Pathways to Professional Development

Building Foundations in Infant and Early Childhood Mental Health

Perinatal Substance Use Disorders at the Intersection of Mental Health

Leah Habersham, MD, MBA, MSCR, FACOG, FASAM

Pathways to Professional Development

Pathways to Professional Development; Building Foundations in Infant and Early Childhood Mental Health was developed to build workforce competence and to prepare professionals working in the perinatal and birth to 5 periods

- 30 webinars focused on the foundations of Infant and Early Childhood Mental Health.
  - Provided live virtually
  - Recorded for viewing as LMS modules

- Diagnostic Classification of Mental Health And Developmental Disorders of Infancy and Early Childhood (DC:0-5) offered virtually.

  - View all offerings here→ https://www.mcsilverta.org/special-initiatives/pathways-to-professional-development/

The aim is to develop a well prepared and competent workforce trained to **identify** and address mental health concerns early, to **promote** awareness of mental health, to **prevent** long-term problems and to **intervene** to help children stay on developmental track.

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Who we are

These trainings are funded by the New York State Office of Mental Health (OMH) and provided by the New York Center for Child Development (NYCCD) in collaboration with CTAC.

- **New York Center for Child Development** (NYCCD) has been a major provider of early childhood mental health services in New York with a long history of providing system-level expertise to inform policy and support the field of Early Childhood Mental Health through training and direct practice.

- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

NYCCD and McSilver also run the **NYC Perinatal + Early Childhood Training and Technical Assistance Center (TTAC)** which offers ongoing training and technical assistance for those working during the perinatal period to age 5

https://ttacny.org/

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Substance Use, Use Disorders, and Mental Illness in Pregnancy & Postpartum Periods:

Clinical, Ethical, and Systems-Level Approaches for All Providers

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No disclosures

Objectives

Identify	Identify current epidemiological trends in substance use, overdose-related deaths, and mental illness.
Explain	Explain how to screen for substance use, substance use disorders, mental illness.
Describe	Describe best practices for treatment, care coordination, and the application of trauma-informed and ethically sound care during pregnancy and postpartum.

Grounding

Personal Motivation

American Journal of Obstetrics & Gynecology
AJOG MFM
Maternal-Fetal Medicine

Log in

SHORT COMMUNICATION | ARTICLES IN PRESS, 100849

An Unexpected Path to Addiction Medicine

Leah L. HABERSHAM, MD MBA MS

Open Access • Published: December 25, 2022 •

DOI: https://doi.org/10.1016/j.ajogmf.2022.100849

Habersham, L. L. (2022). An unexpected path to addiction medicine. *American Journal of Obstetrics & Gynecology MFM*, *5*(3).

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Impact of Stigma

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Double Stigma: Co-Occurring SUD & Mental Illness

- Substance use disorders (SUD) are among the most highly stigmatized health conditions.
- People are often blamed for their SUD and not viewed as a disease
- Adding a mental health diagnosis creates "double stigma"
- Co-occurring SUD + mental illness → more negative stereotypes, more blame…greater than either condition alone.

Corrigan, P. W., Kuwabara, S. A., & O'shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work*, *9*(2), 139-147.

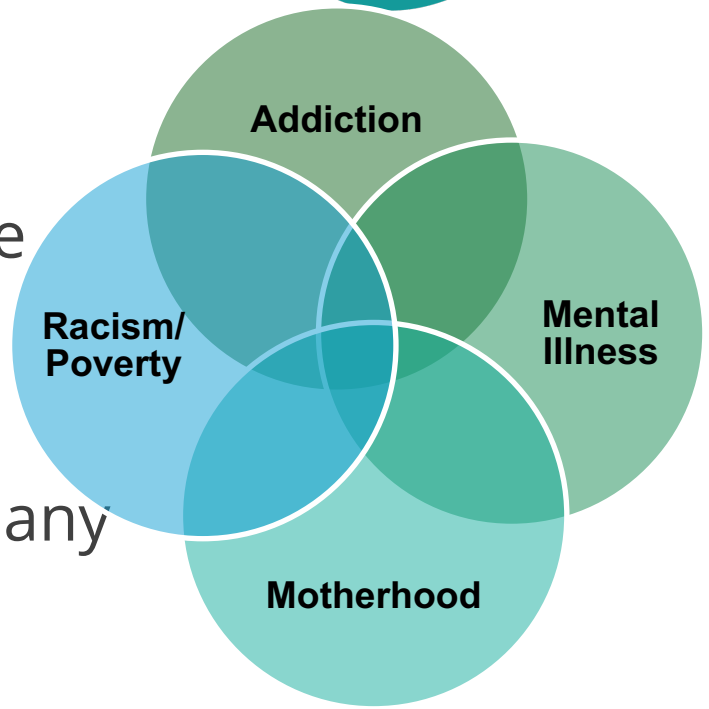
Self-Stigma and Clinical Impact

- Stigma can become internalized as self-stigma in people with co-occurring SUD and mental illness.
- Higher self-stigma is linked to low self-esteem, worsening depression, and suicidality.
- Self-stigma predicts poorer engagement in care and worse treatment outcomes.

Hammarlund, R., Crapanzano, K. A., Luce, L., Mulligan, L., & Ward, K. M. (2018). Review of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug-and alcohol-use disorders. *Substance abuse and rehabilitation*, 115-136.

Structural & Intersectional Stigma in Pregnancy and Parenting

- Structural stigma (laws, policies, and practices) amplifies harms for people with both SUD and psychiatric illness.
- They are more likely to be excluded from services, experience homelessness, and become involved with the criminal/ legal or child welfare systems.
- For pregnant and parenting, stigma is **intersectional**
- Fear of judgment and child welfare involvement leads many to hide symptoms or avoid care—even when highly motivated to protect their child.



Stephenson, K. M., Wahler, A., Berdine, D., McCormick-Cisse, M., Abdelsayed, S., & Kahn, L. S. (2025). “I’m not a bad mother:” the experience of stigma among mothers with substance use disorder in the criminal justice system. *Women & Health*, *65*(1), 50-59.
Adams, Z. M., Ginapp, C. M., Price, C. R., Qin, Y., Madden, L. M., Yonkers, K., & Meyer, J. P. (2021). “A good mother”: Impact of motherhood identity on women's substance use and engagement in treatment across the lifespan. *Journal of Substance Abuse Treatment*, *130*, 108474.
Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review*, *15*(1), 84-99.

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Epidemiology

Epidemiology during Pregnancy

National Survey on Drug Use and Health (NSDUH) data from 2022 found that of pregnant people surveyed, past month use reported for:

- 9.6% “illicit” substance use
  - *up from 7.9% in 2021*
- 8.4% nicotine use
- 11% alcohol use
  - *up from 9.9% in 2021*

8.3% of pregnancies are complicated by **Gestational Diabetes** in the US

https://www.samhsa.gov/data/sites/default/files/reports/rpt42728/NSDUHDetailedTabs2022/NSDUHDetailedTabs2022/NSDUHDetTabsSect8pe2022.htm
https://www.cdc.gov/mmwr/volumes/72/wr/mm7201a4.htm

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Leading Causes of Pregnancy-Related Death

The leading underlying causes of pregnancy-related death include:

- **Mental health conditions (suicide & overdose) (23%)**
- Excessive bleeding (hemorrhage) (14%)
- Cardiac and coronary conditions (heart) (13%)
- Infection (9%)
- Thrombotic embolism (9%)
- Cardiomyopathy (heart) (9%)
- Hypertensive disorders of pregnancy (high blood pressure) (7%)

https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

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Which comes first?

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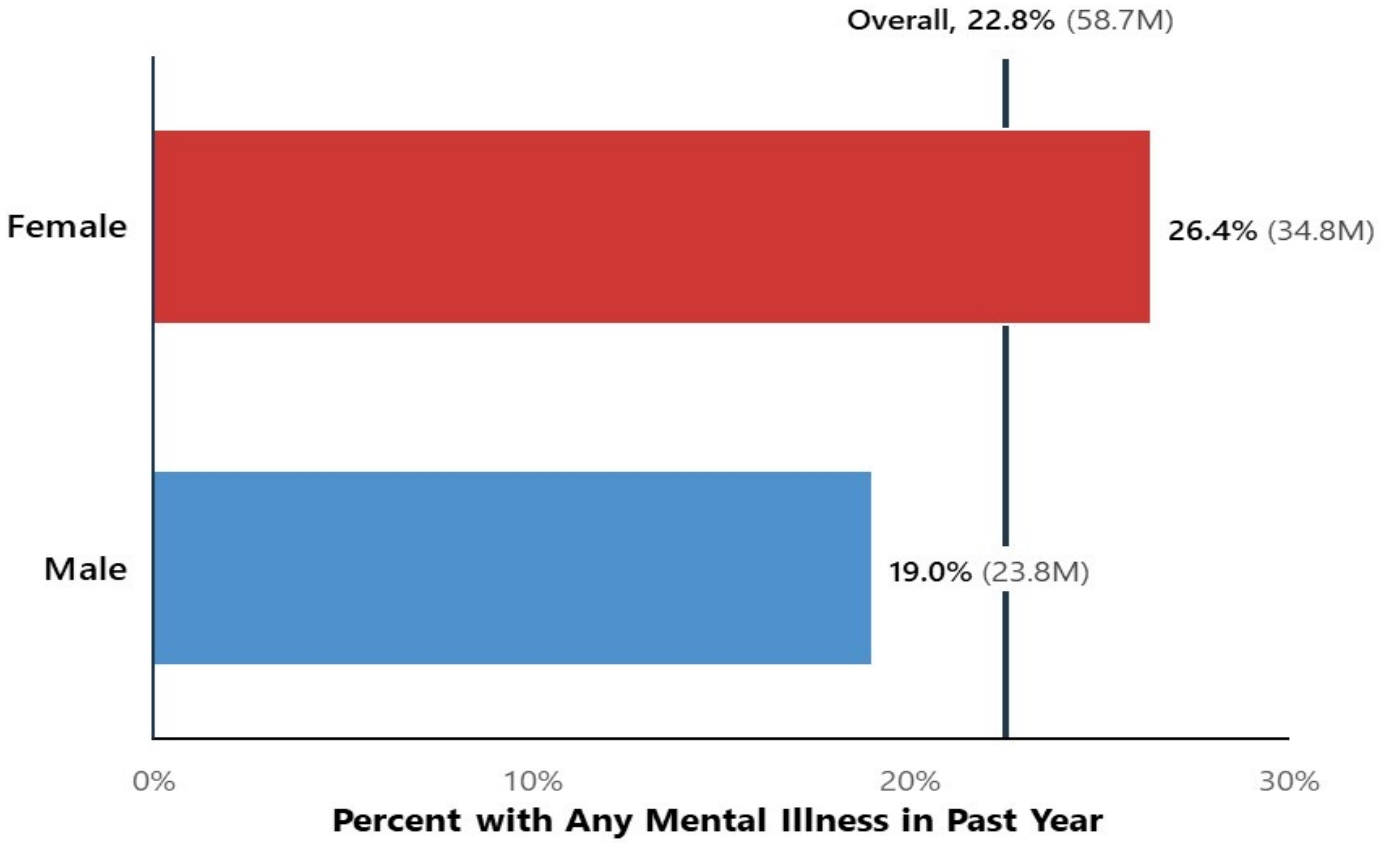
Any Mental Illness in the Past Year by Sex at Birth: Among Adults Aged 18 or Older

- Female adults were more likely to have any mental illness than male adults



- Female adults were more likely to have any mental illness than male adults

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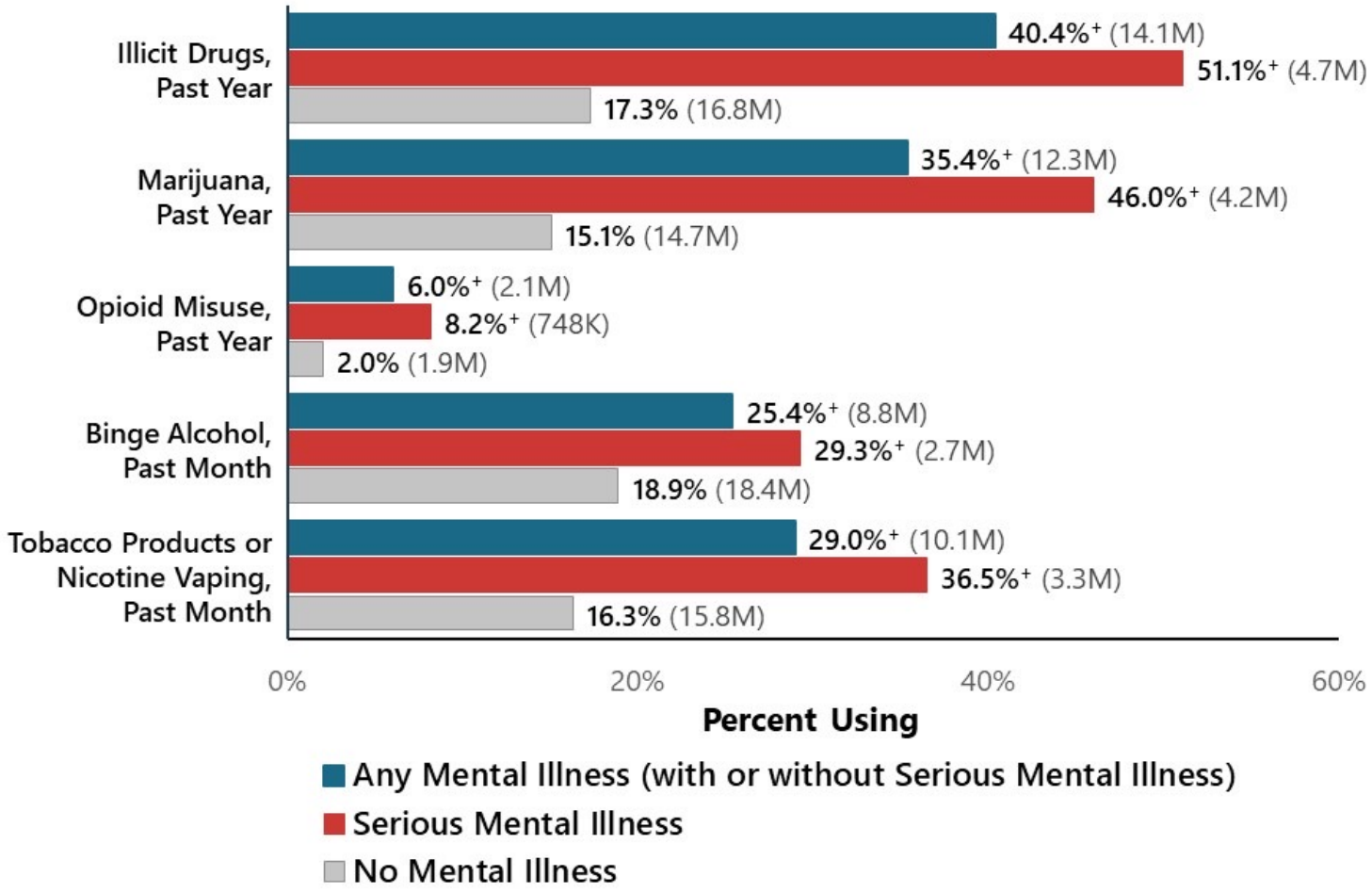
Substance Use by Mental Illness in the Past Year: Among Female Adults Aged 18 or Older



Female adults with SMI or AMI in the past year were more likely to have used or misused these substances than those without mental illness

AMI = any mental illness; SMI = serious mental illness

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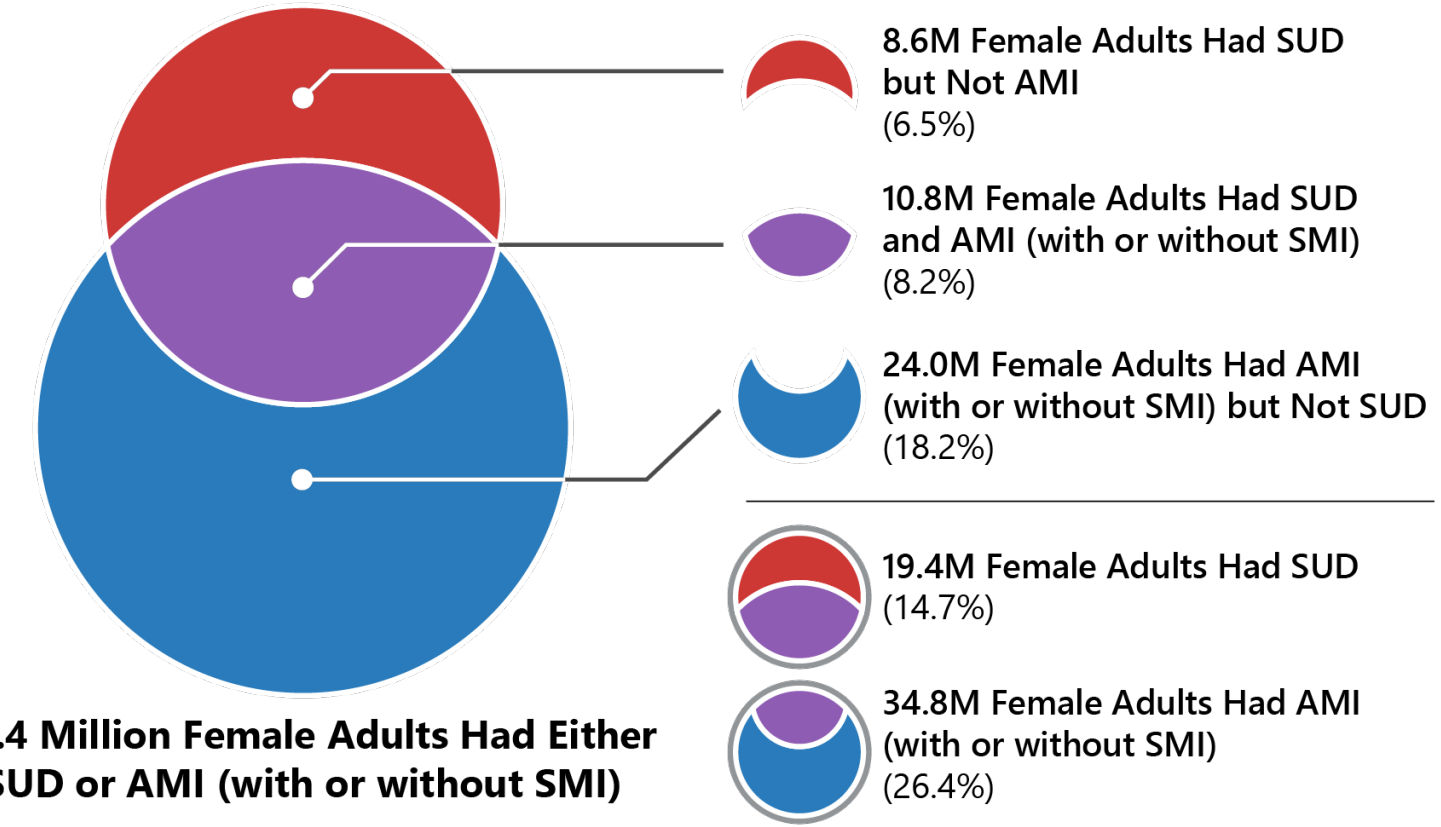
Co-Occurring Substance Use Disorder and Any Mental Illness: Among Female Adults Aged 18 or Older

- AMI = any mental illness; SMI = serious mental illness; SUD = substance use disorder.



- Half (50%) of all female young adults aged 18 to 25 had SUD or AMI
- 10.8 million (8.2%) female adults aged 18 or older had co-occurring SUD and AMI

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Pregnancy-Associated Mortality in New York City, 2022

NYC Health

Annual Report, September 2025

Table 2. Causes, timing, location, and pregnancy outcomes of pregnancy-associated deaths, NYC, 2022

	Pregnancy-associated deaths, n (%)	Pregnancy-related deaths, n (%)
Total	66 (100.0%)	32 (100.0%)
Causes of death[a]		
Mental Health Conditions	21 (31.8%)	7 (21.9%)
Overdose[b]	14	4
Suicide[c]	7	3
Cardiovascular Conditions[d]	8 (12.1%)	6 (18.8%)
Cardiomyopathy	1	1
Other Cardiovascular Conditions	7	5
Cancer[e]	6 (9.1%)	1 (3.1%)
Homicide[f]	6 (9.1%)	2 (6.3%)
Unintentional Injury[g]	6 (9.1%)	1 (3.1%)
Embolism	4 (6.1%)	2 (6.3%)
Hemorrhage	3 (4.6%)	3 (9.4%)
Infection/Sepsis	3 (4.6%)	3 (9.4%)
Blood Disorders	2 (3.0%)	2 (6.3%)
Seizure Disorders	2 (3.0%)	1 (3.1%)
Other[h]	5 (7.6%)	4 (12.5%)

[b] Among the 14 pregnancy-associated overdose deaths, 12 involved an opioid. Among the four pregnancy-related deaths, four involved an opioid.

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Pregnancy-Associated Mortality in NYC, 2022 Annual Report, September 2025

Table 2. Causes, timing, location, and pregnancy outcomes of pregnancy-associated deaths, NYC, 2022

	Pregnancy-associated deaths, n (%)	Pregnancy-related deaths, n (%)
Total	66 (100.0%)	32 (100.0%)
Timing of death		
During pregnancy	17 (25.8%)	8 (25.0%)
Day after the end of pregnancy	2 (3.0%)	2 (6.3%)
1 day after end of pregnancy	2 (3.0%)	2 (6.3%)
2-6 days after end of pregnancy	4 (6.1%)	3 (9.4%)
7-42 days after end of pregnancy	14 (21.2%)	6 (18.8%)
43 days-1 year after end of pregnancy	27 (40.9%)	11 (34.4)

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Pregnancy-Associated Mortality in NYC, 2022 Annual Report, September 2025

Leading cause of death among **Black and Hispanic women is mental health conditions**

Table 1. Demographic characteristics of pregnancy-associated deaths, NYC, 2022

	Pregnancy-associated deaths n (%)	Pregnancy-related deaths n (%)
Total	66 (100.0%)	32 (100.0%)
Race and ethnicity[a]		
Black non-Hispanic	28 (42.4%)	12 (37.5%)
White non-Hispanic	11 (16.7%)	6 (18.8%)
Hispanic	19 (28.8%)	10 (31.3%)
Asian or Pacific Islander	3 (4.6%)	1 (3.1%)
Another race or unknown	5 (7.6%)	3 (9.4%)
Borough of residence[b]		
Brooklyn	12 (18.2%)	4 (12.5%)
Bronx	18 (27.3%)	10 (31.3%)
Queens	9 (13.6%)	4 (12.5%)
Manhattan	15 (22.7%)	6 (18.8%)
Staten Island	7 (10.6%)	6 (18.8%)
Non-NYC	5 (7.6%)	2 (6.3%)

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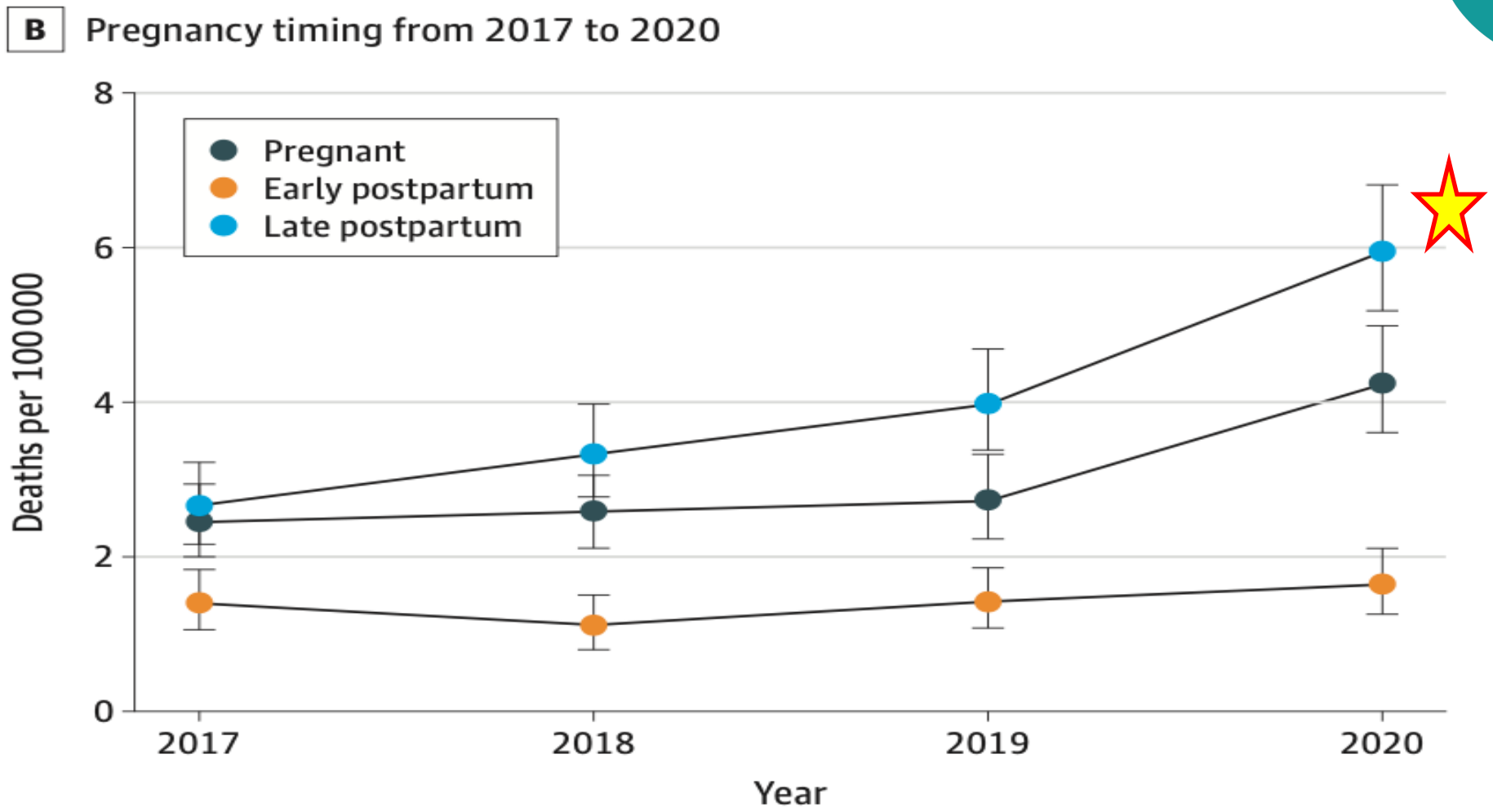
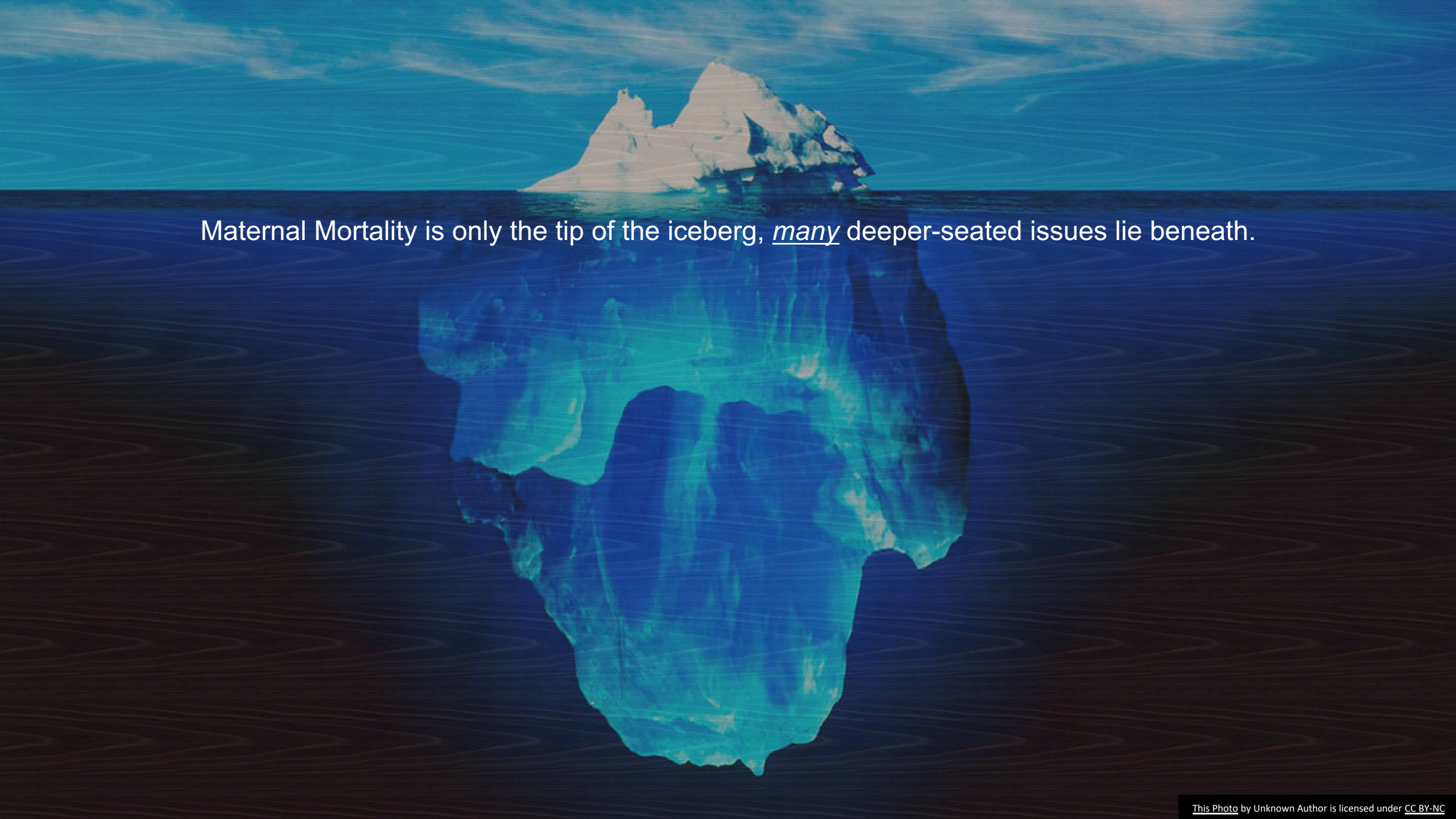
Overdose Deaths—National: During Pregnancy and Postpartum

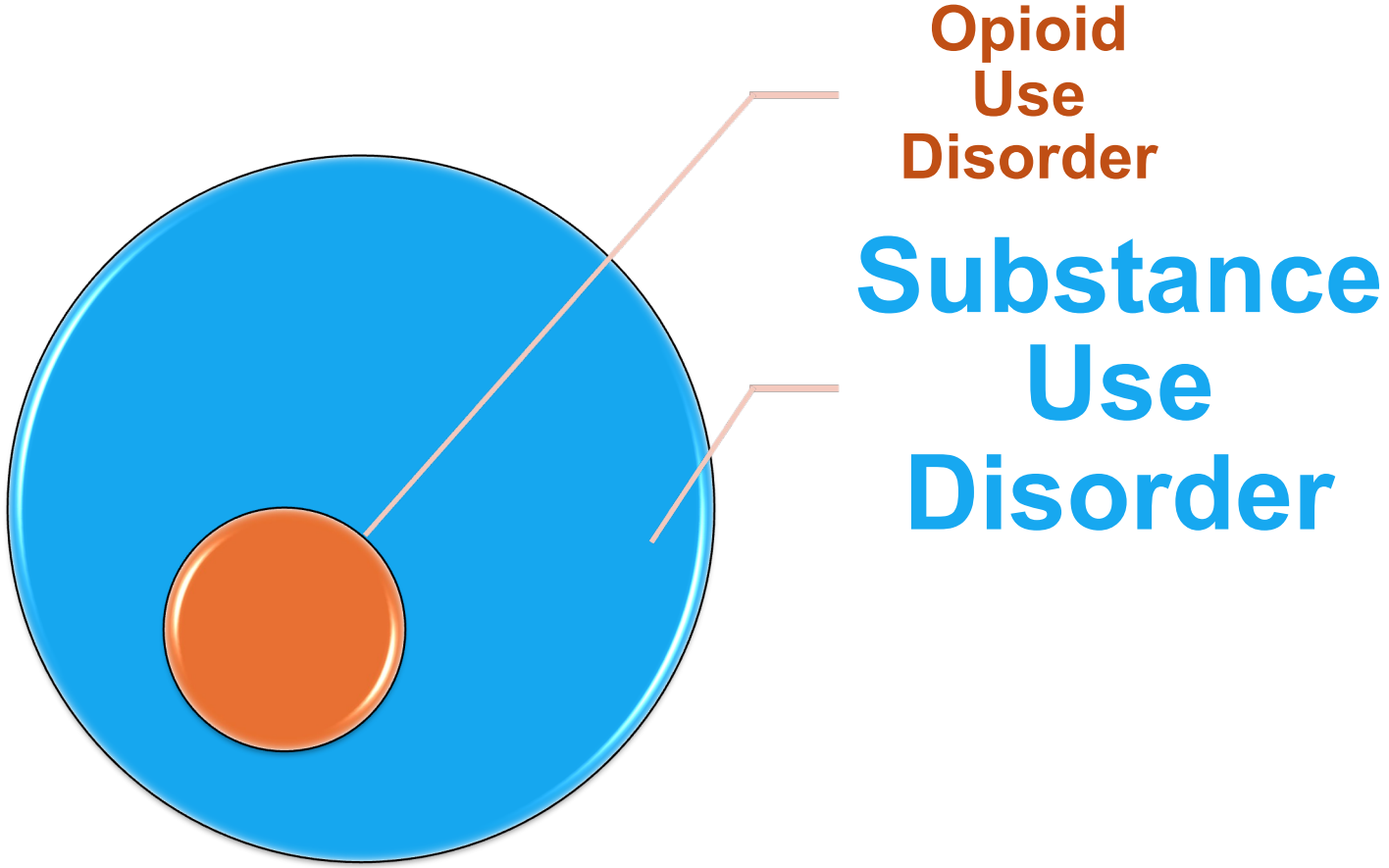


Bruzelius, E., & Martins, S. S. (2022). US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017-2020. *JAMA*, *328*(21), 2159-2161.



Identifying Mental Health Conditions: Substance use disorders and Mental Illness

SUD vs OUD



About 15% of SUDs are OUD in those 12+

Case Presentation

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Case Presentation

- Ms. MD was a 28-year-old female, who initiated prenatal care in the 2nd trimester.
- No medical problems, no significant social history
- Labs all normal, including routine urine toxicology which all our patients received.
- Pregnancy was progressing normally.

Case Presentation

- At 32 weeks GA, patient tearfully stated, “I need to tell you something”:
- Had a h/o addiction to prescribed opioids
- Detoxed herself using high doses of loperamide
  - “Poor Man’s Methadone”
- Continued with her use of loperamide, taking 300-400mg daily
- Weaned herself down to 150-200mg daily

Background

- Loperamide “poor man’s methadone” – ease of access and low cost
- FDA approved for up to 8mg daily OTC, or 16mg daily for Rx
- For those misusing – 70-200mg daily – can affect opioid receptors

American Journal of Emergency Medicine 38 (2020) 693.e5–693.e6

Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

Case Report

Loperamide toxicity mimicking peripartum cardiomyopathy

Anderson Wang [a,*], Michael Nguyen [a], Jesus Diaz, M.D [c], Travis Smith, D.O [a,b]

[a] Lake Erie College of Osteopathic Medicine, 5000 Lakewood Ranch Blvd, Bradenton, FL 34211, USA
[b] St. Vincent's Medical Center Southside Emergency Department, 4201 Belfort Rd, Jacksonville, FL 32216, USA
[c] St. Vincent's Medical Center Southside Critical Care Unit, 4201 Belfort Rd, Jacksonville, FL 32216, USA

Substance Use is a Part of the Human Experience

Substance Use Lies on a Continuum

Savage, C. L. (2016). Substance Use and Substance Abuse—What's in a Name?. *Journal of Addictions Nursing, 27* (1), 47-50. doi: 10.1097/JAN.0000000000000111.

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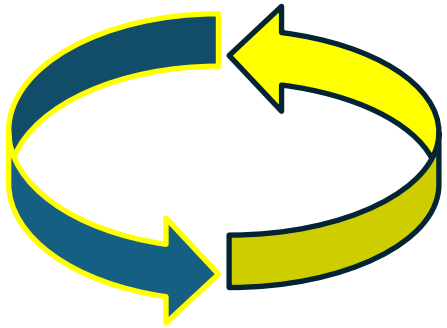
Intersection of Mental Health and Maternal SUD

About 30% of pregnant women enrolled in SUD treatment screen positive for moderate to severe depression, and 40% report having experienced symptoms of postpartum depression

Holbrook, A., & Kaltenbach, K. (2012). Co-occurring psychiatric symptoms in opioid-dependent women: the prevalence of antenatal and postnatal depression. *The American journal of drug and alcohol abuse*, *38*(6), 575-579.

How do we identify SUD and mental illness?

Screen Everyone



USPTF, ACOG, and SMFM all endorse **screening** all pregnant and postpartum people for substance use (SU)/ SUD as well as mental illness (depression/ anxiety)

When SU/ SUD or mental illness are identified we need to provide counseling/ education (**intervention**)

Depending on the level of the problem – **treatment** may be warranted

Icahn School of Medicine at Mount Sinai

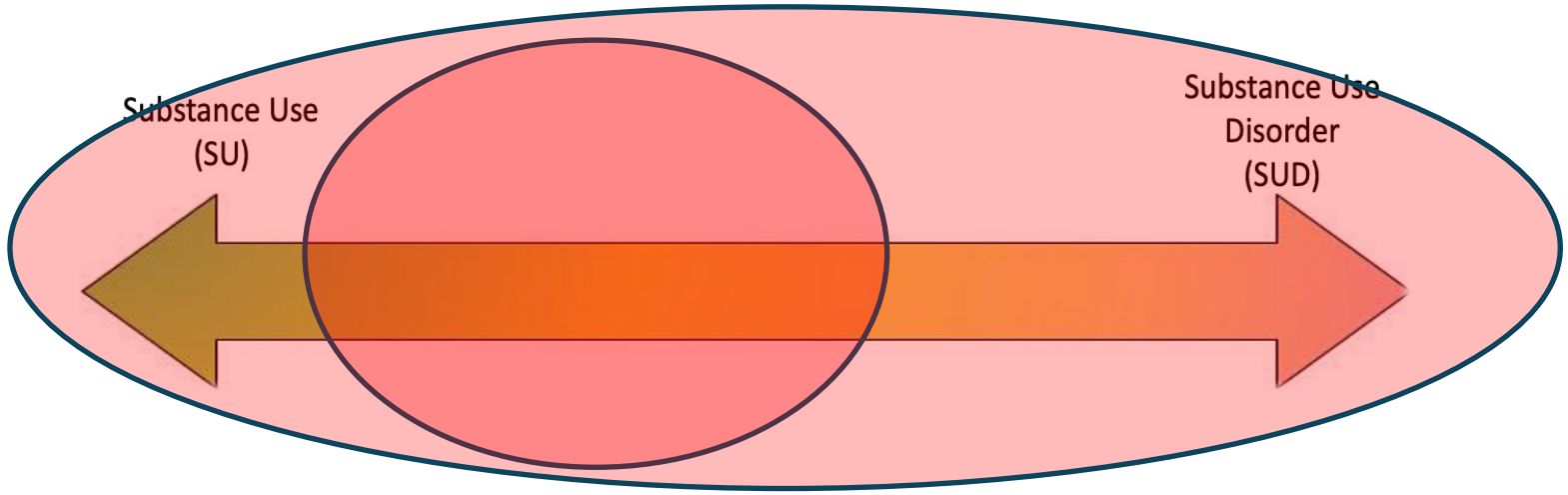
Standard of Care for Mental Health Conditions:

SUD and Mental Illness

Identifying **SU** vs SUD

How do we distinguish substance use vs SUD?

- Toxicology Test
- Screening Tool



Ecker, J., Abuhamad, A., Hill, W., Bailit, J., Bateman, B. T., Berghella, V., ... & Yonkers, K. A. (2019). Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics & Gynecology*, *221*(1), B5-B28.

	DSM V Summary of Diagnostic Criteria for [Substance] Use Disorder
Category	**Criteria**
Impaired Control	• Using [substance] in greater quantities or longer periods than intended
Social Impairment	• Failing to meet obligations at home, school, or work due to continued use of [substance] • Extensive social or interpersonal problems that are exacerbated by [substance] or continued use of [substance] despite such problems • Limiting important social, recreational or occupational activities due to [substance] use
Risky Use	• Use of [substance] leads to physically hazardous situations • Continued use of [substance] despite subsequent physical and psychological problems that result from use
Pharmacological Effects	• Tolerance leading to a need for increasing the amount of [substance] use in order to achieve the desired effect, and/ or decreased effect if the same amount is used. • Withdrawal symptoms experienced when [substance] are decreased or discontinued; the use of [substance] relieve symptoms of withdrawal
Mild: 2-3 criteria **Moderate**: 4-5 criteria **Severe**: 6 or more criteria	

Brezing, C., & Bisaga, A. (2015). Opioid use disorder: Update on diagnosis and treatment. *Psychiatric Times*, *32*(4), 16-16.

What is Utility of Toxicology Testing?

Utility..

Patient presents obtunded/ altered mental status

Patient used substances, needs anesthesia, and unsure of what's really in their system

- Anesthetic of choice interacts with some commonly used substances

Toxicology Testing in Prenatal Setting

Biologic testing not recommended by ACOG/ SMFM as screening method.

While there is a place for biologic testing in certain situations, it shouldn't be the only means of identifying substance use or SUD

False-positive results are not uncommon, with potentially devastating consequences

Committee on Obstetric Practice. (2017). Committee opinion no. 711: opioid use and opioid use disorder in pregnancy. *Obstetrics and gynecology*, *130*(2), e81-e94.
Ecker, J., Abuhamad, A., Hill, W., Bailit, J., Bateman, B. T., Berghella, V., ... & Yonkers, K. A. (2019). Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics & Gynecology*, *221*(1), B5-B28.

Window of Detection by Substance

https://www.bccsu.ca/wp-content/uploads/2022/06/Detection-Time-of-Substances-Urine.pdf

Detection Time of Substances in Urine

Substance	Detection time in urine
ALCOHOL	
Methadone	≤6 days
EDDP (methadone metabolite)	≤6 days[3]
TETRAHYDROCANNABINOL	
Single use	1–3 days[1]
Chronic use	≤30 days[3]

ELSEVIER

AJOG Global Reports

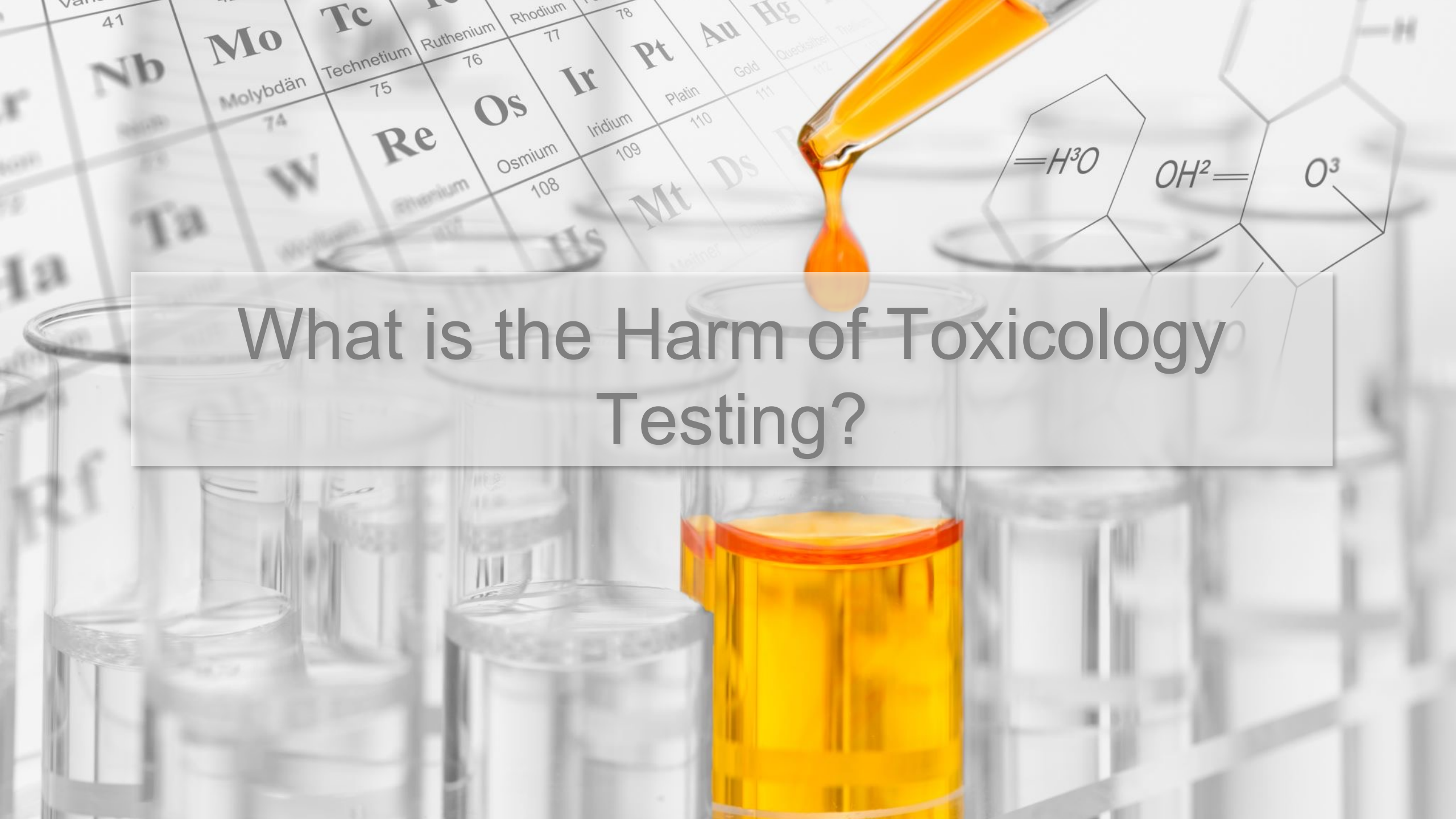
Volume 4, Issue 2, May 2024, 100313

Original Research

Prolonged detection of urine norfentanyl in individuals enrolled in a medication for opioid use disorder in pregnancy and postpartum program: a case series

Miranda K. Kiefer DO [1], Jamie Cowen BA [2], Katherine A. Hinely RN [1], Kara M. Rood MD [1], Jessica R. Gray MD [4], Davida M. Schiff MD [5], Sarah N. Bernstein MD [4]

Addressing Related Inequities


What is the Harm of Toxicology Testing?

Fear

Punitive approaches drive patients away

Toxicology testing tied to CPS reporting creates fear.

Fear leads to avoidance of prenatal care and silence about mental health conditions.

Austin, A. E., Naumann, R. B., & Simmons, E. (2022). Association of state child abuse policies and mandated reporting policies with prenatal and postpartum care among women who engaged in substance use during pregnancy. *JAMA Pediatrics, 176*(11), 1123–1130. https://doi.org/10.1001/jamapediatrics.2022.3159

American Academy of Pediatrics. (2017). A public health response to opioid use in pregnancy. *Pediatrics, 139*(3), e20164070. https://doi.org/10.1542/peds.2016-4070b

Roberts, S. C. M., & Pies, C. (2011). Complex calculations: How drug use during pregnancy becomes a barrier to prenatal care. *Maternal and Child Health Journal, 15*(3), 333–341. https://doi.org/10.1007/s10995-010-0594-7

Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice, 3*, 2. https://doi.org/10.1186/s40352-015-0015-5

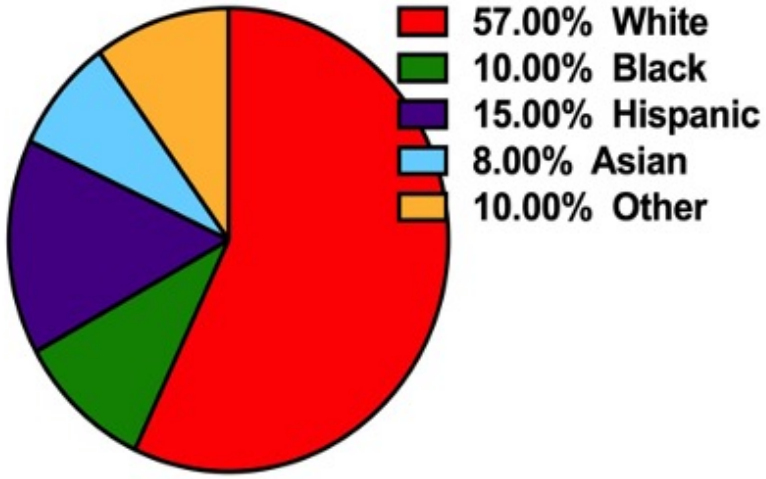
"A positive toxicology result for a parent or a newborn, <u>by itself</u>, does not constitute reasonable suspicion of child abuse or maltreatment, and thus <u>does not necessitate a report to the SCR</u>.

The mother should be screened for substance use disorder and, if a substance use disorder is identified, a Plan of Safe Care should be developed and monitored by the medical provider or healthcare team."

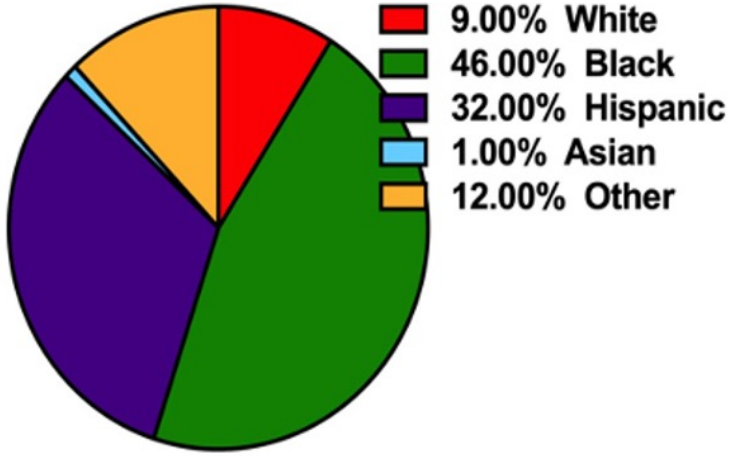
ACS | DOHMH Joint Guidance, issued November 12, 2020

Inequities in Toxicology Testing

Census by Race



Testing by Race



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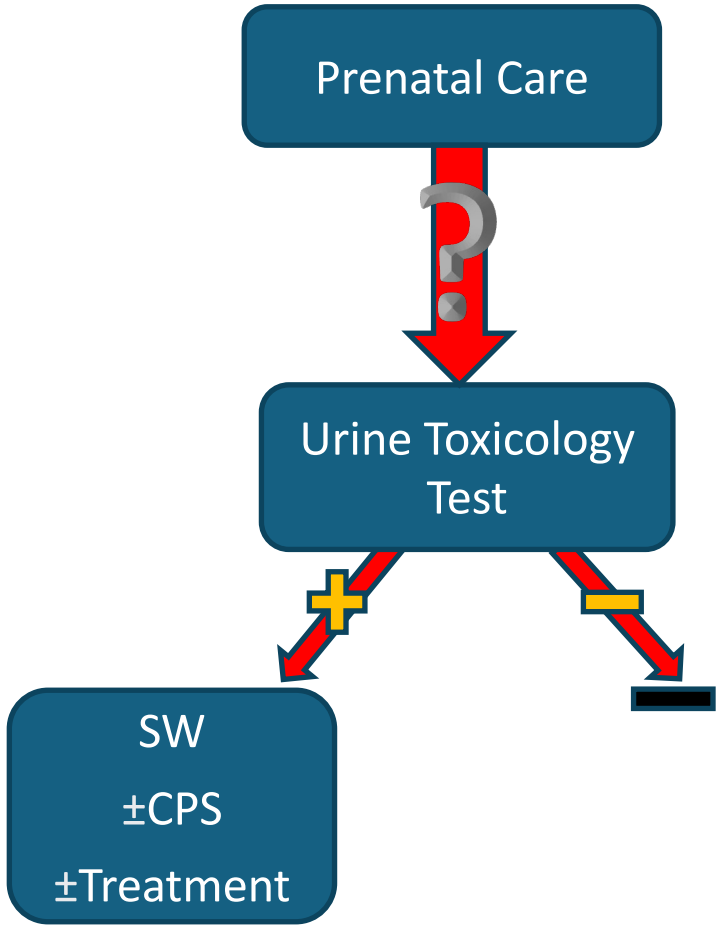
Inequities in Toxicology Testing

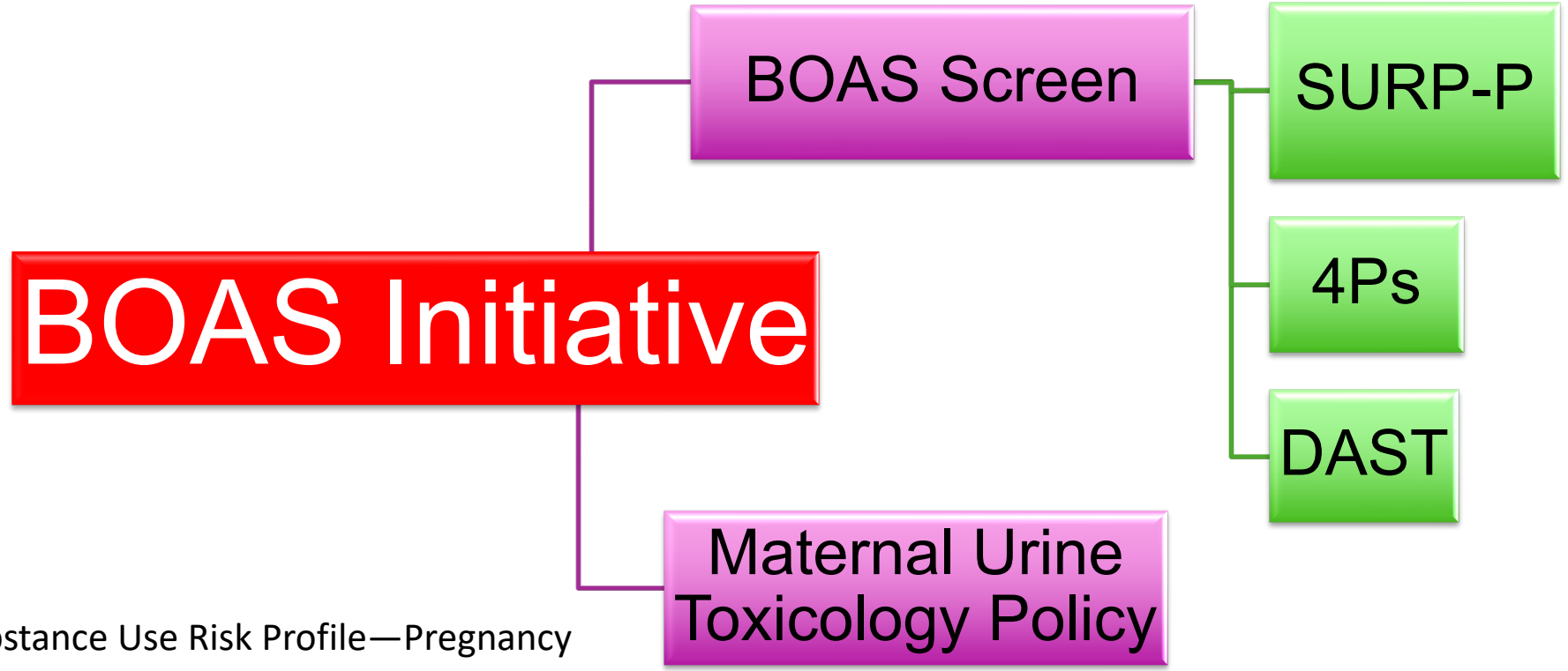
	Unadjusted Model		Adjusted Model	
	Odds Ratio (OR)	95% Confidence Interval	Odds Ratio (OR)	95% Confidence Interval
Testing Allocation				
Black	**32.72**	23.72, 45.13	**4.28**	2.91, 6.29
Hispanic	**14.68**	10.54, 20.45	**1.98**	1.34, 2.94
Other	**7.37**	5.0, 10.87	**2.38**	1.55, 3.64
White	Reference	Reference	Reference	Reference

Habersham et al. *American Journal of Obstetrics & Gynecology*

Substance Use & Use Disorder Identification Workflow



BOAS Initiative



SURP-P: Substance Use Risk Profile—Pregnancy

4Ps: *Parents, Partner, Past, Pregnancy*

DAST: Drug Abuse Screening Test

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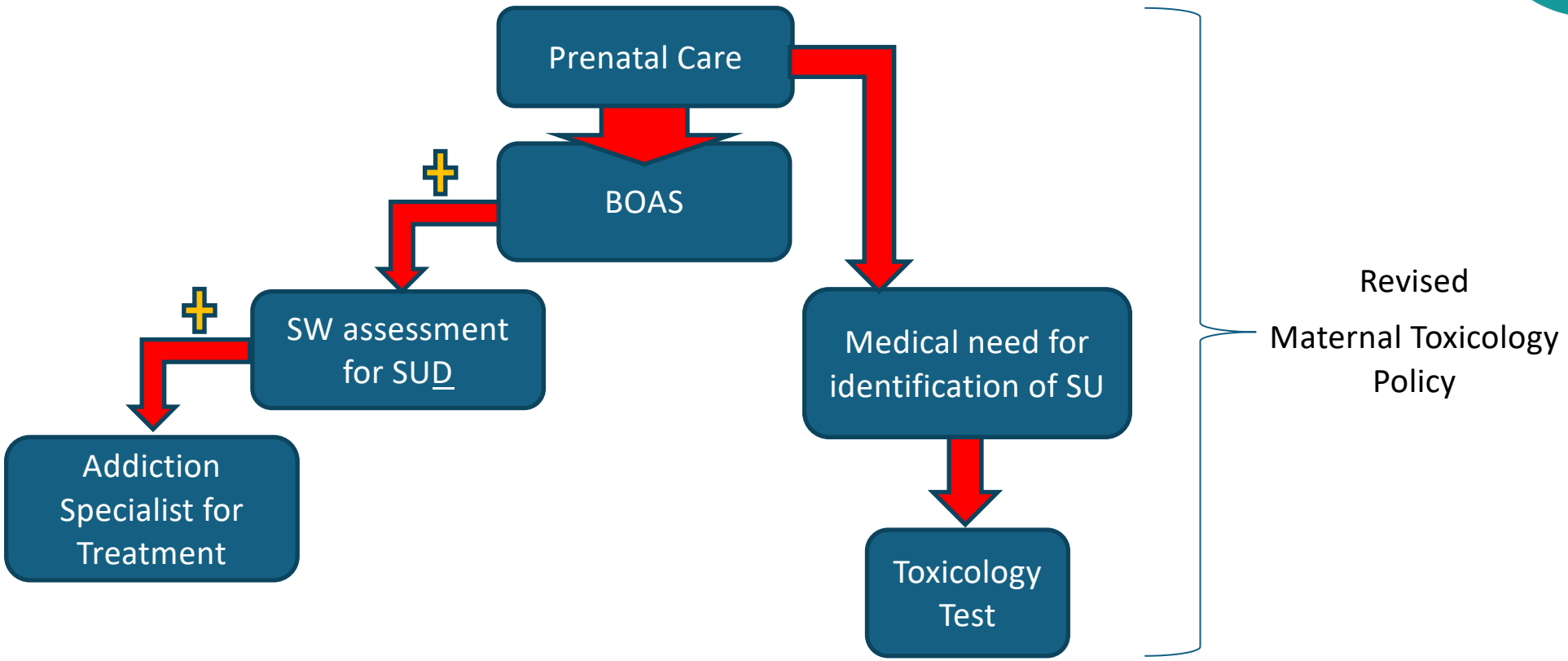
BOAS Workflow



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Post-Intervention

	Unadjusted Model		Adjusted Model	
Post-Intervention				
Testing Allocation				
Black	**5.87**	3.28, 10.51	1.01	0.49, 2.08
Hispanic	**4.18**	2.37, 7.38	0.78	0.38, 1.59
Other	2.1	0.89, 4.96	0.69	0.27, 1.75
White	Reference	Reference	Reference	Reference
Positive Test Result				
Black	1.36	0.42, 4.40	1.6	0.40, 6.37
Hispanic	0.9	0.29, 2.82	1.42	0.37, 5.43
Other	0.36	0.06, 2.31	0.54	0.06, 5.33
White	Reference	Reference	Reference	Reference

Habersham LL, Bianco AT, Kudrich CJ, et al. An Institutional Intervention on Toxicology Testing Reduces Inequities During the Birthing Hospitalization. *Am J Obstet Gynecol*. Published online December 7, 2023. doi:10.1016/j.ajog.2023.11.1254

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SUD Screening Tools for the Pregnant Population

- **4Ps Plus**: 4 questions (Parents, Partner, Past, and Pregnancy) to assess substance use
- **5Ps Plus**: expanded version of the 4Ps Plus and includes five questions (Parents, Partner, Past, Pregnancy, and Protection)
- **T-ACE**: 4 questions (Tolerance, Annoyance, Cut down, Eye-opener) used to identify alcohol use disorders in pregnant women
- **TWEAK-MS**: modified version of the TWEAK screening tool that focuses on identifying alcohol use disorders during pregnancy.
- **ASSIST-Pregnancy**: adapted version of the ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) assesses SUDs in pregnant individuals.
- **NIDA Quick Screen**: single question that asks about past-year drug use: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"
- **Substance Use Risk Profile-Pregnancy (SURP-P):** The SURP-P is a comprehensive screening tool that evaluates substance use, mental health, and psychosocial factors during pregnancy.
- **CRAFFT-Pregnancy**: Adapted from the CRAFFT for adolescents—focuses on identifying SUDs in pregnant individuals.

Ecker, J., Abuhamad, A., Hill, W., Bailit, J., Bateman, B. T., Berghella, V., ... & Yonkers, K. A. (2019). Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics & Gynecology*, *221*(1), B5-B28.

Depression Screening Tools

In June of 2023, the American College of Obstetricians and Gynecologists released new guidelines stating that depression should be screened at least 2 times during pregnancy and again at a postpartum visit using validated instruments.

Depression screens:

- Patient Health Questionnaire: PHQ-2 and PHQ-9
- Edinburgh Postnatal Depression Screen: 10 question screen

Nye, Jessica. "The ACOG Now Recommends Multiple Depression Screenings During Perinatal Period." *Psychiatry Advisor*, 19 Dec. 2023. *Gale Academic OneFile*, link.gale.com/apps/doc/A776714700/AONE?u=nysl_oweb&sid=googleScholar&xid=3e9d7b04. Accessed 11 Dec. 2025.

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Anxiety Screening Tool

https://www.acog.org/programs/perinatal-mental-health

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

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Bipolar I or II Screening Tool

The Mood Disorder Questionnaire (MDQ) - Overview

The Mood Disorder Questionnaire (MDQ) was developed by a team of psychiatrists, researchers and consumer advocates to address the need for timely and accurate evaluation of bipolar disorder.

Clinical Utility

- The MDQ is a brief self-report instrument that takes about 5 minutes to complete.
- This instrument is designed for *screening purposes only* and is not to be used as a diagnostic tool.
- A positive screen should be followed by a comprehensive evaluation.

Scoring

In order to screen positive for possible bipolar disorder, all three parts of the following criteria must be met:

- "YES" to 7 or more of the 13 items in Question 1 **AND**
- "Yes" to Question number 2 **AND**
- "Moderate Problem" or "Serious Problem" to Question 3

Psychometric Properties

The MDQ is best at screening for bipolar I (depression and mania) disorder and is not as sensitive to bipolar II (depression and hypomania) or bipolar not otherwise specified (NOS) disorder.

5Ps
Integrated Screening Tool

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Integrated Screening Tool

Women's health can be affected by emotional problems, alcohol, tobacco, other drug use, and domestic violence. Women's health is also affected when those same problems are present in people close to us. By "alcohol," we mean beer, wine, wine coolers, or liquor.

Parents
Did any of your parents have a problem with alcohol or other drug use?

Peers
Do any of your friends have a problem with alcohol or other drug use?

Partner
Does your partner have a problem with alcohol or other drug use?

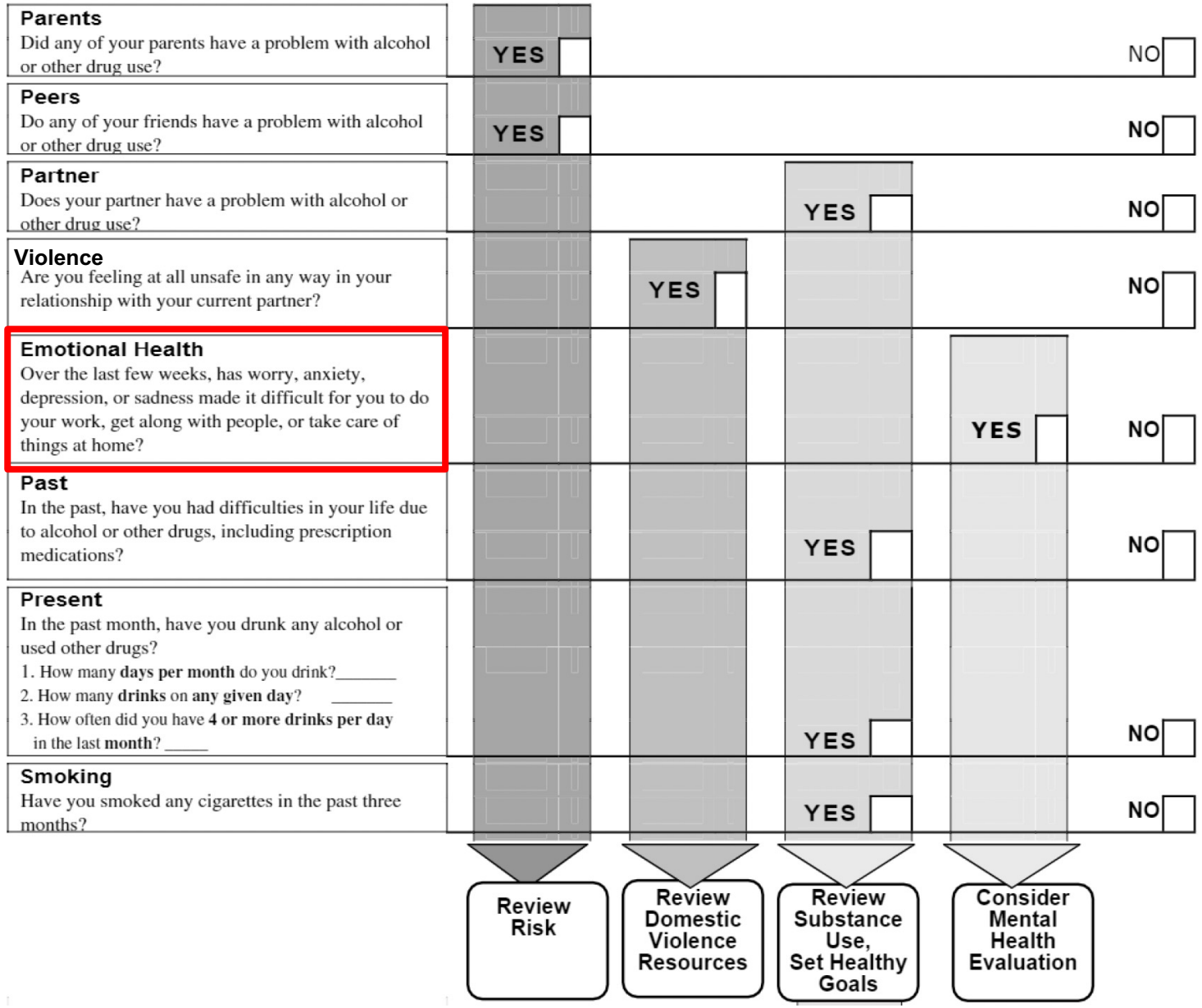
Violence
Are you feeling at all unsafe in any way in your relationship with your current partner?

Emotional Health
Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with people, or take care of things at home?

Past
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?

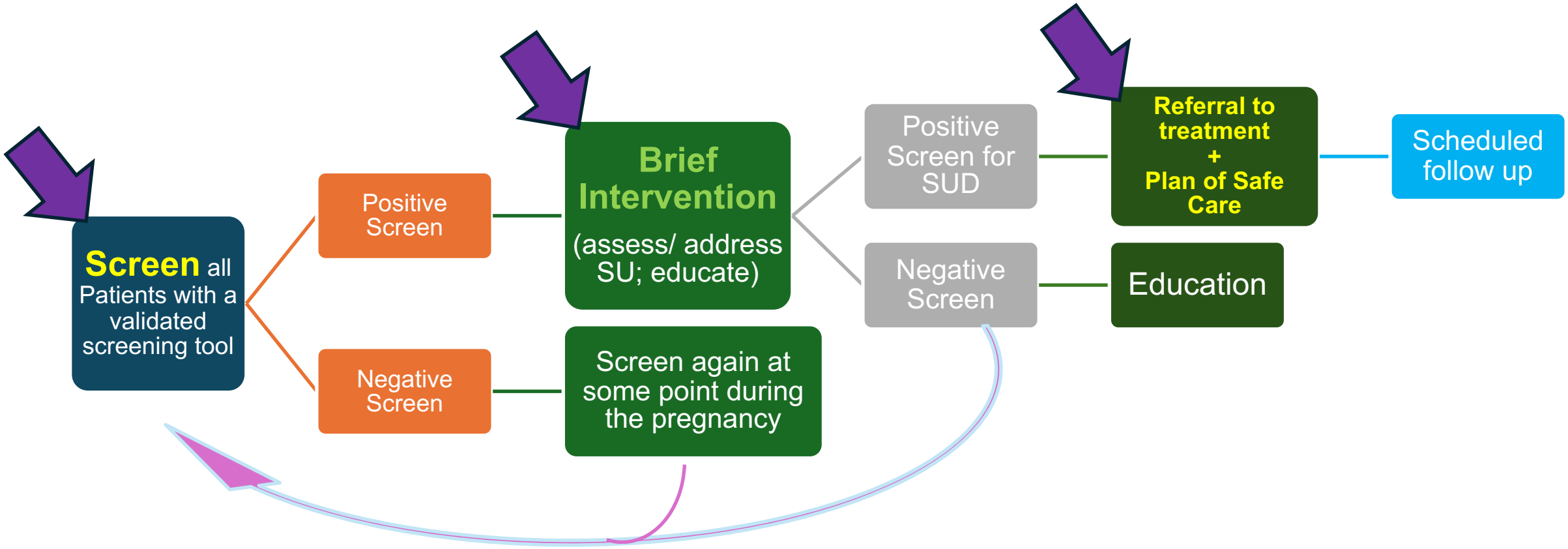
Present
In the past month, have you drunk any alcohol or used other drugs?
1. How many **days per month** do you drink?_____
2. How many **drinks** on **any given day**? _____
3. How often did you have **4 or more drinks per day** in the last **month**? _____

Smoking
Have you smoked any cigarettes in the past three months?



Best Practices for Managing Mental Health Conditions Among Maternal Populations

Sample Workflow



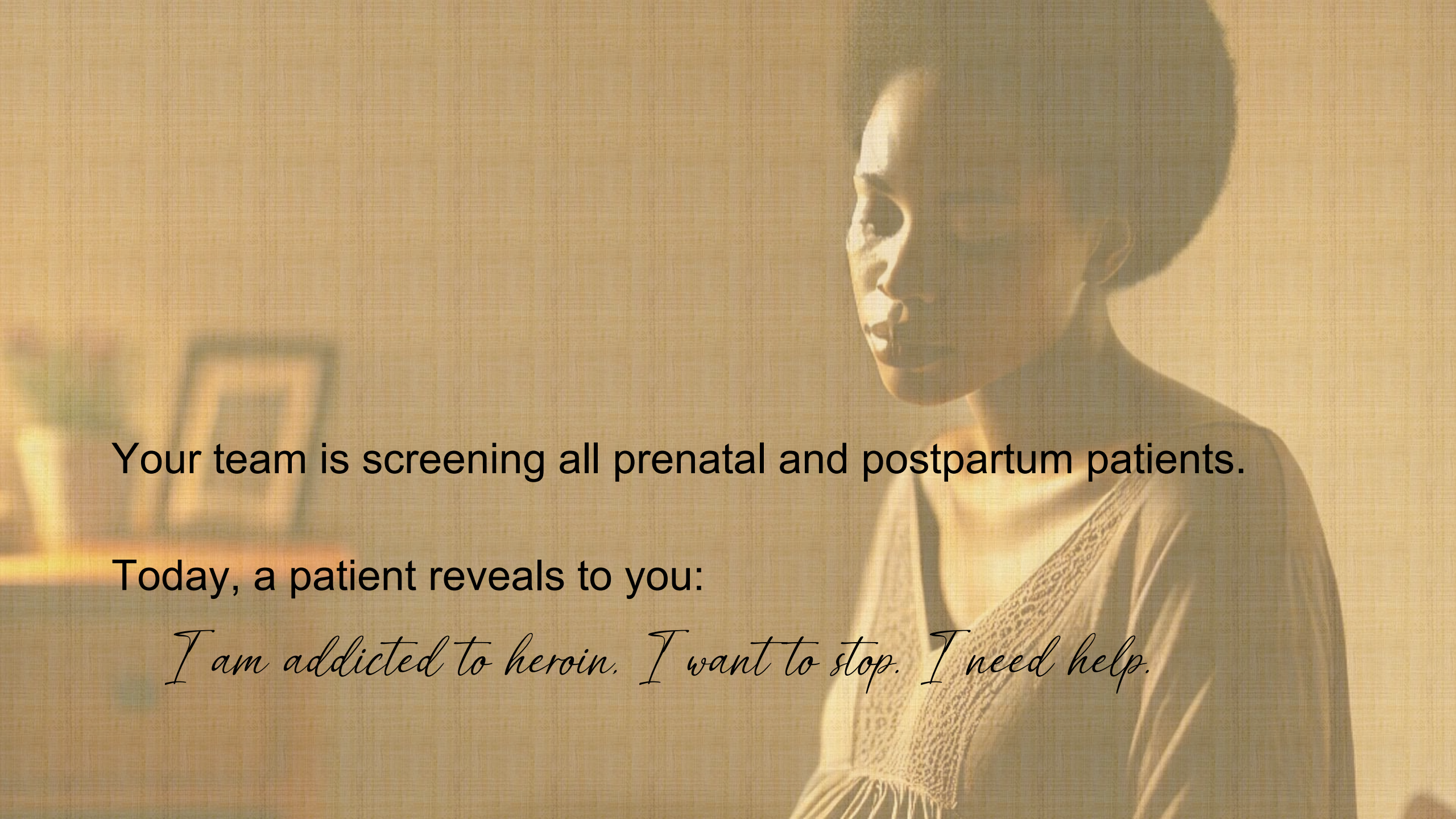
Based upon findings from: Habersham, Leah L., et al. "Content Analysis of Maternal Toxicology Testing Policies to Inform Equity in Substance Use Disorder Identification." *Maternal and Child Health Journal*(2025): 1-9.

Reimbursement for SBIRT

Payer	Code	Description	Fee Schedule
Commercial Insurance	CPT 99408	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$33.41
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$65.51
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	$57.69
Medicaid	H0049	Alcohol and/or drug screening	$24.00
	H0050	Alcohol and/or drug screening, brief intervention, per 15 minutes	$48.00

https://www.samhsa.gov/sbirt/coding-reimbursement

Updated as of 4/17/2024



Your team is screening all prenatal and postpartum patients.

Today, a patient reveals to you:

I am addicted to heroin. I want to stop. I need help.


Now What?

Supportive, Trauma-Informed Care Builds Engagement

When care feels safe, patients show up — and stay engaged in both prenatal care and substance use treatment.

Casey Family Programs. (2023, August 3). *How can prenatal substance use be addressed more effectively through prevention?* https://www.casey.org/prenatal-substance-exposure-prevention/

Morton Ninomiya, M. E., Varcoe, C., Firestone, M., Wells, S., & Poole, N. (2023). Supporting pregnant and parenting women who use alcohol during pregnancy: A scoping review of trauma-informed approaches. *Women's Health, 19*, 1–19. https://doi.org/10.1177/17455057221147459

Center for Health Care Strategies. (2024, January). *Building healthy futures: Addressing mental health and substance use disorders during pregnancy and postpartum.* https://www.chcs.org/media/Building-Health-Futures_Addressing-Mental-Health-and-Substance-Use-Disorders-During-Pregnancy-and-Postpartum.pdf

Casey Family Programs. (2023, March 20). *What are Plans of Safe Care and how do they support infants and families?* https://www.casey.org/infant-plans-of-safe-care/

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Trauma-Informed Care in Action

1. Preempt Fear with Transparency
2. Acknowledge the Lived Reality
3. Create Space for Silence
4. Ask for Permission
5. Reflect Strengths, Not Just Risks
6. Center the Patient's Priorities

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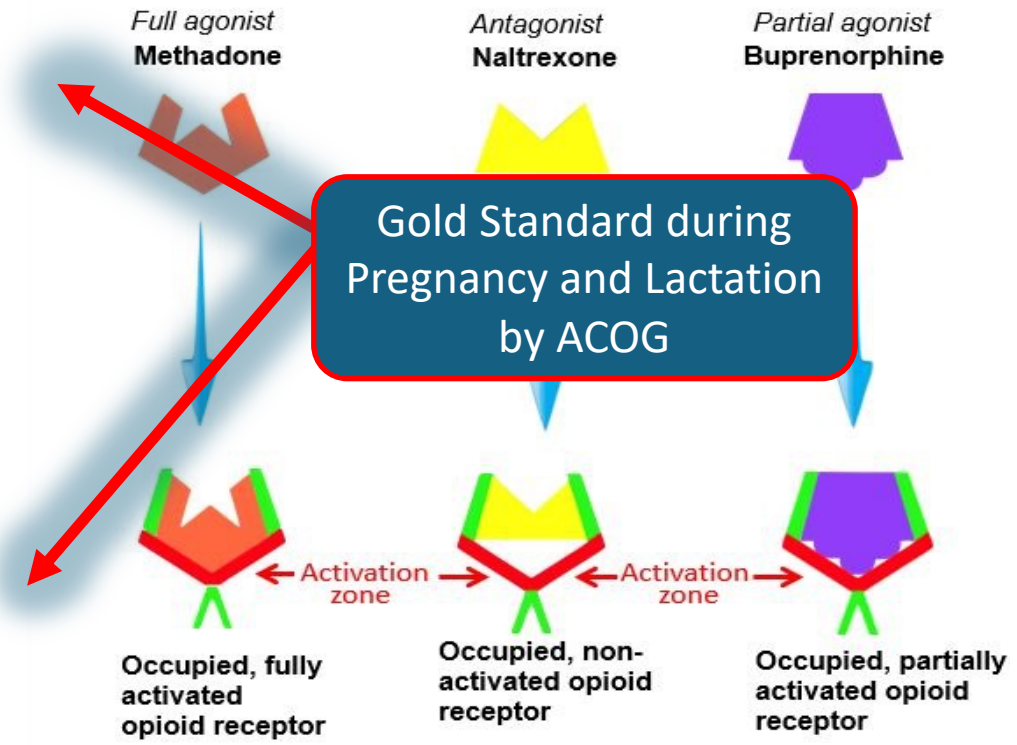
Medications for OUD (MOUD)

Agonist	• **Methadone** • Full agonist of Mu, Delta, Kappa
Antagonist	• Naltrexone • Antagonist at Mu, Delta, Kappa
Partial Agonist	• **Buprenorphine** • Mu partial agonist, Kappa/ Delta antagonist



Soyka, M. (2021). Transition from full mu opioid agonists to buprenorphine in opioid dependent patients—A critical review. *Frontiers in Pharmacology*, 2901

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Mental Illness and Medication Treatment

Most psychotropic medications are *not* absolutely contraindicated in pregnancy. For patients with significant mental illness,* guidelines generally favor continuing effective treatment during pregnancy, given the high risk of relapse with abrupt discontinuation. *The major exception is valproate*, which is contraindicated in pregnancy and should be avoided in women of child-bearing potential.

- Reproductive psychiatrists are specialized in managing mental health conditions during the perinatal period, but there are few of these providers.
- Health providers of maternal patients should err on the side of continuing psychotropics.
- Concerns can be discussed across providers, and if not possible, utilize resources like Project TEACH.

MS, M., & Kay Roussos–Ross, M. D. (2023). Treatment and management of mental health conditions during pregnancy and postpartum. *American College of Obstetricians and Gynecologists*, *141*(6), 1262-1288.
Larsen, E. R., Damkier, P., Pedersen, L. H., Fenger-Gron, J., Mikkelsen, R. L., Nielsen, R. E., ... & Videbech, P. (2015). Use of psychotropic drugs during pregnancy and breast-feeding. *Acta Psychiatrica Scandinavica*, *132*, 1-28.
McAllister-Williams, R. H., Baldwin, D. S., Cantwell, R., Easter, A., Gilvarry, E., Glover, V., ... & Endorsed by the British Association for Psychopharmacology. (2017). British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum 2017. *Journal of Psychopharmacology*, *31*(5), 519-552.
Angus-Leppan, H., Arkell, R., Watkins, L., Heaney, D., Cooper, P., & Shankar, R. (2024). New valproate regulations, informed choice and seizure risk. *Journal of Neurology*, *271*(8), 5671-5686.
Bayrampour, H., Kapoor, A., Bunka, M., & Ryan, D. (2020). The risk of relapse of depression during pregnancy after discontinuation of antidepressants: a systematic review and meta-analysis. *J Clin Psychiatry*, *81*(4), 19r13134.
Vickery, P. B. (2023). Concepts for selection and utilization of psychiatric medications in pregnancy. *Mental Health Clinician*, *13*(6), 255-267.

Levels of Addiction Care

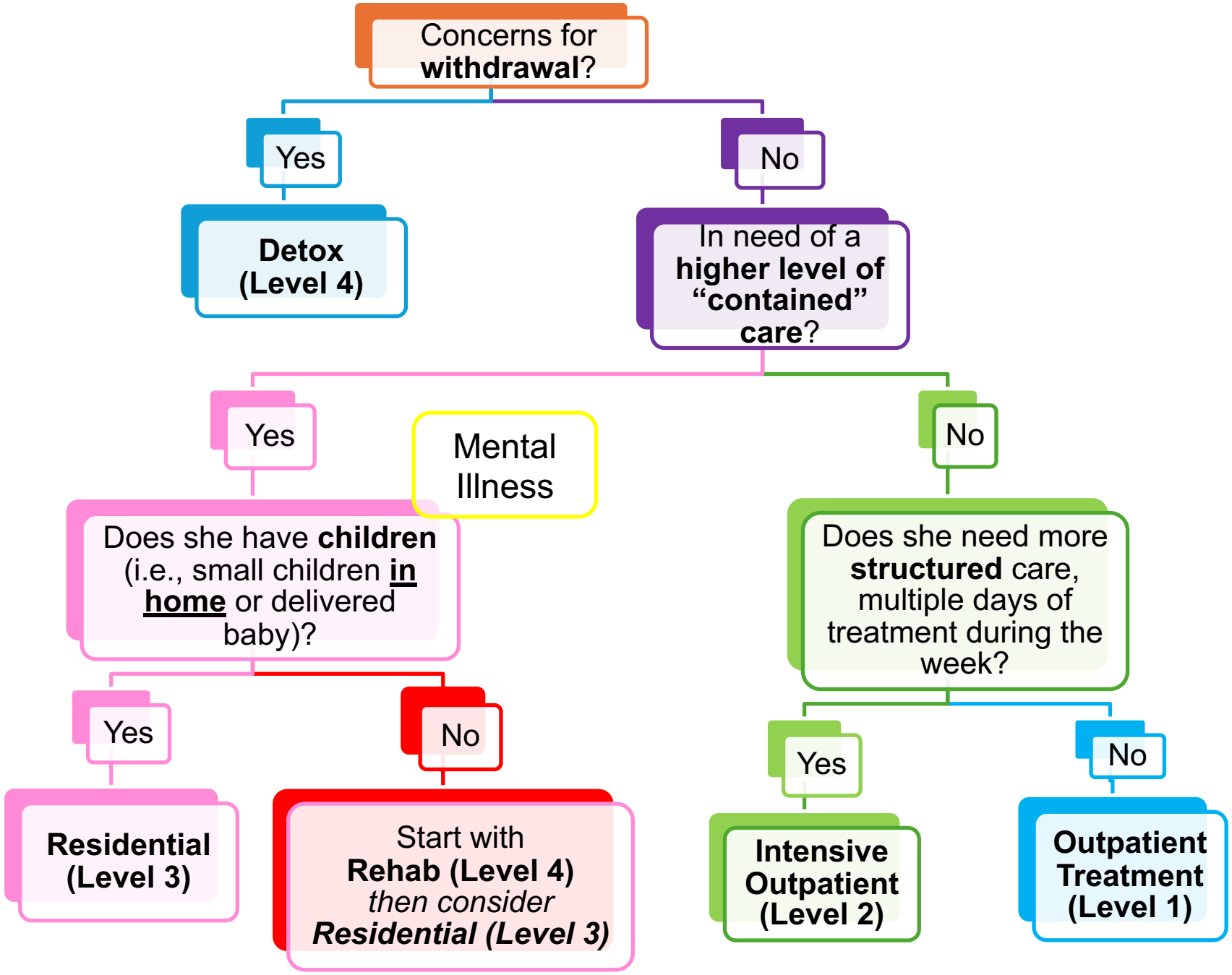
Detox/Rehab

Residential

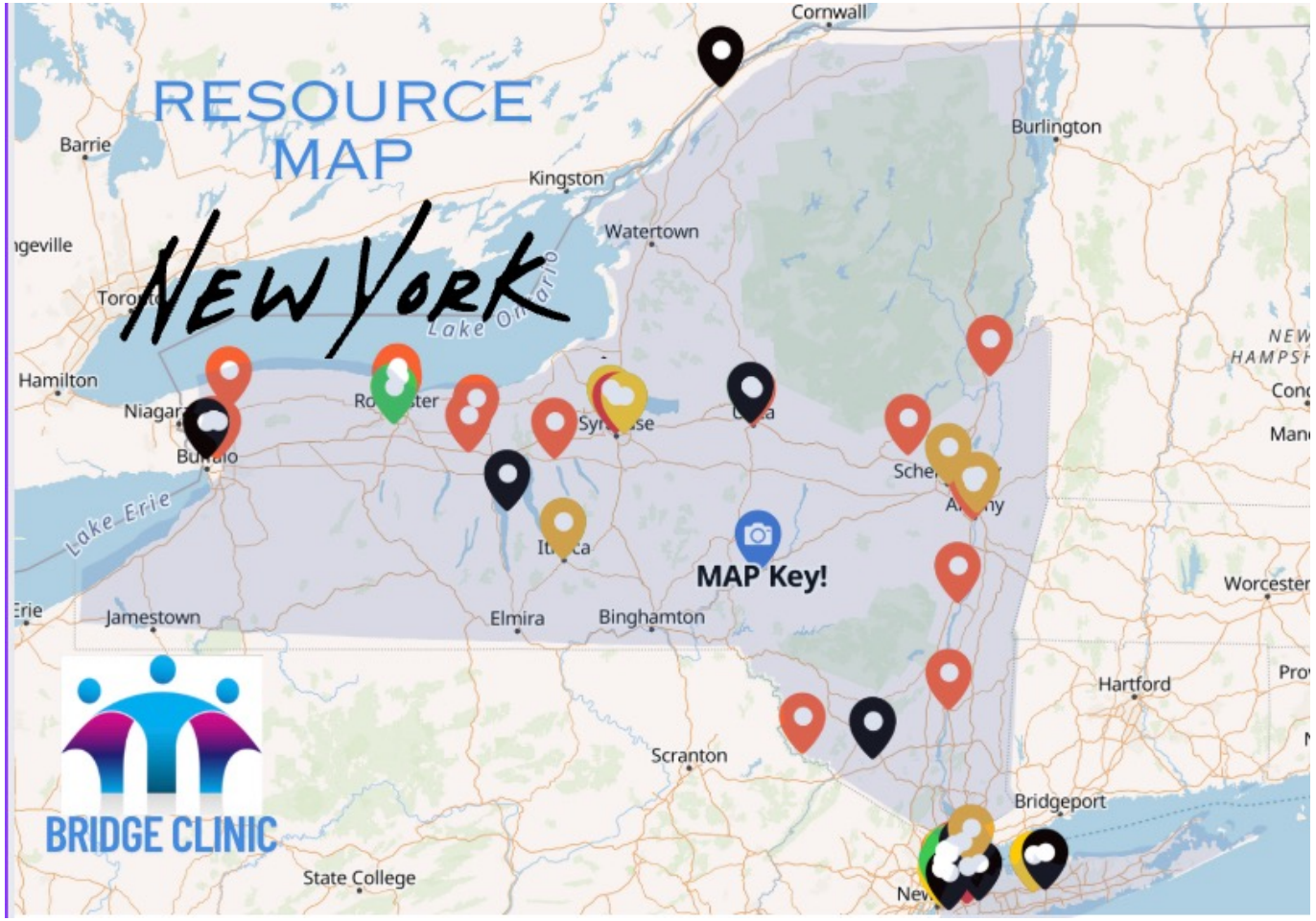
Intensive Outpatient

Outpatient

Maternal Patient With SUD: Decision Tree



NYS Resources



RESOURCE MAP

Adjuncts to Medical Treatment

Behavioral therapy (BT) in the context of addiction treatment is an important and useful adjunct to medication therapy and addressing maternal mental health

- Group therapy
- Individual therapy

- Approaches: Motivational interviewing, Mindfulness, Cognitive Behavioral Therapy (CBT)

Case Management

- **Case management** programs provide linkage and coordination to various aspects of care – culminating in more holistic care that practices are often unable to address

- *Assess* and *Address* the **mental health conditions**, social issues, medical issues, and addiction issues with ongoing follow up

Utilizing the Plan of Safe Care

- Continued follow up is important – linking patients to treatment is not the end
- **Care coordination*** is key to maintaining health
- *Integrated programs and collaborative models are facilitative of care coordination
- **POSC** is a great way to keep the team informed of complexities and details of each dyad's care: monitors care of both infant and mother
- Federally mandated (CAPTA/**CARA**)
- Should be included in care plan during prenatal/postpartum care or at least during birthing hospitalization

Plan of Safe Care

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My Plan of Safe Care (POSC) for Myself & My Baby

My Strengths:

My Thoughts:

NYS Guidance for POSC Initiation During Prenatal Period

Prenatal Period

Who can develop a POSC in collaboration with a pregnant person?

- Case Manager
- Community Health Worker (CHW)
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC)
- Discharge Planner
- Doula
- Family Member/Friend/Support Person
- Home Visitor
- Licensed Mental Health Provider
- Midwife
- Ob/Gyn
- Opioid Treatment Provider
- Primary Care Provider
- Social Worker
- Substance Use Provider

Who should have a POSC?

Pregnant individuals who:

- are diagnosed with a substance use disorder **OR**
- are receiving medication for addiction treatment (MAT) for a substance use disorder **OR**
- are under the care and supervision of a healthcare provider who has prescribed opioids

Consent to include a POSC in EMR or Paper Chart should be obtained from the pregnant person before sharing with other providers.

POSC Consent

https://oasas.ny.gov/system/files/documents/2021/07/trs-2eng.pdf

https://oasas.ny.gov/sample-authorization-access-patient-information-trs-65-plan-safe-care-english

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Authorization for Access to Patient Information
Plan of Safe Care

TEMPLATE

Patient Last Name	Patient First Name	Date of Birth
Patient Address		Patient ID Number

I request that health information regarding my Plan of Safe Care (PoSC) be accessed as set forth on this form. I can choose whether or not to allow my health care providers and health plans to obtain access to my medical records through the health information exchange organization called _____. If I give consent, my medical records from the different places where I get health care can be accessed using a statewide computer network. _____ is a not-for-profit organization that securely shares information about people's health electronically to improve the quality of healthcare and meets the privacy and security standards of HIPAA, the requirements of the federal confidentiality laws, 42 CFR Part 2, and New York State Law. To learn more visit _____'s website at www._____.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice:
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

This consent decision applies to:
- ☐ [Name of OASAS Treatment Provider Organization Only]
- ☐ _____ Information Exchange
- ☐ [Name of Insurance Provider]
- ☐ [Name of Care Management Entity]
- ☐ [Name of OB-GYN]
- ☐ [Name of Primary Care Physician/Practice]
- ☐ [Name of birthing hospital]
- ☐ [Name of Pediatrician]

Extent or nature of information to be disclosed or released:
This consent is limited to the sharing of only my Plan of Safe Care.

Time period:
This consent is valid for one year from the date this consent is executed.

I have been provided a copy of this form and my consent decision applies to all providers noted above.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Intrapartum and Postpartum Approaches

SUD Complicating Birthing Hospitalization Management

Pain Management

- **Increased pain sensitivity** (opioid-induced hyperalgesia) may require multimodal pain management strategies
- **Regional anesthesia (epidural/spinal)** is preferred for labor analgesia and cesarean delivery.
- **Avoid opioid agonist-antagonists (e.g., nalbuphine, butorphanol)** can precipitate withdrawal.

Medication for Opioid Use Disorder (MOUD)

- **Continue methadone or buprenorphine** during labor and delivery. These medications **do not** provide adequate analgesia for labor pain.
- **Split dosing of methadone/ BUP** (e.g., q6-8 hrs) may improve pain control.

Breastfeeding Considerations

- **Encouraged esp. if on stable MOUD**, as it helps reduce NAS symptoms.
- **Contraindications**: ongoing illicit drug use, HIV (in resource-rich settings), or poor maternal adherence to treatment.

Mental Health Considerations

- **Follow up postpartum 1-2 weeks** for a check in
- **Include mental health assessment,** i.e. PHQ-2 or -9, Edinburgh
- Ensure ongoing follow up ***by someone*** throughout first year postpartum (i.e., Addiction provider, Therapist, Psychiatrist)

American College of Obstetricians and Gynecologists. (2017). Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. *Obstetrics & Gynecology*, 130(2), e81–e94.

Multimodal Pain Management is key

	Description	Localization	Description	Etiology	Management
Nociceptive	Tactile on skin and external soft tissues; musculoskeletal	Very localized	Variable but typically sharp, stabbing	Trauma, pressure	Anti-inflammatories, centrally acting agents; opioids as last resort
Visceral	Deeper origin, e.g., gut or brain (colic, obstruction)	Poorly localized (headache, abdominal pain, chest pain)	Dull, achy, colicky, intermittent	Injury or trauma to internal organs	Centrally acting; opioids as last resort, need to pursue cause
Neuropathic	Commonly peripheral extremities (spinal cord injury, herpes zoster, DM neuropathy)	Usually well localized	Burning, piercing, tingling; constant	Chronically damaged nerves from DM, ischemia,	Nerve stabilizers, antidepressants > anti-inflammatory; opioids as last resort
Inflammatory	Soft tissues and joints	Usually well localized	Burning, aching, worse with movement	Soft tissue or joint inflammation locally	Anti-inflammatory; ice, compression; opioids as last resort

https://www.apsf.org/article/multimodal-analgesia-and-alternatives-to-opioids-for-postoperative-analgesia/

https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/ctr-17-0004-multi-model-pain-project-pdf-version-m1.pdf

Class	Drug	Dose	Important Considerations
Alpha-2-agonists	Dexmedetomidine*†	IV loading dose: 0.5–1 mcg/kg over 10 min Infusion: 0.2–1.7 mcg/kg/hr	Can cause severe bradycardia and hypotension Can cause severe hypertension during loading dose Consider dose reduction in geriatric patients
	Clonidine*†	PO†: 0.2 mg BID Epidural: 30–40 mcg/hr	Can cause severe hypotension Can lead to withdrawal if stopped abruptly after regular use Epidural use approved only for severe cancer pain
Anti-convulsants	Gabapentin*†	PO: 300–1200 mg TID	May reduce postoperative pain if given preoperatively[14] Can cause dizziness, drowsiness, water retention Manufacturer recommends discontinuation over 1 week
	Pregabalin*†	PO: 150–600 mg per day in 2–3 divided doses	90% bioavailability vs. gabapentin[13] Starting dose: 150 mg in 2–3 divided doses
NMDA Antagonist	Ketamine[16,†]	IV bolus: 0.3–0.5 mg/kg[16] Infusion: start at 0.1–0.2 mg/kg/hr[16]	Intensive monitoring suggested for bolus doses > 0.35 mg/kg or infusion rates > 1 mg/kg/hr[16] Can cause dysphoria and excessive salivation
Local anesthetics	Lidocaine[17,†]	IV bolus: 1.5 mg/kg[17] Infusion: 1–2 mg/kg/hr[17]	Can cause conduction block, dizziness, seizures, bradycardia[17]
Acetaminophen*		PO: 325–650 mg q 4–6hr IV: 1000 mg q 6 hr IV if >50 kg; if <50 kg, 15 mg/kg q 6 hr	Do not exceed 4 gm/24 hr Reduce to 2 gm/day in chronic alcohol use Potentiates warfarin anticoagulation PO and IV dosing are equivalent
NSAIDS	Diclofenac*	PO: 100–200 mg per day in 2–3 divided doses	Dose-dependent relief Should start at lowest possible dose Prolonged use predisposes to GI, CV, and renal dysfunction For IV and PO ketorolac: limit to 5 days PO ketorolac should only be used to continue therapy after IV initiation Increases lithium levels Prone to gastric ulceration with bisphosphonates
	Ibuprofen*	IV: 400 mg first dose, followed by 100–200 mg q 4–6 hr PO: 1200–3200 mg per day in 3–4 divided doses	
	Ketorolac*	IM or IV: 15–30 mg every 4–6 hr PO: 10 mg q 4–6 hr	
	Meloxicam*	PO: 7.5–15 mg daily	
	Celecoxib*	PO: 50–200 mg daily in a single dose or 2 divided doses	

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Neonatal Opioid Withdrawal Syndrome & Eat, Sleep, Console (ESC)

4th Trimester Considerations

Educate patients on **return-to-use**—risk of overdose*

Level of care still appropriate?

Ensure care coordination for *all conditions* remains ongoing and by whom?

Everyone Can Play a Role

Preventing Postpartum Overdose & Return-to-Use:

Roles Beyond OB Care

Psychiatry & Mental Health

Key Role: Address trauma, depression, and suicidality—key contributors to postpartum deaths —discuss POSC.

Primary and/or Addiction Care

Key Role: Bridge the gap as OB care ends—many patients re-engage here —discuss POSC.

Pediatrics

Key Role: Leverage frequent infant visits to assess maternal wellbeing —discuss POSC.

Care Coordination, Social Work, Legal Advocates

Key Role: Remove systemic barriers that trigger return-to-use (e.g., housing, custody loss, stigma) —discuss POSC.

How we can tie it all together: a case study

Case Overview

- A.M., 29-year-old G2P1 at 18 weeks' gestation
- Screening: PHQ-9 = 18 (moderately severe depression)
- History: Past major depression, did well on escitalopram 15 mg
- Access barrier: No reproductive psychiatrist available; next general psychiatry visit in ~2 months

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Initial Management

- Provider chart review: confirm prior response to escitalopram; no history of bipolar disorder or psychosis
- Provider contacts **Project TEACH** for perinatal psychiatry consultation
- Same-day recommendations: restart escitalopram 5 mg daily, titrate to 15 mg over several weeks as tolerated
- Shared decision-making: patient agrees and starts medication
- Over 4–6 weeks, mood improves (PHQ-9 down to ~8), engagement in care increases

A New Problem Unveiled

- As trust builds and depression improves, patient discloses longstanding opioid use disorder (OUD)
- A.M. reports prior success on buprenorphine; recent relapse when depression worsened

- Provider explains bidirectional relationship: depression worsens opioid use, opioid use worsens depression
- Provider uses nonjudgmental, trauma-informed approach and provides brief intervention (SBIRT)

Buprenorphine & Plan of Safe Care (POSC)

- Refer to addiction specialist
- Specialist confirms moderate–severe OUD and initiates buprenorphine; patient stabilizes and stops non-prescribed opioid use
- Team develops a Plan of Safe Care (POSC) during pregnancy, including:
    - Ongoing escitalopram and buprenorphine
    - Social work support, transportation, and housing resources
    - Identification of infant's pediatrician and postpartum follow-up plan

Delivery, ESC, and Neonatal Course

- At 39 weeks, A.M. delivers a healthy baby boy
- Patient continues buprenorphine through labor and postpartum
- Infant monitored for neonatal opioid withdrawal syndrome (NOWS) using Eat, Sleep, Console (ESC) (ESC focuses on rooming-in, skin-to-skin, breastfeeding, parental involvement)
- Infant has mild symptoms managed with nonpharmacologic ESC care only
- Mother–baby dyad remains together and is discharged on postpartum day 5

First-Year Postpartum: Ongoing POSC & Team Roles

- **Case Manager**: ensures continued and coordinated follow-up
- **Psychiatrist & Therapist:** continues escitalopram; monitors for postpartum depression, anxiety, suicidality
- **Addiction Specialist**: maintains buprenorphine; monitors cravings/return-to-use; provides naloxone and harm reduction
- **Pediatrician**: monitors infant growth, development, bonding; screens for family psychosocial stressors
- **Primary Care Provider (PCP):** oversees long-term medical care and preventive care
- **OB/GYN**: postpartum and ongoing gynecologic care, including contraception and future pregnancy planning
- POSC is updated and shared (with consent) across the team to support the dyad through the first year postpartum

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Summary

Mental Health Conditions are a leading cause of maternal mortality, with rising deaths during pregnancy and postpartum.

Screening, trauma-informed care, and evidence-based treatment improve maternal and neonatal outcomes.

Multimodal pain management, regional anesthesia, continued MSUD, and mental health management are all key to safe prenatal and postpartum care.

All health care providers can play a vital role in maternal health: reducing stigma, expanding access to care, and advocating for policy change.

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Thank you!

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