November 13, 2026

To: California Board of Behavioral Sciences

Re: November 20, 2026 Board Meeting, Riverside, California | Perinatal Mental Health Education and Consumer Protection

Dear Members of the Board of Behavioral Sciences:

On behalf of the undersigned organizations, clinicians, advocates, and community stakeholders, we write in anticipation of the Board's November 20, 2026 meeting in Riverside to reaffirm our October 31, 2025 call for foundational perinatal mental health education.

Our collective request remains unchanged: a minimum of six hours of foundational perinatal mental health education for current and future behavioral health licensees. For future licensees, this education should be integrated into qualifying graduate coursework or completed through approved supplemental coursework before licensure. For current licensees, we request a one-time, six-hour continuing education requirement. Our original request also encompasses comparable educational standards across California's behavioral health licensing boards, including the Board of Psychology.

California continues to face a significant gap in perinatal mental health care. Approximately one in three birthing Californians experiences symptoms of perinatal depression or anxiety, while an estimated one in ten fathers experiences a perinatal mental health condition. With approximately 400,000 births annually and more than 800,000 new parents each year, the impact on California families is substantial. These figures do not account for individuals experiencing infertility, pregnancy and infant loss, or other reproductive challenges.

Foundational provider education is a matter of consumer protection. Californians seeking mental health care should reasonably expect licensed behavioral health professionals to possess the foundational knowledge necessary to recognize perinatal mental health conditions, conduct appropriate assessments, identify psychiatric emergencies, and provide treatment or referrals within their scope of practice. Without minimum educational standards, consumers cannot be assured that their providers have received basic instruction in these conditions.

Since our 2025 letter and the Board's AB 2581 discussion, the Board has taken meaningful steps toward recognizing perinatal mental health as an area of clinical competency. We appreciate the Board's adoption of an informational bulletin in May 2026 and the Workforce Development Committee's ongoing consideration of graduate education requirements.

Every person begins life within the perinatal period, and the mental health of parents and caregivers influences early development, attachment, and family functioning. The effects of perinatal mental health conditions extend far beyond pregnancy and postpartum, emerging in the individual, relational, and family concerns clinicians address throughout the lifespan. **Perinatal mental health is not exclusively a specialty area. It is foundational knowledge relevant to clinical practice across populations and settings.**

Perinatal mental health conditions include perinatal depression, anxiety, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), bipolar disorder, and perinatal psychosis. Clinicians must be able to distinguish expected perinatal adjustment from clinically significant symptoms, apply appropriate differential diagnoses, and recognize perinatal-specific risks, including psychiatric relapse, sleep disruption, hormonal changes, medication discontinuation, traumatic birth experiences, and prior psychiatric history.

Foundational education must also address infertility, pregnancy and infant loss, paternal and partner perinatal mental health, culturally responsive care, and the psychological effects of reproductive transitions. California's Maternal and Infant Health Assessment (MIHA) data identify disparities in perinatal depression and anxiety, particularly among families experiencing financial hardship and Black birthing Californians. These disparities reflect broader structural inequities and barriers to culturally and linguistically responsive care, reinforcing the need for consistent education across the behavioral health workforce.

California's legislative and policy developments further underscore this need. AB 2193 and AB 1936 expanded perinatal mental health screening, while SB 626, signed September 30, 2026, strengthens expectations for clinical evaluation, treatment offers, and care coordination following positive screenings. The Department of Health Care Services' Birthing Care Pathway similarly

emphasizes integrated, trauma-informed care. These initiatives depend on clinicians prepared to recognize perinatal presentations and respond appropriately. **Screening alone cannot ensure appropriate care without a workforce prepared to recognize and respond to perinatal mental health conditions.**

California's maternal mortality review demonstrates that many pregnancy-associated suicide deaths occurred in the context of identifiable mental health concerns and potentially modifiable gaps in care. More than half of the reviewed deaths were judged to have a good-to-strong chance of prevention, emphasizing the importance of competent clinical identification, risk assessment, treatment, and longitudinal follow-up.

The Board's consideration of perinatal mental health education also aligns with AB 2581, which directed California's behavioral health licensing boards to consider maternal mental health education. An informational bulletin is an important resource for current licensees, but it does not ensure that future clinicians enter practice with foundational knowledge of perinatal mental health or that existing licensees have received this education.

We respectfully request that the Board advance a minimum six-hour educational requirement for current and future LMFTs, LCSWs, and LPCCs, consistent with our original request for comparable standards across behavioral health professions, including psychologists. Foundational education should address recognition and assessment of perinatal mental health conditions, differential diagnosis, psychiatric emergencies, pregnancy and infant loss, paternal and partner mental health, culturally responsive care, evidence-based treatment considerations, and appropriate referral and coordination of care.

For future licensees, these competencies could be part of existing foundational graduate coursework or completed through an approved supplemental course before licensure. For current licensees, a one-time, six-hour continuing education requirement would establish the same educational baseline without imposing an ongoing or recurring CE obligation.

This request does not seek to make every licensee a perinatal mental health specialist. It seeks to establish a consistent educational baseline so clinicians can recognize perinatal mental health concerns, respond within their scope of practice, and identify when additional assessment, consultation, or referral is necessary.

California has made important progress in expanding perinatal mental health screening and awareness. Yet, preventable perinatal harm is not solely a failure of screening. It can also reflect failures of clinical recognition, treatment readiness, care coordination, and continuity. Establishing foundational education requirements is a necessary next step to strengthen consumer protection, support timely access to qualified care, and prepare the behavioral health workforce to meet the needs of California families.

We respectfully ask the full Board to advance these educational requirements through its established regulatory process. The undersigned stakeholders remain available to assist in identifying core competencies and practical approaches to implementation.

Sincerely,

Signatories

About Families
Alicia Mittleman, LCSW, PMH-C
Alex Steric, LCSW
American Foundation for Suicide Prevention – California Chapters
Angelica Quezada, LCSW, PMH-C
Be Mom Aware
Black Girls Mental Health Collective
Brain Insights Psychological Solutions, Hilary Gibson, PsyD
California Behavioral Health Association
California Chapter of Postpartum Support International
California Perinatal Wellness Alliance
Casa de Esperanza
Catherine Groves, Esq.
Christina Klein Therapy, Christina Klein, LMFT
Christina McCabe DBA Equity in Birth, Christina McCabe
Christine Bennetts, LCSW
Crisis Support Services of Alameda County
Cultivate Together Psychology, Megan Spence, PsyD
Daniella K Bermudez, LMFT, LPCC, PMH-C
Deepa Ranganathan, LCSW
Diana Barnes, LMFT, PsyD, PMH-C
Disability Community Resource Center
Diversity Uplifts, Inc.
Elyse Springer, LMFT, PMH-C
Eve Mental Health, Markie Damiana, LPCC
Eynav Accortt, PhD
Family Wellness LA
Gracelamp Wellness, Francia Telesford, MSW, ACSW
Headlands Psychotherapy Group, Morgan Howson, LMFT
Heartship Psychological Services, Lauren Cook, PsyD
Heartship Therapy, Alyson Fortner Widell, LCSW
Her Space Therapy LA, Cyla Fisk, LMFT
Ingrid Cognato, LMFT
Julie Kraft, LMFT
Karyn Sprinkle, PMHNP-BC, PMH-C
Kevin Gruenberg, PsyD
Libby Orrick Therapy, Libby Orrick
Love, Dad
Lupine Counseling, Bridget Balajadia
March of Dimes
Marin Perinatal Therapy, Ali Vogt

Marin Perinatal Therapy, Margot Kirschner, PsyD
Marina Counseling Center, Natalie Doyle, MA
Maternal Mental Health Leadership Alliance
Maternal Mental Health NOW
Megan Pitsios, LMFT
Michelle Baumgartner, LCSW, Psychotherapy, Michelle Baumgartner
Millennial Mama Therapy, Lauren Puliz
National Association of Perinatal Social Workers
Northeast Valley Health Corp, Lindsey Whang, FNP
Noticing Growth Therapy Group Inc, Meghann Crane, LCSW
OC Transformations Counseling and Psychological Wellness, Shiva Sarabi, PsyD
Open Doors Therapy / Neurodiversity Training Center, Tasha Oswald, PhD
Open Paths Counseling Center
Penelope Oberhardt, LCSW
Postpartum Health Alliance
Radical Depths Psychotherapy, Zoe Barnow, PsyD
Rebecca Geshuri, LMFT
Return to Zero: Hope
Robert Hickman, LMFT
Second Street Collective, Jaclyn Gojenola, LMFT
Sonja Castañeda-Cudney, MA
SOURCE Psychotherapy: A Marriage and Family Therapy Corporation, Shana Averbach, LMFT
Sutter County Children & Families Commission
Tessa Aoyama, LMFT
TGN Therapy, Tracy Gilmour, LMFT
The Caring Group Counseling Center, Victoria Rutsch
The Center for Men's Excellence, Dan Singley, PsyD
The MaMA Space, Suzanne Mungalez
The Unencumbered Path Therapy Practice, Natalie Baker
Vanita Kunert, MFT
Well Parent Therapy, Ana Velouise, LMFT
Whole Person Psychology, Denise Renye, PsyD
Worth Psychotherapy, Danielle Comerford-Worth, LMFT

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Policy Center for Maternal Mental Health. (2025, May 2). *Fact sheet: Maternal mental health*. https://policycentermmh.org/maternal-mental-health-fact-sheet/

From: Sierra Baker
To: Kitamura, Christina@DCA
Subject: Public Comment for Nov. 20, 2026 Board Meeting – Agenda Item 24 (Perinatal Mental Health Coursework)
Date: Monday, November 16, 2026 2:16:12 PM

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Dear Chair Strack, Members of the Board, and Ms. Kitamura,

Because I am caring for my toddler during Friday's session and am unable to unmute live, please distribute the following public comment and supporting data to all Board Members prior to discussion of **Agenda Item 24** (*Requiring Coursework in Perinatal Mental Health and Alzheimer's, Dementia, and Caregiving*) on Friday, November 20, 2026.

Public Comment Statement:
Good morning, Chair Strack and Members of the Board. My name is Sierra Baker, and I am a Marriage and Family Therapist Trainee, graduate student, and mother in Redding, California.

Every single day in California, over **700,000 women** are pregnant or in their first year postpartum. According to the California Department of Public Health, **more than 1 in 3**—over **140,000 mothers** every year—experience perinatal depression or anxiety, yet **half** never receive care. In rural Northern California communities like mine, that gap in specialized perinatal support is felt even more acutely.

Because MFTs form the backbone of California's behavioral health workforce, requiring foundational perinatal mental health training for every trainee, associate, and licensed therapist is not a niche specialty—it is essential public health infrastructure. Leaving these mothers untreated doesn't just devastate families and impair early childhood development; it costs California **$2.4 billion** every single year in preventable healthcare crises, lost productivity, and generational trauma our state cannot afford.

I strongly urge the Board to adopt foundational perinatal mental health coursework requirements.

Supporting Data & Citations:

- **700,000+ Pregnant & Postpartum Californians Daily:** California records ~402,075 live births annually (1 in 10 U.S. births), meaning ~703,600 Californians are pregnant or within 12 months postpartum on any given day. (*Source: CDC National Center for Health Statistics / March of Dimes PeriStats, 2024 California Birth Data*)
- **Over 1 in 3 CA Mothers Experience PMAD Symptoms (~140,700/year):** 35% of California birthing people report symptoms of perinatal depression or anxiety. (*Source: California Department of Public Health & UCSF Maternal and Infant Health Assessment [MIHA] / California Health Care Foundation Maternity Care Almanac*)
- **50% of Mothers Needing Care Go Untreated (~70,000/year):** Half of California

mothers who report needing mental health support do not receive care from a provider. (*Source: CDPH & UCSF Maternal and Infant Health Assessment [MIHA]*)

- **$2.4 Billion Annual Cost to California:** Untreated PMADs cost California $2.4 billion per annual birth cohort (conception through age 5) in healthcare expenses and lost productivity. (*Source: California Health Care Foundation & Mathematica Policy Research, "The Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in California"*)

Thank you for your time and leadership on behalf of California families.

Sincerely,

Sierra Baker
MFT Trainee & Graduate Student
Capella University
Attune Center for Healing
Supervised by Christina Whitney, LMFT #111050
Redding, CA

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2922 Crenshaw Blvd, Suite 125, Los Angeles, CA 90016

November 17, 2026

Board of Behavioral Sciences
1625 N. Market Blvd. Ste. S-200
Sacramento, CA 95834

RE: Item 24, Discussion and Possible Action on Requiring Coursework in Perinatal Mental Health and Alzheimer's Dementia, and Caregiving

Dear Members of the Board of Behavioral Sciences,

We respectfully ask the Board of Behavioral Sciences (BBS) to consider dedicated graduate-level education requirements on Alzheimer's disease, related dementias, and caregiving for marriage and family therapists. Current requirements are limited and do not ensure that California's next generation of mental health providers can meet the needs of a growing older adult population, particularly individuals and families affected by Alzheimer's and related dementias.

Alzheimer's Los Angeles is a local non-profit serving families affected by Alzheimer's and related dementias in the greater Los Angeles region. Our social workers provide care navigation, guiding families through a complex healthcare system and supporting them in their caregiving journey. Alzheimer's is a progressive neurodegenerative disease that affects a person's ability to think, act, and communicate. Families caring for someone with the disease face many challenges, including stigma, limited education and support, and isolation.

California's population is aging rapidly, and the number of Californians living with dementia is growing sharply. By 2030, nearly 10 million Californians, about a quarter of the state's population, will be older adults (California Department of Aging, 2024). Because age is the greatest risk factor, the number of people with Alzheimer's and related dementias will grow as well. Nationally, one in nine adults age 65 and older has Alzheimer's disease, and an estimated 7.4 million Americans are living with the disease (Alzheimer's Association, 2026). In California, almost 720,000 people age 65 and older have Alzheimer's disease, and by 2040 more than 1.9 million Californians are expected to be living with Alzheimer's and related dementias (Ross et al., 2021).

The number of family caregivers is rising along with the number of people with the disease. Family caregivers are the backbone of long-term care. More than 1.4 million Californians care for someone living with dementia, including spouses, adult children, grandchildren, and even parents (Alzheimer's Association, 2026). They provide emotional, physical, and mental support: helping with daily activities, administering medications, providing transportation, and coordinating healthcare, often at the expense of their own health, financial security, and mental well-being.

In fact, 59 percent of dementia caregivers rated their emotional stress as high or very high, compared to 28 percent of non-dementia caregivers (Kasper et al., 2014). Dementia caregivers are majority women, married, living with a partner, or in a long-term relationship, and the average age is 49 years old (Ross et al., 2021). A quarter of dementia caregivers are the "sandwich generation," simultaneously caring for a parent and children (Ross et al., 2021).

Marriage and Family Therapists (MFTs) can play an important role in supporting people living with dementia and their caregivers throughout the disease. A therapist with experience in caregiving, aging, and dementia can offer emotional support and regulation, communication and behavioral therapy, guidance on changes in family systems and structure, and stronger support networks. As the disease progresses and physical, communication, and behavioral changes increase, MFTs can help families adapt and receive family-centered care.

Dementia's progressive nature creates unique challenges, and MFTs can be equipped to help families understand and cope with them. Because progression can be slow, families may experience grief and ambiguous loss throughout the disease. The person is physically present but may change psychologically or in their relationships, causing grief, shifts in roles and personality, isolation, and "mini griefs" each time an ability is lost. Roles often reverse: someone who was once the caretaker or breadwinner must now rely on family. Men may become caregivers for their wives, and adult children or grandchildren may care for a parent or grandparent, creating emotional and psychological stress. Intimacy can also change. Many couples report less emotional connection, more conflict, and sexual dysfunction. Relationships may become more complex, such as when the person with dementia develops romantic interests in others, loses interest in sex, or becomes hypersexual, creating new challenges for families.

Many social workers we work with in the older adult community say their education did not adequately prepare them to serve older adults. They learned on the job or through their

own caregiving experience how complex the dementia journey is for individuals and families. As the BBS reviews graduate-level course requirements for MFTs, it has an opportunity to better equip the next generation of providers to support families affected by Alzheimer's and related dementias. Requiring dedicated education on these topics would also align with the California Master Plan for Aging, the state's commitment to older adults, people with disabilities, and caregivers.

We encourage the BBS to add education requirements specific to Alzheimer's and related dementias to all graduate-level course requirements. Please contact Barbra McLendon at bmclendon@alzla.org with any questions.

Sincerely,



Joey Milne
President & CEO
Alzheimer's Los Angeles

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Additional Resources

Dementia and Social Work

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Family Centered Care

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