outcomes as the United States experiences a maternal mortality and morbidity crisis. Recent policy efforts have attempted to mitigate adverse outcomes through legislation such as the Taskforce Recommending Improvements for Unaddressed Mental Perinatal and Postpartum Health (TRIUMPH) for New Moms Act of 2021 and postpartum coverage through Medicaid expansion. Even with progress, perinatal mental health policy continues to grapple with a basic truth: The United States lacks an overarching health care system capable of meeting the mental health care needs of perinatal people and their families. Moreover, the burden of undiagnosed and untreated perinatal mental health challenges remains greatest among racially minoritized populations, such as Black, Asian, and multiracial people. A broader understanding of perinatal mental health is needed, grounded in the tenets of reproductive justice. From this perspective, we articulate specific policies to meet perinatal mental health challenges and promote thriving for birthing people and their families.

The current maternal health landscape reinforces a hierarchy of human value in the United States that celebrates birth and parenting among well-to-do White people, while framing reproduction among poor people and people of color as a problem to be solved.[1] Lived experience of this hierarchy of human value has led many women and birthing people of color to have poorer outcomes and to distrust health care providers. The antidote is reproductive justice,[2] a collective human rights framework developed by Black feminist activists in 1994. Reproductive justice consists of the basic rights to bodily autonomy, to have a child, to not have a child, and to raise children in safe and healthy environments.

The reproductive justice framework is relevant for perinatal mental health equity because it couples individual well-being with addressing the structural root causes of health disparities.[3] Joia Crear-Perry and colleagues assert that social determinants of health such as poverty, food insecurity, and housing instability are the products of institutional policies such as redlining, enslavement, and Jim Crow.[4] The COVID-19 pandemic exposed fractures in the US health care system, with fault lines largely separating marginalized communities from those with privilege.[5] In the world of maternal health, the glaring racial and ethnic disparities in birth outcomes illustrate these fault lines all too painfully.[6] Recent policy efforts have attempted to mitigate adverse outcomes through legislation such as the Taskforce Recommending Improvements for Unaddressed Mental Perinatal and Postpartum Health (TRIUMPH) for New Moms Act of 2021 and postpartum coverage through Medicaid expansion. Even with progress, though, perinatal mental health policy continues to grap-

ple with a basic truth: The US lacks an overarching health care system capable of meeting the mental health care needs of perinatal people and their families. Moreover, the burden of mental health problems and entry to the perinatal mental health care treatment pathway is unequal across perinatal populations, where minoritized people experience greater levels of untreated mental health symptoms.

Structural inequity and health disparities can be experienced by the birthing person as traumatic. *Trauma* here is defined as "exposure to an incident or series of events that are emotionally disturbing or life-threatening with lasting adverse effects on the individual's functioning and mental, physical, social, emotional, and/or spiritual well-being."[7] Trauma can be personal, familial, communal, and historical, and extensive research demonstrates the very real biological effects of trauma on pregnancy, infant, and developmental outcomes. The mother's exposure to trauma in her own childhood increases the risk for her to develop gestational diabetes mellitus and depression and for her infant to have low birthweight and preterm delivery.[8] Maternal trauma also "turns on" stress-regulation genes that are in turn passed down to the child, resulting in the very encoding of disparity's traumatic effects in the next generation's DNA—otherwise known as the "intergenerational transmission" of trauma.[9]

Acknowledging and addressing trauma are essential to achieving reproductive justice, and trauma-informed care has emerged as a key component of holistic maternity care that acknowledges lived experience, including inequity. However, a trauma-informed approach alone does not suffice; instead, it must be coupled with healing at a communal and institutional level. A healing-centered approach invites policy makers to move upstream and institute policies that promote reproductive justice—policies that cultivate conditions for women, birthing people, and their families to not only survive pregnancy and the postpartum period but also thrive. To accomplish this, we propose the following seven policies, designed to advance perinatal mental health for all people, especially those living with trauma, inequity, and barriers to care.

Broaden Understanding Of Perinatal Mental Health Challenges

Our first proposed policy is to broaden understanding of what perinatal mental health challenges are and whom they affect. There continues to be a misconception that perinatal mental illness primarily consists of postpartum depression. Mental illness does not just occur after delivery; it can predate conception and continue into pregnancy, start during pregnancy itself, manifest after labor and delivery,[10] or occur after pregnancy loss.[11] Research also demonstrates that depression is not the only perinatal mental health condition. Anxiety in many forms, including panic disorder, obsessive-compulsive disorder, and generalized anxiety, occurs as much as, if not more than, depression.[12] Other mental health challenges are specific to labor and delivery, such as childbirth-related posttraumatic stress disorder.[13] Postpartum psychosis typically emerges within the first two weeks postpartum.[14] Ongoing serious mental illness (SMI) such as schizophrenia, bipolar disorder, and recurrent major depressive disorder carries a significant chance of relapse or symptom exacerbation in the perinatal period without careful management.[15] Substance use disorders (SUDs) often persist into the perinatal period, complicate other behavioral health symptoms, and are a leading cause of maternal mortality.[16]

When policy focuses exclusively on postpartum depression, people experiencing other symptoms might not even be aware that what they are suffering is, indeed, a perinatal mental health concern. Providers may overlook these patients or minimize their complaints. Public awareness campaigns must include the full range and time frame of perinatal mental health challenges to truly reach more than the subset of people who experience only postpartum depression. Similarly, quality improvement measures would benefit from moving beyond depression measurement to screening and treating anxiety, trauma-related disorders, SMI symptoms, and SUDs. Using comprehensive, accurate language could be an effective first step. We propose consistent language by state, federal, and local agencies that encompasses all of the above experiences. Specifically, we suggest using the phrase "perinatal mental health challenges."

In addition to broadening the perspective on what perinatal mental health challenges comprise, a broader understanding is needed of those who are affected. When research fails to sample and include racially, ethnically, and gender-diverse populations, the needs of all perinatal people cannot be fully understood. Recent studies that do include ever-increasing population diversity find that Black and Asian perinatal people receive fewer diagnoses of mental health problems.[17,18] Research findings suggest that screening for perinatal mental health problems in clinical settings—the population-based approach to universally assessing for untreated mental health needs—carries limitations and biases.[19–21] Abbey Sidebottom and colleagues reviewed records of screening rates in one health

system and reported that racial minority women (namely, Black, multiracial, and American Indian/Alaska Native women) were screened less than their White counterparts.[22] There is even less research and understanding of birthing people and parents who identify as LGBTQ+. To advance equity in perinatal mental health efforts, research on perinatal mental health screening, assessment, and treatment will need to include a broader range of subpopulations, including accurate categories of multiracial, Asian American, LGTBQ+, and non-English-speaking populations.

Standardize Provider Certifications

Our second proposed policy is to standardize certifications for specialty-specific perinatal mental health providers and incorporate them into payment models. To achieve this, we propose defining a standard set of competencies in perinatal mental health; identifying or creating training programs to teach these competencies; and acknowledging their completion through a universal, nationally recognized certification. At this time, no accrediting agency or professional organization requires perinatal mental health education for psychiatrists, psychologists, social workers, substance use counselors, or peer specialists. Instead, providers must seek this training on their own, typically through continuing education. Several high-quality training programs are currently offered through national organizations, such as Postpartum Support International, or local efforts, such as Maternal Mental Health NOW in Los Angeles, California. These training programs do offer a "certification" on completion. However, the designations differ by organization, and none is recognized by private payers or the Centers for Medicaid and Medicare Services (CMS). As a result, patients or providers seeking knowledgeable perinatal mental health care or referrals have no standardized way of determining who has taken such training and can offer informed care.

A national certification could be developed and housed through a partnership between CMS (to ensure recognition by federal and state health programs) and one or more nongovernmental organizations with membership from a broad range of disciplines. The certification could be adapted to different specialties, such as psychiatry, psychology, social work, substance use counselors, peers, and others, in accordance with scope of practice. Similar certifications could be developed for interested prenatal care providers, such as obstetricians and midwives, through a partnership with CMS and the American College of Obstetricians and Gynecologists.[23] Certifications would allow providers and patients to reliably identify whether or not a particular prenatal or behavioral health resource is qualified to provide perinatal mental health care.

A potential advantage of a national certification is an expansion of the perinatal mental health workforce.

Another potential advantage of a national certification is an expansion of the perinatal mental health workforce. If the certification were linked to increased reimbursement, providers would have further incentive to complete and maintain certification.

Facilitate Payment For Community-Based Care

Our third proposed policy is to create payment structures and remove payment barriers for community-centered and alternative pregnancy and birthing models. In recent years, the health care landscape has witnessed the elevation of various patient- and community-centered care models aimed at enhancing health care access and quality, particularly for Black birthing people.[24] These models include community-based doula services, perinatal community health workers, birth centers, breast-feeding and lactation peer counselors, group prenatal care, and telehealth. Inclusion of these equity-centered models rooted in reproductive justice has been shown to improve birth experiences and outcomes for Black birthing people.[25] With appropriate funding and the ability to scale, these models could transform the experience of birthing people across the nation.[26]

One critical aspect to consider is that many well-funded maternal health programs, such as home visiting and family case management, primarily focus on reducing negative outcomes for infants and children, with less regard for poor pregnancy-related outcomes and the urgent need to reduce maternal mortality and morbidity.[27] In essence, they adhere to the notion that "the baby is the candy; the mom is the wrapper,"

The ability to care for a family's basic needs significantly improves a parent's mental and emotional health.

as Alison Stuebe has pointed out in media interviews.[27] Furthermore, some of these programs have been criticized for resembling carceral systems because of the perceived surveillance-like approach that portrays low-income Black and Brown people as needing instruction on parenting, exacerbating fears of child removal.[28] Even some well-established, but less community-based, models of home visitation have shown limited impact on pregnancy-related outcomes, as a recent large-scale study of the Nurse Family Partnership found.[29] The limitations in achieving improved maternal health outcomes underscore the pressing need for scaling up patient- and community-centered care models, such as doulas, birth centers, group prenatal care, evidence-based community models, and telehealth.

To begin filling in some of the research gaps to drive the scaling up of community-based doula services, several doula programs (HealthConnect One, SisterWeb, Ancient Song, and Accompany Care Doula) have partnered to establish the Doula Data + Compensation Consortium. The consortium is a crowdsourced data resource specifically designed to gather community-based doula service–level data for ongoing measurement and evaluation in collaboration with other partners.[30]

Many patient- and community-centered care models operate through nonprofit, community-based organizations with limited resources and financial investment from public grants and private sources. These models are promising but face funding barriers. We propose alternative payment models, such as bundled payments, capitation, and shared savings, as mechanisms to financially support patient- and community-centered care models. Alternative payment models shift the focus from fee-for-service to value-based care, making them suitable funding opportunities for these care models, particularly birth centers, which have proved to be protective against mistreatment for Black and Brown birthing people.[31,32]

Past research findings indicate that up to 80 percent of birthing people can safely deliver in community settings, including in birth centers or at home with midwifery support.[33] Demonstrating the economic and clinical advantages of these models, such as improved patient experience and reduced health care costs, should persuade payers and policy makers to include them in payment models. Since the medicalization of birth, there has been an insurmountable power differential between community settings for birth and hospital systems, where nearly 99 percent of births occur.[33] Many community birth centers, such as Birth Detroit, must depend on grassroots support because of limited funding availability.[34] To optimize safe care for delivery in the community, hospitals, community birth settings, and birth workers should collaborate to ensure seamless communication and coordination when escalation of care is necessary.[35]

Expand Funding For Perinatal Psychiatry Access Programs

Our fourth proposed policy is to expand funding for perinatal psychiatry access programs. These programs increase the capacity of nonspecialty providers to assess, diagnose, treat, and manage pregnant and postpartum people with mental health challenges. Because the demand for specialized perinatal mental health care greatly exceeds the supply, perinatal psychiatry access programs are a population-based approach to building providers' capacity to address perinatal mental health and substance use. The Massachusetts Child Psychiatry Access Program (MCPAP) for Moms,[36] launched in 2014, was the original model; the Health Resources and Services Administration now provides funds for twelve states and organizations to adapt and implement perinatal psychiatry access programs.[37] The heart of each program is a provider-to-provider consultation telephone line that any provider caring for a pregnant or postpartum person can call for real-time help with behavioral health management, such as diagnosis, medication or treatment initiation, or referrals to local resources. Perinatal psychiatry access programs have consistently demonstrated increased and more equitable provider capacity, improved access to care, and cost savings.[38,39] This success, coupled with the clear shortages of reproductive mental health care found in most parts of the US, supports further funding for perinatal psychiatry access programs.

Reinstate The 2021 Child Tax Credit

Our fifth proposed policy is to reinstate the federal 2021 Child Tax Credit. Poverty is stress-

ful, and stress negatively affects mental health. The Child Tax Credit, instituted in 2021 as part of the American Rescue Plan Act of 2021, aimed to alleviate financial stress in families with children. In contrast to its predecessor, the 1997 Child Income Tax Credit, the Child Tax Credit increased payments from $2,000 to $3,600 per child, made funds more consistently available by distributing them as monthly payments instead of an annual refund, and applied to families who previously were unemployed or were too low-income to qualify. This provision was particularly important in advancing equity, as the previous policy disproportionately excluded families who were rural, were Black, were headed by a single parent, or had incomes that were below the federal poverty level.

The results on parents' mental health are striking. Research has associated the Child Tax Credit with reduced depression and anxiety symptoms, with a greater reduction seen for Black and Hispanic families compared with White families.[40] Almost 50 percent of the decrease in anxiety and up to 70 percent of the decrease in depression was mediated by the ability to pay for food and housing.[41] Risks for depression and anxiety decreased even as mental health care access and prescriptions remained static, suggesting that the alleviation of financial pressure—rather than mental health care receipt—made the difference.[41] Although these studies were specific to the COVID-19 pandemic, they illustrate an intuitive point: The ability to care for a family's basic needs significantly improves a parent's mental and emotional health.

Congress allowed the Child Tax Credit to expire at the end of 2021. Since then, child poverty has doubled, from 5 percent to 12 percent, demonstrating the dramatic effect of this policy.[42] In response, in February 2024, the US House of Representatives passed a bipartisan bill reinstating a child tax credit that is estimated to assist sixteen million children in low-income families.[43] The bill was stalled in the Senate as of March 2024. Making sure that all children, in all states, have access to basic needs is a federal responsibility that affects parental mental health. It also draws from the reproductive justice principle that everyone has the right to raise a child in a safe and healthy environment.

Implement Universal Basic Income Programs

Our sixth proposed policy is to implement and evaluate universal basic income programs for perinatal families. The universal basic income concept has gained traction in recent years as an alternative to the current eligibility-based social services system. A universal basic income program is defined by five key characteristics: It is distributed at regular intervals; the benefit is cash, not specific services, in-kind services, or vouchers; it applies to all members of a population; it applies to each person and is not dependent on membership in a household; and it is not conditioned on means-testing, employment, or willingness to work.[44] Recent literature and economic modeling analysis have demonstrated that programs providing benefits unconditionally versus conditionally result in significant mental health improvement in nonpregnant populations.[45] Several overlapping themes may have mediated these outcomes.[46] First, participants reported an increase in hope and planning for the future, instead of remaining focused on day-to-day survival. Second, the ability to spend more time with friends and family likely contributed to improvement in mental health, even if poverty was not completely alleviated. Third, several studies reported reduced stigma and increased feelings of being part of the community.[46] A universal basic income for pregnant people could remove barriers, such as the lack of child care or transportation, that prevent them from pursuing social services that they are eligible to receive.

Universal basic income engages reproductive justice principles to improve perinatal mental health in multiple ways. Unconditional and individual payments uncouple having children and the receipt of welfare benefits, thus supporting the right to not have a child. The right to raise a child in a safe and healthy environment is supported when a parent receives payments individually, which can enable them to leave violent partnerships or households. Universal basic income programs may also reduce the isolating, burdensome stigma that both poverty and mental illness incur.

Perinatal mental health challenges serve as a microcosm for the larger US health care landscape.

Promote And Fund Workplace Policies That Support Families

Our seventh proposed policy is to promote and fund workplace policies that support families—specifically, paid family leave and high-quality child care. The United States stands out as the only high-income country in the world without paid family leave. A recent study showed that blue-collar workers and those in the lowest income decile are less likely to have access to paid family leave compared with those in the highest income decile.[47] When parents do return to work, they encounter a broken child care system. Infant care costs can be as high as 75 percent of the median family income for single-parent families; at the same time, child care workers are twice as likely to live in poverty as workers in other sectors.[48] Child care is significantly more expensive or burdensome—or both—for families who live in populous areas, pay for more than one child, have younger children, and are low-income.

Ample evidence links higher-paying and longer-duration parental leave to improved perinatal mental health outcomes,[49,50] particularly for mothers. Although research on child care access and parental mental health is less extensive, available data correlate the struggles of accessing affordable child care with parental mental and physical health. Overall emotional well-being presumably suffers because the financial stress of child care tracks closely with housing instability, food insecurity, and problems accessing and paying for health care.[51]

The US has policy experience with how to support more and better child care and parental paid leave. During the COVID-19 pandemic, the American Rescue Plan Act authorized funding to keep day care facilities open, reduce tuition, and increase pay to child care workers. Thirteen states and the District of Columbia now have mandatory paid family leave systems. Another eight states offer voluntary programs that are funded through private insurance.[52] Preliminary reviews demonstrate improved maternal mental health with paid family leave.[50]

Future Challenges

More work remains to realize reproductive justice for all people with perinatal mental health challenges. The right to have a child demands a rigorous examination of the child welfare system's treatment of parents with mental illness. Historically, women have had children removed for no reason other than their diagnoses. Although this may be appropriate in some cases, there are many other instances where it is not. In particular, Black, American Indian/Alaska Native, and Hispanic children are removed at a highly disproportionate rate compared with White children.[53] The fear of child removal prevents many women from speaking up about their symptoms. Until the child welfare system adopts a whole-family perspective that includes supporting parents' well-being, this barrier will remain.

The right not to have a child has been drastically reduced in the United States since the *Dobbs v. Jackson Women's Health Organization* ruling in July 2022. The majority of states now have complete or significant restrictions on abortion.[54,55] Substantial research shows that abortion denial results in years-long economic hardship, a greater chance of staying with a violent partner or raising a child alone, and negative impacts on child development.[56] Beyond abortion, the right not to have a child also means that each person of childbearing potential has access to the full array of reproductive choice, including contraception and health care. Reproductive empowerment is essential to perinatal mental health wellness for all people.

Perinatal mental health challenges serve as a microcosm for the larger US health care landscape, as they bring into sharp focus systemic gaps in equity, access, integration, data and measurement, social determinants of health, and societal infrastructure. Broadening the understanding of what constitutes perinatal mental illness and wellness and grounding this understanding in reproductive justice would lead to policies that close some of these gaps and serve as an example to other health care sectors. None of these policies is unattainable. The challenges lie in who the nation values and how US society chooses to demonstrate that. ■

NOTES

1 Harris LH, Wolfe T. Stratified reproduction, family planning care, and the double edge of history. Curr Opin Obstet Gynecol. 2014;26(6):539–44.
2 Ross L, Solinger R. Reproductive justice: an introduction. Berkeley (CA): University of California Press; 2017.
3 Matthews K, Morgan I, Davis K, Estriplet T, Perez S, Crear-Perry JA. Pathways to equitable and antiracist maternal mental health care: insights from Black women stakeholders. Health Aff (Millwood). 2021;40(10):1597–604.
4 Crear-Perry J, Correa-de-Araujo R, Lewis Johnson T, McLemore MR, Neilson E, Wallace M. Social and structural determinants of health inequities in maternal health. J Womens Health (Larchmt). 2021;30(2):230–5.
5 Sosin AN, Choo E, Lincoln M. The covid public health emergency is ending: it now joins the ordinary emergency that is American health. BMJ. 2023;381:949.
6 Mathew DM, Ampatey NA, Aaronson JA, Samuels JD, McCullough D, White RS. The association of race and ethnicity on obstetric patients' COVID-19 outcomes: a summary of current literature. Am J Reprod Immunol. 2023;89(5):e13698.
7 Center for Health Care Strategies, Trauma-Informed Care Implementation Resource Center. What is trauma? [Internet]. Hamilton (NJ): CHCS; 2021 [cited 2024 Feb 14]. Available from: https://www.traumainformedcare.chcs.org/what-is-trauma/
8 Kaliush PR, Kerig PK, Raby KL, Maylott SE, Neff D, Speck B, et al. Examining implications of the developmental timing of maternal trauma for prenatal and newborn outcomes. Infant Behav Dev. 2023;72:101861.
9 Mamun A, Biswas T, Scott J, Sly PD, McIntyre HD, Thorpe K, et al. Adverse childhood experiences, the risk of pregnancy complications, and adverse pregnancy outcomes: a systematic review and meta-analysis. BMJ Open. 2023;13(8):e063826.
10 Fisher SD, Wisner KL, Clark CT, Sit DK, Luther JF, Wisniewski S. Factors associated with onset timing, symptoms, and severity of depression identified in the postpartum period. J Affect Disord. 2016;203:111–20.
11 Cuenca D. Pregnancy loss: consequences for mental health. Front Glob Womens Health. 2023;3:1032212.
12 Fairbrother N, Janssen P, Antony MM, Tucker E, Young AH. Perinatal anxiety disorder prevalence and incidence. J Affect Disord. 2016;200:148–55.
13 Kranenburg L, Lambregtse-van den Berg M, Stramrood C. Traumatic childbirth experience and childbirth-related post-traumatic stress disorder (PTSD): a contemporary overview. Int J Environ Res Public Health. 2023;20(4):2775.
14 Bergink V, Rasgon N, Wisner KL. Postpartum psychosis: madness, mania, and melancholia in motherhood. Am J Psychiatry. 2016;173(12):1179–88.
15 Taylor CL, Stewart RJ, Howard LM. Relapse in the first three months postpartum in women with history of serious mental illness. Schizophr Res. 2019;204:46–54.
16 Smid MC, Terplan M. What obstetrician-gynecologists should know about substance use disorders in the perinatal period. Obstet Gynecol. 2022;139(2):317–37.
17 Tabb KM, Beck DC, Tilea A, Bell S, Sugg GA, Vance A, et al. The relationship between diagnosed antenatal depression and anxiety and adverse birth outcomes between 2009 and 2020. Gen Hosp Psychiatry. 2023;85:239–42.
18 Admon LK, Dalton VK, Kolenic GE, Ettner SL, Tilea A, Haffajee RL, et al. Trends in suicidality 1 year before and after birth among commercially insured childbearing individuals in the United States, 2006–2017. JAMA Psychiatry. 2021;78(2):171–6.
19 Hsieh W-J, Sbrilli MD, Huang WD, Hoang T-M, Meline B, Laurent HK, et al. Patients' perceptions of perinatal depression screening: a qualitative study. Health Aff (Millwood). 2021;40(10):1612–7.
20 Salameh TN, Hall LA, Crawford TN, Staten RR, Hall MT. Racial/ethnic differences in mental health treatment among a national sample of pregnant women with mental health and/or substance use disorders in the United States. J Psychosom Res. 2019;121:74–80.
21 Shaff J, Kahn G, Wilcox HC. An examination of the psychometric properties of the Patient Health Questionnaire-9 (PHQ-9) in a multiracial/ethnic population in the United States. Front Psychiatry. 2024;14:1290736.
22 Sidebottom A, Vacquier M, LaRusso E, Erickson D, Hardeman R. Perinatal depression screening practices in a large health system: identifying current state and assessing opportunities to provide more equitable care. Arch Womens Ment Health. 2021;24(1):133–44.
23 Stacy M, Dwyer E, Kremer M, Schulkin J. Obstetrician/gynecologists' knowledge, attitudes, and practice regarding suicide screening among women. J Womens Health (Larchmt). 2022;31(10):1481–9.
24 Sandstrom H. Health Policy Brief: Early childhood home visiting programs and health. Health Affairs [serial on the Internet]. 2019 Apr 25 [cited 2024 Feb 14]. Available from: https://www.healthaffairs.org/do/10.1377/hpb20190321.382895/
25 Almanza JI, Karbeah J, Tessier KM, Neerland C, Stoll K, Hardeman RR, et al. The impact of culturally-centered care on peripartum experiences of autonomy and respect in community birth centers: a comparative study. Matern Child Health J. 2022;26(4):895–904.
26 Liese K, Stewart K, Pearson P, Lofton S, Mbande T, Patil C, et al. Melanated Group Midwifery Care: centering the voices of the Black birthing community. J Midwifery Womens Health. 2022;67(6):696–700.
27 Beck J. New recommendations for postpartum care are long overdue. Slate [serial on the Internet]. 2018 Jun 6 [cited 2024 Feb 14]. Available from: https://slate.com/human-interest/2018/06/postpartum-care-medical-guidelines-are-just-catching-up-with-new-mothers-needs.html
28 Stevens J, Ammerman RT, Putnam FW, Gannon T, Van Ginkel JB. Facilitators and barriers to engagement in home visitation: a qualitative analysis of maternal, provider, and supervisor data. J Aggress Maltreat Trauma. 2005;11(4):75–93.
29 McConnell MA, Rokicki S, Ayers S, Allouch F, Perreault N, Gourevitch RA, et al. Effect of an intensive nurse home visiting program on adverse birth outcomes in a Medicaid-eligible population: a randomized clinical trial. JAMA. 2022;328(1):27–37.
30 Arcara J, Cuentos A, Abdallah O, Armstead M, Jackson A, Marshall C, et al. What, when, and how long? Doula time use in a community doula program in San Francisco, California. Womens Health (Lond). 2023;19:17455057231155302.
31 Karbeah J, Hardeman R, Katz N, Orionzi D, Kozhimannil KB. From a place of love: the experiences of birthing in a Black-owned culturally-centered community birth center. J Health Dispar Res Pract. 2022;15(2):47–60.
32 Sakala C, Hernández-Cancio S, Wei R. Improving our maternity care now through community birth settings. J Perinat Educ. 2022;31(4):184–7.
33 Stapleton SR, Osborne C, Illuzzi J. Outcomes of care in birth centers: demonstration of a durable model. J Midwifery Womens Health. 2013;

58(1):3–14.
34 Community Foundation for Southeast Michigan. Maternal health disparities: Community Foundation invests in Black women–led nonprofits working to close the gap [Internet]. Detroit (MI): CFSEM; 2023 Mar 16 [cited 2024 Feb 14]. Available from: https://cfsem.org/story/maternal-health-disparities-black-women-led-nonprofits/
35 Scrimshaw SC, Backes EP, editors. Birth settings in America: outcomes, quality, access, and choice. Washington (DC): National Academies Press; 2020.
36 Byatt N, Straus J, Stopa A, Biebel K, Mittal L, Moore Simas TA. Massachusetts Child Psychiatry Access Program for Moms: utilization and quality assessment. Obstet Gynecol. 2018;132(2):345–53.
37 Health Resources and Services Administration. Screening and treatment for maternal mental health and substance use disorders (MMHSUD) [Internet]. Baltimore (MD): HRSA; 2023 Sep [cited 2024 Mar 13]. Available from: https://mchb.hrsa.gov/programs-impact/screening-treatment-maternal-mental-health-substance-use-disorders-mmhsud
38 Masters GA, Yuan Y, Li NC, Straus J, Moore Simas TA, Byatt N. Improving front-line clinician capacity to address depression and bipolar disorder among perinatal individuals: a longitudinal analysis of the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms. Arch Womens Ment Health. 2023;26(3):401–10.
39 Deichen Hansen ME, Londoño Tobón A, Kamal Haider U, Moore Simas TA, Newsome M, Finelli J, et al. The role of perinatal psychiatry access programs in advancing mental health equity. Gen Hosp Psychiatry. 2023;82:75–85.
40 Batra A, Jackson K, Hamad R. Effects of the 2021 expanded Child Tax Credit on adults' mental health: a quasi-experimental study. Health Aff (Millwood). 2023;42(1):74–82.
41 Park J, Kim S. Child Tax Credit, spending patterns, and mental health: mediation analyses of data from the U.S. Census Bureau's Household Pulse Survey during COVID-19. Int J Environ Res Public Health. 2023;20(5):4425.
42 Collyer S, Curran MA, Garfinkel I, Harris D, Parolin Z, Waldfogel J, et al. The Child Tax Credit and family well-being: an overview of reforms and impacts. Annals Am Acad Pol & Soc Sci. 2023;706(1):224–55.
43 Cox K, Marr C, Calame S, Hingtgen S, Fenton G, Sherman A. About 16 million children in low-income families would gain in first year of bipartisan Child Tax Credit expansion [Internet]. Washington (DC): Center for Budget and Policy Priorities; 2024 Jan [cited 2024 Mar 13]. Available from: https://www.cbpp.org/research/federal-tax/about-16-million-children-in-low-income-families-would-gain-in-first-year-of
44 Torry M, editor. The Palgrave international handbook of basic income. New York (NY): Springer; 2019.
45 Collins B, Chen T, Reed H, O'Flaherty M, Johnson E, Johnson M, et al. What are the impacts of universal basic income on mental health? A microsimulation economic modelling study. J Epidemiol Community Health. 2023;77(Suppl 1):A14.
46 Wilson N, McDaid S. The mental health effects of a universal basic income: a synthesis of the evidence from previous pilots. Soc Sci Med. 2021;287:114374.
47 Elser H, Williams C, Dow WH, Goodman JM. Inequities in paid parental leave across industry and occupational class: drivers and simulated policy remedies. SSM Popul Health. 2022;18:101045.
48 Landivar LC, Graf NL, Rayo GA. Childcare prices in local areas: initial findings from the National Database of Childcare Prices [Internet]. Washington (DC): Department of Labor, Women's Bureau; 2023 Jan [cited 2024 Feb 14]. (Issue Brief). Available from: https://www.dol.gov/sites/dolgov/files/WB/NDCP/WB_IssueBrief-NDCP-final.pdf
49 Heshmati A, Honkaniemi H, Juárez SP. The effect of parental leave on parents' mental health: a systematic review. Lancet Public Health. 2023;8(1):e57–75.
50 Van Niel MS, Bhatia R, Riano NS, de Faria L, Catapano-Friedman L, Ravven S, et al. The impact of paid maternity leave on the mental and physical health of mothers and children: a review of the literature and policy implications. Harv Rev Psychiatry. 2020;28(2):113–26.
51 Santich E. The impact of child care access on health [Internet]. Denver (CO): Colorado Health Institute; 2023 Jan 23 [cited 2024 Mar 1]. Available from: https://www.coloradohealthinstitute.org/blog/impact-child-care-access-health
52 Bipartisan Policy Center. State paid family leave laws across the U.S. [Internet]. Washington (DC): Bipartisan Policy Center; 2024 Jan 16 [cited 2024 Mar 13]. Available from: https://bipartisanpolicy.org/explainer/state-paid-family-leave-laws-across-the-u-s/
53 Edwards F, Wakefield S, Healy K, Wildeman C. Contact with Child Protective Services is pervasive but unequally distributed by race and ethnicity in large US counties. Proc Natl Acad Sci U S A. 2021;118(30):e2106272118.
54 Heisler M, Cox-Touré T, Kaufman R. US abortion bans violate patients' right to information and to health. Lancet. 2023;401(10387):1480–2.
55 Guttmacher Institute. State bans on abortion throughout pregnancy [Internet]. New York (NY): Guttmacher Institute; 2023 Aug 29 [cited 2024 Mar 1]. Available from: https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions
56 Foster DG. The Turnaway Study: ten years, a thousand women, and the consequences of having—or being denied—an abortion. New York (NY): Scribner; 2021.