ACCESS Mental Health and Substance Use for Moms

Perinatal Mental Health and Substance Use Toolkit

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Yale School of Medicine

CONNECTICUT Mental Health & Addiction Services

Administered by carelon Behavioral Health

Contents

Introduction

Perinatal mental health challenges are some of the **most common conditions complicating pregnancy and the first postpartum year**. Despite the effects on maternal, obstetric, birth, offspring, partner, and family outcomes, perinatal mental health disorders often remain **underdiagnosed, and untreated or under-treated**.

The American College of Obstetricians and Gynecologists (ACOG) recommends that **all patients be screened at least once during the perinatal period for depression and anxiety symptoms using standardized, validated tools.** If patients are screened in pregnancy, the recommendation is to also screen postpartum.

Universal screening for substance use with a validated screening tool, **not urine toxicology**, is recommended in the first prenatal visit.

To facilitate screening practices:

- Create a welcoming and **non-stigmatizing environment by** displaying information about perinatal mental health and substance use disorders.
- **Educate and create awareness** about this important issue for **every patient and their support person(s)**.
- Respond to a positive screen by providing education about **therapy and making a referral, initiating medication treatment when indicated, and referring patients to additional mental health resources**.
- **Establish practice workflows and referral networks** so that patients have **timely access to assessment and both non-pharmacologic and pharmacologic treatment**.

This toolkit includes several commonly used screening instruments to provide a comprehensive assessment of perinatal patients' mental health and substance use and are:

- ✓ Validated or accepted for use in pregnancy and the postpartum period
- ✓ Routinely used
- ✓ Free
- ✓ Easy to administer and score
- ✓ Available in numerous languages

This toolkit provides actionable information, algorithms, and insights so that obstetric providers and practices can successfully address perinatal mental health and substance use conditions within their practice. **Any questions, or if you need clinical guidance and/or resource and referral support for your patient, please contact ACCESS Mental Health and Substance Use (AMHSU) for Moms at 833-978-6667, Monday-Friday 9am-5pm.**

Acknowledgments

We wish to acknowledge and thank the Department of Mental Health and Addiction Services (DMHAS) for funding the ACCESS Mental Health and Substance Use for Moms program and for ongoing support, collaboration, and contribution to this work. We also wish to acknowledge and thank the Lifeline for Moms and Massachusetts Child Psychiatry Access Program (MCPAP) for Moms programs as this toolkit was adapted, with permission, from their work.

Patient Screening Tools

1. Who should be screened for perinatal mental health conditions?

ALL perinatal patients should be screened for mental health conditions. ACOG recommends screening patients at least once during the perinatal period for depression and anxiety. If screening is performed during pregnancy, repeat during the postpartum period, ideally as part of a comprehensive postpartum visit assessing physical, social, and psychological well-being no later than 12 weeks after birth. Universal screening for substance use with a validated screening tool, not urine toxicology, is recommended in the first prenatal visit. Currently, there are no evidence-based guidelines for urine toxicology testing, and it is not superior to the use of standardized screening tools. It has limited utility, is not in itself diagnostic, and might have significant ramifications for patients.

2. When should screening occur?

Onset of depression occurs before delivery for the majority of perinatal patients. Screening at the following times may capture mental health conditions with onset at each time point:

- At the **initial prenatal visit** to identify onset before pregnancy (approximately 27% of cases)
- In the **second half of pregnancy** to identify onset during pregnancy (approximately 30% of cases)
- At the **postpartum visit(s)** (4th trimester visit) to identify onset that occurs in late-pregnancy or early postpartum (remaining 40% of cases)

Patients with a history of depression or other mental health conditions, patients who have previously taken psychiatric medications, or patients who have screened positive in a pregnancy/postpartum episode often need more frequent monitoring. Re-administering screening tools can facilitate monitoring of symptoms and follow-up care with the goal of full symptom remission.

To watch our ACCESS Mental Health and Substance Use for Moms Clinical Conversations trainings on screening tools click **here**.

3. Recommended Screeners

Depression Screening:

- **Edinburgh Postnatal Depression Screen (EPDS):** a widely used and validated 10-item questionnaire to identify patients experiencing depression during pregnancy and the

postpartum period and can take less than five minutes to complete. Items of the scale correspond to various clinical depression symptoms, such as guilt feelings, sleep disturbance, low energy, anhedonia, and suicidal ideation [*click links*].
Initial Screen
Online Scoring Tool
Follow-up Screen

- **Patient Health Questionnaire (PHQ-9):** is a 9-question instrument given to patients to screen for the presence and severity of depression. The PHQ-9 is widely used because it is quick, easy to administer, and does not require 2-steps to make a diagnosis. The results of the PHQ-9 may be used to make a depression diagnosis and determine severity *[click links].*
Initial Screen
Online Scoring Tool
Follow-Up Screen

- **Mood Disorder Questionnaire (MDQ): to screen for lifetime prevalence of mania before initiating antidepressant**, the MDQ is a validated, quick and easy questionnaire to screen adults for bipolar spectrum disorder. The thirteen yes or no questions take about five minutes to complete, focusing on lifetime experience of possible manic and hypomanic symptoms. The MDQ can result in positively detecting Bipolar I Disorder, and co-occurrence and severity of symptoms *[click links].*
Initial Screen
Online Scoring Tool

Important notes about **bipolar disorder**:

- ✓ We recommend screening all patients for bipolar disorder. Minimally it needs to be done prior to initiating an antidepressant because **1 in 5 perinatal patients who screen positive for depression may have bipolar disorder**.

- ✓ Treatment of bipolar disorder with an antidepressant alone is **contraindicated and is associated with worsening of mood symptoms which can increase risk of mania, psychosis, and suicide.** If a patient has bipolar disorder, treatment with a mood stabilizer is generally indicated (see **Assessment and Management of Bipolar Disorder** in this toolkit).

- ✓ In general, if bipolar disorder is suspected, consultation with or referral to psychiatry for further assessment is indicated. **Call AMHSU for Moms: 833-978-6667**

Suicide and Safety Risk Screening:

- **Columbia Suicide Severity Rating Scale:** supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs *[click link].*
Initial Screen

If YES to question number(s) 2 or 3, seek mental healthcare for further evaluation (see **Assessing Risk of Suicide** *page 14-15*) **If the answer to question number 4, 5, or 6 is YES, get immediate help by calling 988, call 911, or go to the emergency room.**

- **Patient Safety Screener:** is designed for use in acute care settings with patients who may be at risk for suicide *[click link]*
  Initial Screen

Anxiety Screening:

- **General Anxiety Disorder (GAD-7):** is a valid and efficient 7-item screening tool for assessing presence and severity of Generalized Anxiety Disorder. The self-report questionnaire has good reliability and may also be used to detect panic disorder, social anxiety disorder, and posttraumatic stress disorder *[click links].*
  Initial Screen
  Online Scoring Tool

- **Yale-Brown Obsessive Compulsive Scale (Y-BOCS):** is a rating scale designed to rate the severity and type of symptoms in patients with obsessive compulsive disorder (OCD) *[click link].*
  Initial Screen

Posttraumatic Stress Disorder (PTSD) Screening:

- **Primary Care PTSD Screen for DSM-5 (PC-PTSD-5):** a screening tool designed to identify patients with probable PTSD. Those screening positive should have further assessment with a structured interview for PTSD, preferably performed by a mental health professional who has experience in diagnosing PTSD *[click links].*
  Initial Screen
  Online Scoring Tool

- **PTSD Checklist – Civilian Version (PCL-C):** is a standardized self-report rating scale for PTSD comprising 17 items that correspond to the key symptoms of PTSD *[click link].*
  Initial Screen

- **PTSD-5 (PCL-5):** is a 20-iten self-report measure that assesses the presence and severity of PTSD *[click link].*
  Initial Screen

Substance Use in Pregnancy Screening:

- **The Tobacco, Alcohol, Prescription medications, and other Substances (TAPS) Tool** consists of a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. This instrument is used to assess patients for tobacco, alcohol, prescription drug, and illicit substance use and problems related to their use and is available for self-administration and interviewer-administration to detect substance use, sub-threshold substance use disorder (i.e., at-risk, harmful, or

hazardous use), and substance use disorders *[click link].*
Initial Screen

- **The Parents, Partners, Past and Pregnancy Scale (4Ps)** is a five-question screening tool that can detect low levels of alcohol or drug use during pregnancy. Positive screens allow practitioners to determine the severity of substance use and whether substance use treatment is recommended. The 4Ps is a reliable and effective screening measure and is recommended because it frequently captures patients typically missed by other screening tools *[click link].*
  Initial Screen

- **5Ps** (with '5Ps' being a mnemonic representing each question in this five-item measure: parents, peers, partner, pregnancy, past) is an adaptation of the 4Ps measure designed for use in pregnancy *[click link].*
  Initial Screen

- **SURP-P** is a three-question screening tool to detect alcohol and other substance use during pregnancy. Research has shown the SURP-P to be among the most predictive of substance use screening tools during pregnancy. The SURP-P can identify use of many different substances, including alcohol, cocaine, sedatives, and opioids. Because it is brief, it can be re-administered throughout pregnancy, which is especially helpful given the risk of relapse during pregnancy for patients with a history of substance abuse *[click link].*
  Initial Screen

- **CRAFFT** is a screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder among youth ages 12-21. It has been implemented as part of universal screening efforts in thousands of busy medical and community health settings, as it yields information that can serve as the basis for early intervention and patient-centered counseling *[click link].*
  Initial Screen

Non-judgmental ways to discuss substance use during pregnancy

- Ask in a confidential setting
- Ask universally
- Listen with empathy and respect
- Discuss substance use as a chronic disease
- Avoid stigmatizing words such as "abuse," "addict," "rehab," "relapse," or "dirty" or "clean" (in reference to drug screens)
- Try instead more value neutral words like "substance use disorder," "substance misuse," "individual with substance use disorder," "treatment," "recovery," "recurrence of use," "positive" drug screen results, etc.

For more resources and guidance see Language Matters from CT Clearing House

4. Who hands out, scores, and responds to the screening tools?

Every office is different, and the workflow for addressing perinatal mood and anxiety disorders and substance use during pregnancy needs to be tailored to each practice environment.

Clinical support staff can often provide the screening tools to patients at the time of 'check-in' or appointment registration, or upon rooming. Patients should be given time to complete it thoughtfully. Time in the waiting room or in the exam room while awaiting the provider can be used. Many electronic health records can be customized with templates for these screening tools.

After a patient completes the screening tools, they should be scored and reviewed by clinical staff and entered into the chart and included in an electronic medical record. Scoring is straightforward and can be done by any level of caregiver. It is imperative that measures are scored before a patient leaves their appointment, so that a positive screen can be promptly addressed.

The responsible licensed independent provider should be made aware of positive screening score(s), if they themselves did not administer the screening tools or did not do the scoring.

5. How do you talk about mental health conditions in a strength-based way?

Patients are often reluctant to discuss mental health for many reasons including stigma. As clinical support office staff are often the first to interact with them regarding screening for mental health, it is important that it is done with an inclusive, strength-based approach that emphasizes:

- ✓ They are common
- ✓ They are medical conditions, like diabetes, that need to be treated
- ✓ They are treatable
- ✓ That the practice screens every patient in pregnancy and the postpartum period
- ✓ The practice cares for the whole patient

For more information, see **How to Talk to Your Patient About Their Mental Health**.

The first administration of perinatal mental health screening tools should be accompanied by the provision of educational materials for the patient and family that outline relevant symptoms and resources (see the **Action Plan for Mood Changes During Pregnancy and After Giving Birth, Self-Care Plan, and Safety Plan** in the Patient Resources section at the end of this toolkit). In addition, patients, their families, and members of their support system should be encouraged to contact the practice if they are concerned about their mental health. Remind everyone that you are there to help and you want them to reach out to you or your colleagues at the practice.

When discussing treatment options, provide a balanced perspective of treated versus untreated illness and associated risks and benefits. Untreated illness has significant risk. Let patients know that a healthy parent is critical to the health of the baby, and it is important to prioritize a patient's health, including mental health. Because of this, you will be checking in with them and their mental health regularly throughout their obstetric care.

6. Where can I find educational materials for patients and families?

Patients and their families, or other members of their support system should be proactively provided with education so that they are aware of signs and symptoms of perinatal mood and anxiety disorders. Having these conversations early in the pregnancy and again in the early postpartum period, can decrease stigma, normalize screening and detection, and encourage patients to discuss any mental health concerns. An environment with ample displays of, and access to, mental health-related information can help to reduce this stigma, and empower patients and their families to seek help, while letting patients know that they are not alone.

Recommendations for education:

- Provide educational materials to all new prenatal patients and again to patients at their postpartum visit.
- Place posters, pamphlets, and other materials throughout your offices.

For more information, see **Educational Resource Materials for Patients** at the end of this toolkit. If you need clinical guidance and/or support for your patient in connecting to local resources and referrals in Connecticut, contact **AMHSU for Moms at 833-978-6667, Monday-Friday 9am-5pm**.

Treatment Guidance & Clinical Algorithms

How to Talk to your Patient About Their Mental Health

Ask open-ended questions

- "How are you feeling, mood-wise?"
- "How is it managing the challenges of a new baby in the house?"
- "What is sleep like these days?"
- "How are you managing to free yourself up to attend therapy appointments?"
- "I'm curious, what seems to be getting in the way of [activity being impacted]?"

Use reflective listening

- "It's been harder than you expected to adjust to this new normal."
- "You're really not sure if your new therapist can be helpful."

Reinforce action, changes, and strengths

- "With all the obstacles that you've described, it's impressive that you've been able to make your therapy appointments. This really speaks to your commitment to yourself and to being the best parent you can."
- "It was difficult, and you still were able to make it to your visit today. That didn't just magically happen, you had to take specific, concrete actions to get to where you are right now."

Normalize concerns

- "It is common to feel concerned about how getting help for depression will affect your life."
- "Based on everything you're going through, it would be unusual for you not to feel overwhelmed."

Summarize the conversation

- "So, based on what you've described, it sounds like you're concerned about your depression because it affects your relationship with your baby and your partner. You also said that you must put in a lot of effort to attend therapy appointments and it costs money to get there, which makes you doubt the process. Do I have that right?"

Ask permission before providing advice/feedback and follow-up

- "Would it be ok if we talk about your depression?"
- "I have some thoughts about strategies to address this, would you be interested in hearing them?"
- "What's it like for you hearing this feedback?"
- "What questions do you have for me?"

Avoid saying "I understand"

- Say instead, "I can't imagine what you're going through" or "that must be very difficult." Sometimes patients are looking for simple validation, rather than a solution.

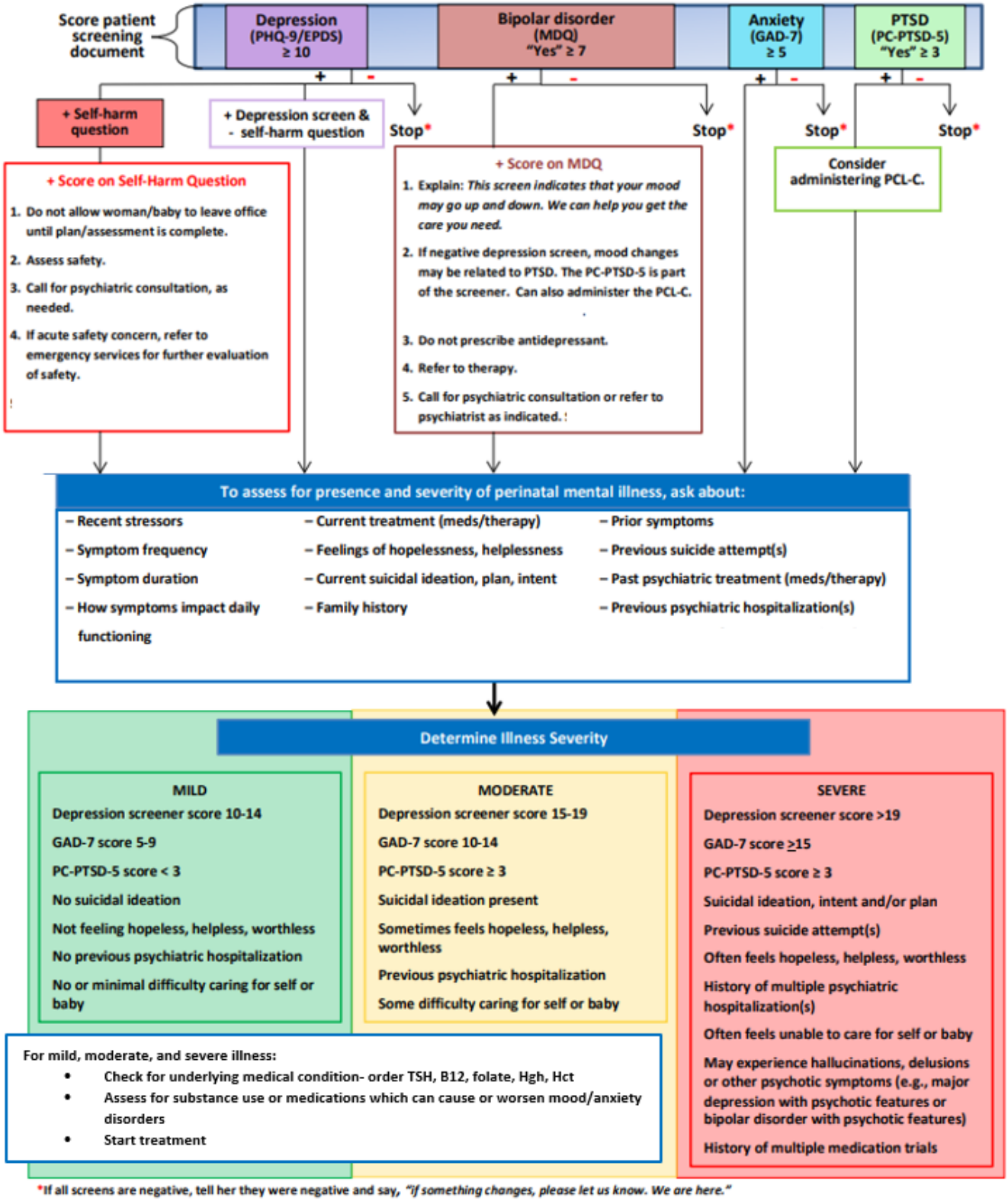
Avoid using the word "but" because it negates what came before it

- Avoid saying something like, "You're working really hard, but you still feel overwhelmed." Instead, use the word "and" to acknowledge both truths: "You're working really hard, and it's important to keep focusing on your mental health and self-care. You've already made progress by being here."

Avoid talking about yourself and your personal challenges or situations

- No matter how well-intentioned, patients often perceive this as you not hearing them.

Assessing Perinatal Mental Health



*If all screens are negative, tell her they were negative and say, *"if something changes, please let us know. We are here."*

EPDS – Edinburgh Postnatal Depression Scale; GAD – Generalized Anxiety Disorder; MDQ – Mood Disorder Questionnaire; PHQ – Patient Health Questionnaire
PTSD – Posttraumatic Stress Disorder; PC-PTSD-5 – Primary Care Post Traumatic Stress Disorder; PCL-C – PTSD Check List-Civilian

Starting Treatment for Perinatal Mental Health Conditions

Consider treatment options based on highest level of illness severity
If severity of symptoms overlap, clinical decisions should be based on the assessment, with strong consideration of higher-level treatment options

MILD	MODERATE	SEVERE
Therapy referral Consider medication treatment	Therapy referral Strongly consider medication treatment If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting).	Therapy referral Medication treatment If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting).

- Use internal resource list to refer patient to therapy
- Call ACCESS Mental Health for Moms 1-833-978-6667 for psychiatric consultation with our Hub team perinatal psychiatrist
- If patient needs help finding treatment, call ACCESS Mental Health for Moms and ask the Hub team psychiatrist for resource and referral support
- If symptoms are mild and patient is able to follow through, direct patients to call their health insurance company or contact Postpartum Support International (PSI) for resources: 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), or direct patients to search online at https://psidirectory.com/

Therapy and Support Options

- All women who screen positive, regardless of illness severity, should be referred to therapy or be advised to continue therapy
- Always discuss and encourage prevention and support options (e.g., peer and social supports and groups, sleep hygiene, self-care, and exercise).

How to Educate Patients About Treatment with Antidepressants

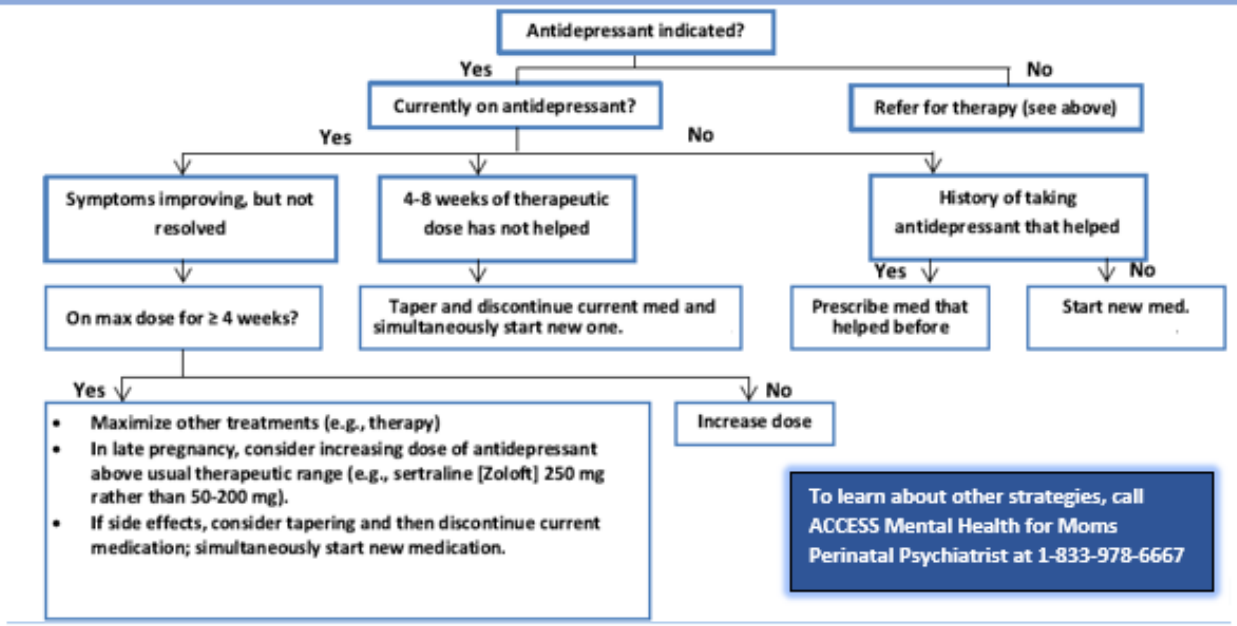
Antidepressant use during pregnancy:

- Does not appear to be linked with birth complications
- Has been linked with small but inconsistent risk of birth defects when taken in the first trimester, particularly paroxetine
- Has been linked with transient (days to weeks) neonatal symptoms (tachypnea, irritability, insomnia)
- Has inconsistent, overall reassuring, evidence regarding long-term (months to years) neurobehavioral effects on children

Under-treatment or no treatment of perinatal mental health conditions:

- Has been linked with birth complications
- Can increase the risk or severity of postpartum depression
- Can make it harder for moms to take care of themselves and their babies
- Can make it harder for moms to bond with their babies
- Can increase risk of mental illness among offspring
- Has been linked with possible long-term neurobehavioral effects on children

Medication Treatment (when indicated)



Starting Treatment for Perinatal Mental Health Conditions *(continued)*

Pharmacological Treatment Options for Depression, Anxiety, and PTSD

- **Choose antidepressant that has worked before. If antidepressant naïve, choose antidepressant based on table below with patient preference in consideration. Antidepressants are similar in efficacy and side effect profile.**
- **In late pregnancy, you may need to increase the dose above usual therapeutic range (e.g., sertraline [Zoloft] 250mg rather than 50-200mg).**
- **If a patient presents with pre-existing mood and/or anxiety disorder and is doing well on an antidepressant, do not switch it during pregnancy or lactation. If patient is not doing well, see Follow-Up Treatment Algorithm**
- **Evidence does not support tapering antidepressants in the third trimester.**
- **Minimize exposure to both illness and medication.**
  - **Untreated/inadequately treated illness is an exposure**
  - **Use lowest effective doses**
  - **Minimize switching of medications**
  - **Monotherapy preferred, when possible**

First-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

Medication	sertraline* (Zoloft)	fluoxetine (Prozac)	citalopram** (Celexa)	escitalopram** (Lexapro)
Starting dose and timing	25 mg qAM (if sedating, change to qHS)	10 mg qAM	10 mg qAM	5 mg qAM
Initial increase after 4 days	↑ to 50 mg	↑ to 20 mg	↑ to 20 mg	↑ to 10 mg
Second increase after 7 more days	↑ to 100 mg			
Reassess Monthly (increase as needed until symptoms remit)	↑ by 50 mg	↑ by 20 mg	↑ by 10 mg	↑ by 10 mg up to 20 mg
Therapeutic range***	50-200 mg	20-80 mg	20-40 mg	10-20 mg
Individualized approach to titration	Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms			

***Lowest degree of passage into breast milk compared to other first-line antidepressants; **Side effects include QTc prolongation (see below); ***May need higher dose in 3rd trimester and when treating an anxiety disorder**
In general, if an antidepressant has helped during pregnancy, it is best to continue it during lactation.
Prescribe a maximum of two (2) antidepressants at the same time

Second-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

Medication	duloxetine (Cymbalta)	venlafaxine (Effexor XR)	fluvoxamine (Luvox)	paroxetine (Paxil)	mirtazapine (Remeron)	bupropion HCL (Wellbutrin XL)
Starting dose and timing	30 mg*** qAM	37.5 mg qAM	25 mg qHS	10 mg qAM (if sedating, change to qHS)	7.5 mg qHS	150 mg qAM
Initial increase after 4 days		↑ to 75 mg	↑ to 50 mg	↑ to 20 mg	↑ to 15 mg	
Second increase after 7 more days	↑ to 60 mg		↑ to 100 mg			
Reassess Monthly (increase as needed until symptoms remit)	↑ by 30 mg	↑ by 75 mg	↑ by 50 mg	↑ by 10 mg	↑ by 15 mg	↑ by 150 mg
Therapeutic range ***	30-120 mg	75-300 mg	50-200 mg	20-60 mg	15-45 mg	300-450 mg

*****May need higher dose in 3rd trimester and when treating an anxiety disorder**

Starting Treatment for Perinatal Mental Health Conditions *(continued)*

	Temporary (days to weeks)	Long-term (weeks to months)
General side effects oral antidepressants	Nausea (most common) Constipation/diarrhea Lightheadedness Headaches	Increased appetite/weight gain Sexual side effects Vivid dreams/insomnia **QTc prolongation (citalopram & escitalopram)

- **Tell women to take medication with food and only increase dose if tolerating; otherwise wait until side effects dissipate before increasing.**
- **Start medication in morning; if patient finds it sedating recommend that she takes it at bedtime**

Medication Treatment for Moderate/Severe Depression with Onset in Late Pregnancy or Within 4 weeks postpartum – Zuranolone (Zurzuvae)

Zuranolone is an FDA-approved oral medication that can be considered for the treatment of severe postpartum depression.

- **It is a synthetic form of allopregnanolone (a neurosteroid) that acts on GABAA receptors**
- **It is given as an oral medication, 50 mg, taken daily in the evening for 14 days**
- **It should be taken with fat-containing food**
- **Improvement in symptoms is usually seen after 3 days**
- **The most common side effect is sedation, and to mitigate the sedating effects it is recommended that patients avoid alcohol, benzodiazepines or other CNS depressants during the 14-day treatment period**
- **If medication is too sedating or patient develops confusion, can decrease dose to 40 mg**
- **Not recommended to start SSRI and zuranolone simultaneously**
- **No indication to discontinue breastfeeding; lactation RID is 0.375% with 40 mg dose**

Clinicians need to send prescription to specialty pharmacy. To get list of specialty pharmacies call 844-987-9882.

Zuranolone is indicated if the onset of depression occurs in the 3rd trimester through 4 weeks postpartum, and if the patient is greater than 6 months postpartum at screening.

More information can be found at Reprotox and LactMed on all pharmacological treatments
AMHSU for Moms is here to help – 1-833-978-6667

Follow-Up Treatment for Perinatal Mental Health Conditions

Once patient is determined to have a mental health condition, repeat screen in 4 weeks and re-evaluate treatment plan via clinical assessment

If no/minimal clinical improvement after 4 weeks

- **If patient has no or minimal side effects, increase antidepressant medication dose until full symptom remission (e.g., EPDS/PHQ-9 < 10, GAD-7 <5, PC-PTSD <3)**
- **If patient has intolerable or serious side effects, taper medication to discontinue, and simultaneously start new antidepressant**
- **Maximize other treatments (e.g., therapy, lifestyle changes, support groups)**
- **If late in pregnancy, given physiological changes in pregnancy, may need to increase the dose of antidepressant above usual therapeutic range (e.g., sertraline [Zoloft] 250 mg per day rather than 50-200 mg)**
- **Consider adding additional medication.**
- **Repeat screens every 4 weeks and re-evaluate treatment via clinical assessment until remission, or, if you are not continuing to manage the patient, provide a hand-off to the primary care physician**

If clinical improvement and no/minimal side effects

- **Re-evaluate every month in pregnancy and postpartum and adjust med accordingly.**
- **Encourage patient to stay on medication and continue therapy**
- **If you are not continuing to manage the patient, provide a hand-off to primary care physician**

If clinical improvement and no/minimal side effects

If you are not continuing to manage the patient postpartum:

- **Contact PCP and provide handoff**
- **Ask patient to make appointment with PCP**
- **Send summary to PCP**
- **See patient again to make sure she is in treatment with PCP**

Once patient experiences remission of symptoms (e.g., 2 sequential EPDS/PHQ-9 scores <10, GAD-7 <5, PC-PTSD <3)

Can consider tapering antidepressant when patient has been in remission for ≥ 6 months for depression and ≥ 12 months for anxiety

Taper medication slowly to minimize risk of relapse and discontinuation syndrome

- **Shorter acting medications (e.g., paroxetine [Paxil], venlafaxine [Effexor]) have higher chance of discontinuation syndrome and thus need to be tapered slowly**
- **Establish postpartum birth control plan to help patients make informed decision regarding family planning**

Adjunctive Support Options

Talk to your patient about adjunctive support options such as:

- **Self-care (See Self-Care Plan)**
- **Balanced nutrition**
- **Substance avoidance**
- **Sleep hygiene**
- **Mindfulness**
- **Exercise**

Social and Structural Determinants of Health

Ask about/consider social and structural factors that can be a barrier to engagement in care:

- **Access to stable housing**
- **Access to food/safe drinking water**
- **Utility needs**
- **Safety in home and community**
- **Immigration status**
- **Employment conditions**
- **Transportation**
- **Childcare**

Assessing Risk of Suicide

Reports thoughts of self-harm and/or +self-harm question on the EPDS/PHQ-9 (any response other than "never")
Follow EPDS/PHQ-9 +self-harm with the Patient Safety Screener (suicide risk screener) to further stratify risk

Ask about thoughts of self-harm or wanting to die

Thoughts of death or of self-harm are common among patients with perinatal mental health conditions. The following wording can help to get information about these thoughts.

Introduce assessment to patient

"Many people have intrusive or scary thoughts. When people are sad or down, they often have thoughts about death or wanting to die. These thoughts can feel awful. They can sometimes feel reassuring or like an escape from a hard life or something else that feels too hard to bear. We are here to help you. We ask about these thoughts because they are so common."

To build up to assessing suicide risk, ask:

1. *"Have you been feeling sad or down in the dumps?"*
2. *"Is it difficult to shake those sad feelings?"*
3. *"Do you sometimes wish you weren't here, didn't exist?"*
4. *"Have you thought about ways to make that happen?"*

To assess risk of suicide, ask:

1. *"In the past two weeks, how often have you thought of death or wanting to die?"*
2. *"Have you thought about ways in which you could harm yourself or attempt suicide?*
3. *"Have you ever attempted to hurt yourself or attempted suicide in the past?"*
4. *"What prevents you from acting on thoughts of death or wanting to die?"*

Assess Risk

LOW RISK	MODERATE RISK	HIGH RISK
• Fleeting thoughts of death or wanting to die • No current intent* • No current plan** • No history of suicide attempt • Future-oriented (discusses plans for the future) • Protective factors (e.g., social support, religious prohibition, other children, stable housing) • No substance use • Few risk factors (e.g., mental health or medical illness, access to lethal means, trauma hx, stressful event)	• Regular thoughts of death or wanting to die • Has thoughts of possible plans yet plans are not well-formulated or persistent • History of suicide attempt • Persistent sadness and tension, loss of interest, persistent guilt, difficulty concentrating, no appetite, decreased sleep • Sometimes feels hopeless/helpless • Somewhat future oriented • Limited protective factors (e.g., social support, religious prohibition, other children) • +/-Substance use • Anxiety/agitation/impulsivity • Poor self-care • Some risk factors	• Persistent thoughts of death/that life is not worth living • Current intent* • Current well-formulated plan** • Hx of multiple suicide attempts, high lethality of prior attempt(s) • Hx of multiple or recent psychiatric hospitalizations • Continuous sadness, unrelenting dread, guilt, or remorse; not eating, < 2-3 hours of sleep/night, unable to do anything, unable to feel pleasure or other feelings • Hopeless/helpless all or most of the time • Not future oriented (no plans for/cannot see future) • No protective factors (e.g., social supports, religious prohibition, other children, stable housing) • Substance use • Not receiving mental health treatment • Anxiety/agitation • Many risk factors

Tell the patient that:

"I hear that you feel distressed and overwhelmed. So much so that you're having thoughts of death and dying." (use patient's language to describe)
"When people are overwhelmed, they often feel this way. It is common."
"I'm so glad you told me. I'm here to help. There are many things we can do to help you."

Intervene and Document Plan		
LOW RISK • Treat underlying illness • Maximize medication treatment and therapy • Monitor closely **Thoughts of suicide are common. Not all patients need to be evaluated urgently or sent to emergency services, especially if risk factors are minimal and there is no plan or intent for suicide.**	**MODERATE RISK** • Treat underlying illness • Maximize medication treatment and therapy • Discuss warning signs with patient and family • Discuss when and how to reach out for help should she feel unsafe • Establish family, friends, and professional(s) she can contact during a crisis • Establish and carry out a plan for close • monitoring and follow-up (within 2 weeks)	**HIGH RISK** • Do not alarm patient (reinforce her honesty). Do not leave patient and baby alone or let them leave until assessment is complete. Call another staff member • If assessed to be at imminent risk of harm to self or others, refer to emergency services • Treat underlying illness • Maximize medication treatment and therapy • Discuss warning signs with patient and family • Discuss when and how to reach out for help should she feel unsafe • Contact family, friends, and professional(s) and establish how you and patient can contact them during a crisis • Establish a plan for close monitoring and follow-up

Ideation: Inquire about frequency, intensity, duration—in last 48 hours, past month, and worst ever
***Intent**: Inquire about the extent to which the patient 1) expects to carry out the plan and, 2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live.
****Plan**: Inquire about timing, location, lethality, access to lethal means (e.g., gun), making preparations (e.g., hoarding medications, preparing a will, writing suicide note).
Behaviors: Inquire about past attempts, aborted attempts, rehearsals (e.g., tying noose, loading gun) vs. non-suicidal self-injurious actions.

Get immediate help by calling 988, call 911 or go to the emergency room

Assessing Risk of Harm to Baby

Ask about unwanted or intrusive thoughts

Unwanted or intrusive thoughts, including those of harming the baby, are common (up to 70%) among postpartum patients. Most patients will not act on these thoughts because they are usually due to anxiety, depression, and obsessive/compulsive disorder, which is very different than thoughts of harming the baby that are due to psychosis/delusions. The following wording can be used to get information about whether these thoughts are present and how current and concerning they are.

"People often have intrusive thoughts or thoughts that seem to pop in from nowhere. Patients 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 from something too hard to bear. We are here to help you. We ask about these thoughts because they are so common."

- *Have you had any unwanted thoughts?*
- *Have you had any thoughts of harming your infant, either as an accident or on purpose?*

If the patient answers yes to the above question, follow up with:

- *How often do you have them?*
- *How recently have you had them?*
- *How much do they scare you?*
- *How much do they worry you?*

Assess Risk

LOW RISK (symptoms more consistent with depression, anxiety, and/or OCD)	MODERATE RISK	HIGH RISK (symptoms more consistent with psychosis)
• Thoughts of harming baby are scary • Thoughts of harming baby cause anxiety or are upsetting (ego dystonic) • Mother does not want to harm her baby and feels it would be a bad thing to do • Mother is very clear she would not harm her baby	• Thoughts of harming baby are somewhat scary • Thoughts of harming baby cause less anxiety • Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do • Mother is less clear she would not harm her baby	• Thoughts of harming the baby are comforting (ego syntonic) • Feels as if acting on thoughts will help infant or society (e.g., thinks baby is evil and world is better off without baby) • Lack of insight (inability to determine whether thoughts are based on reality) • Auditory and/or visual hallucinations are present • Bizarre beliefs that are not reality based • Perception that untrue thoughts or feelings are real

Consider Best Treatment

LOW RISK	MODERATE RISK	HIGH RISK
• Provide reassurance and education • Treat underlying illness • Discuss warning signs with patient and family • Discuss when and how to reach out for help should she feel unsafe	• Treat underlying illness • Discuss warning signs with patient and family • Discuss when and how to reach out for help should she feel unsafe • Establish family, friends, and professionals she can contact during a crisis • Establish and carry out a plan for close monitoring and follow-up	• A true emergency, refer to emergency services, as needed • Do not alarm patient (reinforce honesty) and do not leave patient and baby alone while help is being sought • Treat underlying illness • Discuss warning signs with patient and family • Discuss when and how to reach out for help should she feel unsafe • Establish family, friends, and professionals she can contact during a crisis • Establish and carry out a plan for close monitoring and follow-up

Get immediate help by calling 988, call 911 or go to the emergency room

Assessment and Management of Bipolar Disorder and Psychosis

Why screen for bipolar disorder?

- It is important to address bipolar disorder because 1 in 5 patients who screen positive for perinatal depression may have bipolar disorder.
- Treating with an unopposed antidepressant can induce mania, mixed states, and rapid cycling, all of which carry significant risks.
- Bipolar disorder is associated with increased risk of postpartum psychosis and postpartum psychosis is associated with suicide and infanticide.

How is bipolar disorder different from depression?

Depression	Bipolar disorder
• Depressive episodes • No mania or hypomania • Medication treatment = antidepressant	• Depressive episodes AND manic (Type I) or hypomanic (Type II) episodes • Mood stabilizers or antipsychotics can be used to stabilize mood

Ask about current psychotic symptoms

- Have you heard anything like sounds or voices or see things that others may not?
- Do you hold beliefs that other people may find unusual or bizarre?
- Do you find yourself feeling mistrustful or suspicious of other people?
- Have you been confused at times whether something you experienced was real or imaginary?

Consider bipolar disorder if any of the following are present:

- Patient reports a history of bipolar disorder
- MDQ is positive
- Patient is taking medication for bipolar disorder (e.g., mood stabilizer or antipsychotic)

Assessment of bipolar disorder:

- Assessment with a psychiatric prescriber is generally indicated due to complexity of diagnosis
- Broad DDx (e.g., includes unipolar depression, schizoaffective disorder, borderline personality disorder, PTSD). See Overview of Perinatal Mental Health Conditions in the Supplement Materials section of the toolkit

If patient cannot be assessed by a psychiatric provider in a timely manner:

- One option is to prescribe quetiapine (Seroquel) because it can treat unipolar and bipolar depression as well as mania and psychosis until patient can be assessed, and diagnosis clarified
- Start with quetiapine (Seroquel) 100mg qHS, increase by 100 mg increments as needed up to 800 mg/day

Examples of Clinical Scenarios

Case Example #1:

- Patient is on medication for bipolar disorder or psychosis
- Establish liaison with psychiatry
- Continue current meds
- If not in therapy, refer
- Psychosis does not mean she can't parent
- Not all patients with psychosis will need inpatient psychiatric hospitalization; some can be managed as an outpatient with close monitoring and follow-up

Case Example #2:

Prior history bipolar disorder

No current meds

Case Example #3:

Positive MDQ

Unidentified diagnosis

No current meds

Refer for assessment

For additional clinical guidance, contact AMHSU for Moms at 833-978-6667, Monday-Friday 9am-5pm.

Management of Bipolar Disorder and Psychosis *(continued)*

Medication Use During Pregnancy

Many mood stabilizers and antipsychotics can be used in pregnancy. Discontinuation greatly increases risk of decompensation or relapse.

Reassuring data
Do not discontinue

- Typical* or Atypical** Antipsychotics
- Lamotrigine (Lamictal)
- Lithium
  - monitor lithium levels
  - fetal echocardiogram (16-18 wks GA)

Less reassuring data
Can continue if high risk

- Carbamazepine (Tegretol)
- Oxcarbazepine (Trileptal)

Avoid
Change medication

- Valproic acid (Depakote)

Contraindicated for patients of childbearing age and pregnant and lactating patients because it can cause maternal metabolic syndrome and is a structural and neurodevelopmental teratogen

If patient is on lamotrigine, carbamazepine, or oxcarbazepine, supplement with folate 4mg/day preconception and during pregnancy and obtain a detailed ultrasound evaluation.

Medication Use During Breastfeeding

- Patient must be clinically stable to breastfeed.
- Patient and infant must receive careful treatment plans and monitoring.
- Breastfeeding is not a benefit if it is at the expense of maternal mental health.
- Most mood stabilizers and antipsychotics can be used during breastfeeding.
- Breastfeeding while taking lithium should be done with caution and necessitates close monitoring of the infant.

Reassuring data for antipsychotic use
Do not discontinue

- Typical antipsychotics*: Monitor for stiffness
- Atypical antipsychotics**: Monitor maternal and infant weight and blood sugar

Usually considered compatible with breastfeeding

- Carbamazepine (Tegretol): Monitor drug level, cbc, liver enzymes
- Lamotrigine (Lamictal): Monitor rash, drug level

Must monitor the breastfeeding infant closely for lithium toxicity

- Collaborate with infant's pediatric provider to create a monitoring plan
- Monitor infant lithium level, TSH, BUN, Creatinine at least every 6-8 weeks

Always coordinate with pediatric provider

General Management Strategies

To decrease and manage risk of decompensation:

- Prophylactically treat with a mood stabilizer and/or antipsychotic
- Develop post-birth plan (e.g., clear follow-up plan for after delivery)
- Monitor closely (patient may not recognize labor cues)
- Collaborate with newborn medicine/pediatric provider
- Develop a plan for breastfeeding
- Develop a plan to support adequate sleep (e.g., partner feeds baby at night)
- Develop a plan to support maternal-infant bonding (e.g., engage family in postpartum plan)

Mania or postpartum psychosis:
Patient needs to be evaluated by a mental health provider. This can be done through psychiatric emergency services or as an outpatient depending on acuity level and safety concerns.

*Typical Antipsychotics (1st generation) include: haloperidol [Haldol], perphenazine [Trilafon], chlorpromazine [Thorazine], loxapine [Loxitane], fluphenazine [Prolixin]
**Atypical Antipsychotics (2nd generation) include: quetiapine [Seroquel], olanzapine [Zyprexa], risperidone [Risperdal], aripiprazole [Abilify], clozapine [Clozaril]

For additional clinical guidance, contact AMHSU for Moms at 833-978-6667, Monday-Friday 9am-5pm.

SUD1

Screening and Brief Intervention for Substance Use in Pregnancy

All women should be screened for substance use at the first prenatal visit using a screening tool; e.g., the Modified NIDA Quick Screen (Modified NIDA) *(see SUD2).*

If **positive screen** on Modified NIDA, had aberrant urine test, or clinical suspicion *(see SUD2)*, woman is **at risk**

If **negative** screen, then woman is lower risk

Brief Assessment

1. "What substances have you been using in the past 3 months? During this pregnancy?"
2. "How much of each substance have you been using at a time?"
3. "How frequently are you using them?"
4. "How does this affect your life (job, home life, self-care, health, emotions)?"
5. "Are you being treated for an SUD? Have you had prior treatment?"

Educate

1. Provide brief education about recommendations to not use alcohol, tobacco, cannabis, illicit opioids, or other drugs.
2. Encourage the patient to ask for help in the future, as needed.

Stratify into risk group

High Risk

Current: Opioid use or binge pattern/heavy use of any substance(s) or relapse of any SUD

Moderate Risk

Current: Low-level use of non-opioid substances, engaged in MAT, or other SUD treatment
History: High use in past and/or past treatment for SUD

Low Risk

Current: No use
History: Low-level use prior to learning of pregnancy

Brief Intervention

1. "How ready are you to quit now?" Ask the patient to rate this motivation on a scale from 1-10.
2. "How confident are you that you can stop?" Ask the patient to rate their confidence on a scale from 1-10.
3. "Why did you rate that way?"
4. "How can we increase this score?"

Create Treatment and Monitoring Plan

1. Refer to or provide medication treatment for opioid/alcohol use (see *SUD4*)
2. Recommend non-pharmacological treatment (see *SUD3*)
3. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester
   - Urine testing at least once per trimester
   - Check CPMRS at each visit
4. Identify who will coordinate Family Care Plan (see *SUD3*)
5. Call AMH for Moms with questions

Is the patient currently misusing any substance?

Yes

Brief Intervention

1. "How ready are you to quit now?" Ask the patient to rate this motivation on a scale from 1-10.
2. "How confident are you that you can stop?" Ask the patient to rate their confidence on a scale from 1-10.
3. "Why did you rate that way?"
4. "How can we increase this score?"

Is there an active need for a referral to treatment?

Yes

Monitor and Refer to Treatment

1. Counsel on medication in pregnancy and non-pharmacological treatment (see *SUD3&4*)
2. Formulate a monitoring plan including:
   - Repeat Modified NIDA and Brief Assessment at least once per trimester
   - Urine testing at least once per trimester
   - Check CPMRS at each visit
3. If already in treatment, contact SUD provider
4. Identify who will coordinate Family Care Plan (see *SUD3*)
5. Call AMH for Moms with questions

No

Monitor

1. Repeat Modified NIDA and Brief Assessment at least once per trimester
2. Urine testing at least once per trimester
3. Check CPMRS at each visit
4. If already in treatment, contact SUD provider
5. Identify who will coordinate Family Care Plan (see *SUD3*)
6. Call AMH for Moms with questions

No

For all patients with any opioid use or on MOUD, discuss:

- Overdose prevention (see *SUD6*)
- MOUD during pregnancy/ postpartum(see *SUD4*)
- Neonatal Opioid Withdrawal Syndrome (NOWS) - a.k.a. Neonatal Abstinence Syndrome (NAS)
- Pain management (see *SUD5*)
- Family Care Plan (see *SUD3*)

MOUD: medication for opioid use disorder
SUD: substance use disorder
OUD: opioid use disorder
CPMRS: Connecticut Prescription Monitoring and Reporting System

Assessment of Substance Use in Pregnancy

SUD2

For additional information on screening please refer to Screening for Substance Use in Pregnancy on page 6 and 7 of this toolkit and visit https://www.accessmhct.com/moms/training/ for training videos.

Modified NIDA Quick Screen (Modified NIDA)					
Ask: "In the past three months, how often have you used:"					
Alcohol (four or more drinks a day)	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily
Tobacco products	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily
Prescriptions drugs not used as prescribed or any marijuana	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily
Illegal drugs	☐ Never	☐ Once or twice	☐ Monthly	☐ Weekly	☐ Daily
Any answer other than "never" is a positive screen and should prompt follow-up questions to further characterize which substance(s) are being used, the amount, and the time course (see *SUD1*).					
Adapted from the NIDA Quick Screen					

Behaviors that may warrant clinical suspicion for a substance use disorder (SUD)		
• Dose escalation • Very focused on controlled substances • Substantial effort/time/resources spent on obtaining controlled substances • Requests early refills of controlled substances • Evidence of tolerance • History of withdrawal	• Loses prescriptions for controlled substances • Requesting specific agent, route, frequency • Purchasing illicit drugs • Taking diverted opioids (taking others' prescriptions) • Multiple providers prescribing controlled substances • Mood or personality changes • Emotional lability	• Clinical signs of intoxication (confused, sedated or hyperactive, rapid or slurred speech) • Withdrawal • Evidence of tampering with IV or hoarding pills while inpatient • Crushing/injecting/snorting pills • Seeing drug use paraphernalia (e.g., syringes or pipes) • Physical signs of injection, stigmata of chronic alcohol use, intranasal irritation
Gather more history	**Monitor closely**	**Intervene**

Urine Toxicology Testing

Routine drug screening is controversial and has limited utility, it is not in itself diagnostic, and might have significant ramifications for patients.

Currently, there are no evidence-based guidelines for urine toxicology testing, and it is not superior to the use of standardized screening tools.

Limitations of urine toxicology testing:

- Only reflects recent use and detection time varies (see below).
- Drug levels vary widely depending on fluid intake, time elapsed since use and individual variation.
- They do not capture all substances (e.g., synthetic cannabinoids (K2/spice), synthetic opioids (fentanyl, carfentanil), hallucinogens.
- False-positive test results can occur with immune-assay testing and legal consequences can be devastating to the patient.

Drug	Duration of Detection
Buprenorphine	1-6 days
Methadone	Up to 14 days
Cannabinoids	Up to 60 days (chronic use)
Cocaine	1-3 days
Heroin	1-3 days
Benzodiazepines	Up to 21 days

If urine toxicology is being considered:

- It should be performed only with the patient's consent, which should be documented in the patient's chart.
- If the test is inconsistent with the patient's report a confirmatory test is necessary (e.g., gas chromatography/mass spectrometry).

Treatment Options for Perinatal Substance Use Disorder (SUD)

SUD3

How to Find Treatment and Resources

24/7 Access Line 1-800-563-4086: phone line staffed 24/7 to provide callers with information about services available including where to get an in-person assessment.

DMHAS Addiction Service Availability *[click link]***:** updated daily and provides treatment openings statewide *(see treatment setting definitions below).*

DMHAS Women's and Children's Services *[click link]***:** treatment and recovery services funded by DMHAS specific for women and their families. CT has SUD residential programs for women and their infants/children.

CT BHP MAT MAP *[click link]***:** interactive map created to locate CT prescribers of medication for substance use disorders (MOUD and AOUD) as well as other treatment services that support substance use recovery – search by name, city, or medication.

PROUD (Parents Recovering from Opioid Use Disorder) *[click link]***:** offers clinical, case management, and recovery coaching services to pregnant and postpartum women with substance use disorders and their family members.

Women's REACH Program *[click link]***:** a non-clinical program that offers recovery peer support and care coordination services to pregnant and parenting women and families impacted by substance use.

Family Care Plan (FCP)

A Family Care Plan (FCP) is a document that provides a roadmap of supports for birthing person, baby and family. This includes strategies and services that support the health and wellbeing of newborns and the substance use treatment and recovery of the birthing person**.** The FCP should be reviewed over time as the family's and infant's needs change. **Per federal legislation, people who use substances during their pregnancy should have a Family Care Plan readily verifiable at the time of birth in the event of a CAPTA notification.**

Visit **SEPI-CT** *[click link]* for more information on Family Care Plans including the FCP template.

Treatment Settings for Substance Use Disorders

Level of Care	Services Offered	Additional Notes/Perinatal Options
Outpatient	Counseling	• Individual or group • Facilitated by social workers or mental health/drug and alcohol counselors
	Medication management	• Methadone needs to be administered by a federally licensed facility. • Buprenorphine can only be prescribed by a waivered provider. • Naltrexone, acamprosate, disulfiram, or medications for smoking cessation can be prescribed by any provider *(see SUD4, SUD5).*
Intensive Outpatient	Group and Individual Counseling +/- medication	• Can be used for direct admission or as a step-down from a higher level of care and can vary in length and frequency of sessions. • Examples include: Intensive Outpatient program (IOP) and Partial Hospital Program (PHP) • CT has women's-specific IOPs that offer babysitting while mom is in program
Acute Treatment Services	Medically Supervised Withdrawal Management (Inpatient)	• Indicated for serious or dangerous physiological dependence on alcohol or benzodiazepines requiring 24/7 medical withdrawal management • Provided in a private freestanding psychiatric hospital, general hospital or state-operated facility • Tapering opioids is not recommended during pregnancy.
High-Intensity Residential Services	Step-down and non-pharmacologic withdrawal management	• Some treat co-morbid psychiatric and substance use disorder (dual-diagnosis) and include: Individual, group, family therapy, case management, and linkage to aftercare, and medication. • Some programs admit pregnant women and coordinate with prenatal care providers.
Intermediate and Low-Intensity Residential Services	Structured group living with supervision and treatment provided by addiction professionals	• Examples include intermediate residential programs, transitional living programs, and recovery houses for women. • Many programs assist with employment, parenting skills, and retaining/regaining custody of children. • Some have enhanced services for pregnant/post-partum women and their infants/young children, which include the coordination of perinatal/pediatric care. *[link to 3.5PPW]* • Individual, group therapy, case management

SUD4

Choosing a Medication for the Treatment of Opioid Use Disorder (MOUD)

Medication for Opioid Use Disorder (MOUD) with methadone or buprenorphine is the first line for treatment of OUD during pregnancy. It is important to limit the use of benzodiazepines and other sedating medications to decrease overdose risk.

Is the patient already on a medication for the treatment of opioid use disorder?

YES

Avoid changing medication during pregnancy

- Continue medications that the patient is stable on and optimize the dose.
- The patient may require dose increase as pregnancy advances and dose decrease at 2-4 weeks postpartum.
- If withdrawal symptoms emerge in the third trimester, you may need to increase total daily dose or frequency.

NO

Considerations for initiating medication

- Which medications are readily available?
- Which treatment setting can the patient get to?
- Which medication has the patient done well with before?
- What does the patient prefer?
- For all medication choices, make sure to consider implications for pain management *(see SUD5)* and neonatal withdrawal risk.

First-Line Treatments

	Mechanism	Pros	Cons	Special Considerations in Pregnancy	Lactation
Methadone	Full agonist at the Mu opioid receptor	Administered in structured setting with daily observed treatment Often includes multidisciplinary treatment such as groups and counseling	Must be prescribed through a federally licensed clinic, and clinics are not easy to access Daily observed dosing is not compatible with some work/childcare schedules. Can be sedating at higher doses	Risk of QTc prolongation Rapid metabolism in the third trimester may require dose increase and change from daily to twice daily doses. Pregnant women are eligible for expedited access to a methadone clinic. Multiple drug-drug interactions (e.g., many antiretrovirals, rifampin, phenytoin)	Translactal passage: 1-6 % of the maternal weight adjusted dose Low infant exposure should not preclude breastfeeding. Breastfeeding is encouraged in substance-exposed newborns unless there is active substance use or risk of infection.
Buprenorphine (Suboxone, Subutex, Sublocade)	Partial agonist at Mu opioid receptor High-affinity receptor binding	Office-based treatment; can get a prescription at variable intervals Not usually sedating Low risk for overdose	Must be prescribed by a waivered provider Can complicate pain management in labor (see *SUD5*)	Patient must be in mild withdrawal prior to initiation treatment May require dose increase in third trimester Buprenorphine without naloxone (Subutex) is preferred if available; less-severe neonatal opioid withdrawal	Translactal passage: 1-20 % of the maternal weight adjusted dose (only absorbed sublingually and not orally) Breastfeeding is encouraged in substance-exposed newborns unless active substance use or risk of infection.

Treatments with Less Evidence for Use in Pregnancy

Gradual taper with medication (a.k.a. "detox")	Naltrexone
• Can be done using taper of methadone or buprenorphine • Emerging data for safety in pregnancy but still not standard treatment • High risk of relapse	• Reversible binding of opioid receptor antagonist with efficacy for alcohol and opioid use • Available as oral, daily medication (Revia), and IM monthly injection (Vivitrol) • Very limited and emerging data in pregnancy • Can complicate pain management • Requires 7-10 days of abstinence from all opioids prior to starting naltrexone

SUD5

Management of Pain During and After Delivery

Pregnant patients with opioid use disorder (OUD) must be reassured that their pain during and after delivery can and will be treated. For patients on medication for opioid use disorder (MOUD), it is important to support continued treatment of pain, because adequate pain control is essential for their health and well-being.

Addressing Pain in Patients with OUD

Special considerations for patients on medication treatment for OUD:

- ✓ Medications used for treatment of OUD are not sufficient alone for pain control.
- ✓ Maintenance doses of MAT should be continued throughout labor and delivery.
- ✓ When using buprenorphine and methadone during pregnancy;
  - Increase total daily dose
  - Increase frequency of administration to 2-4x per day
- ✓ Additional opioids may be needed if non-opioid treatments are insufficient.

Buprenorphine	Methadone	Naltrexone

• Avoid butorphanol, nalbuphine, and pentazocine in all patients with OUD or chronic opioid use as these are partial agonists and can precipitate opioid withdrawal.
• If using additional opioids for pain, the patient may require higher doses due to the buprenorphine-blocking effect(high-affinity).
	• Avoid butorphanol, nalbuphine, and pentazocine in all patients with OUD or chronic opioid use as these are partial agonists and can precipitate opioid withdrawal.
	• Confirm the dose with the provider and notify the provider of all pain medications given.
	• Baseline dose is not sufficient for analgesia.
	• Pain relief can be achieved with additional doses of methadone; split dose three times per day.
	• If the patient is NPO, methadone can be given by IV, IM, or SC (if IM or SC, give half the dose divided 2-4 times per day).
		• Blocks the analgesic effects of opioids:
		  ○ Oral naltrexone blocks analgesia for 72 hours after last dose.
		  ○ IM (depot) blocks analgesia for 14-25 days
		• For acute pain management favor regional and non-opioid options.

Optimize non-opioid medication options:

- Acetaminophen
- NSAIDs (e.g., ibuprofen, ketorolac)
- Ketamine, if available
- Neuraxial or regional blocks

Optimize non-medication treatment options:

- Mindfulness
- Meditation
- Hypnosis
- Massage
- Heat/Ice
- Cognitive Behavioral Therapy (CBT)
- Physical therapy/light exercise
- Biofeedback

Opioids can be used if the above strategies do not work (*see Opioid Overdose Prevention SUD6 regarding safe opioid prescribing*).

Managing Medications for Opioid Use Disorder (MOUD) during the Perioperative/Postpartum Period

The dose of buprenorphine or methadone may need to be increased throughout the pregnancy.

- Due to metabolic changes during pregnancy, it is common to have to increase the frequency of methadone and buprenorphine dosing; this can be continued post-delivery while pain management is challenging.
- Metabolism gradually returns to the pre-pregnancy state in the 2-4 weeks postpartum, so dosing needs to be decreased to pre-pregnancy dosing, and pain and sedation levels should be monitored.

Prior to delivery, collaborate with anesthesia colleagues to plan intrapartum pain management.

- Use a regional analgesia if possible (epidural or spinal, regional blocks if appropriate).
- Maximize non-opioid pain relief (avoid NSAIDs prior to delivery).
- Pain must be treated adequately to enable mobility for newborn care and breastfeeding.

Continue methadone and buprenorphine during labor and cesarean or vaginal delivery.

- Do not stop MOUD at the time of delivery because it puts patients at increased risk for relapse and restarting MOUD in the postpartum period is challenging.

Continuation of MOUD in Postpartum period

- Avoid discontinuation of MOUD in 6-12 months to minimize risk of relapse/overdose during this high-risk time.

Opioid Overdose Prevention

SUD6

Opioid overdose is a leading cause of preventable maternal mortality in Connecticut. Opioid use disorder (OUD) greatly increases the risk of death by overdose up to 12 months postpartum.

Safe Opioid Prescribing	
Ensure the patient and caregivers have access to naloxone.	Prescribe a short duration of narcotic medication (3-7 days).
Use short-acting/immediate-release opioids at the lowest effective dose.	Discuss safe storage and disposal of opioid medication to limit risk for diversion and overdose.
Perform urine drug monitoring for patients taking opioids (confirm use of prescribed medication, and check whether the person is taking other illicit agents).	Engage the patient in an agreement for close monitoring.
Check Connecticut's Prescription Monitoring Program: https://portal.ct.gov/DCP/Prescription-Monitoring-Program/Prescription-Monitoring-Program	

Risk Factors for Opioid Overdose

- Combining use of opioids with other drugs (e.g., benzodiazepines or alcohol)
- A recent period without any opioid use – high risk of this with postpartum relapse because of the loss of opioid tolerance
- Contamination of illicit drugs with other active substances (e.g., heroin is often contaminated with fentanyl)
- Medical risks for respiratory depression (e.g., history of respiratory disease/infection, on other sedating medications)
- Previous overdose(s)
- Using alone

Naloxone (Narcan)

Naloxone is an opioid antagonist that reverses the effects of opioid intoxication.

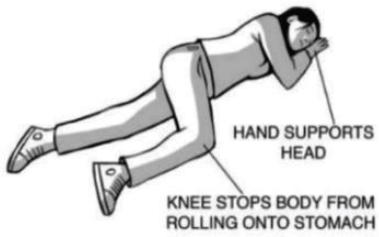
The goal of administering naloxone is to restore respiration and prevent death related to opioid overdose.

Naloxone is most commonly administered intra-nasally.

Prescribe naloxone to all patients at risk for overdose.

Teach patients and friends/family supports how to administer nasal naloxone. Keep Naloxone in the home for those on MOUD and those with an SUD in case of an overdose or accidental ingestion by infant, child or other family member.

Encourage patients and friends/families to download the NORA - Naloxone + Overdose Response App on their phone: https://egov.ct.gov/norasaves/#/HomePage. This is a free app from the CT Department of Public Health that provides information on opioids, recognizing the symptoms of a suspected opioid overdose, and instructions on administering naloxone when needed.

How to Identify an Overdose	Steps to Manage an Overdose	Recovery Position
• Pinpoint pupils • Decrease/absent breathing • Unresponsiveness to loud voice or sternal rub • Body goes limp • Heart rate slows or stops • May have a blue color to skin or nails Counsel patients and their supports about how to identify an overdose.	1. Call 911 and stay until EMS arrives. 2. Remove the kit from packaging (two sprays per kit). 3. Hold nasal spray with your thumb on the bottom of the plunger and two fingers on either side of the nozzle. 4. Insert the tip of the nozzle into either nostril until your fingers touch the bottom of the person's nose. 5. Press the plunger firmly to deliver the first dose. 6. Remove nasal spray. 7. Wait 3 minutes; if there is no response, administer the second dose in the alternate nostril. 8. Place the patient in the recovery position. Advise the person not to place the victim in an ice or water bath, induce vomiting, or try to wake by slapping/hitting.	

Connecticut's Good Samaritan Law protects people who call 911 seeking emergency medical services for an overdose from arrest for possession of drugs/paraphernalia.

SUD7

Impact and Management of Substance Use during the Perinatal Period

OPIOIDS			
Risks of Maternal Use	**Acute Intoxication**	**Withdrawal**	**Ongoing Management**
Fetal effects: Opioids do not cause structural fetal abnormalities. However, opioid use during pregnancy is associated with intrauterine growth restriction, fetal demise, meconium leakage/aspiration, and preterm labor. **Neonatal effects:** Neonatal Abstinence Syndrome (NAS)/Neonatal Opioid Withdrawal Syndrome (NOWS), hypotonia, respiratory depression at delivery **Maternal effects:** Postpartum hemorrhage, risk of maternal overdose (mortality increases first year postpartum)	**Symptoms:** Sedation**,** euphoria**,** decreased respiration **Management:** Naloxone (Narcan), monitoring respiratory status	**Symptoms:** Nausea, vomiting, diarrhea**,** abdominal muscle pain, leg cramping**,** rhinorrhea, lacrimation, recklessness, sweating, anxiety, hot and cold flashes, tachycardia, and yawning **Management**: Initiate agonist therapy to decrease risk for relapse. There is mixed data regarding the negative impact of maternal opioid withdrawal.	Pharmacologic treatment is the first line to decrease relapse risk. **Methadone** can only be obtained through a federally licensed clinic. **Buprenorphine (Suboxone, Subutex)** must be prescribed by a waivered provider. Psychosocial treatments like peer supports, counseling, and sober living should be offered concurrently.

ALCOHOL			
Risks of Maternal Use	**Acute Intoxication**	**Withdrawal**	**Ongoing Management**
Fetal effects: Spontaneous abortion, pre-term labor, stillbirth, intrauterine growth restriction **Neonatal effects:** Fetal Alcohol Spectrum Disorder (FASD) and other developmental/ behavioral problems, intoxication, withdrawal, Sudden Infant Death Syndrome (SIDS) **Maternal effects:** Hepatic/pancreatic toxicity, physiologic dependence, risks of injuries/falls	**Symptoms:** Disinhibition, sedation, slowed reaction time, vomiting, loss of coordination, sedation/loss of consciousness **Management:** IV fluids (supplement with multi-vitamin thiamine and folate)**,** prevention of physical injury	**Symptoms:** Rapid heart rate, increased blood pressure, tremor, anxiety, flushing, diaphoresis, nausea, hallucinosis, delirium tremens, and seizures **Management:** Benzodiazepine taper. Lorazepam (Ativan) is preferred over other benzodiazepines. If the patient is using benzodiazepines, manage the taper with same medication being used. There is limited data regarding the impact of withdrawal on pregnancy. The setting for withdrawal management is individually determined based on obstetric status, gestational age, and medical and psychiatric comorbidity.	**Naltrexone:** Emerging data suggests low risk of adverse birth outcomes. **Disulfiram (Antabuse):** Not recommended for use in pregnancy due to risk of fetal malformation and severe reaction with ETOH use **Acamprosate (Campral):** No human pregnancy data Psychosocial treatments such as peer supports, counseling, or sober living should be offered concurrently.

<table>
<tr><th colspan="4">BENZODIAZEPINES</th></tr>
<tr><th>Risks of Maternal Use</th><th>Acute Intoxication</th><th>Withdrawal</th><th>Ongoing Management</th></tr>
<tr><td rowspan="2">Fetal effects: Not teratogenic, can slow fetal movement

Neonatal effects: Preterm birth, low birth weight, low apgar, withdrawal syndrome, admission to NICU

Maternal effects: Physiologic dependence, worsening of depression and anxiety, cognitive decline</td><td>Symptoms: Anxiolysis, euphoria, amnesia, disinhibition and symptoms similar to alcohol intoxication</td><td>Symptoms: Rapid heart rate, increased blood pressure, tremor, anxiety, flushing, diaphoresis, nausea, hallucinosis, delirium tremens, and seizures</td><td rowspan="2">The primary goal is to manage underlying symptoms and psychiatric comorbidity. Psychosocial treatments such as peer supports, counseling, or sober living should be offered concurrently.</td></tr>
<tr><td>Management: Flumazenil can be used to reverse acute overdose, though it is associated with increased risk of seizure, and there is no human pregnancy or lactation data.</td><td>Management: Benzodiazepine taper. Lorazepam (Ativan) is preferred but may also use the same agent patient is dependent on. If using benzodiazepines, manage the taper with the same medication being used. There is limited data regarding the impact of alcohol or benzodiazepine withdrawal on pregnancy. The setting for withdrawal management is individually determined based on obstetric status, gestational age, and medical and psychiatric comorbidity.</td></tr>
<tr><th colspan="4">CANNABIS</th></tr>
<tr><th>Risks of Maternal Use</th><th>Acute Intoxication</th><th>Withdrawal</th><th>Ongoing Management</th></tr>
<tr><td rowspan="2">Fetal effects: Intrauterine growth restriction, placental abruption, increased risk for still birth

Neonatal effects: Transient hypertonia, irritability, hyperreflexia. Vasoconstriction can increase the risk of necrotizing enterocolitis. There is mixed data on neurodevelopmental impact.

Maternal effects: Hypertension and coronary vasospasm, pregnancy loss</td><td>Symptoms: Euphoria, agitation, hyperactivity, anxiety, disorientation, confusion, and psychosis Risk for placental abruption with binge use</td><td>Symptoms: Sedation/somnolence, dysphoria, vivid dreams</td><td rowspan="2">Anti-craving agents such as topiramate, tiagabine, and modafinil are used in non-perinatal patients, however, have not been well studied in pregnancy and lactation.

Psychosocial treatments are the primary evidence-based treatment – peer supports, counseling, and sober living.</td></tr>
<tr><td>Management: If severe, manage agitation with benzodiazepines or antipsychotic. Acute intoxication can confound assessment of vital signs and management of labor.

Avoid beta blockers.</td><td>Management: Supportive care: symptomatic treatment for physical symptoms, otherwise does not require pharmacologic treatment</td></tr>
<tr><th colspan="4">TOBACCO</th></tr>
<tr><th>Risks of Maternal Use</th><th>Acute Intoxication</th><th>Withdrawal</th><th>Ongoing Management</th></tr>
<tr><td>Fetal effects: Smoking is associated with spontaneous abortion and intrauterine growth restriction. Nicotine is associated with miscarriage and stillbirth.</td><td>Symptoms: Acute use can result in increased heart rate, blood pressure, and GI activity.</td><td>Symptoms: Cessation has been associated with cravings, anxiety, insomnia, and irritability.</td><td>Quitting is the goal, but cutting down has benefits. Nicotine replacement should be used with a goal of cessation, not for ongoing and/or concurrent use.</td></tr>
</table>

Neonatal effects: Preterm birth, low birth weight**,** SIDS, persistent pulmonary hypertension of the newborn **Maternal effects:** Increased risk of deep vein thrombosis, pulmonary embolism, stroke, respiratory illness	**Management:** Supportive care is generally sufficient.	**Management:** Nicotine replacement can help with acute withdrawal, with the goal of eventual, gradual taper.	**E-cigarettes:** not well studied in pregnancy **Bupropion:** minimally effective **Varenicline:** effective, but limited pregnancy data Connecticut Quitline offers free phone counseling

Quick Reference Guide

ACCESS Mental Health for Moms

Overview of Perinatal Mental Health Conditions

Call ACCESS MH for Moms: 833-978-6667

	Baby Blues	Unipolar or Major Depression	Bipolar Disorder
What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason. This is not considered a psychiatric illness.	Depressive episode that occurs during pregnancy or within a year of giving birth.	Bipolar disorder, also known as manic-depressive illness, is a brain condition that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to- day tasks.
When does it start?	First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.	Most often occurs in the first 3 months postpartum. May also have started before pregnancy or begins during pregnancy, after weaning baby or when menstrual cycle resumes.	The average age-of-onset is about 25, but it can occur in the teens, or more uncommonly, in childhood. Some women can have a first onset in pregnancy or in the postpartum period.
Susceptibility factors	N/A	Personal history of depression or postpartum depression. Family history of postpartum depression. Fetal/newborn loss. Lack of personal/ community resources. Substance use/addiction. Complications of pregnancy, relationship stress, labor/delivery, or infant's health. Unplanned pregnancy. Domestic violence or abusive relationship. Adverse Childhood Experiences (ACEs).	No single cause. Likely that many factors contribute to the illness or increase risk (e.g., brain structure and functioning, genetics and family history).
How long does it last?	A few hours to two weeks.	2 weeks to a year or longer. Symptom onset may be gradual.	Lifelong, can be well-managed
How often does it occur?	Occurs in up to 85% of women.	One in seven women.	The condition affects men and women equally, with about 2.6% of the U.S. population diagnosed with bipolar disorder and nearly 83% of cases classified as severe.
What happens?	Dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Baby blues is a risk factor for postpartum depression.	Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms. Thoughts of harming baby. Low self-care.	Manic or hypomanic episodes alternate with depressive episodes.
Resources and treatment	Resolves on its own. Resources include support groups, psychoeducation and sleep hygiene (asking/accepting others' help during nighttime feedings). Address infant behavioral dysregulation - crying, sleep, feeding problems - in context of perinatal emotional complications.	For depression, treatment options include individual therapy, dyadic therapy for mother and baby, group therapy, and medication treatment. Encourage self-care, and engagement in social and community supports. Encourage sleep hygiene and asking/accepting help from others during nighttime feedings.	Bipolar disorder responds well to treatment with individual therapy and medication management. Encourage stability in daily routine and sleep hygiene and asking/accepting help from others during nighttime feedings. Emphasize consistency with medication regime, as early hypomanic episodes can be associated with medication non-compliance and overall decompensation.

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ACCESS Mental Health for Moms

Overview of Perinatal Mental Health Conditions

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	Perinatal Anxiety Disorders	Schizoaffective and Schizophrenia	Postpartum Psychosis
What is it?	A range of anxiety disorders, including generalized anxiety, panic, and social anxiety, experienced during pregnancy or the postpartum period.	Schizoaffective disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression. Schizophrenia is a psychotic illness without mood episodes.	Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous. Psychotic symptoms include auditory hallucinations, delusions, paranoia, disorganization, and rarely visual hallucinations. May put baby at risk.
When does it start?	Immediately after delivery to 6 weeks postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes. May have been untreated before.	Symptoms of schizoaffective disorder and schizophrenia usually start between ages 16 and 30.	Onset is usually between 24 hours to 3 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.
Risk factors	Personal history of anxiety. Family history of anxiety. Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby). Prior pregnancy loss. Adverse childhood experiences (ACEs).	The exact causes of schizoaffective disorder and schizophrenia are not known. A combination of factors may contribute to development of either condition (e.g., genetics, variations in brain chemistry and structure, and environment).	Bipolar disorder, history of psychosis, history of postpartum psychosis (80% will relapse), family history of psychotic illness, sleep deprivation, medication discontinuation for bipolar disorder (especially when done quickly). Prior pregnancy loss.
How long does it last?	From weeks to months to longer.	Lifelong, can be well-managed	Until treated.
How often does it occur?	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in 0.5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2 to 7% of early postpartum women.	1% of the population is diagnosed with schizophrenia. One in every 200 people (0.5%) develops schizoaffective disorder.	Occurs in 1- 3 in 1,000 births.
What happens?	Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts. Fear of going out. Checking behaviors. Bodily tension. Sleep disturbance.	Schizoaffective disorder: hallucinations, delusions, disorganized thinking, depressive and/or manic episodes. Schizophrenia: hallucinations, delusions, thought disorder, disorganized thinking, restricted affect, and cognitive symptoms (e.g., poor executive functioning skills, trouble focusing, "working memory" problems).	Mood fluctuation, confusion, marked cognitive impairment. Bizarre behavior, insomnia, visual and auditory hallucinations and unusual (e.g., tactile and olfactory) hallucinations. May have moments of lucidity. **May include altruistic delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately.**
Resources and treatment	Treatment options include individual therapy, dyadic therapy for mother and baby, and medication treatment. Encourage self-care, exercise, and nutritious eating. Behavioral exercises can be taught to decrease nervous system dysregulation. Encourage engagement in social and community supports (including support groups). Address infant behavioral dysregulation as needed.	These conditions can be well managed with a careful regimen of medication and support. Medication should be continued during pregnancy and closely monitored by a psychiatric provider in combination with outpatient therapy or support groups. When well-managed, women with these conditions can absolutely be skillful and caring parents.	**Requires immediate psychiatric help. Hospitalization usually necessary.** Medication is indicated. If history of postpartum psychosis, preventative treatment is needed in subsequent pregnancies. Encourage sleep hygiene for prevention (e.g., consistent sleep/wake times, help with feedings at night). When well-managed, women with these conditions can absolutely be skillful and caring parents.

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ACCESS Mental Health for Moms

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	Borderline Personality Disorder	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder (OCD)
What is it?	Borderline personality disorder is a condition marked by an ongoing pattern of varying moods, self-image, and behavior. Women often display impulsive actions and problems in relationships. People with borderline personality disorder may experience intense fluctuating feelings. **This is not a mood disorder, yet women are often misdiagnosed with bipolar disorder.** Borderline personality disorder is a pervasive, developmental condition that is not specific to peripartum period.	Distressing anxiety symptoms experienced after traumatic event(s). Symptoms generally cluster around intrusion, avoidance, hyperarousal, and negative world view.	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. May include rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.
When does it start?	Begins early and develops through life, though symptoms typically manifest in late adolescence or young adulthood. However, many women go through their entire lives without an accurate diagnosis.	Onset may be related to labor and delivery process, traumatic delivery, or poor OB outcome. Underlying PTSD can also be worsened by traumatic birth.	1 week to 3 months postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes. May also occur in pregnancy.
Risk factors	The cause of borderline personality disorder is not clear. Research suggests that genetics, brain structure and function, and environmental, cultural, and social factors play a role, or may increase the risk for it. Adverse childhood experiences (ACEs) are also associated with borderline personality disorder.	Depression or trauma/stress during pregnancy, obstetrical emergency, subjective distress during labor and birth, fetal or newborn loss, and infant complication. Prior trauma or sexual abuse. Lack of partner support. History of ACEs.	Personal history of OCD. Family history of OCD. Comorbid depression. Panic or generalized anxiety disorder. Premenstrual dysphoric disorder. Prior pregnancy loss. Preterm delivery. Cesarean delivery. Postpartum worsening.
How long does it last?	Until treated.	1 month or longer.	From weeks to months to longer.
How often does it occur?	Occurs in 6.2% of women.	Occurs in 2-15% of women. Occurs after childbirth in 2-9% of women.	Occurs in up to 4% of women.
What happens?	May experience mood swings and display uncertainty about how they see themselves and their role in the world. Tend to view things in extremes, such as all good or all bad. Their opinions of other people can also change quickly, leading to intense and unstable relationships. Rejection sensitivity, anger, paranoia, self-harm, and impulsivity may be seen.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event. Constantly feeling keyed up.	Disturbing repetitive and invasive thoughts (which may include harming baby), compulsive behavior (such as checking) in response to intrusive thoughts, or in an attempt to make thoughts go away.
Resources and treatment	The gold standard treatment is Dialectical Behavior Therapy (DBT). DBT uses individual, group, and phone therapy to teach mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills to help manage symptoms. Medication can also be helpful in addressing other untreated mental health conditions. A typical course of DBT lasts one year. Treatment is accessible through many community mental health outpatient settings.	Treatment options include individual therapy and group therapy. Encourage self-care, exercise, and healthy eating. Monitor avoidance patterns and emphasize engagement in social and community supports (including support groups). Follow up traumatic birth experiences with women.	OCD can be successfully treated with a combination of behavior therapy and medication. Encourage consistency with daily routines that include self-care and exercise and nutritious diet. Encourage engagement in social and community supports (including support groups). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings.

Patient Resources

If you need clinical guidance and/or support for your patient in connecting to local resources and referrals in Connecticut, contact **ACCESS Mental Health and Substance Use for Moms at 833-978-6667, Monday-Friday 9am-5pm**.

Educational Resources for Patients and Families

Resources from the National Institutes of Health: Moms' Mental Health Matters
Order FREE copies or download a PDF of these materials at
https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/materials

All materials are FREE and available in English and Spanish.

Posters:

- What if the "happiest time of your life" doesn't feel so happy?
- You're Prepared for ALMOST Anything…

Tear Pad: The Action Plan for Depression and Anxiety Around Pregnancy Tear Pad is designed for patients to understand the signs of depression and anxiety and take steps to feel better.

Postcard: The Conversation Starter Postcard is for partners and family members who are concerned about a loved one. It offers ways to provide support.

Resources from Postpartum Support International (PSI)
Download and print materials for free or order copies (charges apply), available in English and Spanish.

DVD: http://www.postpartum.net/resources/psi-educational-dvd/
Healthy Mom, Happy Family: Understanding Pregnancy and Postpartum Mood and Anxiety Disorders: Four women who have suffered and recovered from perinatal mood disorders share their experiences and help reassure and educate new mothers, their family members and friends, and health care professionals. Their poignant stories are complemented by up-to-date information from experts in the field. Movie length: 13 minutes.

Brochure: http://www.postpartum.net/resources/psi-brochure/
A resource about perinatal mood and anxiety disorders for families, groups, clinics, and hospitals.

Posters: http://www.postpartum.net/resources/psi-awareness-poster/
Raise awareness of pregnancy and postpartum mental health and provide messages of help and hope.

Resources for Fathers: http://www.postpartum.net/get-help/resources-for-fathers/

Resources from the American College of Obstetricians and Gynecologists

Frequently Asked Questions (FAQs): Print the PDF for free.

- Postpartum Depression: https://www.acog.org/Patients/FAQs/Postpartum-Depression

Pamphlets: Order copies (charges apply)

- Postpartum Depression: This pamphlet explains the difference between postpartum blues and postpartum depression; reasons for postpartum depression; signs and symptoms; and

treatment and prevention. https://www.acog.org/store/products/patient-education/pamphlets/labor-delivery-and-postpartum-care/postpartum-depression

Resources from Substance Exposed Pregnancy Initiative of Connecticut (SEPI-CT)

Videos:

- Pregnancy and Substance Use Disorder
- Secure Storage of Medication and Other Substances
- What is a Family Care Plan?

Handouts:

- CAPTA and Family Care Plan Patient/Client Quick Guide
- Naloxone is Safe for Everyone

ACTION PLAN FOR MOOD CHANGES DURING PREGNANCY or AFTER GIVING BIRTH

Feeling down, mood swings, feeling anxious, overwhelmed, and scared are very common for women during and after pregnancy. If your feelings are impacting your life or your ability to care for you or your baby, we want to make sure you have the resources and support you need. If a few of these feelings sound like you, see below for what you can do.

If you…	You may be experiencing changes that happen to many pregnant individuals and new parents. You should…
Feel like you just aren't yourself Have trouble managing your emotions (ups and/or downs) Feel overwhelmed, but are still able to care for yourself and your baby Feel mild irritability Have slight difficulty falling asleep Have occasional difficulty focusing on a task Are less hungry than usual	Take special care of yourself. Get your partner to watch the baby, get a babysitter, or team up with another person to share childcare so that you can rest and exercise. Continue to watch for the signs of emotional mood changes in the yellow and red sections below. Talk to your partner, family, and friends about these feelings so they can help you. Call our practice. Your mental health is important to us. We are here to help.

If you…	You may be experiencing emotional changes during or after your pregnancy for which you should get help. You should…
Feel intense uneasiness that hits with no warning Feel foggy and have more difficulty completing tasks than usual Notice that you have stopped doing things that you used to enjoy Have scary or upsetting thoughts that don't go away Feel guilty, or are having thoughts that you are failing at motherhood Are having difficulty falling or staying asleep (that doesn't have to do with getting up with your baby) Are falling behind with your job or schoolwork, or struggling in your relationships with family and/or friends Have family/friends mention that your mood seems off, or you're not acting like your usual self Are being overwhelmed by feelings of worry Have periods of feeling really "up," and overly happy where you are doing more activities than usual, then feel very sad, "down," or hopeless Are taking risks you usually wouldn't Are on edge or always looking out for possible danger/threats Feel numb or detached, like you are just going through the motions Have no interest in eating – food tastes like nothing Have thoughts of hurting yourself	Call our practice. Your mental health is important to us. We are here to help. Call Postpartum Support International (PSI) 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), to contact a volunteer who can provide support and resources in your area, or search online for a mental health provider at https://psidirectory.com/ National Maternal Mental Health Hotline can help – 24/7 – call or text **1-833-852-6262 (1-833-TLC-MAMA)**

If you…	Get help now!
Feel hopeless and in total despair Feel out of touch with reality (you may see or hear things that other people don't) Feel that you may hurt yourself or your baby Have family/friends that are worried about your or other's safety due to your mood swings and/or changes in activity levels	Go to the local emergency room or dial **911 immediately**. If you are experiencing difficult or suicidal thoughts dial **988** for mobile crisis services. Text the Crisis Line at **741741 (US)** Still not sure what to do? Call us and we'll figure it out together

Getting help is the best thing you can do for yourself and your baby. Your mental health is important to us, please call us with any concerns or questions. We are here to help.

Self-Care Plan

When you're pregnant or have a baby, your life can feel very different. It's normal to feel overwhelmed, stressed, or sad. It can be tough to deal with problems when you're feeling down and low on energy. Creating a self-care plan can be helpful for taking care of yourself and your baby's needs.

1. **Simple goals and small steps**. Break your goals down into small steps and give yourself credit for each step you finish.

2. **Make time for pleasurable activities**. Commit to scheduling a simple and enjoyable activity each day. Things I find pleasurable include:

_____ _____

_____ _____

During this week, I will spend at least _____minutes doing (choose one or more activities to try):

_____ _____

3. **Stay physically active**. Make time to move your body and be active, even if it's only a few minutes.

During this week, I will spend at least _____minutes doing (write in ways you'll be active):

_____ _____

_____ _____

4. **Ask for help**. Look to the people in your life who may help you – for example, your partner, your parents, other relatives, your friends.

People I can ask to help me:

_____ _____

_____ _____

During this week, I will ask at least _____person/people for help.

5. Talk or spend time with people who can support you. Explain to friends or loved ones how you feel. If you can't talk about it, that's OK – you can still ask them to be with you or join you for an activity.

People I find supportive:

_____ _____

_____ _____

During this week, I will contact (name/s):

_____ _____

_____ _____

And try to talk with them _____times.

6. **Belly breathing** is about breathing in a certain way that triggers your body's natural calming response.
   - Begin by slowly bringing your breath to a steady, even pace.
   - Focus on breathing in from the very bottom of your belly, almost as if it's from your hips/pelvis.
   - See if you can breathe in a way that makes your belly stick out on the in-breath and deflate totally on the out-breath. Your chest and shoulders should stay quite still. It's all about breathing with your belly.
   - Any amount of time you can find to do this can help. Aim to practice for 10–15 minutes at least 2x/day.

7. **Mindful breathing** helps bring awareness into the present moment using our body's natural rhythm of breath. Bring your attention to your own natural rhythm of breath.
   - Notice physical sensations with breathing, such as the textures of clothing, feet on floor, or movement of your body.
   - When your mind offers a distraction, notice it and bring your attention back to the physical sensation of natural breath. Try and notice the temperature of the in-breath and out-breath. Notice the precise moment in the rhythm where an in-breath becomes an out-breath.
   - Practice this when you feel like you could use some present-moment grounding.

8. **Sleep is a very important part of self-care**. Here are some tips to help you sleep better at night:
   - Watch how much caffeine you take in. Caffeine stays in the body for 10–12 hours. Consider limiting coffee, tea, soda, chocolate, and energy drinks – and setting a cutoff point during the day (such as lunchtime) to stop drinking or eating caffeine.
   - Set a routine. Set regular times for going to bed and waking up, even if you slept poorly the night before. Set up a relaxing routine 1–2 hours before bed where you do something calming and limit your exposure to electronics and light. Getting into a routine will train your body to prepare for sleep near bedtime.
   - Keep the bedroom mellow. Only use your bed for sleep and sexual activity. This helps your body link the bed with sleep rather than other things that keep you awake. Keep your bedroom dark and cool and move your clock to prevent you from constantly checking it throughout the night.

Safety Plan

A suicidal crisis can be hard to predict. Sometimes, these thoughts can come on suddenly, but often they go away on their own. Safety planning is a way to help you become more aware of your feelings when a crisis is building so you can act as soon as possible to decrease your distress and get through the suicidal crisis safely.

My Warning Signs

What thoughts, moods, images, situations, and/or behaviors tell me I might be headed for crisis?

1.

2.

3.

My Coping Strategies

What can I do on my own to take my mind off of my problems? (examples: journaling, exercise)

1.

2.

3.

Who can provide a positive distraction for me when I am feeling bad? (name/contact#)

1.

2.

What places or social settings can provide a positive distraction when I am feeling bad?

1.

2.

My Environmental Safety

Research has shown that **limiting access to dangerous objects saves lives**.

Please review the Suicide Prevention Resource Center handout on limiting access to lethal means. **https://www.sprc.org/sites/default/files/Handout-WhatClientsOrFamilies.pdf**

My Crisis Response

Who can I ask for help to get me and my baby safely through the crisis? (name/contact #)

1.

2.

3.

What is the name and contact number for my doctor, therapist, and/or can I ask for help to get me safely through the crisis? (name/contact #)

1.

2.

3.

What are my reasons for living?

1.

2.

3.

We recommend having your **safety plan** somewhere **you can see it** and access it when you are at risk of a suicidal crisis. Post a copy at home and keep a copy with you. You can take a picture of your safety plan on your phone, have a hard copy, or download a safety planning mobile app on your phone. You can search "Safety Plan" in your app store and see which ones have the components of our recommended safety plan here. **Do whatever it takes to stay safe and make it through the crisis. You are worth it.**

What are urgent/crisis resources if I am in need ?

If you are feeling overwhelmed, sad, or anxious and need someone to talk to, call or text the National Maternal Mental Health Hotline for free and confidential support: **1-833-TLC-MAMA** (1-833-852-6262)

If you are concerned about alcohol or substance misuse, call **Connecticut's 24/7 Substance Use Services Access Line 1-800-563-4086**

If you are experiencing difficult or suicidal thoughts **dial 988** for mobile crisis services.

If you are experiencing a life-threatening situation, **dial 911** immediately.