Substance Use and Mental Health Disorders in Perinatal Individuals:

A Toolkit for Substance Use Disorder Treatment Providers

Massachusetts Child Psychiatry Access Program
MCPAP For Moms

MCPAP for Moms Substance Use Disorder (SUD) Provider Toolkit

MCPAP for Moms is a perinatal psychiatry access program which promotes maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery, to effectively prevent, identify, and manage mental health and substance use disorder concerns.

MCPAP for Moms developed this toolkit tailored specifically to the unique needs of multidisciplinary SUD providers and programs serving perinatal individuals. This toolkit is meant to be a quick reference resource about mental health and SUD specific to perinatal individuals. For individualized guidance or consultation call MCPAP for Moms or consult with the individual's treatment team.

Target audience: Multidisciplinary SUD providers including prescribers, clinicians, counselors, and peer recovery coaches from various program types and levels of care providing treatment for individuals diagnosed with substance use disorders

Perinatal: MCPAP for Moms defines the perinatal period as pregnancy and up to one year postpartum.

MCPAP for Moms is available to support providers and patients in Massachusetts.

To request a peer-to-peer phone consultation: Prescribers (or a team member on their behalf) can reach out to MCPAP for Moms to initiate a consultation with a perinatal psychiatrist.

To request help referring an individual to additional resources: Any member of an SUD team can call to request a list of resources for their perinatal patient/client. Resources can include support groups and/or therapists addressing areas such as perinatal loss, perinatal mood and anxiety disorders, perinatal co-occurring disorders, and infertility.

To schedule a training: We can customize educational offerings based on the needs of each program, including webinar and video conference options.

To access these services and/or schedule a training, please call
855-MOM-MCPAP (1-855-666-6272)
Mondays – Fridays, 9 a.m. – 5 p.m.
Or go to our website, www.mcpapformoms.org.

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Preparing your Client for Perinatal Care: An Overview for SUD Treatment Providers

MCPAP for Moms recommends substance use disorder providers encourage clients involved in any phase of pregnancy (i.e., preconception, all three-pregnancy trimesters, and postpartum up to one year) to discuss with all of their providers what to expect at each of these phases.

1 Medication for SUD and mental health needs during pregnancy and postpartum

- Discourage abrupt discontinuation of any medications. Recommend discussing any concerns with a provider.
- Call MCPAP for Moms with questions.

2 Screening and testing for substances

- Prenatal care providers may screen individuals for SUD with a validated questionnaire at initial OB visit and at various points throughout the pregnancy.
- Encourage patients to talk to their prenatal care provider about what types of lab testing will occur, how frequently to expect these tests, and any potential responses to the results.

3 Plan of Safe Care (POSC) and Department of Children and Families (DCF)

- Encourage the patient to talk with their provider about birthing center policies related to substance-exposed newborns (SEN), including filing a report (51A) with DCF and performing drug tests.
- Even if the exposure is related to medication for opioid use disorder (MOUD), in Massachusetts birth centers will typically file a report with DCF.
- Any provider involved in the patient's care can initiate a POSC, regardless of specialty.

The **POSC** is a living document created jointly by perinatal individuals and their treatment providers to enhance the collaboration and coordination of their treatment and care. DCF will ask if a POSC exists at the time any report is filed. For more information and a POSC template, follow the link below. *http://www.healthrecovery.org/safecare*

4 Labor/Delivery

- Patients with OUD may require higher doses of pain medication due to many factors, including tolerance, the effects of MOUD, and pregnancy.
- Medications used for treatment of OUD are not sufficient alone for pain control. Continue maintenance doses of MOUD throughout labor and delivery. If additional pain management is necessary postpartum consider increasing the dose of MOUD or offer additional treatment options.
- Recommend patients on MOUD and/or untreated OUD proactively discuss with their prenatal care provider a birth and pain management plan. Suggest that they inquire about a consultation with the anesthesia team.
- For more information, obstetric and anesthesia providers can reference *Management of Pain During and After Delivery (page 5)*.

5 Breastfeeding and the Postpartum Period

- Breastfeeding is an important part of treatment of neonatal opioid withdrawal syndrome (NOWS) and has benefits for both infant and the breastfeeding parent.
- Breastfeeding is encouraged in substance-exposed newborns unless there is active substance use or risk of infection.
- Most medications will pass into breastmilk, though this does not preclude one from breastfeeding while taking medication. Check with obstetric and psychiatric provider when discussing birth/postnatal plan. *
- After delivery, MOUD dosing may require adjustment to meet individual needs.

6 Neonatal Opioid Withdrawal Syndrome (NOWS) and Substance exposed newborns (SEN)

- A substance-exposed newborn is not born with an addiction but may have varying levels of physical dependence depending on the medication used. Reassure patient that neonatal opioid withdrawal syndrome is common and can be easily managed with a combination of comfort measures and medication.
- Breastfeeding and skin-to-skin contact is encouraged.

***Empower patients to ask their providers (obstetric, psychiatric, primary care, and pediatric) to call MCPAP for Moms on their behalf.**

855-MOM-MCPAP (855-666-6272)

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Management and Effects of Substance Use during Pregnancy – Part 1 of 2

Risks of Maternal Use	Acute Intoxication	Withdrawal	Ongoing Management
Alcohol			
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), containing/preventing physical injury	**Symptoms:** Rapid heart rate, increased blood pressure, tremor, anxiety, flushing, diaphoresis, nausea, hallucinosis, delirium tremens, seizures **Management:** Benzodiazepine taper. Lorazepam (Ativan) is preferred over other benzodiazepines. If patient is abusing benzodiazepines, manage taper with same medication being abused. Limited data regarding the impact withdrawal on pregnancy. Setting for withdrawal management individually determined based on obstetric status, gestational age, medical and psychiatric comorbidity.	**Naltrexone:** Emerging data for use in pregnancy, few small studies - no adverse birth outcomes **Disulfiram (Antabuse):** Not recommended for use in pregnancy due to data re: fetal malformation and risk of 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.
Benzodiazepines			
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	**Symptoms:** Anxiolysis, euphoria, amnesia, disinhibition and symptoms similar to alcohol intoxication **Management:** Flumazenil can be used to reverse acute overdose though associated with increased risk of seizure and there is no human pregnancy or lacation data	**Symptoms:** Rapid heart rate and increased blood pressure, tremor, anxiety, flushing, diaphoresis, nausea, hallucinosis, delirium tremens, seizures **Management:** Benzodiazepine taper**.** Lorazepam is preferred, but may also use the same agent patient is dependent on. If abusing benzodiazepines, manage taper with same medication being abused. Limited data regarding the impact of alcohol or benzodiazepine withdrawal on pregnancy. Setting for withdrawal management individually determined based on obstetric status, gestational age, medical and psychiatric comorbidity.	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.
Opioids			
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:** Maternal overdose – mortality increases first year postpartum, postpartum hemorrhage	**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, yawning **Management:** Initiate agonist therapy to decrease risk for relapse. Mixed data regarding the negative impact of maternal opioid withdrawal.	Pharmacologic treatment is 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, sober living should be offered concurrently. *(continued)*

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Management and Effects of Substance Use during Pregnancy – Part 2 of 2

Risks of Maternal Use	Acute Intoxication	Withdrawal	Ongoing Management
Cannabis			
Fetal effects: Increased risk for psychiatric and substance use disorders in offspring. Similar risks associated with smoking tobacco. Lipophilic (e.g., stores in fetal brain and body fat). **Neonatal effects:** Associated with deficits in visual processing, executive function, attention, academic achievement. In lactation: Levels of THC in breastmilk can exceed maternal serum levels, and exposure via breastmilk is associated with lethargy, slowed motor development, and increased risk of SIDS. **Maternal effects:** Risks associated with smoking, exacerbation of depression, anxiety or psychosis, or heavy use could trigger hyperemesis syndrome.	**Symptoms:** Euphoria, anxiety or paranoia, impaired judgement, conjunctival injection	**Symptoms:** Irritability, anxiety, sleep difficulty, change in appetite, mood changes, abdominal pain, shakiness, tremors, headache, and diaphoresis	Women should be advised to abstain during pregnancy/breastfeeding. Given dose response for some risks like growth restriction, even cutting down may be beneficial. Assess for mental health or comorbid condition. No FDA-approved pharmacotherapy for cannabis use disorder, psychosocial treatments are indicated.
	Management: Supportive care	**Management:** Generally presents within 2-3 days of cessation of use and can last 2-3 weeks. Symptomatic and supportive care.	
Cocaine, Amphetamines, Other Stimulants			
Fetal effects: Intrauterine growth restriction, placental abruption, increased risk for still birth **Neonatal effects:** Transient hypertonia, irritability, hyperreflexia. Vasoconstriction can increase risk for necrotizing enterocolitis; mixed data on neurodevelopmental impact. **Maternal effects:** Hypertension and coronary vasospasm, pregnancy loss	**Symptoms:** Euphoria, agitation, hyperactivity, anxiety, disorientation, confusion, psychosis; Risk for placental abruption with binge use	**Symptoms:** Sedation/somnolence, dysphoria, vivid dreams	Anti-craving agents such as topiramate, tiagabine, 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.
	Management: If severe, manage agitation with benzodiazepines or antipsychotic. Acute intoxication can confound assessment of vital signs and management of labor. ***Avoid beta blockers.***	**Management:** Supportive care: symptomatic treatment for physical symptoms, otherwise does not require pharmacologic treatment	
Tobacco			
Fetal effects: Smoking is associated with PTB, spontaneous abortion, IUGR, and LBW. Nicotine is associated with miscarriage and stillbirth. **Neonatal effects:** Preterm birth, low birth weight, Sudden Infant Death Syndrome (SIDS), persistent pulmonary hypertension of the newborn **Maternal effects:** Increased risk for DVT/PT, stroke, respiratory illness	**Symptoms:** Acute use can result in increased heart rate, blood pressure, and GI activity.	**Symptoms:** Cessation has been associated with cravings, anxiety, insomnia, and irritability.	Quitting is the goal, but cutting down has benefits. Gradual taper of nicotine replacement therapy in pregnancy with goal of cessation, not ongoing/concurrent use. **E-cigarettes** are not well studied in pregnancy. **Bupropion** is minimally effective. **Varenicline** is effective, but there is limited pregnancy data. Quitworks offers free phone counseling.
	Management: Supportive care is generally sufficient.	**Management:** Nicotine replacement can help with acute withdrawal with goal of eventual gradual taper.	

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Choosing a Medication for Opioid Use Disorder (MOUD)

Methadone and buprenorphine are the first line treatments for OUD during pregnancy. Limit 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 patient is stable on and optimize dose.
- May require dose increase as pregnancy advances, and dose decrease postpartum.
- If withdrawal symptoms emerge in third trimester, may need to increase total daily dose or frequency.

NO

Considerations for Initiating Medication

- Which medications are readily available?
- Which treatment setting can patient get to?
- Which medication has patient done well with before?
- What does patient prefer?
- For all medication choices make sure to consider implications for pain management and neonatal withdrawal risk (*Management of Pain During and After Delivery (page 5)*).

First-Line Treatments

	Mechanism	Pros	Cons	Special Considerations in Pregnancy	Lactation
Methadone	Full agonist at the Mu opioid receptor	Observed medication administration in a structured setting 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 not compatible with some work/childcare schedules Can be sedating at higher doses	QTc prolongation Rapid metabolism in third trimester may require dose increase and change from daily to twice daily doses Pregnant women 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 active substance use or infectious risk
Buprenorphine (Suboxone, Subutex, Sublocade)	Partial agonist at Mu opioid receptor High affinity receptor binding	Office-based treatment; can get an Rx at variable intervals Not usually sedating Low risk for overdose	Must be prescribed by a waivered provider Can complicate pain management in labor (*Management of Pain During and After Delivery (page 5)*)	Patient must be in mild withdrawal prior to initiation treatment May require dose increase in 3rd trimester Buprenorphine without naloxone (subutex) is preferred if available; less-severe neonatal opioid withdrawal	1-20 % of the maternal weight adjusted dose in breast milk and also not absorbed orally (only sublingually) Breastfeeding is encouraged in substance-exposed newborns unless active substance use or infectious risk

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 in 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

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Management of Pain During and After Delivery

Pregnant women with Opioid Use Disorder (OUD) must be reassured that their pain can and will be treated. For women on Medication for Opioid Use Disorder (MOUD), it is important to support continued treatment of pain because it is essential for their health and well-being as is expected in the care of all women.

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 MOUD should be continued throughout labor and delivery.
- For Buprenorphine and Methadone:
  - Increase total daily dose during pregnancy
  - 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, 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 patient is NPO, methadone can be given IV (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 Pharmacological Options	Optimize Non-Pharmacologic Options
Acetaminophen NSAIDs (e.g., ibuprofen, ketorolac) Ketamine if available Neuraxial or regional blocks	Mindfulness, meditation Cognitive Behavioral Therapy (CBT) and other behavioral therapy Physical therapy/Light exercise Biofeedback

Opioids can be used when above strategies fail.

Managing MOUD During and After Birth

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

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

Prior to delivery, collaborate with anesthesia colleagues to plan pain management during and after birth.

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

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.*
- *Metabolic changes gradually return to the pre-pregnancy state in the 2-4 weeks postpartum, so dosing will need to be decreased to pre-pregnancy dosing, and pain and sedation levels should be monitored.*

Continuation of MOUD in Postpartum period

- *Avoid discontinuation of MOUD for 6-12 months to minimize risk of relapse/overdose at this high-risk time.*

For questions about management of pain and MOUD in the peripartum period, call MCPAP for Moms at 855-666-6272.

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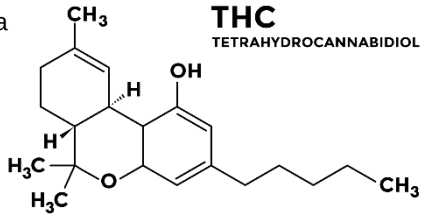
Cannabis

With the legalization of cannabis, there are increasing numbers of pregnant and postpartum individuals reporting use, especially to help manage the symptoms of morning sickness. Cannabis use (including CBD products) is not considered safe while pregnant or breastfeeding.

Cannabis Facts

- Cannabinoids include tetrahydrocannabinol (THC), cannabidiol (CBD), etc.
- Cannabinoids can pass from the mother to the fetus/infant through the placenta and breastmilk.
- Use of cannabis at any point in pregnancy has been associated with negative child outcomes, including impact on cognitive function and attention. Some of these effects may not appear until adolescence.
- First, second, and third-hand smoke exposure can negatively affect one's pregnancy and health.
- Edible or vaporized forms of cannabis also expose the baby to cannabinoids.



Breastfeeding

- Cannabinoids easily pass to the baby through breastmilk.
- Cannabinoids are stored in fat in chronic use and remain in the body for a long time.
- Babies have a high percentage of body fat especially in their developing brains.
- "Pumping and dumping" is not an effective practice to decrease exposure to a breastfed baby.
- The American Academy of Pediatrics recommends that cannabis should not be used while breastfeeding.

Medical Cannabis Use

Discuss risks and benefits of cannabis use and potential alternatives, as appropriate:

- Determine reasoning for use, e.g., nausea, anxiety
- There are alternatives to cannabis that are safer, effective and have more data to support use during pregnancy and breastfeeding.
- Recommend that patients discuss evidence-based treatments for medical or mental health conditions with their provider.

Safe Storage

- Edible cannabis often looks like candy to children. Keep all cannabis containing products in the original childproof packaging and store in a locked, out-of-reach, and out-of-sight location.
- If your child accidentally ingests, call the **MA poison control line at (800) 222-1222**. If symptoms are severe, call 911 or go to your local emergency room.

Patient FAQs

"Since it is natural, is it safe?"

Some people think because cannabis comes from a plant that it is safe; however, there is an association between cannabis use and negative cognitive and behavioral effects on the fetus and newborn.

"Since it is legal, is it safe?"

Just like alcohol and tobacco, being legal does not make it safe during pregnancy.

"Since I use it as a medicine, is it safe?"

There are safer options for pregnant and breastfeeding individuals to alleviate pain, insomnia, and nausea. Talk to your healthcare provider about these other options.

"What if I vape or use edibles instead of smoking cannabis?"

No matter what way cannabis is consumed, there is no safe amount during pregnancy or breastfeeding.

Call MCPAP for Moms at 855-MOM-MCPAP (855-666-6272).

Thank you to the Colorado Department of Public Health and Environment for permission to adapt their handout on this topic. Colorado document adapted with permission: Marijuana and Your Baby
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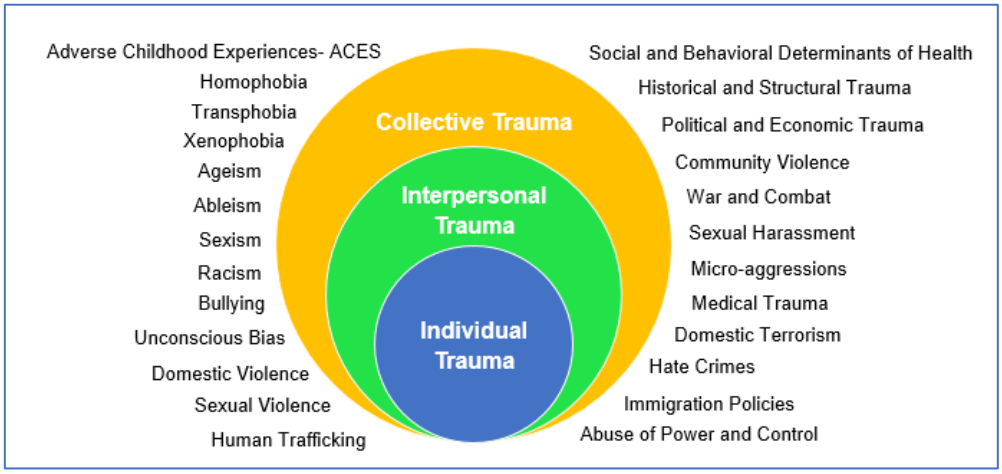
Trauma-Informed Care

Trauma is a pervasive experience, especially in individuals with SUD. Trauma-informed care should be applied universally in all healthcare settings to create environments that promote recovery and safety and avoid inadvertent retraumatization.

Understanding Trauma

"Trauma is defined as an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening, and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."
SAMHSA 2014

Trauma can be experienced concurrently at the individual, interpersonal, and collective level.



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Shifting the Paradigm from… ***"What's wrong with you?"*** **to** ***"What happened to you?" and "How is it affecting you today?"***

Implementing the Six Principles of Trauma-Informed Care in your Organization

Principle	Description	Sample Language
Safety	Throughout the organization, staff and the people they serve feel physically and psychologically safe.	*What can I do to help you feel safer or more comfortable today?* (i.e., Keep clothes on until necessary, door open until procedure begins)
Collaboration and Mutuality	Leveling power differences through partnership and sharing decision making Fostering meaningful relationships	*I would like to work in partnership with you today and during the course of your treatment.* (i.e., collaborative treatment planning, patient views notes as you write, discussion of what goes into notes)
Peer Support	Peer support and mutual self-help are key to building trust, establishing safety and empowerment.	*Would you like to connect with someone who has had a similar experience?*
Empowerment, Voice and Choice	Belief in the ability and resilience of patients and clients and amplifying their voice as a valuable member of their care team.	*I value your opinion and want to hear about your preferences and what has worked for you in the past.*
Cultural, Historic, and Gender Issues	Offers gender and culturally responsive services while recognizing historical trauma. Acknowledging and challenging biases	*What aspects of yourself - your identity, culture, and history are important for me to know?* (i.e., race, ethnicity, gender, religion, roles, etc.)
Trustworthiness and Transparency	Conducts interactions and decisions with the goal of building and maintaining trust. Acknowledging and validating boundaries	*Before we begin, is there anything that you would like to know about today's visit and/or procedure? We can pause, stop, or not talk about a topic.*

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Non-Stigmatizing Language

Reducing Stigma by Using Strength-Based Language

Substance use disorders are chronic illnesses, and recovery can be achieved with treatment and ongoing support. The language that we use can help create an inclusive environment that promotes treatment. Using strength-based and person-first language can help clients feel respected, valued, and help build trust.

Non-Stigmatizing Language	Stigmatizing Language
Person who uses substances	Substance abuser or drug abuser Alcoholic Addict User Abuser Drunk Junkie
Babies affected by maternal opioid use	Addicted babies/born addicted
Substance use disorder or addiction use, misuse Risky, unhealthy, or heavy use Non-medical use	Drug habit Abuse Drug problem
Substance of use	Drug of choice
Person in recovery Abstinent Not drinking or taking drugs	Clean
Medication for addiction treatment (MAT) Medication for Opioid Use Disorder (MOUD)	Substitution or replacement therapy Medication-Assisted Treatment (MAT)
Positive/aberrant, negative (toxicology screen results)	Clean or dirty urine
Opioid Treatment Program (OTP) Dispensing	Methadone clinic Dosing
Impaired Intoxicated	Nodding Stoned High
Non-adherent	Failed/failure Non-compliant
Discharge Transferred	Termination Shipped out
Former client Seeing multiple providers	Frequent flyer Doctor shopping

Call MCPAP for Moms at 855-MOM-MCPAP (855-666-6272).

Adapted from The Grayken Center for Addiction at Boston Medical Center "Words Matter Pledge."

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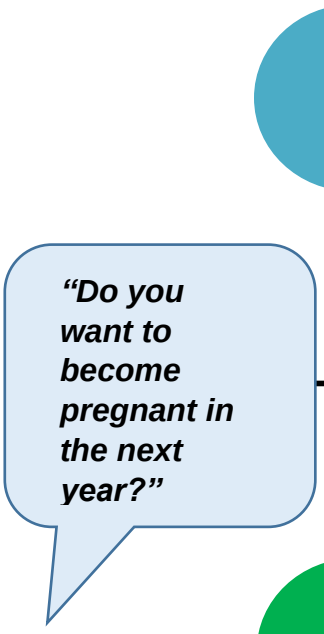
Reproductive Life Planning in SUD Treatment Settings

Substance use disorder (SUD) providers are encouraged to provide patients an opportunity to discuss their reproductive health in order to encourage engagement in education, care, and planning. Individuals with substance use concerns are at greater risk of unintended pregnancy. Planned pregnancies can result in improved maternal and child health outcomes and fewer substance-exposed pregnancies.



Promote Reproductive Autonomy

- Discuss connection with OB/GYN or PCP provider
- Provide an opportunity to discuss sexual and reproductive health
  - Inquire about contraception use
    - Counsel about effective contraception including LARC (Long-acting reversible contraception). See *Contraception Options*.
    - Effect of SUD treatment on menstrual cycle irregularity
  - Educate about STIs and safe sex practices.
    - Most contraception does not protect against STIs
    - Encourage condom use
    - Offer testing as needed/requested
  - Discuss reproductive and sexual health history including sexual activity, ongoing, or past sexual coercion and/or sexual trauma (see *Trauma-Informed Care (page 7)*).

If Unsure

- Discuss relevant information about planning for **and** preventing pregnancy.
- Tailor discussion to individual's goals and circumstances.

Empower a Healthy Pregnancy

- Determine the timeline for desired pregnancy; ask "How soon?"
- Discuss and facilitate connection to OB/GYN care, if not already established.
- Recommend beginning multi-vitamin and/or folic acid.
- Inquire about pregnancy history including impact of past pregnancies on substance use and mental health symptoms.
- Educate about STIs and safe sex practices.
- Gather mental health history including use of medications and other treatments.
- If taking psychiatric medication(s), encourage follow-up with prescriber to discuss medication use in pregnancy.
- Discuss individual's thoughts on breastfeeding.
- Inquire about support network.
- Share information on Plan of Safe Care, see *healthrecovery.org/safecare/*.
- Discuss cessation of substances (i.e., tobacco, alcohol, and cannabis) and maintaining substance use disorder treatment for a healthy pregnancy.
- Provide education on how MCPAP for Moms works and encourage individuals to have their health providers' call with any questions.

If Already Pregnant:

Help client explore all options available so that they can make an informed decision

- Assess whether or not they want to continue the pregnancy
  - If no, may include referral to family planning resources, see *Planned Parenthood*
  - If yes, see above information on empowering patients to have healthy pregnancies
- Emphasize the importance of maintaining substance use treatment during this time

Call MCPAP for Moms at 855-MOM-MCPAP (855-666-6272).

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Discussing Mental Health with Perinatal Individuals

Pregnancy and a new baby can bring a mix of emotions—excitement, joy, but also sadness and feeling overwhelmed. Individuals with a history of substance use or mental health conditions are at higher risk for emotional complications during and after pregnancy, therefore it is important to proactively address mental health needs. Untreated mental health conditions can have a negative impact on the child and family if not addressed.

Throughout Pregnancy and Postpartum

Consider routinely monitoring mental health by administering a standardized screening tool such as the *Edinburgh Postnatal Depression Scale (EPDS) (pages 15, 16)*.

During Pregnancy

- How are you feeling about the pregnancy? What things are you most looking forward to? What things are you most concerned about?
- Who are your sources of support?
- Will you have support in parenting? Co-parent? If you have a partner, how is your relationship?
- Do you have a prenatal care provider?
- What self-care activities do you engage in?
- What are you doing to prepare for the arrival of the baby?

During the Postpartum Period

- How are you feeling about your delivery and/or time in the hospital? Any issues with recovery from delivery?
- Ask about potential DCF involvement or custody challenges.
- Was a 51A filed? How are you feeling about your interactions with DCF so far? Where in the process are you?
- How do you feel when you spend time with your baby?
- Are you able to find time for self-care? (Sleeping, eating, hydration, rest, mindfulness, recovery support activities (AA/NA, therapy, support groups))
- What kind of support are you receiving? Who can you ask for support?

To learn more about types of perinatal mental health disorders, see *Summary of Emotional Complications during Pregnancy and the Postpartum Period (pages 11, 12)*.

For concerns about thoughts of harm to self or baby, see *Risk Assessment: Thoughts of Suicide or Harm to Baby (page 13)*.

For more information on assessing and treating mood disorders, see *Assessment of Depression (page 14)*, *Edinburgh Postnatal Depression Scale (EPDS) (pages 15, 16)*, *Depression Severity and Treatment Options (page 17)*, *Bipolar Disorder (page 18)*, ***and the*** *Mood Disorder Questionnaire (MDQ) (pages 19, 20)*.

Many individuals continue medication use during pregnancy and postpartum, **see** *Key Considerations for Psychiatric Medication Use During Pregnancy and Postpartum Period (page 21)* ***and*** *Antidepressant Treatment Algorithm (page 22)*.

Patient and Family Resources	
Postpartum Support International (PSI): Massachusetts Chapter	https://psichapters.com/ma/
MCPAP for Moms: For Families Resources	https://www.mcpapformoms.org/Resources/SupportGroups.aspx
Institute for Health and Recovery Resource Locator: Community resource locator by zip code	http://www.healthrecovery.org/our-work/pregnant-women-and-families/
Journey Recovery Project: Website for pregnant and parenting women with substance use disorders	www.journeyrecoveryproject.com

Call MCPAP for Moms with questions, Monday – Friday, 9 a.m. – 5 p.m., 855-MOM-MCPAP (855-666-6272).

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Summary of Emotional Complications during Pregnancy and the Postpartum Period – Part 1 of 2

	Baby Blues	Perinatal Depression	Perinatal Anxiety
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	Depressive episode that occurs during pregnancy or within a year of giving birth	A range of anxiety disorders, including generalized anxiety, panic, social anxiety, OCD and PTSD, experienced during pregnancy or the postpartum period
Signs and Symptoms *Important to be culturally responsive in recognizing individual variations in presentation*	Perinatal individuals experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of baby blues; however, 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	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
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 begin during pregnancy after weaning baby or when menstrual cycle resumes	Immediately after delivery to 6 weeks postpartum; May also begin during pregnancy, after weaning baby, or when menstrual cycle resumes
Duration	Less than two weeks	2 weeks to a year or longer; Symptom onset may be gradual	From weeks to months to longer
Prevalence	Occurs in up to 85% of perinatal individuals	One in five perinatal individuals	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in 0.5-3% of perinatal individuals 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum individuals.
Risk Factors	N/A	Personal history of perinatal depression; Personal history of depression; Any mental health history; History of trauma; Family history of perinatal depression; Fetal/newborn loss; Limited social support and psychosocial stressors; Substance use/addiction; Complications of pregnancy, labor/delivery, or infant's health; Unplanned pregnancy; Interpersonal violence	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
Resources and Treatment	Resolves on its own; if it does not consider formal diagnosis of depression. Practice self-care with the following: sleep hygiene and asking for/accepting help from others including during nighttime feedings, gentle exercise and healthy diet, and utilizing social supports.	For depression, anxiety, PTSD, and OCD, first line treatment options include individual therapy, dyadic therapy for mother and baby, and medication. • Sleep hygiene and asking for/accepting help from others including during nighttime feedings • Resources for infant soothing • Psycho-education, social, and community supports (including support groups)* • Exercise and healthy diet • Self-care plan *See MCPAP for Moms website for detailed resources.	

Call MCPAP for Moms at 855-MOM-MCPAP (855-666-6272).

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Summary of Emotional Complications during Pregnancy and the Postpartum Period – Part 2 of 2

	Post-traumatic Stress Disorder	Obsessive-Compulsive Disorder	Postpartum Psychosis
What Is It?	Distressing anxiety symptoms experienced after traumatic events(s)	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	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
Signs and Symptoms *Important to be culturally responsive in recognizing individual variations in presentation*	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event	Disturbing repetitive and invasive thoughts (which may include harming baby), compulsive behavior in response to intrusive thoughts	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 delusions about infanticide and/or homicide and/or suicide that need to be addressed immediately**
When Does It Start?	May be related to trauma before birth or as a result of traumatic birth; Underlying post-traumatic stress disorder (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	Typically occurs rapidly after birth; Onset is usually between 24 hours to 3 weeks after delivery; Watch carefully if sleep deprived for ≥48 hours
Duration	From 1 month to longer	From weeks to months to longer	Until treated
Prevalence	Occurs in 2 -15% of perinatal individuals; Occurs after childbirth in 2-9% of perinatal individuals	Occurs in up to 4% of perinatal individuals	Occurs in 1-2 or 3 in 1,000 births
Risk Factors?	Prior trauma or sexual abuse; Subjective distress during labor and birth; Obstetrical emergency and infant complication; Depression or trauma/stress during pregnancy; Lack of partner support; Fetal or newborn loss	Personal history of OCD; Family history of OCD; Comorbid depression; Panic or generalized anxiety disorder; Premenstrual Dysphoric Disorder (PMDD); Preterm delivery; C-Section delivery; Postpartum worsening in previous pregnancy; Prior pregnancy loss	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
Resources and Treatment	For depression, anxiety, PTSD, and OCD, first line treatment options include individual therapy, dyadic therapy for mother and baby, and medication. • Sleep hygiene and asking for/accepting help from others including during nighttime feedings • Resources for infant soothing • Psycho-education, social and community supports (including support groups)* • Exercise and healthy diet • Self-care plan *See MCPAP for Moms website for detailed resources.		**Requires immediate psychiatric help; Hospitalization usually necessary;** Medication is usually 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)

Adapted from Susan Hickman, PhD, Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, MD, Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996) and O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002.

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Risk Assessment: Thoughts of Suicide or Harm to Baby

While intrusive thoughts of harm to self or others are common in individuals with perinatal complications, acting on those thoughts is rare. Any concern about safety requires additional clinical assessment. Reassessment is needed as circumstances change.

Assessing Risk of Suicide

Ask Patient:

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?"*

Note* *Always ask about harm to baby (see below)*

Ask about Protective Factors	• Future orientation • Stable housing	• Responsibility for other children • Social support and	• Actively engaged in recovery and mental health treatment
Ask about Risk Factors	• Loss of custody • Prior suicide attempt • Initimate partner violence	• Trauma history • Unstable living • Social isolation	• Family history of suicide • Access to lethal means • Lack of engagement in recovery and mental health treatment

	Low Risk	Moderate Risk	High Risk
Current Suicidality	Fleeting thoughts of death, no plan, intent, or behavior	Regular thoughts of wanting to die with possible plan, but no intent or behavior	Persistent thoughts of death/that life is not worth living with strong intent or rehearsal. Any suicidal behavior/attempt.
Intervention Options	• Refer to behavioral health provider for further assessment • Provide crisis lines • National Suicide Prevention Lifeline: 1-800-273-8255 • Consider safety plan	• Contact behavioral health provider for urgent assessment • Provide crisis lines • National Suicide Prevention Lifeline: 1-800-273-8255 • Develop safety plan	• Do not leave alone • Arrange transportation to local emergency room. If transport is unclear, call Emergency Services Program (ESP) team or 911.

Assessing Risk of Harm to Baby

Ask Patient:	Provide Psychoeducation, if Needed
1. *"Have you had any intrusive or unwanted thoughts?"* 2. *"Have you had any thoughts of harm coming to your baby?"* 3. *"Do you ever worry or think about harming the baby yourself?"* If **yes** to any of the above questions, ask, *"how often, how recent and how scary and/or worrisome are the thoughts?"*	• **Warning Signs:** Any signs of postpartum psychosis, avoidance of baby, irritability, impulsivity; see *Summary of Emotional Complications during Pregnancy and the Postpartum Period (pages 11, 12).* • Unwanted or intrusive thoughts, including those of harming the baby, are common among postpartum individuals. • Most people will **not** act on these thoughts because they are usually related to anxiety, depression, and obsessive-compulsive disorder, as opposed to thoughts of harming the baby that are associated with delusions or psychotic thinking. • Postpartum psychosis is most commonly associated with bipolar disorder.

	Low Risk *Diagnosis of depression, obsessive-compulsive disorder (OCD), anxiety*	Moderate Risk *Diagnosis unclear*	High Risk *Confirmed or suspected postpartum psychosis or diagnosis of bipolar disorder*
How to Determine Risk	• Good insight • Thoughts are intrusive and scary • No psychotic symptoms • Thoughts cause anxiety	• Insight is unclear • Thoughts may be disturbing (variable) • Difficult to determine whether patient is psychotic	• Poor insight • Psychotic symptoms (delusional beliefs, distortion of reality, hallucinations, disorganized thinking, paranoia) • Thoughts do not cause anxiety
How to Intervene	• Provide reassurance and education • Engage in mental health treatment • Discuss when and how to reach out for help should they feel unsafe	• Facilitate rapid psychiatric assessment • Engage in mental health treatment • Mobilize supports and create a contingency plan for change in status to higher risk	• Call emergency services/911 • Positively reinforce patient honesty • Do not leave mother and baby unattended • Facilitate psychiatric assessment/ ongoing treatment

Call MCPAP for Moms with questions, Monday–Friday, 9 a.m.–5 p.m., 855-MOM-MCPAP (855-666-6272).

Adapted from Lifeline for Moms Toolkit.

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Assessment of Depression

At least one in five individuals will experience a mental health or substance use disorder in the perinatal period (pregnancy or up to one year postpartum). Individuals with a history of substance use or other mental health conditions are at even higher risk of developing perinatal depression.

Screening and Assessment with the Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) is a commonly used screening tool to help identify pregnant and postpartum individuals experiencing depressive symptoms who may benefit from further mental health assessment. This tool can also identify anxiety symptoms that warrant further intervention. The EPDS is available in a variety of languages click here to access.

We recommend screening for depression by administering the EPDS to every pregnant and postpartum individual at these time points:

- first notification of pregnancy (or between 10 and 14 weeks gestational age)
- once in the third trimester (after 26 weeks gestational age)
- within first month postpartum (2-4 weeks after delivery)

Note: the EPDS can also be used on an as needed basis to assess and monitor perinatal depression and/or anxiety.

Administer EPDS:

1. As a self-administered questionnaire the perinatal individual completes the EPDS. Clinical staff calculates and documents the score.
2. The EPDS can also be administered over the phone or during telehealth appointments.
3. EPDS is not a diagnostic assessment tool, and results should be followed up by clinical assessment.

EPDS Score <10
Does not suggest depression

- Clinical staff to provide psychoeducation around perinatal mental health.
- Monitoring of symptoms is recommended. Future assessment can take place if need or questions arise.
- Provide additional information about community resources (e.g., support groups, MCPAP for Moms website).*

EPDS Score ≥ 10
Suggests patient is depressed

- Evaluate to determine most appropriate treatment (refer to *Depression Severity and Treatment Options (page 17)* and *Discussing Mental Health with Perinatal Individuals (page 10)*).
- Always consider possible comorbid psychiatric illnesses (e.g., anxiety, bipolar, trauma-related disorders, or psychosis) and medical cause of depression (e.g., anemia, thyroid disorders).
- Make a plan for reassessment (administer EPDS again or

Question 10: Any response ≥ 1
(Any response other than "never")
Suggests patient may be at risk of Self-harm or suicide

- Do NOT leave patient/baby in room alone until further assessment or safety/treatment plan has been established.
- Immediately assess further:
  1. *In the past two weeks, how often have you thought of hurting yourself?*
  2. *Have you ever attempted to hurt yourself in the past?*
  3. *Have you thought about how you could harm yourself or attempt suicide?*
  4. *What prevents you from acting on thoughts of death or wanting to die?*
- Refer to ***Assessing Risk of Suicide***
- Collaborate with team on appropriate next steps based on your institution's policies on response to safety concerns.

For Prescribing Providers:

If antidepressant medication is indicated:

1. Screen for bipolar disorder (refer to *Mood Disorder Questionnaire (MDQ) (pages 19, 20)*).
2. Refer to *Key Considerations for Psychiatric Medication Use During Pregnancy and Postpartum Period (page 21)* and *Antidepressant Treatment Algorithm (page 22)*.
3. Collaborate with multi-disciplinary team about treatment plan.
4. Arrange follow-up care including referral to psychotherapy and community resources (e.g., support groups, therapists specializing in perinatal mental health*).
5. If patient is already in mental health treatment elsewhere, ensure follow up appointment is scheduled and collaborate as appropriate.

*Call MCPAP for Moms for assistance.

Call MCPAP for Moms at: 855-MOM-MCPAP (855-666-6272)

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- □ Yes, all the time
- ☒ Yes, most of the time
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - □ As much as I always could
   - □ Not quite so much now
   - □ Definitely not so much now
   - □ Not at all

2. I have looked forward with enjoyment to things
   - □ As much as I ever did
   - □ Rather less than I used to
   - □ Definitely less than I used to
   - □ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - □ Yes, most of the time
   - □ Yes, some of the time
   - □ Not very often
   - □ No, never

4. I have been anxious or worried for no good reason
   - □ No, not at all
   - □ Hardly ever
   - □ Yes, sometimes
   - □ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - □ Yes, quite a lot
   - □ Yes, sometimes
   - □ No, not much
   - □ No, not at all

*6. Things have been getting on top of me
   - □ Yes, most of the time I haven't been able to cope at all
   - □ Yes, sometimes I haven't been coping as well as usual
   - □ No, most of the time I have coped quite well
   - □ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - □ Yes, most of the time
   - □ Yes, sometimes
   - □ Not very often
   - □ No, not at all

*8 I have felt sad or miserable
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Not very often
   - □ No, not at all

*9 I have been so unhappy that I have been crying
   - □ Yes, most of the time
   - □ Yes, quite often
   - □ Only occasionally
   - □ No, never

*10 The thought of harming myself has occurred to me
   - □ Yes, quite often
   - □ Sometimes
   - □ Hardly ever
   - □ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center and from groups such as Postpartum Support International and Depression after Delivery.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.

2. All the items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)

4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Depression Severity and Treatment Options

Interpreting the Edinburgh Postnatal Depression Scale (EPDS)

EPDS scores may be influenced by several factors, including the patients understanding of the language used, their own cultural background, their fear of disclosure of mental health struggles, and perceived stigma that is associated with depression. The EPDS score is only part of a clinical assessment, therefore the score must be integrated into the broader picture to determine most appropriate treatment response. Use the guidance below to help assess severity of symptoms.

		EPDS 0-8	EDPS 9-13	EPDS 14-18	EPDS ≥19
		Limited/No Symptoms	Mild	Moderate	Severe
Symptom Categories	**Mood**	Ranges from occasional, to mild, to pervasive/continuous sadness and misery.			
	Appetite	Can be disrupted either by increased or decreased appetite. In severe cases, may need persuasion to eat.			
	Sleep	Alterations in sleep are common. Consistent difficulty with either increased need for sleep or difficulty initiating or sustaining sleep needs attention.			
	Concentration	May impact ability to have conversations, read, or drive.			
	Thoughts	Increasing thoughts of self-reproach, low self-worth worth. Can include preoccupation, remorse, and irreparable damage. In severe cases, can escalate to thoughts of suicide, death, and harm to baby.			
	Motivation	Can range from difficulty starting everyday simple activities, to inability to do anything without help.			
	Anxiety	Ranges from occasional/intermittent feelings of tension and worry to unrelenting dread, anguish, and overwhelming panic in severe cases.			

Question 10: Self-Harm

For a score ≥1 on Question 10 of the EPDS conduct or arrange immediate further assessment and, if there is any disclosure of suicidal ideation, take action in accordance with clinic/institution protocol and policy.

Options for Intervention and Support

Treatment can include a range of pharmacologic and non-pharmacologic approaches.

EPDS 0-8	EDPS 9-13	EPDS 14-18	EPDS ≥19
Limited/No Symptoms	Mild	Moderate	Severe
	Consider medication	Strongly consider medication	
Therapy for mother; dyadic therapy for mother and baby			
Community/social support (including support groups)			
Consider as augmentation: Complementary/alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate)			
Help with caring for baby including infant soothing techniques, sleep, feeding, and/or lactation support			
Self-care (sleep, hygiene, healthy diet), mindfulness, and physical exercise			

Call MCPAP for Moms at: 855-MOM-MCPAP (855-666-6272)

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Bipolar Disorder

Special Considerations for Perinatal Individuals with Co-Occurring SUD

Important Facts about Bipolar Disorder for SUD Providers

- Bipolar disorder is defined by distinct episodes of depression, mania, or hypomania and/or mixed states.
- It is important to distinguish bipolar disorder from major depressive disorder because the associated risks and management are different.
- People with substance use disorders are diagnosed with bipolar disorder at higher rates than the general population. In addition, people with bipolar disorder are at higher risk of using substances and developing a substance use disorder.
- The co-occurrence of substance use and bipolar disorder can complicate the course and treatment of people affected by these diagnoses.

How is Bipolar Disorder Different from Depression?

	Depression	Bipolar Disorder
Depressive Episode	✓	✓
Mania (Type I) or Hypomania (Type II)		✓
Psychosis	Sometimes	Sometimes
First-line medication	Antidepressant	Mood stabilizer or antipsychotic

Considerations in Diagnosis of Bipolar Disorder in Individuals with Substance Use Disorders (SUD)

Examples of symptoms and mental health diagnoses that can confound assessment:	
Symptoms	▪ Intoxication and withdrawal from substances can mimic mood and affective symptoms. ▪ Mood dysregulation related to other diagnoses can be classified as part of bipolar disorder.
Diagnoses	▪ Trauma-related disorders (e.g., PTSD) ▪ Personality disorders ▪ Attention deficit hyperactivity disorder (ADHD) ▪ Primary psychotic disorders (e.g., schizophrenia and schizoaffective disorders)

Why screen for bipolar disorder?

- ✓ In pregnant or postpartum individuals, 1 in 5 patients who screen positive for perinatal depression may actually have bipolar disorder.
- ✓ Bipolar disorder is associated with increased risk of postpartum psychosis and postpartum psychosis is associated with suicide and infanticide.
- ✓ A validated screening tool (e.g., mood disorder questionnaire) can help rule out a history of (hypo)mania.
- ✓ Avoid use of antidepressants in patients with any history of (hypo)mania in order to avoid precipitating mania.

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)

If a Patient Reports Prior History of Bipolar Disorder:

- Gather more information on how it was diagnosed
- Confirm they are being treated by a psychiatric provider
- Evaluate need for a referral to a psychiatric professional for further assessment.

If you are concerned that a perinatal client may have bipolar disorder, prescribers can call MCPAP for Moms for further guidance related to management at *855-MOM-MCPAP (855-666-6272).*

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Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

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This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

How to Use

The questionnaire takes less than 5 minutes to complete. Patients simply check the yes or no boxes in response to the questions. The last question pertains to the patient's level of functional impairment. The physician, nurse, or medical staff assistant then scores the completed questionnaire.

How to Score

Further medical assessment for bipolar disorder is clearly warranted if patient:

- Answers *Yes* to 7 or more of the events in question #1

AND

- Answers *Yes* to question #2

AND

- Answers *Moderate problem* or *Serious problem* to question #3

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Key Considerations for Psychiatric Medication Use During Pregnancy and Postpartum

Counsel Patient about Medication Use:

- Mental health and wellness are an important part of overall health for the perinatal individual, the pregnancy, the family, and subsequent generations.
- Untreated mental health conditions can have a negative impact on pregnancy, pregnancy outcomes, and the child.
- The risk of taking any medication in pregnancy should be weighed against the risk of the untreated mental health condition.
- Both medication and non-medication options should be considered.
- Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment or as an alternative when clinically appropriate.
- No decision is risk free.

Talking Points

"People take medications during pregnancy for many different reasons. Mental health should be just as important."

"Mental health needs are very common during and after pregnancy. There are safe and effective treatment options available."

Antidepressants

SSRIs are:

- First line treatment for depression and anxiety
- Effective
- Well tolerated during pregnancy
- Among the best studied class of medications during pregnancy

Other types of antidepressant options are available and may be appropriate. Call MCPAP for Moms.

For Prescribers: *Always screen for bipolar disorder before prescribing antidepressant medication. (For additional screening recommendations, see* *Bipolar Disorder (page 18)**.)*

Risks of Antidepressant Use During Pregnancy	Risks of Under Treatment or No Treatment of Depression During Pregnancy
Small, but inconsistent increased risk of birth defects when taken in first trimester, particularly with paroxetine	Increases the risk of postpartum depression
The preponderance of evidence does not suggest birth complications	Birth complications
Studies do not suggest long-term neurobehavioral effects on children	Can make it harder for birthing individuals to take care of themselves and their babies
Possible transient neonatal symptoms	Can make it harder for birthing individuals to bond with their babies

Benzodiazepines

Considerations for safe use of benzodiazepines with individuals with a diagnosis of substance use disorders (SUD):

1. Risk of misuse
2. Tolerance can vary over time and between individuals
3. Risk of withdrawal with abrupt discontinuation
4. Risk of oversedation and overdose, especially when used with other sedating medications and/or substances (e.g., MOUD, sleep aids, antipsychotics, Gabapentin)
5. Recommend short-term or as-needed use, rather than long-term or regular use

Call MCPAP for Moms with questions about benzodiazepines and/or other psychiatric medications (e.g., mood stabilizers, antipsychotics, stimulants, etc.).

Call MCPAP for Moms at: 855-MOM-MCPAP (855-666-6272)

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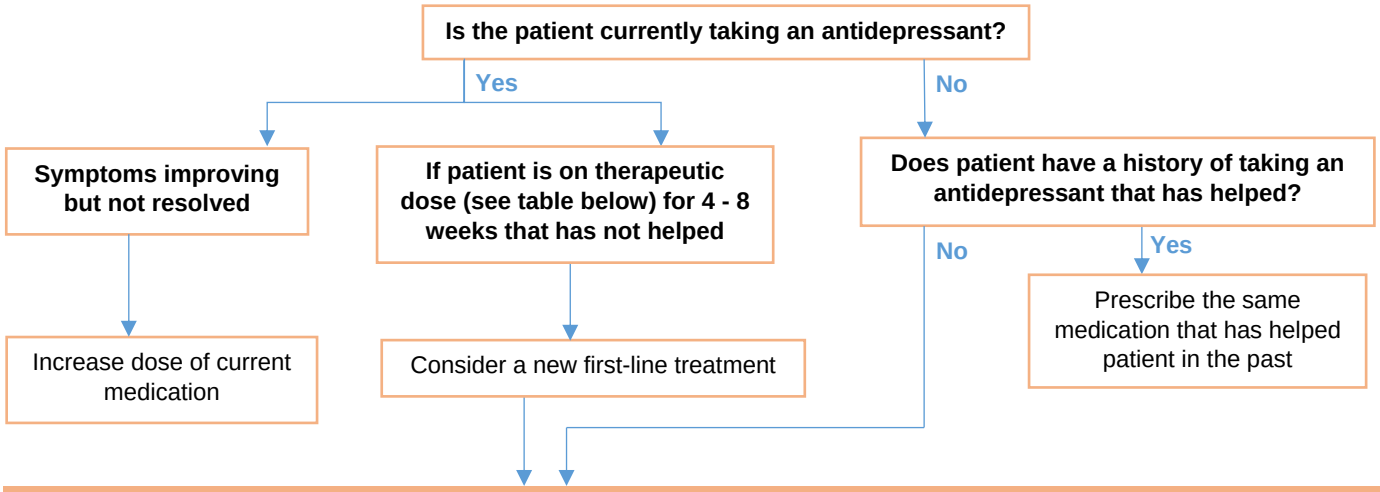
Antidepressant Treatment Algorithm

When antidepressant medication is indicated, review the algorithm below to select the best treatment.



First-Line Treatment				
Medication	**sertraline*** (Zoloft)	**fluoxetine** (Prozac)	**citalopram** (Celexa)	**escitalopram** (Lexapro)
Starting Dose	25 mg	10 mg	10 mg	5 mg
How to Titrate	*↑ to 50 mg after 4 days, ↑ to 100 mg after 7 days, then ↑ by 50 mg until symptoms remit*	*↑ to 20 mg after 4 days, then ↑ by 10 mg until symptoms remit*	*↑ to 20 mg after 4 days, then ↑ by 10 mg until symptoms remit*	*↑ to 10 mg after 4 days, then ↑ by 10 mg up to 20 mg until symptoms remit*
Therapeutic Range	50-200 mg	20-60 mg	20-40 mg	10-20 mg

Second-Line Treatment			
SSRIs	**SNRIs**		**Other**
paroxetine (Paxil) 20-60mg *Increase in 10 mg increments*	**venlafaxine** (Effexor) 75-300mg *Increase in 75 mg increments*	**bupropion** (Wellbutrin) 300-450mg *Increase in 75 mg increments*	**vilazodone** (Vibryd) **levomilnacipran** (Fetzima) **vortlioxetine** (Brintellix) **desvenlafaxine** (Pristiq) Newer medications have not been studied in pregnancy and lactation. Call MCPAP for Moms if considering.
fluvoxamine (Luvox) 50-200mg *Increase in 50 mg increments*	**duloxetine** (Cymbalta) 30-60mg *Increase in 20 mg increments*	**mirtazapine** (Remeron) 15-45mg *Increase in 15 mg increments*	

Lactation Considerations	• Sertraline has the lowest degree of passage into breastmilk and fewest reported adverse effects compared to other antidepressants.* • All of the medications above, when taken during lactation, are present in low amounts in breast milk. • If an antidepressant has helped before or during pregnancy, it is best to continue it during lactation.		
General Side Effects of Medication	**<u>Temporary</u>** Nausea Constipation/diarrhea Lightheadedness Headaches	**<u>Long-term</u>** Increased appetite/weight gain Sexual side effects Vivid dreams/insomnia	*Recommend patients take medication with food to decrease side effects*

Repeat EPDS in 2 – 4 weeks and re-evaluate depression treatment plan via clinical assessment

If no/minimal clinical improvement after 4 - 8 weeks

If patient has **no or minimal side effects**, increase dose
If patient has side effects, switch to a different medication

If clinical improvement and no/minimal side effects

Reevaluate every month and at postpartum visit

Call MCPAP for Moms: 855-MOM-MCPAP (855-666-6272)

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