



Project TEACH

FAMILIES THRIVE WITH GOOD MENTAL HEALTH

**Project TEACH is New York State's
Child/Adolescent & Perinatal Psychiatry Access Program.**

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**Office of
Mental Health**





Recognizing and Assessing Mental Health Concerns in Pregnant and Postpartum Patients: How to Screen and Provide Next Steps in Care

Disclosures

I have no a relevant financial relationship with a commercial interest to disclose.

Learning Objectives

- Apply evidence-based screening protocols for perinatal mental health disorders and substance use disorders using validated tools
- Identify risk and protective factors for perinatal suicide, including individual factors, pregnancy-related factors, and socioeconomic factors, and recognize that suicide is a leading preventable cause of maternal mortality with elevated risk throughout the entire postpartum period.
- Conduct comprehensive suicide risk assessment and safety planning using structured tools and implement appropriate management strategies.

Poll 1

How often do you and your practice conduct perinatal mental health screening?

- **Never**
- **At the initial pregnancy or postpartum visits only**
- **Several times during the perinatal period**
- **At every visit.**

Please delete this slide after creating the poll. I will ask the question while presenting the previous slide. I will want results of this poll to be presented when I'm on slide 29

The Case for Perinatal Mental Health Screening

- **Pregnant people report it is important for their prenatal care clinicians to understand their mental health needs.** (Itani, 2025)
- **Screening**
 - **Is cost effective** (Waqas et al., 2022)
 - **Increases treatment engagement** (Waqas et al., 2022)
 - **Is associated with improved maternal mental health and parenting** (Reilly et al., 2020)
- **Despite recommendations that perinatal individuals be screened multiple times during pregnancy, 1 in 5 individuals report not being asked at all** (Bauman et al., 2020)

Prevalence Perinatal Mental Health Disorders

- **Depression 10-23%** (Bauman et al. 2020)
- **Any anxiety disorder 20%**(Fawcet et al., 2019)
 - **Generalized Anxiety 2.4%** (Fawcet et al., 2019)
 - **Obsessive Compulsive Disorder 2.2%** (Fawcet et al., 2019)
- **Bipolar 2.6%** (Masters et al., 2022)
- **Psychosis 1-2 in every 1000 perinatal individuals** (Sit et al., 2006)

Risk Factors for Developing Mental Health Concerns

Biological	Psychological	Social
Obstetric complications	Family history of mental health condition	Social-role conflict
High-risk pregnancy	Personal history of mental health condition	Intimate partner violence
Hormonal sensitivity	Substance use disorders	Lack of support
Discontinuation of psychiatric medications		Racism/discrimination

Furtado M et al 2018; Hutchens & Kearney 2020; Sommer et al., 2021; Yang et al., 2022

Untreated Perinatal Mental Health Disorders are Associated with Adverse Maternal Outcomes

- Decreased maternal functioning (Field, T, 2010)
- Psychosis, suicidal ideation, homicidal ideation and suicide attempt are psychiatric emergencies that lead to psychiatric hospitalization, maternal death (Rodriguez-Cabezas et al, 2019)
- Bidirectional relationship between depression and gestational diabetes mellitus (Fischer et al, 2023)

Untreated Perinatal Mental Health Disorders are Associated with Adverse Obstetrical Outcomes

- Preterm labor (Bansil P et al, 2010)
- Preterm birth (Grigoriadis S et al, 2013),
- Stillbirth/neonatal death
- Hypertensive disorders of pregnancy (Staub et al, 2012, Thombre et al, 2015, Delanerolle et al, 2022)
- Increased requirement for surgical delivery interventions (Wang SY & Chen CH, 2010) and cesarean delivery (Bansil P et al, 2010)

Untreated Perinatal Mental Health Disorders are Associated with Adverse Infant and Child Development

- Inadequate maternal-infant bonding prenatally and post-delivery (Rossen et al, 2016; Betcher et al, 2020, Dagher et al, 2021)
- Lactation failure or unplanned weaning (Dennis CL & McQueen K, 2009; Stuebe AM et al, 2014)
- Impaired child cognitive, (Tuovinen S et al, 2018), behavioral, and emotional development (Leis JA et al, 2014; Pearson RM et al, 2013)
- Impaired child brain development/antenatal stress from mental illness is associated with accelerated development of offspring neural networks via fetal (developmental) programming (Schinost D et al, 2016; Rotem-Kohavi, N et al, 2020)

Unipolar Perinatal Depression

Major Depressive Disorder (MDD) with Peripartum Onset

includes 5 of the following symptoms, one of which must be either depressed mood or decreased interest or pleasure, beginning in pregnancy or within 4 weeks of delivery

- Depressed mood, often overshadowed by severe anxiety, crying episodes, feel trapped/overwhelmed
- Markedly diminished interest or pleasure in activities- lack of interest in baby/not feeling close to baby
- Appetite disturbance- food has no taste, forces self to eat, poor gestational weight
- Sleep disturbance- cannot fall or stay asleep - even when the baby is sleeping
- Physical agitation (on-edge) or feeling slowed down
- Fatigue or loss of energy, exhausted
- Feelings of worthlessness or excessive or inappropriate guilt – feeling like a bad mother
- Decreased concentration or ability to make decisions
- Recurrent thoughts of death or suicidal ideation –my family/baby would be better off without me
 - †Symptoms must be present most of the day nearly every day for two weeks.

Distinguishing Baby Blues from PPD

	Baby Blues	Postpartum Depression
Prevalence	40-75% of mothers	14% of mothers
Onset	First few days after delivery, typically peaking on fourth or fifth day	Typically emerges in pregnancy and approx. 2 months postpartum
Duration	A few hours or a few days, remitting spontaneously within 2 weeks of delivery	Longer than 2 weeks; can last up to 3 years
Severity	Mild symptoms (mood lability, tearfulness, anxiety, irritability)	Clinical diagnosis of major depressive episode
Impaired functioning	No	Yes
Symptom resolution	Resolves spontaneously	Requires treatment
Association with psychopathology	Unrelated to psychiatric history and not predictive of future problems	More common in women with history of major depression and bipolar disorder and predictive of future depressive episodes

Bipolar Disorder

- **Bipolar 1 Disorder:** characterized by at least one lifetime manic episode
- **Bipolar 2 Disorder:** characterized by at least one lifetime hypomanic episode **AND** a depressive episode

Manic episode (sx for 7 consecutive days) and Hypomanic episode (sx for 4 consecutive days) is characterized by abnormally and persistently elevated or irritable mood and increased activity/energy plus 3 or more if mood is elevated, 4 or more if irritable mood with a change in functioning

- **inflated self-esteem, grandiosity**
- **decreased need for sleep (e.g. feels rested after only 3 hours)**
- **more talkative, pressure to keep talking**
- **flight of ideas, racing thoughts (but not anxious in nature)**
- **Distractibility**
- **increase in goal-directed activity or psychomotor agitation**
- **excessive involvement in activities with high potential for painful consequences**

Clinical Pearls: Perinatal Bipolar Disorder

- **22.6% of individuals with postpartum EPDS ≥ 10 had bipolar disorder** (Wisner KL et al 2013)
- **54% of individuals with a history of a mood disorder have recurrence in perinatal period** (Masters et al., 2022)
- **20% of individuals with Bipolar I experience mania or psychotic depression in perinatal period** (Floria et al., 2013)
- **People who discontinue medication when they become pregnant are more likely to experience recurrences (85.5% vs. 37%) and spend more time ill** (Viguera AC et al, 2007)
 - Abrupt discontinuation of medication is significant risk factor (Alcantarilla et al., 2023)
- **Medication to treat Major Depressive Disorder often differs from medication to treat a depressive episode of Bipolar Disorder**
- **Most recurrences are depressive or mixed (74%) and 47% occurred in first trimester** (Viguera AC et al, 2007)

Common Features of Bipolar Depression

These characteristics increase the likelihood that an individual has bipolar disorder even if they are presenting as depressed currently:

- Depression with mixed symptoms (distractibility, racing thoughts, irritation, and agitation) more common than pure hypomania/mania
- More frequent (>3) episodes of depression
- Non-response to 3 or more anti-depressants
- Younger age of first depressive episode
- Family history of bipolar disorder

Cuellar AK et al, 2005

Generalized Anxiety Disorder

- Excessive worry over many things, for at least 6 months – often focused on fears of fetal/child wellbeing, maternal wellness, partner illness, and parental mortality (Misri et al., 2015)
- Worry is difficult to control
- At least 3 of the following symptoms:
 - Restlessness
 - Fatigue
 - Difficulty concentrating
 - Irritability
 - Muscle tension
 - Sleep difficulties

Obsessive Compulsive Disorder

- **Obsessions - Recurrent and persistent thoughts, urges or images experienced as intrusive/unwanted, cause marked anxiety or distress; individual attempts to ignore or suppress with some thought or action**
- **Compulsions - Repetitive behaviors or mental acts performed in response to an obsession, or according to the rules that must be applied rigidly; these are aimed at preventing or reducing distress or preventing some dreaded event, but are not connected in a realistic way or are clearly excessive.**

Perinatal OCD Presentation

Obsessions/Intrusive Thoughts	Compulsions/Avoidance Behavior
“What if I accidentally cut my child with a knife?”	Throws out knives from the home/avoids cutting things
“What if I don’t see the car, and my baby and I get hit?”	Avoids going outside
“I keep getting images of me drowning my baby”	Avoids washing baby
“I keep imagining that I will touch my baby inappropriately”	Avoids spending time with baby; Avoids changing diaper
“What if I drop my baby?”	Avoids breastfeeding baby
What if my baby stops breathing suddenly?	Stays up at night, frequent checking of baby

Acting on harm thoughts is rare, however can see indirect harm through avoidance/compulsive behaviors

Psychosis During the Perinatal Period

- **Symptoms can include Must include delusions, hallucinations, or disorganized speech, grossly disorganized or catatonic behavior**
- **No specific diagnosis for perinatal psychosis according to DSM-5**
 - **Psychosis can be added as a specifier to a mood or depressive disorder along with *peripartum onset* specifier**

Characteristics of Perinatal Psychosis

- Strongest risk factor for postpartum psychosis is a personal history of bipolar disorder
- Sudden onset within 2 weeks of delivery with >50% of onsets within 3 days of delivery
- Often initially presents as irritability, mood lability, anxiety and insomnia that progresses to mania, depression, mixed episode with delusions and rapid deterioration
 - Delusions can be pregnancy and child related – may include thoughts around harming self or the baby i.e “altruistic” delusions of harm
 - Delusions are ego syntonic and involve limited insight
- Psychiatric Emergency: Associated with increased risk of suicide and potential risk to infant
- large differential diagnosis and work-up required

Tinkleman et al., 2017

Differentiating OCD “Harm Thoughts” from Psychotic Intrusive “Harm Thoughts”

Postpartum OC intrusive thoughts	Psychotic intrusive thoughts
Thoughts are ego-dystonic (inconsistent with their behavior, personality)	Thoughts are ego-syntonic (consistent with confusion, mood lability, bizarre delusions or hallucinations) i.e <i>I must drown my baby to save them eternal damnation</i>
Thoughts associated with guilt, shame, anxiety	Thoughts may not be distressful
Engages in excessive avoidance and rituals in attempt to control thoughts to ensure they do not act on thoughts	Symptoms are not associated with fears or rituals; rather may see disorganized behavior
Very common, not a psychiatric emergency	Much less common, but is <i>psychiatric emergency</i>
Low risk of harm to infant	Patient at risk for unpredictable aggressive behavior



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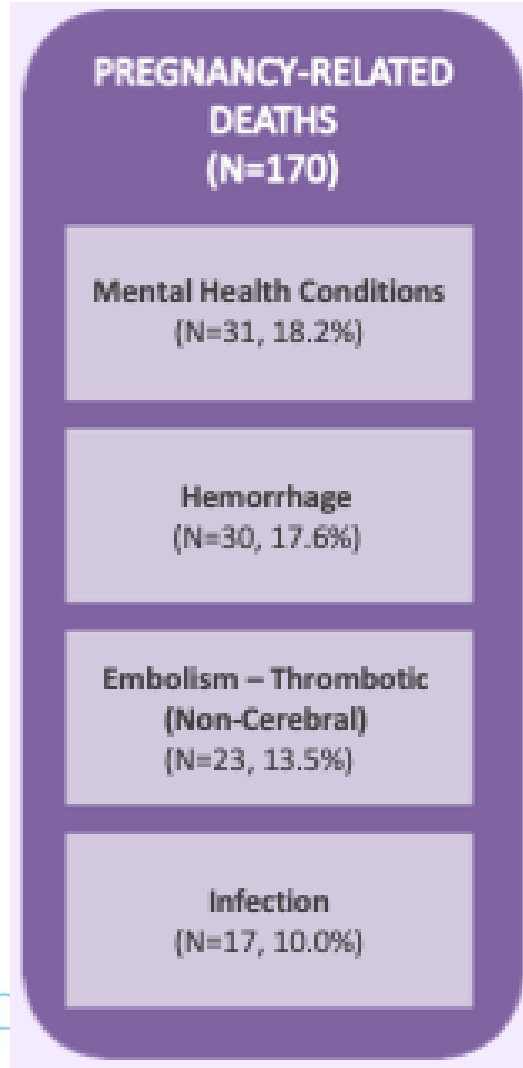
Suicidality During the Perinatal Period

- **Pregnant individuals are more likely than the general population to endorse suicidal ideation** (Gelaye et al., 2017)
- **A 2004 review of 17 studies in high- and low-income countries found the prevalence of suicidal ideation among pregnant and postpartum people to range between 5 and 18% with low-income countries presenting higher prevalence rates** (Lindahl et al., 2005).
- **Rates of suicidal thinking, planning, and attempts increase in the postpartum period compared to the prenatal period**(Karacam et al., 2024)

Perinatal Substance Use

- 22.3% of pregnant people reported using at least one substance in the previous month (Kim, 2022)
 - **Alcohol, tobacco, and cannabis most common** (Bakhireva et al, 2026; Datye et al., 2026)
 - Perinatal individuals often cut down or discontinue during pregnancy (decreases by trimester), use increases postpartum (Kim, 2022)
 - Risk of overdose in postpartum – heightened at 7-12 months (late postpartum period)
- **In New York State in 2024, 9.1 in 1,000 hospital delivered infants experienced neonatal withdrawal syndrome** (NYSDOH 2026)
- **Untreated maternal SUDs are linked to high-risk pregnancies, poor infant health outcomes, suicidality and maternal mortality (Yen et al., 2025)**

Mental Health Conditions Are the Leading Cause of Death



Manner of Death	Mental Health (MH) Conditions as Cause of Death		
	MH Deaths Related to Substance Use Disorder	MH Deaths Other than Substance Use Disorder	Total
Suicide	2	11	13
Non-Suicide	16	2	18
Total	18	13	31

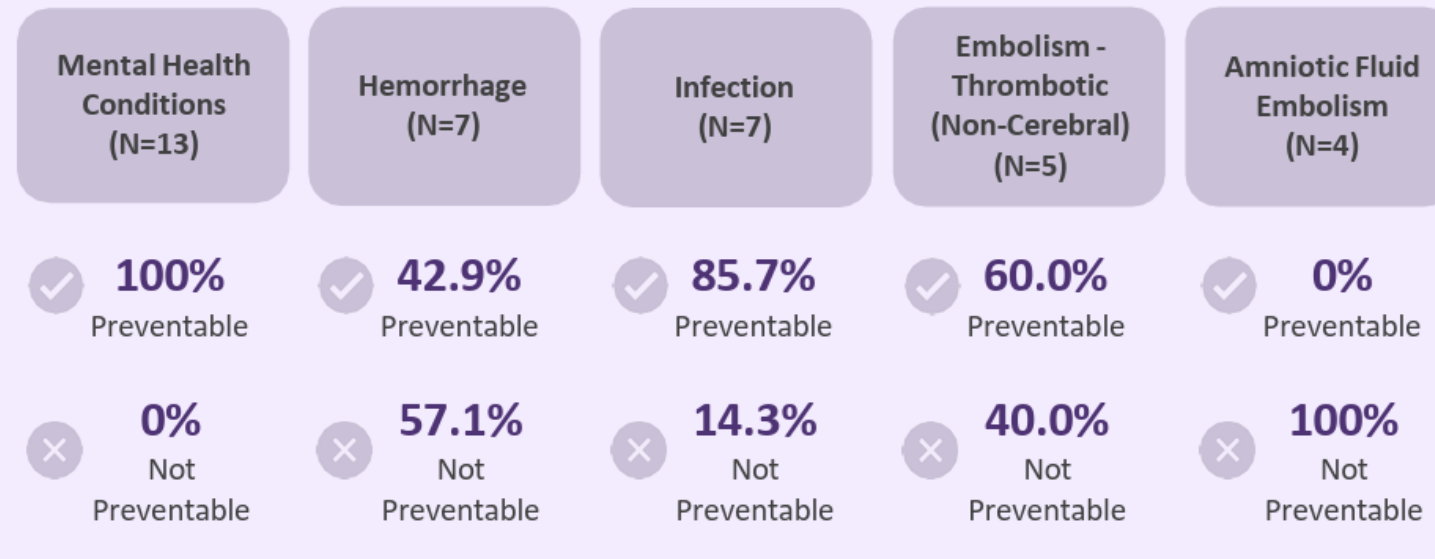
New York State Report on Pregnancy-Associated Deaths in 2021. Albany, NY: New York State Department of Health. 2025.

Mental Health-related Deaths Are Preventable

TABLE 5. PREVENTABILITY OF PREGNANCY-RELATED DEATHS AND CHANCE TO ALTER THE OUTCOME, 2021

Preventability	Good Chance	Some Chance	No Chance	Overall
Preventable	15 (46.9%)	17 (53.1%)	0	32 (65.3%)
Not Preventable	0	0	17 (100%)	17 (34.7%)

FIGURE 22. DISTRIBUTION OF PREVENTABILITY AMONG PREGNANCY-RELATED DEATHS BY LEADING CAUSES OF DEATH, 2021



Perinatal Mental Health Screening

ACOG JUNE 2023 Guideline Summary Recommendations: Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum

- **Everyone receiving annual exams, or prepregnancy, prenatal, and postpartum care should be screened for depression and anxiety using standardized instruments**
- **Screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at the postpartum visits**
- **Mental health screening be implemented with systems in place to ensure timely access to assessment and diagnosis, effective treatment, appropriate monitoring, and follow-up based on severity**
- **Screen for bipolar disorder before initiating pharmacotherapy for anxiety or depression**

Postpartum Mental Health Screening

- **ACOG (2018)** recommends all perinatal individuals have contact with their obstetric care providers within the first 3 weeks postpartum. This initial assessment should be followed up with a comprehensive postpartum visit no later than 12 weeks after birth.
- **40%** of individuals do not attend a postpartum appointment
- **American Academy of Pediatrics (AAP)** recommends that pediatricians screen mothers for postpartum depression at baby's 1, 2, 4, and 6 month visits (Earls 2019)

Standardized Mental Health Screening Tools

Table 2. Commonly Used Perinatal Mental Health Validated Screening Instruments

PMH Condition	Screening Instrument	No. of Items/Self-Administered (Y/N)	Sensitivity and Specificity	Score for Positive Screen
Depression	EPDS	10/Y	Sensitivity: 55–98% Specificity: 68–97%	≥ 10
	PHQ-9	9/Y	Sensitivity: 53–77% Specificity: 85–94%	≥ 10
Anxiety	GAD-7	7/Y	Sensitivity: 73% Specificity: 67%	≥ 5
	EPDS— anxiety subscale (items 3, 4, 5)	3/Y	Not enough data to estimate; correlates with GAD-7	≥ 5
	STAI	20/Y	Sensitivity: 81% Specificity: 78%	≥ 40
Bipolar disorder	MDQ	3 (Q1 with 13 items)/Y	Sensitivity: 44–90% Specificity: 61–92%	≥ 7 of the 13 items in Q1
	CIDI	2–3 (branching logic)/N	Sensitivity: 69–100% Specificity: 98–99%	Yes to Q3 (Q3 is asked if Q1 or Q2 are affirmed)

Abbreviations: CIDI, Composite International Diagnostic Interview; EPDS, Edinburgh Postnatal Depression Scale; GAD-7, Generalized Anxiety Scale-7; MDQ, Mood Disorder Questionnaire; PMH, perinatal mental health; PHQ-9, Patient Health Questionnaire-9; Q, question; STAI, State-Trait Anxiety Inventory.

Data from Byatt N, Masters GA, Bergman AL, Moore Simas TA. Screening for mental health and substance use disorders in obstetric settings. *Curr Psychiatry Rep* 2020;22:62 and Byatt N, Mittal LP, Brenckle L, Logan DG, Masters GA, Bergman A, et al. Lifeline for moms perinatal mental health toolkit. University of Massachusetts Medical School; 2019. Accessed December 7, 2022. <https://www.umassmed.edu/lifeline4moms/products-resources/toolkits-and-apps/2019/11/lifeline4moms-perinatal-mental-health-toolkit/>

Visit projectteachny.org/maternal-rating-scales for additional scales/screeners

Suicide Risk Assessment Recommendations

- **ACOG (2023) recommends that when a patient affirmatively answers a self harm or suicide question clinicians immediately assess for risk and arrange for risk-tailored management**
- **Both the PHQ-9 and the EPDS include questions which can identify the presence of suicidal ideations, but need follow up**
 - **Ask Suicide Screening Questions (ASQ)**
 - **Columbia Suicide Severity Rating Scale (CSSRS)**

Guiding Principles for Suicide Risk Assessment

- Remember that asking about SI does not increase the risk of suicide attempts or “give people ideas”
- Normalize the process: the more uncomfortable you appear, the less forthcoming your patient is likely to be
- Don’t assume a negative response and don’t use vague language/euphemisms
- Follow up and be thorough – adequate risk assessment (and management) requires details
- SI can occur across many diagnosis including depression, postpartum psychosis, PTSD, and OCD

Standardized Suicide Risk Assessments

ASQ

Ask the patient:

1. In the past few weeks, have you wished you were dead? Yes No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
3. In the past week, have you been having thoughts about killing yourself? Yes No
4. Have you ever tried to kill yourself? Yes No

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? Yes No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - "Yes" to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT** safety/full mental health evaluation.
 - **Patient cannot leave until evaluated for safety.**
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
 - "No" to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.
 - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741741

CSSRS

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If YES to 2, ask questions 3, 4, 5 and 6. If NO to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? <i>Examples: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc.</i> If yes, was this within the past 3 months?		High Risk

Perinatal Substance Use Screening Recommendations

- **ACOG (2023), and the American Academy of Pediatrics (Patrick et.al.,2017), recommend universal verbal screening with a validated questionnaire for all pregnant people.**
 - Do not recommend routine drug testing of urine or other biological materials such as hair or oral fluids.
- **The New York State AIDS Institute Clinical Guidelines (2021) recommend that even verbal screenings entail consent because of the potential consequences of a positive screening result in individuals who are pregnant or planning to conceive.**

Standardized Substance Use Screening Tools

Table 3. Screening and Assessment Tools

Tool	Substance Type		Patient Age		Administered by	
	Alcohol	Drugs	Adults	Adolescents	Patient	Clinician
Brief Screener for Alcohol, Tobacco, and Other Drugs (BSTAD)	X	X		X	X	X
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Car, Relax Alone, Forget, Friends, Trouble (CRAFFT)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication and other Substance use (TAPS)	X	X	X		X	X

Adapted from National Institute on Drug Abuse. Screening and assessment tools chart. Accessed April 15, 2024. <https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools>.

Cannabis use during pregnancy and lactation. Clinical Consensus No. 10. American College of Obstetricians & Gynecologists. *Obstet Gynecol* 2025;146:600–611.

Psychosis Screening Questions

New parents often have thoughts about something bad happening to their baby. These thoughts can feel awful and sometimes feel as if they could be an escape. We are here to help you. We ask about these thoughts because they are so common.”

- **Have you had any thoughts of harming your infant, either as an accident or on purpose?**
 - How often do you have them?
 - How recently have you had them?
 - How much do they scare you?
 - How much do they worry you?

Byatt et al., 2019

Psychosis Assessment

- **Is this the patient's first psychiatric presentation?**
- **If she has a psychiatric history, is it of depression, mania, or both?**
- **Is there any family history of bipolar disorder?**
- **Has the patient been using any substances?**
- **Can use Columbia to assess suicide risk.**
- **Assess mental status with Mini Mental State Exam (MMSE) or Montreal Cognitive Assessment (MoCA)**

Osborne, 2018

Assessment

- Remember that a screening tool does not make a diagnosis – further assessment is warranted after any positive screen
- Areas for further assessment:
 - Reproductive history*
 - Severity, chronicity and co-morbidity
 - Safety risk
 - Current stressors
 - Previous treatment experience
 - Treatment preferences
 - Strengths, social support and resources

Informal Assessment

- **Majority of doulas believe it's important for them to play a role in mental health screening** (Nelson et al., 2025)
 - **Some believe formal screens are outside of their scope of practice and lack cultural sensitivity**

[Screening]takes the, I guess, connection out of the experience. Like, I'm connecting with someone...I'm listening to them and hearing and understanding. I do ask them, like, do you sleep and are you hanging out with your friends? Are you getting out? Are you getting time away from the baby? But if I'm asking [using] that paper, I don't get to tell you like, "Yeah, you and babies need breaks from each other. That baby likes breaks from you." And I'm not getting to be me and experience—like establish that relationship [so that] they want to reach back out to me and talk to me later on. And so, I feel like I wouldn't want to do that. I feel like that is definitely the role of a doctor. –Iris, 25-34 years old, 1 year in practice

Practice-Level Response

It is essential to develop a workflow prior to initiating screening

- **Screening and not responding is worse than not screening**
- **It takes the team to respond to mental health needs**

Building Screens into Practice Workflows

- How will screens be administered? (paper vs tablet)
- When will screens be administered? (e.g., at home; waiting room; exam room)
- Who will administer screens? (e.g., automated electronic administration, receptionist, tech, nurse)
- Who will review the screens and how do we make sure positive results aren't missed?
- What are the resources we can offer?
- What is the plan if suicidal ideation is endorsed?
- How to ensure appropriate f/up occurs

Tips for Screening Workflows

- **Team-based approach: every discipline is included in the plan**
- **Communication is key**
- **Leverage electronic health record**
 - **Automated scoring, best practice alerts, etc.**
- **Develop current resource information with existing community mental health resources**
- **Establish partnerships with local mental health clinicians**
- **Readminister tools at future visits if positive**
- **Train entire practice and write up workflows (including billing for screens)**

Address Risk in Workflows

- **ACOG's (2025) recommendations for tailored Perinatal Care provide a model of how to address psycho-social risk factors implicated in maternal mental and physical health throughout the course of the perinatal period**
- **US Preventative Services Task (2019) force recommends clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.**
 - **Counseling interventions associated with 39% reduction in likelihood of perinatal depression (O'Connor et al., 2019)**

Provider Resources

- [Parental Depression Screening for Pediatric Clinicians Implementation Manual](#) Ardis Olsen, Commonwealth fund
- [Postpartum Psychosis Webinar](#) Massachusetts Child Psychiatry Access Program
- Alliance for Innovation on Maternal Health [implementation resources](#)
- New York State Child Abuse Prevention and Treatment Act and Comprehensive Addiction Recovery Act [information and resources](#)
- NYS AIDS Institute Clinical Guidelines [Substance Use Disorder Treatment in Pregnant Adults](#)

Patient Resources

- National Harm Reduction Coalition, [Pregnancy and Substance Use: A Harm Reduction Toolkit](#)
- New York State [Office of Addiction Services and Supports \(Oasis\)](#)
- [MATTERS Network](#) linkage to substance use disorder treatment and harm reduction supplies
- [Suicide and Crisis Lifeline](#), call or text 988 or [chat online](#)
- [Suicide Prevention Center of NY](#)
- [American Foundation for Suicide Prevention](#)

Thank you!

Call us Monday – Friday • 9 am – 5 pm

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