NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Michelle Morse, MD, MPH
Acting Health Commissioner

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Chief Medical Officer
NYC Department of Health and Mental Hygiene

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Dear Colleague,

Perinatal mood and anxiety disorders (PMADs) are among the most common complications of childbirth and are often undiagnosed and untreated.[1] This can lead to long-term consequences for mothers and infants such as impaired mother-child attachment, developmental delays in infants, and increased risk of maternal suicide and/or overdose. As a health care provider, you are in a unique and important position to detect and address PMADs early and to prevent adverse maternal and child outcomes.

Nationally, 1 in 5 pregnant individuals are not screened for depression during prenatal visits, and 1 in 8 are not screened during postpartum visits, missing critical opportunities to identify risks for pregnancy-associated morbidity and/or mortality.[2] A recent report from the New York City (NYC) Maternal Mortality Review Committee (MMRC) found that overdose continues to be a leading cause of pregnancy-associated deaths.[3] Mental health conditions (eg, anxiety, depression, bipolar disorder, personality disorder, posttraumatic stress disorder, schizophrenia, self-inflicted injuries, sleep disorders) are strongly associated with postpartum opioid overdose death.[4] Between 2016 and 2020, there were 241 such deaths in NYC; 62.7% of these deaths were preventable and 43.6% occurred among Black non-Hispanic women and birthing people, who were 4 times more likely to experience pregnancy-associated deaths than white non-Hispanic individuals.[3] These inequities are driven by factors such as[5,6]:

- inadequate screening rates,
- use of screening tools developed with primarily white research participants,
- systemic and interpersonal racism,
- distrust of the health care system because of negative experiences,
- shame and stigma,
- fear of child protective services involvement, and
- logistical barriers, such as transportation and childcare.

PMADs, which encompasses a variety of conditions including depression, anxiety, and in rare cases, psychosis, can appear during pregnancy or up to 1 year after birth and affect at least 1 in 5 pregnant and postpartum individuals,[7] with an even higher prevalence among birthing people of color.[6,8] In contrast, severe and persistent mental illness or severe mental illness may come to a provider's attention due to worsening of symptoms during pregnancy or postpartum, but are distinct as having been diagnosed prior to pregnancy or lasting longer than 2 years.[9]

By incorporating routine mental health screenings for families with new babies, you can provide critical and sometimes life-saving support to new and expectant mothers.[10-14]

- **Educate yourself** on PMADs and ways that you can take action as a clinician.
  - Trainings are offered by Postpartum Support International, Substance Abuse and Mental Health Services Administration (SAMHSA), and New York State (NYS) Project TEACH.
- **Verbally assess** pregnant and postpartum individuals for mental health conditions, substance use, intimate partner violence, and social determinants of health.
  - **Use validated screening tools** such as the **Edinburgh Postnatal Depression Scale (EPDS)** or the **Patient Health Questionnaire-9 (PHQ-9)**.
  - Consider incorporating tools such as the **Jackson, Hogue, Phillips, Contextualized Stress Measure (JHP)** or the **Perceived Stress Scale (PSS)**, to assess racial/gendered and global stress, especially for Black women and birthing people.
- **Incorporate screening reminders** into your electronic health record.
  - Guidelines from the American College of Obstetricians and Gynecologists (ACOG), and American Academy of Pediatrics (AAP) provide recommendations for screening, referrals, and follow-up care.
- **Reassess frequently**. The ACOG recommends screening for perinatal depression and anxiety at the initial prenatal visit, later in pregnancy, and at all postpartum visits. The AAP advises screening for perinatal depression at the 1-, 2-, 4-, and 6-month well-child visits.
- **Include partners and caregivers** in discussions, as family support is crucial for both identifying and managing PMADs. Normalize asking for and accepting support.
- **Offer resources and referrals** to treatment services (see below). If immediate access is limited, recommend community-based resources and provide warm hand-offs to care.
- **Educate patients** about risk factors and warning signs through conversations and handouts.

The NYC Department of Health and Mental Hygiene (NYC Health Department) and NYC Administration for Children's Services (ACS) are committed to improving maternal mental health, particularly in communities disproportionately affected by PMADs. A coordinated approach is needed to ensure understanding of the appropriate and inappropriate use of referrals to child welfare. In 2023, 76% of reports from NYC health care providers to the State Central Register (SCR) did not result in a finding of abuse or maltreatment (ACS, unpublished data).

- **PMADs are a treatable clinical condition**. Prioritize offering mental health screening and support to connect families with appropriate clinical and community-based services.

- **Suspicion or diagnosis of PMADs alone is not a reason to report a family to the SCR**. Inappropriate referrals to child welfare can exacerbate the stigma surrounding mental health and may deter individuals from seeking the medical care they need.
- **Only in cases where there is reasonable cause to suspect child abuse or maltreatment should a call to the SCR be considered**. ACS is also advancing their maternal mental health efforts by raising awareness of PMADs and promoting best practices among child welfare professionals that offer support throughout the perinatal period.[15]

Resources to support you and the families you serve are below. Thank you for your dedication to the health of NYC families.

Sincerely,

Michelle Morse, MD, MPH
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Resources for Providers

- Project TEACH: 855-227-7272
    - Perinatal/reproductive psychiatry consultation for medical professionals
- Postpartum Resource Center of New York: 855-631-0001 (English and Spanish)
    - Open 7 days per week, 9 am-5 pm
- NYC Early Childhood Mental Health Training and Technical Assistance Center (search 'perinatal')
- Postpartum Support International
- NYS Department of Health: Postpartum Maternal Depression Screening Updated Billing Guidance
- NYS Office of Children and Family Services: Mandated Reporter Training

Resources for Patients

- NYS PMAD Helpline: 855-631-0001
- 988 Suicide and Crisis Lifeline: Phone/Text/Chat
- Mayor's Office of Community Mental Health: Mood and Anxiety Disorders Related to Childbirth
- NYS Council on Children and Families: Parent Guide

- NYC ACS: Parent Support Line connect@acs.nyc.gov or 212-676-7667
- National Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262)
- NYC ACS: Maternal Mental Health Resources
- Postpartum Support International
- NYC Coordinated Intake and Referral: 347-396-7979, Monday to Friday, 9 am to 5 pm
  - Families can refer themselves or health care providers can refer expectant and new parents to home visiting programs and community services

Perinatal Mental Health Services and Service Locators

- 988 Suicide and Crisis Lifeline Service Finder
- Postpartum Resource Center of New York: Perinatal Mood and Anxiety Disorder Statewide Resource Directory
- NYC Health + Hospitals: Mental Health Services
- NYC Early Childhood Mental Health Network
- The Child Center of NY: Macari Perinatal Intensive Outpatient Program
- The Motherhood Center of New York: The Day Program

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