California Board of PSYCHOLOGY

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MEMORANDUM

DATE	May 5, 2017
TO	Policy and Advocacy Committee
FROM	 Cherise Burns Central Services Manager
SUBJECT	Agenda Item # 6(b)(1) – AB 244 (Cervantes) Maternal Mental Health

Background:

This bill would create a pilot program, in counties that elect to participate, to increase the capacity of health providers that serve pregnant and postpartum women up to one year after delivery to effectively prevent, identify, and manage postpartum depression and other mental health conditions. The pilot program may include the following: a consultation program utilizing telehealth and e-consult technologies, training and toolkits on screening, assessment, and the range of treatment options, coordination of care for program participants, and access to perinatal psychiatric consultations for program participants. The pilot program would be privately funded and require a report to the Legislature regarding the pilot programs results within six months of the end of the pilot.

AB 244 is a great first step in increasing screening and treatment for women experiencing perinatal mood and anxiety disorders, but could potentially exclude one of the most critical components for treatment, which are psychotherapy services provided by psychologists and other licensed mental health professionals. By only identifying "perinatal psychiatric consultation", this could unnecessarily inhibit pilot programs from utilizing psychologists and other licensed mental health professionals to provide psychotherapy services and limit the timeframe for providing services, resulting in suboptimal use of limited program resources.

On April 21, 2017, the Board took a "Support if Amended" position on AB 244 instructing staff to seek specified amendments to add "postpartum" and "psychological" to the bill to cover the full spectrum of perinatal and postpartum care that is required during pregnancy and a year after giving birth.

The following week, staff called the author's office to discuss the amendments the Board was seeking and was informed that the bill is now a 2-year bill and will not be moving for the remainder of this legislative year. Staff will submit our formal position in writing to the author's office and work with the author when the bill is taken up next year.

Location: Assembly Committee on Health

Status: 4/18/2017 In committee, set first hearing. Hearing canceled at the request of author.

Action Requested:

No action is required at this time. Staff will work with the author to request the Board's suggested amendments when AB 244 is taken up next year.

Attachment A: AB 244 (Cervantes) Bill Analysis - REVISED
Attachment B: AB 244 (Cervantes) Text

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2017 Bill Analysis – REVISED

Author:	Bill Number:	Related Bills:
Cervantes	AB 244	Not Applicable
Sponsor:	**Version:** Amended 03/21/2017	
Subject: Maternal Mental Health.		

SUMMARY

This bill would create a pilot program, in counties that elect to participate, to increase the capacity of health providers that serve pregnant and postpartum women up to one year after delivery to effectively prevent, identify, and manage postpartum depression and other mental health conditions. The pilot program may include the following: a consultation program utilizing telehealth and e-consult technologies, training and toolkits on screening, assessment, and the range of treatment options, coordination of care for program participants, and access to perinatal psychiatric consultations for program participants. The pilot program would be privately funded and require a report to the Legislature regarding the pilot programs results within six months of the end of the pilot.

RECOMMENDATION

SUPPORT IF AMENDED – AB 244 is a great first step in increasing screening and treatment for women experiencing perinatal mood and anxiety disorders, but has one significant problem with the bill as written, that it could potentially exclude one of the most critical components for treatment, which are psychotherapy services provided by psychologists and other licensed mental health professionals. This could unnecessarily inhibit pilot programs from utilizing psychologists and other licensed mental health professionals to provide psychotherapy services and resulting in suboptimal use of limited program resources. Additionally, the bill should reference both perinatal and postpartum services in order to cover the full spectrum of services needed by these women.

Summary of Suggested Amendments

- Add “postpartum” and “psychological” to the recommended pilot program elements in subsection (a)(3).

Other Boards/Departments that may be affected:

☐ Change in Fee(s) ☐ Affects Licensing Processes ☐ Affects Enforcement Processes

☐ Urgency Clause ☐ Regulations Required ☐ Legislative Reporting ☐ New Appointment Required

Policy & Advocacy Committee Position:	Full Board Position:
☐ Support ☐ Support if Amended	☐ Support ☒ Support if Amended
☐ Oppose ☐ Oppose Unless Amended	☐ Oppose ☐ Oppose Unless Amended
☐ Neutral ☐ Watch	☐ Neutral ☐ Watch
Date: _____	Date: April 21, 2016
Vote: _____	Vote: 6 Aye, 0 No, Passed

REASON FOR THE BILL
The Author's office has not supplied this information at this time. The bill's text states that the pilot program is being created to increase the capacity of health providers that serve pregnant and postpartum women up to one year after delivery to effectively prevent, identify, and manage postpartum depression and other mental health conditions.

ANALYSIS
The American Psychological Association (APA) states that it is common for women to experience "baby blues," and feeling stressed, sad, anxious, lonely, tired, or weepy following the birth of a child. But APA also notes that about one (1) in seven (7) women will experience PPD, a much more serious mood disorder, and while far more rare, some women will experience postpartum psychosis, a condition that may involve psychotic symptoms like delusions or hallucinations. Perinatal mood and anxiety disorders, like Postpartum Depression (PPD), can have significant negative effects on the women that experience it and their babies. The Centers for Disease Control and Prevention (CDC) notes that PPD is associated with adverse maternal, infant, and child outcomes, including lower rates of breastfeeding initiation and shorter duration, poor maternal and infant bonding, and infant developmental and behavioral disorders that can last through adolescence. The most serious consequences of untreated PPD and postpartum psychosis can be maternal self-harm and suicide and/or harm to the child including infanticide.

In May 2015, the American College of Obstetricians and Gynecologists, the organization that develops the scope and standards of practice for Obstetricians and Gynecologists issued a Committee on Obstetric Practice opinion recommending the following:

- Clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
- Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders warrant particularly close monitoring, evaluation, and assessment.
- Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
- Systems should be in place to ensure follow-up for diagnosis and treatment.

Screening, early detection, and treatment for perinatal mood and anxiety disorders have proven highly effective, and often include both psychiatric interventions and psychotherapy interventions. Nationally, the CDC noted a decline in the rates of PPD from 2009 to 2012 in the 13 states (excluding California) that participated in their monitoring program and attributes those reductions to better recognition of risk factors

for depression, improved screening and treatment before and during pregnancy, and increased use of antidepressants.

In California, there is currently no requirement for all women to be screened for perinatal mood and anxiety disorders during pregnancy or in the year after giving birth. Previous legislative efforts in California relating to perinatal mood and anxiety disorders have been focused increasing awareness and establishing task forces that would study review, and identify current barriers to screening and diagnosis, current treatment options, and evidence based and emerging treatment options.

AB 244 would be the first legislatively driven pilot project to increase screening and access to mental health services for perinatal mood and anxiety disorders. This bill would create pilot projects in counties that elect to participate, that would be privately funded and would create provider-to-provider and patient-to-provider consultation programs promoting the use of telehealth and e-consult technologies. Each pilot program would include the following program elements:

- Training and toolkits on screening, assessment, and the range of treatment options;
- Coordination of care to link women with individual services in their communities; and
- Access to perinatal psychiatric consultation.

Additionally, the California Health and Human Services Agency (CHHA), six months after the close of the pilot project, would have to report the impacts of the pilot programs to the legislature, including identify methods to expand the pilot program to additional counties or statewide and identify funding opportunities (federal and state) to support the expansion of the pilot program. The pilot project created by AB 244 could potentially become a directed CHHA program and expand to a statewide program in the future if additional funding is identified.

Board staff believes that AB 244 is a great first step in increasing screening and treatment for women experiencing perinatal mood and anxiety disorders, but has one significant problem with the bill as written, that it could potentially exclude one of the most critical components for treatment, which are psychotherapy services provided by psychologists and other licensed mental health professionals. By only identifying “perinatal psychiatric consultation” in the legislation, this could unnecessarily inhibit pilot programs from utilizing psychologists and other licensed mental health professionals to provide psychotherapy services and thus making suboptimal use of limited program resources.

An additional clarifying fix that is needed in the bill is that it only references perinatal services, when it should reference perinatal and postpartum services to more accurately reflect the timeframe the services will be needed, which includes during the pregnancy and up to one year after delivery. Board staff recommends that the Board take a “Support if Amended” position on AB 244 and request that the author add “postpartum”

and “psychological” to the recommended program elements to cover the full spectrum of services needed by these women.

LEGISLATIVE HISTORY

ACR 148 (Lowenthal, Chapter 96, Statutes of 2014) this resolution requested the California Maternal Mental Health Collaborative, a nonprofit organization, to establish a task force on the status of maternal mental health care in order to study, review, and identify current barriers to screening and diagnosis, current treatment options for both those who are privately insured and those who receive care through the public health system, and evidence based and emerging treatment options that are scalable in public and private health settings. The task force should also identify provider population needs and patient needs in order to improve diagnosis and treatment.

AB 402 (Ammiano, Chapter 550, Statutes of 2013) this bill requires every disability income insurance policy issued, amended, or renewed on or after July 1, 2014, that covers short-term limited disability of a duration of 2 years or less, to provide disability income benefits coverage for disabilities caused by severe mental illnesses, including postpartum depression.

ACR 53 (Hernández, R, Chapter 66, Statutes of 2011) this resolution urges hospital providers, including, but not limited to, instructors of childbirth and breast-feeding classes, delivery nursing staff, obstetrician-gynecologists, and other medical providers, mental health care providers, health plans, and insurers to invest resources to educate women about perinatal depression risk factors and triggers. This resolution also requested that a statewide collaborate network of stakeholders explore ways to assist with the development of perinatal depression prevention educational materials.

ACR 105 (Nava, Chapter 9, Statutes of 2010) this resolution declared May as Perinatal Depression Awareness Month, and requested that the Department of Health Care Services, California Department of Public Health, the State Department of Mental Health, First 5 California, the American College of Obstetricians and Gynecologists, Postpartum Support International, and other stakeholders to work together to explore ways to improve women’s access to mental health care at the state and local levels, to facilitate increased awareness and education about perinatal depression, clinically referred to as perinatal mood and anxiety disorders, to explore and encourage the use of prenatal screening tools, and to improve the availability of effective treatment and community support services.

OTHER STATES' INFORMATION

At least 12 states have taken action to improve postpartum screening and care and have either passed legislation, developed awareness campaigns, or convened tasks forces. States that require screening include New Jersey (Findings, Declarations Relative to Postpartum Depression, 2006), Illinois (Perinatal Mental Health Disorders Prevention and Treatment Act, 2008), and West Virginia (Uniform Maternal Screening Act, 2009). States that require education about postpartum depression include Texas (Relating to Information Provided to Parents of Newborn Children, 2005), Virginia

(Certain Information Required for Maternity Patients, 2003), Minnesota (Postpartum Depression Education and Information, 2015), and Oregon (Relating to Perinatal Mental Health Disorders and Declaring an Emergency, 2011). Maine, Maryland, Massachusetts, and Oregon have perinatal depression task forces. Washington has passed a statewide awareness campaign, and California, Michigan, and Oregon have created postpartum depression awareness months. (Rhodes, A. M., & Segre, L. S. (2013). Perinatal depression: A review of US legislation and law. Archives of Women's Mental Health, 16(4), 259-270)

PROGRAM BACKGROUND
The Board advances quality psychological services for Californians by ensuring ethical and legal practice and supporting the evolution of the practice. To accomplish this, the Board regulates licensed psychologists, psychological assistants, and registered psychologists.

This bill would have no impact on the Board of Psychology's operations or programs, but could potentially affect its licensees. Since this bill does not name perinatal psychological consultations as one of the potential elements of the pilot program, the initial pilot program and any extensions or expansions of the program could fail to include the services of psychologists. This would be a lost opportunity for Board licensees and a loss of important services for postpartum women in the program.

FISCAL IMPACT
Not Applicable

ECONOMIC IMPACT
This pilot program could create additional funding for perinatal psychological services and therefore benefit current licensees specializing in this treatment area.

LEGAL IMPACT
Not Applicable

APPOINTMENTS
Not Applicable

SUPPORT/OPPOSITION

Support: None on File

Opposition: None on File

ARGUMENTS

Proponents: None on File

Opponents: None on File

AMENDMENTS

SECTION 1. Section 131120 is added to the Health and Safety Code, to read:

131120. (a) There is hereby created a pilot program, in counties that elect to participate, including the County of Riverside, to increase the capacity of health providers that serve pregnant and postpartum women up to one year after delivery to effectively prevent, identify, and manage postpartum depression and other mental health conditions. The pilot program may be coordinated by the California Task Force on the Status of Maternal Mental Health and shall be privately funded. The pilot program may include a provider-to-provider or patient-to-provider consultation program and utilize telehealth or e-consult technologies. The pilot program may include the following elements:

(1) Training and toolkits on screening, assessment, and the range of treatment options.

(2) Coordination of care to link women with individual services in their communities.

(3) Access to perinatal **and postpartum** psychiatric **and psychological** consultation.

(b) Within six months after the results of the pilot program are reported, the California Health and Human Services Agency, in consultation with the California Task Force on the Status of Maternal Mental Health and state entities, as necessary, shall submit a report to the Legislature, in accordance with the requirements of Section 9795 of the Government Code, regarding the pilot program described in subdivision (a). The report shall do all of the following:

(1) Document the impact of the pilot program on increasing the number of women who were screened, assessed, and treated for maternal mental health disorders.

(2) Identify methods to expand the pilot program to additional counties or statewide.

(3) Identify funding opportunities to support the expansion of the pilot program including federal funding, state funding, and surcharges.