Addiction and Mental Health Perinatal Interventions and Treatment Guide*

Perinatal Population	Intervention	Responsible						Comments
		Community Care Professional	Primary Care Professional	Mental Health Therapist	Perinatal MH Therapist	Psychiatrist/ Perinatal Psychiatrist	Inpatient Care	
Health professionals involved in care of women with perinatal mental health	Interdisciplinary approach to care	•	•	•	•	•	•	Clear communication and continuity of care and care giver across clinical settings is needed.
	Engage in professional training	•	•	•	•	•	•	Improves understanding of care for women with mental illness.
All perinatal women	Provide psychoeducation	•	•	•	•			Increase in mental health challenges is common in perinatal period.
	Involve significant other(s)	•	•	•	•	•	•	Provide information and involve in discussions and care.
	Healthy diet and regular, suitable physical activity	•	•	•	•			Good nutrition and physical activity are associated with emotional wellbeing.
	Healthy sleep	•	•	•	•			Cognitive Behavioural Therapy for insomnia (CBT-I) is an effective nonpharmacological treatment for insomnia during pregnancy (1,2)

*Content adapted from 1) Australian Centre of Perinatal Excellence (COPE) Clinical Practice Guideline for Mental Health Care in the Perinatal Period (2017) and 2) National Institute for Health and Care Excellence (NICE) Antenatal and Postnatal Mental Health: Clinical Management and Service (2014 - Last updated 2018). Additional content is specifically cited.

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	Community based, holistic care	•	•	•	•			Support the development of coping strategies, emotional regulation, and self-efficacy. Understand personal and cultural beliefs about motherhood and mental health
	Complementary therapies (e.g. omega-3 fatty acids, multivitamins)	•	•	•	•	•	•	Omega-3 fatty acids may be used in pregnancy but not as sole treatment for depression.
Women trying to conceive with new, existing or past mental health conditions	Engage in preconception planning	•	•	•	•			Risk of relapse is substantial in pregnancy and especially in the early postpartum period.
Perinatal women with moderate to severe mental health conditions	Goal-focused psychotherapy			•	•	•		Treatment planning is partially dependent on assessment by care team/psychiatrist. CBT, Interpersonal Therapy and Behavioural couple's therapy are leading evidence-based recommendations.
	Screeners as appropriate		•	•	•	•		• Edinburgh Postnatal Depression Scale (EPDS), EPDS-Partner, Perinatal Anxiety Screening Scale (PASS), Generalized Anxiety Disorder 7-item (GAD-7), MacLean screening instrument for Borderline Personality Disorder, Couple Satisfaction Index-4,

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								Attention Deficit Hyperactive Disorder screening part A (ASRS), Adverse Childhood Experiences scores
	Psychoeducation	•		•	•			Structured education (often in groups) on preparation for childbirth, practical aspects of childcare, parenting, and mental health.
	Social support group (peer support)	•		•	•			Enables mutual support by bringing women into contact with other women who are having similar experiences.
	Discuss risks and benefits of medications				•	•		Where possible, involve significant other(s).
Postpartum women with moderate to severe mental health conditions (including experiences with traumatic birth)	Mother-infant interventions	•		•	•			Involves supporting mother-infant interactions, verbal and video feedback, modelling and cognitive restructuring.
	Liaise with other health professionals involved in a woman's care.	•	•	•	•	•	•	This involves clear communication between professionals providing prenatal and maternity care and treating psychiatrists and psychologists. In more complex cases, seek advice from a perinatal and addictions psychiatrists.

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	Maternal access to psychiatry.		•	•	•	•	•	Assists with monitoring safety of the infant, the development of mothering skills and a positive relationship with the infant.
	Care planning/treatment planning	•	•	•	•	•	•	
All perinatal women with severe mental illness (including schizophrenia, bipolar disorder and postpartum psychosis)	Admission to inpatient care		•		•	•	•	Treatment involving medication management should involve close liaison between treating psychiatrists or, where appropriate, the woman's primary care physician and her maternity care provider(s).
All perinatal women on regular medication who become pregnant and then consider medication cessation	Perinatal psychiatrist. Discuss risk of relapse		•		•	•		This needs to be done with advice from a psychiatrist or family physician.
Women using substances during pregnancy	Goal-focused psychotherapy.	•	•	•	•	•	•	Intervention should be based on assessment of readiness to change, weighed with risk. Brief counselling interventions can be very useful in helping women to reduce alcohol intake during pregnancy (3). If a woman continues to drink alcohol during pregnancy, harm reduction/treatment strategies should be encouraged (3).

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								The decision to breastfeed should be made on an individual basis after discussing potential risks and benefits (4).
	Residential treatment, with wrap around services at discharge						•	
	Enhanced Rooming in Programs for Neonatal Abstinence Syndrome.		•	•	•			Brief counselling interventions should be offered to women if concerns about problematic substance use are identified. The decision to breastfeed should be made on an individual basis after discussing potential risks and benefits. Consult addiction medicine providers, and/or Opioid Agonist Treatment.
	Care planning for infant and mother. Eat-Sleep-Console (ESC) care method.		•	•	•	•	•	

References

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4. Ordean A, Wong S, Graves, L. Substance Use in Pregnancy. J Obstet and Gynaecol Can. 2017 39(10):922-937. Available from: https://doi.org/10.1016/j.jogc.2017.04.028