Management and Treatment of Mental Health Presentations in *Pregnancy and Postpartum*

Part II: Rural Maternal Mental Health Training

CHI Health

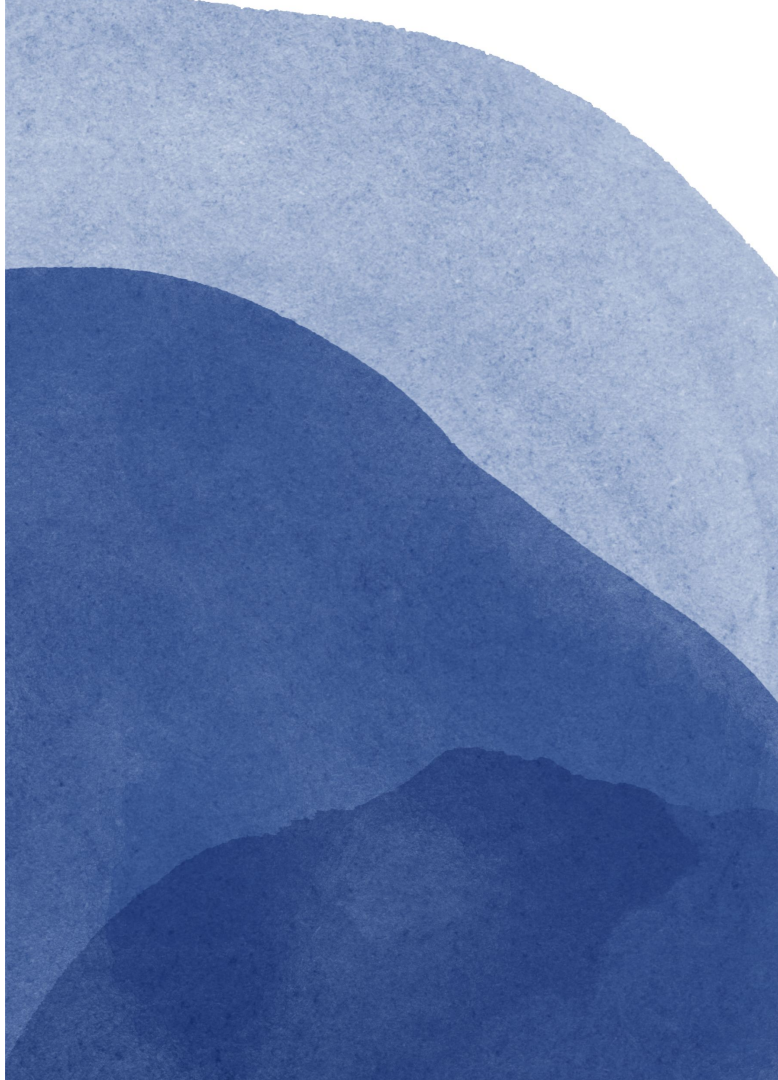
Nebraska Perinatal Quality Improvement Collaborative NPQIC

JOINTLY ACCREDITED PROVIDER™ INTERPROFESSIONAL CONTINUING EDUCATION

MOLINA® HEALTHCARE

Yale SCHOOL OF MEDICINE

Yale NewHaven Health Yale New Haven Hospital



Logistics

- Please enter questions in the Q&A. There will be time reserved at the end for questions.
- For technical support, use Q&A or email Ashley Carroll at: Ashley.Carroll@CommonSpirit.org
- Chat has been enabled for this webinar.

Presenters

Ariadna Forray, MD,
Associate Professor of Psychiatry at Yale School of Medicine

Ken McCartney, MHAL,
Division Director for Behavioral Ambulatory Services at CHI Health Midwest Division

Yale SCHOOL OF MEDICINE

Yale NewHaven Health
Yale New Haven Hospital

Management and Treatment of Mental Health Presentations in Pregnancy and Postpartum

Ariadna Forray, MD
Associate Professor of Psychiatry
Chief, Section of Psychological Medicine
Yale School of Medicine

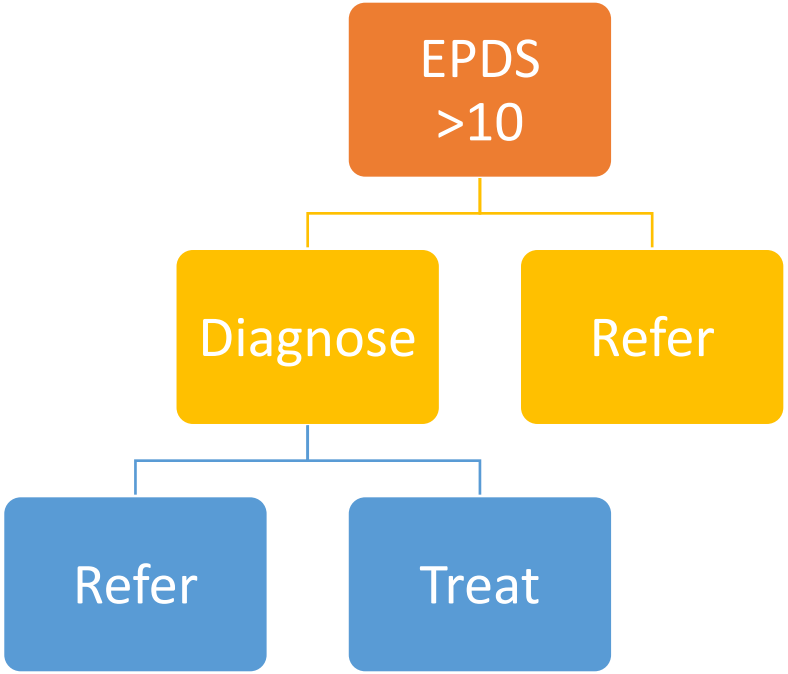
Learning Objectives

- Learn about the different treatment options for mental health disorders in the perinatal period
- Be comfortable developing an appropriate treatment plan, including the use of psychotropic medications for perinatal patients with depression or anxiety
- Awareness of psychiatric services available within your community/Nebraska
- Ability to submit a referral to a Psychiatric Provider as well as helpful documentation to support effective collaboration

Abbreviations:
SSRIs – Selective Serotonin Reuptake Inhibitor
SNRIs – Serotonin Norepinephrine Reuptake Inhibitors
SRIs – Serotonin Reuptake Inhibitors, both SSRIs and SNRIs

Treatment Considerations for Perinatal Individuals

You Screened for Depression - What next?



If suicidal refer to mental health professional

* If actively suicidal with plan send to ED *

Assessing Self-harm and Harm to Others

Asking specifically about thoughts of harm to baby or self

Normalizing this, asking in non-judgmental way

Checking to see if these thoughts are ego-syntonic or ego-dystonic

Are there other psychotic symptoms?

Assessment of Intrusive Thoughts

Anxiety/Depression/OCD

- Insight is preserved
- Thoughts are intrusive and scary
- No psychotic symptoms

Low risk

Postpartum Psychosis

- Poor insight
- Psychotic symptoms
- Delusional beliefs or distorted reality present

High risk

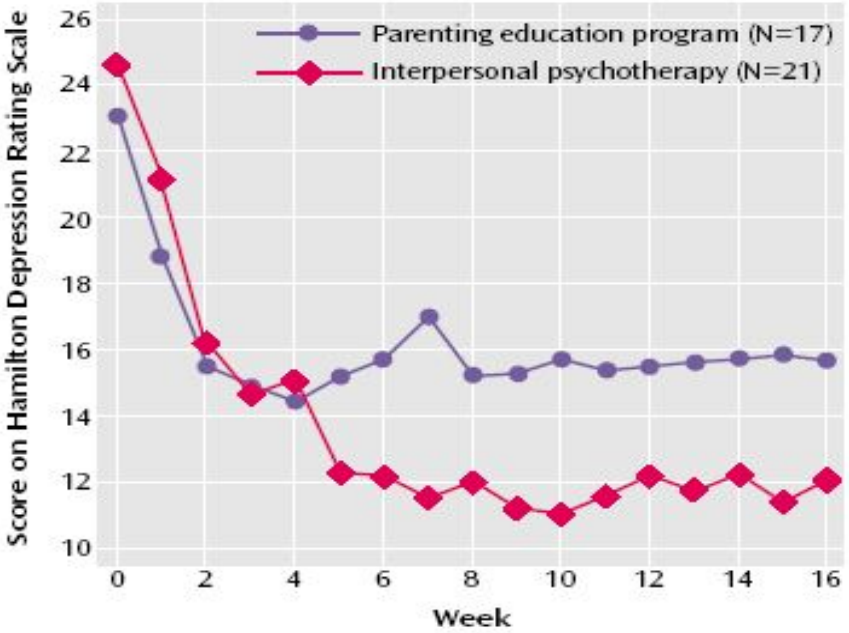
Are Medications Indicated?

- Mild depression
- No suicidal ideation
- Able to care for self/baby
- Engaged in psychotherapy
- Depression has improved with psychotherapy in the past
- Strong preference and access to psychotherapy

- Moderate/severe depression
- Suicidal ideation
- Difficulty functioning caring for self/baby
- History of severe depression and/or suicide ideation/attempts
- Comorbid anxiety
- Psychotic symptoms present

Non-pharmacologic Treatments

- Cognitive Behavior Therapy (CBT) and Interpersonal Psychotherapy are two evidence-based treatment that have been proven effective in treating perinatal depression



Spinelli and Endicott, Am J Psychiatry, 2003; 160:555-562

Other Non-pharmacological Interventions

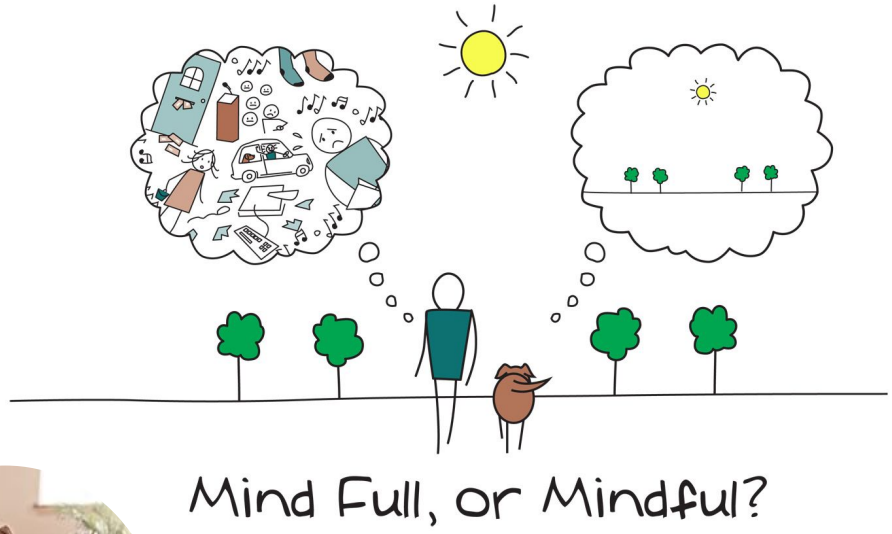
Meditation

Mindfulness

Progressive Muscle Relaxation

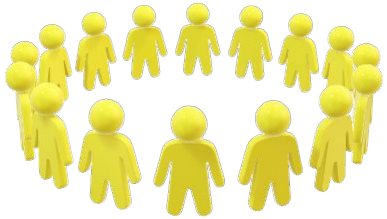
Yoga

Acupuncture



Other interventions

- Sleep hygiene, healthy diet, physical activity, behavioral activation (setting weekly and achievable goals for activities that improve mood)
- Community and social supports (family support, support groups)
- Support with financial stressors: WIC, diaper bank, and other available programs
- There are no major risks with non-pharmacologic treatments for depression in pregnancy



There is no such thing as non-exposure

Balance risks of psychopharmacologic treatment with risks of untreated mental illness on the fetus and infant

Context: Impact of Untreated Maternal Mental Illness

Maternal Impact

- Poor prenatal care
- Substance use
- Preeclampsia
- Maternal suicide
- Relationship discord

Infant Impact

- Low birthweight
- Preterm delivery
- Cognitive delays
- Behavioral problems
- Insecure attachment patterns
- Anxiety and depression
- ADHD and learning disabilities

Bodnar et al, J Clin Psych, 2009
Cripe et al, Pedi & Perinatal Epid, 2011

What Guides Prescribing?

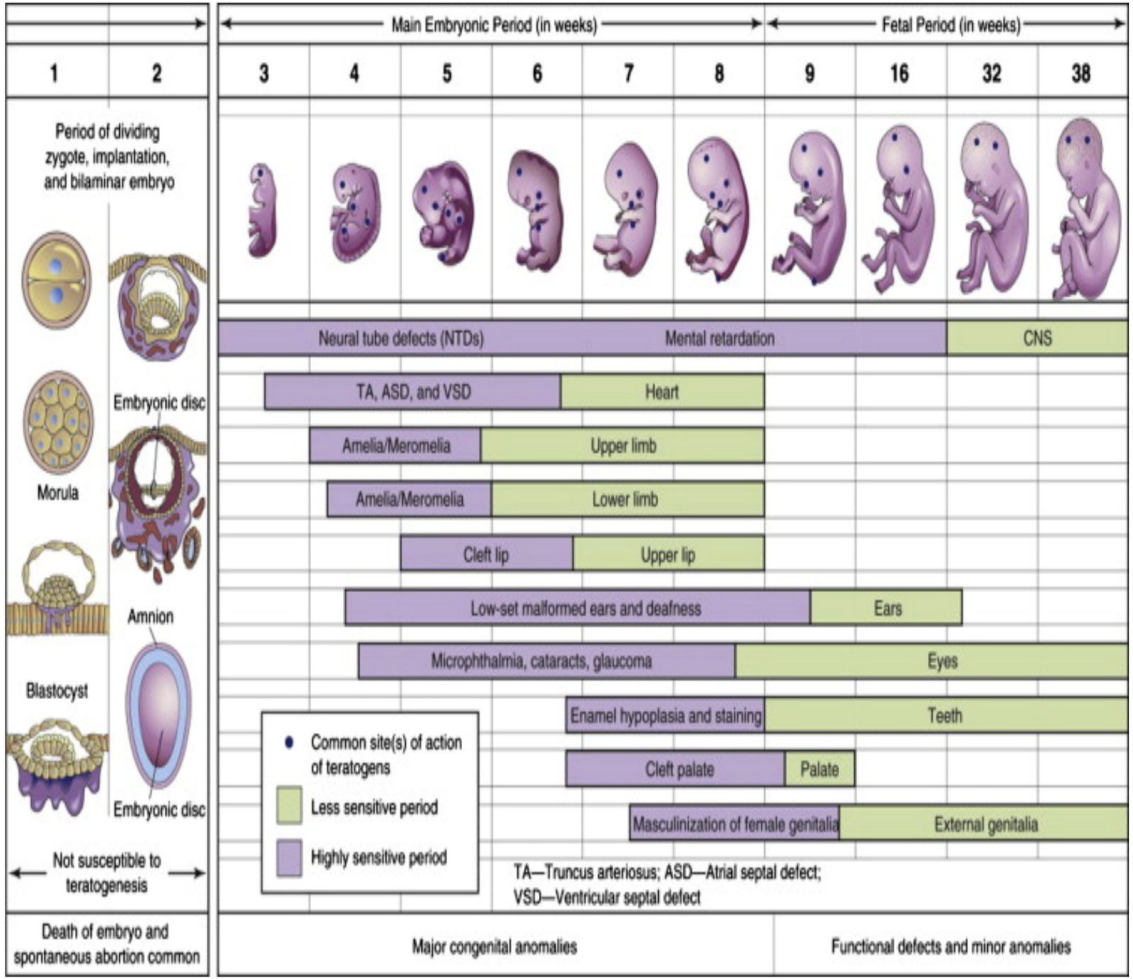
Patient preference

Severity of illness episodes

Previous response to treatments

Degree of recurrence of illness

Duration of current stability



Fetal and Neonatal Physiology (Fifth Edition), 2017

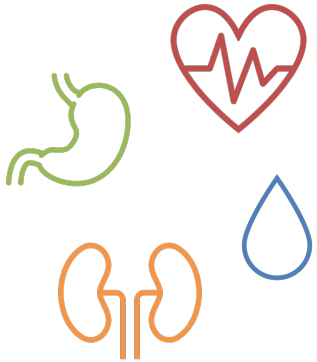
Yale NewHaven Health
Yale New Haven Hospital

Discontinuation of SSRI in Pregnancy

- 53% women discontinued SSRIs in pregnancy
- 57% of these women restarted meds
- Women who discontinued SSRI had higher anxiety and depression scores during pregnancy

Pregnancy Physiology

- Physiologic Changes
  - Slower gastric emptying and small bowel and colonic transit time
  - Increased plasma volume
  - Reduced plasma albumin concentration
  - Lower ratio of lean muscle to adipose tissue
  - Changes in the hepatic clearance of psychotropic medications
  - Increased renal blood flow with associated increase in GFR



- Monitor closely for symptomatic change throughout pregnancy

- Consider divided doses

Prescribing Considerations in Pregnancy

- Maximize non-pharmacologic interventions
- Lowest **effective** dose
- Avoid polypharmacy
- Patient-centered care
- Documentation
- Pregnancy physiology

Lactation Considerations

- Medications have higher excretion in breast milk if they:
  - High lipid solubility
  - Long half-life
  - High oral availability
  - Small molecular weight
  - Low maternal serum protein binding
- Medication half-life
- Infant medical stability

Preventing Decompensation in Women with Bipolar Disorder

- Prophylaxis with mood stabilizer
- Close monitoring throughout pregnancy and postpartum
- Support adequate sleep
- Limit stress
- Ensure adequate social supports
- Discuss plan for infant feeding
- Support maternal-infant bonding

For All Patients Encourage

- Regular prenatal care
- Smoking cessation
- Avoiding alcohol and other substance use

Pharmacotherapy during pregnancy

Pharmacologic Treatments

SSRIs

- Zoloft (sertraline)
- Celexa (citalopram)
- Lexapro (escitalopram)
- Prozac (fluoxetine)
- Paxil (paroxetine)

SNRIs

- Effexor (venlafaxine)
- Cymbalta (duloxetine)

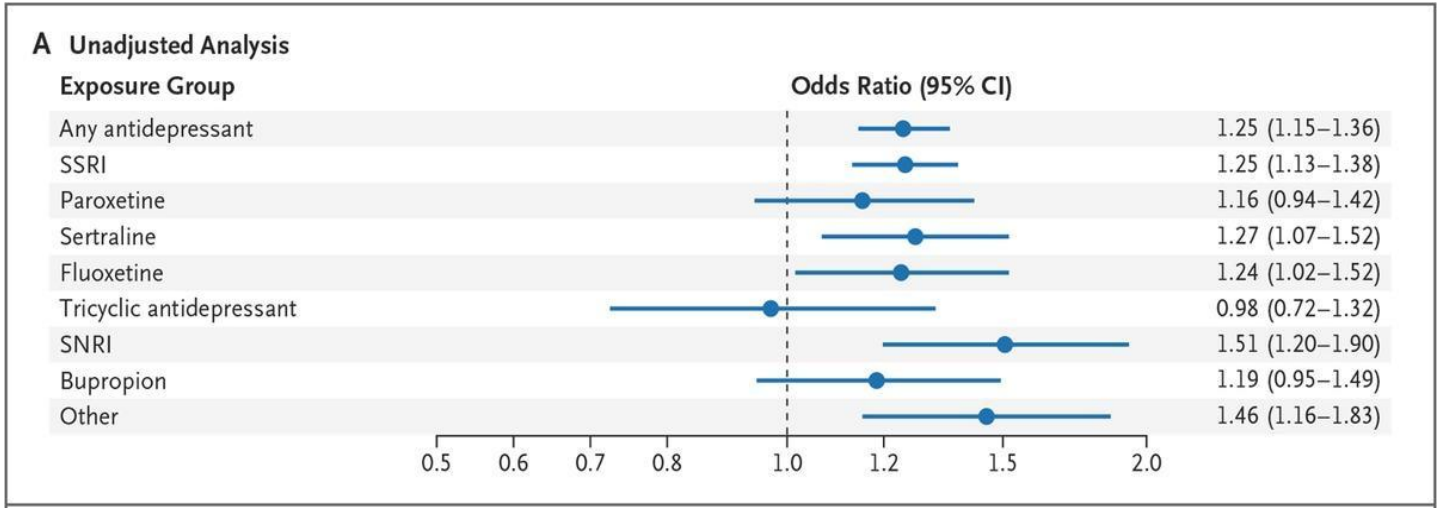
- Wellbutrin (bupropion)
- Benzodiazepines
- Benadryl

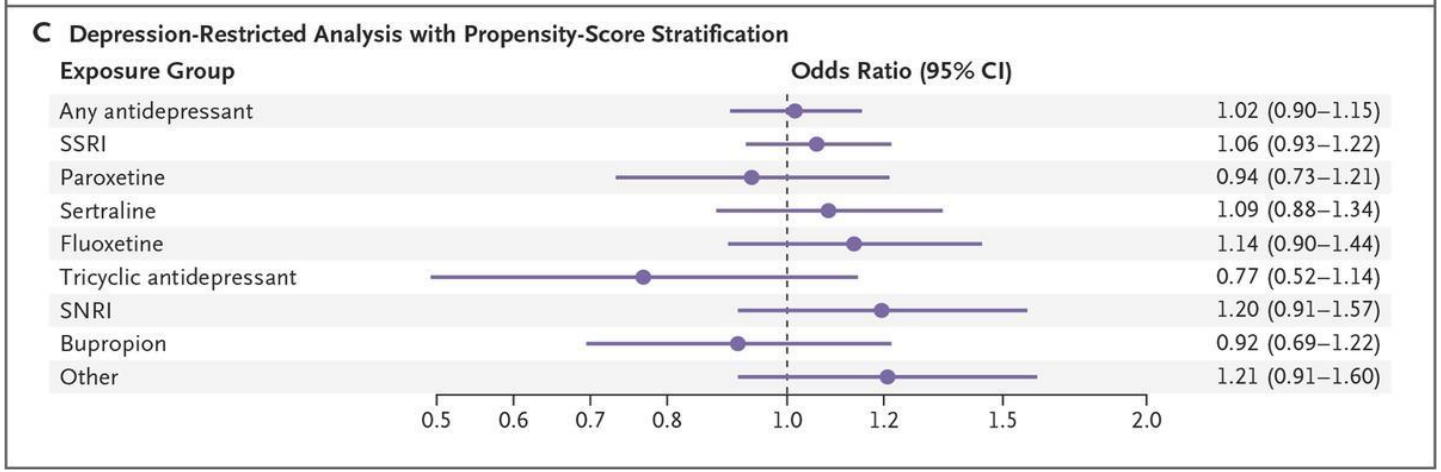
Antidepressant Use in Pregnancy and Associations with Selected Adverse Fetal Outcomes

Outcome	Strength of Finding
Fetal demise	Not associated
Spontaneous miscarriage	Mixed results
Small for Gestational Age/Low Birth Weight	Mixed but weak results; better controlled studies are negative
Major Congenital Anomalies	Mixed but weak results; greater consistency with paroxetine
Persistent Pulmonary Hypertension	Mixed results
Pre-eclampsia, gestational hypertension	Emerging data
Preterm Birth	Highly replicated but small effects
Neonatal adaptation	Moderately well replicated
Autism	Mixed but weak results; better controlled studies are negative
Attention Deficit Hyperactivity Disorder	Mixed but weak results; better controlled studies are negative

SRIs and Risk of Congenital Cardiac Malformations

Medicaid Analytic eXtract n=949,504 and n=217,342 in depression restricted





Huybrechts et al., NEJM, 2014

Clinical implications: Effects of Antidepressants on Risk of Birth Defects

- Most studies do not show an association with between SRI exposure and major malformations
- A small increase the risk of malformations is possible but remains controversial
- Most associations are with ventral septal defects, relatively common malformations
- If risks are real, the absolute risk is low and must be viewed in the context of whether medication is needed
- Other exposures such as alcohol may confound results, particularly in registry studies that typically have limited information about the mother

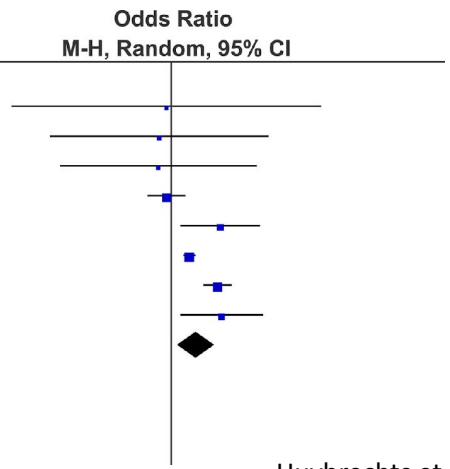
Persistent Pulmonary Hypertension of the Newborn (PPHN)

- Background risk: 10 to 20 newborns in every 10,000 live births (0.1%-0.2%)
- Absolute risk is small with late pregnancy exposure
- In largest cohort study that adjusted for maternal depression, OR 1.10
- In a network meta-analysis sertraline has the lowest risk of PPHN

	Expsoed		Non-Exposed			Odds Ratio	
Study or Subgroup	Events	Total	Events	Total	Weight	M-H, Random, 95% CI	Year
1.1.1 Cohort Studies							
Wichman et al[48]	0	808	16	24406	1.3%	0.91 [0.05, 15.25]	2009
Hammad et al[47]	1	6569	33	173865	2.5%	0.80 [0.11, 5.86]	2009
Andrade et al[46]	2	933	3	1104	2.9%	0.79 [0.13, 4.73]	2009
Kieler et al[49]	33	30115	1899	1588140	17.0%	0.92 [0.65, 1.29]	2012
Colvin et al[25]	8	3297	86	86110	10.4%	2.43 [1.18, 5.03]	2012
Huybrechts et al[13]	322	102179	7630	3360380	20.3%	1.39 [1.24, 1.55]	2015
Nörby et al[50]	60	9100	2051	718533	18.4%	2.32 [1.79, 3.00]	2016
Bérard et al[12]	7	1537	258	141097	10.0%	2.50 [1.18, 5.30]	2017
Subtotal (95% CI)		**154538**		**6093635**	**82.8%**	**1.58 [1.14, 2.19]**	
Total events	433		11976				

Heterogeneity: Tau² = 0.10; Chi² = 25.25, df = 7 (P = 0.0007); I² = 72%

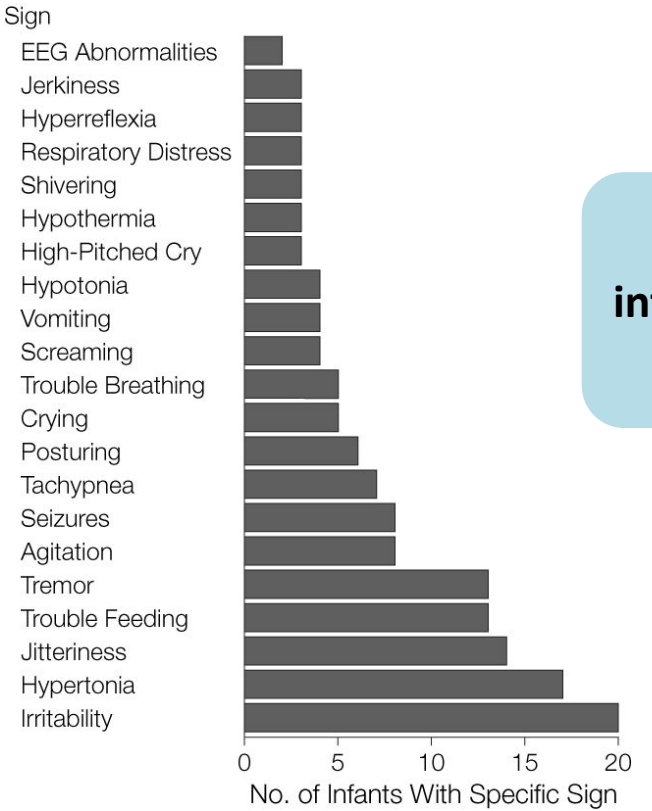
Test for overall effect: Z = 2.72 (P = 0.007)



Huybrechts et al, JAMA, 2015

Masarwa et al, AJOG, 2019

Poor Neonatal Adaptation Syndrome (PNAS)



5-30% of infants exposed to SRI

PNAS Meta-analysis

- 2.2-fold increased risk of respiratory distress (CI=1.81-2.66)
- 7.9-fold increase in tremors (CI=3.33-18.73)

Moses-Kolko, JAMA 2005;293(19):2372-2383
Grigoriadis et al, J Clin Psych 2013;74(4): e309-20

Benzodiazepines and Malformations

- Early case-control studies reported increased risks of facial clefts with benzodiazepine exposure in first trimester
- Recent meta-analyses and cohort studies have failed to find an association between any malformations and benzodiazepine exposure

Dolovich et al, 1998, BMJ, Vol 317:839-43.
Ben et al, 2014, PLoS One, 9(6);

Benzodiazepines and Adverse Birth Outcomes

Increased risk of:

- Cesarean Delivery (OR=2.45; 95% CI=1.36-4.40)
- Low Birth Weight (OR=3.41; 95% CI=1.61-7.26)
- Neonatal Ventilatory Support (OR=2.85; 95% CI=1.17-6.94)
- Preterm delivery (OR=1.41; 95% CI=0.97-4.04)

Yonkers et al, 2017, JAMA Psychiatry; Huitfeldt et al., 2020, JAMA Open

Which medication do I choose? (guiding principles)

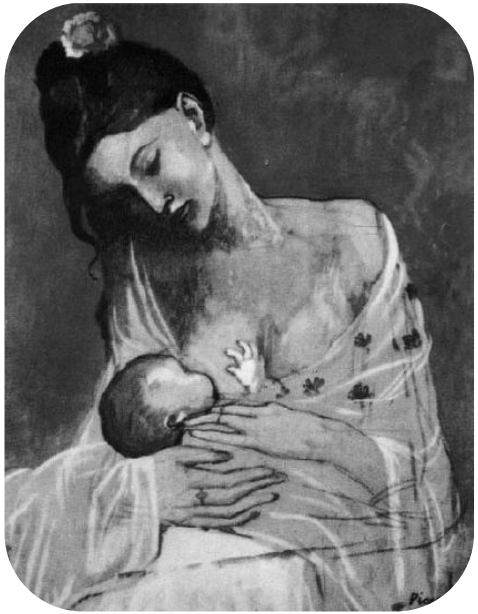
- What is likely to work?
- What are the medication side effects?
- How much data do we have for each of our options?
- What does the data tell us about each of our options?
- What is the patient's preference?

Treatment of postpartum depression

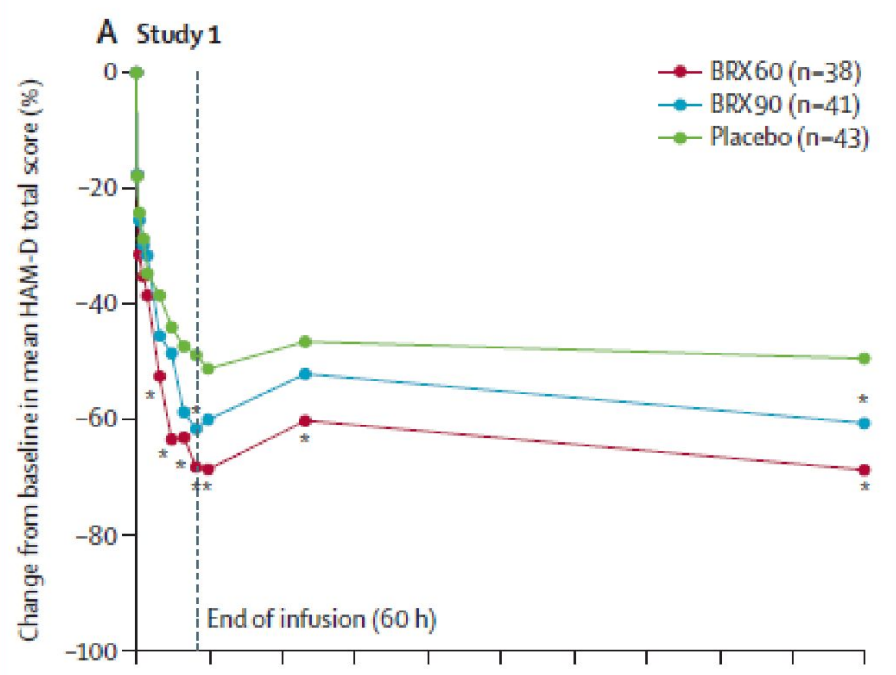
Breastfeeding and antidepressants

- Breastfeeding is generally recommended with antidepressant use

- The baby should be monitored for problems feeding or sleeping, rather than monitoring levels



Brexanolone for Postpartum Depression



- Minimal HAM-D total score ≥26
- Onset of depression in 3rd trimester or one month postpartum
- 60-hour infusion
- Follow up to 30 days
- 4% pre-syncope
- * p<.05 in change in HAM-D
- FDA approved 3/2019

Meltzer-Brody et al, 2018, Lancet, 392:10580-1070

Zuranonlone Study

RCT: Effect of Zuranolone vs Placebo in Postpartum Depression: A Randomized Clinical Trial

POPULATION

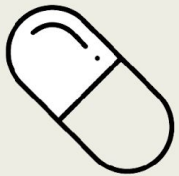
150 Women

Women ages 18-45 y with postpartum depression and Hamilton Rating Scale for Depression (HAMD-17) score ≥26

Mean (SD) age, 28.3 (5.4) y

INTERVENTION

153 Individuals randomized

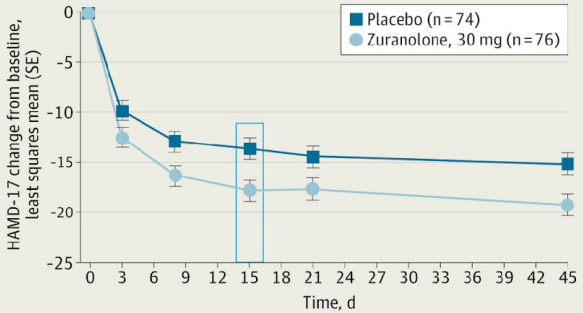


76 Zuranolone
Oral zuranolone, 30 mg, every evening with food for 14 d

74 Placebo
Oral placebo capsule every evening with food for 14 d

FINDINGS

Individuals with postpartum depression who received zuranolone for 2 wk displayed significantly greater reductions in depressive symptoms compared with placebo at day 15



Difference in change in depressive symptoms at 15 wk, zuranolone vs placebo:
−4.2 (95% CI, −6.9 to −1.5); *P* = .003

SETTINGS / LOCATIONS

27 Clinical sites in the US

PRIMARY OUTCOME

Change from baseline in depressive symptoms at day 15, as measured by HAMD-17 score (range, 0-52, with higher scores indicating more severe depression)

Deligiannidis KM, Meltzer-Brody S, Gunduz-Bruce H, et al. Effect of zuranolone vs placebo in postpartum depression: a randomized clinical trial. *JAMA Psychiatry*. Published online June 30, 2021. doi:10.1001/jamapsychiatry.2021.1559

Summary

The treatment of reproductive-age patients generates some unique considerations

- Symptom stabilization is critical for wellbeing of patient and infant
- Antidepressant and antipsychotic use in pregnant individuals may be associated with particular reproductive risks although in general these appear to be small
- Neurosteroids have a role in the treatment of mood symptoms in women

Thank You


obrigado
Dank U
Merci
mahalo
Köszi
спасибо
Grazie
Thank you
mauruuru
Takk
Gracias
Dziękuję
Děkuju
danke
Kiitos

Rural Maternal Mental Health Referrals / Resources

Kenneth McCartney, MHAL
CHI Health Division Director Outpatient Behavioral Services
May 2, 2023

CHI Health

Learning Objectives

1. Understand that advantages for coordinating care with Behavioral Health and how to do so

2. Awareness of psychiatric services available within your community / Nebraska

3. Ability to submit a referral to a Psychiatric Provider as well as helpful documentation to support effective collaboration

Why Coordinate Care?

“Coordination of care across settings permits and integration of services that is centered on the comprehensive needs of the patent and family, leading to decreased health care costs, reduction in fragmented care, and improvement in the patient / family experience of care.”

(American Academy of Pediatrics, 2014)

Benefits of Collaborative Care for Providers

- Collaborative care empowers team members
- Collaborative care helps close communication gaps
- Collaborative care minimizes readmission rates

- Collaborative care promotes teamwork - and a team mentality
- Collaborative care results in patient-centered care

(In Sync Healthcare Solutions, 2021)

CHI Health

Benefits of Collaborative Care for Patients

- Collaborative care leads to better pre and post-surgery results
- Collaborative care helps identify mental health issues before they become severe
- Collaborative care reduces overall costs of medical care

(In Sync Healthcare Solutions, 2021)

CHI Health

What Resources Are Available?

There is hope.

If you or someone you know needs support now, call or text **988** or chat **988lifeline.org**

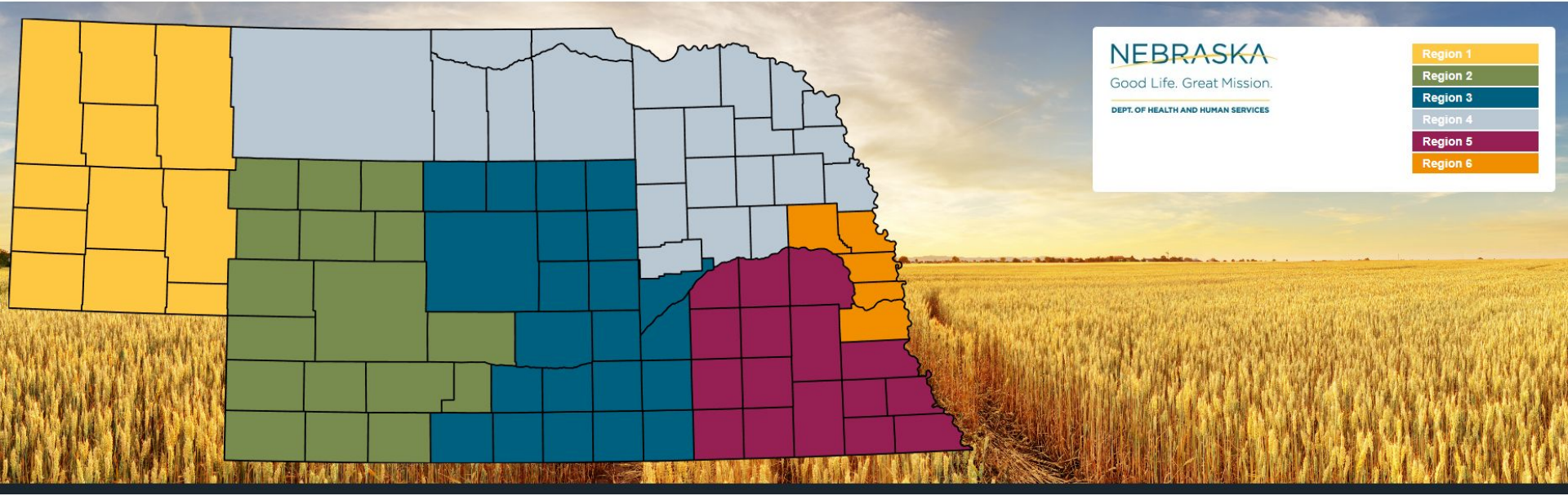
988 SUICIDE & CRISIS LIFELINE

PEP22-08-03-005

Nebraska Network of Care for Behavioral Health

Welcome to the Nebraska Division of Behavioral Health. DBH administers and provides funding and oversight for community-based services throughout six local Behavioral Health Regions.

Our mission is to provide leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans. Click on the Behavioral Health region below to search for a service or resource in your area.



Region 1	308-635-3173	http://region1bs.net	**Region 4**	402-370-3100	www.region4bhs.org
Region 2	308-534-0440	www.r2hs.com	**Region 5**	402-441-4343	www.region5systems.net
Region 3	308-237-5113	www.Region3.net	**Region 6**	402-444-6573	www.regionsix.com

CHI Health

Additional Resources

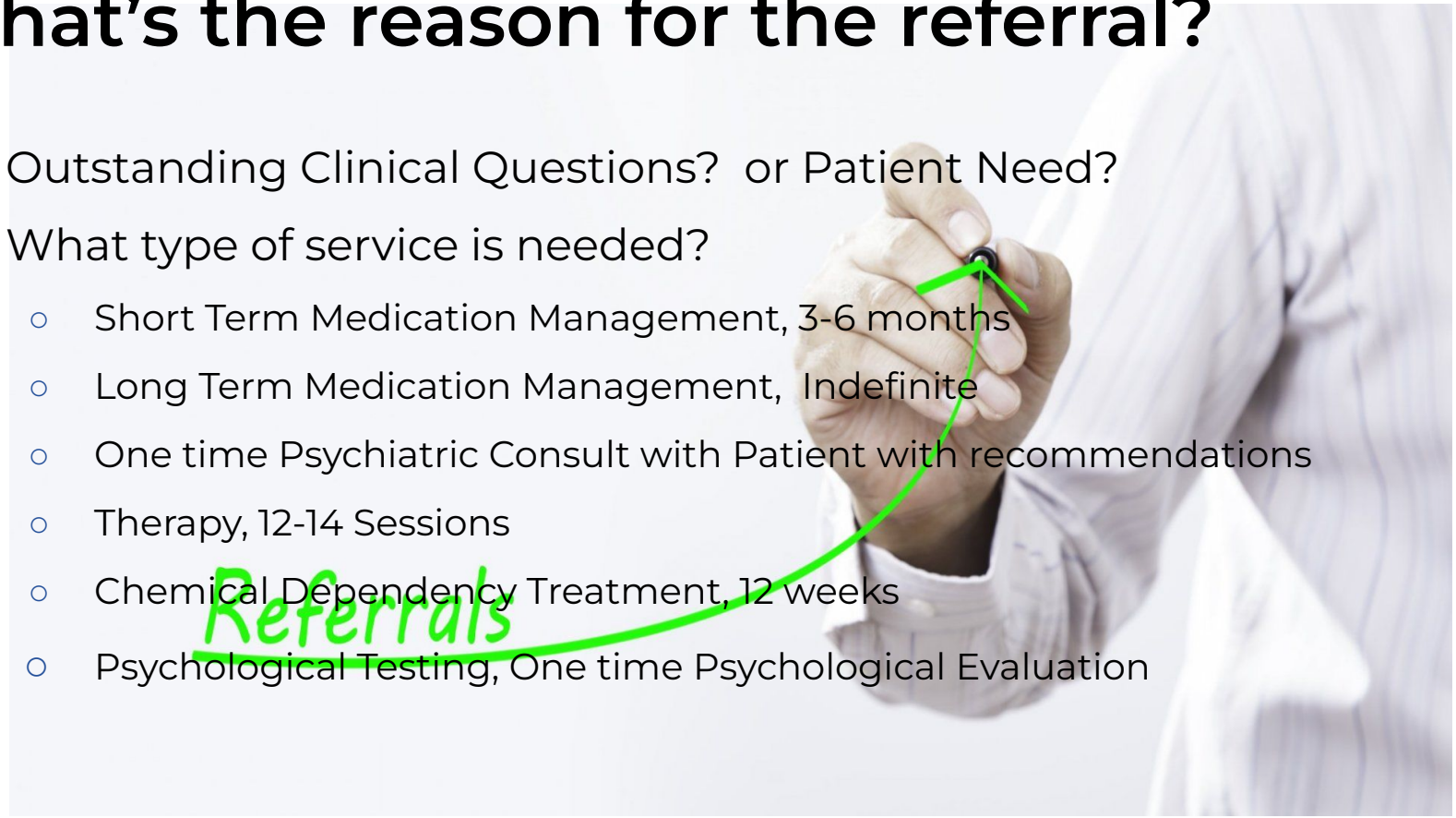
- Nebraska Family Helpline 888-866-8660, 24/7
- Boys Town National Hotline 800-448-3000, 24/7
- NAMI Nebraska 402-345-8101
  - https://naminebraska.org
  - Offers free Family and Individual programs throughout the State
- CHI Health Behavioral Transfer Center 402-717-4673, 24/7
  - Level of Care Determination and bed placement (if beds available) within CHI Health Inpatient Facilities (232 Inpt beds)
  - Centralized Scheduling (virtual and in-person) to 160+ Behavioral Health Providers within the State
  - Virtual Psychiatric Consultation to CHI Health Facilities

CHI Health

What to include when making a referral?

What's the reason for the referral?

- Outstanding Clinical Questions? or Patient Need?
- What type of service is needed?
  - Short Term Medication Management, 3-6 months
  - Long Term Medication Management, Indefinite
  - One time Psychiatric Consult with Patient with recommendations
  - Therapy, 12-14 Sessions
  - Chemical Dependency Treatment, 12 weeks
  - Psychological Testing, One time Psychological Evaluation



Release of Information

- Patients 14 years or older must sign a behavioral health release of information
- Must specify if behavioral health and / or drug and alcohol information is to be disclosed
- Dates of treatment must be included
- Valid for 90 days, unless otherwise specified (cannot exceed 1 year)
- Can be withdrawn at any time
- *Key - Obtaining a completed ROI **at the time of referral** is optimal as it ensures no delay in coordination of care

CHI Health

Release of Information

- Not required “when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person.” (National Association of Social Workers, 2008)
- If you are ever uncertain about the need for a release of information, consult with your agency’s compliance officer

CHI Health

How to best communicate with you regarding individual patient care coordination?

- Fax? Phone? Email?

CHI Health

CHI Health Internal Referral Process

- Grant Funded opportunity to provide free Therapy to CHI Health Perinatal Certified Mental Health Clinicians for CHI Health Patients
- Contact Ken McCartney, kenneth.mccartney@commonspirit.org for more information

CHI Health

Questions?

Continuing Education

Both trainings (4/18 and 5/2) are approved for 1 hour CME/ CE each

Physicians, Physician Assistants, Advanced Practice Registered Nurses, Nurses, Residents & Fellows

Please complete your evaluation

Thank you.

References

- American Academy of Pediatrics, Council on Children With Disabilities and Medical Home Implementation Project Advisory Committee. (2014). Patient- and family-centered care coordination: A framework for integrating care for children and youth across multiple systems. Pediatrics, 133(5), e1451.
- National Association of Social Workers. (2008). Code of ethics of the National Association of Social Workers. Washington, DC. NASW Press.
- In Sync Healthcare Solutions. (2021). Collaborative Care: The Marriage of Physical and Mental Healthcare.