Additional letters and first hand accounts for the Board of Behavioral Sciences and Board of Psychology, 10/30/2025, regarding including Perinatal Mental Heath education requirements

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Dear Members,

On behalf of the Black Girls Mental Health Collective, I write to you with deep urgency regarding the inclusion of Perinatal Mental Health Basic Training in licensure requirements for clinicians across California. Our entire organization exists because of how critical this issue is. We were founded with the understanding that perinatal mental health has been dangerously overlooked in clinical education, despite decades of evidence demonstrating its impact on parents, infants, and families. At present, no master's or doctoral-level clinicians in California are mandated to receive training in perinatal mental health. This is in stark contrast to the widespread prevalence of these conditions: perinatal mood and anxiety disorders (PMADs) are the most common complication of pregnancy and childbirth, affecting 1 in 5 women nationally and as many as 1 in 3 in some studies when risk factors are present. Yet clinicians continue to graduate and begin practice without the skills necessary to identify, screen, or treat these disorders—leaving families in distress and clinicians unsupported.

The evidence is equally clear within California. Research shows that up to 20% of birthing people in California experience a perinatal mood or anxiety disorder, translating

to approximately 100,000 parents each year in our state alone. Among those experiencing postpartum depression, nearly half go untreated, largely due to gaps in provider education and the absence of systemic requirements for training. This lack of consistent preparation is especially alarming when paired with California's leadership role in maternal health reform. In 2024, AB 2581 required Healing Arts Boards to consider maternal mental health education. Yet if no action is taken to implement those requirements meaningfully, the law risks becoming a symbolic gesture rather than a lived protection for parents who desperately need trained, informed care.

The consequences of this oversight are most devastating for Black women and birthing people. Nationally, Black women are twice as likely as white women to experience maternal mental health complications, yet they are half as likely to receive treatment. In California, Black women experience maternal mortality rates 3 to 4 times higher than their white counterparts, and perinatal mental health challenges—when unaddressed—compound risks for both physical and emotional well-being. Our clients routinely share that they felt invisible in their previous therapeutic encounters, with clinicians who were compassionate but not trained to recognize or treat perinatal-specific disorders. These disparities are not accidental; they are the direct result of systemic neglect and the absence of required, standardized training. Without mandated education, we are perpetuating cycles of inequity in care that disproportionately harm Black mothers and families.

At the Black Girls Mental Health Collective, we have made addressing this gap the foundation of our work. We host an 8-hour training on perinatal mental health monthly, ensuring that not only our staff, but community partners, clinicians, and stakeholders have access to foundational, evidence-based education. We mandate that all staff complete both our internal training and Postpartum Support International's (PSI) perinatal mental health training, ensuring that every clinician affiliated with us can recognize, screen, and intervene. In addition, we run a dedicated internship program for Master of Social Work students, specifically focused on equipping them with expertise in perinatal mental health that they would not otherwise receive in their graduate programs. This level of commitment requires significant investment, yet we continue to do it because the evidence—and the need—demand it. Our lived experience as clinicians, and the data before us, have made one thing absolutely clear: without training, families fall through the cracks.

We urge you to act boldly and mandate Perinatal Mental Health Basic Training for all clinicians, pre- or post-licensure. This requirement is not an added burden; it is a lifeline. Families deserve to encounter clinicians who understand that a mother's rage, panic, or despair in the months after birth is not a personal failing but a treatable health condition.

Babies deserve parents who can access informed support. Clinicians deserve the tools to intervene confidently and competently. By including perinatal mental health in licensure requirements, California can lead the nation in closing the most pervasive—and most overlooked—gap in maternal health care. The data, our practice, and the lived experiences of the families we serve leave no room for hesitation.

Sincerely,
Dr. Chyna Hill, PhD, LCSW
On Behalf of the Black Girls Mental Health Collective

I am a perinatal mental health therapist and was personally treated for severe, life-threatening PPD following the births of both my children (now ages 10 and 7).. My treatment included in-patient hospitalization, ECT therapy, medication and and out-patient PHP specifically for perinatal mental health involving intensive group and individual therapy.

While these experiences with PPD were grueling for me and my family, I consider myself incredibly lucky to have received prompt and effective treatment that enabled me to recover fully within a matter of months. This was only possible because my providers were trained and skilled in perinatal mental health and able to implement targeted referrals and interventions for my perinatal-specific symptoms.

I have since received training through PSI and treat other birthing people/couples experiencing PPD/PPA/PPP. Perinatal patients often come to me after not receiving the appropriate care from other providers who lack training in perinatal mental health, including OBGYNs, psychiatrists and therapists. I have seen the toll that misdiagnosis and uninformed care takes on people with perinatal mood disorders, including for one of my patients who now regrets a late stage elective termination of a pregnancy when she was in the throes of severe perinatal depression that she did not receive adequate care for. ***Erin.Bishop, JD, LMFT***

I received therapy after the birth of my twins due to anxiety and depression. Years later as I've become trained in perinatal mental health, I realized that what I was experiencing at that time was significant postpartum depression and anxiety that went undiagnosed and therefore not properly treated. If my MHP had been trained with an understanding of my symptoms, I could have received the proper mental health treatment at that time. The lack of awareness led to an exacerbation of symptoms creating significant distress and trauma for me and my family. Better trained MHPs could have intervened much sooner and with the proper treatment, before it turned traumatic. I have spent the last few years in trauma treatment and am finally healing after a decade. ***Macy Schoenthaler, LMFT***

After the traumatic birth of my child, my son was in the NICU and I experienced severe postpartum PTSD and depression. I felt like the NICU staff (social workers, nurses, doctors) did not have adequate training to assess and support my mental health during this challenging time of my life. If they had at least cursory knowledge of perinatal mental health and the toll that NICU stays often take on parents, I believe I wouldn't have struggled as much as I did. Requiring this training for all mental health professionals should be universal in order to support new moms and lead them to successful parenthood. ***Allyson Fortner Widdell, LCSW***

BE MOM AWARE
SUPPORT FOR MATERNAL WELL-BEING

My name is Brenna Rizan. I am a licensed clinical social worker and hold a doctorate in social work with emphasis on perinatal mental health. I have been in the field for over 20 years and focused the majority of my experience working with children and families.

During my education and licensure experience, perinatal mental health was not discussed. Therefore the first 15 years of my service to children and families did not take into consideration the important developmental milestone of becoming a parent or the increased risk of experiencing mental health conditions.

In 2013, I gave birth to my daughter after a year of IVF treatment. My daughter was born 6-weeks premature and had intrauterine growth restriction due to a placental abnormality known as absent-end diastolic flow. This meant my daughter was small for

her gestational age weighing 2lbs 15 oz at birth. My time in the NICU was fraught with worries about her health and well-being leaving me with a unending pit of anxiety. While I had a NICU social worker who visited me twice during my daughter's month-long admission, beyond "how are you doing?" I was never asked about my mental well-being, coping, or asked to complete a screening tool. I was never provided with information on perinatal mental health signs and symptoms and when to reach out for support. I was not provided with any information on supportive resources for perinatal mental health.

Over the next four years my mental health continued to deteriorate with symptoms of anxiety, unwanted intrusive thoughts, and eventually depression. It affected my work, my relationships, and my sense of self. It was not until I began working in hospital social work in 2016 that I started to learn more about perinatal mental health. Even so, the organization I worked for minimized the impact of the symptoms many birthing people were experiencing. There were no protocols, policies or procedures to guide my practice. This led me to do a deep dive into the research and taking CEUs on the topic eventually finding organizations like Postpartum Support International. Through my self-study, I began to see my own experience reflected in the literature and finally was able to recognize that what I was experience was not a normal part of becoming a parent and get the help I need. It also motivated me to return to school to pursue my doctorate and I am happy to announce that I was recently published in the Clinical Journal of Social Work regarding Therapist Readiness to Address Perinatal Mental Health.

Key findings from this qualitative study revealed that mental health providers are generally not educated about this significant area of mental health that impacts 1 in 5 birthing people and 1 in 10 supportive partners. Therapists, like myself, often find that personal experience leads them to this area of specialization, but there is a paucity of opportunities for supervision and clinical case consultation, the gold-standard for competency. In addition, birthing people face distinctive socio-cultural-political challenges that are not part of existing mental health curricula. The 29 licensed therapists in California that were interviewed for my study overwhelmingly agreed that this is an important topic that is undervalued by the field. I implore you to stand with the over 30,000 birthing people in California who have a perinatal mental health condition at the time of birth annually and the countless more who are diagnosed in the year postpartum or like me realize years after onset that they did not receive the care they needed and deserved in that critical developmental period. ***Brenna Rizan, LCSW***

I am a perinatal therapist that also struggled with postpartum anxiety after the birth of my first daughter, and was unaware that this was what I was struggling with. This is something that all therapists should have some form of training around since so many therapists will come in contact with the perinatal population. ***Alex Steric, LCSW***

I am a therapist in private practice in Pasadena. While I was working with an EAP I once had a client who became pregnant with his wife during our work together. The client shared a number of concerns he had but with which I had no professional or personal experience. With the benefit of certification in perinatal mental health I now see that these were probably serious mental health concerns in the mother, but with no training in this area, I couldn't provide adequate triage support to my client.

As my client's partner was not in therapy, I represented the front lines for the couple, and my training fell short. A minimum requirement for all Master's-level clinicians would help prevent oversights like this. Thank you for your consideration. ***Troy Gabrielson, LCSW***

As a father with lived experience, a mental health clinician and a longtime advocate (since the 1980s) I have been aware of the lack of awareness of healthcare professionals across board about perinatal mental health conditions and their complex presentation and causes. This often leads to ineffective treatment and adverse outcomes including harm to the infant and/or mother.

Of particular relevance is the prevalence of children in California found to have high ACEs scores where the untreated mental health needs of the mother is the child’s first ACE. Toxic stress can have lifelong consequences for children’s development and health. Increased professional awareness can lead to timely, early intervention. Mandating training can and will improve outcomes of this serious, statewide problem. ***Bob Hicklman, LMFT***

I am a licensed psychologist who was one of the first integrated psychologists in OBGYN in the South SF Kaiser. I also mentor graduate students. We need all providers to have training on PPD, for many reasons including this is a very high acuity population with high stakes for multiple generations of a family, a very common problem, and there are gaps in the medical system of care from other providers, putting the responsibility on mental health frequently. ***Megan Spence, PsyD***

As a perinatal mental health specialist and a survivor of PPD, I have experienced and continue to see far too many mental health clinicians who are ill equipped to diagnose and treat maternal mental health issues. Now more than ever, we are seeing an increase in maternal suicide and self harm. I continue to see clients who are coming to me because they have had poor experiences with other therapists who were referred by their insurance companies with zero training in the perinatal field and ultimately don't know how to support mothers. When I was moving through PPD myself a decade ago, I also experienced this. Women need clinicians who know how to provide appropriate support and do not increase the likelihood of worsening symptoms by missing critical signs. ***Bridget Balajadia, LCSW***

I'm a San Diego-based psychologist specializing in paternal perinatal mental health. Reproductive/perinatal mental health training is essential to identify and treat the 10% of dads and the nearly 20% of moms who develop postpartum mental health issues. Our mission is to help these new parents to get the help they need. ***Dan Singley, PsyD***

My name is Francia Telesford and I am the owner and founder of Gracelamp Wellness. I have been doing social work for over 20 years, I am an ACSW, CLE, and PMH-C provider. Over the years I have helped women and families as a former DCFS worker, a counselor for former foster youth, a social worker working with homeless and substance abusing families, a maternal mental health therapist, and currently as a hospital medical social worker and maternal health specialist through my business Gracelamp Wellness. I am also a mother of 2 and a survivor of postpartum depression and anxiety.

I have seen professionally and personally how important maternal health training, awareness and support is for women and families. Specifically I am also a part of the population who has been impacted by the disparity in maternal health for black women as well. I urge you to consider adding maternal health training as a requirement. It is valid and necessary training needed for all professionals dealing with mothers and families. There are so many complex needs that arise in the non-profit, hospital, and even private sectors of therapeutic services that deeply impact the well-being of our families across the nation.

Healthy mothers are at the nucleus of a healthy nation. We need more training to help families and future generations succeed. Please make mental health a part of the required trainings. ***Francia Telesford, ACSW, CLE, PMH-C***

To Whom it May Concern,

I am a mixed-methodology policy researcher and a survivor of perinatal mood and anxiety disorders. Perinatal mood and anxiety disorders are the most common pregnancy complications, affecting one out of every five pregnancies nationwide and one out of three pregnancies in California. As common as they are, health care providers are ill-equipped to treat or even refer out for care for perinatal mood and anxiety disorders due to a lack of education on the issue.

For this reason, it is essential to include perinatal mental health as a mandated learning component for LMFTs, LCSWs, LPCCs, and PsyD's, both prior to licensure and as part of continuing education.

I hope that my story can help the CA Boards to understand this need:

Shortly after I began working with the Saks Institute at USC in 2018, my husband and I learned that I was pregnant with our twin daughters, Ava and Lucía.

Ava and Lucía were due to arrive in the spring of 2019. Due to the serious complications of developing Twin-to-Twin Transfusion Syndrome (TTTS) in their second trimester, my daughters were born on Christmas day, 2018, at exactly 26 weeks old. Ava was treated in the NICU for three and a half months. She came home with us on April 9th 2019, one week after her and Lucía's due date. Our daughter Lucía passed away when she was 11 days old. She had suffered severe bleeding in her brain as a result of the TTTS and was unable to recover.

The traumatic birth of my daughters and the loss of Lucía caused me to develop post-traumatic stress disorder (PTSD) and severe anxiety in my perinatal period. Neither my doctors nor family members realized the severity of my condition until it was almost too late. When I was finally diagnosed I had been back to working full-time for half a year, my household was bearing the brunt of my mental state, and I believed that my family would be better off without me.

Throughout my journey to a diagnosis, I repeatedly asked for help from anyone who would listen to me. I was confused by what I was thinking and my feelings didn't match up with how I thought I was 'supposed' to feel as a new mother. I accepted that my feelings might be mixed up because of my first birth experience, the NICU stay and the loss of a child, but I wasn't able to understand the thoughts that I was having- nor the extreme fear that I carried with me around my daughter Ava's life and safety.

I scored high on every assessment at the appointments that I attended and received no follow-up. I was assigned mental health supports in the hospital during my postpartum period, yet the two appointments that I had with the service provider were focused on my relationship with my partner. During this time, my mental state continued to deteriorate.

Even though I was displaying textbook symptoms of perinatal anxiety disorder and extreme PTSD, I could not access the support that I needed. I experienced firsthand that supports for people experiencing Perinatal Mood and Anxiety disorders (PMADs) or Postpartum Depression (PPD) are rare, and that mental health providers are not educated on the signs and symptoms of these common and dangerous disorders.

My story of needing help and struggling to get it is not unique. More than 800,000 parents in the United States experience Perinatal Mood and Anxiety disorders annually,

and only 25% access care. I am lucky. I am able to write to you as someone who survived this experience and who works to ensure that others don't have to go through what I did. Other California parents, like Liliana Carrillo and Danielle Johnson, are not so lucky – nor are their families.

CA BBS (and BOP), please include perinatal mental health as a mandated learning component for your mental health providers. You will save lives.

Thank you,
Sonja Castañeda-Cudney
Doctoral Candidate, USC

As a psychotherapist certified and specializing in perinatal mental health, I fully support this bill, and thank the Legislative Counsel for considering it. 1 out of 5 women, and 1 out of 10 dads and partners are at risk of developing a Perinatal Mood and Anxiety Disorder during the journey of becoming a parent, which left untreated, can have tremendous ripple effects on attachment with the child, a child's lifetime trajectory with mental and physical health detriments, fiscal impacts with more unanticipated time off work, negative impacts on relationships, and of course impacts on the mental and physical health of the parent. There is also a known disproportionate impact of perinatal mental health on parents of color, particularly due to issues of implicit bias, systemic inequity, and access issues. We also know that these symptoms are treatable, with quality, accessible mental health care.

Moving beyond the statistics, I want to speak to you as a clinician. In my 25 years in this field, I have seen countless examples of clients who has sought my care after seeing other mental health providers untrained in perinatal mental health where unintentional harm was caused due to misdiagnosis, underdiagnosis, or mislabeling symptoms. For example, I have seen numerous clients with perinatal onset OCD (Obsessive Compulsive Disorder) who were improperly treated due to misunderstanding their symptoms. Some were misdiagnosed as psychotic (and improperly treated as such), others' compulsions worsened due to the therapist's lack of knowledge working with this population (by encouraging frequent checking and reassurance seeking). I have also seen clients who have had Child Protective Services called on them to intervene when in fact, there were no safety risks, and instead they were experiencing normal intrusive thoughts (which up to 90% of new parents experience!) Perinatal PTSD after a traumatic birth can present differently than non-perinatal PTSD and is often missed, particularly if there has been a seemingly "good" outcome and clients have been told by

their own therapists to “just focus on the positive”, invalidating their trauma responses and struggles. These are just a few examples of the harm that can be caused when mental health clinicians are not versed in knowing how to properly assess for (much less properly treat) Perinatal Mood and Anxiety Disorders.

As Licensed Clinical Social Workers, we are already required to take continuing education credits in order to appropriately screen for, and refer out for conditions that are beyond our scope, or out of our areas of expertise. We are asking for similar consideration for maternal and perinatal mental health. While there is a recognition that treating perinatal populations requires additional extra training, all mental health clinicians should be able to screen for these perinatal mood disorders, and know where and when to refer out, as appropriate.

This is a consumer protection issue that benefits parents and families getting the appropriate care they deserve so they can heal, positively impacting their and their child’s lifetime trajectory.

Thank you for your time.
Bethany Warren, LCSW