Perinatal CoCM for Psychiatric Consultants

February 28, 2023

Samantha Shaw, MD

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Disclosure

The Michigan Center for Clinical Systems Improvement (Mi-CCSI), Michigan Institute for Care Management and Transformation (MICMT) and Michigan Collaborative Care Implementation Support Team (MCCIST) have been contracted by Blue Cross Blue Shield of Michigan for this project.

This presentation is being recorded.

Michigan Collaborative Care
IMPLEMENTATION SUPPORT TEAM

MICMT
Michigan Institute for Care Management & Transformation

Thank you to Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan has contracted with the Michigan Collaborative Care Implementation Support Team (MCISST) and Mi-CCSI to provide training and implementation on the evidence-based treatment model of Collaborative Care to primary care practices throughout the state of Michigan.

We would like to thank BCBSM for their attention, initiation and support of this important work.

Perinatal in Collaborative Care 2023
Instructions for Psychiatric Consultants

- **Financial Disclosure Information:**
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  - ***See CME Activity Information: Perinatal in Collaborative Care 2023 Feb. 22-28, 2023, handout for full details.***

For questions or concerns, please submit an inquiry via the MICMT contact form.

Learning Objectives – Psychiatric Consultants

- Explore the specific applications and considerations of psychopharmacological interventions with the Perinatal population
- Summarize new treatment options for use with perinatal women experiencing mental health symptoms
- Apply and discuss application of new knowledge to case presentations.

Learning Outcome

- Participants will be able to translate key processes within their practice setting to integrate the Collaborative Care Model, for their perinatal patient visits.

Schedule for today

8:00 - 8:05 AM	Introduction of the day and housekeeping
8:05 - 9:00 AM	Perinatal Psychopharmacology
9:00 - 10:00 AM	Evidence based perinatal medication management
10:00 – 10:30 AM	Building confidence in medical management of perinatal mental health

Speaker Introduction

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Perinatal Psychopathology and pharmacological intervention

Goals for today's training

1) **Perinatal Psychopathology:** Understand mental health conditions and symptom presentations in the perinatal period
2) **Evidence-based perinatal medication management:** Understand perinatal psychopharmacology safety data and prescribing practices including awareness of novel treatments
3) **Building confidence in medical management of perinatal mental health:** Understand challenges of the collaborative care model and practice panel reviews

Identifying baby blues

- Within the first two weeks postpartum
- Emotional instability—intense feelings, positive or negative; tearfulness
- Criteria for depression not met
- Likely due to hormonal fluctuations, sleep deprivation, huge life change

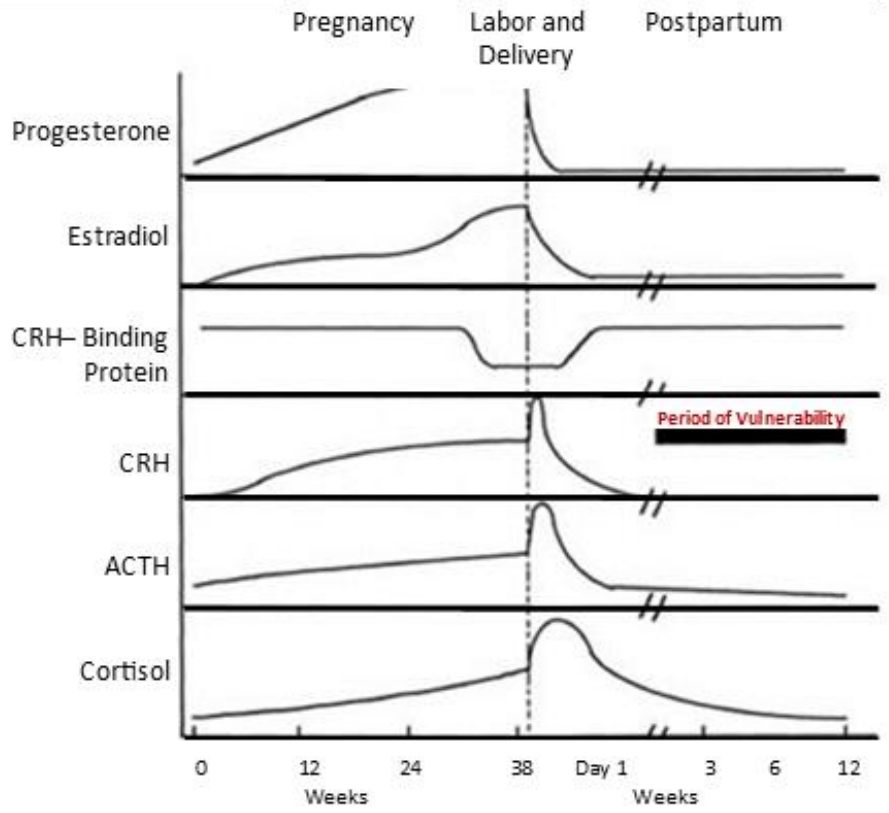


Figure 5. Hormonal changes and period of increased vulnerability to mood disorders and autoimmune phenomena during pregnancy and the postpartum period. The increasing levels of corticotrophin releasing hormone (CHR) in the last trimester, along with the decreasing levels of CRH binding protein, may participate in the initiation and progression of labor. The decreased secretion of estradiol and hypothalamic CRH in the postpartum period is associated with changes in the activity of the stress system, represented here by decreased CRH secretion. ACTH – adrenocorticotropic hormone.

1998 ~ Annals of Internal Medicine ~ Volume 129 ~ Number 3 235

Baby blues—treatment

- Often resolves on its own
- Bolstering mom's supports and making sure she is getting adequate sleep are good first steps
- Continue to monitor patient for potential transformation into postpartum depression

Perinatal depression

Major depressive disorder:

- DSM V: Five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure. Must cause marked distress or dysfunction.
- SIGECAPS

S—**sleep**—too little/too much

I—loss of **interest** in things previously found pleasurable

G—excessive feelings of **guilt**

E—low **energy**

C—poor **concentration**

A—**appetite**—increase or decrease

P—**psychomotor retardation**; moving/responding very slowly

S—**suicidal thoughts**

Depression can occur during pregnancy as well as postpartum. The DSM V puts more strict time frames on when a depressive episode can be called postpartum depression. In practice, we tend to give this diagnosis if the episode occurs within the first year postpartum.

Depression screening: PHQ-9

- **Scoring**
  - 0–9 none/mild
  - 10–14 moderate
  - 15–19 moderate/severe
  - 20–27 severe
- **CoCM < 15**
- **0 on #9**

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score

Depression screening: EPDS

Takes 5 minutes to fill out.

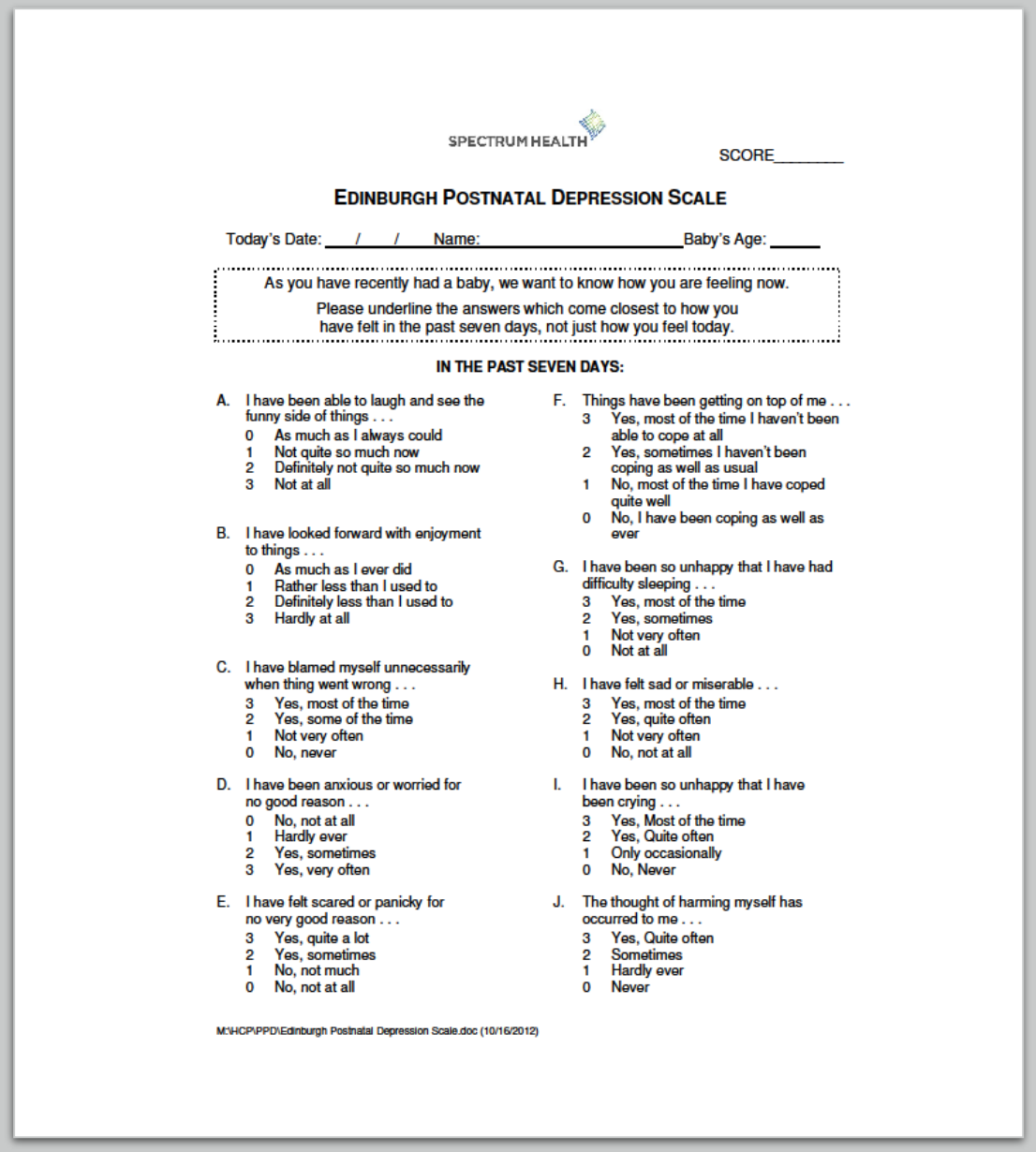
Takes 3 min to score.

>=13 probable major depression

>=10 probable minor depression

Scoring

- CoCM score: 10–18
- 0 on #10
- EPDS >= 19: severe depression



SPECTRUM HEALTH

SCORE_____

EDINBURGH POSTNATAL DEPRESSION SCALE

Today's Date: ___/___/___ Name:_____ Baby's Age: _____

As you have recently had a baby, we want to know how you are feeling now.

Please underline the answers which come closest to how you have felt in the past seven days, not just how you feel today.

IN THE PAST SEVEN DAYS:

A. I have been able to laugh and see the funny side of things . . .
- 0 As much as I always could
- 1 Not quite so much now
- 2 Definitely not quite so much now
- 3 Not at all

B. I have looked forward with enjoyment to things . . .
- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

C. I have blamed myself unnecessarily when thing went wrong . . .
- 3 Yes, most of the time
- 2 Yes, some of the time
- 1 Not very often
- 0 No, never

D. I have been anxious or worried for no good reason . . .
- 0 No, not at all
- 1 Hardly ever
- 2 Yes, sometimes
- 3 Yes, very often

E. I have felt scared or panicky for no very good reason . . .
- 3 Yes, quite a lot
- 2 Yes, sometimes
- 1 No, not much
- 0 No, not at all

F. Things have been getting on top of me . . .
- 3 Yes, most of the time I haven't been able to cope at all
- 2 Yes, sometimes I haven't been coping as well as usual
- 1 No, most of the time I have coped quite well
- 0 No, I have been coping as well as ever

G. I have been so unhappy that I have had difficulty sleeping . . .
- 3 Yes, most of the time
- 2 Yes, sometimes
- 1 Not very often
- 0 Not at all

H. I have felt sad or miserable . . .
- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Not very often
- 0 No, not at all

I. I have been so unhappy that I have been crying . . .
- 3 Yes, Most of the time
- 2 Yes, Quite often
- 1 Only occasionally
- 0 No, Never

J. The thought of harming myself has occurred to me . . .
- 3 Yes, Quite often
- 2 Sometimes
- 1 Hardly ever
- 0 Never

M:\HCP\PPD\Edinburgh Postnatal Depression Scale.doc (10/16/2012)

Perinatal anxiety

General anxiety disorder (DSM V):

- Excessive anxiety and worry occurring most days for at least 6 months, about a number of events or activities (such as work or school performance)
- Difficult to control the worry
- Anxiety or physical symptoms cause clinically-significant distress or impairment in social, occupational, or other important areas of functioning
- Anxiety associated with three (or more) of the following (with at least some symptoms having been present for more days than not for the past 6 months):
  - Restlessness, feeling keyed up or on edge
  - Being easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance

Perinatal anxiety

NOTE: Perinatal anxiety tends to be specific to certain topics, usually the health and safety of the baby, and we tend to make the diagnosis if symptoms have been present for 1–2 weeks (vs. 6 months)

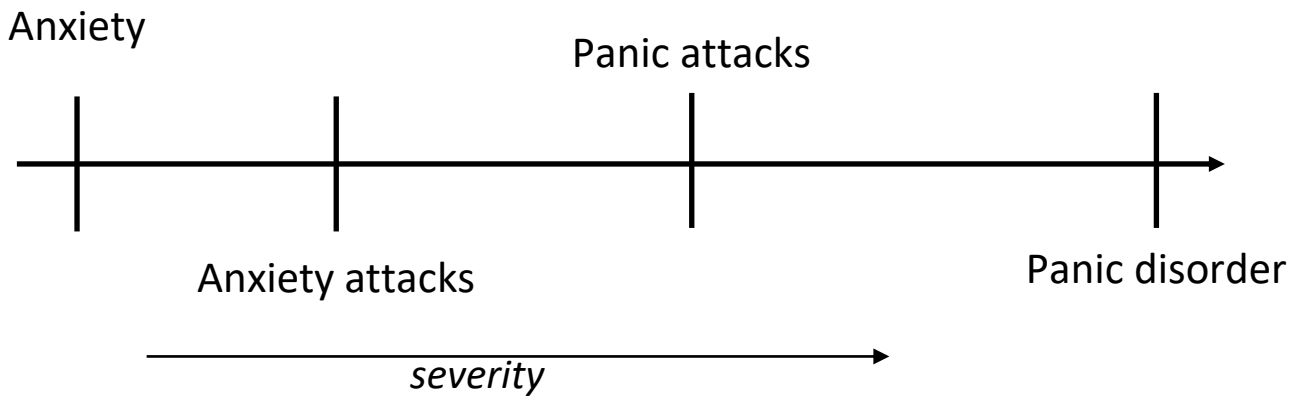
There is no formal DSM V designation for perinatal anxiety, but it is as common, or more common, than perinatal depression

Anxiety screening: GAD-7

- Scoring
  - 0–9 none/mild
  - 10–14 moderate
  - 15+ severe
- CoCM < 15

Over the last 2 weeks, on how many days have you been bothered by any of 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 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

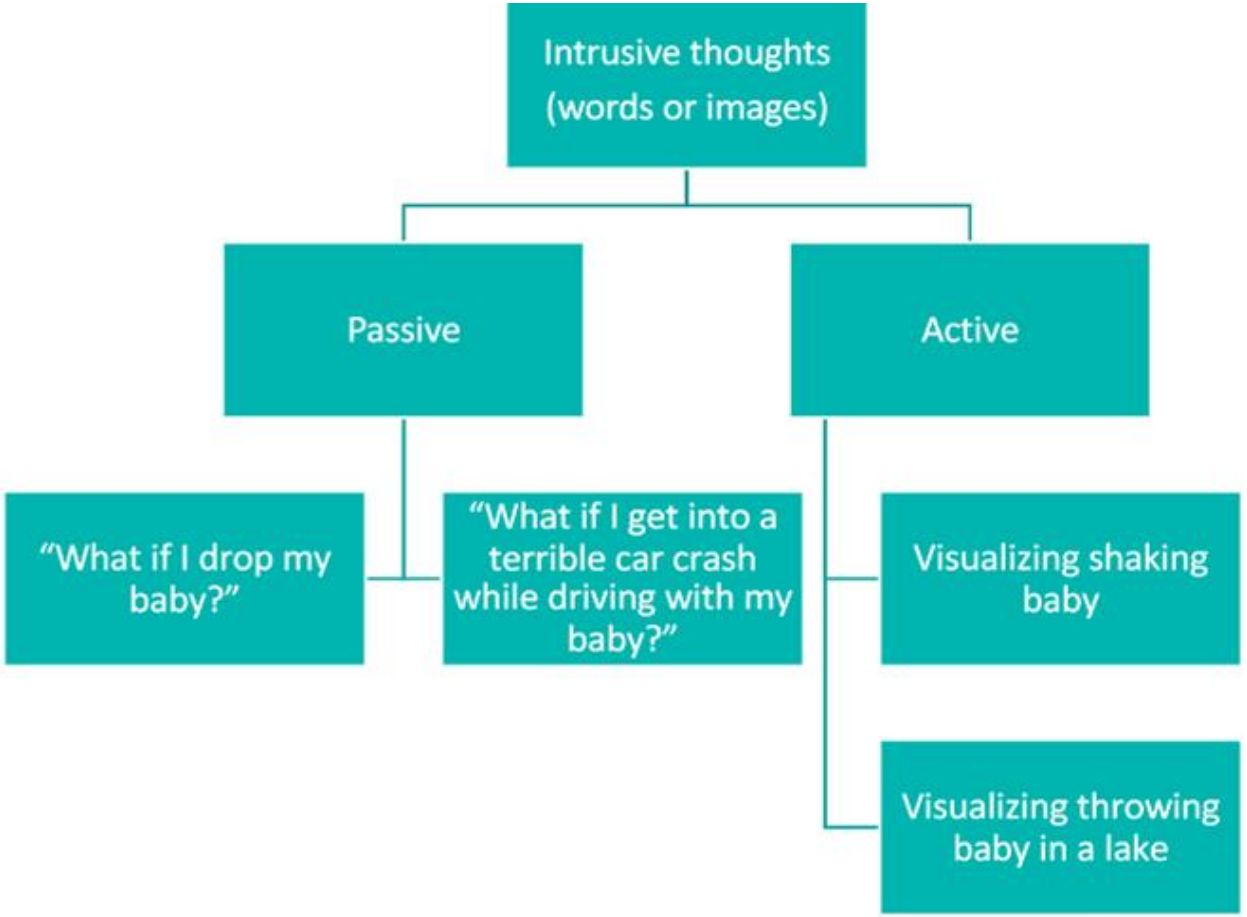
Anxiety and panic



- Anxiety attacks, panic attacks, and panic disorder
  - Anxiety attack: heightened state of anxiety that can last for several hours.
  - Panic attack: severe state of anxiety (patients believe they are dying or about to "go crazy"), doesn't last for more than a few minutes. Usually includes physical symptoms of rapid heart rate, shortness of breath, sweating, tunnel vision.
  - Panic disorder: DSM V diagnosis involving relatively frequent panic attacks such that patient fears having more and avoids situations because of them (can lead to agoraphobia).

Intrusive thoughts

- Involuntary thoughts/images/ideas that are distressing and hard to get rid of
- Not diagnostic of any particular disorder, but are most common in anxiety disorders
- Anxiety and intrusive thoughts are heightened in late pregnancy & postpartum period



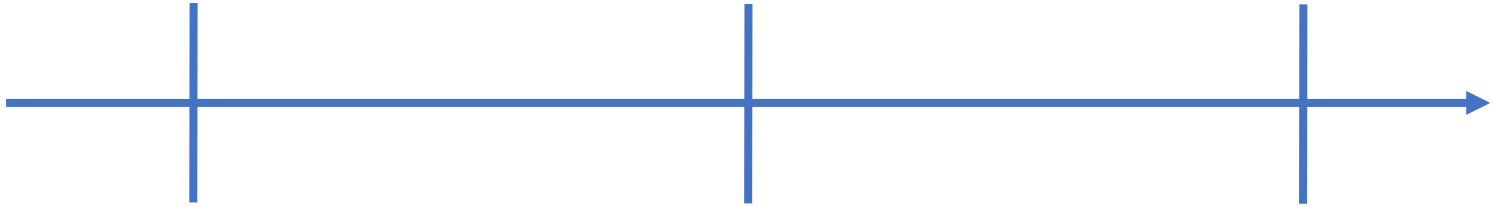
Intrusive thoughts and OCD

- When intrusive thoughts are very intense/frequent, they may be representative of a diagnosis of OCD:
  - Intense, recurrent obsessions
  - May have compulsions (behaviors) they do to try to soothe obsessions
  - Obsessions/compulsions
    - take up a lot of patient's day
    - cause distress/impair functioning
- OCD can have new onset (never had these symptoms before) in the perinatal period

Postpartum anxiety and psychosis: A continuum of worrisome thoughts

Anxiety: excessive worry about possible but relatively unlikely events

Psychosis: intense preoccupation with extremely unlikely/bizarre ideas (delusions)



OCD: "sticky" worry/fixation on moderately to highly unlikely events

Note that patients may fall into "gray areas" along the continuum, not fitting perfectly into any of these categories

Risk assessment for thoughts of infant harm

Low risk

- Ego dystonic/Intrusive (are upsetting to the patient)
- Mother doesn't want to harm baby; states she will not
- Mother has been avoiding certain objects, or the infant, to avoid harm coming to them (i.e., putting away all knives)
- Generally, these are patients with isolated intrusive thoughts, anxiety, or OCD

*In this case, having these thoughts does not at all increase the risk that an individual will act on them

High risk

- Ego syntonic (thoughts are not upsetting or may be comforting to the patient)
- Patient has symptoms of psychosis (hallucinations, disorganized thinking, delusions)
- Patient thinks harming infant would benefit infant/society in some way (due to delusional beliefs)
- Has other bizarre beliefs
- Patient has a history of trauma and expresses wanting to get revenge on baby's other parent
- Generally, these are patients who are psychotic or who have severe personality disorders

High risk patients should be directed to the nearest emergency room or have an ambulance called to escort them there

Case #1: Lilly (postpartum anxiety)

Lilly is a 28-year-old first time mom coming to see her OB for a postpartum mood check. She is **6 weeks postpartum** and is not doing well. She comes in alone—her husband is watching their daughter. Lilly **struggles to sleep** due to **worry** that her daughter might **stop breathing**. She **frequently checks** on her daughter while she is sleeping to make sure she can see the baby's chest rise and fall. She has not yet left the house with the baby, as it's flu season, and she worries about her daughter getting ill. She has been **wiping down** all of the surfaces at home with bleach **daily** to try to prevent this. She feels **exhausted** and **sick to her stomach with worry**. She appears very thin. Her **mind races** with worst case scenarios and because of this she has found it hard to connect with her baby.

Case #2: Ciara (postpartum anxiety with intrusive thoughts)

Ciara is a 32-year-old, second-time mom who presents to her primary care doctor for concerns about some thoughts she has been having. She brings her 8-week-old and her husband in with her. Her husband takes care of the baby throughout the appointment; Ciara rarely looks over at the baby, even when it starts to cry. Ciara is tearful and tells you that for about two weeks now she has been having images flash through her mind of stabbing her daughter with a knife. She knows that she doesn't want to hurt her daughter but is terrified that these thoughts mean that she is going to. Because of this, she has locked up all the knives in the house and tries to avoid being alone with the baby. She generally has been trying to avoid caring for her daughter over this time for fear that she might hurt her in some way.

Trauma

- **Trauma is common among women**
  - 25% have been sexually abused in childhood
  - 20% experience IPV in their lifetime
  - 4–8% experience IPV during pregnancy
  - 30% of births subjectively experienced as traumatic

- **How common is PTSD in women?**
  - Lifetime prevalence of 12% (males ~6%)
  - Childhood sexual abuse strongest single predictor
  - 3% have new onset PTSD after traumatic birth
  - Overall, 3–7% have perinatal PTSD
  - PTSD is a waxing and waning chronic disorder: pregnancy, antenatal care, and birth are potential major triggers for symptom exacerbation

Intimate partner violence screen

- May occur before, begin in, or continue into the perinatal period
- Must screen for
- Screen adapted from "Responding to Intimate Partner Violence During Telehealth Clinical Encounters"

Intake only	Yes	No
1. In the LAST year have you been afraid of someone close (or less close) to you?		
2. In the LAST year have you been hit, slapped, kicked, pushed, shoved, or otherwise physically hurt by someone close (or less close) to you? 3. In the LAST year have you been frequently made upset, ashamed, or embarrassed by someone close (or less close) to you? 4. In the LAST year have you been forced to have sex by someone close (or less close) to you?		

Intake and monthly	Yes	No
5. Do you currently feel safe?		

Simon, M. A. (2021, June 8). Responding to Intimate Partner Violence During Telehealth Clinical Encounters. JAMA, 325(22), 2307. https://doi.org/10.1001/jama.2021.1071

Symptoms of PTSD

- Trauma involving threat and overwhelm
- Intrusive re-experiencing and fearfulness
- Emotional numbing and avoidance
- Negative alteration in mood and cognition (e.g., persistent self-blame, negative mood)
- Negative alteration in arousal and reactivity (e.g., hypervigilance, recklessness, destructive behaviors)
- Lasting more than one month (of note: up to one month is called acute stress disorder)

Primary care PTSD screen

Scale

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event?
YES / NO

If no, screen total = 0. Please stop here.

- If no to first section, screen is negative and complete
- If yes to first section, score is the number of yes responses to questions 1–5
- Cutoff for further questioning is a score of 4 or more

If yes, please answer the questions below.

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to? YES / NO

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? YES / NO

3. Been constantly on guard, watchful, or easily startled? YES / NO

4. Felt numb or detached from people, activities, or your surroundings? YES / NO

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? YES / NO

Trauma- and stressor-related disorders

DSM V: “Unspecified Trauma- and Stressor-Related Disorder”

- Symptoms cause significant stress/dysfunction, but patient does not meet criteria for PTSD/acute stress disorder, etc.
- Helpful when provider does not have sufficient information to make a more specific diagnosis (briefer interactions, emergency room settings)

Is it trauma-related disorder or personality disorder?

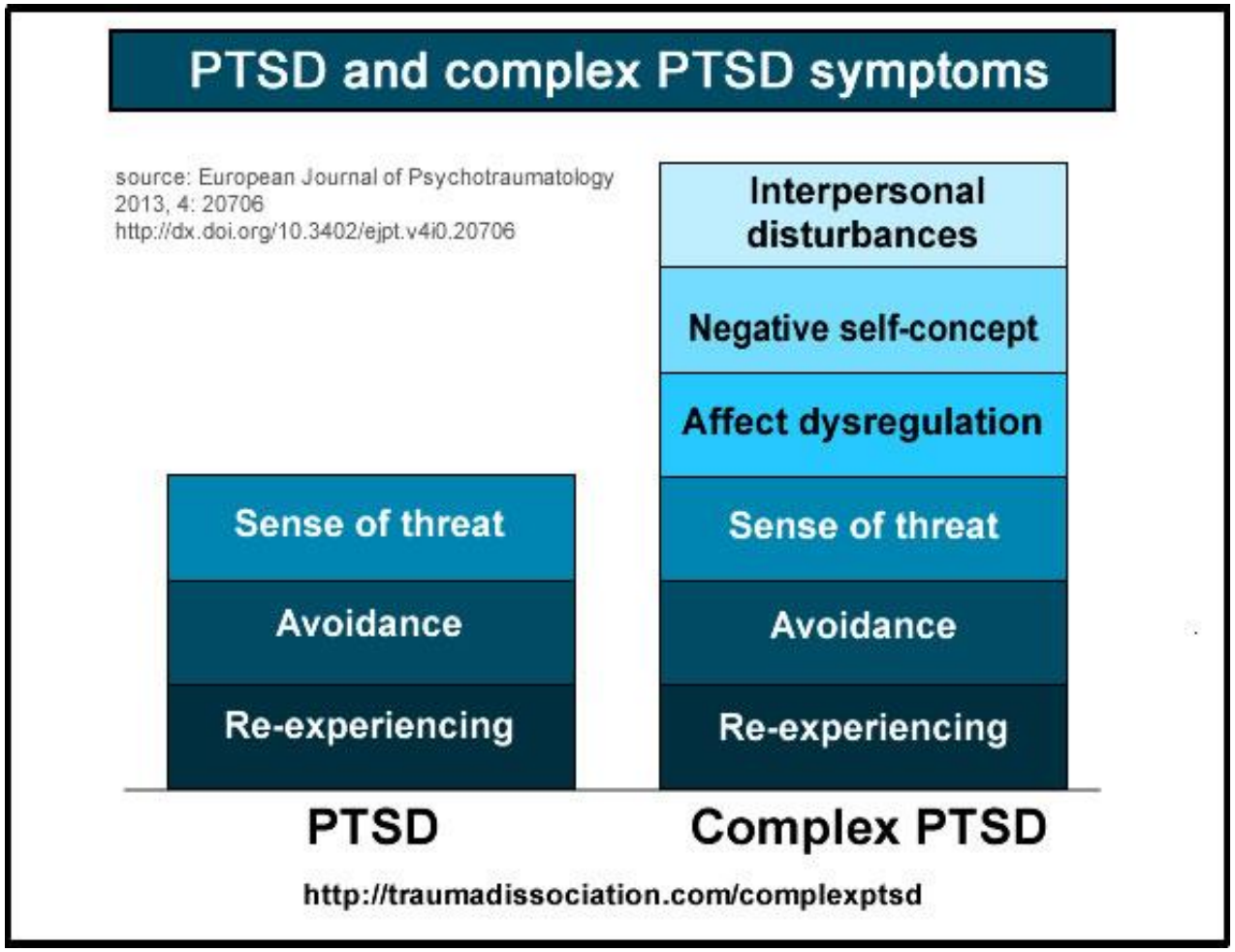
Most interfering with perinatal care: Borderline personality disorder

DSM V: Pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning by early adulthood, five or more of the following:

- Frantic efforts to avoid abandonment
- Unstable/intense personal relationships which alternate between extremes of idealization and devaluation
- Identity disturbance—unstable self image/sense of self
- Impulsivity in at least 2 areas that are self damaging (spending, sex, substance abuse, reckless driving, binge eating)
- Recurrent suicidal behavior, gestures, or threats, or self-harming behaviors
- Affective instability-marked reactivity of mood, usually intense but relatively short-lived episodes of dysphoria, irritability, anxiety
- Chronic feeling of emptiness
- Inappropriate intense anger or difficulty controlling anger
- Transient, stress-related paranoid ideation or severe dissociative symptoms

The concept of complex PTSD

- Multiple traumatic events occurring over a period of time
- For example, multiple incidents of child physical abuse and child sexual abuse, prolonged domestic violence, torture, genocide, etc.



PTSD, trauma- and stressor-related disorders, and personality disorders

- Trauma history is extremely important as it greatly impacts the treatment plan
- Of note, the argument has been made that the above diagnoses may exist and evolve in the same individual over time
  - PTSD symptoms can improve over time such that a patient no longer meets criteria for the disorder, but rather, only qualifies for “unspecified trauma- and stressor-related disorder”
  - Because borderline personality disorder is generally rooted in a history of childhood trauma, one could argue that it is also an “unspecified trauma- and stressor-related disorder”

Case #3: Angela (childbirth PTSD)

Angela has a history of childhood neglect and abuse, depression, and anxiety. She has a baby that is 4 weeks old. Her pregnancy was uncomplicated, but her delivery was complicated by postpartum hemorrhage that was late in being discovered and ultimately required blood transfusion. She kept mentioning to her nurse that she felt light-headed, but her nurse kept reassuring her this was likely due to side effects of anesthesia. Finally, Angela noticed that there was blood soaking through her hospital sheets, at which time, Angela again alerted her nurse who paged the doctor, and the diagnosis of postpartum hemorrhage was made.

Since discharge to home, Angela has had nightmares of this event that wake her up from sleep. She has flashbacks to discovering the blood in her sheets and hearing that she was hemorrhaging and feels constantly on watch for another complication. She feel more irritable and on edge and has gotten into fights with her boyfriend. She is withdrawn from the baby and gets angry when it cries. She is moody and cries at times. She constantly worries that something bad will happen to her or her baby.

Bipolar disorders

- Bipolar I vs bipolar II
- Bipolar II definition: major depressive episodes and hypomania episodes
- What is hypomania according to DSM-5?
  - A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, **lasting at least 4 consecutive days** and present most of the day, nearly every day. But severity less and functionality intact. Usually less than 1 week.
  - Decreased need for sleep
  - Increased activity
  - Increased rate of speech
  - Elevated/euphoric mood OR irrationally irritable mood
  - Excessive spending/risk taking (causing significant consequences)
  - Increased sex drive
  - Psychotic symptoms (paranoia, delusions of grandeur, hallucinations)-mania criterion

Bipolar disorder screening

Mood disorder questionnaire (MDQ) is done if suspicion arises for bipolar disorder

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

How to Use

The questionnaire takes less than 5 minutes to complete. Patients simply check the yes or no boxes in response to the questions. The last question pertains to the patient's level of functional impairment. The physician, nurse, or medical staff assistant then scores the completed questionnaire.

How to Score

Further medical assessment for bipolar disorder is clearly warranted if patient: • Answers Yes to 7 or more of the events in question #1 AND • Answers Yes to question #2 AND • Answers Moderate problem or Serious problem to question #3

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Case #4: Sindhu

Sindhu has no history of mental health problems. She gave birth to her first child 3 months ago. She developed postpartum depression 6 weeks postpartum and was prescribed sertraline 50mg at bedtime. She reaches out to her BHC a week later stating that she can’t sleep and feels “wired” and more anxious; but feels slightly less depressed.

Questions

What could this patient's symptoms represent?

A) Over-activation from sertraline

B) SSRI-induced mania

C) Short-lived side effect of sertraline

D) All of the above

What further questions do you want to ask?

A) How long she has been experiencing these symptoms

B) If she has ever felt like this before or has a history of mania/bipolar disorder

C) If she has been speaking fast, spending a lot of money, taking risks

D) All of the above

Case #5: Naia

Naia is a 32-year-old with a history of depression who gave birth **two weeks ago** and is presenting for a postpartum check up. She appears anxious and her eyes dart around the room. She is unkempt. She brings her son with her and holds him close to her. It is summer, but she has him bundled up in multiple layers of clothing. The baby's face is flushed. She looks at you intently and asks, "are there any cameras in here?" Naia only sleeps "when it's safe" and can't really tell you how many hours she is getting. She is not breastfeeding.

The father of the baby is not involved, and Naia's parents live an hour away. She is currently living with a roommate. She has a few local friends. When you ask Naia what she does during the day, she abruptly starts crying and shaking and tells you she "can't do anything" because it's "not safe." When you look at her chart, it appears she has lost 15lbs since she was discharged after her delivery.

You encourage Naia to try to take some deep breaths. You reassure her that she is safe right now. You try to engage her in more questions, but she doesn't answer them. You ask if you can call her roommate. Patient's roommate states that she is worried about Naia. Naia is usually very neat but lately has been leaving her room and the kitchen a mess. She hears the baby crying a lot at night.

Perinatal psychosis (usually early postpartum)

- Usually rapid postpartum onset (first couple weeks)
- Hallucinations—hearing, seeing things that are not really there
    - Especially concerning if voice(s) telling them to do things (command auditory hallucinations)
- Delusions—false beliefs that are held despite significant evidence to the contrary (i.e., paranoia)
- Bizarre/non-sensical behavior
- In most cases, for patients who do not have a history of these symptoms, they are reflective of a previously undiagnosed/bipolar disorder (as opposed to schizophrenia, etc.)

Postpartum psychosis: a psychiatric emergency

Because individuals with psychosis do not perceive their environment correctly, they are not equipped to appropriately care for an infant

- Do not accurately assess danger in the environment, so can put themselves and child(ren) in dangerous situations
- Can perceive danger in safe environments, making them less likely to seek care
- Can become so preoccupied with symptoms that they are not capable of being sufficiently attentive to child(ren)-->neglect
- Can develop delusions/hallucinations that lead them to harm their child(ren)
- This is not an appropriate case patient for CoCM, and the treating practitioner will send to ED

ADHD

- Prevalence
  - 4.4 percent among 18- to 44-year-olds in United States
  - Majority of people diagnosed with ADHD in childhood continue to meet criteria as adults
- Comorbidity
  - Mood disorders, odds ratio (OR) = 2.7 to 7.5 (95% CI 3.0-8.2)
    - Anxiety disorders, OR = 1.5 to 5.5 (95% CI 2.4-5.5)
    - Intermittent explosive disorder, OR = 3.7 (95% CI 2.2-6.2)
  - Substance use disorders
    - Any substance use disorders (SUD), OR = 3.0 (95% CI 1.4-6.5)
  - Can be hard at times to differentiate from PTSD

ADHD symptoms in adult life

- **Executive dysfunction**
  - Poor sustained attention
  - Poor organizing/prioritizing/time management
  - Poor task follow-through/completion
- **Inattention**
  - Not completing tasks in a timely manner
  - Driving errors (traffic and speeding tickets)
  - Frequently losing things
  - Struggling to focus on one thing at a time (e.g., has to be on phone while watching TV or fidgets during meetings)
- **Impulsivity**
  - Engaging in activities with high potential for negative consequences
  - Premature termination of relationships/jobs
- **Hyperactivity**
  - Fidgety/restless
  - Talking too much/interrupting others
- **Emotional dysregulation**
  - Mood lability/irritability
  - Low motivation

ADHD screening

- We do not regularly screen patients for ADHD
- However, it can significantly affect patient's ability to function, as well as mood, anxiety, and substance use
- Therefore, it is important to pay attention to this diagnosis and treat as is appropriate (discuss with perinatal psychiatrist)
- It may be reasonable for some patients to continue stimulant medications during pregnancy/postpartum

Substance misuse in pregnancy: potential red flags

Patients who are abusing substances may:

- Seek prenatal care late in pregnancy
- Have poor adherence to appointments
- Experience poor weight gain
- Exhibit symptoms of sedation, intoxication, withdrawal, or erratic behavior
- Have track marks from intravenous injection or lesions from interdermal injections or “skin popping,” abscesses, or cellulitis
- May have positive results of serologic tests for HIV, hepatitis B, or hepatitis C

Substance use disorders

- Especially important to identify and treat in pregnancy due to:
  - Impact on fetus
  - Risk of harm to fetus related to high-risk behaviors associated with substance use
- High comorbidity with mental health issues
- If suspicion for use or routinely suggested question:
  - “At our clinic as part of standard of care all patients are asked about their use of prescribed and non-prescribed substances as it may impact the health of mom and baby. Is it okay that we talk about any use of such substances now?”

Substance use screening: 4 Ps and CRAFFT

4 Ps

Parents: Did any of your parents have a problem 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?

Scoring: Any “yes” should trigger further questions

This does not have to be asked verbatim

C: Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?

R: Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A: Do you ever use alcohol or drugs while you are by yourself? Or ALONE?

F: Do you ever FORGET things you did while using alcohol or drugs?

F: Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?

T: Have you ever gotten in TROUBLE while you were using alcohol or drugs?

Scoring: Two or more YES answers suggest a serious problem and need for further assessment

For individuals under 26

Substance use screening: NIDA quick screen

- If patient says “Yes” to one or more days of heavy drinking, patient is an at-risk drinker
- If patient says “Yes” to use of tobacco, patient is at risk
- If the patient says “Yes” to use of illegal drugs or prescription drugs for non-medical reasons, inquire further which ones—**cocaine, stimulants/crystal meth, pain medicines, heroin, fentanyl**—and when last
- Note that marijuana has been legalized in Michigan since this screen was created, so must be asked about in a separate question

Quick Screen Question: In the past year, or since you became pregnant, how often have you used the following?	Never	Once or twice	Monthly	Weekly	Daily or Almost Daily
Alcohol - For men, 5 or more drinks a day - For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

Substance Use

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

30–60% of women with PTSD have SUD

Trauma

Social Determinants of Health

PTSD

Depression

Anxiety

PTSD and depression 60% overlap

Perinatal illness presents often as comorbid conditions; therefore, **always probe for more than depression alone**

Essential knowledge for the treatment of perinatal mental health disorders

The perinatal period and psychosocial factors

- We conceptualize most mental health episodes as arising from both organic predispositions and psychosocial stressors
- The perinatal period is a time of significant increase in psychosocial stressors
- Therefore, the careful prescriber will thoroughly assess whether or not psychosocial stressors exist and if/how they can be addressed before considering or recommending medications
    - Interventions on stressors can be much more powerful than medications

Sleep

- Depression is associated with insomnia, which worsens depression
  - Insomnia or sleep deprivation can induce depression
- Be aware of how method of feeding affects sleep (exclusive breastfeeding can make getting good sleep challenging)
- Patients may be getting less sleep due to anxiety causing them to frequently check to make sure baby is ok at night
- **Approach:**
  - Explore partner relationship dynamics and their willingness/ability to share the responsibility of waking with baby at night
  - Goal of at least one 4-hour block of uninterrupted sleep
  - Fear of not waking up to infant cry due to a sleep aid is a common concern of parents—start at very low doses, make sure baby is not sleeping in bed with parent, have parent use infant monitor and/or enlist partner as back up when first trying medication

Breastfeeding

Breastfeeding is ideal in most cases, when it works for both mom and baby. However, for some parent and baby pairs, it can prove challenging and cause or worsen mental health issues.

- May be physically painful or emotionally painful (patients with trauma history)
- May limit ability to get longer stretches of sleep
  - This is a big concern for mental health, especially Bipolar Disorder, as sleep deprivation can induce mania
- Babies who struggle to gain weight
  - Anxiety can be fueled by limited milk supply/production and worry about how much milk baby is getting—"invisible intake"
- Complicated by:
  - Patient or others' expectations/shame
  - Patient or others' concerns about health and bonding

Breastfeeding: approach

- Lactation consultants, doulas
- Cost-benefit analysis
  - Sensitive, non-judgmental discussion with patient is essential
  - Fed is best
  - Remember that how and what you say to patients about this issue will deeply impact them

The fussy baby

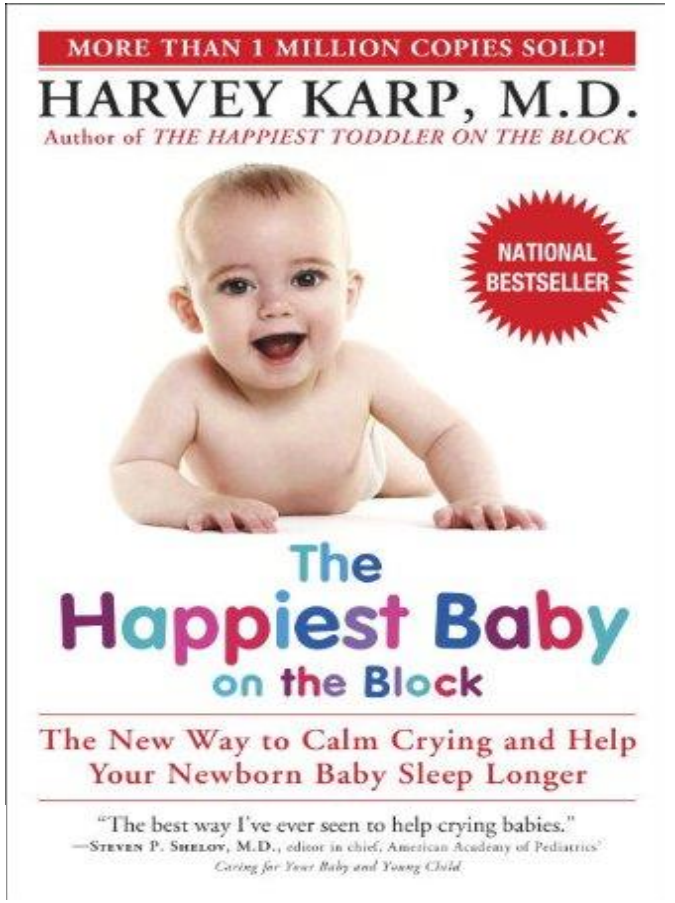
- Maternal depression rates are higher in mothers of babies with colic, even months after the colic/crying subsides
- Maternal anxiety can be high in these situations as well
- Worst case scenario is that the caregiver becomes very frustrated and overwhelmed and harms the baby in some way—i.e., shaken baby syndrome

The fussy baby: assess

The fussy baby: approach

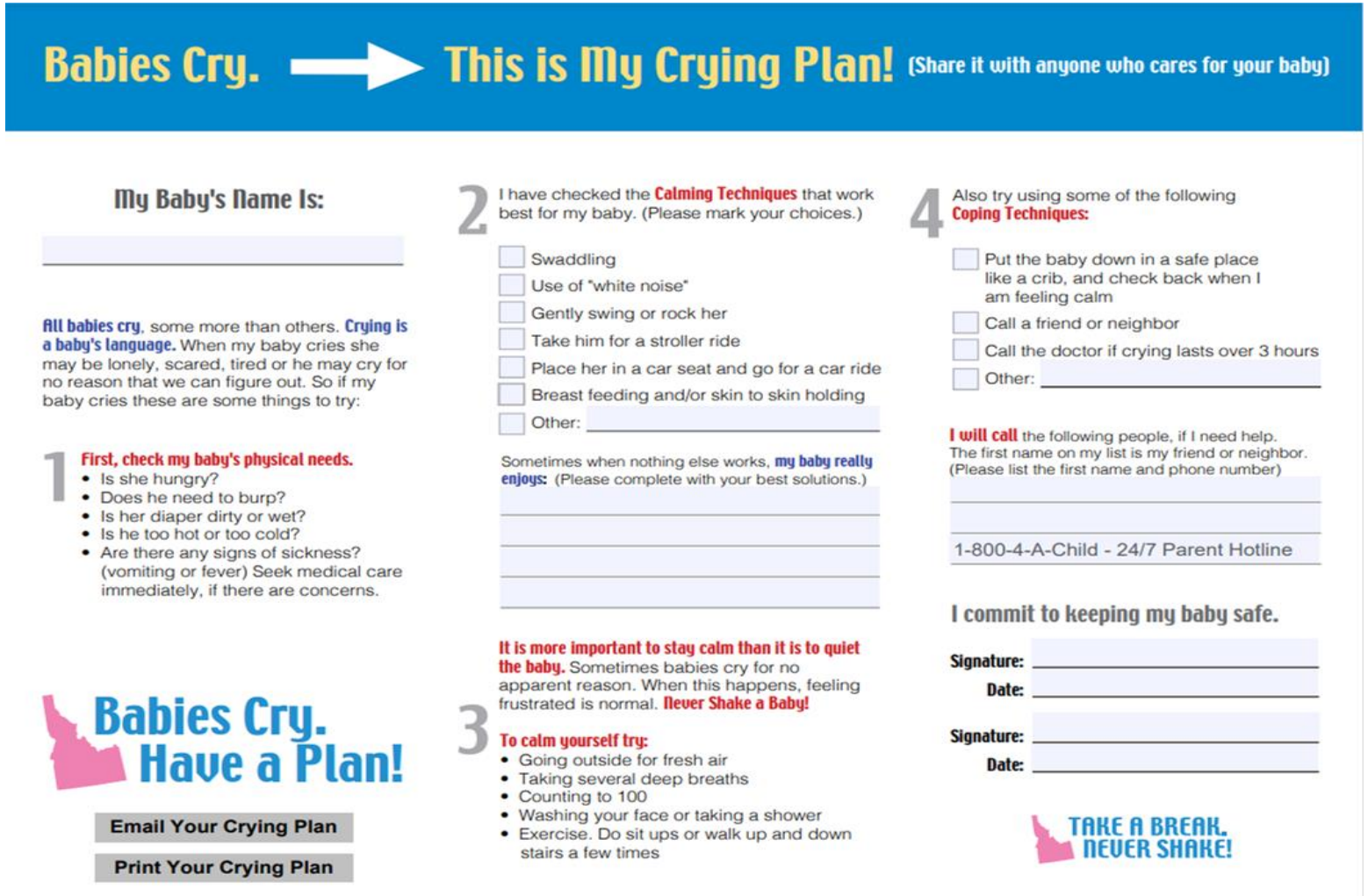
- Happiest Baby on the Block (re-working cognitive distortions)
- 5 S's

SWADDLING SIDE/STOMACH POSITION SHUSHING SOUNDS SWINGING SUCKING



The fussy baby: plan

- Develop a Crying Plan
- Distress tolerance/ taking a break



Babies Cry. → This is My Crying Plan! (Share it with anyone who cares for your baby)

My Baby's Name Is: _____

All babies cry, some more than others. **Crying is a baby's language.** When my baby cries she may be lonely, scared, tired or he may cry for no reason that we can figure out. So if my baby cries these are some things to try:

1 **First, check my baby's physical needs.**
- Is she hungry?
- Does he need to burp?
- Is her diaper dirty or wet?
- Is he too hot or too cold?
- Are there any signs of sickness? (vomiting or fever) Seek medical care immediately, if there are concerns.

Babies Cry. Have a Plan!

Email Your Crying Plan

Print Your Crying Plan

2 I have checked the **Calming Techniques** that work best for my baby. (Please mark your choices.)

- ☐ Swaddling
- ☐ Use of "white noise"
- ☐ Gently swing or rock her
- ☐ Take him for a stroller ride
- ☐ Place her in a car seat and go for a car ride
- ☐ Breast feeding and/or skin to skin holding
- ☐ Other: _____

Sometimes when nothing else works, **my baby really enjoys:** (Please complete with your best solutions.)

_____

_____

_____

_____

It is more important to stay calm than it is to quiet the baby. Sometimes babies cry for no apparent reason. When this happens, feeling frustrated is normal. **Never Shake a Baby!**

3 **To calm yourself try:**
- Going outside for fresh air
- Taking several deep breaths
- Counting to 100
- Washing your face or taking a shower
- Exercise. Do sit ups or walk up and down stairs a few times

4 Also try using some of the following **Coping Techniques:**

- ☐ Put the baby down in a safe place like a crib, and check back when I am feeling calm
- ☐ Call a friend or neighbor
- ☐ Call the doctor if crying lasts over 3 hours
- ☐ Other: _____

I will call the following people, if I need help.
The first name on my list is my friend or neighbor.
(Please list the first name and phone number)

_____

_____

1-800-4-A-Child - 24/7 Parent Hotline

I commit to keeping my baby safe.

Signature: _____
Date: _____

Signature: _____
Date: _____

TAKE A BREAK. NEVER SHAKE!

Evidence-based perinatal medication management

Perinatal approach to treatment

- Assess the family system as a whole to identify and target specific psychosocial stressors
- Optimize non pharmacologic measures first
  - Psychoeducation (i.e., sleep, breastfeeding, fussy babies)
  - Diet and exercise
  - Mindfulness/meditation exercises
  - Psychotherapy
    - Individual
    - Group
  - Support groups
  - Complementary and alternative treatments—supplements, etc.
- Use medications only when needed and in the lowest doses needed

Treatment guidelines

MILD-MODERATE ILLNESS/SYMPTOMS

Psychotherapy + Complementary Alternative Approaches (CAM)

- Brief supportive therapy/CBT/IPT/DBT/Psychodynamic, support groups, insomnia treatment, assistance with sleep or breastfeeding, Complementary Alternative Approaches (CAM)

MODERATE-SEVERE ILLNESS/SYMPTOMS

Psychotherapy + antidepressant therapy; CAM as add-on treatment

- Those who have recurrent depressive disorder may require long-term antidepressant therapy, and this should only be discontinued for next pregnancy after a full risk-benefit analysis given the high relapse rate (~70%)

SEVERE OR TREATMENT RESISTANT DEPRSSION (TRD), BIPOLAR DEPRESSION, MANIA, OR PSYCHOSIS

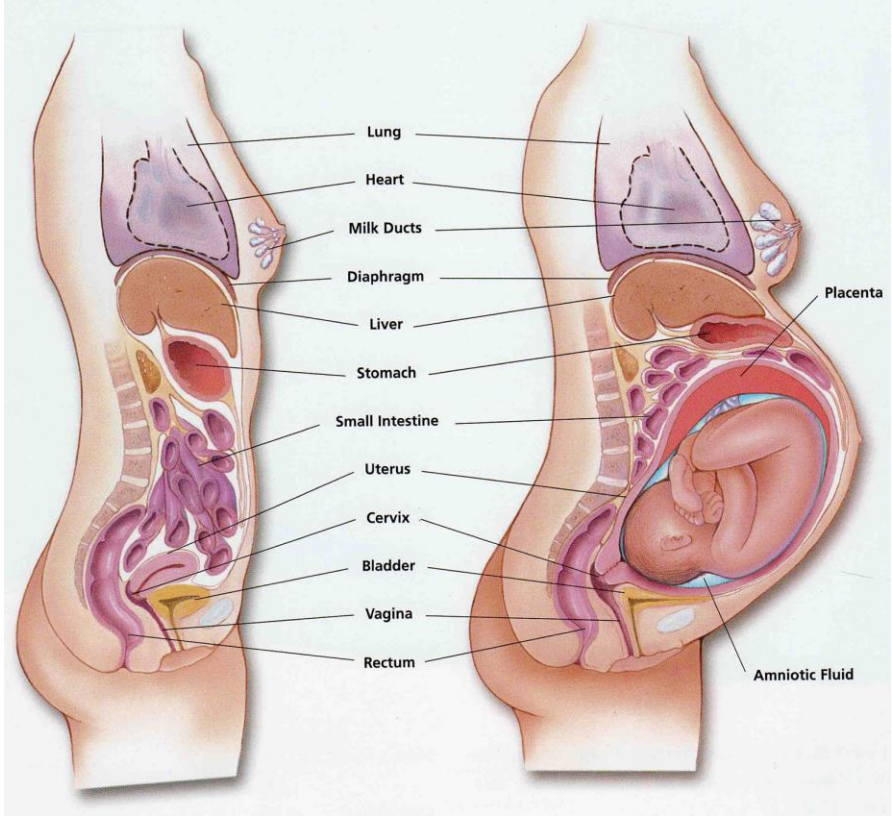
Combination of antidepressants, antipsychotics, mood stabilizers, hypnotics, anti-anxiety medication. and ECT can be considered; psychotherapy & CAM as add-ons

Broad Strokes

- Patients who are successfully treated with safe medications during pregnancy should generally not change medications for the purpose of breastfeeding
- Postpartum patients who start pharmacotherapy should be treated with medications that were efficacious in the past
- Psychotropic polypharmacy should be avoided, if possible
- There is little evidence to support either timing of drug administration or discarding breastmilk (“pump and dump”)

Body systems

- Most are affected
  - Hematologic
    - Blood volume increases 50-100%
    - RBC increases 25-40%
      - Relative anemia (“physiologic”)
- Weight gain of about 20-30 lb



Effects of increased blood volume on medication efficacy in pregnancy

- Some women appear to require higher doses in pregnancy to maintain benefits, potentially due to:
  - Increased blood volume—(drug blood levels decrease)
  - Increased metabolism in late pregnancy
- This may be more noticeable in the third trimester
- Evaluate on a case-by-case basis

Wisner et al., 1993; Altshuler and Hendrick, 1996; Hostetter et al., 2000; Kim et al., 2006; Heikkinen et al., 2003; Sit et al., 2008; Ververs et al., 2009

Gastrointestinal changes

- Slowed GI motility
  - Constipation, early satiety
- Relaxation of lower esophageal sphincter
  - GERD
- Nausea / vomiting
  - Often proportional to HCG level
  - Must differentiate from medication side effect
- Liver / gallbladder
  - Biliary stasis, cholesterol saturation
    - More stones
- Take into account when considering side effect profiles of psych medications

Why so much conflicting data about medication safety?

- No randomized, double-blind, placebo-controlled trials
- Many studies are retrospective database and case-control studies
- Studies monitor prescriptions and diagnoses, not medication exposures and symptoms (databases)
- Unsystematic (if voluntary reporting)
- Confounds (particularly illness exposure)

Review of safety data for antidepressants

- Teratogenicity (congenital malformations)
- Pregnancy/childbirth complications
- Neonatal adaptation syndrome (NAS)
- Persistent pulmonary hypertension of the newborn (PPHN)
- Long-term developmental effects

Teratogenicity

- Baseline population risk for any malformation is 2–4% among healthy, unexposed women
- Any medicine risk must be measured against this baseline risk
- Overall—teratogenicity risk for SSRI/SNRI/TCA , ***if at all***, low

Medication safety and the FDA

FDA removed categories A, B, C, D, X as of 7/1/2015

- Rationale: these aren't simple "grades"
- Each medication requires careful risk-benefit analysis and "subsequent counseling of pregnant women and nursing mothers who need to take medication, thus allowing them to make informed and educated decisions for themselves and their children"

The paroxetine controversy

- In 2005, GSK analyzed own data on n=815 exposed infants
  - 1.5 to 2-fold increased risk for atrial and ventricular septal defects
  - Paroxetine > FDA Category D

- Since 2005, there have been multiple contradicting studies:
  - Increased risk for unspecific malformations
  - Increased risk for specific cardiac malformations
  - No risk for malformation (risk 0.7%)
  - Risk is dose-dependent (>25mg daily) and only when exposed in first trimester

- Bottom line: avoid if possible but may be reasonable to continue in an otherwise refractory patient as long as risks are discussed

Pregnancy/childbirth complications

- Spontaneous abortions
  - No difference between various classes of antidepressants
  - None of the studies took confounders into consideration
    - Poor health habits, psychiatric illness, smoking, etc.
- Preterm birth
  - Associated with late pregnancy SSRI use in 8 studies
  - Same rate of risk exists in untreated depression
- Low birth weight
  - Effect is minimal (< 75g/2.6 oz.) and disappears when control group are untreated depressed mothers

Bottom Line

- When it comes to pregnancy complications, we have not sorted out the confounding effects of SSRI exposure versus untreated depression
- Neither scenario is without some risk
- This needs to be discussed with patients

Neonatal adaptation syndrome (NAS)

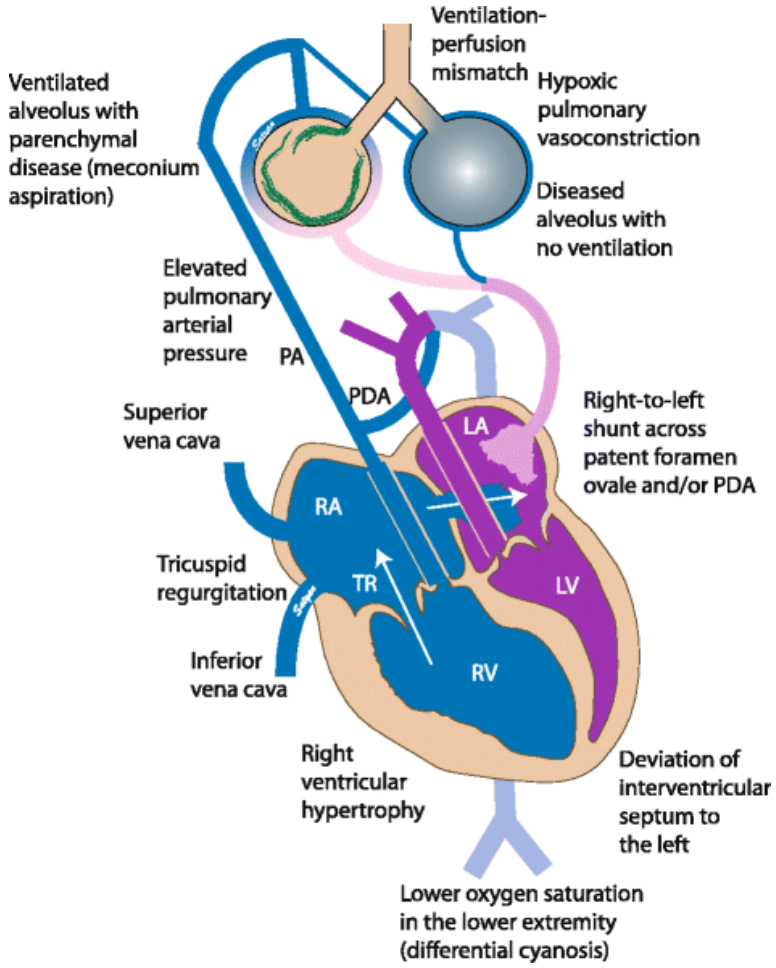
- Withdrawal/discontinuation syndrome
  - Tremors/shaking/jitteriness
  - Irritability
  - Sleep disturbances
  - Poor muscle tone
  - Respiratory distress/seizures (in severe cases)
- Usually does not require intervention

Neonatal adaptation syndrome (NAS) continued

- Per the literature, this is reported in up to 30% of infants exposed to antidepressants in utero
  - In our clinical experience, incidence is less than 1%
  - Symptoms are commonly mild (10% or less are severe) and self-limited
  - No reported long-term sequelae

Persistent pulmonary hypertension of the newborn (PPHN)

- Pulmonary vascular resistance (PVR) remains abnormally elevated after birth, resulting in right-to-left shunting of blood through fetal circulatory pathways → Hypoxemia
- Can be severe and may not respond to conventional respiratory support
- Risk for babies born to mothers taking SSRIs in late pregnancy:
  - 3.0 per 1000 live births vs 1.2-1.9 per 1000 live births in control infants
- Never seen this in our clinical experience



Long-term development

- Literature available on SSRIs, SNRIs, and TCAs
- No differences in cognitive and language development
- No differences in IQ
- No differences in temperament, mood, reactivity, distractibility, or behavioral problems

Antidepressants and autism

Headlines are scary, but:

- Only 0.72% prevalence in general population vs. 1–1.2% in exposed population
- These studies frequently have **significant limitations**:
  - Not comparing women taking antidepressants with women who have **similarly severe** depression and are not taking medication
- Reality: it’s complicated!

Antidepressants and autism

- Literature shows that infants born to moms with health problems face higher risks than infants born to moms that are well
- Evidence from well-designed studies shows that when women taking antidepressants are compared with women who share the same risk profile, antidepressants are no longer linked with poor outcomes
- **Bottom Line:** Risk may run with the disease and not its treatment

Risk-risk discussion

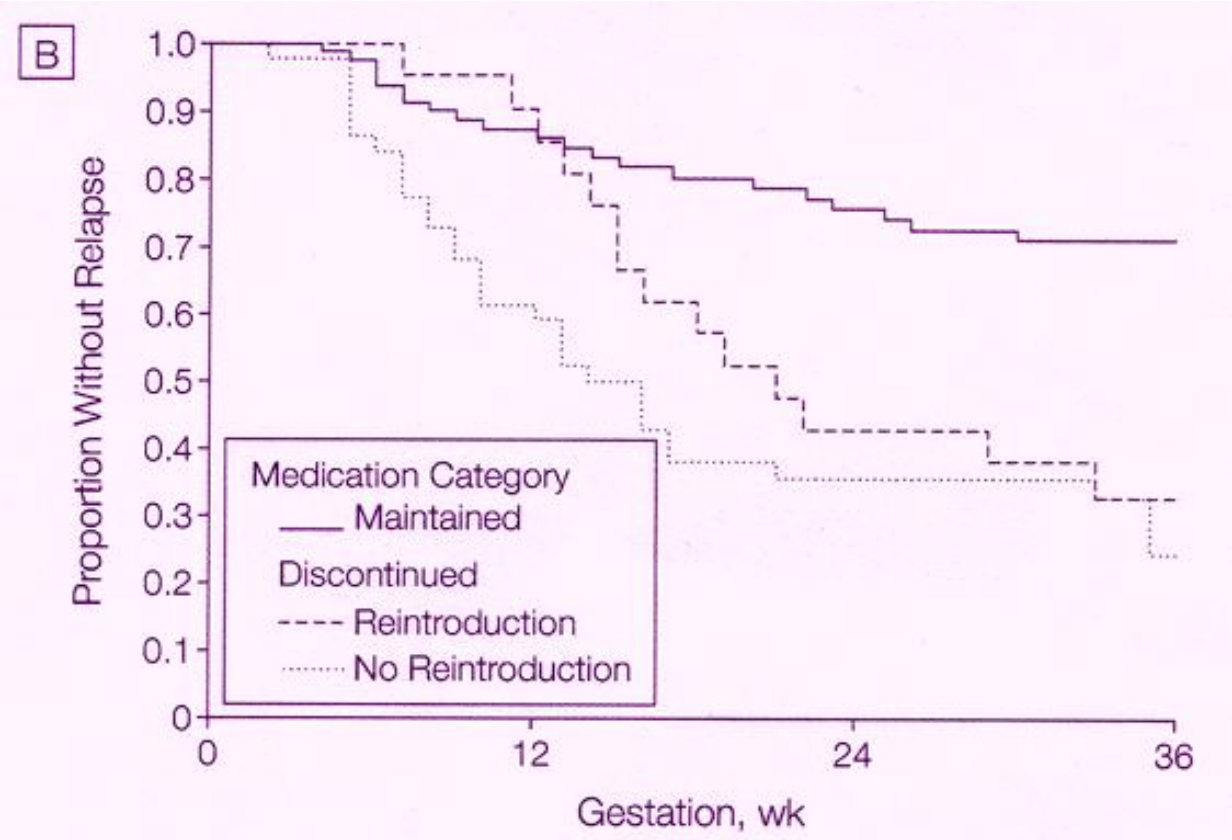
Risk of untreated illness

Risk of treatment

NO RISK-FREE ZONE!!!

Time to depression relapse during pregnancy among euthymic women on/off medications

N = 201. Cohen LS, et al. *JAMA*. 2006;295(5):499-507.



26% when medicine continued

68% when medicine is discontinued

Acute depression

- Any SSRI is first line treatment
  - However, can take a while to become effective
- For patients with significant fatigue/low motivation and minimal to no anxiety symptoms:
  - May consider Wellbutrin due to pseudo-stimulant properties.
- For patients with significant insomnia and poor appetite:
  - May consider Remeron as it helps quickly with sleep/appetite

Benzodiazepines

Risks in pregnancy

- Formerly category D (positive evidence of risk)
  - However, no evidence of congenital malformation; initial concern for cleft lip/palate disproven
- Lorazepam and clonazepam preferred
  - Less likely to accumulate in fetus/neonate
  - Alprazolam rapid on/off = unknown fetal effects

Risks at birth

- “Floppy baby syndrome” (neonatal apnea, hypotonia)
  - Associated with high doses near delivery
  - Generally not present with therapeutic doses
- Neonatal adaptation syndrome
  - Increased incidence with concurrent antidepressant use

Antidepressants and benzodiazepines: breastfeeding

- Generally, SSRIs, SNRIs, Wellbutrin, TCAs have good data
  - Infant levels 1–20% of mom's level depending on drug
  - Sertraline and paroxetine have lowest concentrations found in breast milk (however, this does not correlate with any different/improved clinical outcomes)
- Benzodiazepines are generally ok
  - Infant levels 2.5–8.5% of mom's level
  - Ativan, Klonopin are preferred
  - At prescription doses, generally do not see sedation in baby

Lithium: pregnancy

Risk

- Patomo et al. N Engl J Med. 2017 (n=1,325,563 pregnant women)
  - Relative risk of cardiac malformations calculated was 1.65
  - If the risk of cardiovascular malformations is 1.15% in women with no exposure, the risk rises to about 1.9% in infants exposed to lithium
  - Dose response effect (risk increased approximately threefold in doses above 900 mg per day)

Strategies

- Half-life is short (8–10hrs), causing peaks
  - Dose tid–qid or use extended release
- First trimester exposure: high-resolution US/fetal echo at 16–18 weeks gestation
- Risk of toxicity with pregnancy-related emesis
- Renal excretion of the drug changes throughout the trimesters so need to monitor blood levels frequently and adjust dose accordingly to maintain therapeutic level
- Do very frequent level-monitoring postpartum and return to pre-pregnancy dose immediately postpartum

Lithium: breastfeeding

- Excretion of lithium into breastmilk is highly variable
- Measured infant plasma levels: 30%–40% of maternal plasma levels
- Reports exist of breastfed infants who have shown signs/symptoms associated with lithium toxicity
  - May occur more frequently in infants with elimination impairments (e.g., dehydration) or in newborns/premature infants
- Lithium usually not recommended due to risk for neonatal dehydration and lithium toxicity but can be done if no other choice OR if patient is on relatively low dose, really wants to breastfeed, and physician following infant is comfortable with monitoring

Lamotrigine: pregnancy

- Teratogenicity:
  - 3 out of 4 registries report no more than baseline population risk for malformations (2–4%)
  - 1 out of the 4 registries suggested increase in relative risk for midline facial clefts with 1st trimester exposure, but absolute risk is very low (4:1,000)
- Neonatal Toxicity
  - Transient liver toxicity
  - Watch for skin rash
- Increased excretion in pregnancy; may need to increase dose in later gestation
- **Lamotrigine is the #1 mood stabilizer for bipolar depression in pregnancy—safe and effective**

Valproic acid: pregnancy

- **DO NOT PRESCRIBE** in a woman of childbearing age and **DEFINITELY NOT IN PREGNANCY**
- Teratogenicity: 10%, particularly if exposure in 1st trimester
  - Neural tube defects, dose related
  - Midface hypoplasia and other facial anomalies
  - Cardiac anomalies
  - Folate supplementation up to 5mg daily may reduce risk
- Intrauterine growth restriction (IUGR)
- Mental retardation
- Neonatal toxicity
  - Irritable, jittery, hypotonia, feeding difficulties, liver toxicity
  - Hypoglycemia

Carbamazepine: pregnancy

- Teratogenicity: 6%
  - Neural tube defects
  - Craniofacial and other facial anomalies
  - Worse when in combination with valproic acid
- Fetal vitamin K deficit, fetal bleeding
- IUGR
- Neonatal toxicity
  - Transient liver toxicity
  - Neonatal bleeding, administer 1mg vitamin K to baby

Mood stabilizers: breastfeeding

- Valproic acid
  - Infant levels relatively low
  - Theoretical risk of infant hepatotoxicity, thrombocytopenia
  - Concern re: mom becoming pregnant again
- Carbamazepine
  - Infant levels relatively high
  - Infant monitoring recommended (drug levels, liver enzymes, CBC)
- Lamotrigine
  - Infant levels 30% mom dose; theoretical concerns about risk for Stevens-Johnson syndrome though no infant cases of this have been reported
  - Generally safe

Antipsychotics: pregnancy and breastfeeding

Pregnancy

- Generally safe
- Overall, studies point to a very small increased rate of congenital anomalies (as with essentially all the psychotropic drugs we use in pregnancy)
- Second generation antipsychotics (SGAs) have better safety data than first generation
- Olanzapine, quetiapine have the best safety data of the SGAs
- Abilify is likely safe
- Some concern that Risperdal may increase risk of cardiac malformations

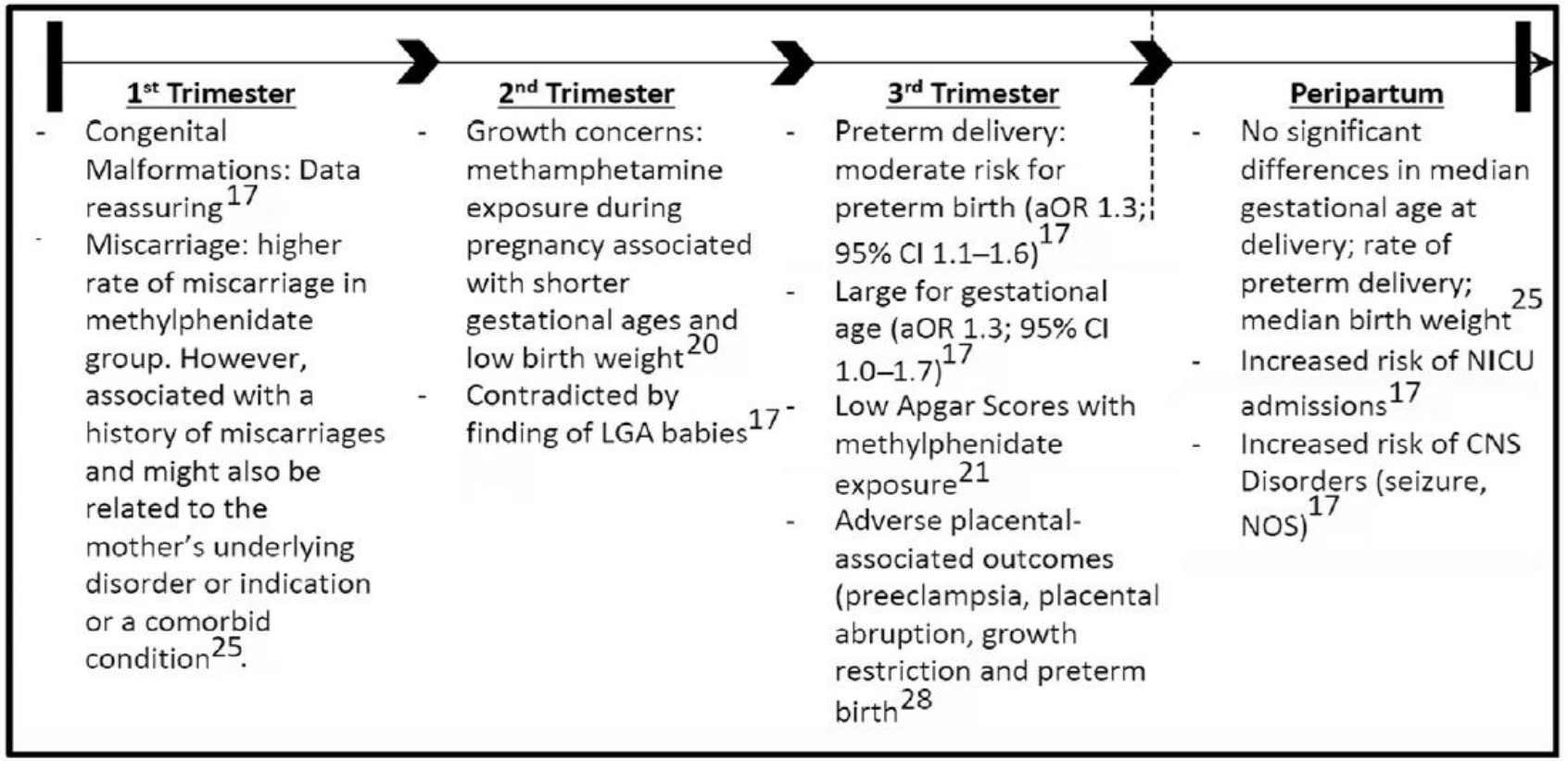
Breastfeeding

- Safety
  - Generally ok
  - Avoid clozapine due to risk of agranulocytosis in infant
- Milk production
  - Inverse relationship between dopamine and prolactin
  - Some case reports of Abilify decreasing milk production (potentially due to partial dopamine agonism?)

Stimulants in pregnancy

- Most effective treatment for ADHD
- ADHD is comorbid with mood, anxiety, and substance use disorders
- Contraindications/concerns
  - High blood pressure
  - Cardiac disease
  - Underweight/eating disorder (appetite suppressant)
  - Substance use disorder (controversial)

Potential risks of stimulants in pregnancy



Bottom line: Possibly increased risk of preterm birth, gestational hypertension, SGA/growth restriction

When to continue stimulants in pregnancy: a question of functioning

Table 2
Adjustment and recurrence strategy for attention deficit hyperactivity disorder during pregnancy

Mild ADHD (Minimal Functional Impairment off Medication)	Moderate ADHD (Some Functional Impairment off Medication)	Severe ADHD (Significant Functional Impairment, Including Driving Safety)
Optimize sufficient nonpharmacologic management strategies and ensure self-management strategies in place (with history of success in supporting functionality of woman in domestic and occupational roles)	Optimize nonpharmacologic strategies; consider when necessary use of stimulant	Maintain medication, consider closer obstetric monitoring for fetal growth and hypertensive disorders of pregnancy

Treatment of ADHD with non-stimulants in pregnancy/breastfeeding

- Bupropion (Wellbutrin)
  - Safe in pregnancy and breastfeeding
- SNRIs (Effexor, venlafaxine)
  - Safe in pregnancy and breastfeeding
- Atomoxetine (Strattera)
  - Very little data in pregnancy/breastfeeding, but so far, nothing negative

Stimulants in breastfeeding

- Are secreted into breastmilk in low levels
- So far, no evidence of harm in infants (short term)
- May decrease breast milk supply in women without established supply

Prescribing pearls

- Perinatal patients are generally in more distress than non-perinatal patients
  - Especially postpartum due to compounding factors of sleep deprivation, drastic hormonal shifts, and significant life change
  - May **titrate antidepressants every two weeks** until reach sufficient symptom relief
  - Remember: **start low, you may go slow if needed for tolerability (i.e., increase dosage by small amounts each time), aim for a target therapeutic dose**
  - For patients with moderate to severe symptoms, consider prescribing **PRN for a short time before other medications kick in**—short term Ativan and Klonopin can be extremely helpful (in patients without risk factors for substance abuse and significant functional impairment/distress)
- Sertraline has the least transfer to breast milk but is not necessarily the best "first-line" medication due to high rate of side effects (GI, sedation, activation, emotional "numbing")
  - Also, the fact that it has minimal excretion into breastmilk is not necessarily correlated with better/different outcomes
- Remeron can be very useful during this time period, particularly with patients who have significant insomnia and poor appetite (+/- nausea)

Acute anxiety/panic attacks

May prescribe PRN medication as appropriate based on pregnant vs. postpartum status (benzodiazepine, gabapentin, hydroxyzine, quetiapine, etc.)

- Not ideal for panic attacks given that may reinforce idea that panic attack must be stopped/patient can't tolerate it
  - Discuss with patient that PRN will likely be short term
- However, therapy can take a while (time to connect, engage, see improvement)

PRN medications for sleep/anxiety

Benzodiazepines

- Helpful for anxiety, insomnia due to anxiety
- Screen for history of SUD/chronic poor coping
- Can be habit forming
- Plan for a time-limited course
- Ativan and Klonopin most commonly used (do not prescribe Xanax)

Gabapentin

- Newer drug, but data reassuring so far
- Can be helpful for people trying to discontinue MJ
- More anxiolytic than sedating (as opposed to next slide)
- Generally well tolerated
- Wide dose range
- Much less risk of dependence/abuse (as opposed to benzos)

PRN medications for sleep/anxiety

Benadryl/hydroxyzine

- Benadryl—OTC; may lose efficacy if used regularly
- Hydroxyzine—avoid in pregnancy-limited data
- Antihistamine properties can decrease breastmilk supply

Unisom

- OTC
- Used frequently in pregnancy (especially for nausea)
- In breastfeeding, avoid prolonged use

Trazodone

- No significant side effects in women other than grogginess
- Ideally, take at bedtime on nights where at least 6-8 hours of sleep can be achieved

Seroquel

Very effective

- Can cause weight gain, other metabolic effects (usually at higher doses)
- Higher risk of side effects (restless leg, akathisia, over sedation)
- Has some anxiolytic effects
- Small potential to decrease breast milk supply due to antihistamine properties

Common patient concerns about sleep medications

- It will make me groggy
  - Plan to start with smallest effective dose
- I won’t wake up with the baby
  - Generally not the case
  - When first trying the med, have another person sleep in the same room just in case
  - Use a baby monitor at high volume
- It will sedate/harm the baby via breastmilk
  - No reports of this happening at appropriately prescribed doses of appropriate medications

Treatment developments in perinatal practice

Treatment developments in Perinatal: new evidence-based medications

- **Brexanolone**
  - Neurosteroid drug boasting depression remission in as little as 24–48 hours
  - 60-hour continuous IV administration requiring 24-hour monitoring by a healthcare professional given that side effects can include excessive sedation and loss of consciousness
  - This is not feasible/cost effective for many patients or healthcare settings
- **Zuranolone**
  - Neurosteroid
  - Data from phase 3 SKYLARK study (randomized, double blind, placebo controlled); n=200, severe depression (Hamilton Depression Rating Scale (HAM-D)-17 score 26 or higher)
  - Over 45-day trial, there was a consistent 3–4 point greater reduction on the HAMD-17 score as compared to placebo; at day 45 (-17.9 vs -14.4, P = 0.0067)
  - Most common side effects were sedation, dizziness, headache, and GI effects

Resources for medications in pregnancy and breastfeeding

FREE

- Mother to Baby: https://mothertobaby.org/
- LactMed: https://www.ncbi.nlm.nih.gov/books/NBK501922/
- Massachusetts General Hospital Women's Mental Health: https://womensmentalhealth.org

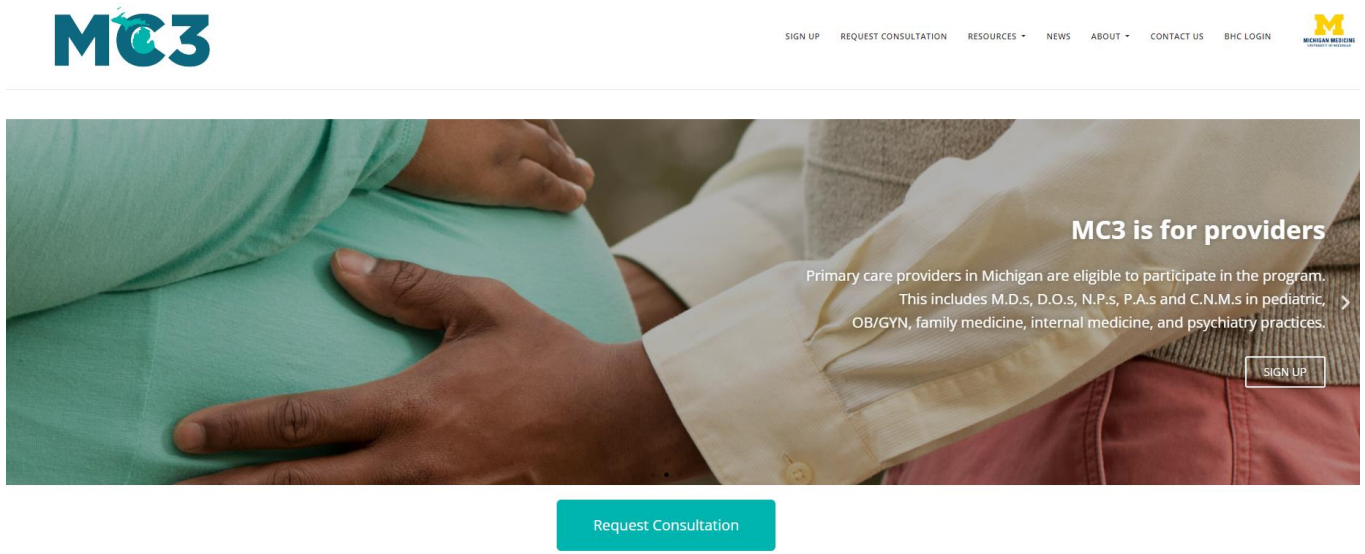
PAY

- Reproductive Toxicology Center: www.reprotox.org
- Infant Risk Center: Infantrisk.com
    - (806)-352-2519 + phone app available

MC3 Perinatal

A phone-based consultation service

- May place a consult to MC3 perinatal (free, same-day consultation with perinatal psychiatrist) via phone call or online request
  - Provider must enroll (fast, free) in MC3 perinatal program to access services
- Website also contains provider toolkit and psychopharmacology reference cards with information about safety of most psychotropics in the perinatal period



Building confidence in the medical management of perinatal mental health

Challenges for psychiatrists using the collaborative care model

- Don’t get to ask patients questions yourself
- Don’t get to see/speak with patients yourself (either to gather or give information)
- Managing higher risk patients may feel a little less comfortable
- Need to set limits around role, responsibilities, and availability
- Providers may have different comfort levels regarding prescribing certain medications

Unclear diagnosis

- Can always have BHCM go back and collect more information—don't have to make a decision about diagnosis or treatment on the spot
- Exact diagnosis may not be as essential if low concern for bipolar disorder (i.e., first line medication for depression or anxiety is SSRI)
- If there is confusion about bipolar disorder vs Cluster B traits/personality disorder, can choose diagnosis of mood disorder NOS and treat with mood stabilizer/SGA that could be helpful to both diagnoses

Unclear which medication to choose from a given class

- If there is not enough information in initial case presentation, can ask BHCM to ask further questions that would help decide (i.e., is patient sleeping well? Are they struggling with energy?)
- May have to ask BHCM to gather more information about previous medication trials (names, doses, length of time)
- May give BHCM/referring provider a couple of options, while giving information about how one agent differs from the other, and let patient decide

High-risk patients

- Can refer to higher levels of care while in the program
  - Local psychiatrist
  - PHP
  - Inpatient admission
- Can consult MC3 Perinatal (phone or online consult)
- Can have BHCM complete a safety plan with the patient and regularly call patient to check-in regarding safety

Setting limits

- Various requests may come up
  - Disability paperwork
  - Patient questions/concerns outside of allocated panel review time
  - Providers wanting you to prescribe a medication for various reasons (don’t feel comfortable with certain medication, patient no longer under their care)
- It is important to anticipate that these things will come up and decide as a group what your policy will be on handling these issues
  - There may be some flexibility involved based on the specifics of the case

Differing prescriber comfort levels

Some providers may be less comfortable prescribing medications we recommend, requiring further conversations to address this issue

- Sometimes a phone call with said provider can clear up a lot of things
  - There is sometimes an element of “liaison” work involved in collaborative care for this reason
  - These encounters can be a great opportunity for education
- Sometimes another provider in the same practice is willing to order the medication in place of the other provider that is uncomfortable

Systematic case review: examples and practice

Patient #1

32-year-old woman who is 20 weeks pregnant, history of anxiety

- Used benzodiazepines as needed for anxiety prior to pregnancy
- Experiencing depression and intense anxiety, which then leads to insomnia
  - Getting about 2 hours of sleep per night
  - Unisom, Benadryl have not been effective
- Notes racing heart, crying spells, loss of motivation
- Took Prozac previously, does not recall if it was helpful

What are considerations for next steps?

- **Do you need more information?**
  - Trauma history?
  - Current safety?
  - Past history of mental illness, e.g., Bipolar disorder, substance use disorder?
- **What are your differential diagnoses?**
- **What will you consider prescribing?**
  - Lexapro and trazodone
  - Remeron
  - Quetiapine
  - Klonopin
  - Prozac

Patient #2

- Patient is a 30-year-old woman who had no previous mental health history. She delivered her second child 6 weeks ago and has had depression as well as intensifying anxiety and panic symptoms, including derealization. Her OB started her on Lexapro, and she has titrated up to 10mg (has been at this dose for 2 weeks). Since starting the medication, she states that she feels numb/finds it hard to feel joy and continues to have intense anxiety although it is somewhat improved.
- She texts her BHCM frequently throughout the week stating that she feels very anxious and wonders if her medication regimen is ideal
- She went to see her PCP about her anxiety who instructed her to stop the Lexapro and start Zoloft 50mg

Questions

What medication recommendations would you make?

A) Wait until she has been on Lexapro 10mg for at least 4 weeks before making a change

B) Prescribe short term Ativan/Klonopin and wait until she has been on Lexapro 10mg for at least 4 weeks before making a change to her Lexapro dose

C) Encourage her to discontinue the Lexapro and start the Zoloft

D) Increase her dose of Lexapro to 20mg and start short term Ativan/Klonopin

Update

- You recommend that she increase her dose of Lexapro to 20mg and start Ativan 0.25–0.5mg BID PRN, and the BHCM relays this information to patient's OB and patient. BHCM also relays that we must be the only ones managing medications in order to prevent confusion and negative outcome for patient.

- Patient is nervous about making these changes. Agrees to increase Lexapro to 15mg but does not want to take Ativan. Continues to frequently text BHCM that she is struggling and requests guidance/reassurance about treatment plan. She also schedules and completes an evaluation with another psychiatric prescriber.

Questions

How do you react to patient again seeking recommendations from an alternate provider?

A. Immediately terminate treatment with the patient
B. Have BHCM let patient know that team will discuss if will continue to manage her care
C. Continue to see patient as is, despite her reaching out to other providers

Does this patient need a higher level of care? If so, what kind?

A. No, her scores are in the mild to moderate range and her medications are not complex
B. Yes, we need to terminate services with her immediately and refer her to a community psychiatrist
C. Yes, we should discuss IOP/PHP treatment and start discussing transfer to a community psychiatrist

Patient #3

Patient is a 21-year-old presenting with “mood swings,” insomnia, and irritability two months after the birth of her first child. Her pregnancy was unplanned. She states she was diagnosed with bipolar disorder when she was a teenager. Her MDQ was positive. Her father was physically abusive. She used to cut herself as a teenager but doesn’t do this anymore. She has struggled with passive suicidal ideation for a long time but has never been psychiatrically hospitalized or had suicide attempts. Her relationship with the father of the baby is rocky with a lot of conflict. She has limited supports and is currently taking care of the baby by herself. Her irritability and insomnia are making it hard for her to function at work. Finances are a stressor.

Questions

What diagnosis do you give this patient?

A. MDD

B. Bipolar disorder

C. Borderline personality disorder

D. Mood disorder NOS

E. None, I relate to BHCM that this is inappropriate for CoCM

Questions

What medication do you prescribe this patient?

A) Lexapro

B) Seroquel

C) Lamictal

D) Abilify

Questions

What therapy do you refer her to?

A. CBT—targets distorted negative cognitions associated with depression and anxiety

B. DBT—supports skills for regulating emotional instability and outbursts and self-harm

C. Infant mental health—home-based service that supports parent-infant bonding and addresses relational traumas

D. Recommend to enroll in CoCM and work with BHCM

E. B and C

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