



Los Angeles County Perinatal Mental Health Task Force

a project of Community Partners

BRINGING LIGHT TO MOTHERHOOD

A Systems Change Proposal for Preventing and Treating Perinatal Depression and Anxiety in Los Angeles County

Diana was 19 when she found out she was pregnant. The baby's father—who had physically and verbally abused her during their year-long relationship—disappeared as soon as he learned the news. During her pregnancy, Diana was constantly crying and losing focus, forgetting to take her prenatal vitamins and even to attend her prenatal appointments at times. Things got even worse after giving birth. She could no longer sleep or eat, and had no energy to take care of her son. But she was scared that if she told anyone, her son—the only thing in her life that gave her joy—would be taken away. So Diana stayed silent.

Our mission is to break Diana's silence—and the silence of all mothers like Diana who are struggling in Los Angeles.



INTRODUCTION

“When caregivers are sensitive and responsive to a young child’s signals, they provide an environment rich in serve and return experiences [which form the basis of healthy development]. However, if depression interferes with the caregiver’s ability to regularly provide such experiences, these connections in the child’s brain may not form as they should. The difference between a child who grows up in a responsive environment and one who does not can be the difference between the development of strong or weak brain architecture, which serves as a foundation for the learning, behavior, and health that follow.”¹

When a mother’s depression or anxiety goes untreated, it is not just she who suffers. As the research shows, a mother’s untreated mental illness leads to poor attachment with her infant, depriving the child of one of his or her most basic needs.² In addition, untreated perinatal depression and anxiety can result in developmental delays, child abuse and neglect, and disability—which cripple our families, communities, and health care systems.

Although often in the shadows due to stigma and shame, perinatal depression and anxiety are among the most common complications of pregnancy and childbirth.³ The current systems of care for these conditions, however, are severely underfunded and disjointed, preventing many women and families from accessing the help they need. Critically, the impact on low-income women is the most profound. Given their heightened risk factors—which may include financial instability, a history of trauma, and lack of social support—they struggle from severe depression and anxiety in greater numbers, but lack the resources to access necessary help.⁴

Fortunately, perinatal depression and anxiety are easily detected and treated, and there is clear evidence that poor attachment between mothers and infants may be repaired.⁵ Emerging awareness of the problem, on the part of both the public and medical providers, is also slowly dismantling stigma, although there is still a long way to go. And changes in our health care system with the advent of the Affordable Care Act⁶ are providing new opportunities for improved screening and treatment. These include interest in integrated behavioral

health services in primary care settings, emphasis on preventive care, and expanded health care coverage for low-income individuals.

The Los Angeles County Perinatal Mental Health Task Force, a public/private consortium of over fifty non-profit organizations, government agencies, health and human service providers, advocacy groups, and individuals who have struggled with perinatal depression and anxiety, has been leading the charge to address these conditions since 2007. This concept paper reflects seven years of experience in gathering and analyzing information across Los Angeles County. We hope this report will lead to effective changes in the delivery of care for women suffering from perinatal depression and anxiety, and their families, and help build capacity for better systems of care in Los Angeles.

We propose a series of recommendations to improve care for women suffering from perinatal depression and anxiety and their families in Los Angeles County by increasing provider capacity, improving access to treatment, and building community awareness. We hope to achieve three goals:

1. **Develop care pathways** to increase screening, assessment, and referral to appropriate and accessible treatment.
2. **Build provider capacity** via training and technical assistance.
3. **Reduce stigma** and increase public awareness of perinatal depression and anxiety.

PERINATAL DEPRESSION & ANXIETY IN LOS ANGELES

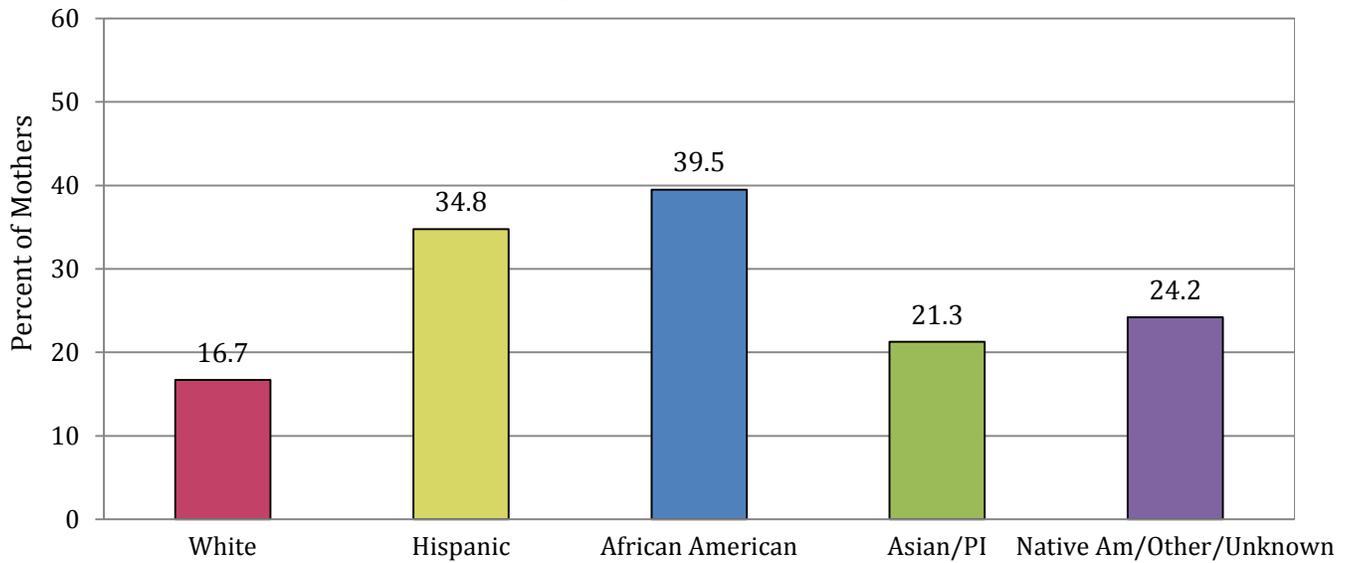
PREVALENCE IN LOS ANGELES COUNTY

Perinatal depression and anxiety can affect women—and as recent research indicates, men⁷—at any time during preconception, pregnancy, and up to one year postpartum. New data released in 2013 revised national statistics to reflect that one in seven new mothers in the United States suffers from postpartum depression.⁸

The situation in Los Angeles County is even grimmer. The 2012 Los Angeles Mommy & Baby (LAMB) Survey of the Los Angeles Public Health Maternal, Child & Adolescent Health Programs asked mothers to self-report symptoms of depression before, during, and after pregnancy. Whereas only 11% reported symptoms of depression before pregnancy, 29.7% reported depressive symptoms during pregnancy, and an astounding 47.3%—**representing more than 62,000 women**—reported depressive symptoms after pregnancy.⁹ Of those reporting depressive symptoms during the postpartum period, 9.9% reported moderate symptoms and 3.4% reported severe symptoms.¹⁰

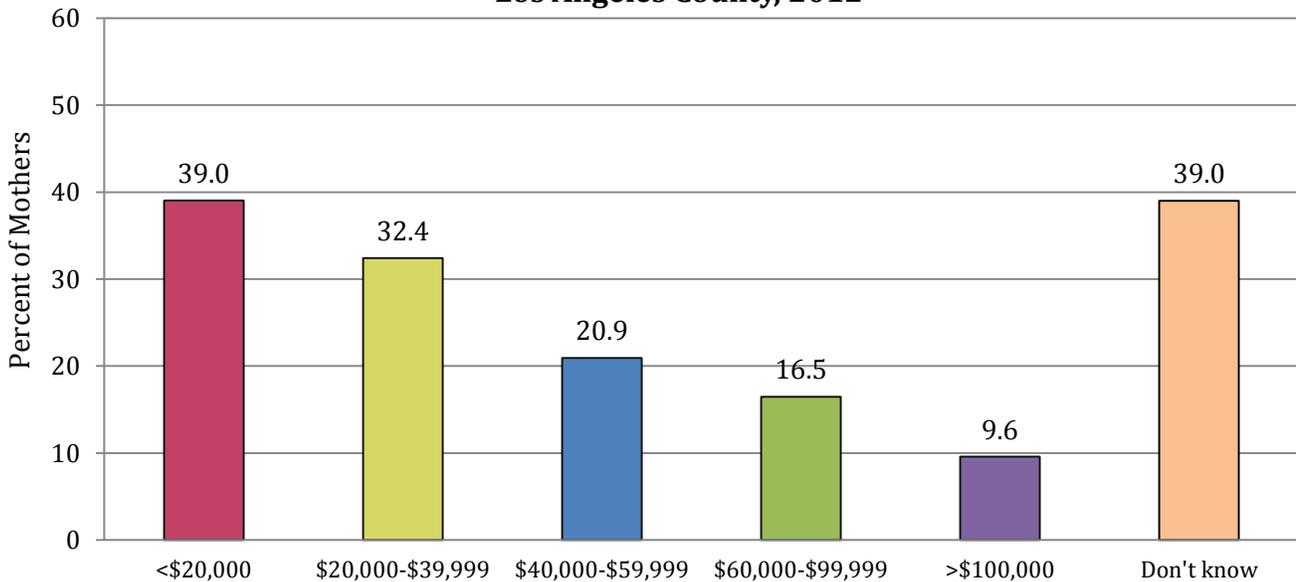
For a variety of reasons, perinatal depression and anxiety is believed to be a problem only among white, upper-class women. But, as the LAMB data demonstrates, that stereotype could not be further from the truth. During pregnancy, the rates of self-reported depression are much higher among Latinas and African-Americans, and those with limited resources:

Self Reported Depressed Mood During Pregnancy by Race/Ethnicity, Los Angeles County, 2012



Source: 2012 Los Angeles Mommy and Baby Survey

Self Reported Depression During Pregnancy by Income, Los Angeles County, 2012



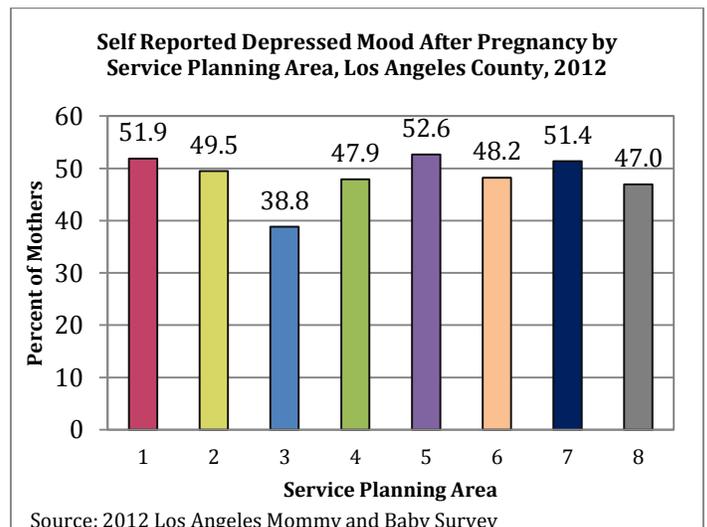
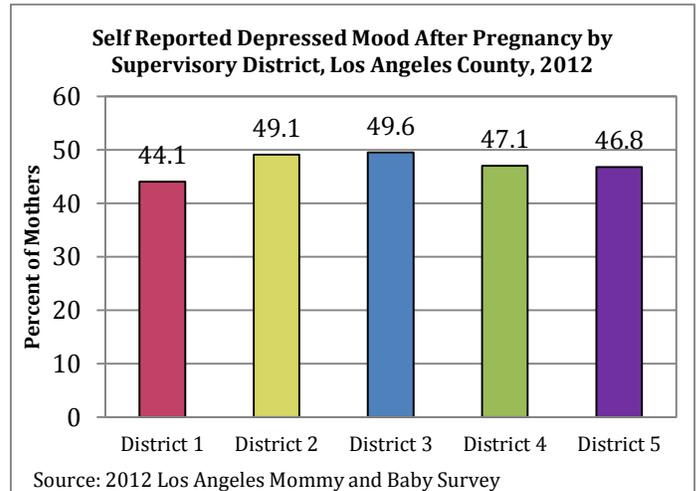
Source: 2012 Los Angeles Mommy and Baby Survey

Reported Family Income

The same holds true during the postpartum period, not only with respect to race and income, but with respect to other factors like education-level and partner support. According to the 2012 LAMB survey:

- African-American mothers were 2.5 times more likely, and Hispanic mothers 2 times more likely, to report severe depressed mood in the months after pregnancy compared to White mothers.
- Mothers with income less than \$20,000 were nearly 3 times as likely to report severe depressed mood in the months after pregnancy compared to mothers with income greater than \$60,000.
- Mothers with less than a high school education were more than 2.5 times as likely to report severe depressed mood in the months after pregnancy compared to mothers with a college education.
- Mothers who had no partner at the time of their delivery were 2 times more likely to report severe depressed mood in the months after pregnancy.¹¹

Although disadvantaged women suffer from the most severe symptoms, the problem of perinatal depression and anxiety is widespread, existing across all supervisory districts and service planning areas in Los Angeles:



The rates of self-reported perinatal depression are extremely high in Los Angeles County, but few women are asked about depression or anxiety at either their pre- or postnatal appointments. According to the 2012 LAMB study, two-thirds of respondents were asked if they felt depressed or anxious at a prenatal appointment, **less than half discussed depression with their provider at a postpartum visit, and only one-third discussed anxiety at a postpartum visit.**¹²

IMPACT ON FAMILIES AND COMMUNITIES

The prevalence of perinatal depression and anxiety is concerning because of the impact on so many aspects of family and community life. For the pregnant woman, these conditions have been linked to **inconsistent prenatal care, increased substance abuse,¹³ and preterm delivery¹⁴** (the number one cause of infant morbidity and mortality). Infants born to depressed and anxious mothers are at risk for being small for gestational age, which may lead to time spent in the neonatal intensive care unit and long-term medical problems.¹⁵ New mothers suffering from depression or anxiety also breastfeed less or for a shorter duration.¹⁶ And, tragically, women are more likely to die by suicide than any other cause in the first year after having a baby¹⁷—a statistic clearly linked to untreated mental illness.

Increasingly, we understand that the biology of being exposed to anxiety and depression *in utero* may make infants more irritable and jittery, with greater lifetime prevalence of psychiatric disorders.¹⁸ For the newborn infant, having a mentally ill mother greatly impacts the bonding, or attachment, that should naturally develop.¹⁹ This disrupted attachment is at the root of many behavioral and psychiatric disorders for children.²⁰ Children of mothers with untreated depression or anxiety also may experience early cognitive developmental delays²¹ and poor academic performance.²² In addition, when these conditions go untreated, **they greatly increase the risk of child abuse and neglect**; as a result, offspring of these women are overrepresented in the child welfare system.²³

The economic impact of perinatal depression and anxiety is profound, particularly for the publicly

funded health and human services system.²⁴ The costs of untreated depression and anxiety for mother and child impact many important sectors:²⁵

- They affect public assistance by decreasing employment and work productivity, increasing demand for programs like unemployment benefits and nutritional assistance.
- Physical health systems are impacted by increased medical disease in depressed mothers, as well as poor birth outcomes of infants.
- Early intervention systems are touched because perinatal depression and anxiety may result in delays in a child's physical, social, and cognitive development.
- Affected children with special needs require special education services, thereby straining the education system.
- The child welfare system grapples with children and families struggling with neglect and abuse as a result of untreated depression and anxiety.

Attempts have been made to assess the financial impact of untreated perinatal depression and anxiety. For instance, one study in Minnesota estimated that **the annual cost of not treating one mother-infant pair with maternal depression was \$22,647.**²⁶ The cost of not treating the mother was \$7,211, based on lost income and productivity; importantly, the study did not take into account health costs, which would increase spending even further. The cost associated with not treating the child was \$15,323, based in part on the cost of treating low-birth-weight and pre-term babies, and future lost income due to delayed brain development. Clearly, in a county as large as Los Angeles, the expense of not treating perinatal depression and anxiety grows very large, very quickly.

BARRIERS TO CARE IN LOS ANGELES COUNTY

Barriers to care for women suffering from perinatal depression and anxiety include widespread systems issues, logistical barriers (particularly for low-income women), ongoing stigma, and lack of education. Systems issues include historically separate care pathways for physical and mental illness, as well as lack of capacity for perinatal and mental health care providers to address maternal depression and anxiety clinically. In Los Angeles County, prenatal care services for most publicly-funded insurance programs are provided in Department of Health Services (DHS) clinics, along with Federally Qualified Health Centers (FQHCs) and community clinics. However, mental health care is typically provided through Department of Mental Health (DMH) clinics or contracted agencies. Separate funding streams, billing systems, and electronic medical records make collaboration between perinatal and mental care providers challenging. However, an emphasis on integrated care within the Affordable Care Act is opening new doors for county leadership to promote perinatal health care systems that include screening and treatment.

A second significant systems issue is that the vast majority of prenatal care providers continues to feel ill-equipped to screen or discuss perinatal depression and anxiety, let alone assess or intervene appropriately. Even mental health care providers themselves often feel inadequately prepared to treat pregnant and postpartum women. Standard screening and referral processes are lacking in most clinics, at least in part because there is a perceived lack of high-quality, affordable services to which to refer. Anecdotally, many women already in psychiatric treatment are taken off medications

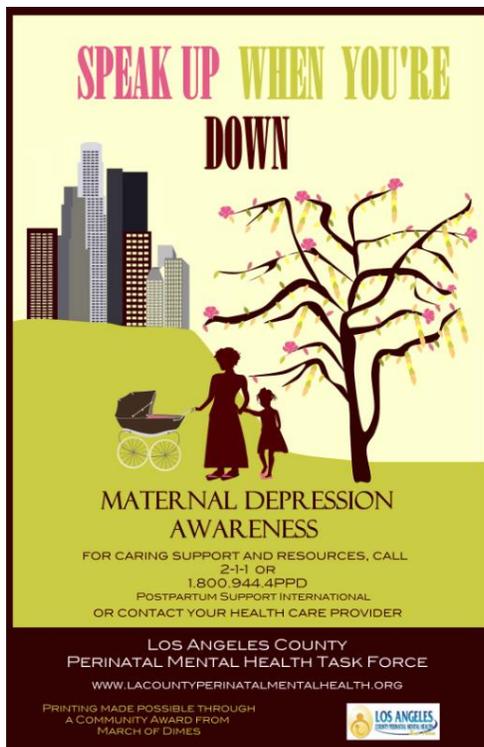
when they become pregnant, frequently leading to relapse, significant health risks, and increased costs of subsequent hospitalization and other higher-intensity services. However, perinatal depression and anxiety are identifiable, diagnosable, and treatable, and with training and technical assistance programs in place, capacity could be greatly increased.

Women themselves face internal and external barriers to care. Stigma remains one of the single largest barriers to care. Women continue to feel ashamed, guilty, and confused when struggling with symptoms of perinatal depression and anxiety, especially when they are led to believe that having a baby should be one of the happiest moments in their lives. Lack of education on all fronts—health care providers, community services, family members, and women themselves—also prevents them from speaking up about their symptoms.

Even if a woman does speak up and is referred to care, multiple external barriers get in the way. Logistical barriers such as transportation and childcare issues significantly impact a woman's ability to get to appointments outside of her usual pre- or postnatal care. Insurance and financial issues also create barriers, with mental health care often “carved out” or not included in health plans. While the Affordable Care Act mandates mental health care parity, as well as “essential benefits” of mental health care, the reality of how these requirements will be implemented is yet to be seen. Moreover, undocumented and incarcerated women—two large populations in Los Angeles County—are not covered by the Affordable Care Act, and questions about mental health services for these two high-risk groups abound.

THE LOS ANGELES COUNTY PERINATAL MENTAL HEALTH TASK FORCE

The Los Angeles County Perinatal Mental Health Task Force was formed in February 2007 as a result of the commitment of the Los Angeles County Office of the Public Defender and the leadership efforts of then Special Counsel/Legislative Analyst Kimberly Wong, a survivor of severe postpartum depression. The Task Force is a project of Community Partners, its 501(c)(3) fiscal sponsor, and is a volunteer network of Los Angeles-based, invested individuals and public and private agencies involved in outreach, screening, and treatment services. The Task Force's mission is to remove barriers to prevention, screening, and treatment of perinatal depression and anxiety throughout the county.



With community support from private foundations, First 5 LA, the Los Angeles County Board of Supervisors, and private supporters, the Task Force has been successful in raising awareness of the needs of women suffering from perinatal depression and anxiety; in training hundreds of health professionals and others providing care to women, infants, and children; and in advancing public policies on a county and statewide level.

The Task Force's achievements to date are numerous in the areas of public awareness, training, and advocacy, and include the following.

Accomplishments in Public Awareness

- Helped secure the passage of ACR 105, which designated May as Perinatal Depression Awareness Month in California.
- Organized a 2011 Perinatal Depression Community Awareness Forum where Supervisor Ridley-Thomas' Office presented a Board Resolution proclaiming May as Perinatal Depression Awareness Month.
- Designed and disseminated hundreds of thousands of copies of the *Speak Up When You're Down* posters and *Six Things Every Mom and Mom-to-Be Should Know About Perinatal Depression* brochures, in seven languages, to county birthing hospitals, community clinics, and child development centers.
- Produced and distributed the *Speak Up When You're Down* Public Service Announcement online, which was seen by over 11,000 people.

Accomplishments in Training and Systems Change

- Developed a Training Institute that delivers tailored trainings—including a 2-day certification training—and customized technical assistance services to all levels of providers across multiple sectors, including early childhood education, health, child welfare, criminal justice, mental health, and more. To date, the Task Force has trained more than 1,800 providers.
- Created a Community Providers Perinatal Mental Health Tool Kit, which includes information on the signs, symptoms, risk factors, effects, screening, assessment, prevention, and intervention for perinatal depression and anxiety disorders, and includes cultural competence issues.
- Launched an innovative, first of its kind pilot project with USC-Eisner Family Medicine to implement an IMPACT model in which perinatal mental health screening and intervention is embedded in primary care visits.
- Piloted the Perinatal Mental Health Map & Resource Directory project, which provides details on 50+ community-based agencies providing perinatal mental health services across all eight SPAs via an interactive database.
- Partnered with 211 LA County to screen women for maternal depression and anxiety who are already working with a 211 LA Care Coordinator on child development concerns and refer women to appropriate resources.
- Co-sponsored the first perinatal mood and anxiety disorder conference in Los Angeles in August 2009, attended by over 200 providers from greater Los Angeles and across the county.

Accomplishments in Advocacy

- Co-sponsored ACR 53 (Hernandez), the Kelly Abraham Martinez Act, which urges hospitals, mental health care providers, health plans, and insurers to invest resources to educate women about risk factors and triggers.
- Co-hosted, with the Los Angeles Best Babies Network, a November 2009 Policy Roundtable in order to build sustainable policies to improve maternal mental health screening practices and treatment services in Los Angeles County. The roundtable led to the publication of a summary report, recommendations, and action plan.
- Published a series of policy briefs including *Access to Quality Care for Maternal Depression: Meeting the Challenge* and *Screening for Postpartum Depression at Well Child Visits*.
- Partnered with the California Maternal Mental Health Collaborative and the American Congress of Obstetricians and Gynecologists to host the 2014 Emerging Considerations in Maternal Mental Health policy summit.
- Received the 2011 National Association of Counties (NACo) Achievement Award in the category of public health for the multifaceted Maternal Depression Improvement Project, which seeks to improve the current service structure for preventing, identifying, and treating maternal depression.

RECOMMENDATIONS

The time has come for feasible, cost-effective, evidence-based recommendations for improving systems of care for perinatal depression and anxiety throughout Los Angeles County. After years of experience collaborating with a wide network of partners and studying the evidence base, the Task Force proposes the following set of recommendations. They can be divided into three sections: **Building Provider Capacity, Increasing Access to Care, and Improving Community Awareness.**

BUILDING PROVIDER CAPACITY

Recommendation 1 <i>Consultation Line</i>	Develop and implement a consultation line for perinatal mental health providers.
Rationale	<p>The Task Force has led the way in training nearly two thousand health providers to assess and treat women suffering from perinatal depression and anxiety. These providers, however, are still learning and need ongoing technical assistance. The consultation line—which would offer psychiatric and psychosocial consultations to mental health professionals, physicians, nurses, social workers, and other social service providers—would provide this assistance.</p>
Proposed implementation	<ol style="list-style-type: none"> 1. Partner with host organizations (e.g., DMH, DHS) to set up infrastructure and pilot consultation line. 2. Develop and refine policies and procedures for call management, liability issues, and ongoing assistance. 3. Target outreach to trained providers to educate them about consultation line. 4. Develop mechanism to track calls for evaluation and further learning purposes.
Progress to date	<p>The Task Force, under the direction of its Training Director, started a monthly consultation group meeting for community-based and health care providers serving pregnant and postpartum women in May 2014. In addition to providing necessary technical assistance to providers, the group will assess the time and expertise needed to staff a consultation line.</p>
Projected costs	<ol style="list-style-type: none"> 1. Licensed staff to provide consultation and clinical support services. 2. Telephone costs and reimbursements. 3. Liability coverage. <p>Initial investment: \$75,000 Ongoing operating costs: \$160,000</p>

Recommendation 2 <i>Increased Training</i>	Train all health and human service sectors that interact with pregnant and postpartum women to recognize and respond to perinatal depression and anxiety.
Rationale	<p>Health and human service providers in the county routinely report poor knowledge of screening and assessment tools, and treatment protocols for perinatal depression and anxiety. Refining and institutionalizing training—for care providers in the publically funded system (DMH, DHS, DPH), for child welfare workers (DCFS), for support services (WIC, community-based workers such as promotoras and sister friends, and faith-based communities), for early childhood educators, and for home visitors—would increase recognition and intervention of these common, treatable conditions, thus improving overall health for both mother and child. In addition, the creation of a perinatal mental health specialization for insurance carriers must be established.</p>
Proposed implementation	<ol style="list-style-type: none"> 1. Continue to work with each sector to refine and package training curricula tailored to the needs of different providers that can be integrated into their routine practices. 2. Identify conferences and other educational opportunities offered by different sectors in which training can be included, and offer to provide this training. 3. Work with insurance carriers to enable mental health providers to self-declare experience working with perinatal depression and anxiety. 4. Advocate for specializations within academic and residency training sites for psychology, psychiatry, other medical fields (such as obstetrics, family practice, and pediatrics), social work, and marriage and family therapy. 5. Work with county and regional chapters of professional provider organizations to provide continuing education credits for training. 6. Continue to offer annual trainings, technical assistance, and mentoring. 7. Develop mobile and web-based trainings.
Progress to date	<p>The Task Force has trained more than 1,800 health and human service providers from both private and public sectors throughout Los Angeles County. Most have received basic training, yet some have had the opportunity to participate in more in-depth training as well as technical support and consultation on complex cases and referral needs. Over 90% of training participants routinely report increased knowledge, comfort level, and preparedness to screen for, discuss, and make referrals for perinatal depression and anxiety as a result of the training.</p>
Projected costs	<ol style="list-style-type: none"> 1. Creation and dissemination of “train the trainer” modules. 2. Cost of supporting policy work aimed at identifying opportunities for partnership, continuing education, and insurance advocacy. 3. Promotion of 2-day certification training. <p>Initial investment: \$120,000 Ongoing operating costs: \$92,000</p>

INCREASING ACCESS TO CARE

Recommendation 3 <i>Resource Directory</i>	Create and continually update the Los Angeles County Perinatal Mental Health Resource Directory.
Rationale	<p>Providers across the county report reluctance to screen for perinatal depression and anxiety given the shortage of appropriate referral resources. The Task Force has taken steps to eliminate this barrier to care by partnering with 211 LA County and the Department of Public Health-Maternal, Child & Adolescent Health Programs (LADPH-MCAH) to create a comprehensive resource guide that is both telephone- and web-based.</p>
Proposed implementation	<ol style="list-style-type: none"> 1. Continue partnership with 211 LA to make perinatal mental health resources available to all callers, not just those already working with a 211 LA Care Coordinator. 2. Continue partnership with LADPH-MCAH to make resources available on a searchable geo-coded map on county and Task Force websites. 3. Ensure directory is current and accessible.
Progress to date	<p>To date, the Task Force has vetted more than 50 perinatal mental health resources, some in each service planning area. It is continuing to vet resources, with the goal of having 100 available by Fall 2014. With respect to 211, a pilot program was launched in May 2014 in which 211 screens a subset of callers already working with a 211 LA Care Coordinator on child development concerns for maternal depression and provides referrals as necessary. LADPH-MCAH has created a static web-based map of the vetted resources, which recently went live. Work on the geo-coded map to be located on the Task Force's web site will begin soon.</p>
Projected costs	<ol style="list-style-type: none"> 1. Costs of hosting website. 2. Costs of Task Force staff time to continually vet and update resources. 3. Outreach to providers informing them of Resource Directory. <p>Initial investment: \$90,000 Ongoing operating costs: \$25,000</p>



Recommendation 4 <i>Home Visitation</i>	Integrate perinatal mental health best practices into county home visitation programs.
Rationale	<p>The county has seen a dramatic increase in home visitation programs over the past few years due to increased federal funding. The home visitor model is an ideal opportunity to address the early stages of postpartum depression, because the relationships that providers build with new mothers in the safety of their own homes engages women who may not otherwise seek help. Indeed, “multiple studies have shown that using care managers to complement the primary care physicians’ role in the treatment of depression improves outcomes and is cost-effective. . . [A]ppropriately trained home visitors could serve such a role.”²⁷ But current home visitation programs report difficulties addressing maternal mental health as well as a dearth of appropriate referrals in the county.</p>
Proposed implementation	<ol style="list-style-type: none"> 1. Collaborate with Home Visitation Consortium to identify opportunities for integrating mental health into regular home visitation services. 2. Increase perinatal mental health training for home visitors and provide necessary technical assistance as well as a “train the trainer” model. 3. Coordinate with home visitation programs to integrate Resource Directory into their regular referral databases to streamline referrals for women needing further support.
Progress to date	<p>Over the past few years the Task Force has trained much of the staff of Nurse Family Partnership and the Welcome Baby program. The Task Force continues to monitor the home visitation growth in the county, and actively participates on numerous policy and programming boards. It will continue to explore opportunities with First5 LA and Early Head Start to provide training, technical assistance, and resources to home visitation programs.</p>
Projected costs	<ol style="list-style-type: none"> 1. Advocacy for more in-depth and advanced training to home visitors, as well as ongoing technical assistance. 2. Administrative costs of linking Resource Directory to existing home visitation referral networks. <p>Initial investment: \$36,000 Ongoing operating costs: \$85,000</p>



Recommendation 5 <i>Integrated Care</i>	Expand integrated perinatal mental health care model to facilitate screening, assessment, and treatment in primary care FQHC/county clinics.
Rationale	<p>While multiple barriers prevent Americans from seeking medical care, women of childbearing age tend to access medical care during pregnancy and post-delivery on a routine basis, either for their own care or the care of their children. This creates an opportunity to identify women in need of services related to perinatal mental health, especially with the advent of the Affordable Care Act's increased emphasis on integrating behavioral health into primary health care settings. Embedding perinatal mental health screening, assessment, and treatment into prenatal and primary health care "medical homes" reduces stigma and other barriers to care, improves access, and facilitates treatment.</p>
Proposed implementation	<ol style="list-style-type: none"> 1. Support and enhance demonstration projects already in practice by facilitating communication and technical assistance between leaders of these projects. 2. Provide expert consultation for medical sites interested in starting new integrated care programs. 3. Identify barriers to integrated perinatal mental health care in county facilities, and promote countywide policies that ease restrictions on billing and other logistical issues. 4. Advocate for continuity of care by helping to bridge the maternal mental health gap between obstetrics and pediatrics.
Progress to date	<p>The Task Force has been collaborating with USC-Eisner Family Medicine Clinic, an FQHC in downtown Los Angeles, for two years to develop and run the New Family Care Team. This demonstration project, based on an IMPACT model of care, has integrated perinatal mental health screening, assessment, and treatment into a primary medical setting. The goals are to identify women during the perinatal period, increase prevention of perinatal mood and anxiety disorders, and provide stepped-care for at-risk families. The program is scheduled to collect and analyze its first data set on quality outcomes and cost effectiveness of this model in late 2014. Discussions with other settings, including pediatric and primary care clinics, are ongoing as interest in replicating this model increases.</p>
Projected costs	<ol style="list-style-type: none"> 1. Collect and disseminate data on feasibility of integrated care model at Eisner. 2. Continue Task Force's role as advisor for emerging integrated care programs. 3. Support policy work aimed at identifying and reducing barriers to integrated care. <p>Initial investment: \$72,000 Ongoing operating costs: \$150,000</p>

Recommendation 6 <i>Universal Screening & Referral</i>	Promote systems for perinatal mental health screening and referral in all pre- and postnatal care settings, including support services such as home visitation, WIC, etc.
Rationale	<p>Screening tools are available in multiple languages and can be administered via a staff member or via self-report, and take less than 10 minutes to complete. By instituting screening procedures, the detection of women suffering will vastly increase, allowing them to be appropriately assessed and referred for treatment. This will, in turn, decrease the impact on child development and lower healthcare costs over time.</p>
Proposed implementation	<ol style="list-style-type: none"> 1. Create provider “cheat sheet” for how, when, where, and why to screen, as well as how to score screens and refer to appropriate resources. 2. Adopt and implement routine screening procedures in all county agencies and medical setting that provide care to pregnant and postpartum women. 3. Clarify and promote appropriate coding and billing procedures for screening services. 4. Advocate that perinatal screening services be included in “essential services” to be provided free of charge for patients in all expanded Medi-Cal and Covered California plans. 5. Support and facilitate communication between pilot projects in pediatric settings that screen for maternal depression and anxiety. 6. Advocate that screening and referral be included in performance metrics used to assess health care services, e.g., through LA Care and Health Net Medi-Cal Managed Care plans.
Progress to date	<p>The Task Force has trained more than 1,800 providers on screening techniques for perinatal depression and anxiety. The PHQ9 and EPDS3 have been identified as evidence-based, easy-to-use screens, and have been promoted in these trainings. Health care advocacy organizations (such as LA Best Babies Network) and home visitation programs (such as Nurse Family Partnership and Welcome Baby) are routinely training their providers to screen for perinatal depression. The Task Force has also published a policy brief for pediatricians that addresses the issue of screening for maternal depression in pediatric settings. Multiple pediatric sites have launched pilot projects to screen for maternal depression and anxiety.</p>
Projected costs	<ol style="list-style-type: none"> 1. Trainings and ongoing technical assistance for screening in different sectors. 2. Support for policy and advocacy work regarding reimbursement and access to care issues. <p>Initial investment: \$85,000 Ongoing operating costs: \$100,000</p>

INCREASING COMMUNITY AWARENESS

Recommendation 7 <i>Public Awareness</i>	Implement culturally and linguistically appropriate public awareness campaign for Los Angeles County to reduce stigma.
Rationale	<p>Perinatal depression and anxiety are the most common complication of childbirth, yet few women or their families are informed about these conditions. In efforts to reduce stigma and increase awareness, the public needs to be educated about this serious public health issue.</p>
Proposed implementation	<ol style="list-style-type: none"> 1. Disseminate a public service announcement in English and Spanish via television and radio. 2. Distribute <i>Speak Up When You're Down</i> brochures in all hospital discharge packets and in First 5 LA New Parent Kits. 3. Create an awareness campaign with ads featured on buses, at bus stops, on billboards, in key threshold language newspapers, via online and social media, and via apps. 4. Expand Task Force's Share Your Stories Speakers Bureau, a collection of firsthand accounts from women who have struggled with perinatal depression and anxiety and affected family members.
Progress to date	<p>The Task Force created the <i>Speak Up When You're Down</i> brochures in multiple threshold languages, hundreds of thousands of which have been distributed through diverse venues. The Task Force also created and continues to expand its Share Your Stories Speakers Bureau, which encourages survivors of perinatal depression and anxiety to share their stories.</p>
Projected costs	<ol style="list-style-type: none"> 1. Printing and storage costs for additional brochures and other materials. 2. Direct mailing of brochures and other distribution strategies. 3. Production and media placement of television, radio, online, and print public service announcements. 4. Development of social media, and online and mobile applications. <p>Initial investment: \$225,000 Ongoing operating costs: \$285,000</p>



TIMELINE

The timeline for implementing the above recommendations would focus first on continuing projects already underway, such as the Perinatal Mental Health Resource Directory and training within home visitation programs. Recommendations that would support those existing projects, such as the consultation line and increased training programs, would be implemented at the same time. Of course, the process of creating partnerships and seeking funding opportunities for the additional recommendations could occur simultaneously. Ideally, these recommendations would take the form of a **five-year plan**:

Year(s)	Recommendations implemented
1-2	#1: Consultation Line #2: Increased Training #3: Resource Directory #4: Home Visitation
3-4	#5: Integrated Care #6: Universal Screening & Referral
5	#7: Public Awareness

CONCLUSION

Left untreated, perinatal depression and anxiety can have far-reaching negative effects on mothers, children, families, and communities. These conditions not only impair the attachment that every infant needs to have with his or her mother, but also physical health, child development, healthy relationships, and economic productivity and strength. Fortunately, they are easily identified, assessed, and treated, as long as all sectors of health and human services are educated, and the women they serve are not afraid to speak out. The time has come to advocate for true systems change that would accomplish these goals. The Task Force looks forward to partnering with providers, advocates, and policymakers throughout Los Angeles County to bring light to motherhood, and ensure that each mother, child, and family has a happy, healthy start in life.

The Task Force is proud to be supported by the following member organizations:

211 LA County
Breastfeed LA
California Maternal Mental Health Collaborative
The Center for Postpartum Health
Children’s Bureau of Southern California
The Children’s Clinic
Children’s Institute, Inc.
LA County Department of Children & Family Services
Department of Health Services – Strong Start
Didi Hirsch Community Mental Health Services
Doula Association of Southern California
Early Childhood Parenting Center
Eisner Pediatric & Family Medical Center
El Nido Family Centers
End Abuse Long Beach
Esperanza Community Housing
First 5 LA
Great Beginnings for Black Babies
Harbor UCLA Medical Center
Inter Agency Council on Child Abuse and Neglect
Jewish Family Service of Los Angeles
Junior Leagues of California/SPAC
Kaiser Permanente
LA Best Babies Network
LA County Department of Mental Health
LA County Department of Public Health MCAH Programs
LA Unified School District – School Mental Health Services
Magnolia Community Initiative
Maple Counseling Center
Maternal Child Health Access
Maternal Wellness Center at LAC+USC
Nurse Family Partnership

PAC/LAC: Perinatal Advisory Council/Leadership, Advocacy and Consultation
Para Los Ninos
Pathways LA
PHFE-WIC
Postpartum Support International (PSI)
Project ABC/Children's Hospital/USC Keck School of Medicine
South Bay Center for Counseling
St. Joseph Center
St. Mary Medical Center
UCLA Center for Healthier Children, Families & Communities
UCLA/Johnson & Johnson Health Care Institute
USC Eisner Family Medicine Center
USC School of Social Work
Welcome Baby

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