Integrated Perinatal Care for Birthing People with Substance Use Disorder

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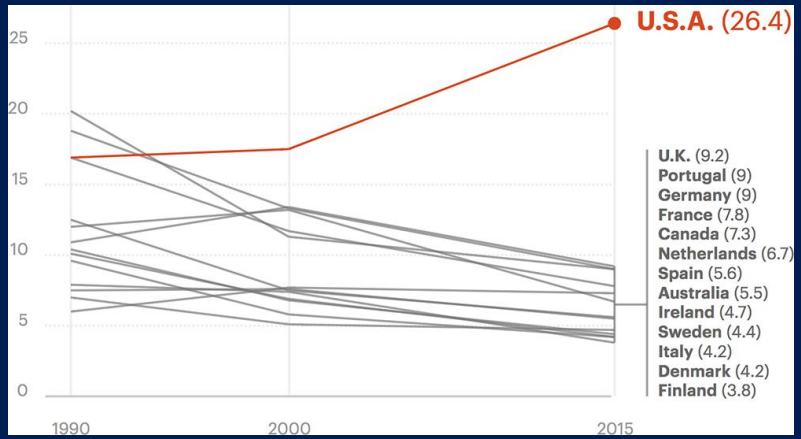
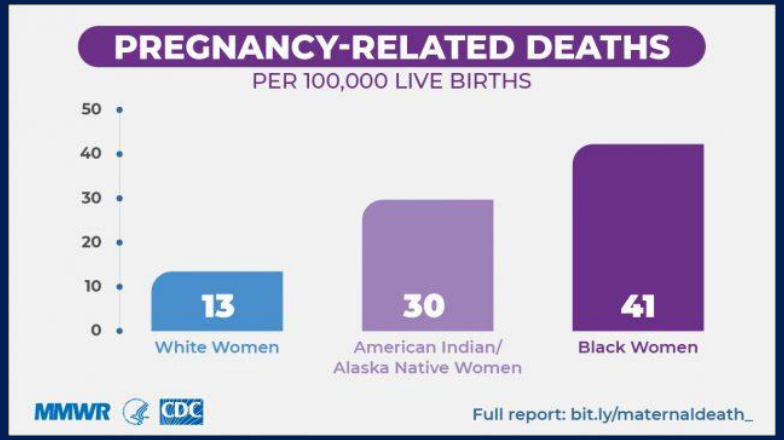
Dr. Muzik has no relevant financial or nonfinancial relationships
to disclose.

US Maternal mortality rates





National Vital Statistics System, (NVSS)

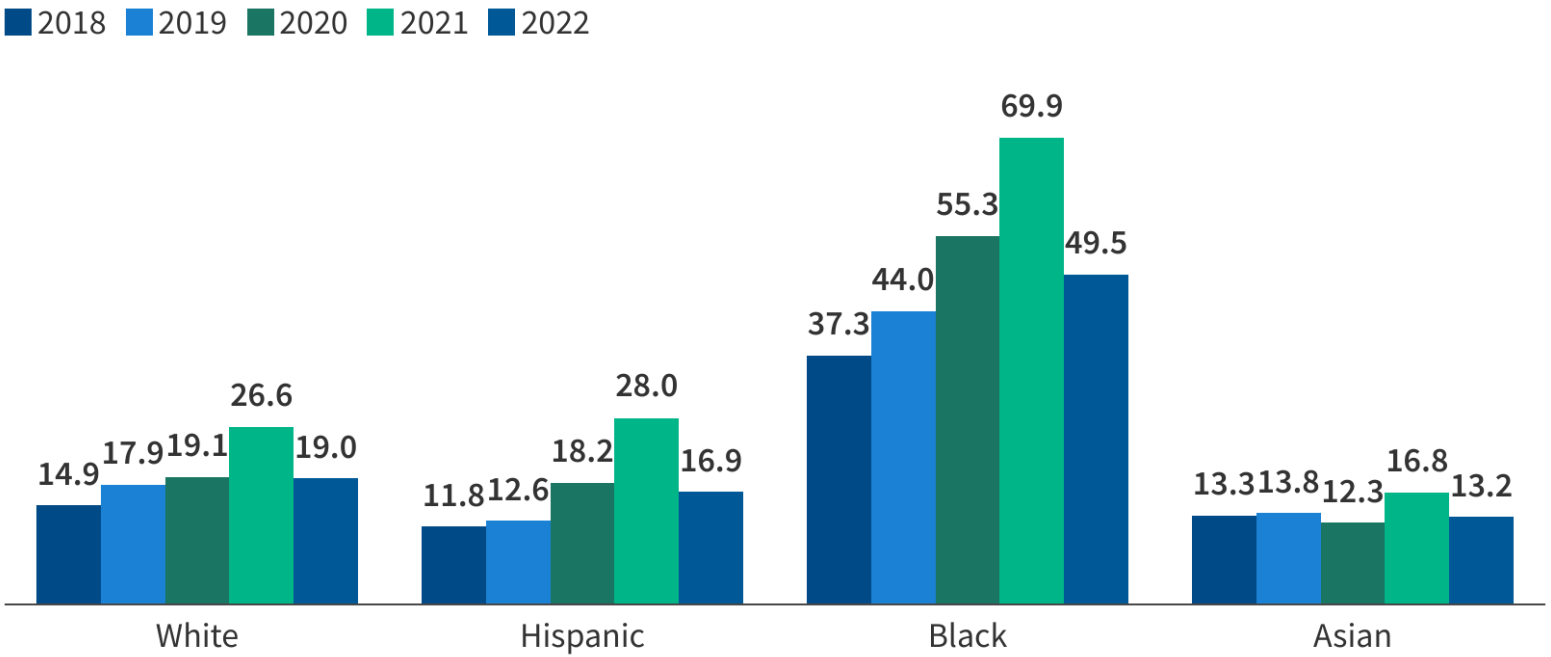
~700 women die each year during pregnancy or first year following pregnancy

U.S. ranks last among industrialized nations in maternal mortality

Women of color die at 3-4x the rate of White women

Figure 2

Maternal Mortality per 100,000 Births by Race and Ethnicity, 2018-2022

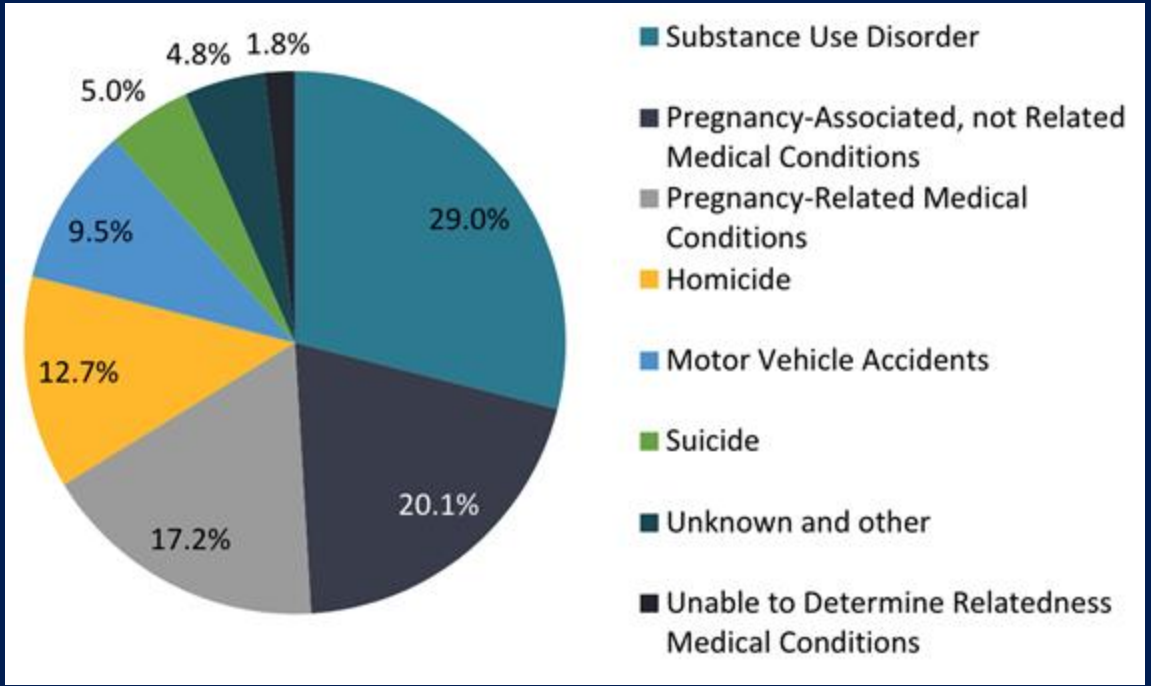


Note: Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Other races are not shown due to small numbers. Maternal deaths are defined as deaths that occur while pregnant or within 42 days of being pregnant.

Source: Hoyert DL. Maternal mortality rates in the United States, 2022. NCHS Health E-Stats. 2024.

KFF

The #1 cause of pregnancy associated mortality



CDC 2021, MDHHS 2023

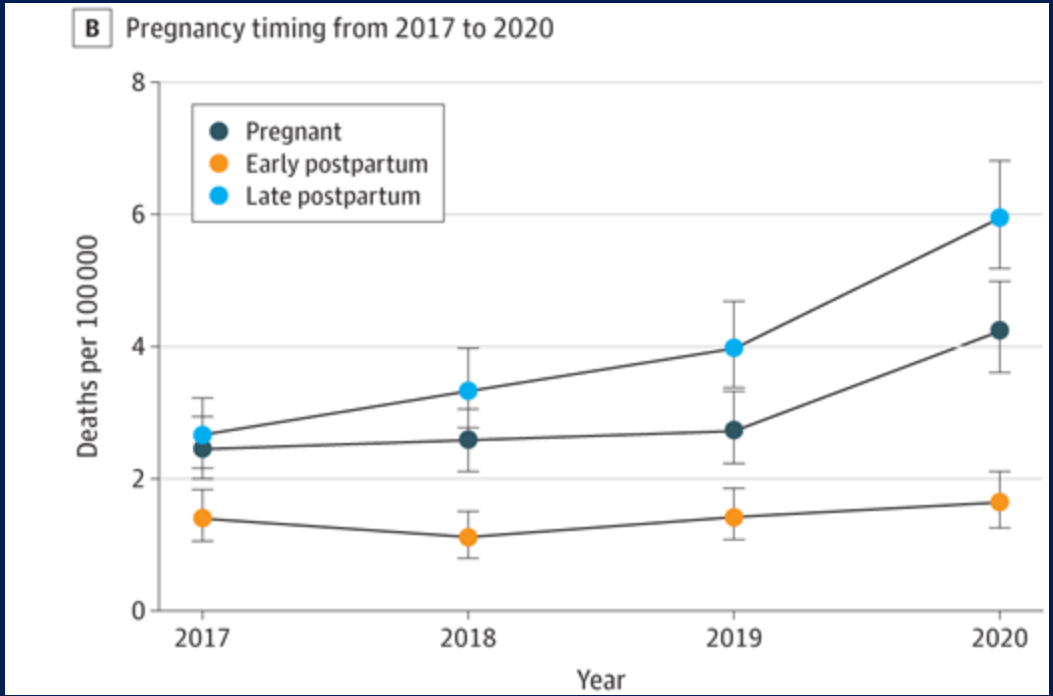
What are opioids?

Opiates are *natural* substances derived from the naturally occurring plant compound in the poppy plant called ”Opium Poppy” which include Morphine, Codeine.

Opioids that are *synthetic or semi synthetic* produced in the laboratory including

- Heroin (diacetylmorphine- make it lipophilic, crosses BBB quickly)
- Methadone,
- Percocet, Percodan, OxyContin (oxycodone),
- Vicodin, Lorcet, Lortab (hydrocodone),
- Demerol (pethidine),
- Dilaudid (hydromorphone),
- Duragesic (fentanyl).

The majority of opioid-related mortality (>75%) occurs postpartum.



CDC 2021, Bruzelius 2022

The effects of OUD/SUD in pregnancy/ postpartum

- Lack of prenatal care
- Structural anomalies (e.g., stimulants, alcohol)
- Fetal growth restriction
- Abruption
- Preterm labor
- Neonatal Withdrawal
- Stillbirth
- Maternal overdose/death
- High-risk activities
- Co-occuring mental health conditions
- Disrupted social networks
- Polysubstance use

Adverse outcomes can be mitigated through routine obstetric care and treatment for substance use disorder.

ACOG 2021

FEAR

#1 reason for not seeking prenatal care in birthing people using substances.

Schiff 2022

Guiding principles to inform care delivery

Words matter

Trauma-informed

Harm Reduction

Social Drivers of Health

Words matter

Goal for language to be:

- Person-centered
- Gender neutral
- Treatment is done WITH patients, not TO them.
- Find the positivity!
  - Small wins
  - Tell stories of success and recovery

Harm reduction: shifts conversation from….

~~Get people to do the "right thing."~~

Get people to come back safely.

Social drivers of health

- Economic stability
- Education
- Health Care Access
- Neighborhood/Build Environment Safety
- Social/Community Context Social Support
- Housing
- Emotional Needs

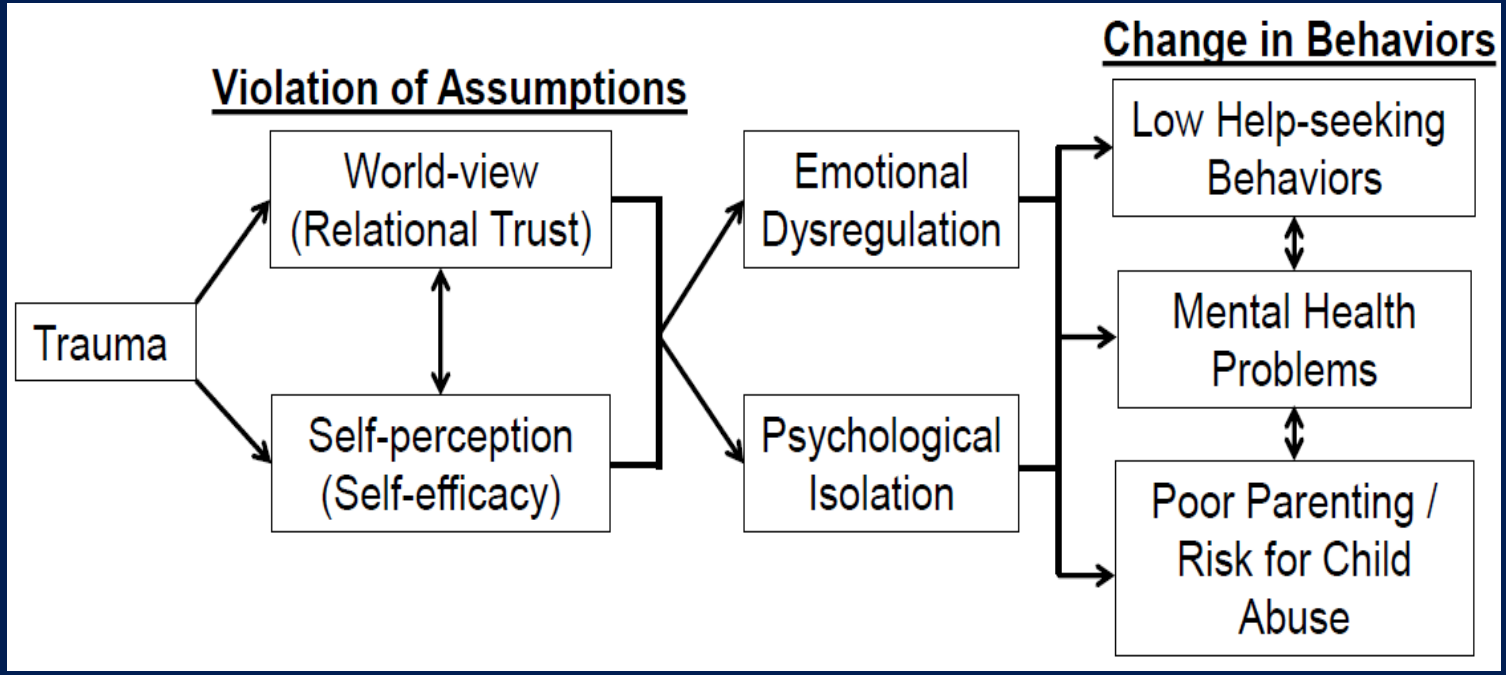
SIREN Network, CDC 2020

80%

of women seeking treatment for addiction report a history of physical/sexual assault

Women with SUD are **12x more likely** to experience PTSD

Trauma changes trust, functioning, and help seeking



Conceptual Framework on trauma and help-seeking
Based on Edna Foa, Mardi Horowitz, John Bowlby &
Liang, Goodman, Tummala-Narra, & Weintraub, 2005

Mental Health and SUDs- Exponentially Common

Substance Use

30-60% of women with PTSD have SUD

80% of women with SUD have a lifetime history of trauma

Trauma SDOH

PTSD

Prevalence of Depression and anxiety in SUD/OUD is ~50% or more

Depression Anxiety

PTSD and depression 60% overlap

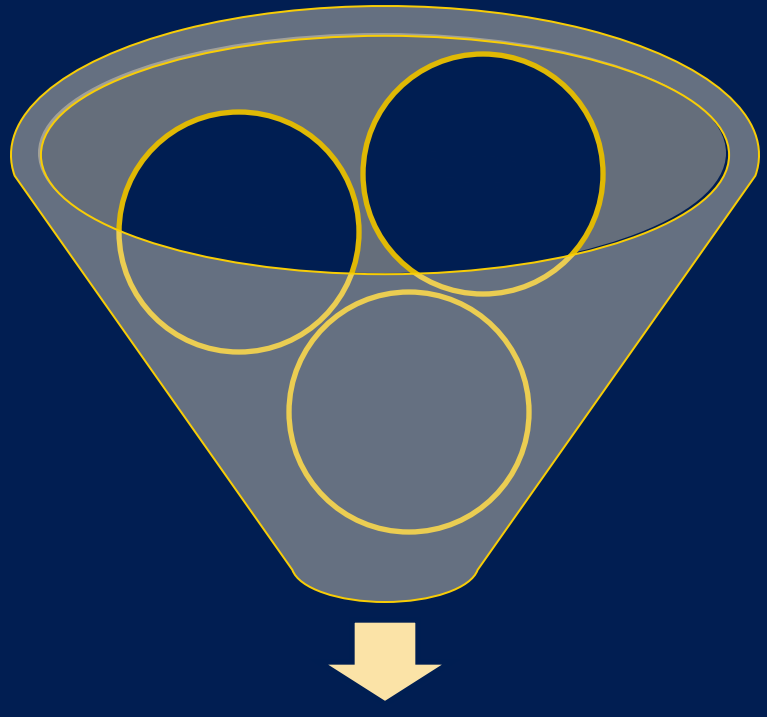
Core Principles of Trauma Informed Care

- Understand Trauma is common
- Create Safety
- Trustworthiness and Dependability
- Collaboration and Empowerment
- Compassion & Empathy
- Self-care to prevent burn-out

Sperlich 2017.

Co-existing Polysubstance Use Disorders

- A 2012–2013 U.S. general population study found that more than 90% of individuals with OUD used more than two other substances within the same year, and over 25% had at least two other substance use disorders along with OUD.
- Polysubstance use may also contribute to risk of overdose, traumatic injury, infectious disease risk, and mortality



Compton 2021; Hassan Ahmed N 2019

Effects of opioids:

General effects:
Inhibition of pain
Euphoria
Anxiolysis
Pinpoint pupils
Mental status change/sedation
Respiratory suppression
Decreased bowel sounds
Hypothermia
Bradycardia
[Overdose]

Pregnancy effects:
Miscarriage
Preterm delivery
IUGR
Stillbirth
Maternal death due to overdose
Neonatal Opioid Withdrawal Syndrome

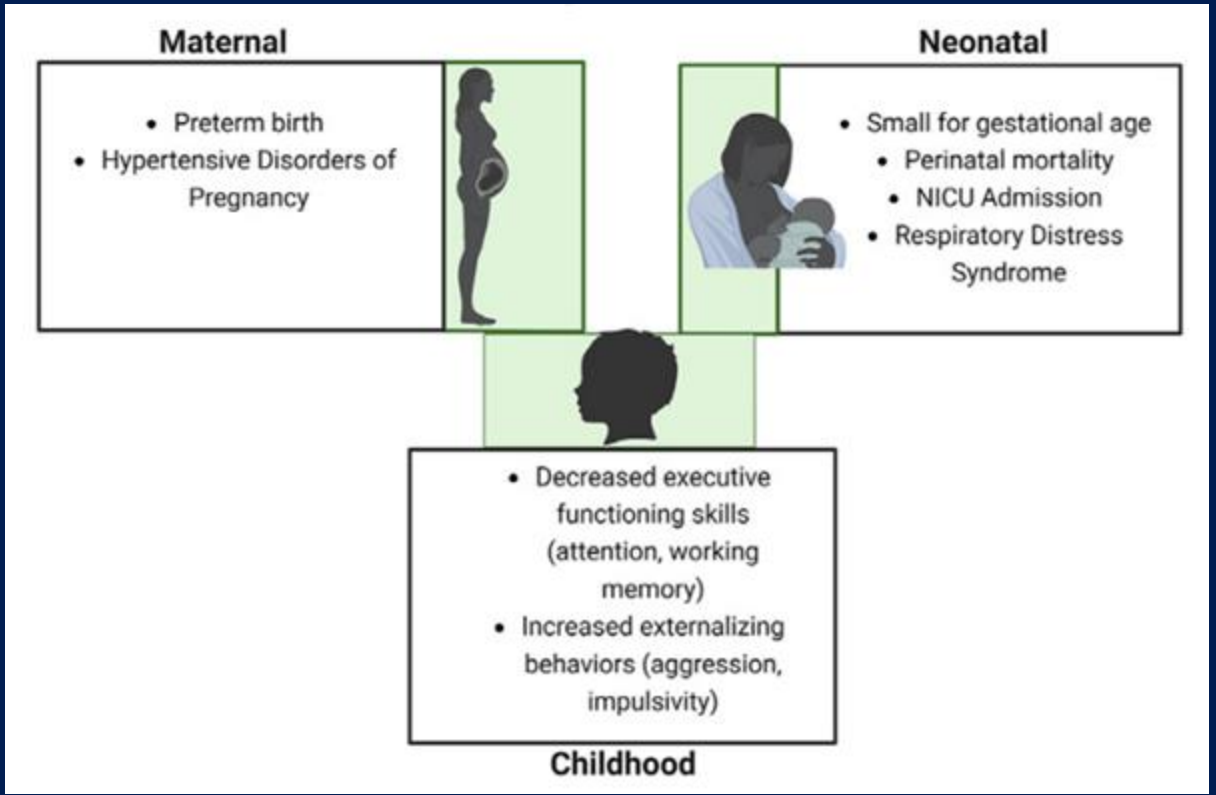
CDC 2021

Other substances to keep in mind:

Substance	Key effects
Stimulants (Methamphetamine, Cocaine)	preE, abruption (cocaine), cardiomyopathy/cardiac, IUGR, PTL, SMMM, fetal neurotoxicity
Alcohol	Fetal Alcohol Spectrum Disorder, SAB/stillbirth
Benzodiazepines	Medication dependent, SAB and low birth weight; Infant withdrawal
Cannabis	Growth restriction, stillbirth, neurodevelopmental effects
Tobacco	Growth restriction, SAB/stillbirth, abruption

CDC 2021

Cannabis Risks in Pregnancy



Drug screening vs. testing

Verbal screening

Series of questions asked of the patient about substance use.

Universal SCREENING reduces inequities in urine drug testing.

Testing

Method to detect/confirm substance use through urine.

Should not be done without consent and sharing implications with patient.

ACOG 2021, Soos 2023

Screening Tools:

NIDA Quick Screen

In the past year, how often have you used the following?*

a. Five or more alcohol drinks in a day for men, four or more alcohol drinks in a day for women
b. Tobacco products
c. Prescription drugs for nonmedical reasons
d. Illegal drugs
e. Cannabis**

*Consider adding “since becoming pregnant”

**Consider adding specific screening

5 Ps

- **Parents**: Did any of your parents have problems with alcohol or other drug use?
- **Partner**: Does your partner have a problem with alcohol or drug use?
- **Past**: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
- **Present**: In the past month, have you drunk any alcohol or used other drugs?
- **Pregnancy**: Now that you are pregnant, are you struggling to stop drugs and alcohol?

NIDA 2017, Knight 2016

Key Steps in treating OUD/SUD:

1. Identify substance use
2. Understand the paths to recovery
3. Understand comorbidities and contributing factors
4. Close follow-up and support!

1. Identify substance use

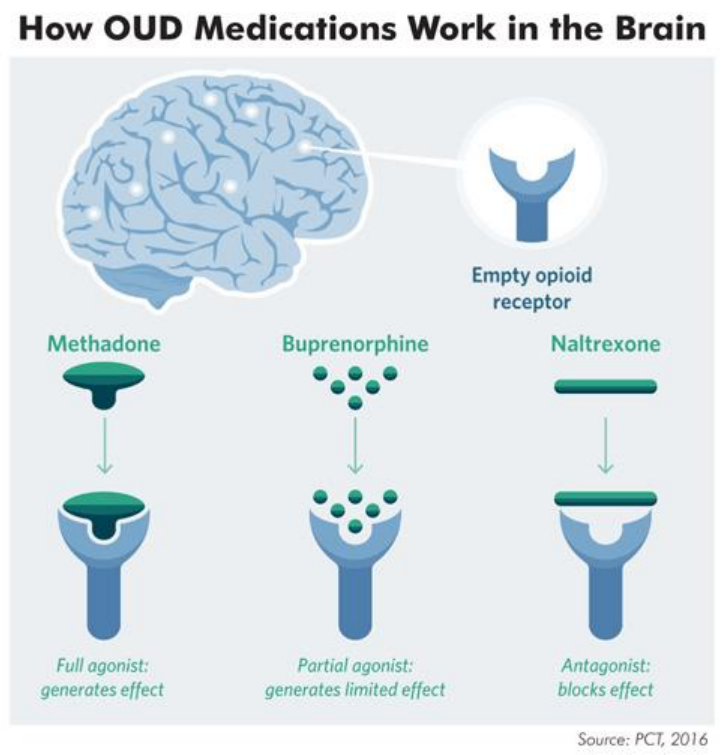
- **Current substance use:** contamination/polysubstance use common, UDS and GCMS (Gas Chromatography-Mass Spectrometry) for confirmation
- **Substance use history:** understand the origin story and prior experiences
- **Treatment/recovery history**: what has worked before? What has their experience with the healthcare system been?

2. Recovery options: Medication for Opioid Use Disorder (MOUD)

Preferred treatment: lower return to use, improved outcomes with prenatal care (97% effective in preventing overdose)

Methadone	Buprenorphine	Naltrexone

Krans 2023, ACOG 2021, SAMSHA 2018, SMFM 2019, Towers 2020


How OUD Medications Work in the Brain
Empty opioid receptor
Methadone
Buprenorphine
Naltrexone
Full agonist: generates effect
Partial agonist: generates limited effect
Antagonist: blocks effect
Source: PCT, 2016

MOUD agonist options

METHADONE

- **Full agonist** at the mu-opioid receptor
- Long half-life (24–50 hours)—once daily as liquid in specialized facility
- Start 20-30mg, titrate by 5–10mg to target
- Daily dose may need to be increased during pregnancy, especially in the 3rd trimester
- Split-dosing may help with increased metabolism
- Mom can breastfeed after birth

BUPRENORPHINE

- **Partial agonist** leading to **precipitated acute withdrawal**
- Partial agonist effects also means that has a ceiling effect for pain relief and respiratory suppression (is safer for OD)
- Long half-life 24–70 hours, sublingual film-tablet
- Also as depot (sublocate, brixadi)- not much data in pregnancy yet
- Dosing 8–16mg, max 24mg
- Daily dose may need to be increased during pregnancy but not common
- Less stringent structure with **office-based treatment**
- Comes as bupe alone or combo w/ naloxone—both safe
- →Transition from methadone to bupe not recommended during pregnancy b/c of risk for precipitated withdrawal
- Mom can breastfeed after birth

MOUD antagonist options

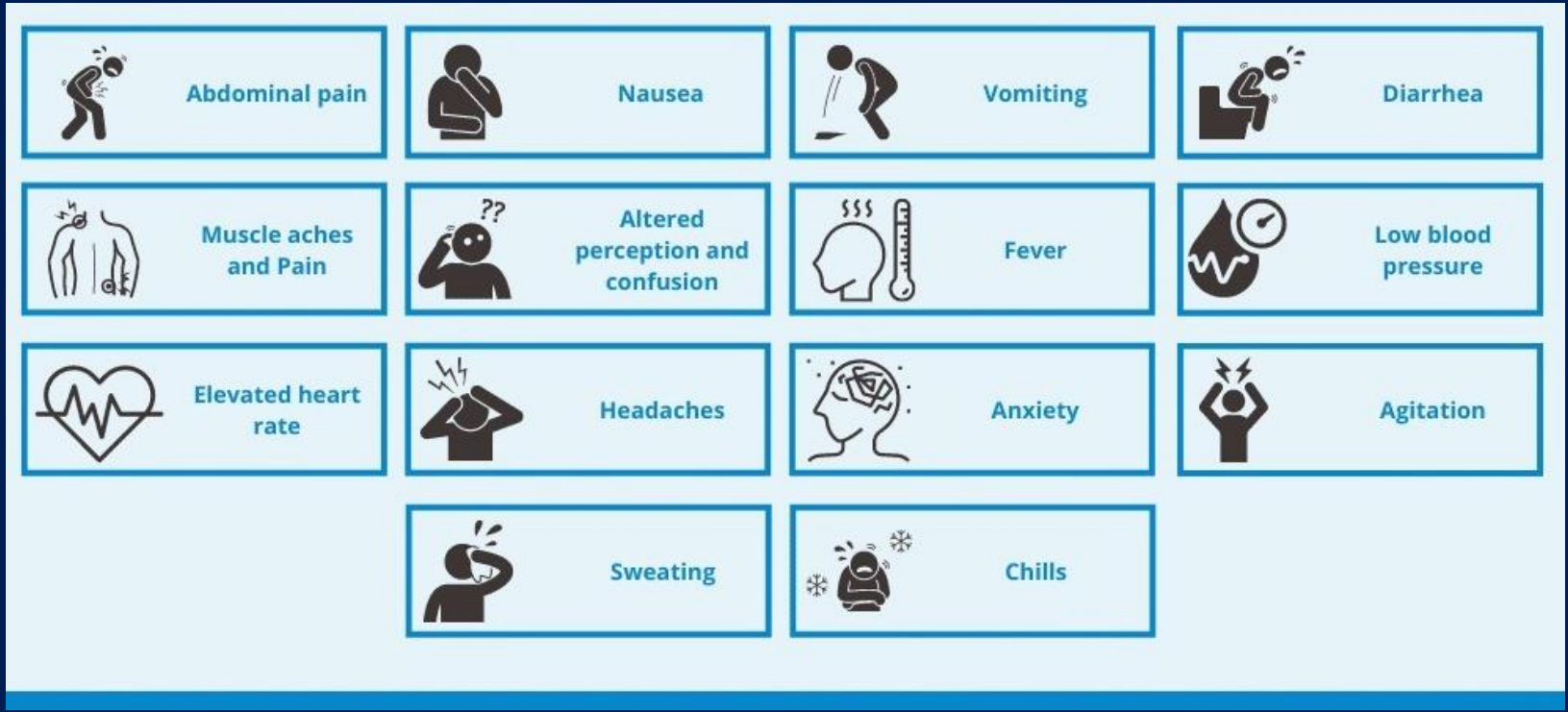
NALTREXONE

- Oral tablet or in a once-monthly, extended-release injectable product [other countries 6-mo depot]
- Not enough data in pregnancy to be first line and some limited concerning animal data
- Controversial at present , but if woman on injectable and pregnant, can keep or stop without withdrawal (if relapse risk low)
- No data on BF
- No NOWS
- Pain management is problematic
    - patients require higher doses of opioids and are at risk for less well-controlled anesthesia and pain in the perioperative period

	Methadone	Buprenorphine	Naltrexone
Mechanism	Agonist	Partial agonist (displaces opioids)	Antagonist (blocks effects of opioids)
Forms	Tablet/liquid	Strip, film, tablet,(Subutex, Suboxone, Zubsolv) injectable (Sublocade; Brixadi); Combined product preferred	Tablet, injectable (Revia, Vivitrol)
Risks	QT prolongation, drug interactions, overdose	↓overdose risk, precipitated withdrawal, dental caries	Precipitated withdrawal
Pregnancy considerations	NOWS rates 60-80%	NOWS rates 20-40%	Less pregnancy specific data. NOWS rates <10%.

Krans 2023, ACOG 2021, SAMSHA 2018, SMFM 2019, Towers 2020

What are symptoms of withdrawal?



Why not medically supervised withdrawal?

- Associated with higher relapse rate (59-90%)
- Lower rate of engagement with prenatal care
- Higher rates of:
  - Infectious disease
  - Accidental overdose
  - Obstetric complications

ACOG 2021, Rementeria 1973, Zuspan 1975, Luty 2003, Bell 2016, Welle-Strand 2015

Neonatal Opioid Withdrawal Syndrome (NOWS)

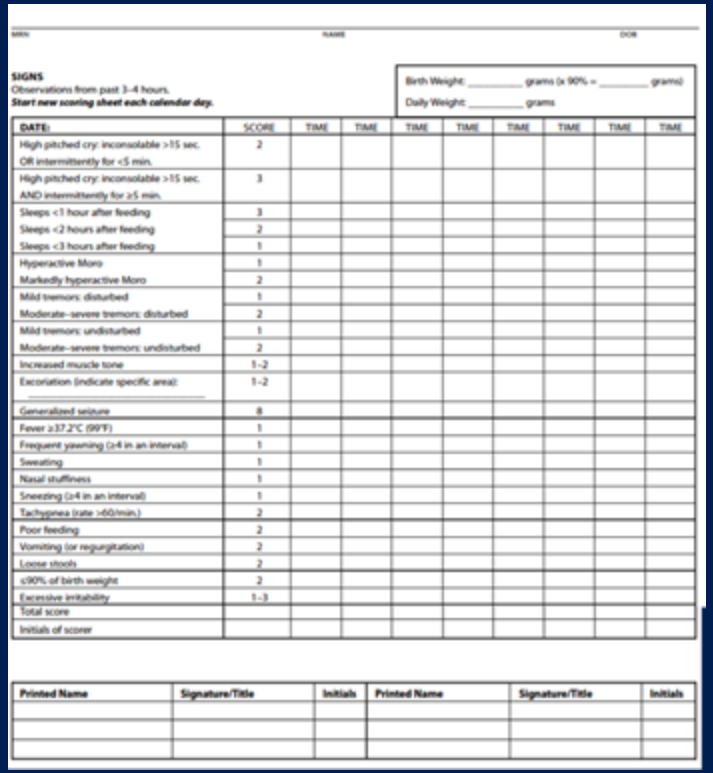
- In-utero exposure of fetus to opioids is associated with a postpartum condition called **Neonatal Opioid Withdrawal Syndrome (NOWS)**

- **How common?**
  - Methadone: in 60-80% and dose dependent
  - Buprenorphine: in 20-40% and dose independent
  - For both breastfeeding recommended
  - **With continued illicit use in 90%**

SYMPTOMS

- Fussiness, excessive crying or having a high-pitched cry
- Body shakes (tremors), seizures (convulsions), overactive reflexes (twitching) and tight muscle tone
- Poor feeding or sucking or slow weight gain
- Breathing problems, including rapid breathing
- Fever, sweating or blotchy skin
- Trouble sleeping and lots of yawning
- Diarrhea or throwing up
- Stuffy nose or sneezing

NOWS: From Finnegan→ Eat, Sleep, Console



MRN: NAME: DOB:

SIGNS
Observations from past 3-4 hours.
Start new scoring sheet each calendar day.

Birth Weight: _____ grams (x 90% = _____ grams)
Daily Weight: _____ grams

DATE:	SCORE	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME
High pitched cry: inconsolable >15 sec. OR intermittently for <5 min.	2								
High pitched cry: inconsolable >15 sec. AND intermittently for ≥5 min.	3								
Sleeps <1 hour after feeding	3								
Sleeps <2 hours after feeding	2								
Sleeps <3 hours after feeding	1								
Hyperactive Moro	1								
Markedly hyperactive Moro	2								
Mild tremors: disturbed	1								
Moderate–severe tremors: disturbed	2								
Mild tremors: undisturbed	1								
Moderate–severe tremors: undisturbed	2								
Increased muscle tone	1–2								
Excoriation (indicate specific area): _____	1–2								
Generalized seizure	8								
Fever ≥37.2°C (99°F)	1								
Frequent yawning (≥4 in an interval)	1								
Sweating	1								
Nasal stuffiness	1								
Sneezing (≥4 in an interval)	1								
Tachypnea (rate >60/min.)	2								
Poor feeding	2								
Vomiting (or regurgitation)	2								
Loose stools	2								
≤90% of birth weight	2								
Excessive irritability	1–3								
Total score									
Initials of scorer									

Printed Name	Signature/Title	Initials	Printed Name	Signature/Title	Initials

Eat, Sleep, Console (ESC) model

- Rooming in
- Feeding on demand , best breastfeeding
- Calming techniques such as swaddling, holding, shooshing, and rocking
- Lots of skin-to skin contact
- Low-stimulation environment (dim light, no beeping)
- Parental presence (or “baby whisperers”)

Wachman 2018

Eat-Sleep-Console

If your baby is in the green zone: Your baby is feeling comfortable

Green Zone Behaviors you see in your baby:	Try one thing at a time to help your baby:
Baby stays awake and is calm	When baby is awake, the lights can be on Show baby a toy or a quiet mobile Read or sing in a quiet voice Take baby for a ride in a stroller Gently rock baby Talk quietly to baby while they swing
Baby sleeps longer between feedings	Keep baby's sleep time quiet Some babies may need to be woken to eat
Baby doesn't need to be held to sleep	Put baby in their own bed to sleep The bed should be empty except for baby Always put baby on their back to sleep
Baby may still have some tight muscles	When baby is awake, help them stretch their arms and legs If baby get upset with a new activity, help them get calm
Baby may like more activities	When they are calm, return to an activity you know they like

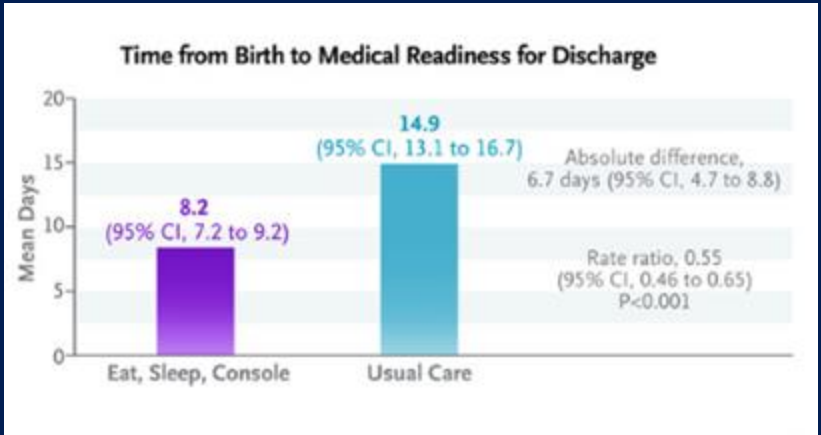
If your baby is in the yellow zone: Your baby needs a little help to be more comfortable

Yellow Zone Behaviors you see in your baby:	Try one thing at a time to help your baby:
Baby cries and fusses easily Baby needs help to stay calm	Offer baby a pacifier Hold baby skin to skin
Baby startles and wakes up easily Baby needs help to stay asleep	Keep the room quiet Limit phone and TV noise Swaddle with baby's hands close to their face
Baby has some short moments of being awake and calm	Lights are okay when baby is awake Quietly sing or read to baby Talk to baby in a quiet voicet
Baby's movements are calmer Baby's arms and legs are still tight Baby may arch their back when upset	Swaddle with baby's hands close to their face Baby may like a slow back and forth motion, such as swinging or rocking Help baby stretch arms and legs when changing a diaper

If your baby is in the red zone: Your baby needs help to be more comfortable

Red Zone Behaviors you see in your baby:	Try one thing at a time to help your baby:
Baby is crying and fussing a lot Baby has a constant, high-pitched cry Baby is hard to calm down	Snuggle baby close Hold baby skin to skin Offer baby a pacifier
Baby is very sensitive to noise	Keep the room quiet Limit phone and TV noise Swaddle with baby's hands close to their face
Baby has trouble falling asleep	Lights are okay when baby is awake Quietly sing or read to baby Talk to baby in a quiet voice
Baby's muscles are tight Baby's body is tense Baby moves in a jittery way Baby's arms and legs won't stop moving Baby arches their back when upset	Keep baby swaddled with hands close to face Rock baby in one direction (such as side to side, or up and down) Baby may like a slow back and forth motion, such as swinging or rocking

Eat, Sleep, Console



When compared to standard Finnegan scoring and opioid pharmacologic treatment, ESC reduced time to readiness for discharge by 6.7 days with equivalent safety outcomes.

Young 2023

Other substances-Treatment

Substance	Key effects	Treatment
Stimulants (Methamphetamine, Cocaine)	PEC, abruption (cocaine), cardiomyopathy/cardiac, IUGR, PTL, increased SMMM (1 in 10), fetal neurotoxicity	No pharmacologic treatment
Alcohol	Fetal Alcohol Spectrum Disorder, SAB/stillbirth	MI, Naltrexone, Acamprosate, disulfram (not preferred)
Benzodiazepines	Medication dependent, SAB and low birth weight; Infant withdrawal	Medication consolidation and tapering
Cannabis	Growth restriction, stillbirth, neurodevelopmental effects	No pharmacologic treatment
Tobacco	Growth restriction, SAB/stillbirth, abruption	Nicotine replacement, Buproprion (not Varenicline)

CDC 2021

3. Understand comorbidities and contributing factors

- **Medical conditions:** Cardiac conditions, infectious disease (HIV, Hepatitis C and B)
- **Mental Health conditions:** 80% comorbid mental health conditions, trauma history
- **Social Drivers of Health**: What barriers/supports do individuals face/have? How can we help overcome them/leverage support for success?

Peripartum care: labor and delivery

- **MOUD:**
  - Continue MOUD!
- **Pain management**:
  - Anesthesia consult, pain may be difficult to manage
  - Use opioid-sparing protocols as baseline
  - OK for short-acting agonist medications, discuss expectations
  - Discuss epidural and alternate pain relief
  - Understand the goal is not to be pain free
- **Neonate**:
  - review expectations for meconium screening
  - Discuss NOWs and Eat-Sleep-Console

Scan for more postpartum pain management information!

Peahl 2020

Peripartum care: postpartum

- **Pain**:
  - Review expectations for pain at home
  - Opioid-sparing protocols+short opioid rx with close f/u
- **Risk reduction**:
  - Greatest risk of return to use and overdose is postpartum
  - Ensure Naloxone Rx
  - Plan of Safe Care (MDHHS)
- **Postpartum care**
  - Lactation support
  - Contraceptive counseling
- **Support**:
  - Plan for postpartum support in the transition to parenthood
  - Consider frequent check-ins, in-person/virtual
  - Discuss care transitions early
  - Consider care for up to 1 year postpartum

MDHSS, Krans 2023

Partnering for the Future (PFF) Program

Located in Ann Arbor, MI and housed within Michigan Medicine's Von Voigtlander Women's Hospital

It is a clinic specifically designed for pregnant patients with:

- Opioid Use Disorder
- Substance Use Disorder
- Chronic pain with long-term opioid use

PFF offers a safe place for patients to tell their story and help get the best care for individuals and their families during and after their pregnancy.

PFF Care Options:

Our clinic meets patients with OUD/SUD/Chronic Pain where they are through 3 key approaches.

Consultation

Our team works directly with the patient to build a perinatal care plan. We share the plan and supporting materials with you!

Co-Management

Are you an obstetric provider who needs help managing MOUD? An addiction medicine provider looking for prenatal services for patients with OUD/SUD? We can co-manage patients with you!

Referral

PFF can provide comprehensive clinical care for patients during the perinatal period and up to 1 year postpartum.

PFF Clinic

Clinical Care

Research

Education

Engagement

The PFF Comprehensive Care Model

1. **What?** Integrated care for birthing people with OUD/SUD/Chronic Pain
2. **Who?** Multidisciplinary team (see next slide!)
3. **Where?** All together in a co-located clinic
4. **When?** Every week with lots of contact between visits

Our Clinical Team

Core Team

- Ob/Gyn
- Addiction medicine
- Perinatal Psychiatrist
- Social Work- BHC
- Program Coordinator
- Peer Recovery Specialist

Supporting Team

- Anesthesiology
- Physical Therapy
- Pediatrics
- Nursing
- Addiction Consult Team

Comprehensive care is an evidence-based intervention for:

1. Continuation of care
2. Engagement with OUD services
3. Maintenance of MOUD
4. Maintaining family cohesion
5. Addressing co-occurring issues including SDOH, Mental health problems, parenting and childcare etc.

Comprehensive care is effective because it provides care for the whole person, with reduced barriers to entry for all services.

Recovery is a

PROCESS

not a singular event

Date	Appt Time	Name	Demographics	SUD/OUD hx	Obstetric Care/ Chronic Conditions	Mental Health Conditions	MC3/SW	Learners	Supports	Notes
6/23/2025	1230 & 110	Nora Nelson	30 y.o G1 @ 6w PP	chronic pain w/ suboxone to manage.	Fibromyalgia, gestational diabetes	PTSD, Anxiety, Depression, EPDS: 19	In clinic SW and CMH	Molly Med Student	partner	wants housing support
	110 & 130	Paige Peterson	34 y.o. G13P3 @ 36w5d	hx polysubstance (cocaine, fentanyl, IV heroin) recieves suboxone	HepC, endocarditis	anxiety, depression	In clinic SW	Frank Fellow	ACT(additction care team), mom	MOUD managed by outside provider, needs postpartum plan
	150 & 210	Jessica Johnson	28 y.o G2P1 @ 22w6d	hx SUD (cocaine and cannabis)	Hypothyroidism	bipolar 2 disorder(on Lithium), hx hospitalizations for SI	In clinic SW	Molly Med Student	Recovery support group	Check in on dose adjustments
	210 & 230	Cindy Carlson	36 y.o G4P1 @ 33w6d	OUD (fentanyl)	Gestational hypertension, Intrauterine Growth Restriction	anxiety, panic disorder	In clinic SW trying to connect	Frank Fellow	partner, friends	interested in inpatient microinduction

Cases-Nora G1 6 wks pp

Ob/Gyn: Nora's chronic pain is largely due to fibromyalgia. Her pain was managed by her primary care doctor, Dr. Smith, prior to pregnancy, who been working with since she referred Nora. Nora had an uncomplicated vaginal delivery supported by a doula, but has been feeling more pelvic and lower back discomfort since then. Carol, our physical therapist, if you could jump in and help today, we will try and get her on your schedule. Her suboxone was uptitrated during pregnancy from 2mg once daily to 4mg total in divided doses. We will talk about down titrating that as we move out of the pregnancy episode. For her routine postpartum care, she did have gestational diabetes and was unable to complete her postpartum glucose tolerance test while admitted postpartum. We will encourage her to complete it with her next visit- Chelsea (SW) if you could help her plan this with transportation that would be great. That's it for me, from our psychiatry team…

Psychiatrist: "In early pregnancy Nora had EPDS of 19 and was recommended sertraline (Zoloft) for depression and also PTSD . She didn't start immediately but started in the 2nd trimester and has titrated up to 150mg. She did okay 3rd trimester but now after childbirth reported worsening depression and intermittent anxiety. At her last visit 2 weeks ago we increased sertraline to 200mg. She also talked about how birth was traumatic and we added prazosin 1mg at bedtime. Today, I will check in with Nora about her medication doses, make any adjustments, and assess any changes in her mood postpartum.

Social Worker: "I've been following her through phone check in's and we are discussing options for long-term therapy. I referred her to a postpartum doula last week as well. Nora is adjusting to having a new baby at home and is stressed due to housing issues. She currently lives with her Mom, but will need to find a new place in a few weeks. We're looking at housing options together and I'm helping her submit the appropriate paperwork."

Cases-Paige. 36w+5d

OB: Paige is moving into the end of her 3rd trimester, she has been in recovery for several years. At her last visit she reported increasing cravings likely to normal pregnancy physiology which leads the suboxone to be “chewed up” a bit faster. It is a common and expected occurrence that we talk to all of our patients about. We increased her dose last appointment from 8mg TID to 8mg QID, and we will see how she is doing with that this week. Chelsey (SW), could you help us ensure she doesn’t have any further issues with medication coverage? From a pregnancy perspective, she’s 36 weeks and will need her group B strep today, if our nursing staff can get that teed up with her that would be wonderful. We will also do some birth planning today. She completed her anesthesia consultation virtually last week and we will help her to complete her birth partnership plan and make sure she feels prepared. For her hepatitis C she was connected with Dr. Davies and they were able to complete her infectious disease consultation and she’s planning on treatment after birth. Cardio obstetrics did an appointment with her early in her pregnancy for her history of endocarditis. She had a normal echo and nothing else to follow up at this point.

Psychiatrist: “In our last appointment, Paige reported more mood symptoms. She attributes the mood shift to family stress with baby arriving. Last time we discussed medicines for mood and explained options but she did not feel comfortable starting in pregnancy. We also discussed counseling support. Paige is interested in individual therapy and wants to discuss medications after delivery. I will check in about that both today and discuss a tight follow up after delivery within the first 2-4 weeks.”

Social Work**:** “I met with Paige last time she was in clinic and we discussed some strategies for improving her mood and anxiety; how to use coping strategies. I will revisit this with her today. Paige feels well supported in her recovery journey by her mom and she has good support from her Peer Recovery Coach.”

Cases-Jessica. 22w+6d

OB: Jessica was new to us and had her first prenatal visit at our last clinic so we are really just starting to get to know her better. She was able to discontinue cocaine use with a positive pregnancy test, but has continued to use cannabis multiple times a day primarily for nausea, appetite, and sleep. I am really hoping the psych team could help to manage some of those symptoms and I will continue to work with her on the nausea as we continue to move through the second trimester. We have talked about the risks of those substances in pregnancy and she wanted to bring her partner today so we could talk about it all together. For her hypothyroidism, she has a normal TSH so we will continue her synthroid and get another TSH withher 24-week labs. We will make sure the MA gives her a glucola (sugar drink) today so she can complete those before her next appointment.

Psychiatrist: "Jessica reported a depressed mood dip with once a week fleeting suicidal ideation. She wanted to adequately treat her mood instability and suicidal ideation and we discussed psychiatric medication. She has been prescribed lithium, abilify, wellbutrin, and seroquel at various times. Last time Jessica had shared that Lithium had worked for her in the past but that she had been off since pregnancy. We discussed the benefits and concerns of Lithium in pregnancy and made a shared decision to restart 300 mg once a day. Today we will see how she is tolerating and if possible escalate to 600 mg twice a day and then do a level. That will guide the next dosing. We will discuss how to monitor Lithium blood levels around delivery to reduce risk for toxicity.

Social Worker: "I have been following Jessica and assessing her mood to monitor for worsening SI or mania/hypomania. We also discussed Partial Hospitalization as an option if she does not feel current treatment is enough. She reports feeling confident in her recovery journey and has good support from her recovery group. She is interested in starting a perinatal DBT group and we will discuss that more today."

Cases-Cindy 33w+6d

OB: We've been following Cindy throughout her pregnancy. SHe first came to us after an ER admission after an overdose with fentanyl around 14 weeks. For the first few months of knowing her, she was really interested in harm reduction activities. She and her partner have worked to make their use safer: she now only uses fentanyl in the presence of her partner and they are using clean needles. They both have Naloxone. Initially she was precontemplative about initiating MOUD, but she is really motivated by being able to bring her baby home and now she's interested in starting medication (buprenorphine induction). Because of her gestational age, we will plan an inpatient admission with the Addiction Consult Team team so we can monitor her and her baby and have tighter control of experiences in the process. We are planning that for Monday when the team will be available. From an OB perspective, she has had some troubles coming in for weekly antenatal testing so we've been trying to streamline that care as much as possible, including working with an outside OB provider to get some of that testing done. The baby has growth restriction and is in the 9th percentile but so far dopplers have all been normal.

Psychiatrist: "Cindy has been reporting an increase in anxiety and nightmares throughout her last few appointments. We have increased her prazosin from 1 mg to 3 mgs and I will check in today to see how that has been going. Last appointment we discussed and decided on adding a 1-2 week trial of low-dose seroquel three times a day to help with anxiety and daytime distress. I will also check in on this medication change. We started discussing that medications alone aren't enough to treat her anxiety and I encouraged reaching out to our social worker to discuss some non-pharmacological strategies."

Social Worker: "Great, thanks for suggesting that, I've been trying to get in touch with Cindy and haven't had much luck. If it's okay with you, I'll come with you into the room to introduce myself and discuss some options for trauma-focused therapy, CBT for PTSD group, and grounding techniques."

Resources

We're here to support birthing people

To make an appointment, call 734-763-6295 Monday through Friday, 8:30 a.m. – 4:30 p.m.

Mention the Partnering for the Future Clinic

Our Website ->

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Questions?

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