Massachusetts Child Psychiatry Access Program
MCPAP For Moms

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Depression Screening Algorithm for Obstetric Providers

The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following Glucola test
- *If high-risk patient,** 2 weeks postpartum
- 6 weeks postpartum visit

If first EPDS screen → Clinical support staff explains EPDS

If subsequent EPDS screen → Give EPDS to woman to complete

Woman completes the EPDS. Staff tallies score and enters into medical record. Staff informs OB provider of score prior to patient appointment.

EPDS Score

Provider steps are in this purple box

Score <10

Does not suggest depression

Clinical support staff educates woman about the importance of emotional wellness

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org), and we encourage women to engage in social supports. If woman is already in treatment, ensure follow up appointment is scheduled.

Score ≥ 10

Suggests patient is depressed

1. Assess to determine most appropriate treatment (refer to **Assessment of Depression Severity and Treatment Options** and **Key Clinical Considerations** documents)

Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).

If antidepressant medication is indicated

1. Screen for bipolar disorder **(**refer to **Bipolar Depression Screen)**
2. Refer to **Recommended Steps before Beginning Antidepressant Medication Algorithm** and **Antidepressant Treatment Algorithm**
3. Offer psychotherapy

Positive score on question 10

Suggests patient may be at risk of self-harm or suicide

Do NOT leave woman/baby in room alone until further assessment or 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?*

Document assessment and plan in medical record.

If there is a clinical question, call MCPAP for Moms ***855-Mom-MCPAP (855-666-6272)*** or refer to emergency services.

ALWAYS DISCUSS ALL SUPPORT/TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS

* *High-risk = women with a history of Depression or a positive EPDS Score, or those taking or who have taken psychiatric medications.*

Funding provided by the Massachusetts Department of Mental Health

Depression Screening Algorithm for Obstetric Providers

(with suggested talking points)

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The EPDS should be administered during:
- Initial intake or first obstetrics visit
- Visit following Glucola test
- *If high-risk patient,** 2 weeks postpartum
- 6 weeks postpartum visit

The clinical support staff/ provider *speak the italicized text*

If first EPDS screen

If subsequent EPDS screen

Clinical support staff explains EPDS

Emotional complications are very common during pregnancy and/or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. It is important that we screen for depression because it is twice as common as diabetes and it often happens for the first time during pregnancy or after birth. It can also impact you and your baby's health. We will be seeing you a lot over the next months and want to support you.

Woman completes the EPDS. Staff tallies score and enters into medical record. Staff informs OB provider of score prior to patient appointment.

Give EPDS to woman to complete

EPDS Score

Provider steps are in this purple box

Score <10

Does not suggest depression

Clinical support staff educates woman about the importance of emotional wellness:

From the screen, it seems like you are doing well. Having a baby is always challenging and every woman deserves support. Do you have any concerns that you would like to talk to us about?

Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.

Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org).

My office staff and I are available to help you and provide ongoing support.

If woman is already in treatment, ensure follow up appointment is scheduled.

Score ≥ 10

Suggests patient is depressed

You may be having a difficult time or be depressed. What things are you most concerned about? Getting help is the best thing you can do for you and your baby. It can also help you cope with the stressful things in your life (give examples). You may not be able to change your situation right now; you can change how you cope with it. Many effective support options are available.

Assess to determine most appropriate treatment (refer to **Assessment of Depression Severity and Treatment Options** and **Key Clinical Considerations** documents)

Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).

If antidepressant medication is indicated

1. Screen for bipolar disorder **(**refer to **Bipolar Depression Screen)**
2. Refer to **Recommended Steps before Beginning Antidepressant Medication Algorithm** and **Antidepressant Treatment Algorithm**
3. Offer psychotherapy

Positive score on question 10

Suggests patient may be at risk of self-harm or suicide

It sounds like you are having a lot of strong feelings. It is really common for women to experience these kinds of feelings. Many effective support options are available. I would like to talk to you more about how you have been feeling recently.

Do NOT leave woman/baby in room alone until further assessment or 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?*

If concerned about the safety of woman/baby: *You and you baby deserve for you to feel well. Let's talk about ways we can support you.*

Document assessment and plan in medical record. If there is a clinical question, call MCPAP for Moms ***855-Mom-MCPAP (855-666-6272)*** or refer to emergency services.

ALWAYS DISCUSS ALL SUPPORT/TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS

** High-risk = women with a history of Depression, a positive EPDS Score, or those taking or who have taken psychiatric medications.*

Funding provided by the Massachusetts Department of Mental Health

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

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 <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

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)

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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Assessment of Depression Severity and Treatment Options[1]

EPDS SCORE or clinical assessment

EPDS 0-8	EPDS 9-13	EPDS 14-18	EPDS≥19

SIGNS AND SYMPTOMS OF DEPRESSION

**Signs and symptoms in each column may overlap*

LIMITED TO NO SYMPTOMS	MILD SYMPTOMS	MODERATE SYMPTOMS	SEVERE SYMPTOMS
• Reports occasional sadness	• Mild apparent sadness but brightens up easily	• Reports pervasive feelings of sadness or gloominess	• Reports continuous sadness and misery
• Placid - only reflecting inner tension	• Occasional feelings of edginess and inner tension	• Continuous feelings of inner tension/ intermittent panic	• Unrelenting dread or anguish, overwhelming panic
• Sleeps as usual	• Slight difficulty dropping off to sleep	• Sleep reduced or broken by at least two hours	• Less than two or three hours sleep
• Normal or increased appetite	• Slightly reduced appetite	• No appetite - food is tasteless	• Needs persuasion to eat
• No difficulties in concentrating	• Occasional difficulty in concentrating	• Difficulty concentrating and sustaining thoughts	• Unable to read or converse without great initiative
• No difficulty starting everyday activities	• Mild difficulties starting everyday activities	• Difficulty starting simple, everyday activities	• Unable to do anything without help
• Normal interest in surroundings & friends	• Reduced interest in surroundings & friends	• Loss of interest in surroundings and friends	• Emotionally paralyzed, inability to feel anger, grief or pleasure
• No thoughts of self-reproach, inferiority	• Mild thoughts of self-reproach, inferiority	• Persistent self-accusations, self-reproach	• Delusions of ruin, remorse or unredeemable sin
• No suicidal ideation	• Fleeting suicidal thoughts	• Suicidal thoughts are common	• History of severe depression and/ or active preparations for suicide

TREATMENT OPTIONS

**Treatment options in each column may overlap*

LIMITED TO NO SYMPTOMS	MILD SYMPTOMS	MODERATE SYMPTOMS	SEVERE SYMPTOMS
		• Consider inpatient hospitalization when safety or ability to care for self is a concern	• Consider inpatient hospitalization when safety or ability to care for self is a concern
	• Consider medication	• Strongly consider medication	• Strongly consider medication
• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby
• Community/social support (including support groups)	• Community/social support (including support groups)	• Community/social support (including support groups)	• Community/social support (including support groups)
• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies(bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)
• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	Support with dysregulated baby; crying, sleep, feeding problems • Physical activity
• Self-care (sleep, hygiene, • healthy diet)	• Self-care (sleep, hygiene, healthy diet)	• Self-care (sleep, hygiene, healthy diet	• Self-care (sleep, hygiene, healthy diet)

[1]Information adapted from: Montgomery SA, Asberg M: A new depression scale designed to be sensitive to change. *British Journal of Psychiatry* 134:382-389, 1979

Limited or no symptoms of depression ***Severe symptoms of depression***

 Funding provided by the Massachusetts Department of Mental Health Auth ors: Byatt N., Biebel K., Hosein S., Lundquist R., Freeman M., & Cohen L. www.mcpapformoms.org Telephone: 855-Mom-MCPAP (855-666-6272)

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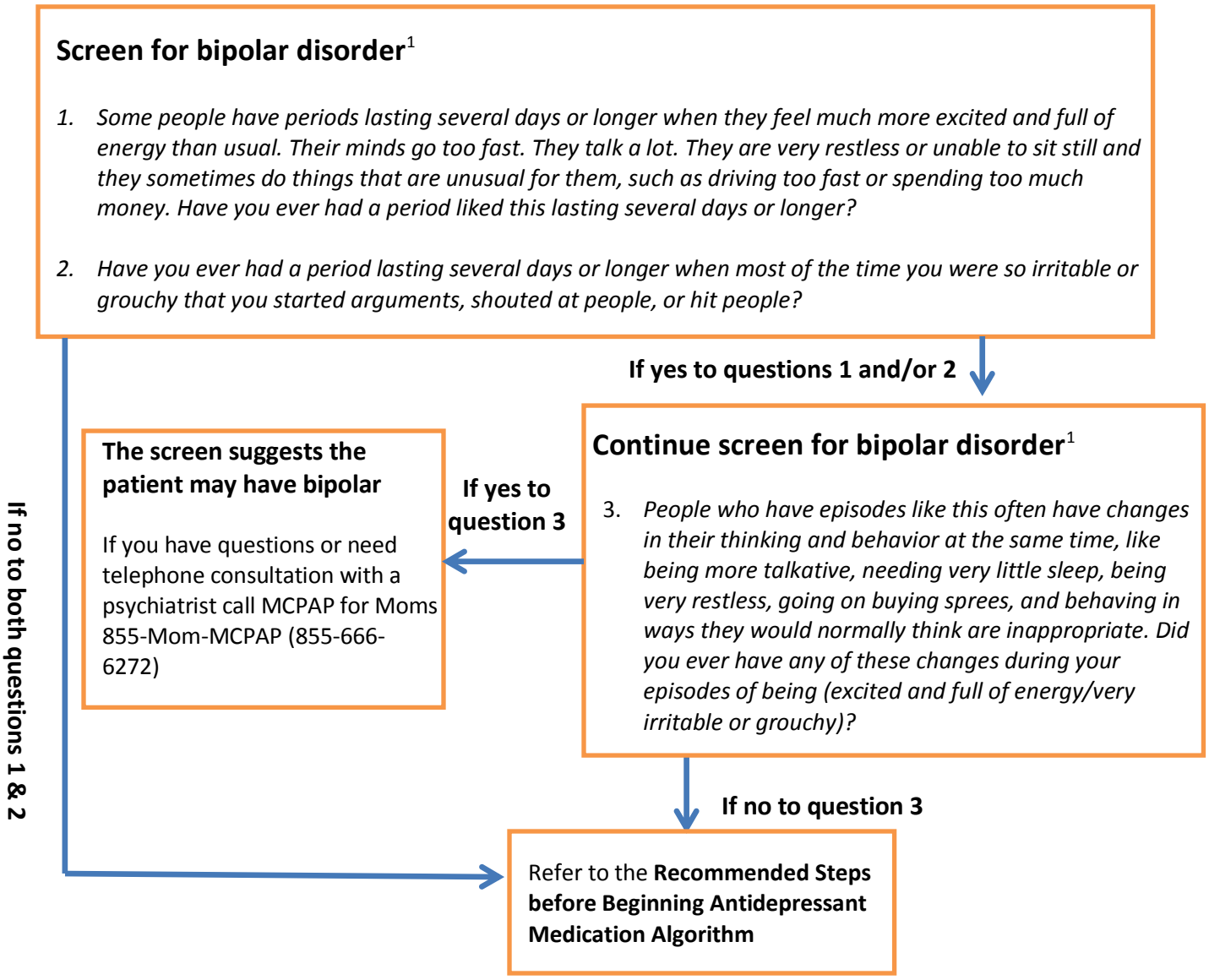
Bipolar Disorder Screen

This algorithm can be used when treatment with antidepressants is indicated, in conjunction with the **Depression Screening Algorithm for Obstetric Providers**.

In this algorithm, the provider *speaks the italicized text* and summarizes other text.



CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

[1]Taken from the Composite International Diagnostic Interview-Based Bipolar Disorder Screening Scale (Kessler, Akiskal, Angst et al., 2006)

Funding provided by the Massachusetts Department of Mental Health

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Summary of Emotional Complications During Pregnancy and the Postpartum Period

	Baby Blues	Perinatal Depression	Perinatal Anxiety	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder	Postpartum Psychosis
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 and PTSD, experienced during pregnancy or the postpartum period.	Distressing anxiety symptoms experienced after traumatic events(s).	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. 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.
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 begin after weaning baby or when menstrual cycle resumes.	Immediately after delivery to 6 weeks postpartum. Occasionally begins after weaning baby or when menstrual cycle resumes.	May be present before pregnancy/birth. Can present as a result of traumatic birth. 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.	Typically presents rapidly after birth. Onset is usually between 2 – 12 weeks after delivery. Watch carefully if sleep deprived for ≥48 hours.
Risk factors	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Life changes, lack of support and/or additional challenges (difficult pregnancy, birth, health challenges for mom or baby, twins). Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Lack of partner support, elevated depression symptoms, more physical problems since birth, less health promoting behaviors. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	Family history of OCD, other anxiety disorders. Depressive symptoms. Prior pregnancy loss. Dysregulated baby-crying feeding, sleep problems.	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. Dysregulated baby-crying feeding, sleep problems.
How long does it last?	A few hours to a few weeks.	2 weeks to a year or longer. Symptom onset may be gradual.	From weeks to months to longer.	From 1 month to longer.	From weeks to months to longer.	Until treated.
How often does it occur?	Occurs in up to 85% of women.	Occurs in up to 19% of women.	Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in .5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2-7% of early postpartum women.	Occurs in 2-15% of women. Presents after childbirth in 2-9% of women.	May occur in up to 4% of women.	Occurs in 1-2 or 3 in 1,000 births.
What happens?	Women experience dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Postpartum depression is independent of blues, but 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 psychotics symptoms.	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.	Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event.	Disturbing repetitive thoughts (which may include harming baby), adapting compulsive behavior to prevent baby from being harmed (secondary to obsessional thoughts about harming baby that scare women).	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	May resolve naturally. Resources include support groups, psycho-education (see MCPAP for Moms website and materials for detailed information) and sleep hygiene (asking/accepting other help during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications.	For depression, anxiety, PTSD and OCD, treatment options include individual therapy, dyadic therapy for mother and baby, and medication. Resources include support groups, psycho-education, and complementary and alternative therapies including exercise and yoga. Encourage self-care including healthy diet and massage. Encourage engagement in social and community supports (including support groups) (see MCPAP for Moms website and materials for detailed resources). Encourage sleep hygiene and asking/accepting help from others during nighttime feedings). Address infant behavioral dysregulation -crying, sleep, feeding problems- in context of perinatal emotional complications. Additional complementary and alternative therapies options for depression include bright light therapy, Omega-3, fatty acids, acupuncture and folate.				**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).

[1] Adapted from Susan Hickman, Ph.D., Director of the Postpartum Mood Disorder Clinic, San Diego; Valerie D. Raskin, M.D., Assistant Professor of Clinical Psychiatry at the University of Chicago, IL ("Parents" September 1996)

[2] **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. [Epub ahead of print]**

Funding provided by the Massachusetts Department of Mental Health

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Key Clinical Considerations When Assessing the Mental Health of Pregnant and Postpartum Women

Assessing Thoughts of Harming Baby	
Thoughts of Harming Baby that Occur Secondary to Obsessions/Anxiety	**Thoughts of Harming Baby that Occur Secondary to Postpartum Psychosis /Suspected Postpartum Psychosis**
• Good insight • Thoughts are intrusive and scary • No psychotic symptoms • Thoughts cause anxiety ↓ **Suggests not at risk of harming baby**	• Poor insight • Psychotic symptoms • Delusional beliefs with distortion of reality present ↓ **Suggests at risk of harming baby**

Suggests Medication May Not be Indicated	Suggests Medication Treatment Should be Considered
• Mild depression based on clinical assessment • No suicidal ideation • Engaged in psycho-therapy or other non-medication treatment • Depression has improved with psychotherapy in the past • Able to care for self/baby • Strong preference and access to psychotherapy	• Moderate/severe depression based on clinical assessment • Suicidal ideation • Difficulty functioning caring for self/baby • Psychotic symptoms present (call MCPAP for Moms) • History of severe depression and/or suicide ideation/attempts • Comorbid anxiety dx/sxs

Risk Factors for Postpartum Depression[1]	
• Personal history of major or postpartum depression • Family history of PPD • Gestational diabetes • Difficulty breastfeeding • Fetal/Newborn loss • Lack of personal or community resources • Financial challenges	• Complications of pregnancy, labor/delivery, or infant's health • Teen pregnancy • Unplanned pregnancy • Major life stressors • Violent or abusive relationship • Isolation from family or friends • Substance use/addiction

Other Considerations During Clinical Assessment	
• Past history of psychiatric diagnosis • Previous counseling or psychotherapy • Previous psychiatric medication • History of other psychiatric treatments such as support groups	• History of substance use or substance use treatment • Anxiety and worry • Trauma history • Domestic violence

How to Talk about Perinatal Depression with Moms[1]

- *How are you feeling about being pregnant/a mother?*
- *What things are you most happy about?*
- *What things are you most concerned about?*
- *Do you have anyone you can talk to that you trust?*
- *How is your partner doing?*
- *Are you able to enjoy your baby?*

[1]This guideline has been adapted from materials made available by HealthTeamWorks and the Colorado Department of Public Health and Environment (CDPHE) http://www.healthteamworks.org/guidelines/depression.html.

Funding provided by the Massachusetts Department of Mental Health

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Recommended Steps before Beginning Antidepressant Medication Algorithm

(Discussion should include yet not be limited to the below)

Counsel patient about antidepressant use:

- No decision regarding whether to use antidepressants during pregnancy is perfect or risk free
- SSRIs are among the best studied class of medications during pregnancy
- 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

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 ➢ The preponderance of evidence does not suggest birth complications ➢ Studies do not suggest long-term neurobehavioral effects on children ➢ Possible transient neonatal symptoms	➢ Increases the risk of postpartum depression ➢ Birth complications ➢ 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

- *If pregnant: In your situation, the benefits of taking an antidepressant outweigh the chance of the things we just discussed.*
- *If lactating: SSRIs and some other antidepressants are considered a reasonable treatment option during breastfeeding. The benefits of breastfeeding while taking antidepressants generally outweigh the risks.*

SEE ANTIDEPRESSANT TREATMENT ALGORITHM ON BACK FOR GUIDELINES RE: PRESCRIBING MEDICATIONS

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

Funding provided by the Massachusetts Department of Mental Health

Massachusetts Child Psychiatry Access Program
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Antidepressant Treatment Algorithm

Is patient currently taking an antidepressant?

Yes

Symptoms improving but not resolved

Increase dose of current medication

If patient is on therapeutic dose (see table below) for 4 - 8 weeks that has not helped

Consider changing medication

No

Does patient have a history of taking an antidepressant that has helped?

Yes

Prescribe the same medication that helped the patient in the past

No

	First line treatment†	Other SSRI Options		
Medication	**sertraline‡ (Zoloft)**	**fluoxetine (Prozac)**	**citalopram (Celexa)**	**escitalopram (Lexapro)**
Starting dose	**25 mg**	**10 mg**	**10 mg**	**5 mg**
How to ↑	**↑ 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**

†if not currently on a medication that is helping
‡a safer alternative in lactation: lowest degree of translactal passage & fewest reported adverse effects compared to other antidepressants

In general if an antidepressant has helped, it is best to continue it during lactation

General side effects of medication

Temporary
Nausea
Constipation/diarrhea
Lightheadedness
Headaches

Long-term
Increased appetite/weight gain
Sexual side effects
Vivid dreams/insomnia

Recommend patients take medication with food to decrease side effects

Tell women only to increase dose if tolerating; otherwise wait until side effects dissipate before increasing
For effects on fetus/neonate see *Educating Patients About Antidepressant Medication during Pregnancy and Lactation*

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

Authors: Byatt N., Biebel K., Mittal L., Lundquist R., Freeman M., & Cohen L., Moore Simas T.

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 MassPAT at each visit
4. Identify who will coordinate Plan of Safe Care (see *SUD3*)
5. Call MCPAP 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 MAT in pregnancy (see *SUD4*) and non-pharmacological treatment (see *SUD3*)
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 MassPAT at each visit
3. If already in treatment, contact SUD provider
4. Identify who will coordinate Plan of Safe Care (see *SUD3*)
5. Call MCPAP 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 MassPAT at each visit
4. If already in treatment, contact SUD provider
5. Identify who will coordinate Plan of Safe Care (see *SUD3*)
6. Call MCPAP for Moms with questions

No

For all women with any opioid use or on MAT for OUD, discuss:

- Overdose prevention (see *SUD6*)
- MAT during pregnancy/postpartum (see *SUD4*)
- Neonatal Opioid Withdrawal Syndrome (NOWS) - a.k.a. Neonatal Abstinence Syndrome (NAS)
- Pain management (see *SUD5*)
- Plan of Safe Care and DCF reporting (see *SUD3*)

MAT: medication for addiction treatment
SUD: substance use disorder
OUD: opioid use disorder
MassPAT: Massachusetts Prescription Awareness Tool

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Assessment of Substance Use in Pregnancy

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)

Gather more history	Monitor closely	Intervene
• 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

Interpretation of Urine Drug Tests

Urine drug tests are useful for monitoring high-risk women and preferred over universal screening because they can:

- Detect undisclosed substances
- Help identify risk for neonatal withdrawal
- Help with risk assessment for medical complications (withdrawal, management of hypertension)
- Confirm use of prescribed medications

Discussion of urine drug tests results with patients should focus on promoting safety and not be punitive in nature.

Approximate Detection Times in Urine

Drugs	*Duration of Detection in Urine*
Buprenorphine	*1-6 days*
Methadone	*Up to 14 days*
Cannabinoids	*Up to 60 days (in chronic users)*
Cocaine	*1-3 days*
Heroin	*1-3 days*
Benzodiazepines	*Up to 21 days*

Urine drug tests have limitations because:

- They only reflect recent use, and detection times vary.
- Drug levels may vary widely depending on fluid intake, time elapsed since use, or individual variation.
- Providers need to know the characteristics of tests used within their institution because different assays may be used by different labs.
- They do not capture all illicit use (e.g., synthetic cannabinoids (K2/Spice), synthetic opioids (fentanyl, carfentanil), hallucinogens (LSD)).
- Patients can tamper with their urine specimen.
- The opioid urine assay tests primarily for heroin, morphine, and codeine and **does not** test for synthetic opioids like oxycodone, fentanyl, methadone, and buprenorphine, which each have their own urine test.

If the urine drug test is inconsistent with the patient's report, order confirmatory testing (e.g., Gas Chromatography/Mass Spectrometry – a.k.a. GC/MS).

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Treatment Options for Perinatal Substance Use Disorder (SUD)

How to Find Treatment and Resources

Bureau of Substance Abuse Services (BSAS) Helpline: Helps patient/provider determine treatment needs	1-800-327-5050 www.helplinema.org
Massachusetts Behavioral Health Access (MABHA) Service Locator: Provider-oriented treatment locator	www.mabhaccess.com/SUD.aspx
Institute for Health and Recovery Resource Locator: Community resource locator by zip code	www.healthrecovery.org/resource-search
The Journey Project: Website for pregnant and parenting women with substance use disorders	www.journeyrecoveryproject.com

Psychosocial Treatments

Peer Support	Professionally led	Residential
• Alcoholics Anonymous: www.aa.org • Narcotics Anonymous: www.na.org • SMART recovery: www.smartrecovery.org	• Cognitive Behavioral Therapy • Motivation enhancement • Mindfulness-based treatments • Couples/family • Group counseling	• Inpatient rehabilitation • 28-day programs/"rehab" • Long-term residential • Sober living • Therapeutic community
Patients can self-refer to any of the above options	Call MCPAP for Moms for assistance with referrals	

Plan of Safe Care (POSC)

The Plan of Safe Care is a document created jointly by a pregnant or parenting woman and her providers. This document helps a women and her team determine services or supports they may find useful to record and organize the patient's engagement in care.

- All women with a history of SUD should have a POSC coordinated.
- The POSC is intended to enhance collaboration and coordination of care.
- SUD treatment providers licensed by the MA BSAS are required to create a POSC and communicate about the POSC with other providers.
- POSC can be initiated at any time to facilitate the patient's engagement in care.
- POSC can be used to identify additional resources that may be helpful.
- DCF will ask if a POSC exists at the time any report is made.

A suggested template can be found at http://www.healthrecovery.org/safecare/.

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 • Can vary in length and frequency of sessions • Examples include: Intensive Outpatient program (IOP), Structured Outpatient Addiction Program (SOAP), and Partial Hospital Program (PHP)
Acute Treatment Services (a.k.a. "Detox")	Medically Supervised Withdrawal (Inpatient)	• Indicated for physiological dependence on alcohol or benzodiazepines • Difficult to access during pregnancy • Tapering opioids is not recommended during pregnancy.
Short-Term Residential (under 30 days)	Step-down and non-pharmacologic "detox"	• Examples include Clinical Stabilization Services (CSS) and Transitional support Services (TSS) or "holding." • 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.
Long-term Residential (over 30 days)	Structured group living with supervision and treatment provided by addiction professionals	• Examples include 4-6 month recovery homes or "halfway houses" and specialized residential programs for women, families, and youth. • 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, which include the coordination of perinatal/pediatric care. • Individual, group therapy, case management
Involuntary Commitment/ Section 35 (up to 90 days)	Court-ordered treatment for medically supervised withdrawal and step-down services	• Family/providers can petition the local court with evidence that the patient is a danger to self/others due to substance use. • The patient is brought before the judge, who decides if commitment is warranted.

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

Medication for addiction treatment (MAT) 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

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Management of Pain During and After Delivery

Pregnant women with opioid use disorder (OUD) must be reassured that their pain during and after delivery can and will be treated. For women on medication for addiction treatment (MAT), 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

- 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).

Methadone

- 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).

Naltrexone

- 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
- Acupuncture

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

Managing Medication for Addiction Treatment (MAT) 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 MAT at the time of delivery because it puts women at increased risk for relapse, and restarting MAT in the postpartum period is challenging.

Continuation of MAT in Postpartum period

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

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Opioid Overdose Prevention

Opioid overdose is a leading cause of preventable maternal mortality in Massachusetts. 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 the Massachusetts Prescription Awareness Tool (MassPAT): All licensed prescribers in Massachusetts have access to MassPAT - https://massachusetts.pmpaware.net/login.	

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.	

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.	
The Massachusetts Good Samaritan Law protects people from prosecution for drug possession if seeking help for an overdose.		

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Massachusetts Child Psychiatry Access Program
MCPAP For Moms

Summary of Impact and Management of Substance Use during the Perinatal Period

SUD7

Risks of Maternal Use	Acute Intoxication	Withdrawal	Ongoing Management
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:** 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			
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.
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 it is associated with increased risk of seizure, and there is no human pregnancy or lactation data.	**Symptoms:** Rapid heart rate, increased blood pressure, tremor, anxiety, flushing, diaphoresis, nausea, hallucinosis, delirium tremens, and seizures **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.	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.

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Massachusetts Child Psychiatry Access Program
MCPAP For Moms

Summary of Impact and Management of Substance Use during the Perinatal Period (cont'd) SUD8

Risks of Maternal Use	Acute Intoxication	Withdrawal	Ongoing Management
Cannabis			
Fetal effects: There is increased risk for psychiatric and substance use disorders in offspring. There are 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 cannabinoids in breastmilk can exceed maternal serum levels, and exposure via breastmilk is associated with lethargy, slowed motor development, and increased risk of Sudden Infant Death Syndrome (SIDS). **Maternal effects:** Risks are associated with smoking, exacerbation of depression, anxiety or psychosis; heavy use could trigger hyperemesis syndrome .	**Symptoms:** Euphoria, anxiety or paranoia, impaired judgement, conjunctival injection **Management:** Supportive care	**Symptoms:** Irritability, anxiety, sleep difficulty, change in appetite, mood changes, abdominal pain, shakiness, tremors, headache, and diaphoresis **Management:** Generally presents within 2-3 days of cessation of use and can last 2-3 weeks. Symptomatic and supportive care.	Women should be advised to abstain during pregnancy/breastfeeding. Given the dose response for some risks, like growth restriction, even cutting down may be beneficial. Assess for mental health or comorbid condition. There is no FDA-approved pharmacotherapy for cannabis use disorder. Psychosocial treatments are indicated.
Cocaine, Amphetamines, and Other Stimulants			
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	**Symptoms:** Euphoria, agitation, hyperactivity, anxiety, disorientation, confusion, and psychosis Risk for placental abruption with binge use **Management:** If severe, manage agitation with benzodiazepines or antipsychotic. Acute intoxication can confound assessment of vital signs and management of labor. ***Avoid beta blockers.***	**Symptoms:** Sedation/somnolence, dysphoria, vivid dreams **Management:** Supportive care: symptomatic treatment for physical symptoms, otherwise does not require pharmacologic treatment	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.
Tobacco			
Fetal effects: Smoking is associated with spontaneous abortion and intrauterine growth restriction. Nicotine is associated with miscarriage and stillbirth. **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	**Symptoms:** Acute use can result in increased heart rate, blood pressure, and GI activity. **Management:** Supportive care is generally sufficient.	**Symptoms:** Cessation has been associated with cravings, anxiety, insomnia, and irritability. **Management:** Nicotine replacement can help with acute withdrawal, with the goal of eventual, gradual taper.	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. **E-cigarettes:** not well studied in pregnancy **Bupropion:** minimally effective **Varenicline:** effective, but limited pregnancy data Quitworks offers free phone counseling.

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How to Find a Primary Care Practitioner

A primary care practitioner (PCP) is typically your first resource when you have a medical concern, including mental health concerns. For the purpose of most health insurance plans, this is also the person to coordinate your care. Your PCP's role is to provide preventive care to you, such as conducting a physical exam. They can also identify and treat common medical concerns, like a cold. It is important that you build a relationship with a PCP. This happens by seeing them over an extended period of time, so they become familiar with your medical history and can help identify specialists that can treat any specific needs that come up. Your PCP can also help optimize your mental health by providing direct treatment and/or ensuring that you receive the mental health care you need and deserve.

How do I start my search for a Primary Care Practitioner?

- Contact your insurance company, either by phone or online, to obtain a list of available practitioners that qualify as PCPs in your area. PCP's can be internal medicine doctors, family practitioners, nurse practitioners or physician assistants. In some cases, a doctor who is an obstetrician/ gynecologist can also be a PCP.
- A personal referral is another good way to identify a PCP. You may want to ask for suggestions from friends or family members that you trust. You can also ask your child's pediatrician or your OB/midwife that helped you during your pregnancy whom they would recommend. When asking for suggestions, consider your own temperament and qualities of the individuals that you have found comforting. A family member or friend who likes someone who is more strict and to the point might not be a good fit for you if you are looking for someone that values spending time with their patients and is more available for questions or concerns.
- State level medical associations, nursing associations or physician assistant associations also maintain lists of who is practicing in your area and can make referrals to providers who are members of the association.

How do I choose a Primary Care Practitioner?

- Making the final decision is up to you. Below are some questions you may want to consider:
  - Do you prefer working with a male or female PCP?
  - Is the age of the PCP or the years of experience important to you?
  - If a PCP is recommended by someone, do you know why they would recommend them?
  - Does this practice or PCP accept your insurance?
  - Is the PCP's office staff or location important?
  - Do you need a PCP who is available to you online so you can access them when you have time rather than during the typical work day?
  - Do you want a PCP who has certain training or experience?
  - What are your current health needs? Are you generally in good health and do not anticipate needing to see your PCP often, or do you have an ongoing medical issue where you may need ongoing support and consultation?
  - Does the PCP offer urgent appointments and who covers when your PCP is away?

What should I do if I don't have health insurance?

- All Massachusetts residents are required to have health insurance. If you are concerned you cannot afford health insurance, you can apply for MassHealth coverage. To apply for MassHealth, call the MassHealth Enrollment Center at 888-665-9993 or go online to download an application at: http://www.mass.gov/eohhs/consumer/insurance/apply-for-masshealth.html
- If you qualify for insurance through your work but have not enrolled because you are concerned about the costs, you may qualify for help for paying your premiums. To learn more about this option visit the Massachusetts Health Connector at: https://www.mahealthconnector.org/
- Having a baby is considered a "qualifying event," which means you can revisit your benefits if you need to change your plan to ensure your baby is covered. If you had insurance available to you through your work but didn't take it for yourself, you can now choose to enroll to cover yourself and your baby.
- You can also talk with the hospital at the time of delivery to ensure that your child has MassHealth if you do not have other insurance. At the time of delivery, you can also enroll in MassHealth as well.
- If you are just not sure where to turn or you need help in applying, contact Health Care for All, which has a free helpline available Monday through Friday from 9am to 5pm at 1-800-272-4232 or contact them at their website: https://www.hcfama.org/

Funding provided by the Massachusetts Department of Mental Health

Pregnant or just had a baby? Are you worrying about your mental health?

How to talk to your health care provider

Emotional complications are very common during pregnancy and/or after birth. 1 in 8 women experience depression, anxiety or frightening thoughts during this time. Depression often happens for the first time during pregnancy or after birth. It can impact you and your baby's health. Getting help is the best thing you can do for you and your baby. You may not be able to change your situation right now; however, you can change how you cope with it. Many effective support options are available. Women see health care providers a lot during pregnancy and after giving birth and it is important to let your health care provider know how you are feeling.

How do I know if I should talk to a health care provider about my mental health?

- Your mental health is an important aspect of your overall health during and after pregnancy. Just as you would talk with your health care provider about any other health related experience, you should let your provider know about any mental health experiences you've had.
- If you are planning on becoming pregnant, are currently pregnant or just had a baby and you have a history of depression, anxiety or other mental health concerns.
- If you have experienced any of the following for 2 weeks or more: feeling restless or moody, feeling sad, overwhelmed, or hopeless, having no energy or motivation, crying a lot, not eating enough or too much, feeling that you are sleeping too little or too much, not feeling like you can care for your baby, having no interest in your baby or are worrying about your baby so much that it is interfering with caring for yourself and/or baby.
- If you have experienced strong feelings that could include thoughts about hurting yourself or your baby, seeing or hearing things that aren't there or worrying that people may be out to get you or want to hurt you. If you are experiencing these kinds of feelings, it is important that you call your health care provider right away or go to the emergency room to seek help.

How do I prepare to talk with my health care provider?

- Start a list of specific things that are concerning you and how they affect your life. Include any questions and details about any previous mental health concerns. This will help ensure that you do not forget anything and that your questions are answered.
- Consider asking someone to attend your appointment with you like a family member or friend. You may hear a lot of new information and it can help to have someone with you so you do not miss anything.
- If you feel at any point that your provider is not hearing your concerns, let them know that you feel as if they are not hearing you. You also can also ask to speak with a different health care provider.

What will happen when I talk to my health care provider?

- They may talk with you to better understand the experiences you are having. This will allow him/her to offer you the most appropriate resources or treatment for your situation.
- They may suggest that you meet with a therapist to support you and help you learn how to cope with the intense emotional experiences that you may be experiencing.
- They may refer you to a support group to help you connect with other new mothers having similar experiences.
- They may discuss medication as a treatment option. If you took medication prior to becoming pregnant, talk with your provider about whether they would recommend that you stay on the medication during pregnancy.

Having a baby is always challenging and every woman deserves support.

 Authors: Byrns H., Hannah M., Byatt N., Biebel K., & Debordes-Jackson, G.
Funding provided by the Massachusetts Department of Mental Health

Massachusetts Child Psychiatry Access Program
MCPAP For Moms

MCPAP for Moms Enrollment Agreement

Practice Name: _____

Practice Address: _____

Practice Phone: _____

(If applicable) Practice Site 2 Name and Address: _____

_____

(If applicable) Practice Site 3 Name and Address: _____

_____

Number of Deliveries Annually_____

Care Manager/Social Worker on Site? Yes/No

If yes, Care Manager/Social Worker Name: _____

If yes, Care Manager/Social Worker Email: _____

Medical Director/Physician Leader of Practice Name:_____

Medical Director/Physician Leader of Practice Email: _____

Practice Manager Name: _____

Practice Manager Email: _____

Office Fax: _____

In what practice setting do you work?

☐ Obstetric ☐ Family practice/Family medicine

By enrolling in the MCPAP for Moms program:

- I agree to, when possible, participate in MCPAP for Moms training and educational opportunities.
- I agree to inform patients that I may engage the MCPAP for Moms program on their behalf and will share health information with the program unless the patient declines the MCPAP for Moms services.
- I agree to complete periodic surveys about my use and satisfaction with MCPAP for Moms.
- I agree to continue to manage the mental health care of women for whom it is appropriate.
- I understand that MCPAP for Moms psychiatrists will not be prescribing medications.

Signature:_____

Date: _____

Practice ID number (office use only) _____

Revised 7.23.18

Fax: 855-284-8260
Email MCPAP for Moms at: mcpap@beaconhealthoptions.com

MCPAP for Moms Provider Information Sheet					
Provider Name	**Title**	**Provider Type (e.g., MD, DO, RNCS, midwife)**	**FTE/hours worked**	**Email**	**Practice Site**

Guide for Enrolled* Obstetric Practices Using MCPAP for Moms

MCPAP for Moms supports providers to address depression and other mental health concerns among women who are pregnant or within one year of delivery

How Do I Access MCPAP for Moms?

Call **855-Mom-MCPAP** (855-666-6272), Monday through Friday, 9am-5pm.

Can I Call MCPAP for Moms for Crisis Services?

No. MCPAP for Moms is not an emergency service. If there is an acute safety concern, we recommend arranging an evaluation at your local emergency room.

What Happens When I Call MCPAP for Moms?

A MCPAP for Moms Resource and Referral specialist will answer the phone and gather some basic information about the patient. If the request requires a telephone consultation with a MCPAP for Moms Psychiatrist, the Resource and Referral specialist will ask for the provider's contact information. A MCPAP for Moms Psychiatrist will return the call within 30 minutes whenever possible to speak with the provider who requested the consult.

Who Can Access MCPAP for Moms?

Any obstetric, pediatric, primary care, or psychiatric provider with questions about addressing the mental health concerns of pregnant or postpartum women. For obstetric practices, this includes **physicians, nurse practitioners, midwives, nurses, medical assistants, and embedded case managers, social workers, and behavioral health clinicians.** MCPAP for Moms is free to all Massachusetts providers.

Can Patients Call MCPAP for Moms?

No. The MCPAP for Moms phone line is only for providers; patients should not call MCPAP for Moms.

What Requires a Telephone Consultation Between a Medical Doctor, Nurse Practitioner, or Midwife and a MCPAP for Moms Psychiatrist?

- Questions regarding best-practices for management of pregnant and postpartum patients with mental health concerns (e.g., detection, assessment, and treatment of depression).
- A request for a one-time face-to-face assessment of a patient with a MCPAP for Moms Psychiatrist.
- A request for a Resource and Referral specialist to work directly with a patient to arrange mental health services (e.g., therapy). The need for this type of telephone consultation will be reassessed once a practice actively uses the program for a sustained period of time.

What Is Available Without a Telephone Consultation Between a Medical Doctor, Nurse Practitioner, or Midwife and a MCPAP for Moms Psychiatrist?

- A list of mental health providers (e.g., prescribers, therapists) matched to patient insurance and location.

What is Available on the MCPAP for Moms website (www.mcpapformoms.org)?

- **Provider Toolkit**: MCPAP for Moms toolkit documents including assessment tools (e.g., EPDS) in multiple languages, a depression screening algorithm, a bipolar screen, and an antidepressant treatment algorithm.
- **Patient Resources**: Perinatal mental health information for mothers, fathers and family members including a database of support groups, print resources, information in Spanish, and other mental health resources. (See the "For Mothers and Families" tab)

Does MCPAP for Moms Provide Materials about the Program and Perinatal Depression for Patients?

Yes. MCPAP for Moms can provide your practice with brochures, business cards, and posters to educate about perinatal depression and direct patients towards relevant mental health resources. To request materials please call MCPAP for Moms at **855-Mom-MCPAP** 855-(666-6272).

*MCPAP for Moms enrollment entails completing: 1) a practice training with a M4M psychiatrist; and 2) paperwork regarding practice demographics