Physicians for Reproductive Health

November 9, 2026

Assembly Standing Committee on Health
Assembly Standing Committee on Mental Health
Assembly Hearing Room, 19th Floor
250 Broadway
New York, New York

Re: Maternal Mental Health

Dear Chairwoman Paulin, Chairwoman Simon, and Members of the Committee:

Physicians for Reproductive Health (PRH) is a physician-led national advocacy organization working to ensure access to equitable, comprehensive sexual and reproductive health care for the communities we serve. Our network includes physicians of various specialties across the country, including New York, committed to meeting the needs of the patients they serve. Pregnant and postpartum birthing people deserve full, comprehensive health care that tends to both their physical and mental health and well-being. We write to draw your attention to the impacts of the child welfare system on maternal health and mental health outcomes, and the role of the Maternal Health, Dignity and Consent Act in addressing this issue.

Untreated maternal mental health and substance use are a leading cause of maternal mortality.

Over the last decade, the mental health of mothers in the United States has worsened. Between 2016 and 2023, mothers reported a nearly 65 percent increase of "fair to poor mental health."[1] Maternal mental health conditions are the leading underlying cause of pregnancy related deaths in the U.S., accounting for 28% of pregnancy related deaths.[2] Of the 28% of pregnancy related deaths that are maternal mental health condition related, 51% are determined to have substance use disorder as the underlying cause of death.[3] We must recognize substance use disorder as a mental health condition deserving of care, compassion, and destigmatized medical treatment if the patient chooses.

Challenges persist in accessing perinatal substance use and mental health treatment.

Substance use treatment or mental health treatment that accepts pregnant patients can be very difficult to access. Only 13% of outpatient-only and residential substance use treatment facilities offer special treatment programs for pregnant or postpartum women, and among hospital inpatient treatment facilities, this figure was 7%.[4] Transportation, childcare, and insurance cliffs can exacerbate issues accessing care. Pregnant and postpartum people face similar challenges accessing mental health care. In general, there are not enough mental health providers with perinatal expertise. General therapists and psychiatrists often lack specific training in perinatal

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[1] Policy Center for Maternal Mental Health. "Maternal Mental Health Fact Sheet," July 2026. https://cdn.policycentermmh.org/2026/07/2026-MMH-Fact-Sheet-1.pdf
[2] Centers for Disease Control and Prevention. "Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees," April 2026. https://www.cdc.gov/maternal-mortality/php/data-research/mmrc/index.html
[3] Ibid.
[4] Policy Center for Maternal Mental Health. "Substance Use Disorders and Maternal Mental Health," March 2025. https://policycentermmh.org/substance-use-disorders-and-maternal-mental-health/

mental health or feel uncomfortable treating perinatal mental health conditions as well as perinatal substance use disorder.[5]

Consensual and non-punitive screening for perinatal mental health and substance use disorders to connect pregnant people with needed healthcare is critical. However, there is no standard practice for this. Rather, pregnant people are routinely drug tested without their consent and reported to child protective services upon any evidence of substance use. It is important to note that a drug test alone is not evidence of a substance use disorder, or a measure of one's ability to parent. Regardless, patients with a positive test are treated as dangerous and requiring intervention. While health care providers may be well intended, a report to CPS rarely leads to referrals to support or rehabilitative services. Furthermore, the family regulation system is not equipped to provide the care, support or services needed to navigate connecting families with care.

Drug testing of pregnant and birthing people is rarely clinically indicated. For the majority of pregnant and birthing patients, conversations with a trusted health care provider is both sufficient and preferred to informing the course of care including referral for substance use disorder treatment. Furthermore, screening does not always lead to medical treatment or help, but instead punishment and surveillance. Despite research showing equivalent rates of substance use across racial demographics, research consistently shows that health care providers disproportionately test and report Black, Latine, and Indigenous patients, and patients with low income, regardless of whether or not they meet hospital guidelines for drug testing.[6]

Across New York State, health care providers unnecessarily drug test pregnant, birthing and postpartum people and their infants without their knowledge or informed consent. Patients are screened and tested for substance use without any context for why or how their responses will be used. Health care providers will then report a positive drug screen or test or the child welfare system, subjecting families to harmful surveillance and potential separation. This practice and process is called "test and report."

<u>Fears of punishment and non-consensual drug testing cause patients to avoid seeking health care, negatively impacting health outcomes.</u>

The practice of "test and report" violates pregnant and postpartum people's sense of safety and trust in their medical care and drives people away from seeking the health care they want and need. Numerous studies and reports document how "test and report" dissuades people from seeking prenatal and postpartum care due to their fear of being subjected to family surveillance and separation.[7]

Fear of punishment prevents people from seeking health care. Women with illicit substance use were 2.88 times more likely to not receive adequate prenatal care compared to women who did not

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[5] Ibid.

[6] Marc A. Ellsworth, BS, Timothy P. Stevens, MD, MPH, and Carl T. D'Angio, MD, Infant Race Affects Application of Clinical Guidelines When Screening for Drugs of Abuse in Newborns, Pediatrics, (May 17, 2010) https://pubmed.ncbi.nlm.nih.gov/20478941/

[7] Roberts, S. C. M., & Pies, C. (2011). Complex calculations: how drug use during pregnancy becomes a barrier to prenatal care. Maternal and Child Health Journal, 15(3),333–341. https://doi.org/10.1007/s10995-010-0594-7

report use, and this statistic is similar for receiving postpartum care.[8] This is not because people don't want care, it is because they are afraid of the consequences if they do seek care.

Separating newborns from their parents during a critical time of maternal-infant bonding is traumatic and has long-lasting consequences for both the child[9] and parent.[10] Separating a child from their parents can cause a "monsoon of stress hormones" to "flood the brain and body," and prolonged exposure to high levels of these hormones can "increase the risk of lasting, destructive [health and mental health] complications.[11] There are also severe consequences for the birthing parent, with research telling us that mothers whose children are forcibly separated from them have greater odds of having a postpartum depression or anxiety diagnosis,[12] and higher rates of maternal mortality.[13] To put it succinctly, family separation is toxic for children and families.[14]

Patients deserve trust, respect, and dignity.

Addressing perinatal substance use requires trust-based conversations and person-centered treatment—not criminalization. When providers are required to separate parents from their newborns, the system undermines the best medical practices and a provider's ethical obligation to act in the best interest of their patients. As clinicians we trust our patients to know what is best for their health, lives, families, and futures.

When patients – especially pregnant or postpartum parents – fear that being honest with their provider could result in investigation and loss of their child, they are less likely to seek care. This can result in poor behavioral health outcomes and dangerous untreated physical health problems

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[8] Nidey N, Kair LR, Wilder C, Froehlich TE, Weber S, Folger A, Marcotte M, Tabb K, Bowers K. Substance Use and Utilization of Prenatal and Postpartum Care. J Addict Med. 2022 Jan-Feb 01;16(1):84-92. doi: 10.1097/ADM.0000000000000843. PMID: 33758116; PMCID: PMC8449796. https://pmc.ncbi.nlm.nih.gov/articles/PMC8449796/

[9] Kimberly Howard et al., Early Mother-Child Separation, Parenting, and Child Well-Being in Early Head Start Families, Attach Hum Dev. (January 2011). https://pmc.ncbi.nlm.nih.gov/articles/PMC3115616/

[10] Rosa Furneaux, Forcibly Separating Children From Their Mothers Doesn't Just Hurt the Kids, Mother Jones. (June 2018), https://www.motherjones.com/politics/2018/06/trump-forced-family-separation-children-devastating-effects-mothers-1/.

[11] See Allison Eck, Psychological Damage Inflicted by parent-Child Separation is Deep, Long-Lasting, NOVA (June 20. 2018), https://www.pbs.org/wgbh/nova/article/psychological-damage-inflicted-by-parent-child-separation-is-deep-long-lasting/?utm_source=FBPAGE&utm_medium=social&utm_term=20180620&utm_content=1603761016&linkId=53285432&utm_source=FBPAGE&utm_medium=social&utm_term; see also Trauma Caused by Separation of Children From Parents, American Bar Association (Last updated Jan. 2020), available at https://www.americanbar.org/content/dam/aba/publications/litigation_committees/childrights/child-separation-memo/parent-child-separation-trauma-memo.pdf;

[12] Wall-Wieler, E., Roos, L. L., Brownell, M., Nickel, N. C., Chateau, D., & Nixon, K. (2018). Postpartum Depression and Anxiety Among Mothers Whose Child was Placed in Care of Child Protection Services at Birth: A Retrospective Cohort Study Using Linkable Administrative Data. *Maternal and child health journal*, *22*(10), 1393–1399. https://doi.org/10.1007/s10995-018-2607-x

[13] Wall-Wieler, Elizabeth & Roos, Leslie & Nickel, Nathan & Château, Dan & Brownell, Marni. (2018). Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis. American journal of epidemiology. 187. 10.1093/aje/kwy062.

[14] Nguemeni Tiako MJ, Sweeney L. The Government's Involvement in Prenatal Drug Testing May Be Toxic. Matern Child Health J. 2022 Apr;26(4):761-763. doi: 10.1007/s10995-020-03110-2;

for infants and parents. We cannot turn medical settings into environments where patients are punished rather than cared for, and ultimately keep people from accessing the care they need.

The Maternal Health, Dignity, and Consent Act prioritizes patient autonomy, decision-making, and well-being.

Informed consent is a core component of providing care that acknowledges the dignity and bodily autonomy of the pregnant person. It can contribute to building person centered and compassionate care. This is especially true for care during and following pregnancy. Informed consent roots the patient-provider relationship in trust. Without trust, or when that trust is broken, patients may delay or avoid seeking care, which can lead to poor maternal health outcomes. Ensuring that patients are fully informed of the consequences of prenatal and postpartum drug testing and screening as well as the medical reason for testing and screening allows the decision regarding disclosure of substance use to be a fully informed one.

The patient-provider relationship is wholly dependent on trust. Giving patients the right to be fully informed about their health care will only bolster trust and honesty. With mental health care already difficult to access for a multitude of reasons, we cannot allow our health care settings to become a place of surveillance and punishment. I encourage the Committee to take under consideration the Maternal Health, Dignity, and Consent Act as a way forward for improving maternal mental health outcomes for New Yorkers.

Respectfully,

Dr. Jamila Perritt
President & CEO
Physicians for Reproductive Health