Dear Healthcare Professional

Mental health complications during the perinatal period, from time of conception through the infant's first year of life, are a growing concern for our community. Like other public health problems, Perinatal Mood and Anxiety Disorders (PMADs) by their complexity require broad interdisciplinary approaches and solutions.

NYS is in a period of transformation on how healthcare is delivered and received with a greater emphasis on prevention and a whole patient approach. Reimbursements are being structured on value rather than fee for service.

The Staten Island PPS is working to build provider capacity in incorporating behavioral health services in various healthcare settings, in order to prepare for these changes and provide the highest level of care and achieve the triple aim of improving health, enhancing the patient care experience which encompasses access, quality, and reliability, and reduce or control the cost of care. As you are aware, Staten Island is in the middle of a substance abuse epidemic, these issues along with depression and anxiety can play an important role in the etiology, course and outcomes associated with chronic diseases.

Because people with co-occurring disorders are everywhere in our communities, every point of entry into the health care system is an opportunity for out-reach, education, and connection to needed services. In order to better serve your patients we strongly recommend the following:

- **Universal screening for substance use and mental health issues such as depression and anxiety**
- **Create systems to link your patients to behavioral health resources in the community**
- **Refer your Medicaid patients to SI CARES**

This Toolkit provides valuable resources for clinicians on how these issues impact wellness. Included in your toolkit is a referral grid for services focusing on Mental Health and Substance use as well as patient education material. We will be following up with you soon to explore how the Staten Island PPS can better support you in the behavioral health integration efforts.

In the meantime please visit the Staten Island PPS web site for more information and resources.
http://www.statenislandpps.org/home

Sincerely,

Nadeen Makhlouf Pharm D., MPH
Manager, Clinical Performance Improvement
Staten Island Partnership for Community Wellness (SIPCW)

Moms get Distressed – Sometimes it's Serious

SPEAK UP WHEN YOU'RE DOWN

MATERNAL MENTAL HEALTH DISORDERS **ARE** TREATABLE.

SIGNS CAN INCLUDE:

SLEEP DISTURBANCE & **CHANGES IN APPETITE**

FEELINGS OF **HOPELESSNESS**, **HELPLESSNESS**, **GUILT** & **DESPAIR**

FEELING **INADEQUATE** AS A MOTHER

ANXIOUS OR **IRRITABLE** FEELINGS

FEELING **EMOTIONALLY DISCONNECTED** FROM YOUR BABY

LACK OF INTEREST IN FAMILY AND FRIENDS

OBSESSING OVER BABY'S SAFETY

UP TO 20% OF **PREGNANT** & NEW **MOMS** WILL **EXPERIENCE** SOME FORM OF **MATERNAL MENTAL HEALTH DISORDER**.

CALL POSTPARTUM SUPPORT INTERNATIONAL

1.800.944.4773

2020Mom

2020Mom.org

TheBlueDot project

thebluedotproject.org

The American College of Obstetricians and Gynecologists Committee Opinion and recommendations Optimizing Postpartum Care (**Number 736 - May 2018)**

- To optimize the health of women and infants, postpartum care should become an ongoing process, rather than a single encounter, with services and support tailored to each woman's individual needs.

- Anticipatory guidance should begin during pregnancy with development of a postpartum care plan that addresses the transition to parenthood and well-woman care.

- Prenatal discussions should include the woman's reproductive life plans, including desire for and timing of any future pregnancies. A woman's future pregnancy intentions provide a context for shared decision-making regarding contraceptive options.

- All women should ideally have contact with a maternal care provider within the first 3 weeks postpartum. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth.

- The timing of the comprehensive postpartum visit should be individualized and woman centered.

- The comprehensive postpartum visit should include a full assessment of physical, social, and psychological well-being.

- Women with pregnancies complicated by preterm birth, gestational diabetes, or hypertensive disorders of pregnancy should be counseled that these disorders are associated with a higher lifetime risk of maternal cardiometabolic disease.

The American College of Obstetricians and Gynecologists Committee Opinion and recommendations Optimizing Postpartum Care (**Number 736 - May 2018)**

- Women with chronic medical conditions, such as hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, mood disorders, and substance use disorders, should be counseled regarding the importance of timely follow-up with their obstetrician–gynecologists or primary care providers for ongoing coordination of care.

- For a woman who has experienced a miscarriage, stillbirth, or neonatal death, it is essential to ensure follow-up with an obstetrician–gynecologist or other obstetric care provider.

- Optimizing care and support for postpartum families will require policy changes. Changes in the scope of postpartum care should be facilitated by reimbursement policies that support postpartum care as on ongoing process, rather than an isolated visit.

The American College of Obstetricians and Gynecologists Committee Opinion and recommendations Optimizing Postpartum Care (**Number 736 - May 2018)**

Table 1. Suggested Components of the Postpartum Care Plan*

Element	Components
Care team	Name, phone number, and office or clinic address for each member of care team
Postpartum visits	Time, date, and location for postpartum visit(s); phone number to call to schedule or reschedule appointments
Infant feeding plan	Intended method of infant feeding, resources for community support (eg, WIC, Lactation Warm Lines, Mothers' groups), return-to-work resources
Reproductive life plan and commensurate contraception	Desired number of children and timing of next pregnancy Method of contraception, instructions for when to initiate, effectiveness, potential adverse effects, and care team member to contact with questions
Pregnancy complications	Pregnancy complications and recommended follow-up or test results (eg, glucose screening for gestational diabetes, blood pressure check for gestational hypertension), as well as risk reduction recommendations for any future pregnancies
Adverse pregnancy outcomes associated with ASCVD	Adverse pregnancy outcomes associated with ASCVD will need baseline ASCVD risk assessment, as well as discussion of need for ongoing annual assessment and need for ASCVD prevention over lifetime.
Mental health	Anticipatory guidance regarding signs and symptoms of perinatal depression or anxiety; management recommendations for women with anxiety, depression, or other psychiatric issues identified during pregnancy or in the postpartum period
Postpartum problems	Recommendations for management of postpartum problems (ie, pelvic floor exercises for stress urinary incontinence, water-based lubricant for dyspareunia)
Chronic health conditions	Treatment plan for ongoing physical and mental health conditions and the care team member responsible for follow-up

Abbreviations: ASCVD, atherosclerotic cardiovascular disease; WIC, Special Supplemental Nutrition Program for Women, Infants, and Children.

*A Postpartum Care Plan Template is available as part of the ACOG Pregnancy Record.

The American College of Obstetricians and Gynecologists Committee Opinion and recommendations Optimizing Postpartum Care (**Number 736 - May 2018)**

Box 1. Components of Postpartum Care

Mood and emotional well-being

- Screen for postpartum depression and anxiety with a validated instrument[1,2]
- Provide guidance regarding local resources for mentoring and support
- Screen for tobacco use; counsel regarding relapse risk in postpartum period[3]
- Screen for substance use disorder and refer as indicated[4]
- Follow-up on preexisting mental health disorders, refer for or confirm attendance at mental health-related appointments, and titrate medications as appropriate for the postpartum period

Infant care and feeding

- Assess comfort and confidence with caring for newborn, including
  - feeding method
  - child care strategy if returning to work or school
  - ensuring infant has a pediatric medical home
  - ensuring that all caregivers are immunized[5]
- Assess comfort and confidence with breastfeeding, including
  - breastfeeding-associated pain[6]
  - guidance on logistics of and legal rights to milk expression if returning to work or school[7,8]
  - guidance regarding return to fertility while lactating; pregnancy is unlikely if menses have not returned, infant is less than 6 months old, and infant is fully or nearly fully breastfeeding with no interval of more than 4–6 hours between breastfeeding sessions[9]
  - review theoretical concerns regarding hormonal contraception and breastfeeding, within the context of each woman's desire to breastfeed and her risk of unplanned pregnancy[7]
- Assess material needs, such as stable housing, utilities, food, and diapers, with referral to resources as needed

The American College of Obstetricians and Gynecologists Committee Opinion and recommendations Optimizing Postpartum Care (**Number 736 - May 2018)**

Sexuality, contraception, and birth spacing

- Provide guidance regarding sexuality, management of dyspareunia, and resumption of intercourse
- Assess desire for future pregnancies and reproductive life plan[10]
- Explain the rationale for avoiding an interpregnancy interval of less than 6 months and discuss the risks and benefits of repeat pregnancy sooner than 18 months
- Review recommendations for prevention of recurrent pregnancy complications, such as 17α-hydroxyprogesterone caproate to reduce risk of recurrent preterm birth, or aspirin to reduce risk of preeclampsia
- Select a contraceptive method that reflects patient's stated needs and preferences, with same-day placement of LARC, if desired[11]

Sleep and fatigue

- Discuss coping options for fatigue and sleep disruption
- Engage family and friends in assisting with care responsibilities

Physical recovery from birth

- Assess presence of perineal or cesarean incision pain; provide guidance regarding normal versus prolonged recovery[12]
- Assess for presence of urinary and fecal continence, with referral to physical therapy or urogynecology as indicated[13,14]
- Provide actionable guidance regarding resumption of physical activity and attainment of healthy weight[15]

Chronic disease management

The American College of Obstetricians and Gynecologists Committee Opinion and recommendations Optimizing Postpartum Care (**Number 736 - May 2018)**

- Discuss pregnancy complications, if any, and their implications for future childbearing and long-term maternal health, including ASCVD
- Perform glucose screening for women with GDM: a fasting plasma glucose test or 75 g, 2-hour oral glucose tolerance test[16]
- Review medication selection and dose outside of pregnancy, including consideration of whether the patient is breastfeeding, using a reliable resource such as LactMed
- Refer for follow-up care with primary care or subspecialist health care providers, as indicated

Health maintenance

- Review vaccination history and provide indicated immunizations, including completing series initiated antepartum or postpartum[17]
- Perform well-woman screening, including Pap test and pelvic examination, as indicated[18]

The American College of Obstetricians and Gynecologists Committee Opinion and recommendations Optimizing Postpartum Care (**Number 736 - May 2018)**

Team Member	Role
Family and friends	• Ensures woman has assistance for infant care, breastfeeding support, care of older children • Assists with practical needs such as meals, household chores, and transportation • Monitors for signs and symptoms of complications, including mental health
Primary maternal care provider (obstetrician–gynecologist, certified nurse midwife, family physician, women's health nurse practitioner)	• Ensures patient's postpartum needs are assessed and met during the postpartum period and that the comprehensive postpartum visit is completed • "First call" for acute concerns during postpartum period • Also may provide ongoing routine well-woman care after comprehensive postpartum visit
Infant's health care provider (pediatrician, family physician, pediatric nurse practitioner)	• Primary care provider for infant after discharge from maternity care
Primary care provider (also may be the obstetric care provider)	• May co-manage chronic conditions (eg, hypertension, diabetes, depression) during postpartum period • Assumes primary responsibility for ongoing health care after comprehensive postpartum visit
Lactation support (professional IBCLC, certified counselors and educators, peer support)	• Provides anticipatory guidance and support for breastfeeding • Co-manages complications with pediatric and maternal care providers
Care coordinator or case manager	• Coordinates health and social services among members of postpartum care team
Home visitor (eg, Nurse Family Partnership, Health Start)	• Provides home visit services to meet specific needs of mother–infant dyad after discharge from maternity care
Specialty consultants (ie, maternal–fetal medicine, internal medicine subspecialist, behavioral health care provider)	• Co-manages complex medical problems during postpartum period • Provides prepregnancy counseling for future pregnancies

Abbreviation: IBCLC, international board certified lactation consultant.

A Menu of Treatment Options: Stepped Care, Evidence Based Prevention and Treatment Options for Maternal Mental Health

This "menu" of treatment options was adapted from the MCPAP for Moms Adult Provider Toolkit, to note the range of overlapping evidence-based prevention and treatment options that are available.

Prevention Strategies & Treatment Options[103]	Limited to no symptoms	Mild symptoms	Moderate symptoms	Severe symptoms
– Self-care, including sleep-hygiene and grooming, as desired	x	x	x	x
– Nutrition including adequate omega-3 fatty acids, vitamin D, folate	x	x	x	x
– Exercise	x	x	x	x
– Dyadic mother-baby support for dysregulated baby; crying, sleep, feeding problems	x	x	x	x
– Consider as augmentation: complementary/alternative therapies (bright light therapy, acupuncture, massage, yoga, meditation)	x	x	x	x
– Reducing isolation by getting outdoors/outside of the home	x	x	x	
– Reducing isolation by socializing and community support (including receiving emotional support from partner, friends, family or others; attending support groups or new baby care/parenting classes, home visiting, community health workers)	x	x	x	x
– Practical support (from partner*, friends, family*, or postpartum doula with household duties and baby/child care)	x	x	x	x
– Support groups for depression/anxiety		x	x	x
– Therapy for mother – Dyadic therapy for mother/baby		x	x	x
– Consider medication		x	xx**	xx**
– Consider inpatient hospitalization when safety or ability to care for self is a concern			x	x

Treatment options in each column may overlap.
*This may include fathers or grandparents taking job-protected unpaid leave under the Family Medical Leave Act. **Strongly consider.

Table 4. Excerpted from A Report from the California Task Force on the Status of Maternal Mental Health Care, 4/2017

WISCONSIN ASSOCIATION for Perinatal Care

ANTIDEPRESSANT MEDICATION CHART

(This chart is intended for clinicians who provide primary care to pregnant and postpartum women)

Data current as of December 2015

Antidepressants	Trade Name	Usual Daily Dose	Benefits	Maternal Risks	Fetal/Neonatal Risks	Breastfeeding: Relative infant dose=(RID)	Breastfeeding: Half-life ($t_{1/2}$)/ metabolites	Breastfeeding: Reported side effects in breastfed infants
DRUG CLASS: Selective Serotonin Reuptake Inhibitors (SSRIs)								
Citalopram	Celexa®	20-40mg	• Few interactions with other medications • No adverse morphologic consequences for infant found	• Side effects include nausea, insomnia, dizziness, and somnolence	• Behavioral consequences for infant unknown • Possible increased risk of growth restriction • Possible increased risk of neural tube defects and cardiac defects (ASD)	3.60%	• 1-2 days • 3 weak metabolites with little activity	• Somnolence • Decreased feeding • Weight loss
Escitalopram	Lexapro®	10-20mg	• Few interactions with other medications • No adverse morphologic consequences for infant found	• Side effects include nausea, insomnia, somnolence, dizziness, fatigue, diarrhea, sexual dysfunction, and dry mouth	• No systematic studies in human pregnancy • Morphologic and behavioral consequences for infant unknown • Possible increased risk of growth restriction	5.2-8%	• 1-2 days (drug and active metabolite)	• Somnolence • Decreased feeding • Weight loss
Fluoxetine	Prozac®	20-80mg	• More studies in human pregnancy, including meta-analysis and neurodevelopmental follow-up • No adverse behavioral consequences for infant found	• Side effects include nausea, drowsiness, and sexual dysfunction • Possible drug interactions	• More reports of neonatal side effects than some other antidepressants • Possible morphological consequences	1.6-14.6%	• Days to weeks (drug and active metabolites) • Serum levels similar to those in adults reported in some symptomatic infants	• Severe colic • Fussiness • Crying
Fluvoxamine	Luvox®	50-300mg	• No adverse morphologic consequences for infant found	• Side effects include nausea, drowsiness, anorexia, anxiety, and sexual dysfunction • Possible drug interactions	• Behavioral consequences for infant unknown	0.3-1.4%	• 12-24 hours • Major metabolite not active	• No reported concerns
Paroxetine	Paxil®	20-60mg	• None--avoid during pregnancy if possible	• May increase risk of miscarriage • Side effects include nausea, drowsiness, fatigue, dizziness, and sexual dysfunction.	• Behavioral consequences for infant unknown • Possible association with cardiovascular malformations in infant	1.2-2.8%	• Hours to days • No active metabolites	• Studies suggest minimal to no effect on breastfed infants
Sertraline	Zoloft®	50-200mg	• Relatively well-studied in human pregnancy • No adverse behavioral consequences for infants found • Fewer reports of neonatal side effects than other antidepressants	• Side effects include nausea, loose stools, tremors, insomnia, and sexual dysfunction • Possible drug interactions	• Possible specific association with cardiac septal defects, omphalocele, and craniosynostosis	0.4-2.2%	• 1-2 days (drug and weakly active metabolite) • Detectable levels in some infants, but no adverse effects	• Studies suggest minimal to no effect on breastfed infants

For additional information contact: Wisconsin Association for Perinatal Care | 211 S. Paterson St., Suite 250 | Madison, WI 53703 | www.perinatalweb.org Email: wapc@perinatalweb.org

WISCONSIN ASSOCIATION for Perinatal Care

ANTIDEPRESSANT MEDICATION CHART

(This chart is intended for clinicians who provide primary care to pregnant and postpartum women)

Data current as of December 2015

Antidepressants	Trade Name	Usual Daily Dose	Benefits	Maternal Risks	Fetal/Neonatal Risks	Breastfeeding: Relative infant dose=(RID)	Breastfeeding: Half-life ($t_{1/2}$)/ metabolites	Breastfeeding: Reported side effects in breastfed infants
DRUG CLASS: Tricyclic antidepressants (TSAs)								
Amitriptyline	Elavil®	25-300mg	• More studies in human pregnancy, including neurodevelopmental follow-up • No adverse morphologic consequences for infant found • No adverse behavioral consequences for infant found • May be useful if sedation desired	• Side effects include sedation, weight gain, dry mouth, constipation, and orthostatic hypotension--baseline ECG recommended • Possible drug interactions	• Fetal and neonatal side effects include tachycardia and urinary retention	1.9-2.8%	• 1-2 days (drug and active metabolite, nortriptyline)	• No reported adverse events in infants found • Monitor for sedation and poor feeding
Desipramine	Norpramin®	100-300mg	• More studies in human pregnancy, including neurodevelopmental follow-up • No adverse morphologic consequences for infant found • No adverse behavioral consequences for infant found • May be useful if sedation desired	• Side effects include sedation, weight gain, dry mouth, constipation, and orthostatic hypotension--baseline ECG recommended • Possible drug interactions	• Fetal and neonatal side effects include tachycardia and urinary retention	0.2-0.9%	• 1-2 days (drug and active metabolite) • Not detected in infants	• No reported adverse events in infants found
Nortriptyline	Pamelor®	50-150mg	• More studies in human pregnancy, including neurodevelopmental follow-up • No adverse morphologic consequences for infant found • No adverse behavioral consequences for infant found • May be useful if sedation desired	• Side effects include sedation, weight gain, dry mouth, constipation, and orthostatic hypotension--baseline ECG recommended • Possible drug interactions	• Fetal and neonatal side effects include tachycardia and urinary retention	1.7-3.1%	• ≥1 day • No active metabolites	• No reported adverse events in infants found
DRUG CLASS: Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)								
Desvenlafaxine	Pristiq®	50-100mg	• Balanced antidepressant; may be effective when selective agents are not • No adverse morphologic consequences for infant found	• May increase risk of miscarriage • Side effects include hypertension, nausea, sweating, dry mouth, dizziness, insomnia, somnolence, and sexual dysfunction	• No behavioral studies in human pregnancy • Possible neonatal risk of respiratory distress, cyanosis, apnea, seizures, temperature instability, and feeding difficulties	5.9-9.3%	• 10-11 hours • No active metabolites	• Monitor for excessive sedation and adequate weight gain
Duloxetine	Cymbalta®	40-60mg	• Balanced antidepressant; may be effective when selective agents are not • Low cord to maternal serum ratio suggests limited transfer across the placenta	• Side effects include nausea, dry mouth, constipation, diarrhea, vomiting, decreased appetite, fatigue, dizziness, somnolence, tremors, sweating, blurred vision, and insomnia	• No systematic studies in human pregnancy • Morphologic and behavioral consequences for infant not reported	0.10%	• 8-20 hours • No active metabolites	• No reported adverse events in infants found
Venlafaxine	Effexor®	75-375mg	• Balanced antidepressant; may be effective when selective agents are not • No adverse morphologic consequences for infant found	• May increase risk of miscarriage • Side effects include hypertension, nausea, sweating, dry mouth, dizziness, insomnia, somnolence, and sexual dysfunction	• No behavioral studies in human pregnancy • Possible neonatal risk of respiratory distress, cyanosis, apnea, seizures, temperature instability, and feeding difficulties	6.8-8.1%	• Approx 5 hrs (11 hrs for active metabolite, desvenlafaxine)	• Detectable plasma levels in several breastfed infants were not associated with any adverse effects • Monitor for excessive sedation and adequate weight gain

WISCONSIN ASSOCIATION for Perinatal Care

ANTIDEPRESSANT MEDICATION CHART

(This chart is intended for clinicians who provide primary care to pregnant and postpartum women)

Data current as of December 2015

Antidepressants	Trade Name	Usual Daily Dose	Benefits	Maternal Risks	Fetal/Neonatal Risks	Breastfeeding: Relative infant dose=(RID)	Breastfeeding: Half-life ($t_{1/2}$)/ metabolites	Breastfeeding: Reported side effects in breastfed infants
DRUG CLASS: Other								
Aripiprazole	Abilify®	2-15mg	• No adverse morphologic consequences for infant reported	• Side effects include headache, extrapyramidal reaction, sedation, dizziness, nausea, agitation, insomnia, weight gain	• May increase risk of prematurity and fetal growth restriction	1%	• 3-5 days	• Somnolence
Bupropion	Wellbutrin® Zyban®	300-450mg	• Helps with smoking cessation (never tested in pregnancy)	• May increase risk of miscarriage • Side effects include dizziness, headache, dry mouth, sweating, tremor, agitation, insomnia, and rare seizures • Possible drug interactions	• Behavioral consequences for infant • Possible increased risk of CHD • Possible increased risk of fetal cardiac arrhythmia	0.6-2%	• Approx 1 day • Plasma levels undetectable in breastfed infant	• One reported case of seizure in a 6 month old
Gabapentin	Neurontin®	900-2400mg	• No adverse morphologic consequences for infant reported	• Side effects include somnolence and dizziness	• May increase risk of prematurity and low birth weight	1.3-6.6%	• Approx 14 hrs • Drug excreted unchanged	• Drowsiness • Poor weight gain
Mirtazapine	Remeron®	15-45mg	• No adverse morphologic consequences for infant found • Helps restore appetite in women who are not gaining weight • Less likely to exacerbate nausea and vomiting	• May increase risk of miscarriage • Side effects include somnolence, nausea, weight gain, and dizziness	• Behavioral consequences for infant unknown • May increase risk of preterm birth • Possible hypothermia	1.6-6.3%	• 1-2 days (drug and active metabolite) • Very low plasma level detected in 1 of 3 infants tested	• No adverse effects reported • Observe for sedation
Quetiapine	Seroquel®	100-800mg	• No adverse morphologic consequences for infant reported • Low transplacental passage	• Side effects include drowsiness, headache, weight gain, increased triglycerides and cholesterol, dry mouth • Avoid concomitant use with other drugs that prolong QT interval		<1.0%	• 6-12 hours (drug and active metabolite)	• No adverse effects reported

Breastfeeding and Medications: Maternal Considerations

1. Avoid random switching of medications based on data alone. Choose drugs for which published data is available, rather than those recently introduced.
2. Most drugs are quite safe in breastfeeding mothers.
3. If the Relative Infant Dose (RID) is less than 10%, most medications are relatively safe to use. The RID of the vast majority of drugs is <1%.
4. Choose drugs with a short half-life, high protein binding, low oral availability, or high molecular weight.
5. Medications used in the first 3-4 days postpartum generally produce sub-clinical levels in the infant due to the limited volume of milk.
6. Avoid using medications when possible. Herbal drugs, high dose vitamins, unusual supplements, etc. that are not necessary should be avoided.

Adapted from Hale, T.W. & Rowe, H.E. (2014). *Medications and Mothers' Milk* (16th ed.)

Breastfeeding and Medications: Neonatal Considerations

1. Evaluate the infant for risks: Premature infants and neonates in general are at greater risk than older infants are.
2. Inquire about the infant: Always inquire about the infant's age, size, and stability. This is perhaps the most important criteria to be evaluated prior to using the medication.
4. Infant stability: Unstable infants with poor GI stability may increase the risk of using medications.
5. Pediatric approved drugs: These generally are less hazardous if long-term history of safety is recognized.

Adapted from Hale, T.W. & Rowe, H.E. (2014). *Medications and Mothers' Milk* (16th ed.)

WISCONSIN ASSOCIATION for **Perinatal Care**

ANTIDEPRESSANT MEDICATION CHART

(This chart is intended for clinicians who provide primary care to pregnant and postpartum women)

Notes

(1) Dosage information: www.medscape.com (Accessed December 14, 2015.).

Table based on Wisner, K.L., Parry, B.L., & Piontek, C.M. (2002). Clinical Practice. Postpartum Depression. *New England Journal of Medicine*, 347(3), 194-199 and related articles.

Breastfeeding information from Hale, T.W. & Rowe, H.E. (2014). *Medications and Mothers' Milk* (16th ed.) and Micromedex® Healthcare Series. 1974-2010. Greenwood Village, CO: Thomson Healthcare.

Clinicians may consider initiating treatment with these agents at half of the lowest recommended therapeutic dose. Treatment decisions should be based on patient characteristics and clinical judgment. Recommended dosages can be found in the most recent editions of the *Physician's Desk Reference* and the *Drug Information Handbook*.

(2) Reported side effects in breastfeeding infants are based on case reports and case series.

(3) Medications vary in the amount and quality of data available about effects in human pregnancy. A better-studied medication may have more reported side effects than a less-studied medication because more is known about it, not necessarily because it is riskier.

(4) Data presented here are based on reports from and studies during human pregnancy. The Food and Drug Administration's Pregnancy Risk Categories, as found in the *Physician's Desk Reference*, are based on a combination of animal and human studies.

Comments

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

- Risks of antidepressants during pregnancy and lactation must be weighed against the risks of untreated symptoms. Treatment should be individualized.
- Monitor for dose adjustment through pregnancy. The dose of the medication may need to be increased to maintain response.
- All antidepressants, if abruptly discontinued during pregnancy or at the time of birth, can lead to discontinuation side effects. Discontinuation side effects can be minimized by a partial dose taper during the last month of pregnancy, if the patient is asymptomatic, with a return to full dose after delivery to prevent postpartum recurrence.
- If a patient is on other medications, consult with a pharmacist or other appropriate specialists for interaction information.
- See also ACOG Practice Bulletin No. 92: Use of psychiatric medications during pregnancy and lactation. (2008/Reaffirmed 2014) *Obstetrics and Gynecology*, 111(5), 1001-1020.
- As a class, SSRI antidepressants may be associated with an increased risk of miscarriage; gestational age decreased by an average of one week; and increased risk of persistent pulmonary hypertension in the newborn with exposure after 20 weeks gestation.
- For more information on SSRIs and pregnancy, see:

Byatt N et al. (2013). Antidepressant use in pregnancy: a critical review focused on risks and controversies. *Acta Psychiatrica Scandinavica*, 127, 94-114.

Deligiannidis KM et al. (2014). Pharmacotherapy for mood disorders in pregnancy: A review of pharmacokinetic changes and clinical recommendations for therapeutic drug monitoring. *Journal of Clinical Psychopharmacology*, 34(2), 244-255.

Grigoriadis S et al. (2013). Antidepressant exposure during pregnancy and congenital malformations: Is there an association? A systematic review and meta-analysis of the best evidence. *Journal of Clinical Psychiatry*, 74(4), e293-e308.

Huybrechts KF et al. (2014). Antidepressant use in pregnancy and the risk of cardiac defects. *New England Journal of Medicine*, 370(25), 2397-2407.

Reefhuis J et al. (2015). Specific SSRIs and birth defects: bayesian analysis to interpret new data in the context of previous reports. *BMJ*, 350, h3190.

Wemakor A et al. (2015). Selective serotonin reuptake inhibitor antidepressant use in first trimester pregnancy and risk of specific congenital anomalies: a European register-based study. *European Journal of Epidemiolology, 30*(11), 1187-1198.

This chart was compiled by a multidisciplinary work group of leaders in their respective disciplines including OB/GYN, family practice, psychiatry, nursing, genetics, and pharmacy, practicing in Wisconsin and representing WAPC and/or the Wisconsin Section of the American Congress of Obstetricians and Gynecologists.

Updated December 2015

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For additional information, contact Wisconsin Association for Perinatal Care | 211 S. Paterson St., Suite 250 | Madison, WI 53703 | www.perinatalweb.org | Email: wapc@perinatalweb.org