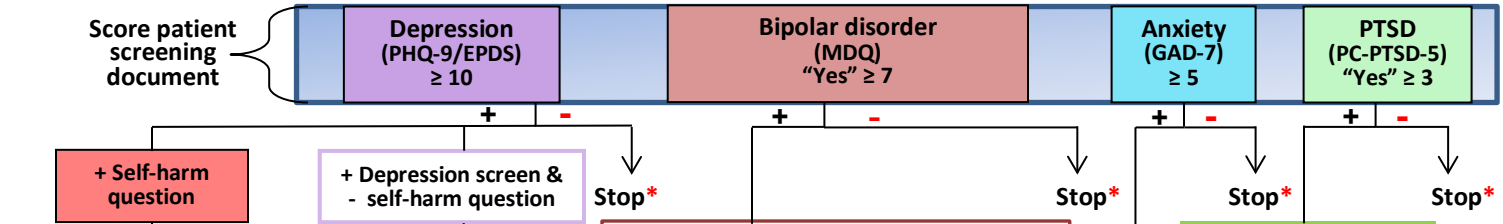
Lifeline for moms

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."*

Continue to other side →

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

 Revision 10-12-22. Lifeline for Moms Perinatal Mental Health Toolkit. Funding provided by CDC grant number U01DP006093.
Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

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

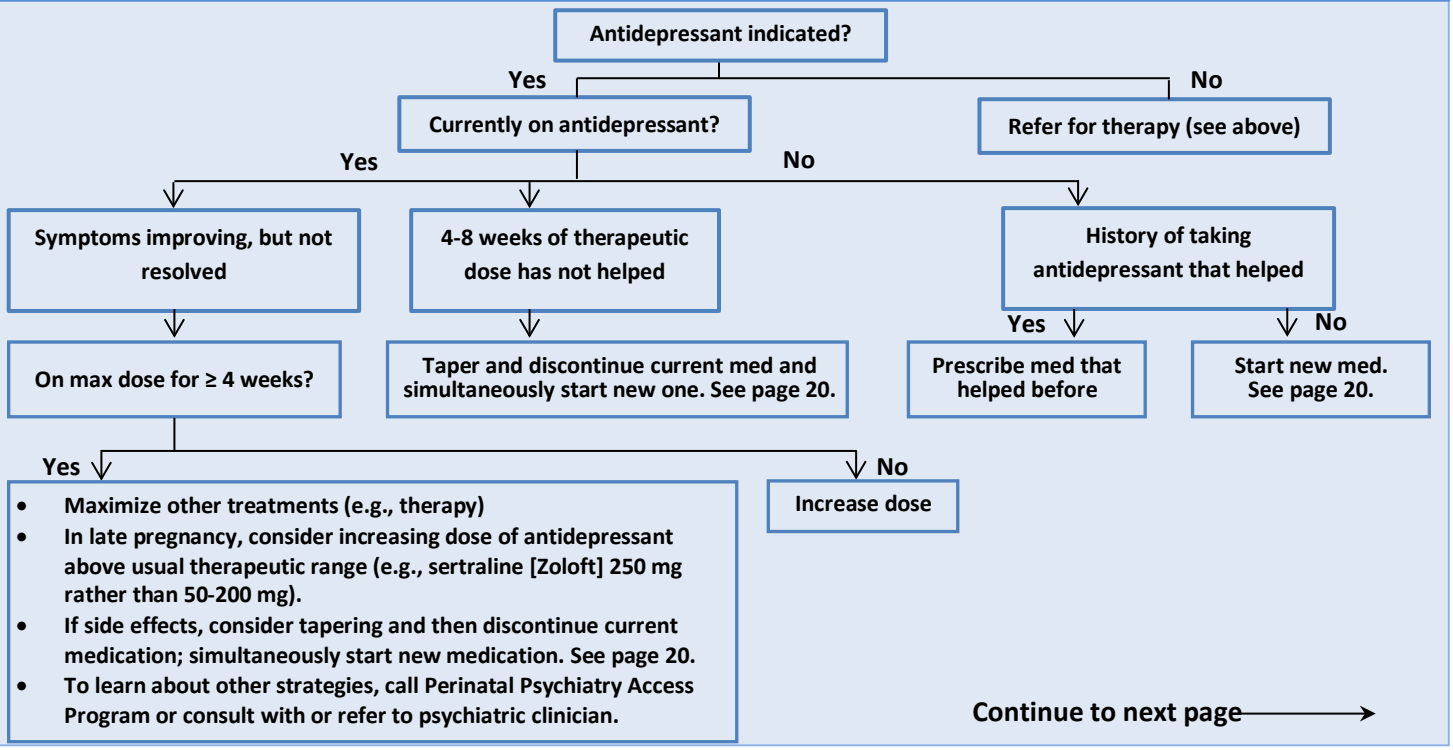
Antidepressant use during pregnancy:

- 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)



Continue to next page

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

 Revision 10-12-22. Lifeline for Moms Perinatal Mental Health Toolkit. Funding provided by CDC grant number U01DP006093.
Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

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

 Revision 10-12-22. Lifeline for Moms Perinatal Mental Health Toolkit. Funding provided by CDC grant number U01DP006093.
Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

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]

 Revision 10-12-22. Lifeline for Moms Perinatal Mental Health Toolkit. Funding provided by CDC grant number U01DP006093.
Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

Summary of Perinatal Mental Health Conditions

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

 Funding provided by CDC grant number U01DP006093. Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

Summary of Perinatal Mental Health Conditions

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

 Revision 01-05-2023. Lifeline for Moms Perinatal Mental Health Toolkit. Funding provided by CDC grant number U01DP006093. Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

Summary of Perinatal Mental Health Conditions

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

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) and O'Hara MW, Wisner KL. Perinatal mental illness: Definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol. 2013 Oct 7. pii: S1521-6934(13)00133-8. doi: 10.1016/j.bpobgyn.2013.09.002.

 Revision 01-05-2023. Lifeline for Moms Perinatal Mental Health Toolkit. Funding provided by CDC grant number U01DP006093. Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

How to Talk to Your Patient About Their Mental Health

Ask open-ended questions

- "How are you managing to free yourself up to attend therapy appointments?"
- "I'm curious, what seems to be getting in the way of [use patient's own words]?"
- "What was your experience with that?"

Use reflective listening

- "You're really not sure if your new therapist can be helpful."

Reinforce action, changes, and strengths

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

Acknowledge and validate concerns

- "I hear that you feel concerned about how these mental health challenges will affect your life."
- "It sounds as though you've been through a lot. How have you managed to cope with all of this?

Summarize the conversation

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

Ask permission before providing advice/feedback and follow-up

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

Avoid saying "I understand"

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

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

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

Avoid talking about yourself and your personal challenges or situations

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

 Funding provided by CDC grant number U01DP006093.
Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T.

Skillful and Effective Communication Examples for Talking to Patients Who Are Grieving

"I can't imagine what you're feeling right now"

"The pain you're feeling right now is the echo of the love you felt for…"

"It would be weird if you weren't feeling the way you're feeling now"

"Any idea that grief proceeds in a step-wise or linear way is total bullshit. Everyone experiences the process in their own way."

"What wouldn't you have to care about to not feel what you're feeling now? If given the choice, would you have it any different way?"

"Give yourself the kindness to feel whatever you're feeling in this moment."

"What would you tell a close friend if they were going through what you're going through now? Can you offer even a small part of that to yourself?"

"Some days are going to feel like you're getting better, then you may feel guilty for feeling better. This is all part of it, again just feel what you feel."

"Most people are terrible about expressing condolences and may say things like, 'I know what you're going through' or 'I felt the same way when…,' try to attend to their intentions, not their words"

"Access your support network when it feels helpful, and take time for yourself if helpful – though be mindful of isolating"

"I'm here with you"

"I see the pain you're in"

"Pain is the natural response to what you've been through, suffering comes from how we respond to pain"

Inquire about religious/spiritual/cultural traditions or practices that the patient can apply, even if no longer active. Familiar rituals can provide a sense of direction and stability when everything feels overwhelming.

Provider displays of emotion are completely normal. Without taking the focus off of your patient, put words to what is happening without trying to mask your feelings. "I'm noticing that I'm very moved by what you're sharing."

 Funding provided by CDC grant number U01DP006093. Authors: Byatt N., Brenckle L., Masters G., Bergman A., Moore Simas T

Action Plan for Mood Changes during Pregnancy or After Giving Birth

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

If you…	You may be experiencing emotional changes that happen to many pregnant individuals and new parents. You should…
Feel like you just aren't yourself Have trouble managing your emotions (ups and/or downs) Feel overwhelmed, but are still able to care for yourself and your baby Feel mild irritability Have slight difficulty falling asleep Have occasional difficulty focusing on a task Are less hungry than usual	Take special care of yourself. Get your partner to watch the baby, get a babysitter, or team up with another person to share childcare so that you can rest and exercise. Continue to watch for the signs of emotional mood changes in the yellow and red sections below. Find someone to talk to if things get worse. Talk to a health care provider if you feel unsure.

If you…	You may be experiencing emotional changes during or after your pregnancy for which you should get help. You should…
Feel intense uneasiness that hits with no warning Feel foggy and have more difficulty completing tasks than usual Notice that you have stopped doing things that you used to enjoy Have scary or upsetting thoughts that don't go away Feel guilty, or are having thoughts that you are failing at motherhood Are having difficulty falling or staying asleep (that doesn't have to do with getting up with your baby) Are falling behind with your job or schoolwork, or struggling in your relationships with family and/or friends Have family/friends mention that your mood seems off, or you're not acting like your usual self Are being overwhelmed by feelings of worry Have periods of feeling really "up," and overly happy where you are doing more activities than usual, then feel very sad, "down," or hopeless Are taking risks you usually wouldn't Are on edge or always looking out for possible danger/threats Feel numb or detached, like you are just going through the motions Have no interest in eating – food tastes like nothing Have thoughts of hurting yourself	Contact us. Your mental health is important to us. We are here to help. Talk to your partner, family, and friends about these feelings so they can help you. Contact your insurance company to find mental health providers. Visit the Anxiety and Depression Association of America's telehealth providers: https://adaa.org/finding-help/telemental-health/provider_listing Call Postpartum Support International (PSI) 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), to contact a volunteer who can provide support and resources in your area, or search online for a mental health provider at https://psidirectory.com/ Search the National Center for Posttraumatic Stress Disorder (PTSD) at https://www.ptsd.va.gov/ Read or complete workbook materials: *Pregnancy & Postpartum Anxiety Workbook* by Pamela S. Wiegartz and Kevin Gyoerkoe

If you…	Get help now!
Feel hopeless and in total despair Feel out of touch with reality (you may see or hear things that other people don't) Feel that you may hurt yourself or your baby Have family/friends that are worried about your or other's safety due to your mood swings and/or changes in activity levels	Go to the local emergency room or call 9-1-1 for immediate help. Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free and confidential emotional support Text the Crisis Line at 741741 (US) or 686868 (Canada) Still not sure what to do? Call us and we'll figure it out together

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

 Revision 01-05-2023. Action Plan for Mood Changes During Pregnancy and After Giving Birth and Self-Care Plan. Funding provided by CDC grant number U01DP006093. Authors: Byatt N., Mittal L., Brenckle L., Logan D., Masters G., Bergman A., Moore Simas T

Self-Care Plan

Your life may feel drastically changed during this time, and feeling overwhelmed, stressed, or sad are very common and understandable responses. It can be hard to cope with problems when you're feeling sad and have little energy. A self-care plan can be a useful tool to help you attend to your own wellness needs, and those of your baby.

1. **Make time for pleasurable activities.** Commit to scheduling some simple and enjoyable activity each day.
   Things I find pleasurable include: _____
   During the week I will spend at least_____ minutes doing (choose one or more of activity to try in the coming week) _____

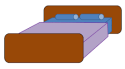
2. **Stay physically active.** Make sure you make time to do some activity, even a few minutes of activity can be helpful.
   During the week, I will spend at least _____minutes doing (write in activities) _____ _____.

3. **Ask for help.** Look to those in your life who you can ask for help - for example your husband or partner, your parents, other relatives, your friends.
   People I can ask to help me: _____
   During the week I will ask at least _____ person/people for help.

4. **Talk or spend time with people who can support you.** Explain to friends or loved ones how you feel. If you can't talk about it, that's OK – you can still ask them to be with you or join you for an activity.
   People I find supportive include _____. During the week, I will contact _____ (name/s) and try to talk with them _____times.

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

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



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

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