

THE STATE OF PERINATAL MENTAL HEALTH IN CALIFORNIA

Progress Since 2019 and Emerging Insights from 2026

A Landscape Brief Prepared by the California Perinatal Wellness Alliance

October 8, 2026 | Draft for Participant Review

Executive Summary

California's perinatal mental health (PMH) landscape has changed substantially since the [California Task Force on the Status of Maternal Mental Health Care](#) issued its strategic recommendations in 2017 and assessed progress in 2019. California has expanded screening requirements, postpartum coverage, Medi-Cal benefits and care coordination, clinical guidance, community-based services, maternal health data, and quality-improvement infrastructure.

Yet significant need persists. Approximately one in three California birthing people reports symptoms of perinatal depression or anxiety. While most report being screened at least once, screening remains uneven, and only about half of those who report needing help with their emotional wellbeing report receiving treatment from a doctor or mental health professional.

In April 2026, the California Perinatal Wellness Alliance (CPWA), in partnership with the Office of the First Partner, Office of the California Surgeon General, California Maternal Quality Care Collaborative, and El Camino Health, convened more than 40 leaders across government, healthcare, health plans, community organizations, advocacy, research, and lived experience to examine California's evolving PMH landscape.

Five themes emerged:

1. California has built important tools and policies, but implementation remains uneven.

Policies, benefits, programs, clinical guidance, and community resources do not yet consistently function as a connected system.

2. Screening has improved, but the pathway from identification to care remains inconsistent.

Families can still encounter gaps between screening, assessment, referral, navigation, treatment and support, and follow-up.

3. Workforce gaps are structural.

California needs both specialized PMH expertise and stronger integration, training, support, and reimbursement across the broader clinical and community-based workforce.

4. Financing does not always support integrated care.

Navigation, coordination, prevention, peer and community support, and continuity across settings can remain difficult to finance.

5. Trust, equity, and community connection are essential infrastructure.

Culturally responsive care, lived experience, trusted relationships, and community-based organizations are integral to whether families can access and remain connected to care.

Taken together, the landscape suggests that California's next PMH challenge is increasingly one of **implementation, connection, and accountability**: making existing investments work together so families experience a coherent continuum of support from pregnancy through postpartum and early parenting.

The question moving forward is therefore not simply whether California needs another PMH initiative or structure, but **what functions require stronger ownership, coordination, financing, implementation, and accountability—and which policy, administrative, clinical, community, or cross-sector mechanisms are best suited to accomplish them.**

1. Introduction

In 2019, California had a relatively clear picture of the scale and consequences of perinatal and maternal mental health (PMH/MMH) conditions.

The 2015-2016 California Task Force on the Status of Maternal Mental Health Care brought together leaders across healthcare, government, advocacy, philanthropy, and research to document the prevalence, costs, disparities, and systemic barriers surrounding PMH. The Task Force originated with ACR 148 (2014), which requested that the California Maternal Mental Health Collaborative establish a cross-sector task force to examine barriers to screening, diagnosis and treatment and identify opportunities for improving maternal mental health care. The Task Force issued [California's Strategic Plan](https://cdn.policycentermmh.org/2017/05/California's%20Strategic%20Plan.pdf) in 2017, identifying five key PMH care barriers and twelve recommendations for tackling them.¹ In 2019, a follow-up report provided an accounting of progress on the recommendations and related statewide efforts.²

Seven years later, California's landscape looks meaningfully different.

California has enacted legislation, expanded public insurance coverage, created new benefits and clinical guidelines, developed statewide maternal health initiatives, strengthened data

¹ <https://cdn.policycentermmh.org/2024/05/Report-CATaskForce-1.24.18.pdf>

² <https://cdn.policycentermmh.org/2024/09/CA-Task-Force-Report-2019.pdf>

collection and quality improvement, and supported new models of community-based care. At the same time, broader changes in California's healthcare and behavioral health systems have created both new opportunities and new questions about where PMH fits within increasingly complex systems.

The April 28, 2026, [California Roundtable to Align Systems for Perinatal Mental Health](#) provided an opportunity to examine that evolution collectively. More than 40 leaders from state agencies, healthcare systems, health plans, community organizations, advocacy, research, and lived experience came together to foster shared understanding, strengthen relationships across sectors, and identify potential areas for collaboration.

This report connects the 2019 and 2026 moments. It first describes the scale of the need and what has changed since 2019, drawing on the [April 2026 Roundtable pre-reading](#). It then examines what the PMH system looks like for providers, families, and communities today, drawing on the [Roundtable presentations](#) and [post-event memo](#) to identify broader patterns and questions emerging from the field.

This report is not a formal set of policy recommendations. It is intended as a shared reference point: a way to understand where California's PMH field has been, what has been built since 2019, where important implementation gaps remain, and what questions may warrant further attention and coordinated action.

2. The Case for Perinatal Mental Health

PMH conditions – including depression, anxiety, obsessive-compulsive disorder, bipolar disorder, post-traumatic stress disorder, and postpartum psychosis – are among the most common complications associated with pregnancy and the postpartum period.

In California, available data demonstrate the persistent scale of need, significant disparities in who is affected and receives care, and the consequences of untreated PMH conditions.

- **PMH challenges are widespread.** Approximately 1 in 3 birthing people experiences symptoms of perinatal depression or anxiety. Black birthing people report higher rates of both depression and anxiety symptoms than white birthing people. Additionally, 10% of fathers and partners experience perinatal depression.³
- **Screening has increased but it remains uneven.** Although most birthing people (82.4%) report being screened at least once, only half report being screened during and after pregnancy. Asian, Black, and Hispanic birthing people, younger birthing people, and people with lower incomes report the lowest screening rates. About 25% of Medi-Cal

³ <https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Maternal-Mental-Health-Report.aspx>

participants reported never being screened, compared with 10% of privately insured participants.⁴

- **Treatment is far from universal.** Just half of birthing people who reported needing help for their emotional wellbeing also reported receiving treatment from a doctor or mental health professional.⁵
- **The most commonly reported barriers to care are birthing people feeling they can handle mental health challenges themselves, are too busy or overwhelmed, or don't know where to go for help. Stressors such as poverty, housing insecurity, and food insecurity also contribute.**⁶
- **Workforce shortages are a major constraint.** California has fewer than five non-prescriber PMH providers per 1,000 births⁷ and approximately 1,500 PMH-certified professionals statewide, including doulas and peer support professionals.⁸ Long waitlists and insurance coverage further limit access.⁹
- **The consequences extend beyond individual wellbeing.** PMH conditions are connected to maternal mortality, family wellbeing, infant and child outcomes, and broader social and economic costs.¹⁰ California's estimated annual cost of untreated maternal mental health conditions is \$2.4 billion.¹¹

These data provide the context for assessing what California has built and what families experience today. The central story is that **the need persists even as California has substantially expanded the solutions intended to respond to that need.**

3. California's PMH System Since 2019

The most significant changes in California's PMH landscape since the Task Force span several interconnected areas: policy and legislation, Medi-Cal benefits and financing, clinical knowledge and treatment, community-based infrastructure, and data, quality improvement, and accountability. The subsections below describe the major changes within each area.

3.1 Policy and Legislation

California has moved from establishing a basic policy foundation for PMH toward embedding PMH more explicitly within broader maternal health, behavioral health, and workforce policy.

⁴ <https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Maternal-Mental-Health-Report.aspx>

⁵ <https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Maternal-Mental-Health-Report.aspx>

⁶ <https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Maternal-Mental-Health-Report.aspx>

⁷ <https://policycentermmh.org/e71663d2-8917-4537-b70e-281b6aa19666>

⁸ <https://psidirectory.com/listing/california>

⁹ https://calpwa.org/wp-content/uploads/2026/05/Powerpoint_CAPMHAAgencyRoundtable.pdf

¹⁰ https://calpwa.org/wp-content/uploads/2026/05/Powerpoint_CAPMHAAgencyRoundtable.pdf

¹¹ <https://www.chcf.org/wp-content/uploads/2019/04/CaliforniaSocietalCostsUntreatedPMAD.pdf>

In 2014, [ACR 148](#) established the framework for a statewide task force to examine maternal mental health care and develop recommendations for improving identification and treatment.

Several important pieces of legislation were going into effect as the Task Force was completing its 2019 report. [AB 2193](#) (2018) required licensed health care practitioners providing prenatal or postpartum care to ensure that patients were offered or appropriately screened for maternal mental health conditions. The law did not specify screening frequency, allowing flexibility to align with professional clinical guidelines. It also required health plans and insurers, including Medi-Cal managed care plans, to develop maternal mental health programs designed to promote quality and cost-effective outcomes. [AB 3032](#) (2018) established a related hospital requirement: hospitals with perinatal units must provide education about maternal mental health conditions to patients, families, and appropriate staff.

These laws represented an important shift: PMH was no longer solely dependent on individual providers or organizations; screening, education, and health plan programming became matters of state policy. More than 140 (of 240+) California birthing hospitals subsequently participated in the associated [PMH Learning Community](#).

Subsequent legislation strengthened this foundation. [AB 1936](#) (2024) expanded screening requirements to include at least one screening during pregnancy and at least one additional screening during the first six weeks postpartum, with additional postpartum screening when medically necessary and clinically appropriate. [AB 2581](#) (2024) required specified healing arts boards to consider adding PMH training requirements.

In 2026, [SB 626](#) further strengthened California's maternal mental health framework by addressing what happens following screening, including care coordination and follow-up responsibilities. Its enactment represents a continued shift from establishing screening expectations toward strengthening the pathway between identification and care.

Beyond PMH-specific legislation, in 2024 California voters passed Proposition 1, restructuring the state's behavioral health financing system through a \$6.4 billion bond.

Taken together, **these developments show an evolution from establishing PMH screening and education requirements toward a broader policy focus on whether families can move from identification to appropriate care and support.**

3.2 Medi-Cal Benefits, Coverage, and Financing

Shifts in Medi-Cal maternity care since 2019 have been some of the most consequential in PMH care.

[California Advancing and Innovating Medi-Cal](#) (CalAIM), launched in 2022, has increasingly connected physical health, behavioral health, care coordination, and health-related social

needs. Medi-Cal extended postpartum coverage to 12 months, introduced Enhanced Care Management (ECM), expanded Community Supports, and established a statewide Medi-Cal doula benefit. ECM specifies that intensive care coordination for eligible members includes pregnant and postpartum individuals at risk for adverse perinatal outcomes. Community Supports cover needs such as housing, nutrition, and other social drivers of health. The doula benefit, effective January 2023, reimburses doulas for person-centered physical, emotional, and informational support throughout pregnancy, birth, and up to one year postpartum.

The [Department of Health Care Services' Birthing Care Pathway](#) (BCP, 2025) offers a comprehensive Medi-Cal maternity roadmap. It prescribes 42 policy solutions across eight focus areas; one year after its release, DHCS reported that 28 policy solutions had been completed and 14 remained in progress. Importantly for PMH, the BCP does not treat behavioral health as a separate specialty issue. Its policy solutions include behavioral health and trauma-informed care, risk assessment across medical, behavioral, and social domains, care-management and referral pathways, and stronger connections between healthcare and community-based providers.

In 2025, California was also selected for the federal [Transforming Maternal Health \(TMaH\) Model](#), a 10-year initiative providing \$17 million to DHCS to implement a value-based maternal health model in five Central Valley counties (Fresno, Kern, Kings, Madera, and Tulare). TMaH includes whole-person care, access to midwives, doulas, and community health workers, and value-based payments. It is designed to complement the statewide BCP.

The result is a substantially different coverage and delivery environment than existed in 2019. **Medi-Cal now has more mechanisms to support postpartum continuity, care coordination, community-based services, and connections between healthcare and social needs.**

3.3 Clinical Knowledge and Treatment

The clinical foundation for PMH care has also become increasingly explicit and evidence-based.

In 2018, the American College of Obstetricians and Gynecologists (ACOG) issued its [Optimizing Postpartum Care Committee opinion](#) recommending a minimum of two postpartum visits (at 3 and 12 weeks). The Department of Health Care Services (DHCS) also released [screening counseling reimbursement guidance](#) (2019).

In 2023, ACOG established dedicated Clinical Practice Guidelines for [screening and diagnosis](#) and [treatment and management](#) of PMH disorders. Specifically, ACOG now recommends standardized screening for depression and anxiety at the initial prenatal visit, later in pregnancy, and at postpartum visits, with systems in place for assessment, diagnosis, treatment, and follow-up.

New treatment options have also emerged. In 2023, the FDA approved [zuranolone, the first oral medication specifically approved for postpartum depression](#). In 2024, Los Angeles County was awarded a [Federal HRSA grant to create a telepsychiatry consultation program to support OB providers](#) in screening for maternal mental health disorders (2024).

California has also continued to develop specialized PMH treatment models, including specialized hospital-based and inpatient services. El Camino Health's inpatient PMH program offers an example of specialized care—and of the challenges involved in sustaining, connecting families to, and potentially scaling highly specialized services.

These developments have strengthened the clinical foundation for PMH care, with more explicit guidance on screening, diagnosis, treatment, and follow-up and a broader range of treatment options and delivery models. They also reflect a growing recognition that PMH care requires attention across the perinatal period rather than at a single postpartum encounter.

3.4 Community-Based Infrastructure

The PMH ecosystem has also continued to expand beyond traditional healthcare providers.

Doulas, community health workers, peer supporters, promotoras, midwives, culturally rooted birth workers, and community organizations are increasingly recognized as critical parts of the ecosystem supporting pregnant and postpartum people. Their contributions extend beyond clinical treatment to include navigation, relationship-based support, education, advocacy, connection to social resources, and continuity across systems.

As previously noted, Medi-Cal transformation has allowed for some of this work to be reimbursed (e.g., doula benefit, community health worker benefit, and Community Supports). California has also invested in infrastructure intended to help community organizations participate more meaningfully in Medi-Cal. The PATH initiative, for example, provides funding and technical assistance to community organizations, hospitals, county agencies, tribes, and other partners to build the organizational, billing, data, and contracting capacity required to participate in the Medi-Cal delivery system.

The significance of this shift is broader than the addition or recognition of new workforce roles. It reflects a growing understanding that **PMH is shaped by relationships and conditions beyond the clinical encounter** – including housing, food security, safety, social connection, racism, economic stability, and the ability to navigate fragmented systems.

These evolutions expand how California understands the PMH ecosystem. Care and support extend beyond traditional clinical settings, and community-based workers can play important roles in navigation, relationship-based support, education, and continuity. Simultaneously, Medi-Cal and other state investments have created new pathways for this work to connect with the formal healthcare system.

3.5 Data, Quality Improvement, and Accountability

California has also developed substantially more data infrastructure for understanding and improving maternal health.

The state's first [Pregnancy-Associated Mortality Review](#) (2019) shone a spotlight on mental health as a significant contributor to maternal mortality. It highlighted that the majority of maternal deaths occurred more than 42 days postpartum and were linked to psychosocial stressors; that 60% of women had pre-existing mental health conditions, and 25% had new onset during or after pregnancy; and that 51% of the 99 pregnancy-associated suicides between 2002-2012 were preventable. The review emphasized screening, coordination between obstetric and mental health care, adequate pregnancy and postpartum care beyond the traditional 6-week postpartum period, and culturally and linguistically appropriate support as key prevention strategies. Additional reviews are underway for two regions, with a dedicated statewide mental health review in progress.

In 2022, DHCS released the [Comprehensive Quality Strategy \(CQS\)](#) and incorporated goals of improving maternal depression and anxiety screening rates by 50% by 2025. Although the targets were not achieved, the 2025 data shows 6-7 percentage point increases in prenatal and postpartum depression screening rates over the measurement period.¹² Beginning in 2026, DHCS' new Behavioral Health Transformation measures will integrate a broader set of statewide measures to assess mental illness and substance use disorder within physical health delivery.

Most recently, in 2026 the CDPH Maternal, Child, and Adolescent Health Division released [Supporting the Mental Health of California Mothers](#). This analysis of 2020-2021 Maternal and Infant Health Assessment (MIHA) population-level survey data offers the clearest picture yet of the state of PMH in California, with a focus on the prevalence of depression and anxiety and mental health screening and treatment rates. As outlined in [The Case for Perinatal Mental Health](#), the data suggests a substantial gap between what policy expects and what families experience.

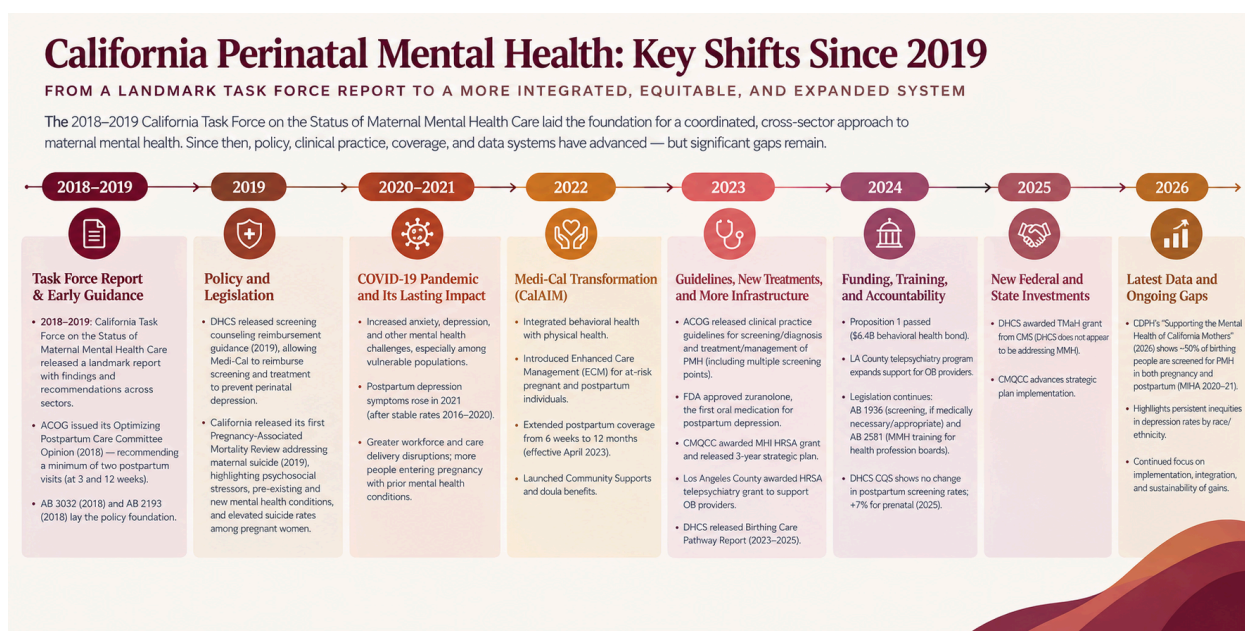
The state has also built substantial quality improvement infrastructure. California's Perinatal Quality Collaborative (CMQCC) was awarded a [maternal health innovation \(MHI\) HRSA grant](#) in 2023 and released a [3-year maternal health strategic plan](#). CMQCC's quality improvement toolkits are used across more than 200 hospitals, representing approximately 95% of California births. In fall 2026, the new [California Perinatal Quality Collaborative \(CA-PQC\)](#) is launching as an umbrella structure integrating CMQCC, the California Perinatal Quality Care Collaborative (CPQCC), and the High Risk Infant Follow-up Program, with an explicit goal of strengthening

¹² <https://www.dhcs.ca.gov/wp-content/uploads/2026/04/2025-Comprehensive-Quality-Strategy.pdf>

alignment among healthcare, public health, community services, and people with lived experience.

Although California does not yet have a CMQCC-published PMH-specific quality-improvement toolkit, this evolving infrastructure represents an important potential asset for strengthening PMH quality improvement and coordination. Maternal Mental Health Now and the California Health Care Foundation also offer [publicly available PMH training resources](#) for frontline providers and supporting stakeholders.

The overall picture is therefore one of substantially greater data, measurement, and quality-improvement infrastructure than existed in 2019. There are clearer patterns in PMH screening, treatment, maternal mortality, and disparities, and the broader maternal and behavioral health quality infrastructure continues to develop.



4. The PMH System in 2026

The April 2026 Roundtable provided an opportunity to level-set on the PMH landscape – shifts since 2019 and into the present day. Participants acknowledged important progress in California's policy, financing, clinical, community, data, and quality-improvement foundations. These developments exist within a broader maternal health landscape in which California has achieved comparatively strong maternal health outcomes¹³ and has been recognized nationally for its maternal mental health policy environment.¹⁴ At the same time, the Roundtable focused

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<https://www.gov.ca.gov/2026/06/01/icymi-california-ranks-1-in-u-s-for-supporting-maternal-mental-health/>

14 <https://policycentermmh.org/state-report-cards/>

less on the existence of individual policies or programs than on how those pieces function together and what work remains.

The question at the Roundtable evolved into not just what has changed, but how those pieces are functioning together and what work remains. The following reflect key themes that emerged: where participants identified momentum, persistent gaps, and potential starting points for continued collaboration.

4.1 California Has Built Important Tools and Policies – But Implementation Infrastructure Is Lagging and Fragmentation is a Core Systems Challenge

Participants underscored the substantial progress California has made since 2019, including expanded Medi-Cal postpartum coverage, the statewide doula benefit, PMH legislation, quality improvement initiatives and toolkits, maternal mortality review, and peer support efforts.

At the same time, participants described implementation as highly uneven across regions, systems, and populations. Despite new policies and programs, participants described gaps in accountability mechanisms, financing structures, and operational coordination that can make implementation uneven across regions, systems, and populations.

Many participants described the current landscape as fragmented, a “system of silos” in which public health, behavioral health, maternal care, managed care, hospitals, and community-based organizations often operate with different incentives, data systems, and definitions of success. Strong individual programs and local stop-gaps exist, but the systems-wide coordination across them are limited.

This creates a central tension in the current landscape: **California has built many of the component parts of a PMH system, but those parts do not yet consistently function as a connected system.**

4.2 Screening Has Improved – But the Pathway from Identification to Care Remains Inconsistent

Screening is one of the clearest areas of progress since 2019. California now has statutory requirements, clinical guidance, and quality measures supporting PMH screening, and [2026 MIHA data](#) indicate that approximately 80% of birthing people reported being screened at least

once during the perinatal period and about half reported being screened during and after pregnancy.¹⁵

The Roundtable conversation, however, highlighted what happens after screening as a less-developed part of the system. Participants repeatedly emphasized that screening alone does not improve outcomes unless accompanied by referral pathways, care navigation support, timely access to treatment, and accountability for follow-up. A recurring concern was the absence of a clearly owned “screen-to-care” pathway and continuity of care across the perinatal period.

That raises a fundamental implementation question: **Who is responsible for what happens after a positive screen?**

The answer becomes less clear as care crosses organizational boundaries – for example, from an OB practice to a behavioral health provider, from a health plan to a community organization, or from a hospital to outpatient care. Several attendees emphasized that the current system places the burden of coordination on the person experiencing the PMH challenge, often during periods of crisis, exhaustion, or instability.

Roundtable presenters offered examples of these disconnects in practice. El Camino Health reported that patients seeking its specialized inpatient PMH services frequently learn about the program through family members or online searches rather than through systematic referral pathways, even while capacity can remain available.¹⁶

One idea raised during the Roundtable was using existing claims infrastructure to track follow-up after a positive PMH screen, illustrating the broader interest in moving from measuring whether screening occurs to understanding what happens next.

SB 626 responds to part of this implementation challenge by strengthening expectations around what happens following maternal mental health screening. Its implementation therefore offers an important opportunity to examine how screening, care coordination, referral, treatment and support, and follow-up function across payers and care settings.

4.3 Workforce Gaps Are Significant and Structural

The Roundtable discussion reinforced that workforce capacity remains a major constraint on access to PMH care, among both specialized PMH providers and the broader behavioral health workforce.

Participants flagged gaps in graduate and clinical education: no California licensing board currently requires specific PMH training across relevant professions, including therapists,

¹⁵ <https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Maternal-Mental-Health-Report.aspx>

¹⁶ N. Dhami, Systems Reality Check: What’s Working & What’s Not, April 28, 2026.

nurses, physicians, and other behavioral health providers. And yet, providers are often expected to identify and manage PMH conditions and to integrate or address trauma-informed care, culturally responsive care, or the biopsychosocial dimensions of PMH.

Attendees also highlighted workforce shortages, burnout, reimbursement limitations, and uneven geographic access, particularly in rural communities. In Plumas County, for instance, the closest labor and delivery unit is 1.5 hours away.

At the same time, participants emphasized that the PMH workforce extends well beyond specialists. Doulas, midwives, promotoras, peer supporters, community health workers, and culturally rooted birth workers are already “doing the work” – providing trusted, relationship-based support, navigation, education, and continuity that families often need. The challenge is that these workforces remain unevenly integrated into healthcare systems and, in many cases, operate with limited or unstable reimbursement.

The question emerging from the discussion was therefore broader than how to produce more specialists: What should different members of the perinatal care ecosystem be equipped, authorized, supported, and reimbursed to do? What alternative pathways might be developed to enable this (e.g., grant and scholarship initiatives, provider consults, PMH hotline, first aid course, virtual care platforms, etc.)?

These questions encompass clinical education, community workforce development, referral pathways, consultation and supervision, reimbursement, and scope of practice.

4.4 Payment Structures Can Discourage Integrated Care

Roundtable participants repeatedly identified financing and reimbursement as major barriers to delivering integrated, effective PMH care.

Key concerns included fragmentation between physical and behavioral healthcare financing, low reimbursement rates for intensive coordination and community-based services, limited incentives for prevention and continuity of care, and unclear reimbursement pathways for dyadic or mother-baby care models.

These challenges are notable given the direction of California’s broader health system reforms. CalAIM, Enhanced Care Management, Community Supports, the doula benefit, and the Birthing Care Pathway have all expanded the mechanisms through which physical health, behavioral health, social needs, and care coordination can be addressed. Yet participants described persistent difficulty financing some of the activities that make integrated care possible. This includes not only clinical treatment, but also navigation, coordination, peer support, community relationships, and continuity across settings.

The result is a tension between an increasingly integrated vision of care and financing structures that do not always support the work required to make that vision operational.

Roundtable participants surfaced several approaches for further exploration, including:

- case-rate structures
 - enhanced reimbursement pathways
 - expanded peer support reimbursement
 - billing mechanisms for dyadic care
 - research and campaigns to demonstrate to health plans the linkages between positive PMH outcomes and dyadic care to birth outcomes and child development outcomes
 - sustainable financing for specialized PMH treatment and consultation models and leadership buy-in for innovative models, such as El Camino Health's inpatient PMH unit
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4.5 Trust, Equity, and Community Context Cannot Be Treated as Secondary Issues

Participants emphasized that inequities are not peripheral to PMH systems design. They shape whether people seek care, whether they trust providers, and whether they are able to remain engaged.

The Roundtable discussion highlighted structural racism, financial and housing instability, fear of surveillance or criminalization, immigration risks, stigma, cultural responsiveness, and prior negative healthcare experiences as factors affecting people's experiences of the PMH system. These concerns are particularly important in light of the disparities documented in California's PMH data.

To address these barriers, participants emphasized the role of trusted providers, intermediaries, and community-based organizations that are culturally rooted providers, family-centered, and survivor-led. This suggests that equity cannot be treated simply as an additional programmatic consideration or an outcome measure layered onto the existing system. **Trust, community connection, lived experience, and culturally responsive care are themselves part of the infrastructure through which PMH care reaches families.**

5. Unresolved Questions: From Programs to a Coherent System

A recurring framing question at the Roundtable was: ***Who owns PMH in California?*** No single agency, payer, healthcare provider, community organization, or other institution spans the full PMH continuum. Rather, PMH currently sits across multiple systems. This creates an unresolved question about statewide coordination, accountability, and leadership.

While no formal recommendations emerged, there was substantial interest in exploring what statewide coordination infrastructure could or should look like moving forward. Participants surfaced three potential pathways:

1. Restarting a statewide Perinatal Mental Health Task Force
2. Building a comprehensive statewide Perinatal Mental Health roadmap or master plan
3. Developing a statewide Office of Perinatal Mental Health (or similar entity) modeled, in part, after California's Office of HIV/AIDS.

Participants discussed whether such vehicles for PMH could coordinate statewide strategy, align funding streams, support local implementation, and provide accountability and sustained leadership across agencies and systems. For instance, a Task Force could explore the unresolved questions surfaced repeatedly throughout the Roundtable:

- What statewide entity or structure should ultimately coordinate PMH strategy and accountability?
- What would it take to move from isolated excellence to consistent statewide implementation?
- How should California measure success across the PMH continuum?
- What financing structures are necessary to support integrated and preventive care models?
- How can systems better support continuity across pregnancy, postpartum, and early parenting?
- How do we ensure that community-based and lived-experience leadership are structurally embedded rather than supplemental?
- How should California prepare for potential federal Medicaid changes that could disproportionately affect populations already at highest risk?

The Task Force or smaller working groups might also explore the opportunities identified at the Roundtable:

- financing and reimbursement modifications, including claims modifiers tied to positive PMH screening follow-up and reimbursement pathways for dyadic mother-baby care,
- expansion of inpatient PMH treatment capacity and education around their availability,
- development of a specialized PMH provider directory,
- adaptation of community mental health training models for PMH,
- stronger integration between community-based birth workers and healthcare systems,
- creation of implementation "blueprints" based on successful models such as El Camino Health,
- technology innovation, mindful of concerns around trust, surveillance, and equitable access.

The Roundtable surfaced several possible vehicles for advancing these questions, including renewed statewide planning or task-force structures, administrative or regulatory action, legislative oversight, targeted legislation, budget action, professional standards, quality-improvement initiatives, implementation partnerships, and regional or statewide coordination mechanisms. No single vehicle emerged as a formal recommendation. A central

consideration moving forward is matching the mechanism to the function or problem it is intended to solve.

6. Looking Ahead to What's Next

Since the April Roundtable, CPWA and partners have continued to build on the convening through:

- disseminating a [Post-Roundtable Participant Memo](#) and bringing survivor and community perspectives into the statewide conversation;
- continuing cross-sector planning and relationship-building with state, healthcare, quality-improvement, and community partners; and
- exploring opportunities to strengthen implementation, accountability, regional-to-state connection, and durable statewide PMH coordination.

One lesson emerging from these conversations is that a coordination mechanism should be understood as a vehicle for achieving shared outcomes, rather than an outcome in itself. Different challenges may require different tools: implementation partnerships, quality-improvement initiatives, administrative or regulatory action, professional standards, legislative oversight, targeted legislation, budget action, statewide planning, or other approaches. The relevant question is whether a proposed mechanism addresses the underlying implementation problem and has appropriate ownership, authority, and resources.

Taken together, California's PMH landscape is substantially more developed than it was in 2019—but the connections among its individual components remain less developed. California has moved considerably beyond the question of whether PMH should be addressed. The state now has more policies, benefits, community-based resources, clinical guidance, quality-improvement infrastructure, and data than it did seven years ago.

The next challenge is making those investments function as a coherent system: strengthening the pathway from identification to care, clarifying responsibility across organizational boundaries, supporting the workforce and community infrastructure families rely on, aligning financing with integrated care, and creating meaningful accountability for whether families actually receive support.

California's progress creates an opportunity to move from building individual pieces toward connecting them—and to ensure that families experience a continuum of care that is as coordinated as the system increasingly aspires to be.

Appendix

California PMH Policy & Implementation Landscape: Shifts Since the Task Force

The following non-exhaustive landscape tracker builds on the April 2026 Roundtable pre-reading and has been updated through October 2026. It highlights selected policies, programs, research, quality-improvement initiatives, and other developments relevant to California's evolving PMH system in chronological order. Inclusion does not imply endorsement or a determination of effectiveness.

Initiative / Policy	Lead Agency / Org	What It Does	Implementation Status	Category
Comprehensive Perinatal Services Program (CPSP) (1987)	DHCS / CDPH	This long-standing Medi-Cal benefit provides psychosocial assessment, nutrition, and health education from conception through 60 days postpartum.	Active since 1987. It is now supplemented by BCP, which extends the care period to 12 months.	Medi-Cal Transformation
ACR 148 (2014) — Task Force on the Status of Maternal Mental Health Care	CA Legislature	Requested the California Maternal Mental Health Collaborative establish a cross-sector task force to examine barriers to screening, diagnosis and treatment and recommend improvements to maternal mental health care.	Adopted in 2014. Provided the legislative foundation for the Task Force's subsequent work, including its 2017 strategic recommendations and 2019 progress assessment.	Legislation
AB 3032 (2018) — Maternal Mental Health Conditions Education, Early Diagnosis, and Treatment Act	CA Legislature	Requires any general acute care hospital or special hospital that has a perinatal unit to develop and implement a program to provide education and information to appropriate health care professionals and patients about PMH conditions.	In effect since January 1, 2020. More than 140 (of 240+) birthing hospitals participated in the Hospital Quality Institute and Maternal Mental Health NOW's PMH Learning Community , which provided education, technical assistance, and peer support through December 2021. It's unclear how many hospitals implemented required programs – there is no compliance monitoring, no reporting requirement, and no enforcement mechanism.	Legislation
AB 2193 (2018) — Maternal Mental Health Screening Mandate	CA Legislature	Requires licensed prenatal and postpartum care practitioners to ensure patients are offered or appropriately screened for maternal mental health conditions, without specifying screening frequency. Also	In effect since July 2019. The Institute for Medicaid Innovation Implementation Study (2023) points to ongoing challenges – recommending improved access	Legislation

Initiative / Policy	Lead Agency / Org	What It Does	Implementation Status	Category
Institute for Medicaid Innovation Implementation Study (2023) Mandated Perinatal Mental Health Screening in California: A Mixed-Methods Exploration (2026)	Institute for Medicaid Innovation, funded by CHCF	requires health plans and insurers to develop maternal mental health programs designed to promote quality and cost-effective outcomes.	access to screening and MH services, expanded education and information sharing, enhanced data and measurement, and a stronger focus on equity and justice. A 2026 research study found that prenatal and postpartum screening rates increased between 2019 and 2023, but that 43% of patients still did not have documented screening at both timepoints.	
CA Task Force on Maternal Mental Health (2017)	Policy Center for MMH (2020 Mom) Funded by CHCF and CA Endowment	Landmark cross-sector effort documenting PMH prevalence, costs, disparities, and system recommendations across providers, hospitals, payers, agencies, and other stakeholders.	The Task Force issued its strategic recommendations in 2017 and a follow-up report assessing progress in 2019. Many elements of California's PMH landscape have evolved since then; this report provides an updated view of that progress and of implementation questions emerging in 2026.	Foundational
CA Pregnancy-Associated Review Committee (PARC) & CA Pregnancy-Associated Mortality Review (PAMR) The California Pregnancy-Associated Mortality Review Report: Pregnancy-Associated Suicide, 2002-2012 (2019)	CDPH Maternal, Child, and Adolescent Health Division	In-depth case review of California pregnancy-related deaths statewide. Drives QI toolkits. Mental health in-depth review currently underway; findings pending.	Active. Reviews are underway for two regions: Southern CA (2019–present), Central Valley (launched late 2024). The mental health review in progress — findings have not yet been published.	Data & Research
Cost of Maternal Mental Health Issues in California Issue Brief (2019)	Mathematica	Issue brief on the <i>Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in California</i> .	Key finding: \$2.4B annual cost of untreated maternal mental health issues in California.	Data & Research
CalAIM (California Advancing and Innovating Medi-Cal) Overview (2022) CalAIM Explained	DHCS CHCF	This multi-year Medi-Cal transformation introduced Enhanced Care Management (ECM), Community Supports, doula benefit, and 12-month postpartum coverage	Live since 2022. Extending postpartum coverage to 12 months in effect since April 2023. The doula benefit is live. ECM waiver renewal negotiations with CMS are underway through 2026.	Medi-Cal Transformation

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		extension. Includes a Birth Equity' ECM population of focus.		
DHCS Bold Goals / CalAIM Dashboard (2022-Present)	DHCS	Public dashboard tracking 5 equity-focused goals, including 50% improvement in maternal and adolescent depression screening rates by 2025.	DHCS incorporated maternal depression screening into its quality strategy and Bold Goals. In the 2025 Comprehensive Quality Strategy, reported prenatal depression screening increased from 10% in MY2022 to 17% in MY2023 and postpartum depression screening increased from 7% to 13%. DHCS continues to incorporate behavioral health and maternity measures within its broader quality strategy.	Data & Research
NCQA HEDIS Perinatal Depression Measures	NCQA / DHCS	Clinical quality measures for postpartum depression screening and follow-up care. Reporting is required for Medi-Cal managed care plans (MCP) and encouraged for commercial plans under AB-2193.	Required for Medi-Cal MCPs since 2023. Commercial plan adoption expected post-AB 2193. Enables first-ever consistent statewide data on screening rates across payers.	Data & Research
Community Health Worker (CHW) Benefit (Medi-Cal) (2022)	DHCS / MCPs	Covers CHW services under Medi-Cal as a preventive benefit to support prevention, navigation, and health promotion — relevant to PMH outreach and follow-up.	Live since July 2022.	Equity & Community
Doula Benefit (Medi-Cal) (2023)	DHCS / MCPs	Covers doula services under Medi-Cal as a preventive benefit. Doulas provide emotional, physical, and informational support across the pregnancy-postpartum continuum.	Live since January 2023. Payment increased from \$450 to \$1,154 per birth. Workforce and reimbursement challenges persist. Commercial coverage is not mandated; in 2026, UnitedHealthcare expanded access to doula coverage .	Equity & Community
Centering Black Mothers in California (2023)	CDPH / UCSF	Statewide analysis of structural racism's role in Black maternal health outcomes. The report documents three pathways – neighborhood conditions, chronic stress from racism, and lack of respectful care – and informs DHCS' equity strategy.	Published in 2023. The findings are integrated into DHCS Bold Goals and BCP equity framing, often serving as a foundational reference for equity-focused PMH work.	Equity & Community

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ACOG Extended Postpartum Guidance (2023)	ACOG	Updated clinical guidelines extending PMH screening beyond the traditional 6-week cutoff. Recommends screening at initial prenatal visit, later in pregnancy, and all postpartum visits (3 and 12 weeks postpartum). Referenced in AB 1936.	Guidelines published in 2023. Adoption by providers and plans varies widely; the guidelines are referenced in state legislation as the standard.	Quality Improvement
AB 1936 (2024) — Expanded Screening Frequency	CA Legislature	Strengthened California's maternal mental health screening requirements to include at least one screening during pregnancy and at least one additional screening during the first six weeks postpartum, with additional postpartum screening when medically necessary and clinically appropriate.	Signed in 2024 and in effect. Builds on AB 2193 by strengthening expectations for screening across pregnancy and postpartum.	Legislation
AB 2581 (2024) — Healing Arts: Continuing Education: Maternal Mental Health	CA Legislature	Requires Healing Arts Board (Physician Assistant Board, Board of Registered Nursing, Board of Behavioral Sciences, Board of Psychology, Dentist Board) to <i>consider</i> adding a requirement for MMH training.	Signed 2024. All boards declined to legislate; MMH training is optional. Note: AB 845 (2019) would have required MMH training for MDs, but it did not pass.	Legislation
SB 626 (2026) — Perinatal Health Screenings and Treatment	CA Legislature	Strengthens California's maternal mental health framework by aligning screening requirements with applicable clinical guidelines and requiring health plans and insurers to provide case management or care coordination through existing programs for enrollees or insureds who screen positive for a maternal mental health condition.	Signed by Governor Newsom September 30, 2026; Chapter 973, Statutes of 2026. Implementation begins in 2027. SB 626 builds on California's screening framework by strengthening the connection between identification and follow-up through health-plan care coordination.	Legislation
Proposition 1 / Behavioral Health Services Act (BHSA) (2024) Cal Budget Center's Prop 1 Explainer	DHCS / 58 counties	Replaced 2004 Mental Health Services Act. \$6.4B bond for facilities and housing. Restructures county behavioral health funding with new allocation formula; adds substance use as a covered need.	Passed March 2024. Counties in transition; BHSA Integrated Plans due June 30, 2026. Full implementation July 1, 2026. PMH is not a named priority — the focus is on the risk of being crowded out by homelessness and substance abuse.	Behavioral Health System
OSG California Maternal Health Blueprint (2024)	CA Office of the Surgeon General	OSG's framework for statewide maternal health action, informed by themes identified by the Perinatal Advisory Group. There are two primary goals: (1) help reproductive-age	Published September 2024. The blueprint informs cross-sector alignment but is not an implementation vehicle, given	Foundational

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		Californians assess pregnancy risk; (2) reduce maternal deaths by 50% by December 2026.	OSG's primary role in convening and communication rather than delivery.	
CHCF's Improving MMH Care (2024)	CHCF	An overview of CHCF's PMH funding, including in data, delivery system interventions, payment, policy, narrative change, and innovations.	CHCF has funded PMH projects since 2015, but will be sunsetting as CHCF transitions to focus on the maternity care system.	Foundational
DHCS Birthing Care Pathway (BCP) Report (2025) DHCS The Postpartum Pathway Concept Paper (2025)	DHCS	Comprehensive policy and care roadmap for all pregnant and postpartum Medi-Cal members from conception through 12 months postpartum. There are eight policy domains including behavioral health.	Report published February 2025. Implementation across the 8 domains is ongoing. In January 2025, DHCS was selected for the CMS Transforming Maternal Health (TMaH) 10-year model, which includes \$17M to improve Medicaid/CHIP maternal health outcomes. The project covers the Central Valley region (Fresno, Kern, Kings, Madera, Tulare) and entails whole-person care, midwifery access, and reducing disparities through value-based payments.	Medi-Cal Transformation
BH-CONNECT (1115 Behavioral Health Waiver) (2025-2029)	DHCS	This initiative is intended to strengthen Medi-Cal behavioral health services, particularly for at-risk individuals (those with serious mental health conditions, involved in the justice system, experiencing homelessness or SUD). It is a separate Medi-Cal waiver that includes outpatient, residential, and community-based care.	Approved to run from January 2025, through December 2029. The initiative operates alongside CalAIM and intersects with county BHSA planning.	Medi-Cal Transformation
Policy Center's State Legislation Report (2025) Policy Center's CA Policy Tracker (2025)	Policy Center for Maternal Mental Health	The Policy Center maintains a national scan of state MMH legislation. Tracks all California PMH legislation with status and analysis.	Ongoing tracking	Foundational
Policy Center: Maternal Suicide Issue Brief (2025)	Policy Center for Maternal Mental Health	Issue brief on <i>Maternal Suicide in the U.S.: How the Government is Improving Data Collection and Continued Opportunities for Health Care System Change</i> .	Key finding: Up to 20% of perinatal postpartum deaths are due to suicide — more common than hemorrhage or hypertensive deaths.	Data & Research

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Black Girls Mental Health Foundation Community Needs Assessment (2025)	Black Girls Mental Health Foundation	This community needs assessment on Black maternal health identified as structural barriers: limited access to Black providers, distrust in healthcare systems, and fragmented support systems. It advocates for culturally affirming care, noting community requests for therapy/counseling, peer support groups, and breastfeeding/lactation services, as well as an interest in technology solutions (e.g., stress-tracking wearables).	Published January 2025.	Equity & Community
CHCF Maternity Care in California Almanac (2026)	CHCF	Comprehensive CA maternity care data, including PMH rates, racial disparities, geographic access gaps, and payer breakdowns.	Updated and published March 31, 2026. CHCF is currently funding an effort to take stock of CA's MMH progress over the last 10 years and next steps. They have offered to share findings with roundtable participants when the findings are published later this year.	Data & Research
Supporting the Mental Health of California Mothers (2026)	CDPH Maternal, Child, and Adolescent Health Division	An analysis of 2020-2021 Maternal and Infant Health Assessment (MIHA) survey data, monitoring the prevalence of depression and anxiety symptoms, mental health screening and treatment rates.	Key finding: 1 in 3 people are impacted by perinatal depression or anxiety symptoms; anxiety is more common than depression; mental health screening is associated with treatment.	Data & Research
Artificial Intelligence & MMH Issue Brief (2026)	Policy Center for Maternal Mental Health	Overview of how AI is currently used in mental health, highlighting its potential, risks, and considerations.	Research is growing but still limited; the landscape is expected to shift rapidly given rising AI use.	Data & Research
CMQCC Toolkits & Maternal Data Center	CMQCC / Stanford / CDPH	Evidence-based QI toolkits for leading causes of maternal death. 200+ hospitals participate (~95% of CA births). Toolkits exist for hemorrhage, CVD, preeclampsia, sepsis — but not yet PMH. CA-PARC mental health review underway.	Active. Mental health in-depth review in progress. QI model proven for physical conditions but is a key PMH infrastructure gap. Maternal Mental Health Now and CHCF have a publicly available toolkit .	Quality Improvement
Supporting New Fathers: An Overview of Paternal Mental Health Statistics, Insights, and Resources (2024)	Maternal Mental Health Leadership Alliance	Research indicates 1 in 10 fathers experiences depression or anxiety during pregnancy or the first year following pregnancy.	California does not currently track data on fathers. Coroner reports do not indicate if a male died by suicide as an expecting or new father.	Paternal MH

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Pregnancy Risk Assessment Monitoring System (PRAMS) for Dads: A piloted randomized trial of public health surveillance of recent fathers' behaviors before and after infant birth (2022)	CDC, Lurie's Children's Hospital of Chicago	The PRAMS for Dads is a CDC- and Lurie Children's Hospital-led survey that evaluates new fathers' health and wellbeing during the perinatal period.	The CDC and the Georgia Department of Public Health piloted PRAMS for Dads in 2018-2019. Since then, 8 states/counties (and Japan) have implemented it: Georgia, Massachusetts, Michigan (Kent County & Detroit), North Dakota, Ohio, Maine, and Wisconsin.	