



THE PERISCOPE PROJECT

PERINATAL SPECIALTY CONSULT PSYCHIATRY EXTENSION

This toolkit was produced by the Medical College of Wisconsin and is provided to health care providers through The Periscope Project. The goal of this toolkit is to provide practitioners with an up-to-date, reliable, and easy to use source of information for mental health conditions during the perinatal period. The content is based on the latest available evidence-based guidelines and research whenever possible. If you are aware of new guidelines or research, or if you have suggestions that can help improve this toolkit, please contact cwichman@mcw.edu. Please read our disclaimer before using our toolkit.

This toolkit is for educational purposes only and does not constitute medical advice. The toolkit is not a replacement for careful medical judgments by qualified medical personnel. There may be information in the toolkit that does not apply to or may be inappropriate for the medical situation at hand.

NEXT STEPS: FAQ

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I've started medications in my pregnant or postpartum patient; how long do I continue this medication?

- According to American Psychiatric Association (APA) practice guidelines for treating depression, **continuation on the same medication and dose that has effectively mitigated depressive symptoms for 4-9 months is the standard of care.** This reduces the high risk of relapse.
- Considerations for **continued “maintenance” treatment** (beyond 4-9 months): the patient is at a higher risk of recurrence if there is persistence of subclinical depressive symptoms despite treatment, prior history of multiple major depressive episodes, ongoing psychosocial stressors, persistent sleep issues, family history of psychiatric illness, and presence of a chronic medical issue.

What if my patient becomes pregnant again while on this medication?

- There is a sizable body of evidence supporting the **high risk for relapse** of major depression in pregnant women with a history of depression.
- From a safety/risk standpoint, discuss with your patient the available data on medications used to treat depression and the risk of harm to mother and fetus when depression during pregnancy is untreated.
- If medications are discontinued based upon the patient's preferences, she should be monitored regularly throughout her pregnancy for signs of recurrent depressive/anxiety symptoms.
- Available evidence of the use of antidepressant medications in pregnancy do not support decreasing a previously effective dose of medication in the context of pregnancy.

What discussions should I have with my patient before she becomes pregnant?

- There is a 50% unplanned pregnancy rate across all sociodemographic groups in the US; this rate is even higher (up to 80%) in the population of women who suffer with psychiatric symptoms.
- Attending to the topic of **reliable contraception** if the patient does not wish to become pregnant in the next year allows for thoughtful discussions about the patient's treatment options. Hopefully, this leads to a safer pregnancy if/when the patient decides to conceive.

Who should manage these medications when this patient is no longer seeing me regularly for prenatal or postpartum visits?

- Often, a patient's primary care physician will be comfortable managing a stable dose of an antidepressant medication. If this is not the case, and the patient has access to a psychiatrist in her community, providing the patient with an adequate supply until she can establish with a new provider is encouraged.