CoCM in Perinatal Practice

July 20, 2023

Maria Muzik, MD

Samantha Shaw, MD

Welcome to CoCM in Perinatal Practice

While we're waiting for others to join…

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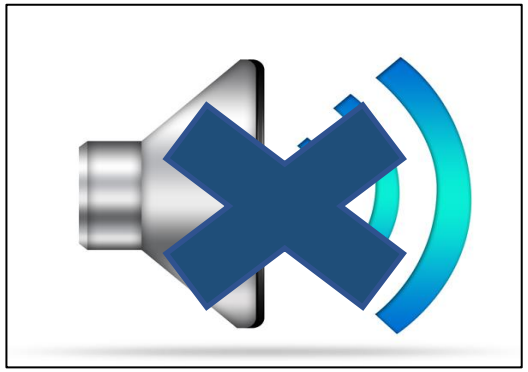

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Disclosure

The Michigan Institute for Care Management and Transformation (MICMT) and the 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.

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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) to provide training and implementation on the evidence-based treatment model of Collaborative Care to medical care practices throughout the state of Michigan.

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

Collaborative Care Model: Perinatal Training 2023 Instructions for Behavioral Health Care Managers and other Practice Staff:

Following the course completion on 7/25/2023

- You will receive an e-mail from the Michigan Institute for Care Management and Transformation
  - Please allow up to 24 hours to receive the e-mail. If you do not receive within 24 hours, please submit an inquiry via the MICMT contact form.
- Please follow the link to complete the evaluation within (5) business days for each session you attend to earn credit.
- MICMT highly encourages you to ***submit*** an evaluation for the sessions you attend.

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The nurse planner, content experts', faculty, and others in control of content have no relevant financial relationships with ineligible companies.

Successful completion of the course includes ***have audio and see the slides live; join the course by your individual computer***

- Social Work participants:
  - must attend Day 1 of the training 8:00am – 9:30am: "Perinatal Collaborative Care: Symptomology, Screening & Assessment"
  - thereafter attendance at the entire session(s)
  - credit awarded as commensurate with participation
- Nursing participants
  - attendance at the entire session(s)
  - credit awarded as commensurate with participation

Nursing:

- Upon successful completion of this activity the participant may earn a maximum of 7.0 Nursing CE contact hour.
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  - ***See CME Activity Information: "Collaborative Care Model: Perinatal Training July 2023" handout for full details.***

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Learning Outcome

- Participants will be able to implement the Behavioral Health Collaborative Care Model, incorporate workflows and other operational techniques unique to Collaborative Care within their practice to address the behavioral health needs of the perinatal population with fidelity to the Collaborative Care Model.

Learning Challenge

Identify 7 areas to consider when working with perinatal patients in CoCM and 3 assessment/intervention strategies

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Schedule for today

Providers/BHCM 8:00 AM - 11:10 AM

8:00 – 8:05 AM	Introduction of the day/ housekeeping
8:05 – 8:10 AM	CoCM Model Summary
8:10 – 8:35 AM	Introduction to CoCM in Perinatal Practice
8:35 – 9:30 AM	Symptomology, Screening and Assessment
9:30 – 9:40 AM	**Break (PCs join)**
9:40 – 11:10 AM	Symptomology, screening, assessment cont., Psychopharmacology overview

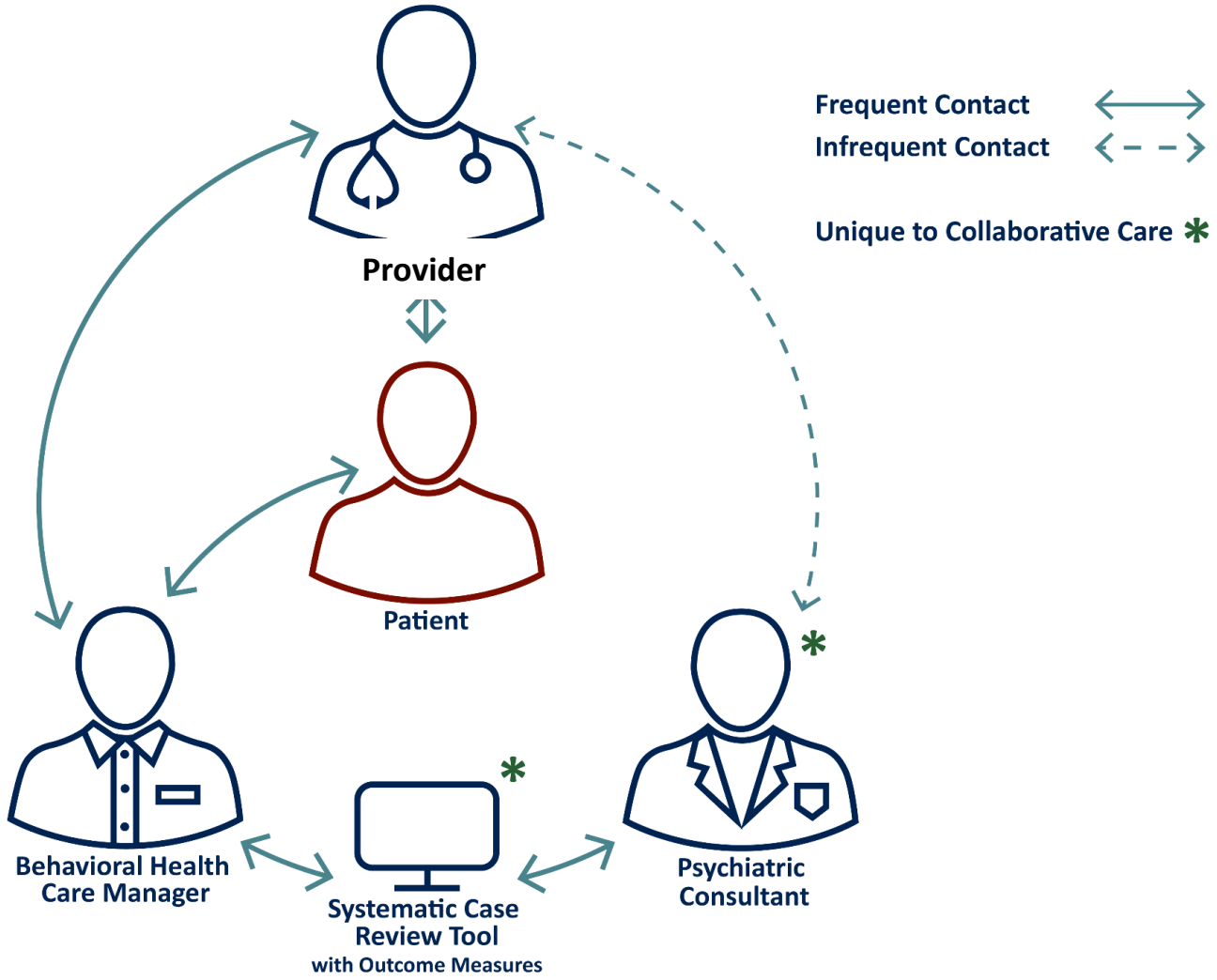
Psychiatric Consultants 9:30 AM – 12:20 PM

9:30 – 9:40 AM	Housekeeping
9:40 – 11:10 AM	Symptomology, screening, assessment cont., Overview Psychopharmacology
11:10 – 11:20 AM	Break
11:20 – 12:20 PM	Medication management, Treatment developments, Systematic case review

CoCM Model and Roles

A quick refresher

The Collaborative Care Treatment Team



The Basics of CoCM

Behavioral Health Care Manager

- Manages a caseload of patients
- Works closely with the provider to facilitate patient engagement and education
- Performs structured outcomes-based assessments along with risk assessment and safety planning
- Systematically tracks treatment
- Supports patient in self-management planning

https://aims.uw.edu/resource-library/care-manager-role-and-job-description

Behavioral Health Care Manager

- Provides brief behavioral interventions, monitors adherence to treatment plan and supports medication management
- Engages patients in relapse prevention planning
- Uses the systematic case review to systematically review caseload and ensure no patients are falling through the cracks
- BHCMs come from many different backgrounds and skill sets, e.g. social worker, nurse, licensed professional counselor, psychologist

The Basics of CoCM

Psychiatric Consultant

- Supports PCP and BHCM by regularly reviewing cases with the BHCM in scheduled systematic case reviews
- Recommends treatment planning for all enrolled patients, particularly those who are new, not improving, or need medication adjustments
- Reviews treatment plan and makes behaviorally-based recommendations
- The psychiatric consultant may suggest treatment modifications for the PCP to consider, recommend the PCP see the patient for an in-person consultation, or directly consult on patients who are clinically challenging or who need specialty mental health services. The consultant does not see the patient.
- Documents recommendations
- Provides psychopharmacology education to the PCPs and clinical staff

https://aims.uw.edu/resource-library/psychiatric-consultant-role-and-job-description

The Medical Provider

- Oversees all aspects of a patient's care and diagnoses behavioral health concerns
- Introduces the collaborative care program and makes referrals (ideally a warm hand-off)
- Prescribes medications and adjusts treatment following consultation with the BHCM and the psychiatric consultant
- Speaks with the psychiatric consultant as needed (this may be infrequent)
- Remains the team lead and will decide whether to incorporate recommendations from the consulting psychiatrist

Introducing our presenter

Samantha Shaw, M.D.

Clinical Assistant Professor

Perinatal and Reproductive Psychiatrist

Perinatal and Reproductive Psychiatry Clinic Department of Psychiatry

University of Michigan

Introduction to CoCM in perinatal practice

Learning Objective

1) Identify the unique factors of CoCM with the OB population, scope of application and approach considerations

Identifying patients for CoCM

Persons who are cared for **during perinatal period:**

- Pregnancy
- Postpartum (up to 1 year after childbirth depending on your service)
- Persons who have experienced reproductive loss (up to 1 year post loss)
- Note: While we're focusing on perinatal persons, any person that is being followed on a regular basis by their OB provider could be considered for CoCM

AND have **co-occurring mental health needs:**

- CoCM is designed for mild to moderate presentations of:
  - Diagnosis of depression and/or anxiety (often historical per chart)
  - And/or current PHQ-9 and/or GAD-7 of score of approximately >10
  - There is some flexibility in which patients can be managed by this model

Identifying patients for CoCM (cont.)

Caveat: boundaries are at times blurry

- Pregnancy/birthing /postpartum hormonal changes may reactivate symptoms or make presentations more complex
- Mild symptoms may not meet criteria for MDD or GAD
  - Grief/loss, adjustment difficulties, mild depression/anxiety
  - Use clinical judgement – mild cases may benefit from CoCM and prevent worsening
- Moderate symptoms also may fall into different diagnosis categories
  - Bipolar II disorder, PTSD, personality disorders
- Consider OB/GYN practice workflow when identifying patients
  - Explore following patients at frequent intervals for longer periods if enrolled in CoCM
  - If plan is to discharge a patient back to their PCP, explore coordinating any CoCM services with that provider

Special considerations for treating perinatal patients

- Flexibility needed—e.g., may continue working with a patient who has suffered a loss then becomes pregnant again, etc.
- Awareness of high prevalence of trauma among women:
  - Past (developmental, relational), new (related to current perinatal episode), or ongoing (experiencing intimate partner violence)
  - Perinatal period may “re-activate” previous trauma; previous trauma may make women more susceptible to new trauma in the perinatal period
- Awareness of racial differences in the perinatal experience—discrepancy in mortality rates, systemic racism

Special considerations for treating perinatal patients (cont.)

- Patients/providers may have strong feelings about medications
- Awareness of identity changes—unique experiences of what it is to be pregnant, what it is to be a parent, etc.
- Awareness of body and life changes (e.g., work, partner relationship, etc.)
- Awareness of cultural differences—variety of cultural practices and attitudes towards pregnancy and postpartum

What about severe patients?

Higher level of care—who are these patients?

- PHQ or GAD scores greater than 19
- Patients who are not showing improvement despite careful monitoring and treatment adjustments
- Patients who are struggling to function
  - Can’t care for self
  - Can’t care for child(ren)
- Patients with safety risks/concerns
  - Active safety concerns: Active suicidal ideation
  - Severe substance use disorders
  - Active psychosis-like delusions or mania
  - Significant developmental disabilities
  - Personality disorders requiring long-term specialty care
- Patients with complex diagnoses and unstable symptomology
  - PTSD/personality disorder
  - Bipolar I – mania in past
  - Schizophrenia, schizoaffective disorder

Acute safety concerns: suicidal ideation

Suicidal ideation is a common symptom of depression

- PHQ-9, Question 9: Thoughts that you would be better off dead or of hurting yourself in some way?
- EDPS, Question 10/J: The thought of harming myself has occurred to me

Important to discern when immediate intervention is needed

- Positive responses on these questions require further acuity assessment
- A workflow for suicidal ideation should be built into any Collaborative Care model as well as a policy that all practice staff are familiar with

NOTE: a suicide prevention protocol is a required component of the CoCM initiative with BCBSM

Higher level of care

- May be transferred to a community psychiatrist, if available
- May be eligible for Community Mental Health
- May be referred to PHP, IOP, or inpatient psychiatric hospital, with higher level of care arranged as follow-up (psychiatrist in the community)

Symptomatology, screening, and assessment

A brief review of possible presentations

Learning Objectives

1) Identify symptoms/syndromes of perinatal/postpartum pre-existing and new onset mental health conditions.
2) Understand the impact of perinatal/postpartum mental health problems on obstetric, maternal and child outcomes.
3) Understand the importance of cultural humility and trauma-informed care in perinatal care.
4) Understand risk/resiliency factors for perinatal mental health and importance of patient-centered assessment (e.g., how to talk with patients about medications).

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

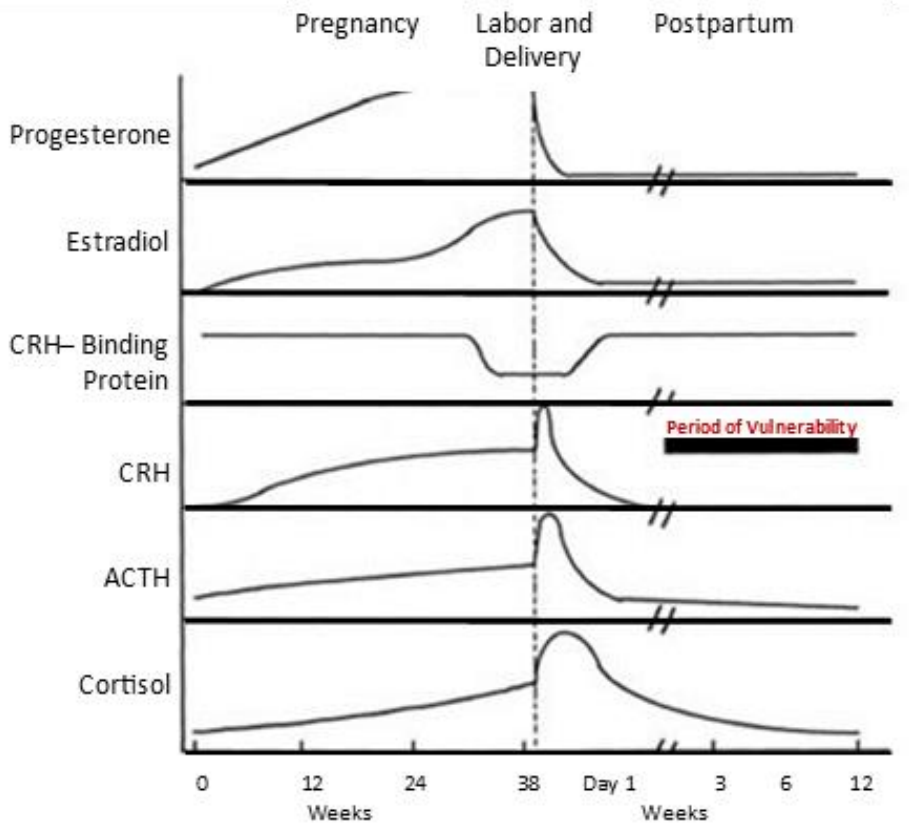


Figure 5. Hormonal changes and period of increased vulnerability to mood disorders and autoimmune phenomena during pregnancy and the postpartum period. The increasing levels of corticotrophin releasing hormone (CHR) in the last trimester, along with the decreasing levels of CRH binding protein, may participate 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 inclusion**
  - Score is approximately >10
  - Or if inclusion is clinically indicated
- **Regarding #9**
  - Further assess acuity of ideation to determine if CoCM is appropriate

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

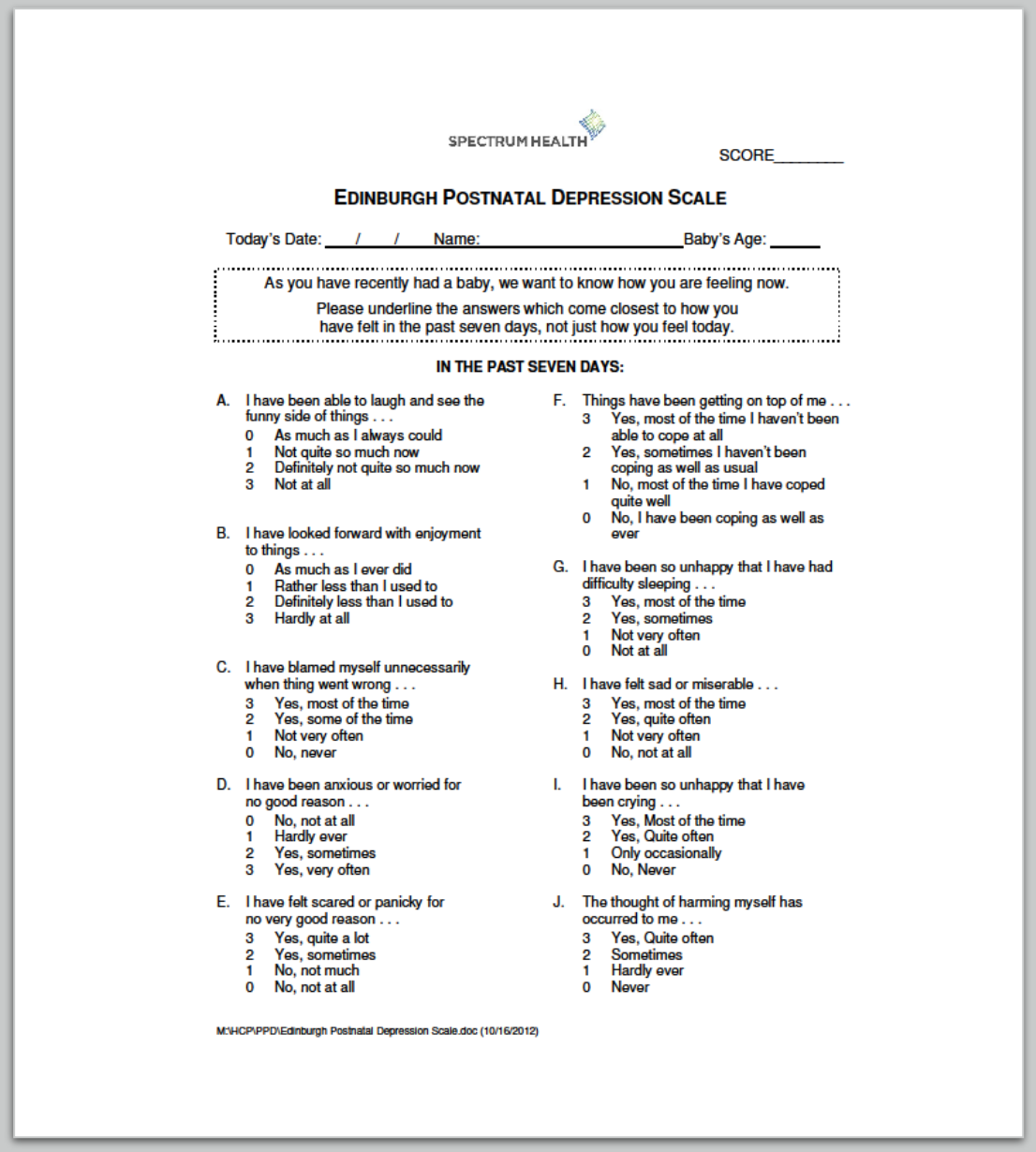
Scoring

>= 19 probable severe depression
>= 13 probable major depression
>= 10 probable minor depression

CoCM inclusion

EDPS score approximately 10–18

On #10/”J” – assess acuity further to determine CoCM inclusion



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)

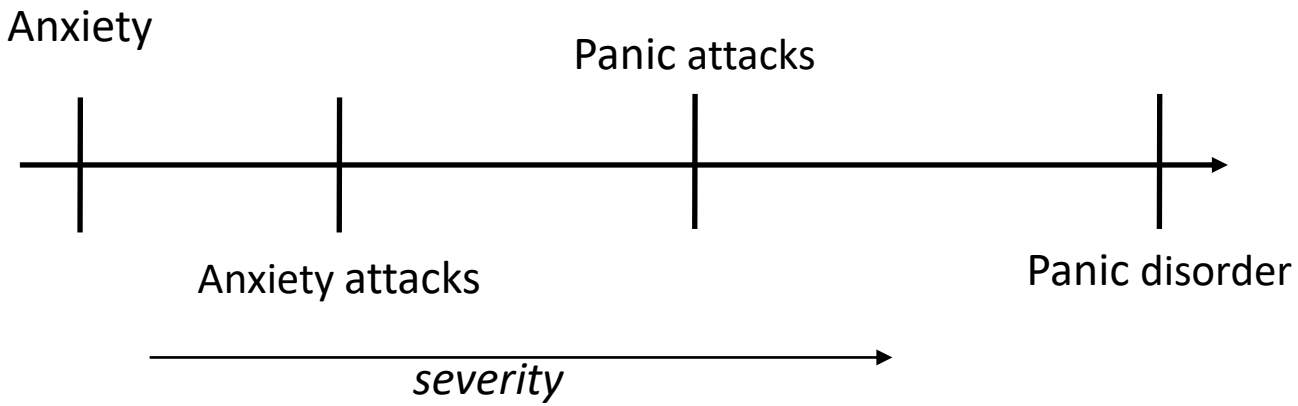
There is no formal DSM V designation for perinatal anxiety, but it is as common, or more common, than perinatal depression

Anxiety screening: GAD-7

- Scoring
  - 0–9 none/mild
  - 10–14 moderate
  - 15+ severe
- CoCM inclusion
  - Score is approximately >10
  - Or if inclusion is clinically indicated

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

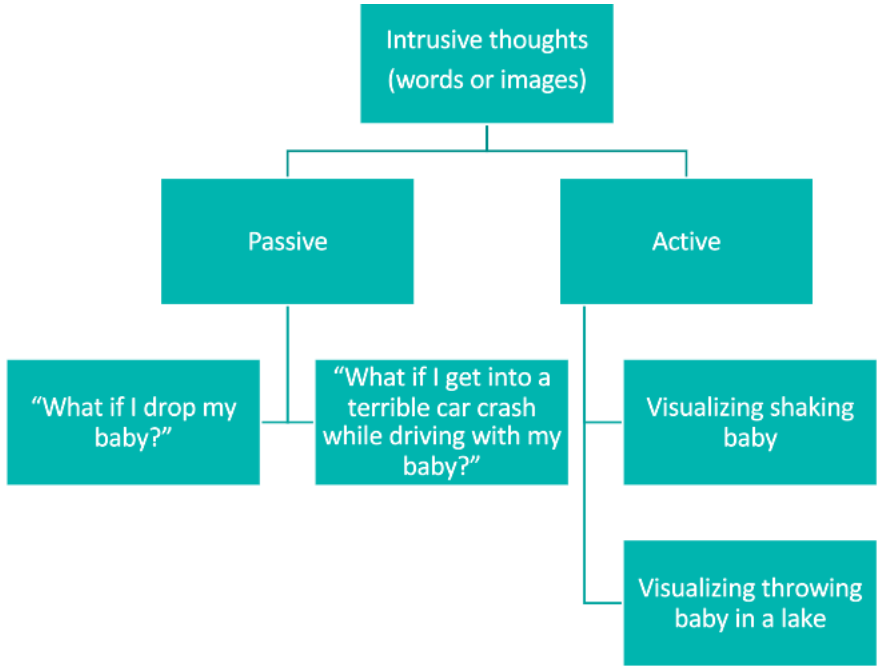
Anxiety and panic



- 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



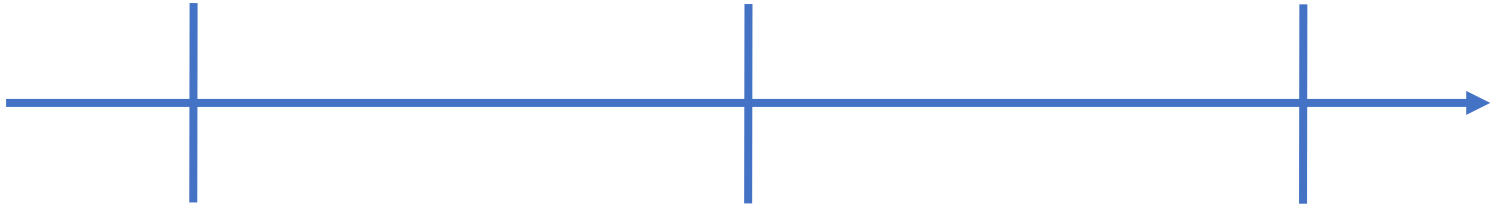
Intrusive thoughts and OCD

- 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

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 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.

Review questions

What is this patient's diagnosis?

A) Postpartum depression

B) Postpartum Obsessive-compulsive disorder (OCD)

C) Psychosis

D) Postpartum anxiety

E) Not enough information

What are next steps/is disposition?

A) Normalize patient's symptoms and tell her they will resolve on their own

B) Refer patient to mental health treatment (e.g., CMH)

C) Refer patient to CoCM

D) Send patient to the emergency room

Case #1, cont. : Lily

You meet with Lily a second time and she appears particularly anxious and tearful. After some time, she finally discloses to 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.

Questions:

What is this patient's diagnosis?

A) Postpartum depression

B) Obsessive-compulsive disorder (OCD)

C) Psychosis

D) Postpartum generalized anxiety

E) not enough information

What are next steps/is disposition?

A) Normalize patient's symptoms and tell her they will resolve on their own

B) Refer patient to mental health treatment (e.g., CMH)

C) Refer patient to CoCM

D) Send patient to the emergency room

Case #3: Angela

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.

Questions (as poll):

Is the patient's childhood trauma history important to her current mental health issue?

A) Yes

B) No

What is her diagnosis?

A) GAD

B) PTSD

C) Borderline personality disorder

D) MDD

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)

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)

Personality disorders

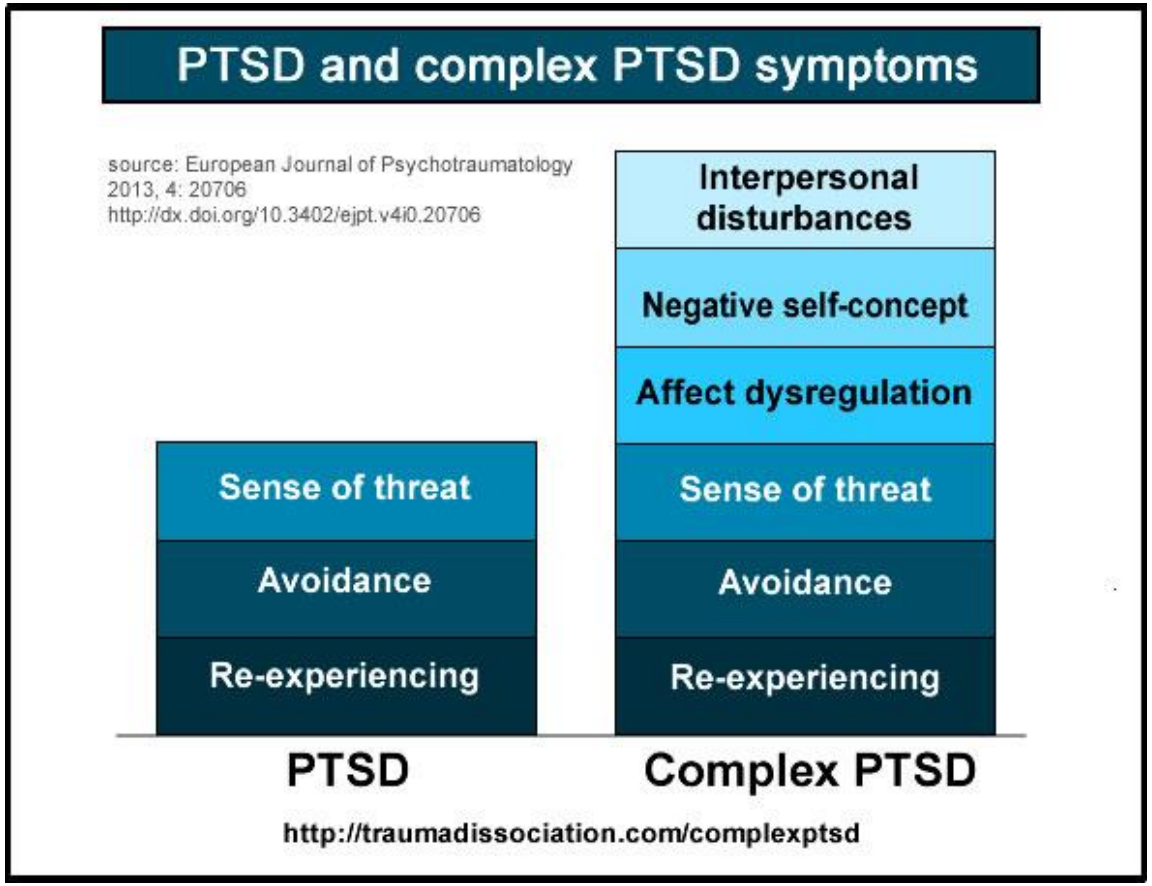
Most interfering with perinatal care: Borderline personality disorder

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 in 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”

Bipolar disorders

BOTH episodes of depression AND episodes of mania or hypomania

- Depression—as described before
- Mania/hypomania-periods of 3+ days of:
  - 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
  - MAY have psychotic symptoms (paranoia, delusions of grandeur, hallucinations)

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

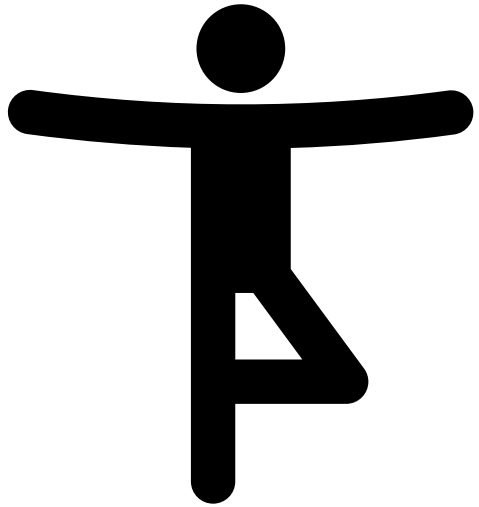
B) If she has ever felt like this before or has a history of mania/bipolar disorder

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

D) All of the above

Break

9:30 – 9:40 AM



For Psychiatric Consultants joining us:

- Please take a moment to ensure that your full name is reflected on screen
- Please review the housekeeping handout you received
- Your session will begin at 9:40 AM and end at 12:20 PM

Introducing our next presenter

Alyssa Stevenson, M.D.

Clinical Instructor
Department of Psychiatry
University of Michigan

Symptomatology, screening, and assessment, continued

A brief review of possible presentations

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.

Questions (poll/correct answer in bold):

What is this patient's diagnosis?

A) Postpartum depression

B) Obsessive-compulsive disorder (OCD)

C) Psychosis

D) Postpartum anxiety

E) Not enough information

What are next steps/is disposition?

A) Normalize patient's symptoms and tell her they will resolve on their own

B) Refer patient to mental health treatment (e.g., CMH)

C) Refer patient to CoCM

D) Send patient to the emergency room

Perinatal psychosis (usually 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 (send to ED)

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)

Review case #5: Naia

- Patient needs to be evaluated at an ED and needs admission
- Let patient know that you believe that she is quite ill and needs to be evaluated at the hospital
- Continue to reassure her that you are doing your best to help keep her safe
- IN PERSON: Fill out a petition, call an ambulance to take patient to ED
- REMOTELY: Encourage patient to present to ED; if she will not go, could have police do a welfare check

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

Case #6: Ashanti

Ashanti has her intake into the program when she is 8 months pregnant. She was late to getting prenatal care. She endorses symptoms of “mood swings” and states that she has a history of bipolar disorder. When asked about substance use, she pauses for a long time before answering, and finally states that she did abuse cocaine at one time but has discontinued in pregnancy.

Questions: (discussion)

How confident do you feel in Ashanti's diagnosis of bipolar disorder and why?

A) Confident, as this is what patient reported she was diagnosed with

B) Not confident, as substance intoxication can mimic manic symptoms, so a diagnosis of bipolar disorder may be incorrect if it was made during a period of substance abuse

What do you think are the chances that she is still using substances?

Do you discuss this further with her?

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

Risky behaviors: pregnancy and addiction

- Risky behaviors undertaken to support habit:
  - Prostitution
  - Theft
  - Violence

Such activities expose women to sexually transmitted infections, becoming victims of violence, and legal consequences, including loss of child custody, criminal proceedings, or incarceration.

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					

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

Substance Use

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**

Why is it important to treat mental health conditions in the perinatal period?

A mother's mental health throughout the perinatal period has the potential for long-term consequences

Learning Objective

1. Discuss the cost/benefit analysis of medication during perinatal/post-partum

Risks of untreated mental health disorders on obstetric, neonatal outcomes

- Inadequate weight gain
- Risk for preeclampsia
- Pre-term birth (PTB)
- Low birth weight (LBW)
- Small for gestational age (SGA)
- Increased uterine artery resistance
- Elevated maternal prenatal cortisol and neonatal cortisol

PTSD in pregnancy interferes with healthy pregnancy

Associated Complications	PTSD n=455	Control n=638	p*	Adjusted odds ratio**
Ectopic	10%	6%	.008	1.7
Miscarriage	16%	9%	<.001	1.9
Excessive vomiting	9%	2%	<.001	3.9
Preterm contractions	30%	23%	.004	1.4
Fetal growth impact	17%	11%	.007	1.5

** Significant after Bonferroni correction*

*** Adjusting for age, ethnicity, victimization, and drug use during pregnancy.*

*** All variables significant at p<.001.*

Seng et al., 2001

PTSD in postpartum interferes with healthy bonding and adaptation

- More likely to have co-morbid depression
- Higher likelihood for relapse with substance use, even if mother in recovery during pregnancy
- Less likely to breastfeed
- PTSD interferes with infant bonding
  - Particularly if the baby is a trigger (traumatic childbirth or perinatal loss)
- PTSD interferes with positive parenting
  - More intrusive or avoidant
  - Less warmth and sensitivity

Impact of mental health disorders on child and maternal outcomes

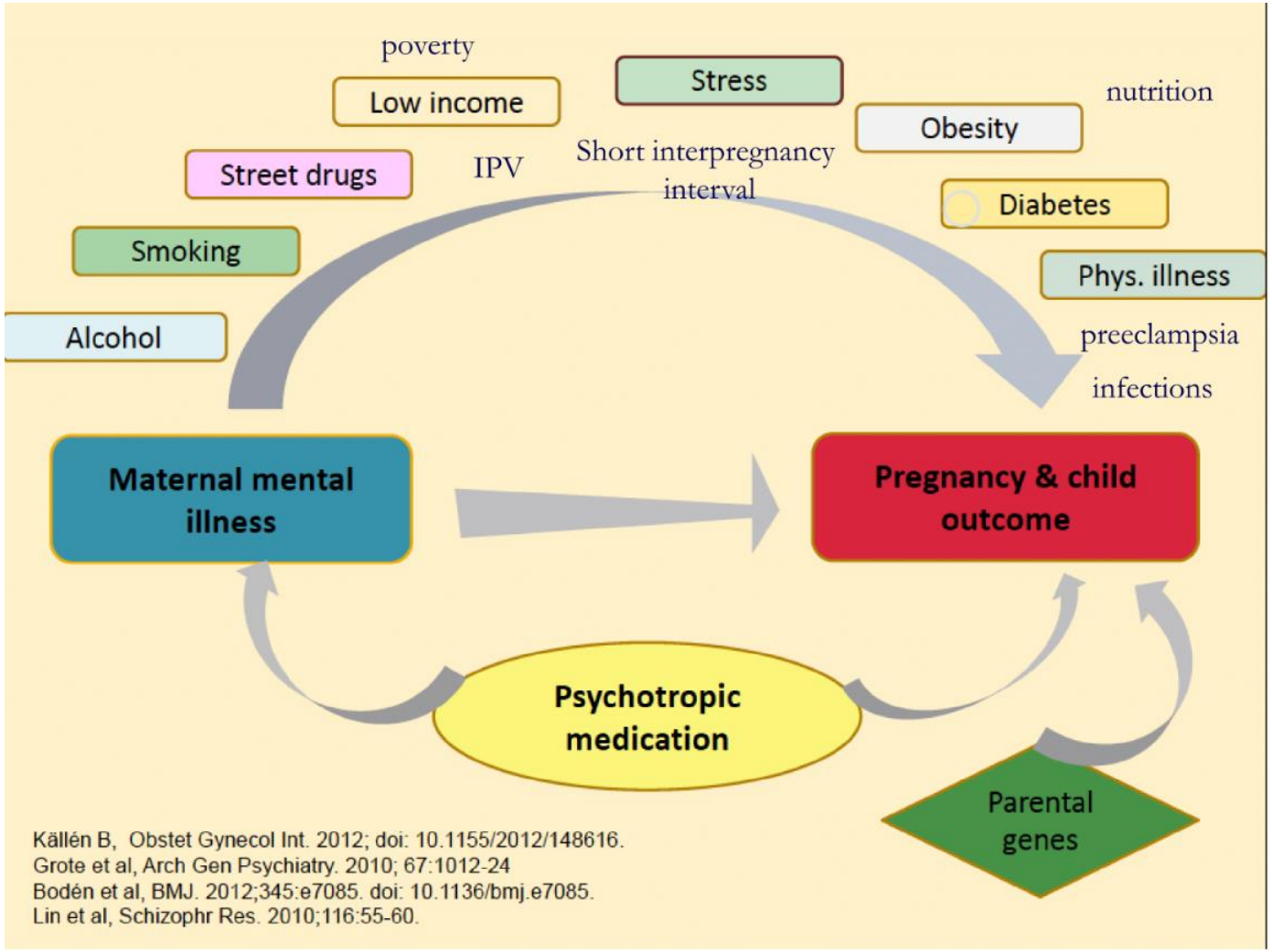
- Difficult infant temperament
- Increased risk for later child behavior problems
- Negative effects on child cognition
- Impaired mother-infant interaction
- Decreased rates of breastfeeding

Does maternal perinatal depression have negative impact on the child?

Yes, but…..effect is moderated by:

- Poverty
- Social isolation
- Mom’s young age
- Infant boys more vulnerable
- Mother’s depression severity & chronicity
- Comorbidity with other MH problems
- Trauma exposure
- Parenting support

Impact on the pregnancy and child is shaped by many factors



Essential knowledge for the treatment of perinatal mental health disorders

Learning Objectives

1) Understand the risk-risk analysis of using psychotropic medications in the perinatal period
2) Understand how to talk to patients about medications
3) Understand challenges of the collaborative care model

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

Common patient misconceptions about medications

- Addiction
  - Most psychotropic medications are not addictive or habit forming
- Have to be on it forever
  - Patients who have mild illness and/or no history of mental health problems are often able to eventually discontinue a medication
- Have to “rely” on a medication
  - Mental health is an illness like any other, so it is reasonable to use a medication to treat it (i.e., you would not decline insulin for diabetes)

Common patient misconceptions about medications

- “Selfish” to take a medication due to potential harm to baby
  - Having untreated depression/anxiety poses risks to baby
- The medication will make me feel numb/not myself
  - While this is a potential side effect, it is not common, and we want to hear about any side effect you experience so that we can make adjustments if needed

Challenges of the collaborative care model for providers

- Discomfort with prescribing recommended medication? Bottom line:
  - There is no risk-free zone—untreated illness also has consequences
  - Most psychotropic medications are safe in pregnancy and when breastfeeding
  - "Fetal/infant exposure always occurs, be it to treatment or to illness"—Zack Stowe, personal quote, 2001
  - **Of note:** 50% of pregnancies are unplanned, thus early exposure has often already occurred
- Treatment decision must be evaluated individually, considering:
  - Current symptoms
  - Past treatment history and course of illness
  - Personal and family considerations
  - Access to reliable alternatives such as therapy, self-care, stress reduction, support
  - Of note: one size does not fit all
- The consulting psychiatrist is here to support your decision making
  - However, at the end you are the prescriber and make the decision based on your assessment weighing all the pros and cons

You have two (or more) patients

- Treatment potentially **benefits** both the mother and fetus/child
- Failure to treat poses **potential risks** to both the mother and fetus/child

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

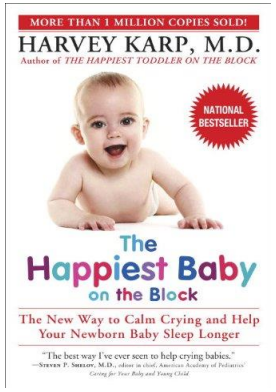
- Cost-benefit analysis
  - Sensitive, non-judgmental discussion with patient is essential
  - Fed is best
  - Remember that how and what you say to patients about this issue will deeply impact them

The fussy baby

Maternal depression rates are higher in mothers of babies with colic, even months after the colic/crying subsides

Approach:

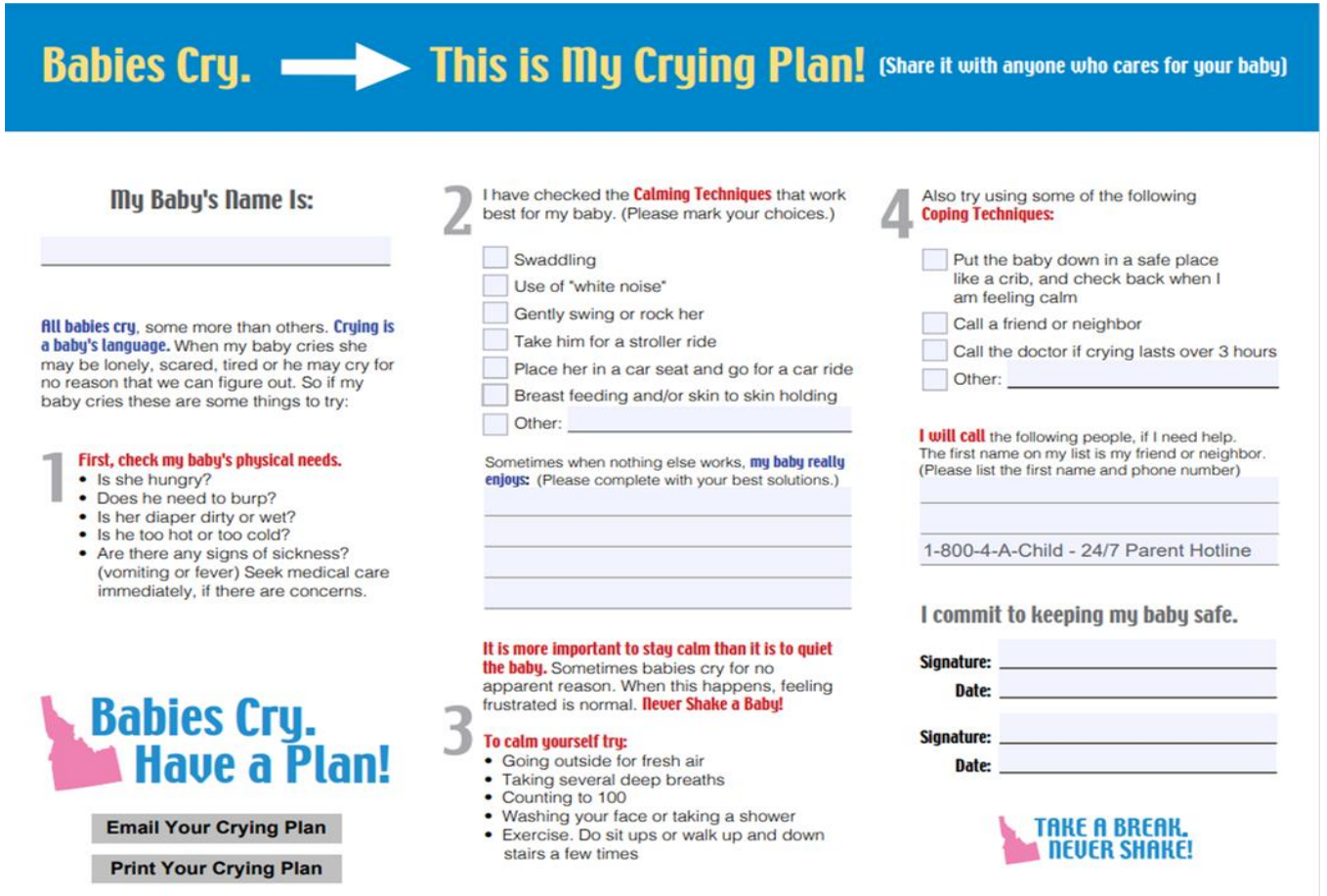
- Happiest Baby on the Block (re-working cognitive distortions)
- 5 S's
- Also, purple crying acronym



The fussy baby

Approach

- Distress tolerance/taking a break
  - Crying plan



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!

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
- Overall—teratogenicity risk for SSRI/SNRI/TCA , ***if at all***, low
- 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"

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

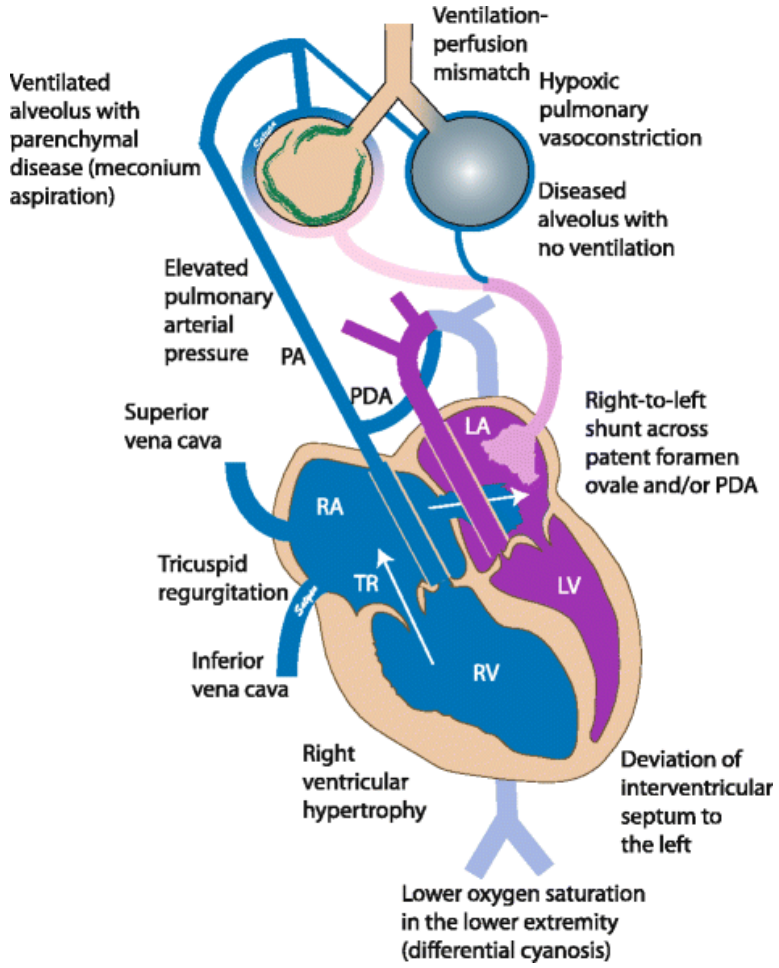
- Low birth weight
  - Effect is minimal (< 75g/2.6 oz.) and disappears when control group are untreated depressed mothers

Neonatal adaptation syndrome (NAS)

- Withdrawal/discontinuation syndrome
  - Tremors, irritability, sleep disturbance, poor muscle tone
  - Respiratory distress/seizures (in severe cases)
  - Usually does not require intervention
- Per the literature, this is reported in up to 30% of infants exposed to antidepressant exposure 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)

- Abnormal flow 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
- Autism?
  - 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

What about the safety in pregnancy of other classes of medications?

- Benzodiazepines
  - Can be safe in small doses (avoid Alprazolam)
  - Consider short-term benzodiazepine as a bridge until SSRI is working
- Mood stabilizers
  - Lamictal is very safe
  - Lithium has some limited risks; can be used carefully when there are no good alternatives
  - Depakote and carbamazepine are not safe
- Antipsychotics
  - Second generation antipsychotics are safer than first generation
    - Olanzapine and quetiapine have best safety data, aripiprazole too
- Stimulants
  - Fairly safe—only use if patient unable to function without them and there are no safer treatment alternatives

Safety of medications in breastfeeding

- Most medications are excreted in very small amounts in breastmilk (less than 10% of dose mom is taking)
- Most psychotropic medications (antidepressants, antipsychotics, benzodiazepines) are safe in breastfeeding (short and long term)
  - Mood stabilizers are more complicated
- There is no evidence to support the practice of “pumping and dumping”
- Stimulants may decrease breastmilk supply
- Medications with antihistamine properties may decrease breastmilk supply
  - Benadryl, hydroxyzine

Risk-risk discussion

Risk of untreated illness

Risk of treatment

NO RISK-FREE ZONE!!!

Perinatal psychopharmacology overview

Learning Objective

1) Understand the use of psychotropic medications in the perinatal period

Medications for depression/anxiety

- SSRIs (Selective Serotonin Reuptake Inhibitors)
  - Sertraline (Zoloft)
  - Citalopram (Celexa)
  - Escitalopram (Lexapro)
  - Paroxetine (Paxil)
  - Fluoxetine (Prozac)
- SNRIs (Serotonin–Norepinephrine Reuptake Inhibitors)
  - Duloxetine (Cymbalta)
  - Venlafaxine (Effexor)
  - Desvenlafaxine (Pristiq)

Medications for depression/anxiety

- Bupropion (Wellbutrin)
- Mirtazepine (Remeron)
- Vortioxetine (Trintellix)
- TCAs (Tricyclic antidepressants)—3rd Line—only consider after failing multiple SSRIs/SNRIs
- MAOIs (Monoamine oxidase inhibitors)—4th Line—rarely used)

Generic (Trade)	S: start dose(mg), T: target dose(mg/day)	Titration Schedule	N: Notes; S: side effects; R: risks	P: pregnancy data; L: lactation data
Fluoxetine (Prozac)	S: 10, T: 20-60	10mg q 2 weeks	N: long half-life—self tapering; S: can be activating	L: likely greater amount in breast milk (10%) although this does not correlate with harmful effects
Sertraline (Zoloft)	S: 25-50, T: 100-200	25-50mg q 2 weeks	S: can be activating or sedating or cause emotional numbing; more GI effects than others	L: negligible amounts transmitted into breast milk (<1%)
Escitalopram (Lexapro)	S: 5, T: 10-20	5-10mg q 2 weeks	N: quite well tolerated	
Citalopram (Celexa)	S: 10, T: 20-60	10mg q 2 weeks	S: due to warnings about inc. Qtc, may consider getting EKG at doses above 40mg	
Mirtazapine (Remeron)	S: 7.5, T: 15-45	7.5mg q 2 weeks	N: causes sedation and increased appetite—helpful for anxious/depressed patients with insomnia who are not eating; S: weight gain	
Duloxetine (Cymbalta)	S: 30, T: 60-120	30mg q 2 weeks	N: helpful for chronic/neuropathic pain	P/L: less data than SSRI's but no significant documented risks—use second line
Venlafaxine (Effexor, Effexor XR)	S: 75, T: 150-300	XR: 75mg q 2 weeks Non XR: 37.5mg q 2 weeks	S: may cause hypertension, XR less likely to cause withdrawal when tapered	P/L: less data available than SSRI's, with no significant documented risks
Bupropion (Wellbutrin SR, Wellbutrin XL, Zyban)	S: 150, T: 150-450, SR BID dosing	150mg q 2 weeks	N: activating properties help with low energy/motivation/lack of focus. Can be used alone or to augment SSRI/SNRI; S: can increase anxiety and lowers seizure threshold	P: Not to exceed 450 mg (seizure risk), greater concern for seizure in those with a history of seizure or those engaging in purging behaviors. Helpful for smoking cessation in pregnancy. May help ADHD and other addictive disorders, such as overeating in pregnancy.
Paroxetine (Paxil, Paxil CR)	S: 10, T: 20-40 CR: 25	10mg q 2 weeks CR: 12.5 mg q 2 weeks	S: can be sedating, cause withdrawal effects due to short half life, CR form less likely to cause withdrawal when tapered	P: Older data demonstrated potential for a 1.5- to 2.0-fold increase risk in cardiovascular malformations, leading to a 2005 warning. Recent data show no consistent information to support teratogenic risks.

Medications for mood disorders/bipolar

- Lithium
- Antiepileptics
- Antipsychotics—second generation

Generic (Trade)	S: start dose(mg), T: target dose(mg/day)	Titration Schedule	N: Notes; S: side effects; R: risks	P: pregnancy data; L: lactation data
Lithium (Eskalith, Lithobid)	S: 150-300, T: 900-1200, blood level 0.6-1.2 mEq/L	150-300mg q 3-7 days	N: narrow therapeutic window; S: thyroid malfunction, toxicity with NSAID's, GI upset	P: small increase cardiac malformations (1.15 % vs 1.9%), need to carefully monitor levels during pregnancy, delivery due to shifts in blood volume; L: high rate of excretion into breastmilk; breastfeeding not recommended or if mom wants to BF need to monitor carefully baby for tox effects (sedation, feeding problems, lethargy, seizures) and measure blood levels
Valproic acid (Depakote, Depakene) **DO NOT PRESCRIBE TO WOMEN OF CHILDBEARING AGE**	S: 250-500, T: 500-1000, blood level 50-120 mg/L	250-500mg q 3-4 days	S: weight gain, hair loss; R: hepatitis, pancreatitis	P: risk of neural tube defects 10% esp in 1st trimester (as well as facial and cardiac abnormalities), IUGR, mental retardation, neonatal toxicity, not recommended; L: theoretical risk infant hepatotoxicity /thromobocytopenia
Carbamazepine (Tegretol) **DO NOT PRESCRIBE IN PREGNANCY/BF MOTHERS**	S: 100mg, T: 300-1200	100mg q 5-7 days	S: glaucoma; R: Stevens–Johnson syndrome, agranulocytosis	P: risk of defects 6% (neural tube, craniofacial), risk fetal vitamin K deficiency/bleeding, IUGR, neonatal toxicity; L: high levels in breastmilk-need to monitor baby's bloodwork
Lamotrigine (Lamictal) regarded as first choice for mood stabilization, esp for bipolar depression	S: 25, T: 200 (as 100mg bid)	25mg/day x 2wks, then 50mg/day x 2 weeks, then 100mg/day x 2 weeks, then 100mg bid	R: Stevens–Johnson syndrome	P: no increased risk of malformation, some risk for neonatal toxicity (rare); L: infant levels are 30% of mom's dose; theoretical risk of SJS but no cases reported; not absolute contraindication for BF
Topiramate (Topamax)	S: 25-50, T: 50-400	25-50mg q 3-7 days	S: sedating; R: increased ammonia, metabolic acidosis, glaucoma, kidney stones	P: some reports of increased risk of cleft palate, low birth weight; L: small case series showed no adverse effects

Generic (Trade)	S: start dose(mg), T: target dose(mg/day)	Titration Schedule	N: Notes; S: side effects; R: risks	P: pregnancy data; L: lactation data
Risperidone (Risperdal)	S: 0.5-1, T: 1-6	0.5-1mg q 3-5 days	S: ↑prolactin, ↑metabolic risk	
Aripiprazole (Abilify)	S: 1, T: 2-15	1-5mg q 3-5 days	S: akathisia	L: may decrease breastmilk supply
Ziprasidone (Geodon)	S: 20 QD, T: 20 BID - 60 BID	20mg BID q 3-5 days	N: relatively weight neutral; S: ↑Qtc	
Quetiapine (Seroquel)	S: 12.5-25, T: 12.5-300	12.5-50mg q 3-5 days	N: may use in small doses as PRN for anxiety (ie 12.5mg TID PRN), moderate doses for sleep aid (25-50mg), higher doses for mood stabilization (100-300mg); S: sedation, weight gain	P: has lots of safety data; best risk/benefit ratio
Olanzapine (Zyprexa)	S: 2.5, T: 2.5-10	2.5-5mg q 3-5 days	S: ↑metabolic risk, sedation	P: has most safety data
Paliperidone (Invega)	S: 1, T: 3-9	1-2mg q 3-5 days	S: ↑prolactin	
Lurasidone (Latuda)	S: 20, T: 40-120	20mg q 3-5 days	N: must be taken with at least 350cal meal; S: some sedation	
General safety data/Reference	Antipsychotics have been shown to confer no increased risk of congenital malformations to babies exposed to them in utero, with the exception of risperidone, which seemed to confer some increased risk of overall and cardiac malformations (RR 1.26) (Huybrechts KF, Hernández-Díaz S, Patorno E, et al. Antipsychotic Use in Pregnancy and the Risk for Congenital Malformations. JAMA Psychiatry. 2016;73(9):938–946). Less data is available on the effect of these medications on potential pregnancy complications.			

Medications for anxiety/sleep

- Benzodiazepines
- Trazodone (Desyrel)
- Gabapentin (Neurontin)
- Zolpidem (Ambien)

Generic (Trade)	S: start dose(mg), M: maximum dose(mg/day)	Frequency	N: Notes; S: side effects; R: risks	P: pregnancy data; L: lactation data
Alprazolam (Xanax) DO NOT USE	S: 0.25-0.5, M: 1 TID		N: recommend not to use this short acting medication due to increased risk of rebound anxiety and tolerance/addiction	P: avoid in first TM to prevent potential for malformation (risk less than 0.7%), and use low dose in late pregnancy or BF . (risk with high doses near time of delivery--floppy baby syndrome and infant sedation) L: ok in small doses, in high doses risk infant sedation
Lorazepam (Ativan)	S: 0.25-0.5, M: 1 TID	May take up to 3x/day; prefer standing dosing over PRN	N: highly effective, especially upon initiation of SSRI, for anxiety and for rumination	same as above
Clonazepam (Klonopin)	S: 0.25-0.5, M: 1 TID	May take up to 3x/day; prefer standing dosing over PRN	N: longer acting than Ativan-may provide better coverage for consistently highly anxious patients; Highly effective, especially upon initiation of SSRI, for anxiety and for rumination	same as above
Zolpidem (Ambien)	S: 5, M: 10	Bedtime	N: patient may sleep walk Rapid onset of action	P: limited data, but so far no evidence for increased risk of malformation; L: OK in small doses as low transfer to BM
Gabapentin (Neurontin)	S: 100, M: 900 TID	May take up to 3x/day, PRN	N: good option for patient with history of substance abuse; S: few to no side effects	P: limited data but so far no evidence for increased risk of malformation;

Break

11:10 AM – 11:20 AM

Behavioral Health Care Managers:

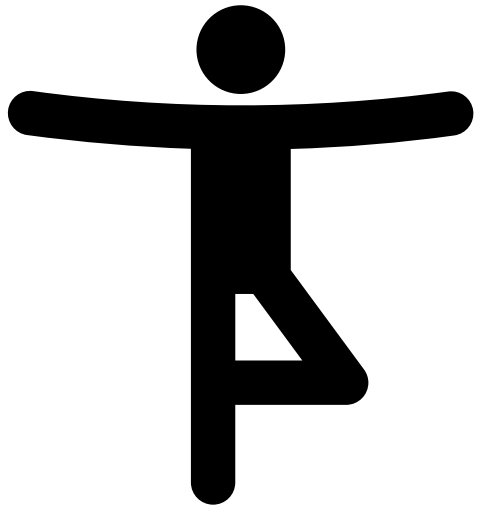
- This concludes your training for today
- Please complete the evaluation

Medical Providers:

- This concludes your required training
- You are welcome to remain for the final hour tailored for PCs if you'd like
- Please complete the evaluation

Psychiatric Consultants:

- We will resume at 11:20 AM for the final hour of your required training



Introducing our final presenter

Mahela Ashraf, MD

Clinical Instructor
Department of Psychiatry
University of Michigan

Psychotropic medication management in the perinatal period

Meds 101

- Golden Rule
- **Start low, go slow, keep going**
  - Takes 6 weeks to effect but should see something in 2–4 weeks

Most commonly-used medicines in CoCM:

- Depression/SSRI: sertraline and escitalopram
- Anxiety: lorazepam & clonazepam (or quetiapine & gabapentin)
- Sleep: trazodone, doxylamine (Unisom), quetiapine

Review: perinatal approach to treatment

- Assessing 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”)

Talking to patients about taking medications in the perinatal period

- “Is it OK if I share some information with you about the safety of taking medications in pregnancy and breastfeeding?”
- “It is important to know that there are also risks to having untreated or undertreated depression/anxiety in the perinatal period.”
- “The postpartum period can be very challenging. I want to make sure you are in the best place possible mentally to cope with those challenges.”

Talking to patients about taking medications in the perinatal period

- “The risks associated with taking medications in pregnancy are similar to those of having untreated mental illness. The exception is poor neonatal adaptation syndrome which is rare, usually mild, and has no long-term impact on the child.”
- “You have the final say in all decisions regarding whether you take medications during this time. I will respect and support your decision.”
- “If I feel that your symptoms are severe or not getting better without medication, I may remind you that medication is an option.”

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

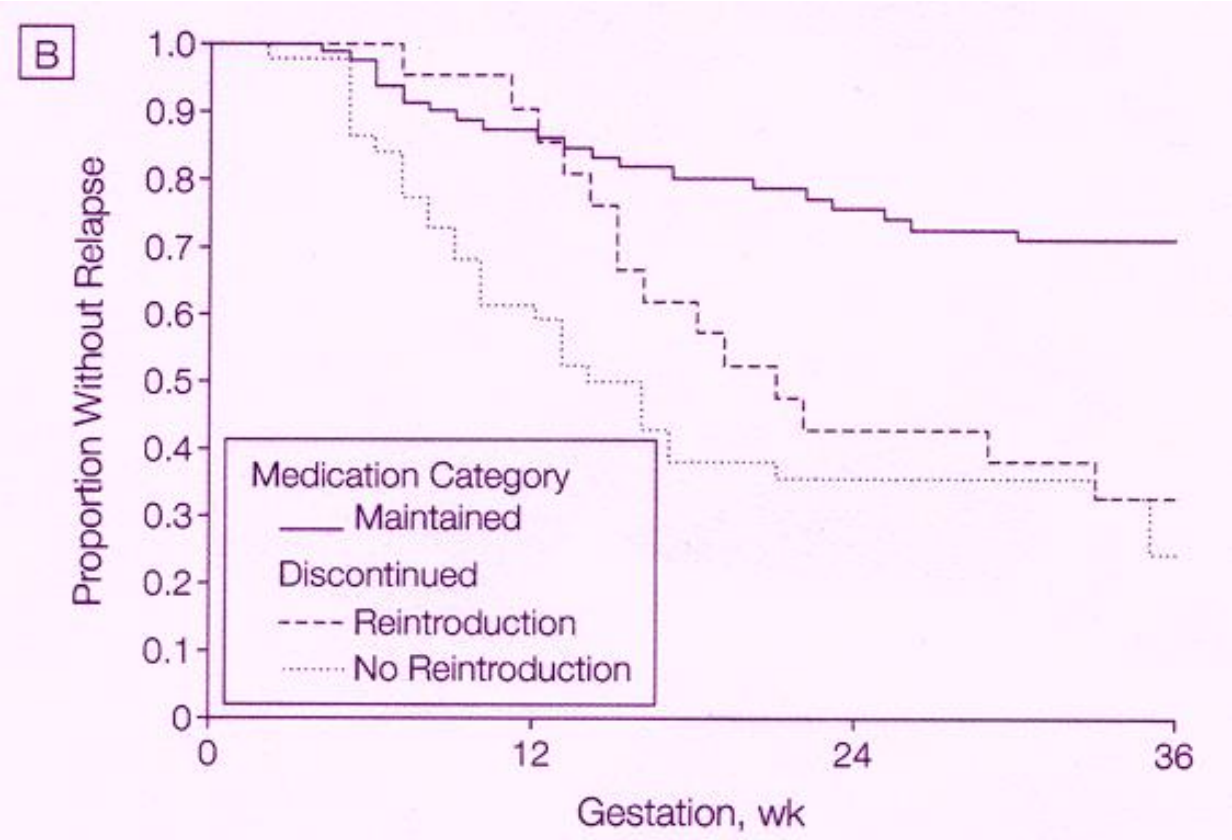
Risk of untreated illness

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

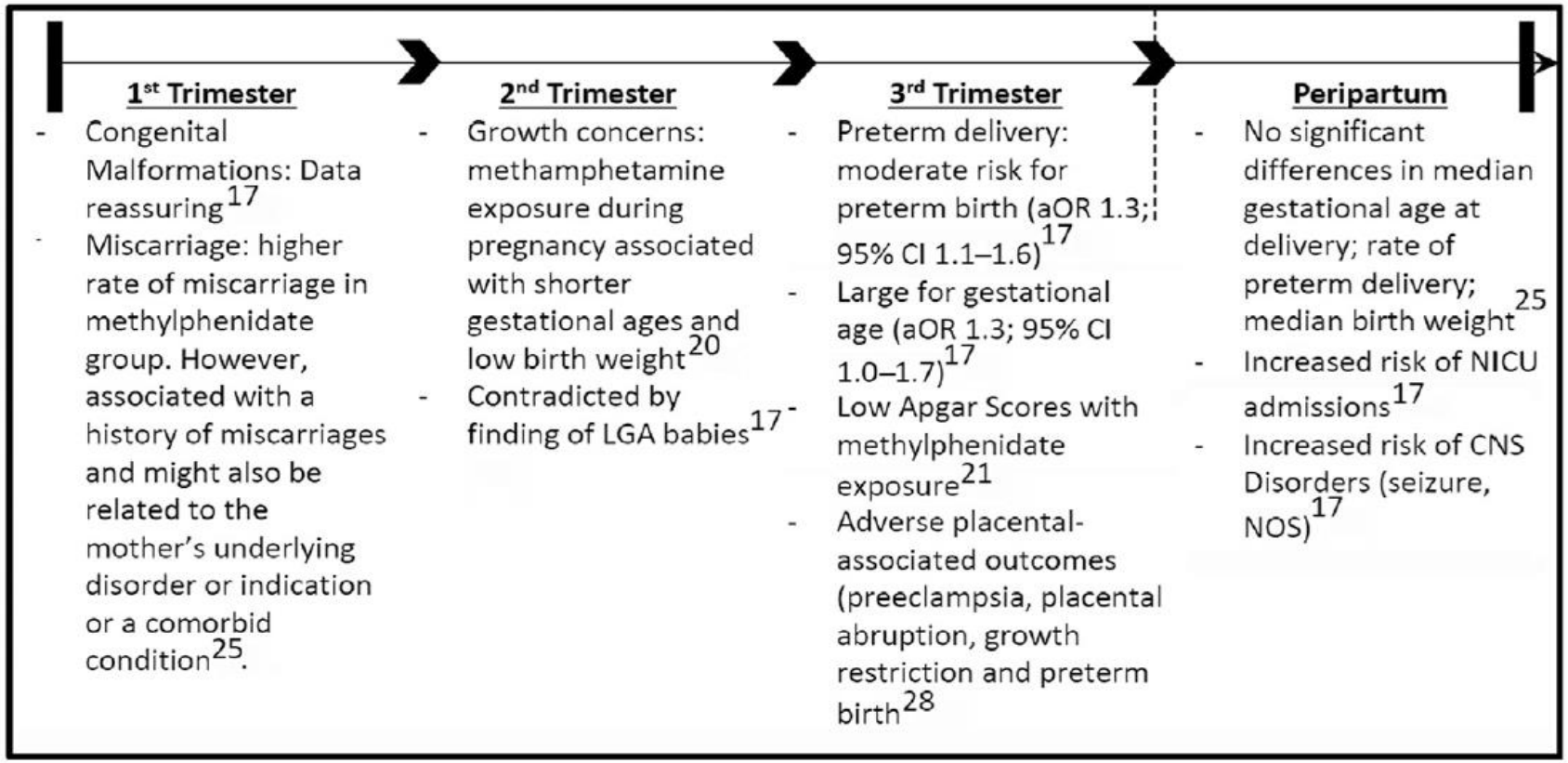
Breastfeeding

- 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

Building confidence in the medical management of perinatal mental health

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

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 recommend referral to higher levels of care while in the program
  - Local psychiatrist
  - Health provider
  - Inpatient admission
- 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

- There is sometimes an element of “liaison” work involved in collaborative care which can be uncomfortable for providers
- Some providers may be less comfortable prescribing medications
- Further conversation is recommended to address this issue
  - Phone calls are helpful if possible
  - Great opportunity for educating providers

Systematic case review: examples and practice

Patient #1

32-year-old woman who is 20 weeks pregnant with a 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, she has titrated up to 10mg and has been on 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

Question

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 requests consent to reach out to this patient's primary care provider so that care can be coordinated, and one prescriber be identified for medication management 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.

Question

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.

Question

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

Question

What medication do you prescribe this patient?

A) Lexapro

B) Seroquel

C) Lamictal

D) Abilify

Question

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

Any questions?

Reminder

- The slide deck will be available within a week on the MICMT website

  LINK: https://micmt-cares.org/training/collaborative-care-model/perinatal

- A recording of this presentation is available upon request. Please contact MCCIST.

Thank You!

Contact Us

The training partners at MCCIST remain available to answer any questions you may have.

MCCIST-Inquiries@umich.edu