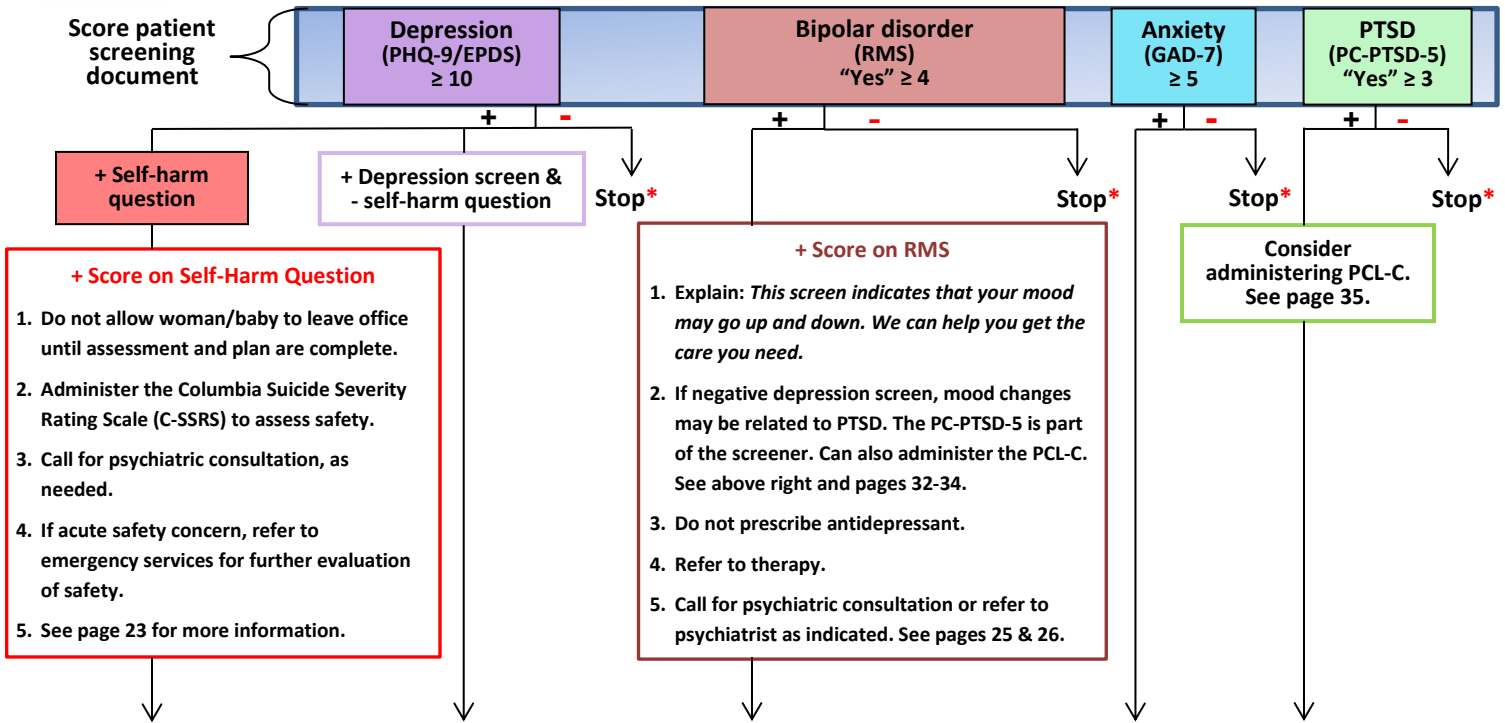




Perinatal Mental Health Toolkit
*Selected Perinatal Mental
Health Algorithms and
Resources*



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 32-34 for more on perinatal mental health conditions

Determine Illness Severity

MILD	MODERATE	SEVERE
Depression screener score 10-14	Depression screener score 15-19	Depression screener score > 19
GAD-7 score 5-9	GAD-7 score 10-14	GAD-7 score ≥ 15
PC-PTSD-5 score < 3	PC-PTSD-5 score ≥ 3	PC-PTSD-5 score ≥ 3
No suicidal ideation	Suicidal ideation present	Suicidal ideation, intent, and/or plan
Not feeling hopeless, helpless, worthless	Sometimes feels hopeless, helpless, worthless	Previous suicide attempt(s)
No previous psychiatric hospitalization	Previous psychiatric hospitalization	Often feels hopeless, helpless, worthless
No or minimal difficulty caring for self or baby	Some difficulty caring for self or baby	History of multiple psychiatric hospitalization(s)
<p>For mild, moderate, and severe illness:</p> <ul style="list-style-type: none"> - Start treatment; see page 20. - Check for underlying medical condition - order TSH, B12, folate, HGB, HCT. - Assess for substance use or medications, which can cause or worsen mood/anxiety. 		

* If all screens are negative, tell the patient 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-7 – Generalized Anxiety Disorder; RMS – Rapid Mood Screener; PHQ-9 – Patient Health Questionnaire
PTSD – Posttraumatic Stress Disorder; PC-PTSD-5 – Primary Care Posttraumatic Stress Disorder; PCL-C – PTSD Check List-Civilian

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
<p>Therapy referral</p> <p>Consider medication treatment</p>	<p>Therapy referral</p> <p>Strongly consider medication treatment</p> <p>If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum, and if the patient is up to 12 months postpartum at screening, consider zuranolone. See page 21</p>	<p>Therapy referral</p> <p>Medication treatment</p> <p>If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum, and if the patient is up to 12 months postpartum at screening, consider zuranolone. See page 21</p> <p>Call for psychiatric consultation/referral</p>

- Use internal resource list to refer patient to therapy
- Zuranolone Clinical Practice Update: <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2023/08/zuranolone-for-the-treatment-of-postpartum-depression>
- Book an appointment with the Postpartum Support International (PSI) Perinatal Psychiatric Consultation Program at <https://postpartum.net/professionals/perinatal-psychiatric-consultation/> or call 1-503-218-3818 to schedule a consultation by phone
- Call a Perinatal Psychiatry Access Program, if one is available in your state. Check at <https://www.umassmed.edu/lifeline4moms/Access-Programs/>
- Direct patients to 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 online at <https://psidirectory.com/> or the Maternal Mental Health Hotline: 1-833-TLC-MAMA (1-833-852-6262) or online at <https://mchb.hrsa.gov/programs-impact/national-maternal-mental-health-hotline> for support

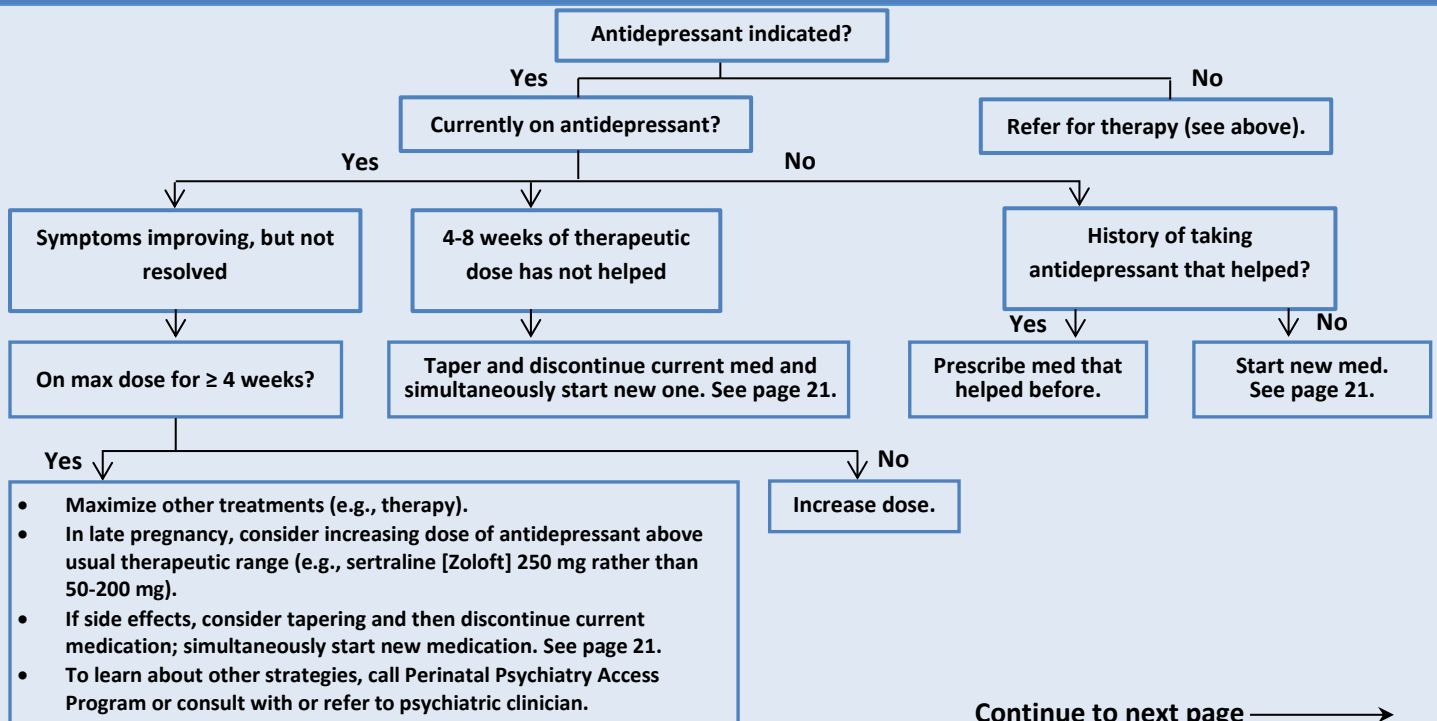
Therapy and support options

- **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 pages 28-30.

How to educate patients about treatment with antidepressants

- Small and inconsistent risk of miscarriage and preeclampsia
- Small increase in absolute risk of postpartum hemorrhage
- Small and inconsistent risk of birth defects when taken in the first trimester, particularly paroxetine
- Linked with transient (days to weeks) neonatal symptoms (tachypnea, irritability, insomnia; ~20-30%); self-limited with comfort measures
- Small increase in risk of persistent pulmonary hypertension of the newborn (PPHN; ~2-4/1,000 births)
- Inconsistent, overall reassuring, evidence regarding long-term (months to years) neurobehavioral effects on children
- 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 →

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 22.
- Evidence does not support tapering antidepressants in the third trimester.
- If depression onset is in the third trimester or within 4 weeks postpartum, consider using zuranolone in the postpartum period (see below).
- 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 20 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)

Nausea (most common)
Constipation/diarrhea
Lightheadedness
Headaches

Long-term (weeks to months)

Increased appetite/weight gain
Sexual side effects
Vivid dreams/insomnia
**QTc prolongation (citalopram & escitalopram)

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

Medication Treatment for Moderate/Severe Depression with Onset in Late Pregnancy or Within 4 Weeks Postpartum: zuranolone (Zurzuvae)

FDA-approved 14-day oral medication treatment in the postpartum period (i.e., within 12 months of delivery) for depression with onset in the third trimester or within 4 weeks postpartum. A neuroactive steroid and positive allosteric modulator of gamma-aminobutyric acid (GABA). Has a faster onset of action (within 3 days) than other oral antidepressants (within 2-4 weeks) to symptom improvement.

- 50mg qHS with a fatty meal (400-1,000 calories, 25%-50% fat) for 14 days; do not take more than 1 dose in a day – extend treatment course beyond 14 days if doses missed; dose adjustments or discontinuation needed if hepatic or renal disease, or experiencing significant CNS depressant effects, respectively (see [ACOG Zuranolone Clinical Practice Update](#))
- Can be used alone or as an adjunct to other oral antidepressant therapy like SNRIs or SSRIs; avoid use with other sedating meds
- Avoid pregnancy until 1 week after treatment; no direct neonate data regarding human milk feeding – simulated data reassuring
- Side effects include CNS depression, diarrhea, cold-like symptoms, and less commonly, increased suicidal thoughts/behaviors
- Advise patients not to drive or engage in potentially hazardous activities requiring complete mental alertness

More information can be found at [Reprotox](#) and [LactMed](#) on all pharmacological treatments

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 clinical improvement and no/minimal side effects

- 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 21
- 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 clinician

**If clinical
improvement
and no/minimal
side effects**

- Re-evaluate every month in pregnancy and postpartum and adjust medication accordingly. See page 21
- 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 clinician

If you are not continuing to manage the patient postpartum:

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

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 an informed decision regarding family planning

Adjunctive Support Options

Talk to your patient about adjunctive support options such as:

- Self-care (see page 29, Self-Care Plan)
- 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

Quick Reference Guide for Perinatal Behavioral Health Resources

Immediate Mental Health Support



IL MOMS Line (IL Perinatal Depression Hotline)

For patients 24/7: provides support & help navigating patients to mental health referrals, free, no insurance needed
Phone: 866-364-MOMS (6667)



IL DocAssist

Free clinical consultation for providers with a perinatal psychiatrist to help with perinatal mental health & SUD treatment and management
Phone: 866-986-2778; M-F, 9am-5pm CST



Postpartum Support International (PSI)

A toll-free telephone number anyone can call to get basic information, support, and resources; callbacks between 8AM-11PM EST
Phone (English): 800-944-4773
Text (Español): 971-203-7773



Illinois MAR Now

24/7 fast access to opioid use disorder and alcohol use disorder treatment and follow up care coordination
Phone: 833-234-6343



Illinois CARES Crises Hotline

24/7 hotline for mental health crises
Phone: 800-345-9049



National Maternal Mental Health Hotline

The Hotline is free, confidential, and available 24/7 in English and Spanish
Phone: 833-TLC-MAMA (833-852-6262)

Provider Directories and Referrals



Service Provider Identification and Exploration Resource (SPIDER) Database

Database of Illinois providers, agencies, and services for patients with Medicaid, including providers and services specializing in mental health treatment, substance use treatment, and domestic violence.



Postpartum Support International (PSI) Provider Directory

Search here for a mental health therapist, healthcare provider, psychiatrist, doula, lactation counselor, sleep coach, and more! All providers have specialized training in perinatal mental health.



SAMHSA Treatment Finder

Confidential substance use & mental health treatment resources



Online Referrals with Warm Handoffs to PMH Care

A list of statewide resources that providers can use to refer patients to mental health care with a warm handoff



Medicaid Behavioral Health Services



Illinois Medicaid Behavioral Health Toolkit



- Behavioral health benefits covered by Illinois Medicaid
- All Medicaid health plans offer 24-hour Behavioral Health Crisis Line with mental health professionals who answer questions, assess mental health, and help navigate to needed mental health services



Community-Based Services

- SPIDER Database (Database of Illinois providers, agencies, and services for patients with Medicaid)
- Directory of Managed Care Plan to call for information on covered mental health providers



In-Home Support



Home Visiting Programs

- iGrow coordinated intake contact list (list of early childhood home visiting programs by community)
- DHS office locator (identify DHS offices or service providers in your community)
- ILPQC expanding access to home visiting programs in Illinois handout



Doula Support

- Illinois Medicaid-Certified Doula Program
- Doulamatch.net (discover doulas serving your community)
- ILPQC Expanding Doula Access handout



Substance Use & Recovery Support



IL DocAssist

Free clinical consultation with a perinatal psychiatrist for prescribers on perinatal mental health & SUD treatment and management

Phone: 866-986-2778; M-F, 9am-5pm CST



Illinois MAR Now

24/7 fast access to opioid use disorder and alcohol use disorder treatment and follow up care coordination

Phone: 833-234-6343



SAMHSA Treatment Finder

Confidential substance use & mental health treatment resources



Intensive Outpatient and Inpatient Perinatal Programs



Ascension Perinatal Intensive Outpatient Program

Provides in person and virtual services

Phone: 224-299-3220



UIC Women's Mental Health and Reproductive Psychiatry

Provides inpatient and outpatient services. Accepts most major insurances, including Medicaid

Phone: 312-996-2242



Contact IL DocAssist (866-986-2778) for additional intensive outpatient and inpatient programs

Peer Support



Illinois Department of Healthcare and Family Services Perinatal Depression Support Group Search Tool by County



PSI Peer Support Groups





ILLINOIS **DocAssist**

CONSULTATION AND RESOURCES FOR PEDIATRIC AND PERINATAL MENTAL HEALTH

Our psychiatric consultants can quickly assist you with addressing the mental health and substance use needs of your patients.

Illinois DocAssist is a FREE statewide service.

SERVICES INCLUDE:

- Same Day Telephone Consultation
- Treatment Referral Assistance
- Provider Resources
- Continuing Education



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866-986-ASST (2778)

Illinois MOMS Line

Are you or a loved one feeling:
Overwhelmed with a new baby?
Worried during pregnancy?
Heartbroken by loss or infertility?
Not yourself, and you don't know why?

Answered live by **mental health** professionals

- Free and confidential
- Emotional support
- Mental health referrals
- Any language
- Anyone can call



You are not alone. With support, you can feel better.

Anyone can call us. We can help.

We answer 24/7/365.

1-866-364-MOMS (6667)

Línea para MAMÁS de Illinois

¿Usted o un ser querido se siente:

Abrumada por el nacimiento de su bebé ?

Preocupada durante el embarazo?

Triste por una pérdida o por problemas de fertilidad?

No como tú misma y no sabe porque?

Atendida en directo por profesionales de salud mental

- Gratis y confidencial
- Apoyo emocional
- Remisiones de salud mental
- En todos los idiomas
- Cualquiera puede llamar



No está sola. Puede sentirse mejor si recibe apoyo.

Cualquiera puede llamar, podemos ayudarla.

Atendemos 24 horas/365 días

1-866-364-MOMS (6667)