MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families
A Project of Community Partners

ZERO TO THREE
Early connections last a lifetime

BRIEFING PAPER

MOVING FORWARD

Collaborative Solutions for Perinatal Mental Health in Los Angeles County

December 2017

INTRODUCTION

For the past year Maternal Mental Health NOW has been working with ZERO TO THREE and the Maternal Mental Health Policy and Systems Change Committee. This paper represents our collaborative thinking. Maternal Mental Health NOW would like to thank ZERO TO THREE for elevating the voice of the baby to this important work. Maternal Mental Health NOW (formerly the Los Angeles County Perinatal Mental Health Task Force) is a public/private consortium of over fifty non-profit organizations, government agencies, health and human service providers, advocacy groups, and individuals with lived experience. Since 2007, we have been leading the charge to address maternal mental health in Los Angeles County through training and technical assistance, policy and advocacy, and public awareness. In August 2014, we released our first concept paper outlining seven recommendations for improving the system of care for women struggling with maternal mental health conditions and their families.

Since then, much has changed. In the past three years, we, along with our partners, have made significant progress on many of those recommendations, requiring us to revisit them, and revise them with what we have learned. We also convened a policy roundtable in May 2015, bringing together leaders from all sectors that interact with new mothers and families, which resulted in additional creative solutions to improve the system of care. Since then, we have been working on bringing many of those solutions to life.

Outside of Los Angeles County, the issue of maternal mental health has become much more prominent. A steady stream of new research studies confirm the correlation between untreated perinatal mental health issues and poor child development, and shed new light on the importance of a trauma-informed, two-generational approach to maternal mental health. Influential health care experts—including the U.S. Preventive Services Task Force and the American Congress of Obstetricians and Gynecologists—have issued new recommendations on screening expectant and new

mothers. In addition, the California legislature convened a task force to study the status of maternal mental health care in the state. These developments have contributed to a growing sense of urgency around this issue, both locally and nationally.

There is significant momentum within Los Angeles County among public agencies, philanthropic partners, and health providers to bolster access to early intervention services for mothers and young children.

- In December 2016, the Los Angeles County Board of Supervisors unanimously passed a motion to establish a county-wide system for home visitation. National data suggests that home visits may detect maternal depression, prevent child abuse and neglect as well as promote mother-infant interaction.*
- In the expanded system envisioned by the Department of Public Health (DPH) and its partners, including First 5 LA, the Department of Mental Health (DMH), the Department of Social Services (DPSS) and the Los Angeles County Perinatal and Early Childhood Home Visiting Consortium, home visitors will assess and route mothers to appropriate behavioral and social support services. This effort is being furthered in concert with the Office of Child Protection (OCP), the entity responsible for leading a broad partnership to implement meaningful solutions to improve the lives of children and families. The OCP strategic plan highlights the need for improved supports for parents of young children to strengthen families and support positive child development.
- Relatedly, First 5 LA, in partnership with LA Care, Department of Public Health, and the American Academy of Pediatricians (AAP), recently completed an extensive planning process for Help Me Grow, a model of promoting healthy child development through early identification and intervention of children's developmental needs, in partnership with over 75 organizations, agencies and programs across Los Angeles County.
- Finally, the recent creation of a Health Agency, bridging the County's mental health, substance abuse, and health services, provides a sustainable platform to provide integrated care for mothers and dyads with mental health needs so that resiliency continues to grow in our communities.

There is significant momentum within Los Angeles County among public agencies, philanthropic partners, and health providers to bolster access to early intervention services for mothers and young children.

With this briefing paper, we hope to build on this momentum, driving meaningful change for all of the women and their families who are struggling. We propose a series of recommendations to improve the system of care in Los Angeles County by:

1. further increasing provider capacity for universal screening and treatment,
2. further improving access to treatment and supports, and
3. further building community awareness and reducing stigma.

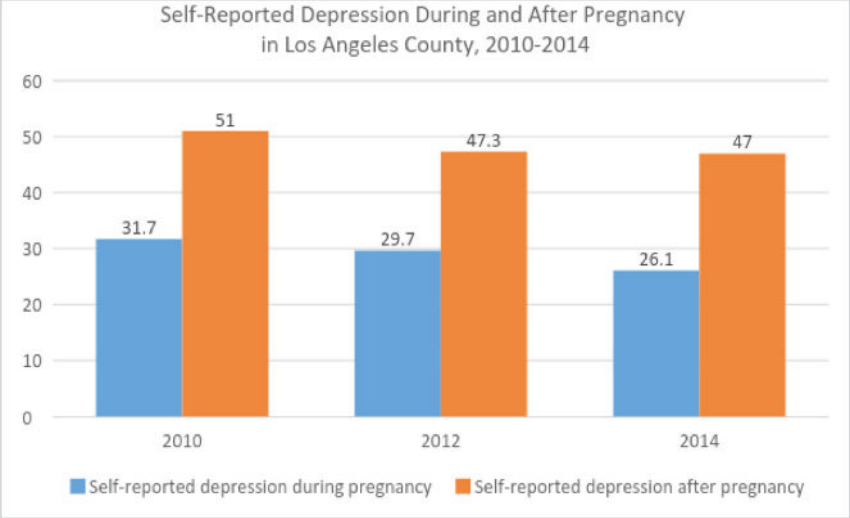
Our hope is that by continuing to partner with providers, advocates, and policymakers to implement these recommendations, **we can move this issue forward, ensuring that each mother, child, and family has a joyful, healthy start in life.**

MATERNAL DEPRESSION IN LOS ANGELES COUNTY

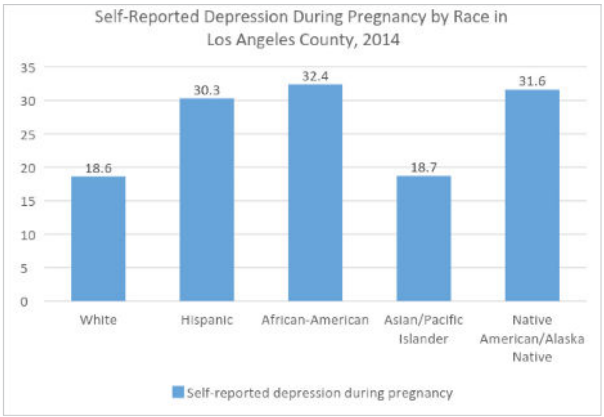
Maternal depression and anxiety can affect expectant and new mothers—and new fathers[i]—at any time during preconception, pregnancy, and up to two years postpartum. Nationally, it is estimated that one in seven new mothers suffers from postpartum depression. And in California, one in five women giving birth experienced either prenatal or postpartum depression in 2013[ii].

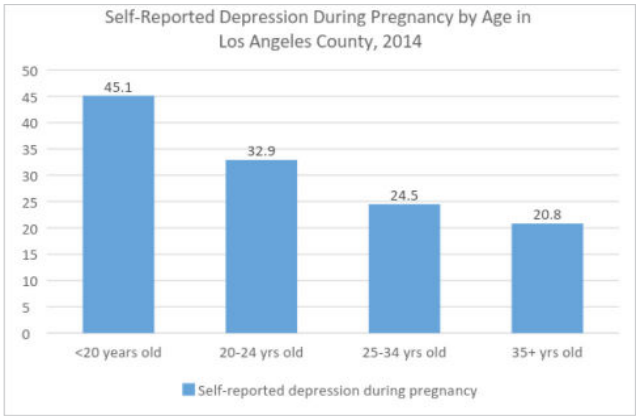
In Los Angeles County, the rates are even higher. The 2014 Los Angeles Mommy & Baby (LAMB) Survey of the Los Angeles Public Health Maternal, Child & Adolescent Health Programs asked mothers to self-report symptoms of depression before, during, and after pregnancy. While only 10% reported symptoms of depression before pregnancy, 26.1% reported depressive symptoms during pregnancy[iii], and an astounding 47%—representing more than 62,000 women—reported depressive symptoms after pregnancy[iv].

Since 2010, the rates of self-reported depression, both during pregnancy and in the postpartum period, have decreased only modestly, indicating that there is still significant room for improvement in Los Angeles:



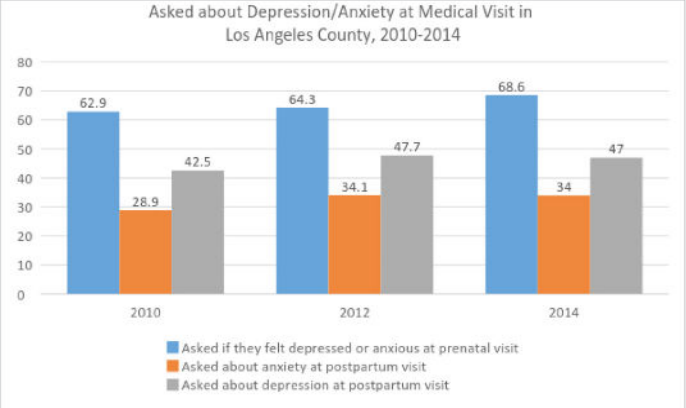
In addition, the rates of self-reported depression are stubbornly high among Latina, African-American, and Native American mothers, as well as vulnerable groups, including very young mothers—especially during pregnancy:





The greatest predictor of postpartum depression, regardless of race or ethnicity, is depression during pregnancy: mothers who reported depression during pregnancy were far more likely to report depressed mood after pregnancy (73.4%) compared to of mothers who did not report depression during pregnancy (only 37.7%).

The LAMB survey also asked new mothers if their medical providers discussed anxiety or depression at either their prenatal or postpartum care visits. While it is promising to see that these rates have slightly increased since 2010 the numbers were stagnant between 2012-2014.



The prevalence of maternal mental health disorders is concerning because, when they go untreated, they can impact many aspects of family and community life. Research clearly demonstrates that untreated maternal depression can become chronic. According to the 2014 LAMB survey, mothers who were depressed during their pregnancy were significantly more likely to report depression more than two years after giving birth (60%) compared to mothers who were not depressed during their pregnancy (27%). Among mothers who were depressed during their pregnancy, 74.4% of African-American, 61.4% of Latina, and approximately 46% of White and Asian/ Pacific Islander mothers reported depression more than two years after giving birth.

For the pregnant woman, untreated maternal depression has also been linked to inconsistent prenatal care, increased substance abuse [v], development of physical health problems such as gestational disabilities, and preterm delivery [vi] —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 [vii]. New mothers suffering from depression or anxiety are less likely to breastfeed and when they do it is for shorter durations [viii]. And, tragically, depressed mothers are more likely to die by suicide than any other cause in the first year after having a baby [ix]—a statistic clearly linked to untreated mental illness.

The economic impact of maternal depression is profound, particularly for the publicly-funded health and human services system [x]. The costs of untreated depression and anxiety for mother and child impact many important sectors [xi]:

- They affect public assistance systems by decreasing employment and work productivity, increasing demand for programs like unemployment benefits and nutritional assistance, especially when untreated maternal depression becomes chronic.
- Health providers and health plans are adversely impacted by increased medical disease in depressed mothers, as well as when maternal depression contributes to poor birth outcomes.
- Early intervention systems are impacted when untreated maternal depression results in delays in a child's physical, social, and cognitive development.
- In turn, children with special needs require special education services, thereby straining the public education system.
- The child welfare system grapples with children and families struggling with neglect and abuse as a result of untreated depression and anxiety.

Although assessing the financial impact of untreated maternal depression is difficult, attempts have been made to do so. For instance, one study in Minnesota estimated that the annual cost of not treating a mother-infant pair with maternal depression was $22,647 [xii]. The cost associated with 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 preterm babies, and future lost income due to delayed brain development. Clearly, in a county as large as Los Angeles, the expense of not treating maternal depression grows very large, very quickly.

UNTREATED PERINATAL DEPRESSION, TRAUMA, ATTACHMENT AND CHILD DEVELOPMENT

Untreated maternal depression impairs the healthy development of infants and young children. It is via the attachment relationship that optimal development occurs. Children whose parents and grandparents have depression are at higher risk for depression and anxiety. Maternal depression can also affect the parent-child relationship. Since a child's emotional health and a strong parent-child attachment provide the foundation for healthy development throughout life, maternal depression can have a long-lasting impact on infant and early childhood mental health.

Infant and early childhood mental health is the capacity of the child to form close and secure adult and peer relationships, experience, manage, and express a full range of emotions, and explore the environment and learn—all in the context of family, community, and culture [xiii]. Infant mental health is synonymous with healthy social and emotional development. Infant mental health also refers to the mental wellness of the caregiving relationship between parent and child.

A woman's poor mental health while pregnant can have negative consequences. Exposure to depression and anxiety during pregnancy may result in infants that are more irritable, a reduced ability to respond to stress, and a greater lifetime prevalence of psychiatric disorders. For the newborn infant, having a mother with depression impacts the bonding and attachment that should naturally develop. Early identification and treatment of depression in perinatal women is critical for the mother's and children's health and well-being.

In the postpartum period, maternal depression can continue to negatively affect the baby's healthy development. Attachment, one aspect of the caregiving relationship, is a critical component of emotional development. Babies innately strive for strong, emotional connections with primary caregivers. This attachment permits children to develop trust and confidence as well as the ability to regulate stress and distress. The quality of the attachment predicts later development. A secure attachment early in life is more likely to result in positive relationships with peers, better performance in school, and displays of resilience when faced with adversity [xiv], [xv]. A disrupted attachment is at the root of many behavioral and psychiatric disorders for children. Children of mothers with untreated depression or anxiety may experience early cognitive developmental delays and poor academic performance. In addition, when these conditions go untreated, they greatly increase the risk of child abuse and neglect; as a result, infants and young children born to women with untreated depression are overrepresented in the child welfare system [xvi], [xvii].

Healthy brain development requires parent-child interactions that are sometimes referred to as "serve and return." This back and forth cadence of a relationship can be impaired when a mother is chronically depressed [xviii]. Two disruptive patterns may evolve in a depressed parent: (1) hostile and intrusive or (2) disengaged and withdrawn. If a parent is hostile or intrusive, the ball is "served" in a manner that makes it difficult for the child to return the ball. Alternatively, when a parent is disengaged or withdrawn, the child may serve the ball but it is not returned by the parent. A depressed mother is less likely to respond to their baby's cues or engage with their child in positive ways: "The caregiver's effectiveness in providing age-appropriate, sensitive care to the infant or young child is an important influence on the child's ability to trust and rely on the caregiver to meet physical and psychological needs." [xix], [xx], [xxi] The problematic patterns are of concern because these negative parent-child exchanges may continue even after the mother's depression has improved if

they are not addressed. There then can be an increased likelihood for the child to have negative interactions with other prominent caregivers [xxii], [xxiii]. Maternal depression, if left untreated, interferes with the quality of the parent-child relationship and may adversely affect the infant or young child's overall health, development, and learning.

Additionally, untreated maternal mental illness is an adverse childhood event (ACE) that can often lead to other adverse events such as child abuse and neglect. Research on ACES, community trauma, and toxic stress has provided the impetus for changes on an organizational and systems level across the country and in Los Angeles County. Vulnerability or resilience in the face of trauma is strongly influenced by what happens to infants in the perinatal period. The first days, months and years of life are crucial for establishing later capacities and deficits. Our early years are formative and unusually influential. Resilience and vulnerability to trauma also get passed intergenerationally. Mothers with untreated mental illness find it difficult to perform the essential functions involved in helping their infants and young children regulate their own states which in turn impact their life trajectory.

Resiliency refers to the capacity of individuals, families, and communities to heal from unmanageable stress and trauma, and even to strengthen their well-being and adaptability. "Individuals are not born resilient to trauma. Resilience must be built in via the mother and other caregivers through the mechanisms of attachment which in turn contribute to positive and healthy brain development." *

Related to this is the fostering of individual and family resilience which can be supported, not only by timely mental health intervention, but also by programs that promote healthy attachment from the start. As organizations and systems become more adept at assessing for, recognizing and responding to the symptoms of perinatal mental illness and are able to screen, refer and treat, they must also implement programs and policies that help individuals, families, and communities to strengthen their resiliency. Resiliency is cultivated when community level and individual level programs that empower parents of young children are put into place. An approach, such as Strengthening Famiiles, Protective Factors Framework**, builds upon the strengths already present in the community by focusing on the protective factors of parental resilience, reducing social isolation by fostering social connections, improving knowledge of parenting and child development, and fostering the social and emotional competence of children. It has been demonstrated to reduce child abuse and neglect and promote thriving and well-being across generations.

BARRIERS AND OPPORTUNITIES IN LOS ANGELES COUNTY

Barriers to care for women suffering from maternal depression 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 to address maternal depression clinically, as well as a dearth of trained OB/GYNs, pediatricians and primary care providers who have the opportunity to interact with women at frequent intervals during prenatal and well-child visits.

In Los Angeles County, a significant portion of prenatal care services for women with publicly-funded insurance are provided by the Department of Health Services (DHS) clinics and Federally Qualified Health Centers (FQHCs). However, determining the most appropriate behavioral health provider for a woman enrolled in Medi-Cal managed care who is afflicted with depression or anxiety is challenging; the severity of her mental illness determines who pays and provides services. Women with mild mental health conditions can be served in primary care. Medicaid health plans are responsible for providing behavioral health services to members with moderate behavioral health conditions, typically provided through contracted Behavioral Health Organizations that maintain a network of health providers, which may include private therapists or clinics. And finally, the Department of Mental Health (DMH) is responsible for Angelinos who are seriously mentally ill, who receive services at Department of Mental Health (DMH) clinics or contracted agencies.

Separate funding streams, billing systems, and electronic medical records make collaboration between physical and mental care providers challenging. With the Affordable Care Act's focus on integrating physical and mental health care, we are seeing a slight shift as fragmented systems begin to work better with one another—but there is still a long way to go.

A second significant systems issue is that the vast majority of prenatal care providers feel ill-equipped to screen or discuss maternal depression, 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, and/or accessible 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, maternal depression is identifiable, diagnosable, and treatable, and with more systematized 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 greatest barriers to care. Women continue to feel ashamed, guilty, and confused when struggling with symptoms of maternal depression, 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. Additional education is required to ensure that women enrolled in managed care plans access and can receive covered outpatient mental health care, including:

- Individual and group mental health testing and treatment (psychotherapy)
- Psychological testing to evaluate a maternal mental health condition
- Outpatient services that include lab work, drugs, and supplies
- Outpatient services to monitor drug therapy
- Psychiatric consultation
- Screening, brief intervention and referral to treatment

While the Affordable Care Act mandates mental health care parity, as well as "essential benefits" of mental health care, additional referring provider and patient education is required to ensure women access behavioral health services in a timely fashion. Moreover, undocumented and incarcerated women—two large populations in Los Angeles County—are not covered by the Affordable Care Act, and although incarcerated women receive health care via the County and undocumented women are enrolled in My Health LA and receive access to behavioral health services, their access to perinatal mental health care remains quite poor. Notably, LA County faces a significant challenge in getting women enrolled in Medi-Cal to return for postpartum health care of any kind, creating a significant and persistent barrier to maternal mental health screening. Women who are not engaged in postpartum health care, despite access to health care, are at risk.

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NEW DEVELOPMENTS IN MATERNAL MENTAL HEALTH

In many ways, the past two years have been a turning point for maternal mental health. Public awareness has grown with new documentaries about the issue, high-profile celebrities sharing their struggles, and near-daily articles touching on the subject.

The medical community at large has also begun to recognize the importance of screening and treating expectant and new mothers, with many influential medical experts issuing recommendations echoing those made by the American Academy of Pediatrics in 2010.

Universal depression screening of all pregnant and postpartum women is now recommended by multiple societies including the Unites States Preventive Task Force (USPSTF), The Council on Patient Safety in Women's Health Care, The American College of Obstetricians and Gynecologists (ACOG), The Agency for Research Health and Quality (ARHQ) The American Psychiatric Association (APA) and the Health Resources and Services Administration (HRSA). In October 2017, The American Medical Association adopted a new policy calling for more routine depression and anxiety screenings in new and expectant moms. Specifically a resolution was adopted to implement screening during prenatal, postnatal, pediatric or emergency room visits. In addition, efforts are underway to make screening all perinatal patients for depression a HEDIS requirement.

Los Angeles County itself has also seen a greater commitment to this issue. In May 2015, Maternal Mental Health NOW hosted a policy roundtable attended by more than 100 stakeholders and leaders throughout the county. Speakers included: Dr. Bruce Perry, an internationally-recognized expert on trauma and its relationship to maternal mental health; Deb Wachenheim, a leading maternal mental health advocate; Dr. Marvin Southard, then Director of the Department of Mental Health; Cynthia Harding, Interim Director of the Department of Public Health; and State Senator Holly Mitchell. All of the speakers discussed why maternal mental health is a critical public health issue and urged the attendees to continue working to improve the system of care. The attendees then broke out into roundtable discussions on various topics—ranging from child welfare and maternal mental health, to the integration of maternal mental health into medical settings, to the importance of social support. The ideas coming out of the event and subsequent developments are reflected in our updated recommendations below.

Another important development is the county's commitment to trauma-informed care, with influential groups like First 5 LA, the Department of Health Services, the Department of Mental Health, philanthropic organizations, and other departments and agencies making considerable investments in this movement. As we know, untreated maternal depression can lead to an insecure attachment relationship between a mother and her infant, which in turn can lead to emotional dysregulation in the infant, the buildup of toxic stress, and lifelong physical and emotional problems. The work nationally being done on ACES lets us know that indeed, having a depressed parent is itself an "adverse childhood experience." But we also know that, just as trauma can be passed down through generations, so too can resilience. For that reason, we base all of our work on a dyadic, two-generation, trauma and resilience informed approach. We applaud the county for working similarly and look forward to creating a trauma and resilience informed community together.

MATERNAL MENTAL HEALTH NOW

Maternal Mental Health NOW was formed in 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. We are a network of Los Angeles-based, invested individuals and public and private agencies involved in outreach, screening, and treatment services.

OUR MISSION
is to remove barriers to the prevention, screening, and treatment of prenatal and postpartum depression in LA County.

With community support from many LA based foundations, First 5 LA, the Los Angeles County Board of Supervisors, and private supporters, we have been successful in raising awareness of the needs of women suffering from maternal depression; in training thousands of health and human service professionals and others providing care to women, infants, and children; and in advancing public policies on a county, statewide and national level.

Maternal Mental Health NOW's numerous achievements in the areas of public awareness, training, and advocacy include the following:

ACCOMPLISHMENTS IN PUBLIC AWARENESS

1. Helped secure the passage of ACR 105, which designated May as Perinatal Depression Awareness Month in California.
2. Organized a 2011 Perinatal Depression Community Awareness Forum where Supervisor Ridley-Thomas' Office presented a Board Resolution proclaiming May as Perinatal Depression Awareness Month in Los Angeles County.
3. Designed and disseminated hundreds of thousands of copies of the *Speak Up When You're Down* posters and *Six Things Every New Mom and Mom-to-Be Should Know About Perinatal Depression* brochures available in English, Spanish, Chinese, Korean, Vietnamese, Farsi, Armenian and Tagalog.
4. Created and distributed an infographic using the LAMB data to depict why maternal mental health is a critical public health issue for the county.
5. Produced multiple Public Service Announcements in English and Spanish.
6. Spearheaded the peer-based Share Your Story movement, which brings together women with lived experience to reflect on their struggles with maternal mental health and the stigma surrounding this issue.
7. Organized multiple Speak Up When You're Down Family Festivals, encouraging mothers in low-income communities to prioritize self-care and to let them know about the communities of support that surround them.

ACCOMPLISHMENTS IN TRAINING AND TECHNICAL ASSISTANCE

1. Developed a Training Institute that delivers tailored trainings 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, we have trained 15,000 providers.
2. Developed an online and on-demand Maternal Mental Health Certification Training for all levels of providers who cannot attend an in-person training.
3. Launched a webinar-based consultation group in which providers of all levels can receive expert advice and support from a maternal mental health clinician.
4. Conduct annual conferences on special topics such as The Intersection Between Trauma and Maternal Mental Health and Diversity and Disparities in Perinatal Mental Health.
5. 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 maternal depression disorders, and includes cultural competence issues. This is available for free at materntalmentalhealthnow.org.
6. Developed a web based psychoeducational app to improve patient engagement amongst perinatal women.
7. Developed, implemented and began to spread a model of collaborative integrated care in which perinatal mental health is integrated into medical settings particularly in FQHC's such as Eisner Family Medical Center and Harbor Community Clinic and clinics in the county health system such as Martin Luther King Outpatient Medical Center.
8. Provide training and technical assistance and consultation to medical providers and entire hospital systems wishing to integrate perinatal mental health into their settings.

ACCOMPLISHMENTS IN POLICY & ADVOCACY

1. Developed a first-of-its kind, online Maternal Mental Health Resource Directory, which is fully searchable and contains approximately 340 resources, two-thirds of which accept Medi-Cal or are no- or low-cost.
2. Work with DPH-MCAH to use the LAMB data to inform our work, and understand where gaps are in services for this population in each Service Planning Area.
3. Launched an innovative, first of its kind pilot project with USC-Eisner Family Medicine to implement an IMPACT Collaborative Care model, in which perinatal mental health screening and intervention was embedded in primary care visits.
4. Expanded this integrated care initiative to several other clinics and medical providers in the safety net, who are now screening expectant and new mothers and either referring them using our online directory or providing mental health services themselves.
5. 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.
6. Hosted two policy roundtables in 2009 and 2015 in order to build sustainable policies to improve maternal mental health screening practices and treatment services in the county.
7. Published a series of policy briefs on maternal mental health care in Los Angeles County.

RECOMMENDATIONS

The following updated recommendations are put forth to improve the maternal mental health system of care in Los Angeles County. They can be divided into three sections: Building Provider Capacity, Increasing Access to and Engagement In Care, and Improving Community Awareness. Preliminary action items are listed. Items generated at the Moving Forward Policy Roundtable on December 8, 2017 will inform a strategic plan for realizing the recommendations below.

BUILDING PROVIDER CAPACITY

Recommendation 1:	Develop and implement a sustainable perinatal psychiatry consultation line for medical providers
Rationale:	OBGYNs, pediatricians, primary care doctors, even psychiatrists can be hesitant to screen for perinatal depression because, if prescribing psychiatric medications to pregnant and nursing women is indicated, they often lack the expert consultation to do so. Time and again, we have heard from physicians that they are uncomfortable treating maternal mental health disorders in-house and would rather refer them out. The problem, of course, is that there is a dearth of perinatal psychiatrists in Los Angeles County, and little or no access to them particularly in the safety net. This leaves vulnerable woman in an impossible position, preventing them from accessing potentially life-saving treatment options. Other municipalities, including Massachusetts and Illinois, have solved this problem by developing consultation lines staffed by specialist perinatal psychiatrists that can provide real-time consultations to physicians.
Progress to date:	Since 2014, we have been in talks with several entities to create a consultation phone line but there has been little progress to date. At the same time, the county has seen an increase in e-consult initiatives, developing simultaneously in various county health departments and insurers. Although currently fragmented, the e-consult systems being developed are a promising way to connect physicians to expert perinatal psychiatrists. The current e-consult line (DMH/DHS) is focused on chronically and persistently mentally ill women and is a great beginning. The need for a telephone consultation line, in real time that serves medical providers dealing with all women experiencing perinatal mental health concerns is greatly needed in LA county. This would increase the county's capacity to treat this population exponentially.
Next steps:	Build on the e-consult system that has launched with DHS and DMH. Develop a robust telephone consultation line. Look to innovative and successful models across the country for guidance and expertise, such as MCPAP for Moms in Massachusetts. Work with partners to create, implement and sustain.

Recommendation 2:	Institutionalize maternal mental health training for all sectors that interact with expectant and new mothers
Rationale:	Health and human service providers in the county routinely report poor knowledge of screening and assessment tools, and treatment protocols for maternal depression. Although MMH-NOW is training in all of the county departments and in a wide array of agencies, system penetration is not yet comprehensive. Institutionalizing training—for care providers in the publically-funded system (DMH, DHS, DPH), child welfare workers (DCFS), support services (WIC, community-based workers such as promotoras and sister friends), early childhood educators, and home visitors—would increase recognition and intervention of these common, treatable conditions, thus improving overall health for both mother and child. Ultimately, the use of screening and assessment tools are only institutionalized when they are built into the provider's electronic medical record; this ensures that all women undergo basic assessment during pregnancy and in the postpartum period.
Progress to date:	Maternal Mental Health NOW is the go-to trainer around this issue in the county and state and we have trained 15,000 health and human service providers from both private and public sectors. 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. Our trainings are tailored to all sectors, medical providers, mental health clinicians, community based human service workers, etc. Over 90% of training participants routinely report increased knowledge, comfort level, and preparedness to screen for, discuss, and make referrals for maternal depression as a result of the training. We also offer an on-demand online certification training, making it easier for all levels of providers to access this material in their own time. In addition, we have made significant progress in institutionalizing our training. We have trained all Welcome Baby! home visitors, and they are all screening and referring clients to informed care, as is Nurse Family Partnership. The Department of Mental Health and Department Child and Family Services have all made some progress towards system wide training but there is a need for further penetration and support.
Next steps:	Continue advocating for systematic maternal mental health training in all relevant county departments. Identify funding streams to support those trainings. Focus on HEDIS Quality measures for community clinics to include Maternal Mental Health as a core competency of all clinicians. Partner with health plans to improve pre- and postpartum visit rates, as reported via HEDIS quality metrics. This is imperative as only women who are engaged in care can be screened.

INCREASING ACCESS AND ENGAGEMENT IN TIMELY CARE

Recommendation 3:	Incorporate Maternal Mental Health NOW's Resource Directory into county referral systems
Rationale:	Since our founding in 2007, we have learned that providers are reluctant to screen for maternal depression because of the shortage of accessible referral resources. We have sought to change that by developing a fully-vetted, online resource directory.
Progress to date:	MMH-NOW launched the Maternal Mental Health Resource Directory in 2015. The directory contains approximately 340 fully-vetted resources, two-thirds of which offer low-cost or no-cost services, or accept Medi-Cal. The directory provides a wealth of information about the referrals—including services offered, languages spoken, and insurances accepted—and is searchable by these features and many others. Even without significant marketing, the directory receives a great deal of traffic. We now hope to integrate the resource directory into other county referral systems, including those that offer a care coordination function. 211 LA and First 5 LA's developing Help Me Grow program are two such examples. Help Me Grow will educate pediatricians about developmental and other screenings, and provide care coordination services for families with young children over the phone. We look forward to maternal depression being a focus of Help Me Grow, with medical providers learning how to screen for maternal depression and mothers who are struggling getting linked to informed care by care coordinators using our directory.
Next steps:	Continue to vet and add new resources to the directory and update current ones. Work with stakeholders across the county to more fully integrate the directory into all referral systems so that it can have maximum utilization. Work with partners to develop a system to keep the directory up to date. Create more functionality to evaluate usage of the resource directory across clinical disciplines. Ensure that women with publically funded Medi-Cal contact their health plan, which maintains the most current and accurate provider information for outpatient mental health services. This is available at: http://www.lacare.org/members/member-tools/find-doctor-or-hospital. Health plans are now required by California law to maintain an accurate provider directory.

INCREASING ACCESS TO CARE

Recommendation 4:	Strengthen and expand the integration of perinatal mental health into countywide home visitation programs
Rationale:	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 maternal 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. Additionally, multiple barriers that often prevent women from seeking treatment—including lack of transportation and childcare, and the stigma associated with going to a mental health clinic—do not exist when mental health care is provided in the home. Unfortunately, however, while home visitors in the county are screening expectant and new mothers, the programs do not have sufficient in-home clinicians to treat the mothers.
Progress to date:	Over the past couple of years, home visitation has come a long way in the county. The establishment of the Los Angeles County Perinatal and Early Childhood Home Visitation Consortium (LACPECHVC) has brought together stakeholders from all over the county to ensure that home visitation programs themselves, of which there are many, and ancillary services and advocates are all collaborating. This has resulted in streamlined referrals into home visitation programs, data collection systems, and best practices. We hope to continue to work with the consortium to identify opportunities to bring more mental health support to existing programs. Additionally, this year, the LA County Board of Supervisors passed a motion directing the Los Angeles County Department of Public Health, in partnership with First 5 LA, the LACPECHVC, the Office of Child Protection, the Children's Data Network, and the Departments of Health Services, Mental Health, Public Social Services, Children and Family Services, and Probation, to work together in order to enhance, expand, and advocate for high quality home visiting programs to serve more expectant and parenting families so that children are healthy, safe and ready to learn. Enhancing mental health supports is critical to this effort. Finally, the Whole Person Care-MAMA'S model (DHS) will build upon the Mama's Neighborhood Program and create a synergy between the data driven collaborative care of the existing MAMA'S Neighborhood model with the intensive case management of home-visitation, thereby extending the reach of both programs to hard-to-reach or clients ineligible for other home visiting programs.
Next steps:	Work with LACPECHVC, the Department of Mental Health, and the new partnership formed by the BOS motion, to build stronger bridges between the systems, enabling more women to access in-home mental health support. Identify funding streams to support mental health clinicians in home visitation programs themselves and develop a pilot project. Look to other counties who have integrated a mental health service model into their home visitation programs. Further train existing home visitors on models of intervention within their scope of practice to address mental health concerns of the mothers and infants they see in the home

Recommendation 5:	Spread the integration of perinatal mental health care into medical settings countywide
Rationale:	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 health or the health of their children. This creates an opportunity to identify women in need of services related to perinatal mental health, especially with 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 postnatal, OB, pediatric and primary health care medical homes reduces stigma and other barriers to care, improves access, and facilitates treatment.
Progress to date:	In 2013, MMH-NOW launched a pilot project that integrated perinatal mental health care into USC-Eisner Family Medicine Clinic. Patients were screened for maternal depression and treated by clinicians in-house. With the lessons learned, we have begun to spread integration to many other sites, including Harbor-UCLA, UCLA Westwood Pediatric Group, Martin Luther King Hospital, Eisner Family Medical Center, Harbor Community Clinic, and LAC+USC Family Wellness Clinic. The goal is to improve the recognition and response to maternal depression throughout pregnancy and the first two years postpartum. A Best Practice Resource Guide on integrating perinatal mental health care into medical settings will be published in December 2017 and serve as a guide to helping clinics wishing to integrate perinatal behavioral health into their medical settings. There remain many unresolved billing and logistical issues that stand in the way of true integration—including FQHCs being unable to bill for physical health and mental health services rendered to the uninsured on the same day, uncertainty about billing for maternal mental health screenings by pediatricians, and even confusion about whether pediatrician's should put a mother's screening in the infant's chart since she is not the patient. Strong Start/ MAMA's neighborhood is a successful program working to integrate mental health specifically in pregnancy and the first 6 weeks postpartum into medical settings.
Next steps:	Work with statewide partners to resolve billing and logistical issues by pursuing legislative and administrative advocacy. Collaborate with established provider and health plan partners industry groups with expertise in behavioral health integration and reimbursement in primary care. Once the Best Practice Resource Guide is completed, work to spread the perinatal mental health integrated care model to medical providers countywide. Work with key stakeholders who wish to move the dot on clinic engagement.

Recommendation 6:	Promote systems for maternal mental health screening and referral in all pre- and postnatal care settings, including health and human service settings
Rationale:	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 recognition of women suffering will vastly increase, allowing them to be responded to appropriately and referred for treatment and/or other support services. This will, in turn, decrease the impact on child development and lower healthcare costs over time.
Progress to date:	Influential medical groups—including the U.S. Preventive Services Task Force, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists—all now recommend that pregnant and postpartum women be screened for maternal depression by their medical providers. Many insurers have taken note, with some like L.A. Care offering incentives to providers that screen for maternal depression and initiate treatment. And advocacy efforts are beginning nationwide to include maternal depression as a metric in the Healthcare Effectiveness Data and Information Set (HEDIS), a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Locally, we have trained thousands of medical and health and human service providers to screen, and many have instituted protocols requiring screening in their programs. Anecdotally, we have heard that the Maternal Mental Health Resource Directory has made providers more willing to screen, knowing that vetted referral resources are at their fingertips.
Next steps:	Continue to train and provided technical assistance to medical and health and human service providers on culturally competent, trauma informed, effective screening. Support statewide and nationwide advocacy surrounding metrics and reimbursement for screening. Support efforts to embed tools in electronic health records and workflows to institutionalize screening.

Recommendation 7:	Promote perinatal mental health for women experiencing homelessness in the homeless service system (Coordinated Entry System and Continuum of Care)
Rationale:	There is robust evidence that mothers experiencing homelessness have disproportionally higher rates of depression and anxiety disorders compared with the general population. Women experiencing homelessness struggle to protect their families. Children living with a depressed parent have poorer medical, mental health, and educational outcomes. Despite the adverse impact on children, depression among mothers experiencing homelessness remains unacknowledged, unrecognized, and untreated in the homeless service system.
Approach and Next steps:	Identify Homeless Family Solution Centers in Los Angeles County that will work on preventive and therapeutic interventions for homeless mothers and children. Once families are housed and urgent issues addressed, the focus would be to conduct routine maternal depression screening, and provide culturally competent parenting supports, trauma-informed services, and treatment for major depressive disorders. Train and encourage many more providers to screen, and to implement care coordination services to ensure intervention and needed supportive services. To ensure quality care, training must be available for the staff. Given the increasing numbers of homeless families and high rates of maternal depression and its negative impact on children, support for these programs should become a high public health priority. The ultimate goal will be to develop guidelines for adapting and implementing maternal mental health services directly by programs serving homeless families.

INCREASING COMMUNITY AWARENESS AND DESCREASING SOCIAL ISOLATION

Recommendation 8:	Continue to develop and spread culturally informed support groups, including peer based models for pregnant mothers and new parents.
Rationale:	Support Groups are an essential part of the system of care for this population. They provide an opportunity to build individual and community resilience, empower parents and in addition help them find more targeted mental health services when they are needed.
Progress to date:	Several promising models are in existence, including Jewish Family Services New Moms Connect, Black Infant Health's Sister Friends and MMH-NOW's Share Your Stories groups. However there is a dearth of SUPPORT groups in the county
Next steps:	Work collaboratively across the county to find ways to build a network of support groups fro pregnant mothers and new parents.

Recommendation 9:	Implement culturally and linguistically appropriate public awareness campaign for Los Angeles County to reduce stigma around maternal mental health.
Rationale:	Maternal depression is 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. Stigma is also reduced through programs that emphasize peer support and reduce social isolation.
Progress to date:	MMH-NOW's *Speak Up When You're Down* brochures in multiple threshold languages, have been distributed to clinics, hospitals, the LA Public Library System, and other sites throughout the county. We have also produced two PSAs in both English and Spanish. Since 2015, our grassroots Share Your Stories Speaker's Movement has spread. We have continued to work with community coalitions that focus on a population change approach and parent and resident empowerment programs such as the Magnolia Community Initiative and Best Start LA to bring education about signs, symptoms and resources for maternal mental health to community members. Models such as Sister to Sister and the Promotora movement have also integrated perinatal mental health into their parent education activities.
Next steps:	Identify partners and funding streams to develop and implement a county-wide public awareness campaign around maternal depression. Spread peer based support models for pregnant and new parents such as Sister to Sister and the Share Your Stories movement to diverse communities in Los Angeles and identify more opportunities for women to support one another.

CONCLUSION

Left untreated, maternal depression and related conditions 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 can also impact physical health, child development, healthy relationships, and economic productivity and strength.

Fortunately, maternal depression is easily identified, assessed, and treated, as long as all sectors of health and human services have developed the capacity to recognize and respond, and the women they serve are not afraid to speak out. We are thrilled that the county has seen real progress around this issue and thank our many partners for working to achieve this progress together. We look forward to continuing to partner and bring the recommendations in this updated briefing paper to life, thereby bringing even more light to motherhood.

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REFERENCES

[i] Garfield, C. F. et al. (2014). A longitudinal study of maternal mental health during transition to fatherhood as young adults. Pediatrics, 133(5): 836–843.

[ii] Wisner, K. L. et al. (2013). Onset timing, thoughts of self-harm, and diagnosis of postpartum women with screen-positive depression findings. JAMA Psychiatry, 70(5):490-498.

[iii] Los Angeles County Department of Public Health, Los Angeles Mommy and Baby (LAMB) survey. (2012).

[iv] LAMB survey.

[v] Adams, E.K., Miller, V.P., Ernst, C., Nishimura, B.K., Melvin, C., & Merritt, R. (2002). Neonatal health care cost related to smoking during pregnancy. Health Economics, 11(3), 193–206.

[vi] Grote, N.K., Bridge, J.A., Gavin, A.R., Melville, J.L. Iyengar, S., & Katon, W.J. (2010). A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. Archives of General Psychiatry, 67(10), 1012–1024.

[vii] Grigoriadis, S., VonderPorten, E.H., Mamisashvili, L., Tomlinson, G., Dennis, C.-L., Koren, G., Ross, L.E. (2013). The impact of maternal depression during pregnancy on perinatal outcomes: A systematic review and metaanalysis. Journal of Clinical Psychiatry, 74(4), e321 – e341.

[viii] Ystrom, E., (2012). Breast-feeding satiation and symptoms of anxiety and depression: a longitudinal cohort study. BMC Pregnancy Childbirth, 12(1):36–42.

[ix] Oats, M.P. (2003) Perinatal psychiatric disorders: A leading cause of maternal morbidity and mortality. British Medical Bulletin, 67:219–229.

[x] Diaz, J.Y., & Chase,R. (2010). The cost of untreated maternal depression. St. Paul, MN: Wilder Research.

[xi] Sontag-Padilla, L., Schultz D., Reynolds, K.A., Lovejoy, S.L. & Firth, R. (2013). Maternal depression: Implications for systems serving mother and child. Santa Monica, CA; RAND Corporation. RR-404-CCBHO.

[xii] Diaz, J.Y., and Chase, R. (2010).

[xiii] ZERO TO THREE (2017). The basics of infant and early childhood mental health. Available at https://www.zerotothree.org/resources/1951-the-basics-of-infant-and-early-childhood-mental-health

[xiv] Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). Patterns of attachment: A psychological study of the strange situation. Hillsdale, N.J.: Erlbaum.

[xv] Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2001). Affect regulation, mentalization, and the development of the self. New York: Other Press.

[xvi] Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. Clinical Psychology Review, 20(5), 561-592.

[xvii] Onunaku N. Improving Maternal and Infant Mental Health: Focus on Maternal Depression. Los Angeles, CA: National Center for Infant and Early Childhood Health Policy at UCLA; 2005.

[xviii] Center on the Developing Child at Harvard University (2009). Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8. http://www.developingchild.harvard.edu.

[xix] ZERO TO THREE (2016). DC:0-5™ Diagnostic classification of mental health and developmental disorders of infancy and early childhood. Washington, DC: Author.

[xx] Field, T., Pickens, J., Prodromidis, M., Malphurs, J., Fox, N., & Bendell, D. (2000). Targeting adolescent mothers with depressive symptoms for early intervention. Adolescence, 35, 381-414.

[xxi] Gladstone, T. R. G., & Beardslee, W. R. (2002). Treatment, intervention and prevention with children of depressed parents: A developmental perspective. In S. H.Goodman & I. H. Gotlib (Eds.). Children of depressed parents: Mechanisms of risk and implications for treatment (pp. 277-305). Washington, DC: American Psychological Association.

[xxii] Seifer, R., Dickstein, S., Sameroff, A. J., Magee, K. D., & Hayden, L. C. (2001). Infant mental health and variability of parental depression symptoms. Journal of the American Academy of Child and Adolescent Psychiatry, 40, 1375–1382.

[xxiii] Tronick, E., & Reck, C. (2009). Infants of depressed mothers. Harvard Review of Psychiatry, 17, 147-156.

[*] Bruce Perry- From his Keynote Speech at the MMH-NOW Bringing Light to Motherhood Policy Roundtable 2015.

[**] Center for the Study of Social Policy- Strengthening Families, A Protective Factors Framework