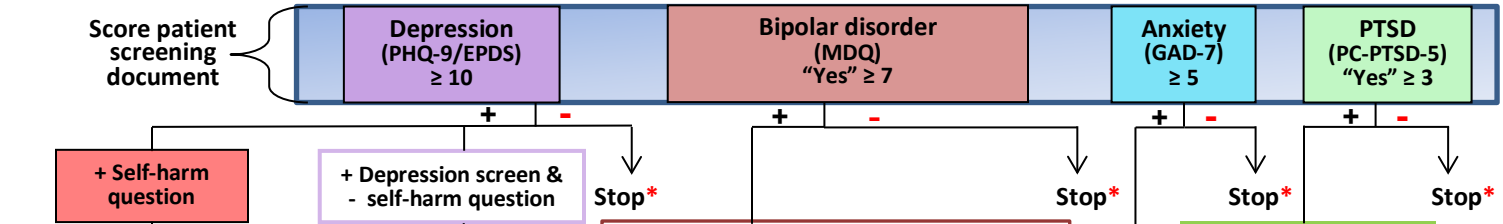
Lifeline for moms

Assessing Perinatal Mental Health



+ Score on Self-Harm Question

1. Do not allow woman/baby to leave office until plan/assessment is complete.
2. Assess safety.
3. Call for psychiatric consultation, as needed.
4. If acute safety concern, refer to emergency services for further evaluation of safety.
5. See page 25 for more information.

+ Score on MDQ

1. Explain: *This screen indicates that your mood may go up and down. We can help you get the care you need.*
2. If negative depression screen, mood changes may be related to PTSD. The PC-PTSD-5 is part of the screener. Can also administer the PCL-C. See above right and page 32.
3. Do not prescribe antidepressant.
4. Refer to therapy.
5. Call for psychiatric consultation or refer to psychiatrist as indicated. See pages 24 & 25.

Consider administering PCL-C. See page 32.

To assess for presence and severity of perinatal mental illness, ask about:

- Recent stressors
- Symptom frequency
- Symptom duration
- How symptoms impact daily functioning
- Current treatment (meds/therapy)
- Feelings of hopelessness, helplessness
- Current suicidal ideation, plan, intent
- Family history
- Prior symptoms
- Previous suicide attempt(s)
- Past psychiatric treatment (meds/therapy)
- Previous psychiatric hospitalization(s)
- See pages 29-31 for more on perinatal mental health conditions

Determine Illness Severity

MILD

Depression screener score 10-14

GAD-7 score 5-9

PC-PTSD-5 score < 3

No suicidal ideation

Not feeling hopeless, helpless, worthless

No previous psychiatric hospitalization

No or minimal difficulty caring for self or baby

MODERATE

Depression screener score 15-19

GAD-7 score 10-14

PC-PTSD-5 score ≥ 3

Suicidal ideation present

Sometimes feels hopeless, helpless, worthless

Previous psychiatric hospitalization

Some difficulty caring for self or baby

SEVERE

Depression screener score >19

GAD-7 score ≥15

PC-PTSD-5 score ≥ 3

Suicidal ideation, intent and/or plan

Previous suicide attempt(s)

Often feels hopeless, helpless, worthless

History of multiple psychiatric hospitalization(s)

Often feels unable to care for self or baby

May experience hallucinations, delusions or other psychotic symptoms (e.g., major depression with psychotic features or bipolar disorder with psychotic features)

History of multiple medication trials

For mild, moderate, and severe illness:

- Start treatment, see page 22.
- Check for underlying medical condition - order TSH, B12, folate, Hgb, Hct
- Assess for substance use or medications which can cause or worsen mood/anxiety disorders

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

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

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Starting Treatment for Perinatal Mental Health Conditions

Consider treatment options based on highest level of illness severity

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

MILD	MODERATE	SEVERE
Therapy referral Consider medication treatment	Therapy referral Strongly consider medication treatment If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See page 20.	Therapy referral Medication treatment If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See page 20.

- Use internal resource list to refer patient to therapy
- Call Postpartum Support International (PSI) at 1-877-499-4773 to schedule a consultation by phone with a perinatal psychiatry expert
- Call a Perinatal Psychiatry Access Program, if one is available in your state. Check at https://www.umassmed.edu/lifeline4moms/
- If symptoms are mild and patient is able to follow through, direct patients to call their health insurance company or contact Postpartum Support International (PSI) for resources: 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), or direct patients to search online at https://psidirectory.com/

Therapy and support options

- All women who screen positive, regardless of illness severity, should be referred to therapy or be advised to continue therapy
- Always discuss and encourage prevention and support options (e.g., peer and social supports and groups, sleep hygiene, self-care, and exercise). See page 27.

How to educate patients about treatment with antidepressants

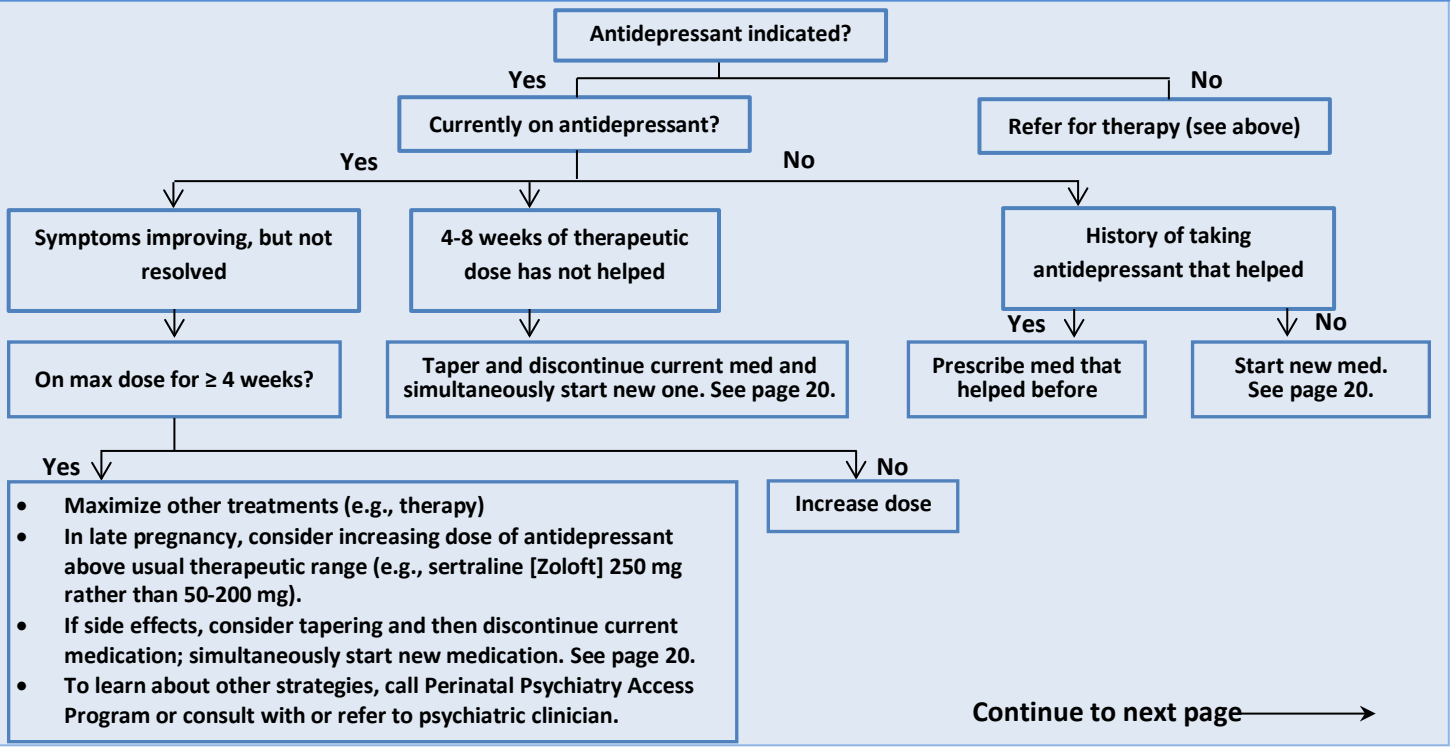
Antidepressant use during pregnancy:

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

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

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

Medication treatment (when indicated)



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Starting Treatment for Perinatal Mental Health Conditions

Pharmacological Treatment Options for Depression, Anxiety, and PTSD

- Choose antidepressant that has worked before. If antidepressant naïve, choose antidepressant based on table below with patient preference in consideration. Antidepressants are similar in efficacy and side effect profile.
- In late pregnancy, you may need to increase the dose above usual therapeutic range (e.g., sertraline [Zoloft] 250mg rather than 50-200mg).
- If a patient presents with pre-existing mood and/or anxiety disorder and is doing well on an antidepressant, do not switch it during pregnancy or lactation. If patient is not doing well, see page 21.
- Evidence does not support tapering antidepressants in the third trimester.
- Minimize exposure to both illness and medication.
  - Untreated/inadequately treated illness is an exposure
  - Use lowest effective doses
  - Minimize switching of medications
  - Monotherapy preferred, when possible

See page 19 for how to educate patients about treatment with antidepressants

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

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

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

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

Medication	duloxetine (Cymbalta)	venlafaxine (Effexor XR)	fluvoxamine (Luvox)	paroxetine (Paxil)	mirtazapine (Remeron)	bupropion HCL (Wellbutrin XL)
Starting dose and timing	30 mg*** qAM	37.5 mg qAM	25 mg qHS	10 mg*** qAM (if sedating, change to qHS)	7.5 mg qHS	150 mg qAM
Initial increase after 4 days		↑ to 75 mg	↑ to 50 mg	↑ to 20 mg	↑ to 15 mg	
Second increase after 7 more days	↑ to 60 mg		↑ to 100 mg			
Reassess Monthly (increase as needed until symptoms remit)	↑ by 30 mg	↑ by 75 mg	↑ by 50 mg	↑ by 10 mg	↑ by 15 mg	↑ by 150 mg
Therapeutic range ***	30-120 mg	75-300 mg	50-200 mg	20-60 mg	15-45 mg	300-450 mg
Individualized approach to titration	Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms					

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

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

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

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

Brexanolone is an FDA-approved medication that can be considered for treatment of moderate to severe postpartum depression.

Brexanolone:

- is a formulation of intravenous allopregnanolone (a neurosteroid) that acts on GABA-A receptors
- requires an IV infusion over 60 hours
- has a faster onset of action (symptom reduction in 1-2 days) compared to available oral antidepressants, which generally take 4-8 weeks to work
- has been shown to maintain the reduction in depression symptoms at 30 days post-infusion

When is Brexanolone indicated?

If onset of depression occurs in 3rd trimester through 4 weeks postpartum and if patient is <6 months postpartum at screening, consider Brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting).

More information can be found at Reprotox and LactMed on all pharmacological treatments

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Follow-Up Treatment of Perinatal Mental Health Conditions

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

If no/minimal clinical improvement after 4 weeks

- If patient has no or minimal side effects, increase antidepressant medication dose until full symptom remission (e.g., EPDS/PHQ-9 < 10, GAD-7 <5, PC-PTSD <3)
- If patient has intolerable or serious side effects, taper medication to discontinue, and simultaneously start new antidepressant
- Maximize other treatments (e.g., therapy, lifestyle changes, support groups)
- If late in pregnancy, given physiological changes in pregnancy, may need to increase the dose of antidepressant above usual therapeutic range (e.g., sertraline [Zoloft] 250 mg per day rather than 50-200 mg)
- Consider adding additional medication. See page 20.
- Repeat screens every 4 weeks and re-evaluate treatment via clinical assessment until remission, or, if you are not continuing to manage the patient, provide a hand-off to the primary care physician

If clinical improvement and no/minimal side effects

If clinical improvement and no/minimal side effects

- Re-evaluate every month in pregnancy and postpartum and adjust med accordingly. See page 20
- Encourage patient to stay on medication and continue therapy
- If you are not continuing to manage the patient, provide a hand-off to primary care physician

If you are not continuing to manage the patient postpartum:

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

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

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

Taper medication slowly to minimize risk of relapse and discontinuation syndrome

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

Adjunctive Support Options

Talk to your patient about adjunctive support options such as:

- Self-care (See Self-Care Plan (page 27))
- Balanced nutrition
- Substance avoidance
- Sleep hygiene
- Mindfulness
- Exercise
- Books and workbooks (e.g., *The Pregnancy and Postpartum Anxiety Workbook* by Pamela S. Wiegartz and Kevin Gyoerkoe)

Social and Structural Determinants of Health

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

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

Refer to social services as indicated

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Assessing Risk of Suicide

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

Ask about thoughts of self-harm or wanting to die

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

Introduce assessment to patient

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

To build up to assessing suicide risk, ask:

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

To assess risk of suicide, ask:

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

Assess Risk

Assessment

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

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

Intervene and Document Plan

Treatment

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

Ideation: Inquire about frequency, intensity, duration—in last 48 hours, past month, and worst ever

***Intent:** Inquire about the extent to which the patient 1) expects to carry out the plan and, 2) believes the plan/act to be lethal vs. self-injurious. Explore ambivalence: reasons to die vs. reasons to live.

****Plan**: Inquire about timing, location, lethality, access to lethal means (e.g., gun), making preparations (e.g., hoarding medications, preparing a will, writing suicide note).

Behaviors: Inquire about past attempts, aborted attempts, rehearsals (e.g., tying noose, loading gun) vs. non-suicidal self-injurious actions.

Assessing Risk of Harm to Baby

Ask about unwanted or intrusive thoughts

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

"People often have intrusive thoughts or thoughts that seem to pop in from nowhere. Women often have thoughts about something bad happening to their baby. These thoughts can feel awful and sometimes feel as if they could be an escape from something too hard to bear. We are here to help you. We ask about these thoughts because they are so common."

- *Have you had any unwanted thoughts?*
- *Have you had any thoughts of harming your infant, either as an accident or on purpose?*
- If the patient answers yes to the above question, follow up with:
  - *How often do you have them?*
  - *How recently have you had them?*
  - *How much do they scare you?*
  - *How much do they worry you?*

Assess Risk

Assessment

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

Consider Best Treatment

Treatment

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

Assessment and Management of Bipolar Disorder and Psychosis

Why screen for bipolar disorder?

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

How is bipolar disorder different from depression?

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

Ask about current psychotic symptoms

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

Consider bipolar disorder if any of the following are present:

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

Assessment of bipolar disorder:

- Assessment with a psychiatric prescriber is generally indicated due to complexity of diagnosis
- Broad DDx (e.g., includes unipolar depression, schizoaffective disorder, borderline personality disorder, PTSD). See page 29-31 of the toolkit

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

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

Examples of Clinical Scenarios

Case Example #1:

Patient is on medication for bipolar disorder or psychosis

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

Case Example #2:

Prior history bipolar disorder

No current meds

Case Example #3:

Positive MDQ

Unidentified diagnosis

No current meds

→ **Refer for assessment**

Management of Bipolar Disorder and Psychosis

Medication Use During Pregnancy

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

Safer ⟷ Higher Risk

Reassuring data; do not discontinue

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

Less reassuring data; can continue if high risk

- Carbamazepine (Tegretol)
- Oxcarbazepine (Trileptal)

Avoid, change medication

- Valproic acid (Depakote)

Valproic acid is contraindicated for women of childbearing age and pregnant and lactating women because it can cause maternal metabolic syndrome and is a structural and neurodevelopmental teratogen

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

Medication Use During Breastfeeding

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

Safer ⟷ Higher Risk

Reassuring data for antipsychotic use; do not discontinue

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

Usually considered compatible with breastfeeding

- carbamazepine (Tegretol): Monitor drug level, cbc, liver enzymes
- lamotrigine (Lamictal): Monitor rash, drug level

Must monitor the breastfeeding infant closely for lithium toxicity

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

Always coordinate with pediatric provider

General Management Strategies

To decrease and manage risk of decompensation:

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

Mania or postpartum psychosis:

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

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

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