# Louisiana Perinatal Mental Health Task Force

## Policy Brief

A REPORT PREPARED BY
THE INSTITUTE OF WOMEN & ETHNIC STUDIES &
THE LOUISIANA DEPARTMENT OF HEALTH

## ABOUT THE INSTITUTE OF WOMEN & ETHNIC STUDIES (IWES)

Founded in 1993, IWES is a national non-profit health organization that creates initiatives to heal communities, especially those facing adversity. Through community-driven research programs, training, advocacy, and partnerships, IWES helps to build emotional and physical well-being, resilience and capacity among women, their families and communities of color, especially those which are disadvantaged. IWES creates culturally proficient programs, activities and research to address and advocate for the emotional and physical well-being, resilience, and capacity of women of color, their families and communities, to heal and create sustainable change. IWES works in the following areas: Adolescent Health; Maternal and Child Health (MCH); Resilience, Well-being and Mental Health; and STI/HIV Prevention & Care.

During the 2021 Legislative Session, Representative Royce Duplessis introduced HOUSE CONCURRENT RESOLUTION NO. 105 (HCR 105) to establish a task force dedicated to the education, treatment, and overall improvement of maternal mental healthcare within the state. The Louisiana Department of Health, Bureau of Family Health partnered with the Institute of Women and Ethnic Studies (IWES) to lead the task force, conduct the research, and develop the recommendations outlined in this document.

## ABOUT THE LOUISIANA DEPARTMENT OF HEALTH

The mission of the Louisiana Department of Health (LDH) is to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana. LDH is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner. The Bureau of Family Health (BFH) is part of the LDH Office of Public Health (OPH), and works to promote the health of Louisiana families in every stage of lift. The Bureau administers the state's Title V Maternal and Child Health Block Grant program, the Title X Family Planning program, and multiple other programs, projects, and initiatives designed to improve the health of pregnant women, babies, children, teens and adults, and youth with special health care needs. BFH's mission is to elevate the strengths and voices of individuals, families, organizations, and communities to catalyze transformational change to improve population health and achieve equity.

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# EXECUTIVE SUMMARY

The terms 'perinatal' and 'maternal' are often used interchangeably when talking about a mother's/birthing person's mental health. Both terms refer to mental health issues which occur during pregnancy and/or in the postpartum period following the birth of a child. According to the Diagnostic and Statistical Manual (DSM-5), diagnoses of mental health issues associated with pregnancy should be made within four months after birth, however in clinical practice, maternal mental illness may be recognized up to 24 months after birth.

Perinatal mental and anxiety disorders (PMADs) are gravely under-diagnosed and often untreated, yet carry significant and critical implications for the multigenerational health of birthing people and their children over the life course. Perinatal depression, anxiety, and postpartum psychosis are reported to affect one in seven pregnant and postpartum mothers nationwide, making them among the most common mental health conditions encountered by women of reproductive age. Perinatal mood and anxiety disorders are associated with increased risks of maternal and infant mortality and morbidity and are recognized as a significant patient safety issue.

When left untreated, PMADs can have profound adverse effects on women and their children, ranging from increased risk of poor adherence to medical care, exacerbation of medical conditions, loss of interpersonal and financial resources, smoking and substance use, suicide, and infanticide. Factors that might influence the length or severity of postpartum depression include age, race, education, marital status, gestational diabetes or high blood pressure, and past history of mental illness. Other risk factors for poor perinatal health include psychosocial factors such as ongoing conflict with one's partner, poor social support, and ongoing stressful life events.

Early detection of perinatal psychiatric disorders is needed to address this crisis which typically compounds in severity for the individual, in the quantity of others (family/community) negatively affected, and the societal costs to mitigate or eliminate the problem with passing time. **While the human costs cannot be quantified, as will be explored later within this brief, conservative estimates (58,941 live births in Louisiana in 2019 and an average annual $5,300/birth and child PMAD cost) indicate an annual economic impact of more than $312 million for untreated PMADs. Additionally, this figure does not take into account the other costs that subsequently accrue when untreated PMADs begin a long-term dependency on social services.**

Routine screenings during primary and OB/GYN appointments are essential to identify and effectively manage symptoms before they worsen. Protocols are urgently needed to implement perinatal mental health screening at key milestones in maternal care: initiation of obstetric care, later in pregnancy, and then again in the postpartum period.

Substance use disorders (SUDs) are a key component of compromised perinatal mental health.

SUDs are a related area of acute national concern which has been shown to likely contribute to more than one in three (37%) pregnancy-associated deaths. Universal screening for mental health issues and SUDs is strongly recommended as a first step to identify birthing persons in need of treatment. In 2019, 2,031 infants met the criteria of a "substance exposed newborn," which represents 3.5% of all live births in Louisiana.

**To document the demonstrated need for comprehensive perinatal mental health services in Louisiana, HCR 105 addresses the additional barriers for Black and Brown women as it relates to perinatal mental health, noting these key factors:**

- Black people can be considered the most vulnerable group in the United States, with a history of significant experiences of pain, disappointment, oppression, exploitation, and/or marginalization.
- Black people are more likely to be victimized by crime, to live in poverty, and to suffer chronic conditions such as diabetes and cardiovascular disease.
- A stigma remains associated with Black people and mental health.

Human rights-based approaches to addressing perinatal mental disorders, specifically among Black, Indigenous, and People of Color (BIPOC) communities, underscores the importance of considering social and structural determinants of health. The chronic stressors of housing insecurity, exposure to interpersonal violence, and access to basic needs like nutritious food and clean water have an undeniable impact on the mental health of birthing people.

The Bureau of Family Health has supported the work of the Louisiana Maternal Mental Health Task Force as a current and future guide to prioritizing the health of birthing persons across the state and ensuring inclusivity—especially of persons who are oppressed. The end goal of the Task Force is to produce action steps and definitive measures that can be presented to various leaders to ensure that policy and legislation exists. Where legislation does not exist, it should be enacted to increase optimal perinatal mental health outcomes.

**The recommendations outlined in this report emphasize:**

1. *Incorporating universal PMAD screening into key care systems for pregnant and postpartum persons*
2. *Expanding direct access to mental health services for birthing people in need of perinatal mental health services by integrating primary care and mental health*
3. *Optimizing and expanding the care coordination system for birthing people in need of perinatal mental health services*
4. *Ensuring that the Louisiana Department of Health supports Louisiana's mental health and substance use provider network in meeting and addressing in a timely manner the mental health needs of pregnant and postpartum persons, particularly persons who are most impacted by structural and social barriers to health*

# METHODOLOGY

**House Concurrent Resolution No. 105 (HCR 105)** passed on June 9, 2021 and enacted the formation of the Louisiana Maternal Mental Health Task Force, stipulating representation from specified agencies, advocacy organizations, and service providers. Additional members serving Black and Brown birthing families were invited by the Bureau of Family Health (BFH) and the Institute of Women and Ethnic Studies (IWES), a community-based public health organization based in New Orleans. The Task Force had 43 members, which included physicians, public health practitioners, social service providers, birth workers, persons with lived experience, and representatives from community-based organizations supporting pregnant and parenting Black and Brown families.

The Task Force was co-led and supported administratively by members of IWES. Working meetings of the full group began on September 27, 2021 and continued to January 2022. In addition to Task Force meetings, individual consultation interviews were conducted, transcribed, and summarized by IWES staff to complement the research and landscape scan, and to perform a document review that informed the systems-level recommendations presented in this issue brief.

Per the focal areas stated in HCR 105, the Task Force assessed formal clinical services and upstream factors related to perinatal mental health, including:

- Acknowledging the role of cultural oppression in mental illness
- Centering at the margins and giving voice and power to those who are voiceless or disempowered by current systems of care
- Being innovative to build on the strengths of individuals and their communities to emphasize the extent to which oppressed peoples have survived under oppressive conditions
- Working to resist and interrupt the intergenerational transmission of racist narratives of Black and Brown people, migrants, and people who are seeking asylum in the US

## things to keep in mind

- Though the mental health status of a birthing person before conception and for several years following pregnancy is strongly associated with maternal and child outcomes, the perinatal period defined as pregnancy up to two years post birth is a focal point of this report. Two years after delivery represents a time when women are at high risk for a depressive disorder, and the pediatric venue offers a unique opportunity for the identification and management of depression at well-child visits.
- The terms *perinatal mental health*, *perinatal mood and anxiety disorders*, *postpartum depression*, *maternal mental health conditions*, and *major depressive disorders* will be used to reference aspects of the continuum of perinatal mental illness.
- The terms women, mothers, and birthing persons will be used to include people of any gender identification who experience mental health challenges during the perinatal period, including the prenatal, pregnancy, and postpartum phases.
- The language in cited sources will be retained to maintain consistency with the voice and terminology used by the original authors; however, whenever possible, this report will intentionally adopt language that is gender-inclusive and affirming to any person who has conceived or given birth.

# THE ISSUE

# THE ISSUE

## What is Perinatal/Maternal Mental Health?

Perinatal mental health (PMH) illness is a significant complication of pregnancy and the postpartum period. A study of mothers and infants (n= 4500) at the National Institute of Health (NIH) Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) found that postpartum depression symptoms can last from four months to three years after birth. Regardless of the length of time specified, perinatal mental health disorders include depression, anxiety disorders, and postpartum psychosis, which usually manifests as bipolar disorder.

Peripartum depressive disorders are clinically defined as depression with an onset of mood symptoms that occurs during pregnancy or within four weeks following delivery. It is important to note that mood episodes can begin during pregnancy or postpartum, and 50% of "postpartum" major depressive episodes actually begin prior to delivery. Maternal depression associations for newborns includes lighter infant birth weight, poor infant growth, higher rates of diarrhea, shorter breastfeeding duration, and slower child development. The risk factors that promote poor perinatal health are well documented and include past history of depression, anxiety, or bipolar disorder, as well as psychosocial factors, such as ongoing conflict with one's partner, poor social support, and ongoing stressful life events.

Perinatal depression and anxiety are common, with prevalence rates for major and minor depression up to almost 20% during pregnancy and the first three months postpartum. Studies have shown that "baby blues" are common and increase the risk for a postpartum major depressive episode. Postpartum mood episodes (depression or mania) with psychotic features appear to occur in one in 500 to one in 100 deliveries and are more common in first pregnancies. The risk of postpartum episodes with psychotic features is particularly increased for women with prior postpartum mood episodes and for women/birthing people with a prior history of depression or a personal/family history of bipolar disorders.

### how perinatal mental health disorders present

The spectrum of perinatal mental health disorders covers a wide range of issues, some moderate and others much more severe in terms of symptom and healing. Disorders include:

- Antenatal depression and anxiety
- Postpartum depression and anxiety
- Postpartum anxiety/panic disorder
- Postpartum obsessive-compulsive disorder
- Postpartum post-traumatic stress disorder
- Postpartum psychosis

Perinatal mental health disorders are associated with:

- Greater perceived stress
- More negative life events
- More financial problems
- More illness among close relatives

Perinatal mental health disorders may also cause the following impacts:

- Lower levels of household functioning (household care)
- Increased chance of homelessness
- Increased likelihood (approximately 1.5 times more) to be at risk for homelessness than non-depressed mothers.

## Racial and Socioeconomic Accelerators

Early postpartum depressive symptoms are reported by

50% Hispanic Mothers

45% African American mothers

31% White mothers

*Only 40% of mothers with perinatal mood and anxiety disorders seek treatment.*

*Consequences for the mother and infant can be long term and life-threatening, and may lead to severe emotional problems and general medical problems in mothers, fathers and children if early appropriate treatment is not received.*

Focusing on reducing the risk of postpartum depression in lower income women is especially important when considering the following ways structural forces affect maternal health outcomes:

- Poverty is associated with twice the rate of postpartum depression.
- Socioeconomic adversity amplifies the negative effects of postpartum depression on infant development.
- Poverty limits access to resources such as mental health services.
- Minority women are among the most affected by maternal depression in part due to contributors of socioeconomic disadvantage. Rates of up to 50% have been documented in African-American women.
- Low socioeconomic status, poor access to education and healthcare, adolescent age, African-American race, and recent immigrant status are thought to lead to a postpartum depression rate of up to 25% in each population demographic.
- Lack of social support, perceived stress, prior history of depression, and a history of sexual or physical violence have been most frequently identified as potential risk factors for perinatal depression. Additional risk factors include the mother's perception of her pregnancy, family criticism, self-efficacy, self-esteem, substance use, parental stress, community violence, anxiety, and African-American ethnicity.

## The Crisis in Perinatal Mental Health

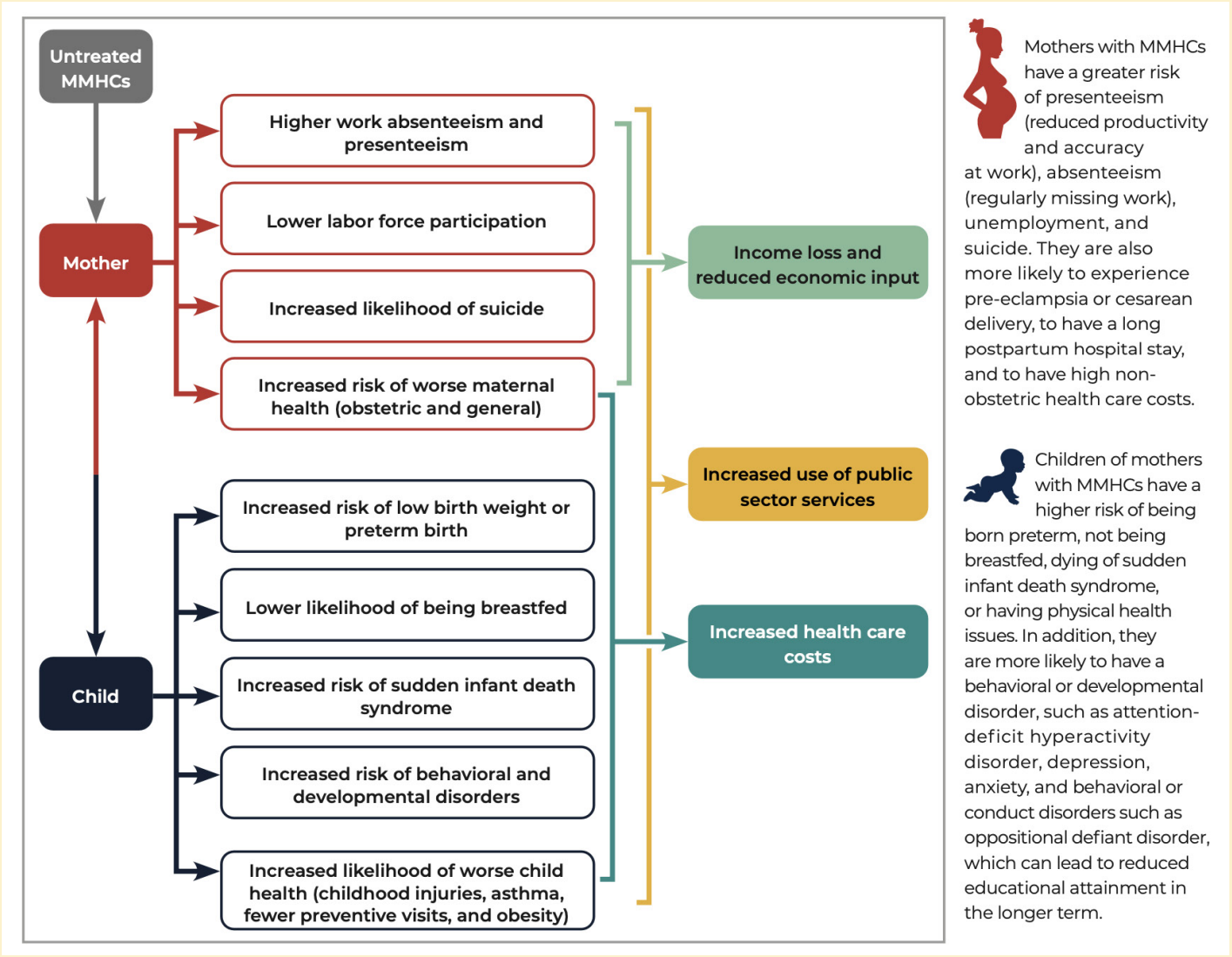
- About 10%–16% of women who have given birth experience postpartum depression that is associated with more severe depressive symptoms, social dysfunction, and marital maladjustment than depression unrelated to the postpartum period.
- With approximately four million live births occurring annually in the United States, this equates to approximately 600,000 women experiencing perinatal depression.
- These statistics consider live births alone and do not take into account women who miscarry or have stillbirths. Considering these additional risks would increase the overall incidence of perinatal depression to up to 900,000 annually.
- 20% of women will continue to have the depressive episode beyond the first year after their delivery, about 13% after two years.
- Women with childhood trauma experienced greater depressive symptoms through six months postpartum, which then predicted negative child outcomes at one year.
- Women with a history of depression, anxiety disorders or serious mood disorders such as bipolar disorder are 30%-35% more likely to develop perinatal depression.
- If a woman has experienced depression with previous births, she is 10%-50% more likely to experience it again with subsequent births.
- Instances of maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality.

## The Impact of Poor Perinatal Mental Health

Perinatal Mood and Anxiety Disorders (PMADs) are common in the United States and untreated PMADs represent a heavy economic burden and a growing public health concern. Across the country, the pattern of under-diagnosing and under-treating these conditions persists despite the existence of screening tools and effective treatments. Approximately 75% of perinatal women who are diagnosed with depression do not receive any treatment. Efforts to curb PMADs not only benefit women's, children's, and their entire family's health, but would also improve women's productivity and decrease their use of social services.

A 2020 study produced estimates of the economic burden of PMADs in the United States to inform the financial and public policy rationale for improving perinatal mental health treatment. Using a six-year timeframe as the parameter for analysis, the cost per affected mother–child dyad was close to $31,800, and the average annual cost of a mother–child dyad with PMADs was $5,300. Through economic modeling, the study estimated that the societal cost of untreated PMADs from conception through five years postpartum was $14 billion for the 2017 birth cohort. Approximately half of these costs occurred in the year of conception through birth—notably a time period during which perinatal mental health is considered highly treatable. About two thirds of the costs of untreated PMADs from birth through the first five years of a child's life were attributable to maternal outcomes, whereas one third were attributable to child outcomes.

In 2021 the study was replicated to examine the costs for one state, Texas. The findings were similar and reinforced the findings of a mathematical model that quantifies the monetary costs of untreated maternal mental health conditions to society and to Medicaid. The estimated total monetary cost of untreated PMADs from conception through five years postpartum in Texas is $2.2 billion. As stunning as it is, this monetary cost does not fully capture the acute and chronic human costs of untreated mental health conditions for mothers/birthing people, their children,

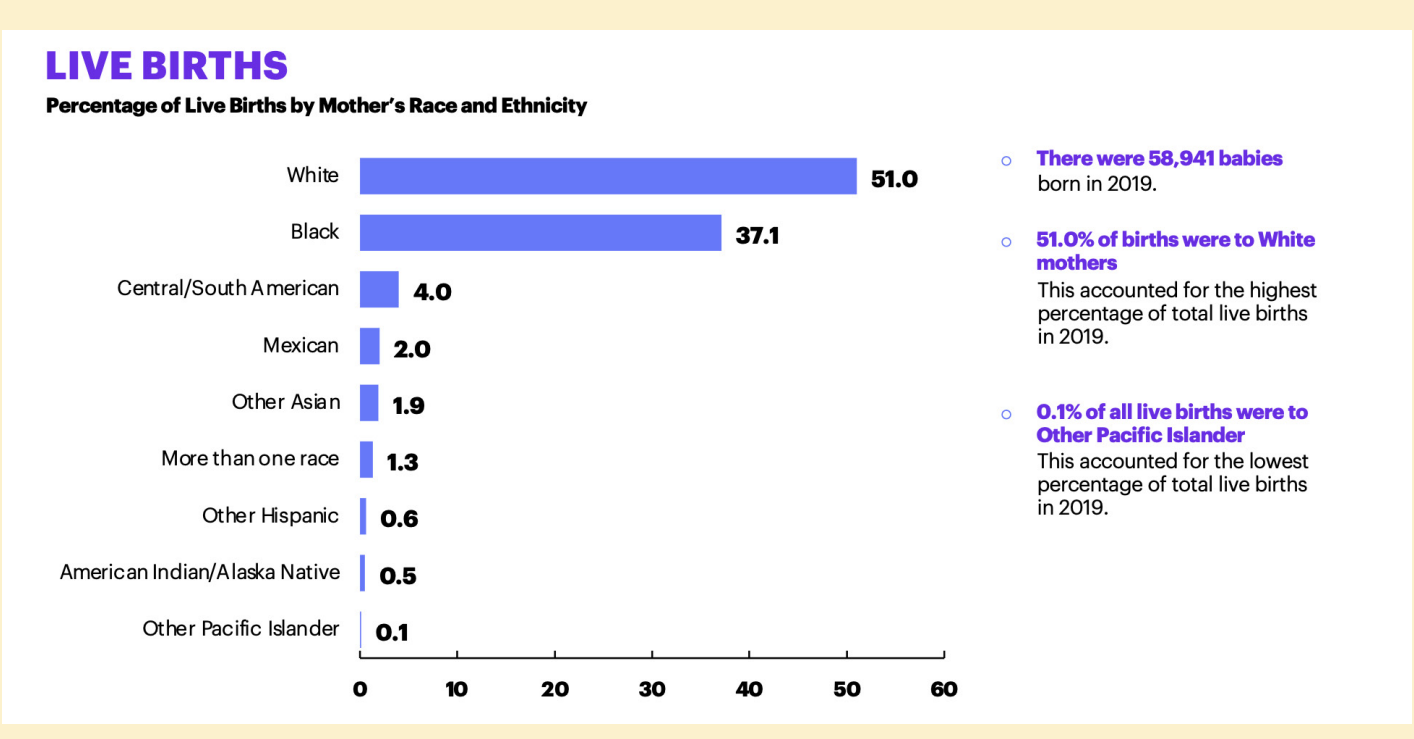



*Margiotta 2021. Untreated Maternal Mental Health Conditions in Texas Costs to Society and to Medicaid*

families and communities.

While a similar statewide impact analysis has not yet been calculated for Louisiana, the model illustrates the human and economic damage. Societal toll in the Texas state model include direct costs such as medical expenses and indirect costs such as lost work time. Costs to Medicaid include direct medical costs and exclude the costs of lost work time, suicide, and sudden infant death syndrome.

In 2019 there were 58,941 live births in Louisiana. The population of women of childbearing age (ages 15-44) in Louisiana in 2019 was estimated to be 922,449. Overall there are more females (56.2%) than males (43.8%) enrolled in Medicaid. According to the Louisiana Medicaid 2020 annual report, 1,883,015 people—approximately 40.5% of the state's population—were insured by Medicaid (1,048,807 were females and 462,548 were females aged 15-44). As of December 3, 2021, over 337,812 newly enrolled women accessed services through this expanded coverage. Women account for 61.3% of enrollment, which can probably be explained by the programs available for pregnant women, a disproportionate number of female enrollees in very low income




*Healthy Moms, Strong Babies. March of Dimes Peristats 2019*

households, and a longer life expectancy for females. These trends are true of all racial groups and recipients by race and gender.

## The Opportunity To Make A Change

Perinatal mood and anxiety disorders can be successfully treated with a variety of approaches, including social support, lifestyle modifications, talk therapy, and medications. Of all PMADs, postpartum depression is particularly amenable to prevention. Research has increased the feasibility of identifying high-risk mothers with a clear marker for onset at child birth and defined period of heightened risk—the three-month period after childbirth.

Several screening instruments (see Depression Screening Tools table on next page) have been validated for use during pregnancy and the postpartum period to assist with systematically identifying patients with perinatal depression. According to the American College of Obstetricians and Gynecologists (ACOG), the Edinburgh Postnatal Depression Scale (EPDS) is the instrument most frequently used in clinical practice and research settings. The scale consists of self-reported questions that include anxiety symptoms, which are a prominent feature of PMADs. Symptoms of depression are also the primary focus of the Patient Health Questionnaire 9, the Beck Depression Inventory, and the Center for Epidemiological Studies Depression Scale. These other instruments have at least 20 questions and require more time to complete and to score in order to provide patients with close follow-up.

## Table 1. Depression Screening Tools

| Screening Tool | Number of Items | Time to Complete (Minutes) | Sensitivity and Specificity | Spanish Available |
|---|---|---|---|---|
| Edinburgh Postnatal Depression Scale | 9 | Less than 5 | Sensitivity 59-100%<br>Sensitivity 49-100% | Yes |
| Postnatal Depression Screening Scale | 35 | 5-10 | Sensitivity 91-94%<br>Sensitivity 72-98% | Yes |
| Patient Health Questionnaire 9 | 9 | Less than 5 | Sensitivity 75%<br>Sensitivity 90% | Yes |
| Best Depression Inventory | 21 | 5-10 | Sensitivity 47.6-82%<br>Sensitivity 85.9-89% | Yes |
| Beck Depression Inventory-II | 21 | 5-10 | Sensitivity 56-57%<br>Sensitivity 97-100% | Yes |
| Center for Epidemiological Studies Depression Scale | 20 | 5-10 | Sensitivity 60%<br>Sensitivity 92% | Yes |
| Zung Self-Rating Depression Scale | 20 | 5-10 | Sensitivity 45-89%<br>Sensitivity 77-88% | No |

# PERINATAL PROGRAMS IN THE US

### why the nation has taken action

Perinatal mental health is not solely a social and ethical responsibility to act, failure to address this crisis comes at a high price, and the costs of inactivity have shown to increase exponentially with time. As the cycle previously mentioned illustrates, the effects of untreated PMH seeps into the well-being of the mother well beyond the perinatal period, and ultimately the child, as well. From physical to mental to social, the costs add up.

***NATIONALLY, 75% OF PERINATAL WOMEN WITH A DIAGNOSIS OF DEPRESSION DO NOT GET THE TREATMENT THEY NEED.***

National responses to the perinatal mental health crisis focus on recommendations for maternal health promotion that are increasingly moving toward a holistic vision of women's health in order to meet the complete needs of mothers and birthing people. These comprehensive policies include paid maternity leave, childcare coverage, and expanded housing access for mothers and their families. This is even more true as the COVID-19 pandemic disproportionately impacts pregnant and birthing people in underserved communities. It is important that medical providers and professional birth workers implement rigorous follow-up procedures outside the hospital to continue to support parents during this critical time for adult caregivers and infants.

The American College of Obstetricians and Gynecologists (ACOG); the American Academy of Pediatrics (AAP); the Association of Women's Health, Obstetric, and Neonatal Nurses; and the American Psychiatric Association (APA) all recommend consistently screening perinatal women in obstetric or pediatric clinical settings and providing comprehensive treatment of PMADs, if indicated. Furthermore, the US Preventive Services Task Force recommends primary care screening for depression during pregnancy and postpartum and counseling interventions to prevent perinatal depression.

## A Sampling of Programs Around The Nation

### comprehensive systems

The state of Iowa, through The Early Childhood Iowa Program, provides a strong example of general policy recommendations to establish a comprehensive system for addressing maternal depression. Key features of the program include:

- Advocating to assure Medicaid and private insurers provide adequate reimbursement for treatment and screening for maternal depression at prenatal and well-child visits.
- Developing a system of specialized training for counselors and other professionals to recognize and treat maternal depression.
- Integrating systems to facilitate effective collaboration between primary care providers and maternal and child mental health providers.
- Removing the limits to the number of visits for mental health services that currently exist in many private insurance and Medicaid policies.

## PMAD screenings

- North Carolina: A pilot project embedded maternal screenings into the more formal services provided for Medicaid-eligible children through the **Early Periodic Screening, Diagnosis, and Treatment** program. The success of the initial project prompted this approach to be implemented statewide.
- Chicago: The **University of Illinois Chicago Perinatal Mental Health Project** provides training to more than 3,000 individuals to aid in screening assessments. The program also offers telephone-based consultations for primary care providers who need additional information or guidance. Moreover, this project offers mothers self-care tools to help them deal with depression on a daily basis.
- Southeastern Pennsylvania: The **MOMobile** program is located in eight sites and sends community health workers into local neighborhoods to target families with infants, new parents, and pregnant women. The program screens newly registered clients for perinatal depression, and provides parenting education and general services and support.
- New Jersey: The **Postpartum Depression Law** was passed in April 2006. This law mandates that healthcare professionals screen all mothers who have recently given birth and provide education to pregnant women about postpartum depression—the most common and under-treated PMAD. The legislation also created a statewide perinatal mental health referral network.

## integrating primary care and mental health

- Arkansas: The **University of Arkansas Medical Sciences ANGELS** program has a call center staffed by experienced registered nurses 24 hours a day, seven days a week. They provide telephone triage of immediate perinatal mental health concerns for patients of UAMS, OB/GYN services (or other contracted care providers), counseling services for mental health or bereavement issues, referrals to mental health crisis intervention and follow up phone call services to patients recently discharged from the hospital. ANGELS also provides assistance for physicians with evidence-based research and standards of care while caring for high-risk obstetrical patients in their local healthcare facilities.

## interventions for depression

- Massachusetts: **Reaching Out about Depression (ROAD)** provides services to low-income women with depression through supportive action workshops, social action events to promote self-empowerment resource advocacy teams, and leadership development.
- New York City: **Sister Circles** are peer-to-peer support groups which have been proven to decrease depression in Latina and African American women. The program provides referrals for those with maternal depression, and older community members offer direct support and services.
- Cincinnati: **Every Child Succeeds** embeds cognitive behavioral therapy into three different home visiting models. Specially trained therapists treat mothers for depression in their homes and work to prevent relapses. Early studies of this pilot program show that effectiveness of this program is comparable to treatment with antidepressants.

**policy to increase awareness**

- In 2005, Minnesota passed the **Postpartum Depression Education Law**. This piece of legislation requires healthcare professionals who provide prenatal care to make information about postpartum depression available in their practice. The law also mandates that hospitals give new parents written information about postpartum depression upon their departure from the hospital after the birth of a child. The state also ensures that mental health professionals are available at pediatric clinics, screening parents for mental health issues in the prenatal, perinatal, and postpartum periods.
- Illinois passed the **Perinatal Mental Health Disorders Prevention and Treatment Act** in 2007. This law emphasized increasing public awareness about perinatal depression and promoting early detection and treatment. The state's Department of Healthcare and Family Services is also required by law to create a plan that addresses improving birth outcomes and perinatal depression. Illinois has a 24-hour crisis hotline for women with maternal depression and mandates depression screenings for parents and developmental screenings for young children. The state has issued a specific Medicaid policy for reimbursement of maternal depression screenings as part of its wider initiative addressing mental health issues.

| State | Task Force, Review Program or Committee | State Maternal Health Policy |
|---|---|---|
| AL | Yes | n/a |
| AK | Yes | n/a |
| AZ | Yes | SB 1290<br>SB 1040<br>SB 1392 |
| AR | Yes | HB 1440<br>HB 1215<br>ACT 607 |
| CA | Yes | AB 935<br>ACR-75<br>AB 1893<br>AB 2193<br>AB 3032<br>AB 845 |
| CO | No | n/a |
| CT | Yes | SB 471 |
| DE | Yes | Title 16 801 D |
| FL | No | Families First Act of 2018 (SB 138/HB 937)<br>CS HB 1381 |
| GA | No | HR 707 |
| HI | No | Act 203<br>SB 2317 |

| State | Task Force, Review Program or Committee | State Maternal Health Policy |
|---|---|---|
| ID | Yes | n/a |
| IL | Yes | PA 101-0386<br>PA 101-0512<br>PA 100-0574 |
| IN | Yes | SB 10 |
| IA | Yes | IDPH Title V<br>SF 11 |
| KS | Yes | Maternal depression screening policy |
| KY | Yes | HB 294<br>HB 287 |
| LA | Yes | HCR 103<br>HCR 105<br>House Bill 468 |
| ME | Yes | LD 265 |
| MD | Yes | HB 775/SB 600<br>SB 923 |
| MA | Yes | HB 2285 |
| MI | Yes | Maternal Infant Health Program (MIHP) |
| MN | Yes | Minnesota State Statute 145.906 Postpartum Depression Education and Information |
| MS | Yes | n/a |
| MO | Yes | SB 788 |
| MT | No | n/a |
| NE | Yes | LB 416 |
| NV | Yes | Senate Bill 253 |
| NH | Yes | n/a |
| NJ | Yes | SB 1759<br>Companion Bill A1099 |
| NM | Yes | SB 108 |

| State | Task Force, Review Program or Committee | State Maternal Health Policy |
|---|---|---|
| NY | Yes | 2018 Women's Agenda<br>Senate S4000<br>S.7881<br>A.10066 |
| NC | Yes | n/a |
| ND | Yes | n/a |
| OH | Yes | SB 104 |
| OK | Yes | SB 419 |
| OR | Yes | House Bill 2666<br>House Bill 3625<br>House Bill 2235 |
| PA | Yes | HB 1271<br>SB 370<br>SR 108<br>HR 306<br>SB 74<br>SB 1269 |
| RI | Yes | n/a |
| SC | Yes | n/a |
| SD | Yes | n/a |
| TN | Yes | n/a |
| TX | Yes | SB 750<br>HB 253<br>HB 2466 |
| UT | Yes | n/a |
| VT | Yes | n/a |
| VA | Yes | HB 2613 |
| WA | Yes | n/a |
| WVA | Yes | n/a |
| WI | Yes | n/a |
| WY | Yes | n/a |

# IDENTIFIED BARRIERS AND POSSIBLE SOLUTIONS

# Steps to Improve Perinatal Mental Health In Louisiana

The information to follow comes from the work of the task force to address barriers and suggest solutions for overall improvement of perinatal mental healthcare within the state, with a particular focus on exploration of barriers for black and brown women and those who receive care through Medicaid.

The Perinatal Mental Health Task Force identified patient and provider challenges related to early recognition and response to perinatal mental health concerns and the system barriers contributing to those challenges. Below is a summary of the major barriers that were identified, how they present, and possible solutions. The summary also includes policies, initiatives, and programs that are currently underway in Louisiana that can be built upon with the end result of developing a more comprehensive system to address the mental health needs of pregnant and postpartum persons, with a particular focus on a system that meets the needs of black and brown women.

Of note, a very promising solution to barriers that exist at the provider level is the integration of perinatal mental health into primary healthcare settings. A Collaborative Care Model (CCM) has proven particularly effective for providing PMH services during pregnancy for patient and providers because:

- Approximately one-third of women consider their OB-GYN to be their primary care provider, often trusting them to provide primary, specialty, and preventative care during key developmental periods such as pregnancy and menopause. OB-GYN physicians provide a disproportionate amount of care for minority women living in poverty.
- Physical and mental health care at a familiar location decreases mental healthcare stigma for patients. CCM is designed to create patient-centered team care including primary care and mental health providers using shared care plans that incorporate patient goals. In this way, a psychiatrist is accountable for treatment outcomes by working collaboratively with the primary care provider and a behavioral health care manager.
- With the CCM model Accountable Care Providers are reimbursed for quality of care and improvement, not just volume. Studies have shown effectively integrating mental health services into primary healthcare settings reduces emergency room visits for mental health crises, and ultimately reduces costs, with a potential return on investment for $6.50:1.

## STEP 1 – PATIENT BARRIERS AND SOLUTIONS

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Personal Time** | Patients insured by Medicaid are often hourly workers. Long wait time or multiple appointments in order to access treatment can be a deterrent to accessing care due to the impact on employment, child care, and other demands on the lives of mothers/birthing people. | Conduct PMH screenings during pediatric visits to optimize the time of the mother and increase the opportunities to screen throughout the postpartum period.<br><br>Utilize telemedicine with patients and tele-consultations between mental health and primary care providers. | |
| **Lack of Providers/ Accessibility** | The opportunity for patients to see familiar, accessible and cost-effective providers is limited when PMH services are not available during routine healthcare visits for mothers/birthing people.<br><br>Disjointed services negatively influence patient motivation to reach out for help.<br><br>Being unable to access practitioners who can offer appropriate services will impact patient compliance with their care plan. | Implement the **Collaborative Care Model** in order to allow patients the opportunity to experience more timely access to members of their care team.<br><br>Ensure that the statewide mental health and substance use provider network can adequately meet healthcare provider referrals.<br><br>Create a directory of PMH providers in the community in case a patient needs to change providers given limited availability. | Louisiana's **Local Governing Entities** (LGEs) are quasi-state agencies which provide direct services locally around the state. LGEs are currently treating adults and children with serious mental illnesses or emotional disturbances via clinics throughout the state. These behavioral health clinics provide a variety of services and inability to pay does not affect receipt of services. |

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Affordability** | The inability to pay for additional services not deemed medically necessary by insurers deters patients from seeking treatment for perinatal mental health issues and discussing symptoms of PMADs with providers. | Mandate screenings in obstetrical and other prenatal healthcare settings.<br><br>Mandate that all required PMH screenings in primary care settings extend beyond the early post-partum period and continue periodically throughout the second year after delivery<br><br>Extend postpartum Medicaid coverage for 12 months after birth for eligible pregnant individuals. | One of the most significant health policy changes made in the state to improve access to mental health services was the expanded eligibility for health insurance coverage through Medicaid in 2016. Medicaid covers services which are available for mothers in treatment of anxiety and depression, including those with co-occurring Substance Use Disorders.<br><br>The LDH Business Plan for FY 22 calls for policy and programmatic changes to increase access to maternal care services to include the consideration of an amendment to the Medicaid state plan to extend postpartum Medicaid coverage for 12 months after birth for eligible pregnant individuals. |

## STEP 1 – PATIENT BARRIERS AND SOLUTIONS *(continued)*

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Lack of Awareness/ Stigma** | Patients may ignore their symptoms and not recognize their importance if they are unaware of the implications of what they are experiencing. | Educate patients, family & friends, and the general public about perinatal mood disorders in order to destigmatize and normalize the conversation.<br><br>Provide information about and resources for perinatal mental health conditions at the initiation of prenatal care, throughout pregnancy, during postpartum care, at pediatric well visits, and at discharge from hospital.<br><br>Help family members recognize the signs/ symptoms of poor maternal mental health.<br><br>Advise what to do when symptoms present.<br><br>Inform community members of what resources are available in their community. | |

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Trust** | Patients may not want to admit to mental concerns due to long standing distrust of health systems and pervasive stigmas around mental health in poor and/or minority communities. | Use a behavioral health care manager (BHCM) to allow patients to experience consistent treatment of care and management of care<br><br>The BHCM can access a patient's primary care physicians on their behalf. | Louisiana's **Nurse-Family Partnership (NFP)** model pairs first-time pregnant individuals with a nurse early in pregnancy through the child's second birthday. In recent years, the state has also begun to offer another evidence-based model, **Parents as Teachers (PAT),** in certain areas of the state which pairs a parent educator with pregnant and parenting families. Both services are supported by mental health consultants that help ensure that the providers working with families are able to recognize and respond to potential mental health concerns, including caregiver depression. |

## STEP 2 – PROVIDER BARRIERS AND SOLUTIONS

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Provider Time and Service Payment** | Provider appointment time is often tightly linked to insurance reimbursements.<br><br>Providers are demotivated to provide services that they are not expecting to be properly compensated for. | Fund the use of alternative communication methods and referral systems for treatment, consultations, and referrals such as telemedicine to allow providers to offer services with an appropriate demand on their time.<br><br>Mandate/fund PMH screening, and therefore funding, in primary care settings.<br><br>Implement/fund tax incentives, such as tax credits, to place both maternity services and pediatric clinics within a primary care setting so that women can seek medical care for their chronic condition and perinatal mood and anxiety disorders while receiving prenatal care.<br><br>Increase and improve provider reimbursement rates for PMH care and treatment. | Medicaid and the Office of Public Health partnered to make changes in policy related to developmental screening in pediatric settings. In January 2021, the state began to cover a separate reimbursement to pediatric providers that implement certain evidence-based screenings, including one that addresses caregiver depression. |

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Provider Time and Service Payment** *(continued)* | | Expand Medicaid eligibility to increase access to PMH treatment and resources before, during, and after pregnancy in order to ensure affordable and comprehensive healthcare<br><br>Increase funding for PMH resources, providers, and treatment overall at the local, community, and state levels.<br><br>Fund referral systems to deliver quality, culturally appropriate PMH care and treatment for Black women, women of color, and women on Medicaid. | |
| **Relevant Training** | Practitioners may have inadequate training to know what symptoms to look for and how to screen for PMH issues.<br><br>Practitioners have inadequate training on trauma-informed care. | Mandate/implement training for primary care providers on proper PMH screening techniques and procedures to be implemented in their practice. | The Office of Behavioral Health partnered with the Louisiana State University to establish a statewide training and resource center for mental health providers called the Center for Evidence to Practice. Its mission is to support the state and its agencies, organizations, |

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Relevant Training** *(continued)* | | Mandate cultural competency and cultural humility trainings for providers and staff to encourage sensitivity to the high rates of PMH in poor and minorities and patience reticence to own these issues<br><br>Implement training on trauma-informed care. | communities, and providers in the selection and implementation of evidence-based interventions to promote youth and family well-being, improve behavioral health outcomes, and address challenges related to sustaining quality practice. |
| **Integrated Care** | Providers need to have similar processes, screening tools and databases for shared results in order to optimize their ability to communicate in similar ways, to access patient history, and share in care plan recommendations. | Utilize the Collaborative Care Model to allow patients to access a variety of PMH resources and treatment in their primary care setting.<br><br>Establish referral systems for quality, culturally appropriate PMH treatment for Black women, women of color, and women who are insured by Medicaid.<br><br>Utilize the Collaborative Care Model for PMH in primary care settings in order to team primary care providers with a consulting psychiatrist and behavioral health care | The **Louisiana Mental Health Perinatal Partnership (LaMHPP)** is a statewide provider-to-provider consultation system piloted by the state and available to all medical and mental health clinicians in the state who work with pregnant and parenting families. The purpose of this system is to support first-line management of mental health and substance use disorders and make effective referrals to additional community resources. |

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Integrated Care** *(continued)* | | manager who contribute additional support and resources in the management and administration of the mother's care. | With the goal of launching statewide initiatives to address the leading clinical contributors to preventable maternal death, the Louisiana Department of Health Business Plan for Fiscal Year 2022 calls for a launch in January 2022 of a Louisiana Perinatal Quality Collaborative initiative to support perinatal depression screening by pediatric providers. |

## STEP 3 – SYSTEM BARRIERS AND SOLUTIONS

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Funding** | Mandate standardized coverage of basic PMH care. | Close the gap for provider reimbursement rates.<br><br>Fund/support implementation of the Collaborative Care Model in primary care settings, telemedicine efforts, and implementation of doulas, midwives, BHCMs, and consulting psychiatrists into PMH treatment across the state. | The **Louisiana Developmental Screening Initiative** and the associated guidelines, toolkits, and consultation services are an important complement to the Medicaid policy change related to screening for caregiver depression in pediatric practices. The initiative encompasses extensive resources for integrating evidence-based perinatal depression screening into pediatric clinical encounters. |
| **Number of Qualified/Trained Providers** | Enable/mandate provider education on how to incorporate PMH screening and care as standard practice. | Utilize TANF/SNAP as a possible checkpoint and opportunity for PMH screening.<br><br>Establish/implement a community health workers (CHWs) model and provide training for TANF/ SNAP case managers to conduct PMH screenings. | |

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Policy** | Without statewide policy, many of the options for education, funding and service will remain siloed and insufficient to cover the demographic in need. | Establish and/ or support a Collaborative Care Model in primary care settings, as many OB-GYNs provide a disproportionate amount of the health care minority women living in poverty will access.<br><br>Utilize patient passports in order to allow patients to play an active role in their treatment and receive information about their screening that they are able to share with various providers.<br><br>Establish a management algorithm in each maternity care setting to provide a more objective system to improve consistent and effective completion of routine PMH screening and facilitate appropriate interventions/ adequate referrals for women screening positive for a perinatal mood and anxiety disorder. | Medicaid and the Office of Public Health partnered to make changes in policy related to developmental screening in pediatric settings. In January 2021, the state began to cover a separate reimbursement to pediatric providers that implements certain evidence-based screenings, including one that addresses caregiver depression. |

## STEP 3 – SYSTEM BARRIERS AND SOLUTIONS *(continued)*

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Uniform Screening/ Process** | Practitioners using the same guidelines, language, and tools (screening and care standard) will better keep an entire care team on the same page as to the patient's conditions, needs, and care plan. | Establish standard screening processes, referrals, and care options for all providers to use in the PMH care.<br><br>Create shared systems to aid with collaborative care and tracking of appropriate referrals and follow up. | Louisiana Department of Health developed a **Substance Use Disorder Toolkit** presentation that offers free Continuing Education credits for Louisiana providers. The toolkit emphasizes screening, assessment of comorbid conditions, brief intervention, referral to treatment, education-assisted treatment, naloxone distribution, and resources, among other topics. |
| **Long Term Cost Benefit Analysis** | | Examine the long-term return on investment of PMH care, treatment, and resources in saved costs for the mother, children, and other members of the family unit.<br><br>Share with local legislatures that the cost of PMH treatment is significantly less than the cost of untreated mental health disorders for mothers and children. | |

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Care Coordination** | Fractured resources lead to the underutilization of existing services, lack of awareness of options, and a compounding of issues due to failed early intervention. | Provide care coordination support or services to facilitate connection of the patient to mental health treatment providers and other community resources and supports that can mitigate the negative impact of perinatal mental health conditions. | The LDH Business Plan for Fiscal Year 2022 calls for policy and programmatic changes to increase access to maternal care services and plans to enroll one hundred Medicaid beneficiaries in enhanced care coordination services for pregnant women with substance use disorder. |
| **Adequate and Accessible Statewide Network of Mental Health and Substance Use Providers** | Providers have a continuum of culturally competent mental health and substance use providers and services to which they can refer patients whose mental health concerns cannot be managed in the primary care clinic. | Create a network of mental health and substance use providers that can adequately meet the needs of people with perinatal mental health conditions.<br><br>Give providers access to information to assist them in connecting patients to the appropriate level of service.<br><br>Make telehealth services available for patients who experience barriers to accessing mental health and substance use services, e.g., no transportation, lack of local mental health services. | The Louisiana Department of Health Office of Behavioral Health is currently working with Medicaid to develop a modern, innovative, and coordinated statewide adult crisis response system that provides a person-centered continuum of services that diverts persons from institutional levels of care, yet respects bed-based crisis services without relying on them as a foundation. |

## STEP 3 – SYSTEM BARRIERS AND SOLUTIONS *(continued)*

| BARRIER | HOW IT PRESENTS | SOLUTIONS | LOUISIANA EXAMPLES |
|---|---|---|---|
| **Adequate and Accessible Statewide Network of Mental Health and Substance Use Providers** *(continued)* | | Invest in additional infrastructure to train mental health and SUD treatment providers in culturally responsive perinatal mental health.<br>Maintain a statewide map which shows where those who have this specialized training are practicing. | |

# TASK FORCE RECOMMENDATIONS & CONCLUSION

As is evident in the preceding tables, Louisiana has implemented some key policy changes, programs, and initiatives that have created some forward momentum towards improving the system of care for pregnant and postpartum persons who are experiencing perinatal mental health concerns. More concerted policy and programmatic efforts are needed to both sustain current efforts and to address system gaps and the deep-rooted inequity in health care structures. The next few pages outline the Perinatal Mental Health Task Force's priority recommendations.

# 1.

# INCORPORATE UNIVERSAL PMAD SCREENING INTO KEY CARE SYSTEMS FOR PREGNANT AND POSTPARTUM PERSONS

Form a work group to design a protocol for healthcare providers and insurers for PMH screenings and subsequent care pathways for addressing positive screens.

Assess where statewide policy or mandates for screening may be most beneficial for mothers/birthing people during pregnancy and up to two years postpartum.

The **Doula Registry Board** (Act 182 of the 2021 Regular Session of the Louisiana Legislature) provides an opportunity to expand the types of providers screening for PMDs. Doula support is positioned to become another touch point for preliminary PMH assessments that are more widely available to support individuals during the sensitive pregnancy and postpartum periods.

# 2.

## EXPAND DIRECT ACCESS TO MENTAL HEALTH SERVICES FOR BIRTHING PEOPLE IN NEED OF PERINATAL MENTAL HEALTH SERVICES BY INTEGRATING PRIMARY CARE AND MENTAL HEALTH.

Promote and integrate the Collaborative Care Model (CCM) into systems of care.

Elevate the capacity of all healthcare providers to recognize and respond to perinatal mental health by promoting and investing long-term in the **Louisiana Mental Health Perinatal Partnership**, a statewide program that provides education and provider-to-provider mental health consultation to healthcare providers who are serving pregnant and postpartum women. This project is currently funded through a grant from the Health Services and Resources Administration (HRSA) which ends in September 2023; a sustainable funding model will need to be developed to sustain this capacity-building support.

Develop and implement reimbursement models that facilitate integration of primary care and mental health services.

# 3.

# OPTIMIZE AND EXPAND THE CARE COORDINATION SYSTEM FOR BIRTHING PEOPLE IN NEED OF PERINATAL MENTAL HEALTH SERVICES.

Clarify provider and managed care organization (MCO) coordination roles for facilitating timely access to diagnostic services and treatment. Identify where care coordination services need to be expanded.

Optimize the use of a new "in lieu of" benefit to provide coverage of a comprehensive pregnancy medical home model of care to individuals with substance use disorders who are 18 years of age and older and pregnant or up to 12 months postpartum. The model includes care coordination, health promotion, individual and family support, and linkages to community/support services, behavioral, and physical health services.

# 4.

## REQUIRE LDH TO ENSURE LOUISIANA'S MENTAL HEALTH AND SUBSTANCE USE PROVIDER NETWORK CAN MEET AND ADDRESS IN A TIMELY MANNER THE MENTAL HEALTH NEEDS OF PREGNANT AND POSTPARTUM PERSONS, WITH A FOCUS ON THE NEEDS OF BLACK AND BROWN WOMEN.

Conduct a network adequacy study that includes information about providers available to treat pregnant and postpartum women and offer culturally appropriate intervention services.

Develop and strengthen telehealth options to improve access to perinatal mental health services in areas where specialized services are scarce.

Outline best practices in PMH education and training to include both primary care and mental health providers.

Inform the development of LDH Office of Behavioral Health's adult crisis system to ensure that it can meet the needs of pregnant and postpartum persons.

# CONCLUSION

Perinatal mood and anxiety disorders (PMADs) are common and occur among 20% of birthing persons, but persons who are from oppressed groups, such as Black and Brown women, and/or who are low income can experience PMADs at rates as high as 50%. Perinatal mental health conditions that go unidentified and are left untreated can not only be seriously debilitating for the birthing person, but can also have a long term impact on the physical, social and emotional development of the child. Early identification and treatment are key solutions to mitigating the negative impact of PMADs, yet, despite the existence of effective screening tools and interventions, **PMADs continue to go under-diagnosed and untreated, disproportionately impacting Black and Brown persons and other marginalized and oppressed persons.**

By enacting the formation of the Maternal Mental Health Task Force, HCR 105 was not only a call to action to improve the systems of care for all pregnant and postpartum birthing persons who are experiencing mental health conditions, but was also a call to action to ensure that the voices and experiences of Black and Brown women featured prominently in the successful completion of its charge to identify both barriers and solutions to improving perinatal mental health care.

This report brings clarity to efforts throughout Louisiana that are already working towards improving perinatal mental health services. However, it additionally highlights the actions and policy measures that need to be taken to strengthen and expand the current efforts and to fill gaps that exist which prevent birthing persons from receiving optimal care and treatment. Through focused and concerted efforts, which intentionally elevate the voices and experiences Black and Brown birthing persons, Louisiana can create a system that elevates the quality of perinatal mental health for birthing persons, which in turn will improve the health and wellbeing of the infants in their care and the ability of both to decrease their need for ongoing social services.

# ENDNOTES & TEAM MEMBERS

## task force members

Named in HCR and attended meetings*****
Named in HCR but never attended meetings*****
Attended meetings*****

1. Dr. Lisa Richardson, PhD - Institute of Women and Ethic Studies*****
2. Dr. Denese Shervington, MD, MPH - Institute of Women and Ethic Studies*****
3. Dr. Veronica Gillispie-Bell - OB/GYN, Medical Director of the Louisiana Perinatal Quality Collaborative, and the Pregnancy Associated Mortality Review for the Louisiana Department of Health*****
4. Jensine Speed, MSSA, LCSW - Siha, LLC.*****
5. Dana Foster - Psychologist, Louisiana Department of Health, the Office of Behavioral Health
6. Karen Evans - New Orleans Children and Youth Planning Board
7. Paulette Carter - Louisiana Department of Health, Office of Public Health, Bureau of Family Health*****
8. Dr. James Hussey - Louisiana Office of Behavioral Health, Chairman of the Heroin Opiate Prevention and Education Advisory Councils and Drug Policy Board, Former Medicaid Behavioral Health Medical Director*****
9. Karen Stubbs - Louisiana Department of Health, Office of Behavioral Health*****
10. Ashley Politz, MD - American Academy of Pediatrics, Louisiana Chapter*****
11. Frankie Robertson - Founder and President of the Amandla Group, on behalf of National Birth Equity Collaborative*****
12. Dr. Julianna Finelli - Tulane University School of Medicine, Louisiana Mental Health Perinatal Partnership*****
13. Dr. Lauren Teverbaugh, MD, FAAP - Tulane University School of Medicine and Teverbaugh Consulting*****
14. Kimberly Novod - Founder and Executive Director of Saul's Light Foundation*****
15. Charlotte Claiborne - Bridge Center for Hope*****
16. Cathy Griffths - Woman's Hospital Baton Rouge*****
17. Representative Royce Duplessis
18. Shelina Davis, MPH, MSW - Louisiana Public Health Institute*****
19. Rheneisha Robertson, MPH - Covenant House New Orleans*****
20. Allison Dejan - Louisiana Medicaid*****
21. Amanda Brunson - Louisiana Governor's Women's Policy*****
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27. Renee Antoine - March of Dimes, Louisiana*****
28. Jacqueline Brown - Louisiana Department of Children and Family Service*****
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30. Eboni Buchanan - Woman's Hospital, GRACE Program*****
31. Melanie Richardson - Training Grounds, Inc*****
32. Marketa Walters*****
33. Mark Thomas - Human Services Interagency Council*****
34. LaShonda Williams - National Alliance on Mental Health*****
35. Dr. Elizabeth Lapeyre, MD - American Congress of Obstetrics and Gynecology*****
36. Thea Ducrow - Executive Director, Louisiana State Nurses' Association
37. Dr. Amanda Dumas - Louisiana Medicaid
38. Kayla Tamplain - Director of Care Management
39. Amber Parden - Psychiatrist

*Special Thanks: Sabrina Amani, Jallure Harrell, Jennifer Latimer, Rebecca Majdoch, Mary Rockwell, Tylar Williams*

## endnotes


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# Louisiana Perinatal Mental Health Task Force

POLICY REPORT