Promoting Maternal Mental Health During and After Pregnancy

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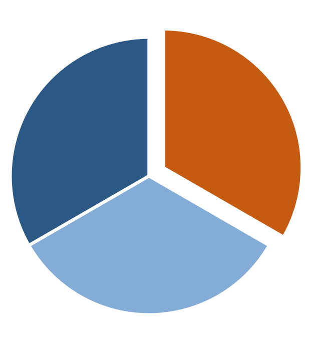

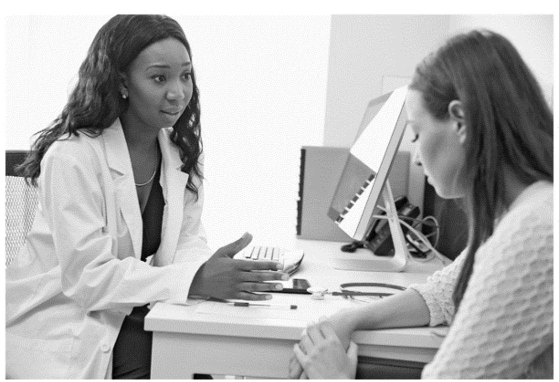

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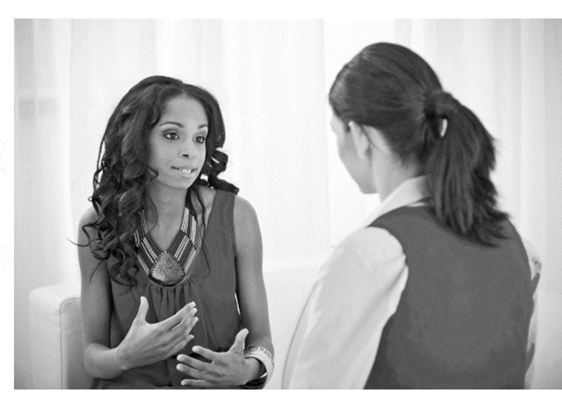

Massachusetts Child Psychiatry Access Project
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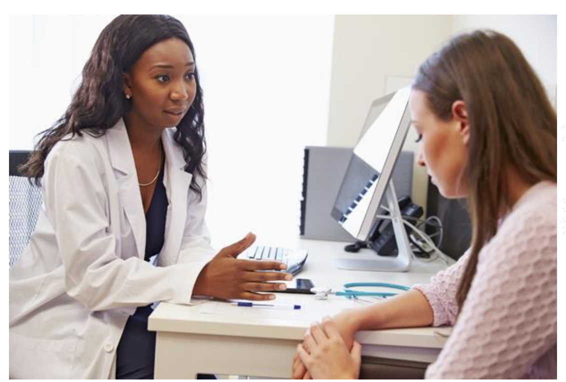
For Moms



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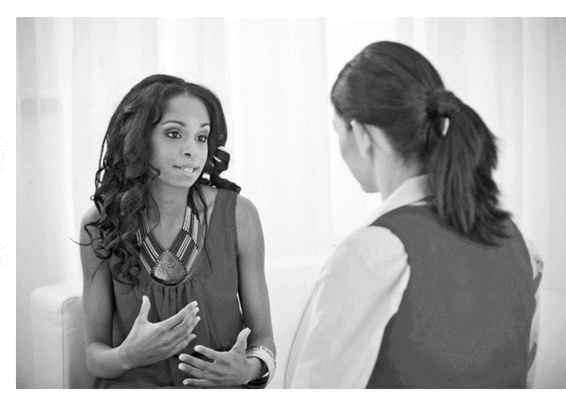

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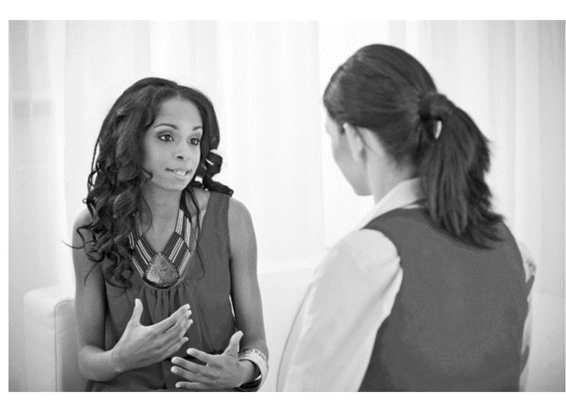

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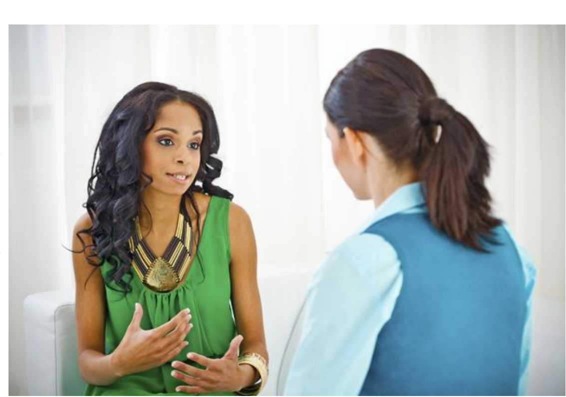

Massachusetts Child Psychiatry Access Project
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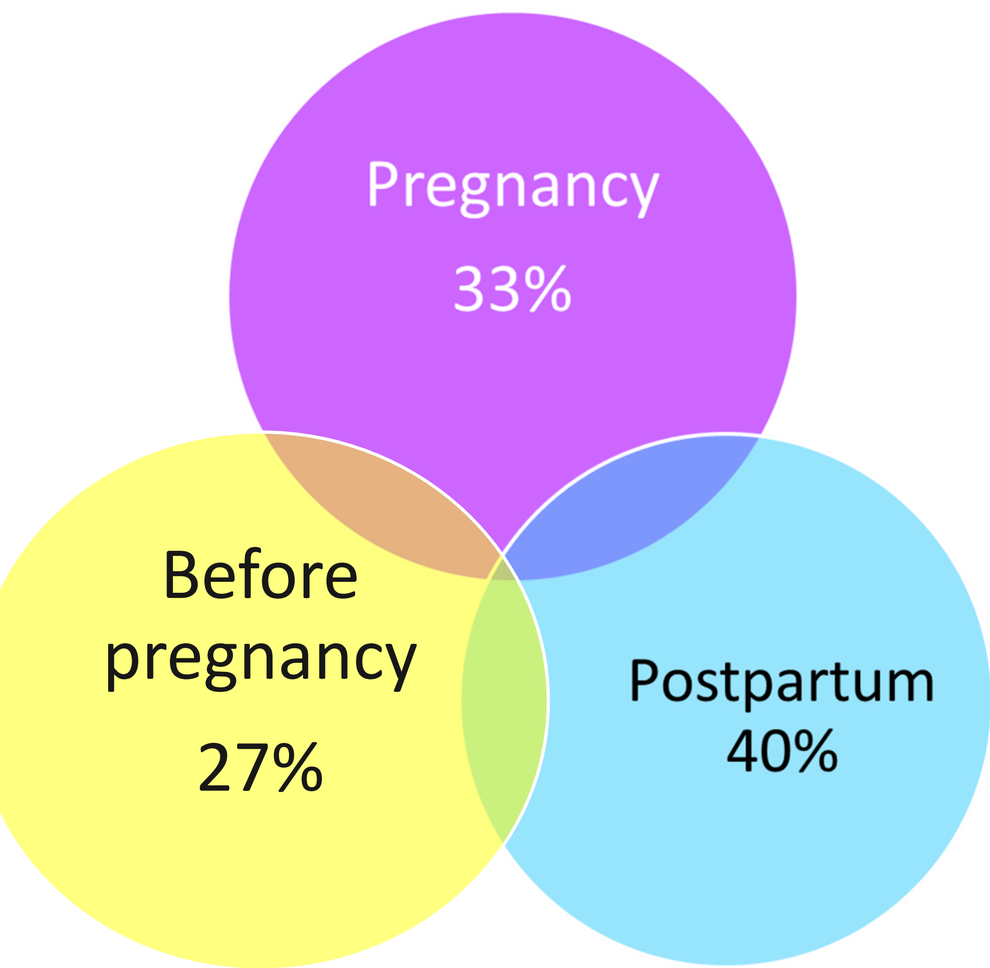
For Moms

1 in 7 women suffer from perinatal depression

Gavin et al. *Ob Gyn* 2005, Vesga-Lopez et al. *Arch Gen Psychiatry* 2006.

Two – thirds of perinatal depression begins before birth



Wisner et al. *JAMA Psychiatry* 2013

Perinatal depression is under-diagnosed and under-treated

Treated Women

Untreated women

Byatt et al. *Obstetrics and Gynecology*.2015

Barriers to Treatment

Patient	Provider	Systems
Lack of detection	Lack of training	Lack of integrated care
Fear/stigma	Discomfort	Screening not routine
Limited access	Few resources	Isolated providers

Women do not disclose symptoms or seek care

Underutilization of Treatment

Unprepared providers, With limited resources

Poor Outcomes

Perinatal depression effects mom, child & family

Poor health care
Substance abuse
Preeclampsia
Maternal suicide

Low birth weight
Preterm delivery
Cognitive delays
Behavioral problems

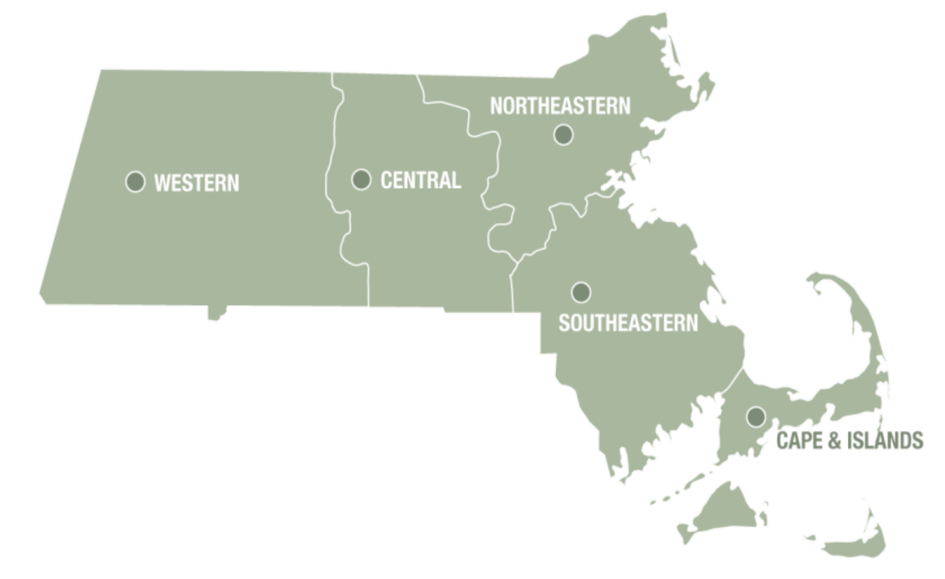
Bodnar et al. *The Journal of clin psych* 2009. Cripe et al. *Pedi and perinatal epidemiology* 2011. Forman et al. *Dev and psych* 2007

In 2010, Massachusetts passed a Postpartum Depression Act

PPD Commission

PPD Screening Regulation
(if screen must report CPT S3005, 0-6 months)

MCPAP for Moms Funding



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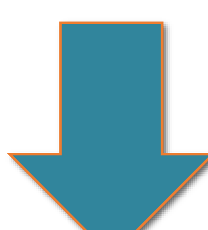
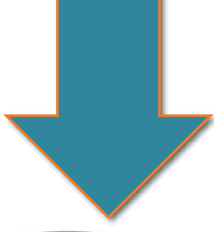


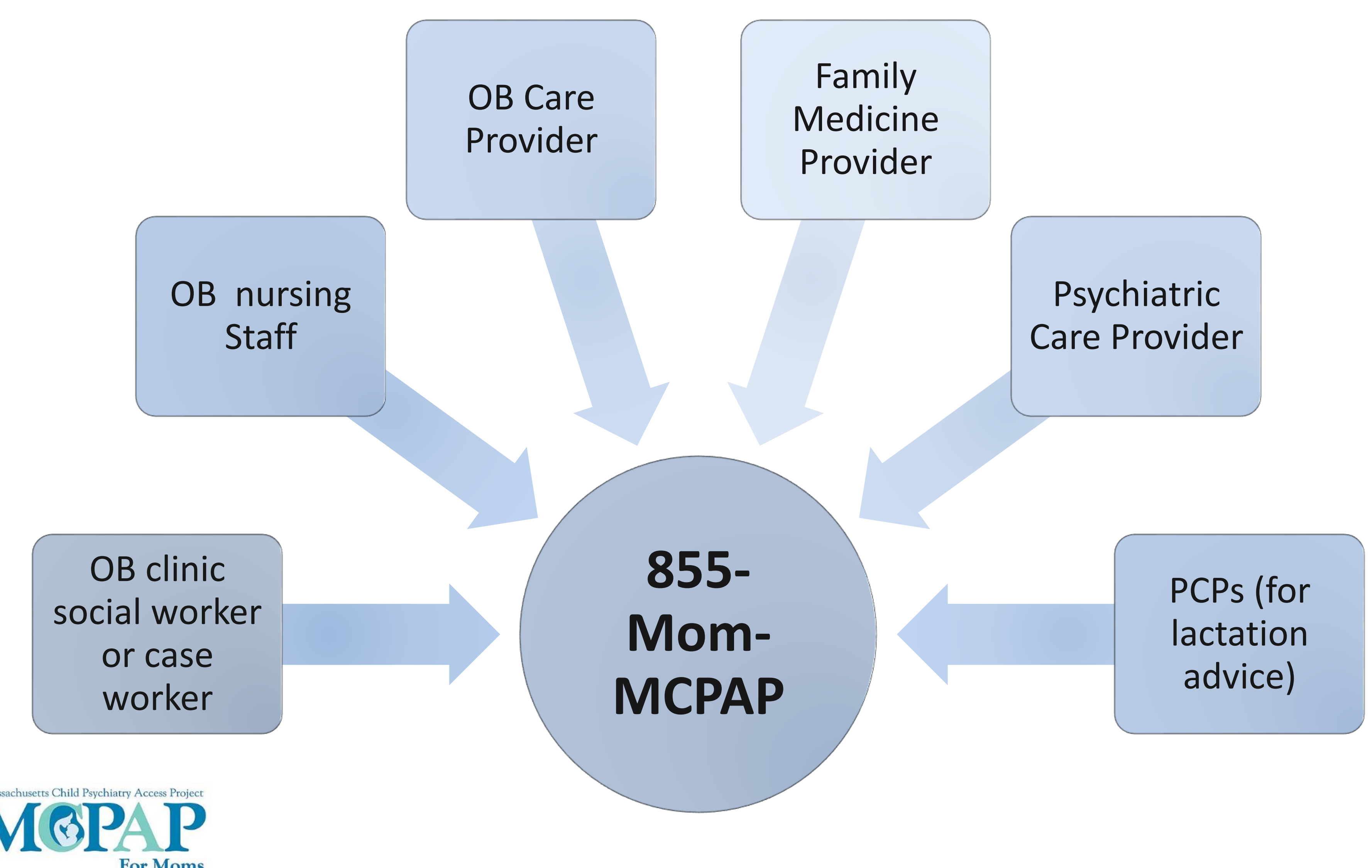


Education

855-Mom-MCPAP

Care Coordination

MCPAP for Moms serves providers



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Linkage to resources

Referral psychiatrist & psychotherapist

Telephone consultation

Can refer moms to www.mcpapformoms.org

Massachusetts Child Psychiatry Access Project
MCPAP
For Moms

Contact number for providers:
855-Mom-MCPAP (855-666-6272)

Promoting Maternal Mental Health
During and After Pregnancy

About MCPAP for Moms | How We Help Providers | Provider Toolkit | Our Team | For Mothers and Families

PLAY VIDEO ▶

MCPAP for Moms promotes maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage depression.

Detect → Assess → Engage → Triage → Treat

Obs 80%
&
Psychiatrists 20%

Improved outcomes for moms, babies and families

Gilbody et Al. (2008). *CMAJ*, *178*(8), 997–1003.; Yonkers et Al. (2009). *Psychiatric Services*, *60*(3), 322–328.

1-855-Mom-MCPAP

Telephone Consultation

Patients should provide consent in order for you to share personal information with MCPAP for Moms

Management of perinatal psychiatric disorders

Preconception

Pregnancy

Depression & Anxiety

Bipolar & Psychosis

Postpartum

Think pregnancy for ALL reproductive aged women

Half of pregnancies are unplanned

Discuss and document birth control and risks of teratogenic medication, e.g. valproic acid

Be aware of interaction between BCP and mood stabilizers

- BCP can decrease lamictal levels
- Trileptal and Topomax can decrease BCP efficacy

Discuss and document preconception planning

Preconception planning is imperative

Prenatal vitamin (ALL women):

folic acid – 1 gm

iodide least 150 micrograms

Beyond prenatal vitamin (if AED):

folic acid - 4gm daily starting 12wk prior to conception

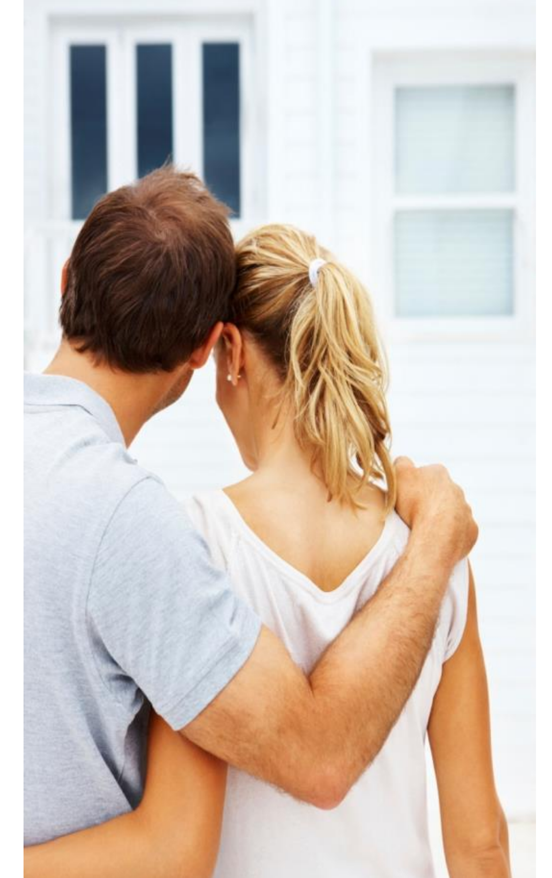
Preconception planning is critical

Attempting conception and being pregnant can be (often are) stressful

Therapy is evidence based treatment for depression and anxiety

If on psychiatric medication, preconception is an opportunity to plan and streamline treatment

Call MCPAP for Moms



Management of perinatal psychiatric disorders

Preconception

Pregnancy

Depression & Anxiety

Bipolar & Psychosis

Postpartum

High risk of relapse during pregnancy in woman discontinuing antidepressants preconception

Continue

Discontinue

*If tapering medication prior to conception, continue to follow women during pregnancy.

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

No recent relapse off medication

Moderate/severe depression

Suicidal ideation

Difficulty functioning caring for self/baby

Psychotic symptoms

History of severe depression

Recent relapse off medication

Failed trial of psychotherapy

Prescribing principles for preconception, pregnancy and breastfeeding

- Use what has worked
(considering available reproductive safety information)
- Use lowest EFFECTIVE dose
- Minimize switching
- Monotherapy preferable
- Be aware of need to adjust dose
- Discourage stopping SSRIs prior to delivery

Duration and number of depressive episodes is the # 1 risk factor for relapse during pregnancy

Socioeconomic status

Marital status

Duration of depressive illness and number of previous episodes

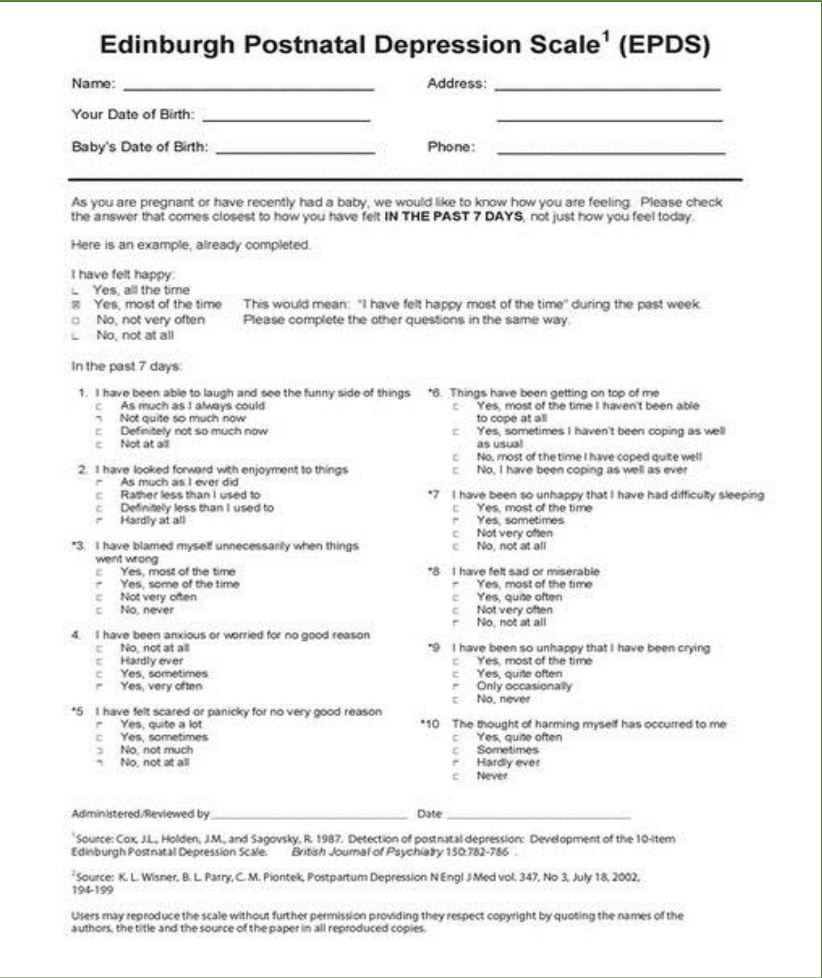
Family history of postpartum depression

Edinburgh Postnatal Depression Scale (EPDS)

Validated in pregnancy and postpartum

10 items

Asks about self-harm



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ____________ Address: ____________

Your Date of Birth: ____________ ____________

Baby's Date of Birth: ____________ Phone: ____________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.
- No, not very often
- No, not at all

In the past 7 days:

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

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

*3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

*5 I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

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

*7 I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

*8 I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

*9 I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

*10 The thought of harming myself has occurred to me
   - Yes, quite often
   - Sometimes
   - Hardly ever
   - Never

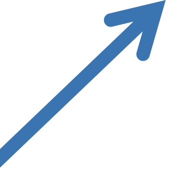
Administered/Reviewed by ____________ Date ____________

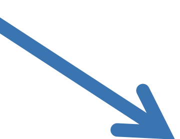
[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

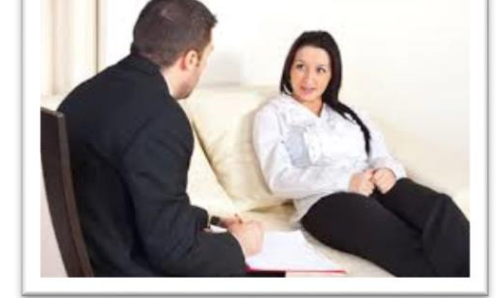
[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

Education about various treatment and support options is imperative







The U.S. FDA antidepressant risk categorization is limited

Lack of systematic human data

Lack of clear differentiation between categories

Risk of maternal illness and benefits of the medication not accounted for

Does not inform decision making

No decision is risk free

Vs.

SSRIs are among the best studied classes of medications used in pregnancy

Byatt et al. *Acta Psych Scand* 2013.

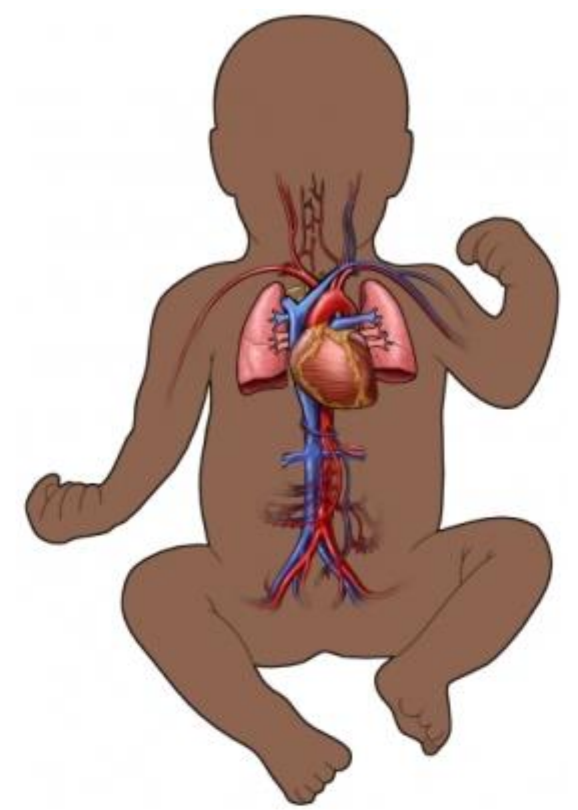
Case of Ms. Y

Absolute risk of birth defects when antidepressants taken in first trimester is small

Data is inconsistent, paxil has most been controversial

Byatt et al. *Acta Psych Scand* 2013.

Absolute risk of persistent pulmonary hypertension (PPHN) appears small



Baseline rate of 1-2 per 1000 births, may increase to 3-4 in 1000 births

Chambers et al. *NEJM* 2006, Kallen et al. *Pharmacoepidemiol Drug Saf* 2008, Andrade et al. *Pharm Drug Saf* 2009.

Small increase risk of preterm labor & low birth weight

Depression can also increase risk of preterm labor and low birth weight

Huybrecht et al. *PLoS ONE*. 2014

Possible transient neonatal symptoms with exposure to antidepressants

Transient and self-limited syndrome that may occur in up to 30% of neonates

No data to support taper in third trimester

Moses-kolko et al JAMA 2005, Warburton et al. *Acta Psychiatr Scand* 2010.

Studies do not suggest long-term neurobehavioral effects on children

Nulman et al. *AJP* 2012, Croen et al. *AGP* 2011, Rai et al *BMJ* 2013.

Case of Ms. X

When possible, slowly taper benzodiazepines, with goal to be on lowest possible dose

Possible risks

- Cleft lip/palate
- Preterm birth
- Low birth weight
- Neonatal withdrawal syndrome/possible small risk of floppy infant

Guidelines

- Monotherapy preferable to polypharmacy, so optimize SSRI first
- Fewer/no active metabolites (lorazepam) may be safer

Management of perinatal psychiatric disorders

Preconception

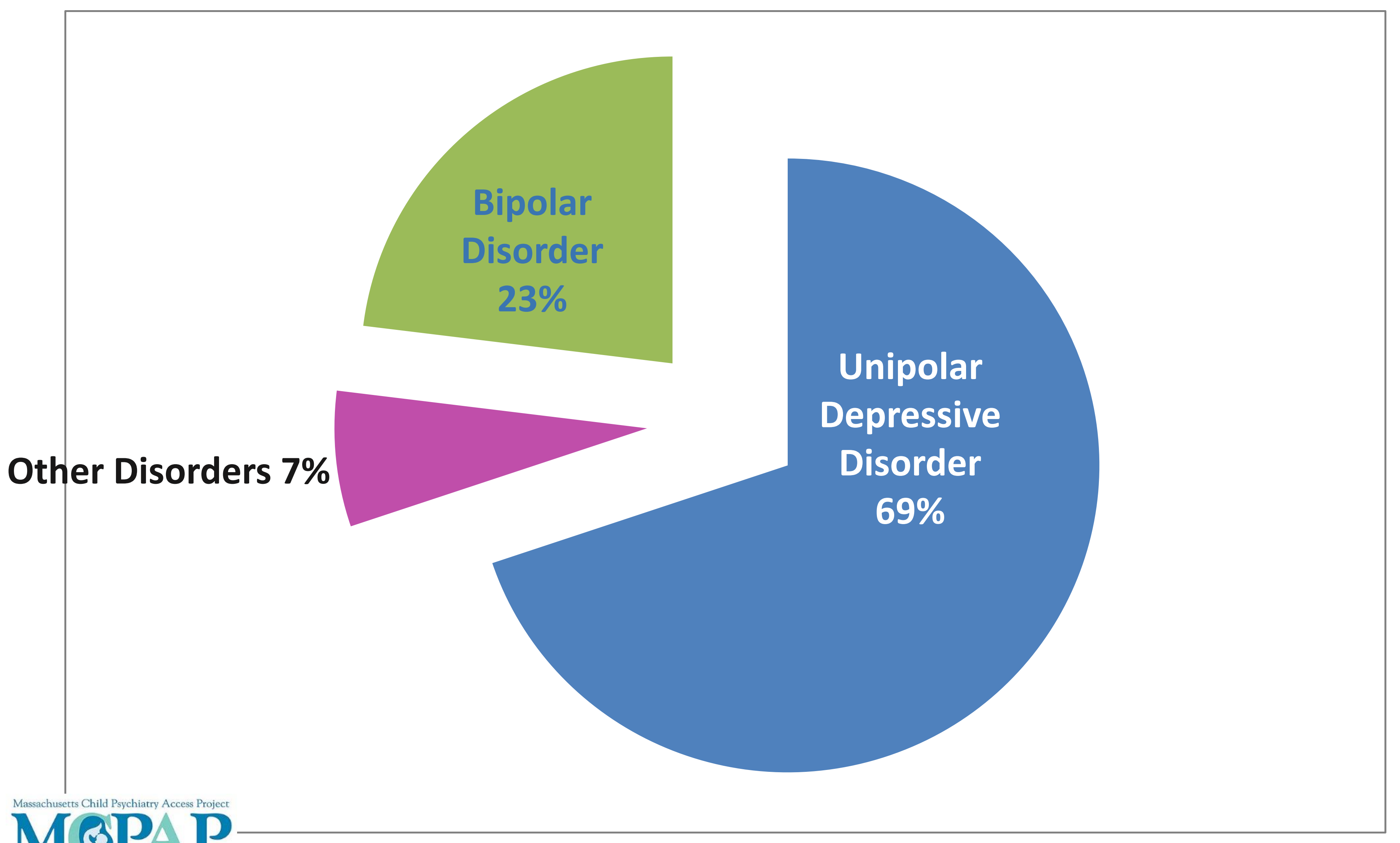
Pregnancy

Depression & Anxiety

Bipolar & Psychosis

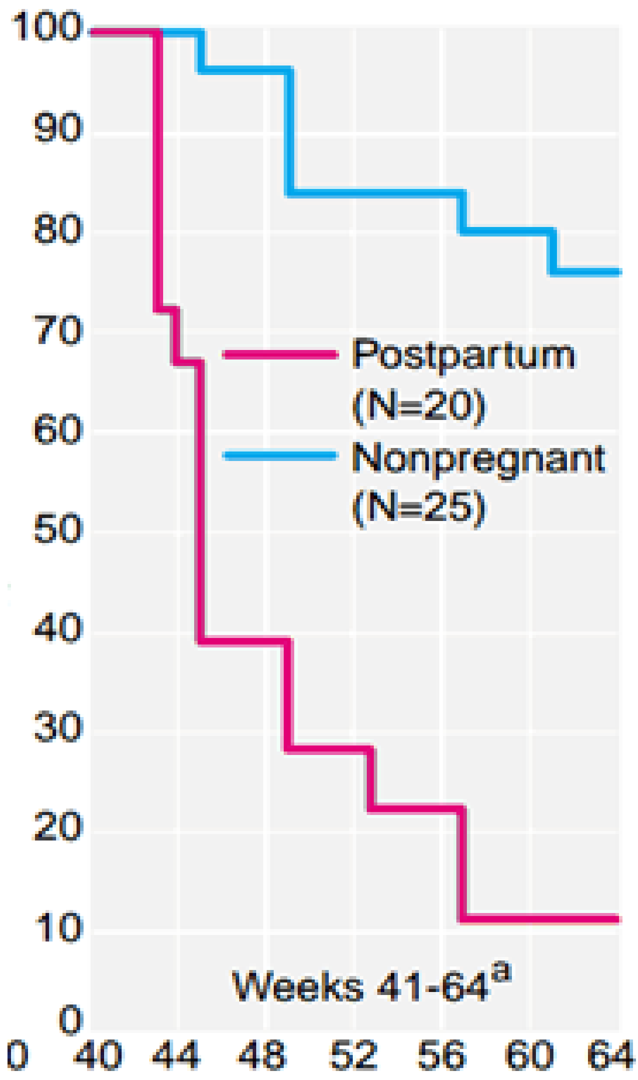
Postpartum

Imperative to address bipolar disorder



Wisner et al. *JAMA Psychiatry.* 2013

High risk of relapse for bipolar disorder after medication discontinuation postpartum



Viguera et al. AJP 2000

Risk for recurrence of bipolar disorder increases after medication discontinuation in pregnancy

	Risk of recurrence
Abrupt Discontinuation	100%
> 14 day taper	62%

(Y-axis: 0–120)

Yonkers et al. AJP 2004

Bipolar disorder increases risk of postpartum psychosis

1-2/1000 women

>70% bipolar disorder

24 hrs – 3 weeks postpartum

Mood symptoms, psychotic symptoms & disorientation

R/o medical causes of delirium

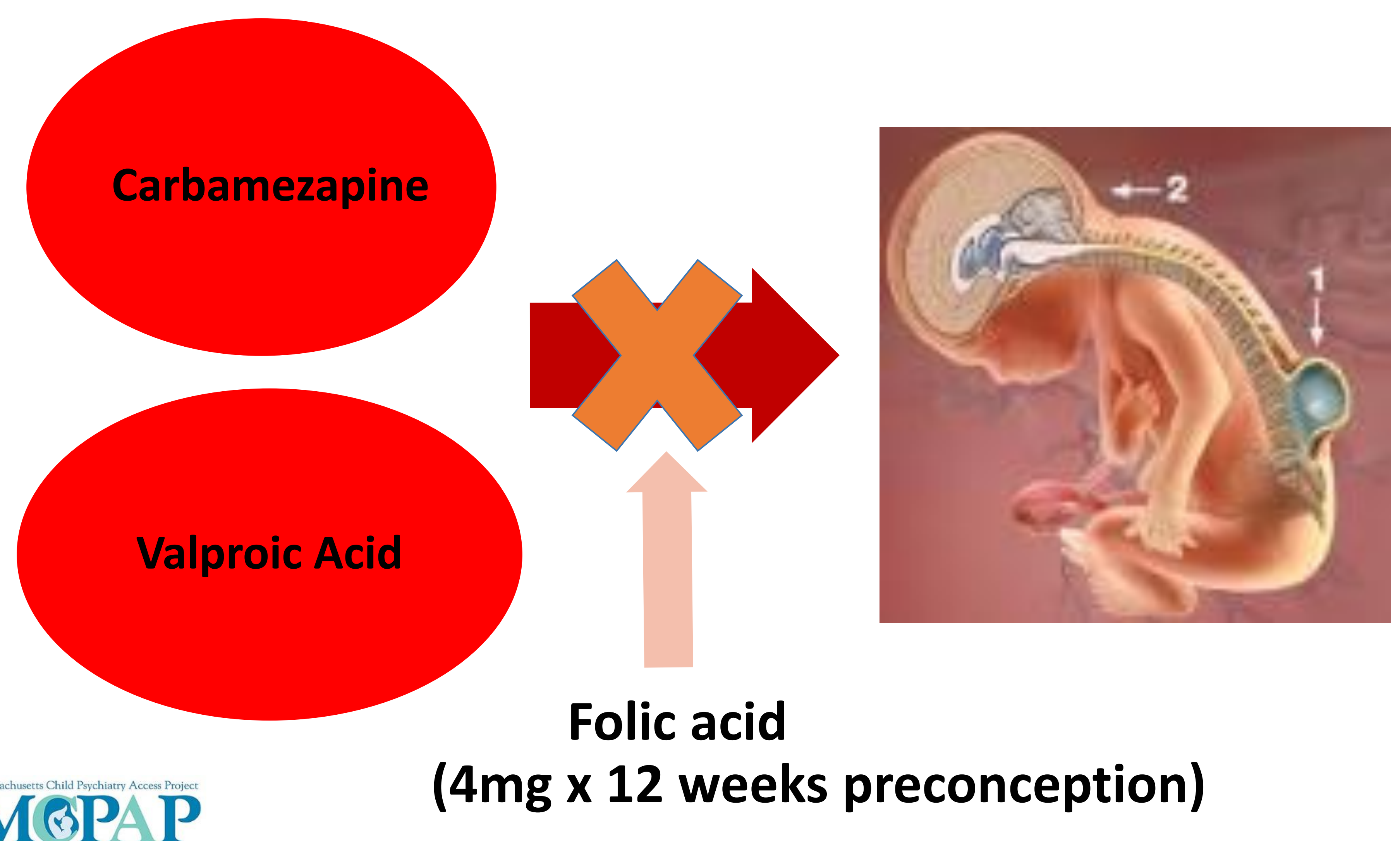
Psychiatric emergency

4% risk of infanticide with postpartum psychosis

Relative Safety In Pregnancy	Mood Stabilizer	Key Clinical Evidence
Safer	**Typical antipsychotics (haloperidol, perphenazine)**	**Used clinically in pregnancy for over 50 years.**
	Lamotrigine	**Not show increase in teratogenicity. Not show delay in neurodevelopment.**
Caution	**Atypical antipsychotics**	**While no major findings, data is limited.**
	Lithium	**Absolute risk of cardiac malformation rare. (Epstein's anomaly 0.01-0.05%) Watch for 'floppy baby' syndrome.**
Avoid if possible	**Carbamazepine**	**Increased risk of cleft lip/palate. Risk of reduced head circumference, lower birth weight and shorter length.**
	Valproic acid	**Increase risk of multiple malformations. (~8-9%) Lower IQ.**

Marsh W, Viguera, **Bipolar D/o Through Pregnancy and Postpartum ,** Psych Annals '12

Folic acid supplementation with AED in Pregnancy



Lithium use in pregnancy as been associated with risks to mother and baby

Maternal risks

Preterm labor

Polyhydramnios & polyuria/polydipsia

Neonatal risks:

Prematurity

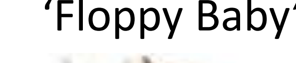
Large for gestational age

Cardiac defects: Epstein's anomaly

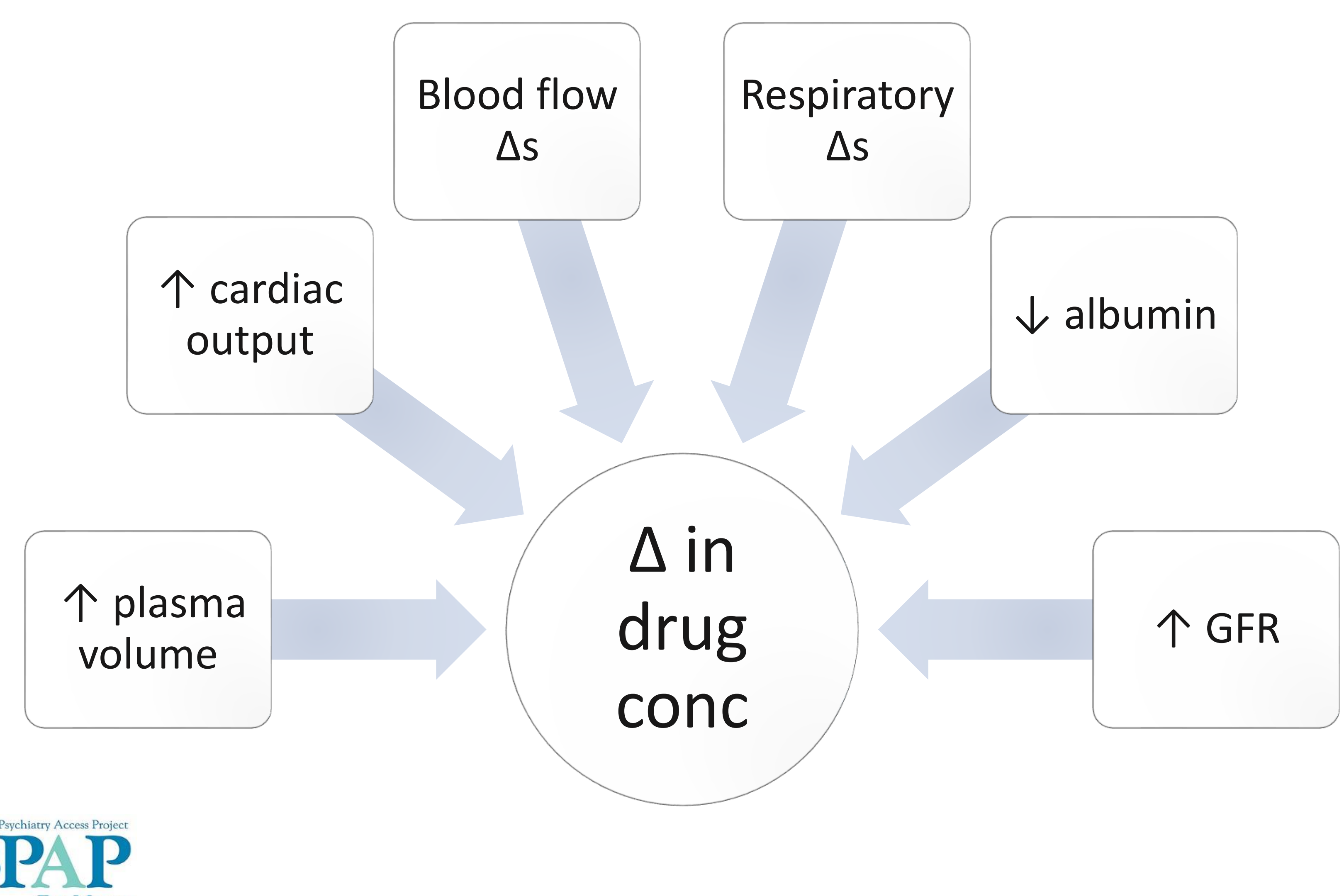
Neural tube defects: possible small

Neonatal adaption/floppy baby

Long-term developmental issues?



Pharmacokinetics change during pregnancy



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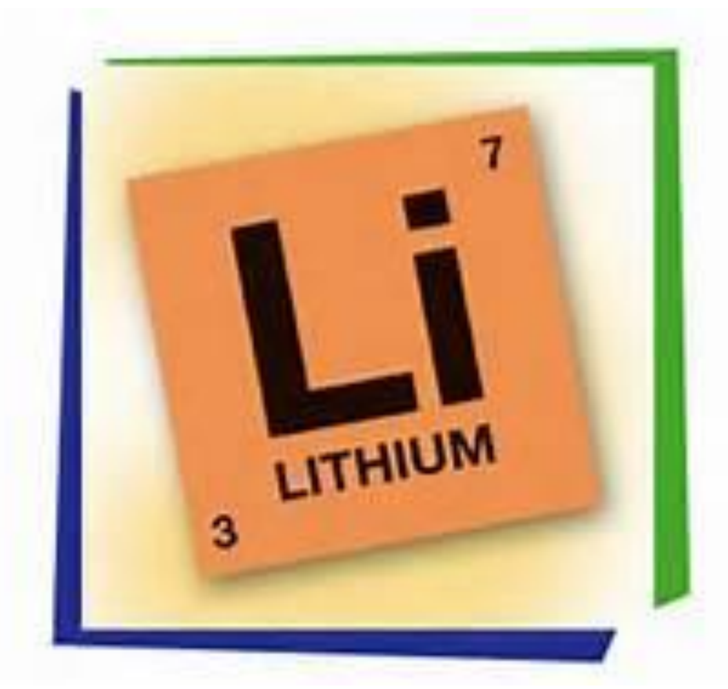
Lithium serum concentration decreases in pregnancy

Therapeutic index of 0.6-1.2 mEq/L

Li clearance is 20-30% of GFR

Varies with GFR



Preconception

1st trim

2nd trim

3rd trim

birth

postpartum

Clearance increases by 30-50%

Vascular volume rapidly ↓ lithium clearance ↓ to pre-pregnancy levels

***Established therapeutic drug level and narrow therapeutic index of 0.6-1.2mEq/L**

****Lithium clearance increases by 30-50% due to ↑ renal blood flow**

Deligiannidis et al. J Clin Psychopharm 2013. In Press.

Frequent TDM may be required in some cases

Medical combordities affecting absorption clearance

Titrating lithium for symptom management

Monthly

Weekly or biweekly month prior to delivery

Monitor closely around delivery

Check maternal lithium level when women present for delivery

Adequate hydration

Avoid nephrotoxins and NSAIDS

Deligiannidis et al. J Clin Psychopharm 2013. In Press.

Other monitoring for Lithium during pregnancy is also needed

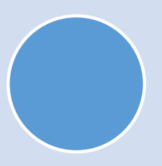
Followed by a high risk Ob

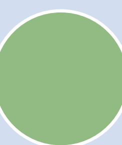
Ultrasound and fetal echocardiogram at 16 to 18 weeks

May consider twice daily dosing, to avoid higher lithium peak levels

Consider monitoring infants' lithium serum levels, TSH and renal function

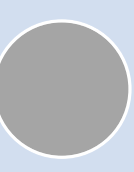
Unclear evidence for holding Li 24-48 hrs before delivery





Birth

Check level 24 hrs after birth & after each dose adjustment



Deligiannidis et al. J Clin Psychopharm 2013. In Press.

Management of perinatal psychiatric disorders

Preconception

Pregnancy

Depression & Anxiety

Bipolar & **Psychosis**

Postpartum

Psychosis and schizophrenia in pregnancy pose substantial risks to mother and baby

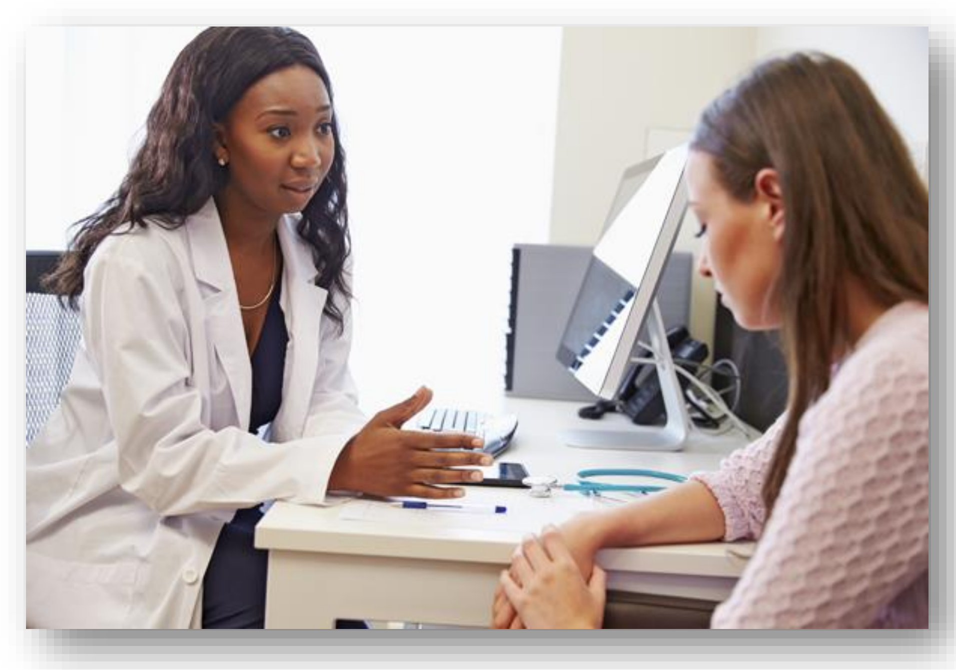
Less prenatal care

Smoking

Prematurity

Poor maternal-fetal attachment

Postpartum psychosis



Matevosyan NR; Arch GynObstetFeb '11;283(2):141-7.

Risk of harm to baby

OCD/anxiety	Postpartum Psychosis
• Good insight • Thoughts are intrusive and scary • No psychotic symptoms • Thoughts cause anxiety	• Poor insight • Psychotic symptoms • Delusional beliefs or distorted reality present

Low risk

High risk

Use antispychotics that work, while taking into account relative risks of medications

Preterm delivery

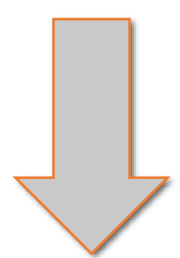
Low birth weight

No single malformation consistently reported

Increased risk of postnatal adaptation symptoms

Infant hospitalization NICU stay

Typicals
(lower risk)



Atypicals
(higher risk)

Small risk of transient abnormal muscle movement

Evidence suggests NO long-term developmental effects

Metabolic complications

Possible large for gestational age

NO data on long-term effects

There is no such thing as no exposure

Need to balance and discuss the risks and benefits of medication treatment and risks of untreated depression

Management of perinatal psychiatric disorders

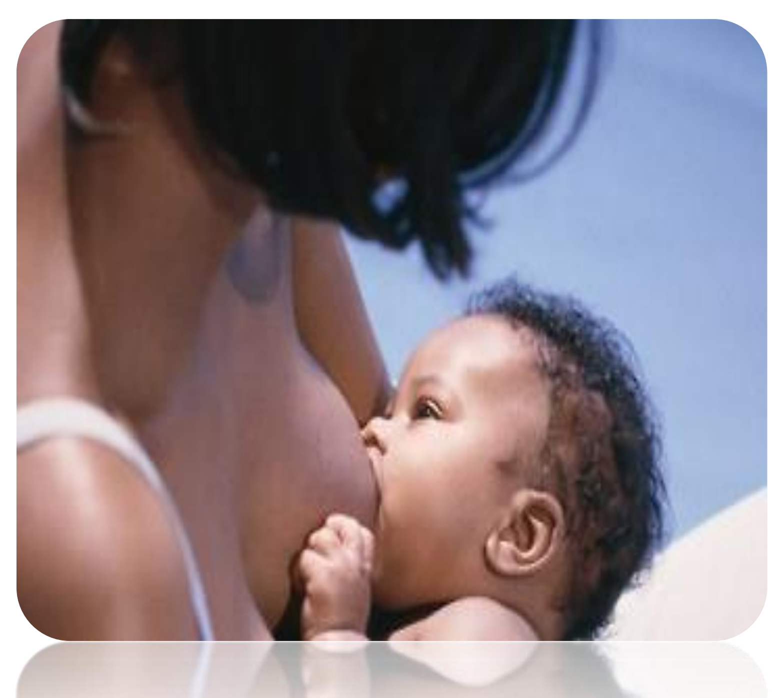
Preconception

Pregnancy

- Depression & Anxiety
- Bipolar & Psychosis

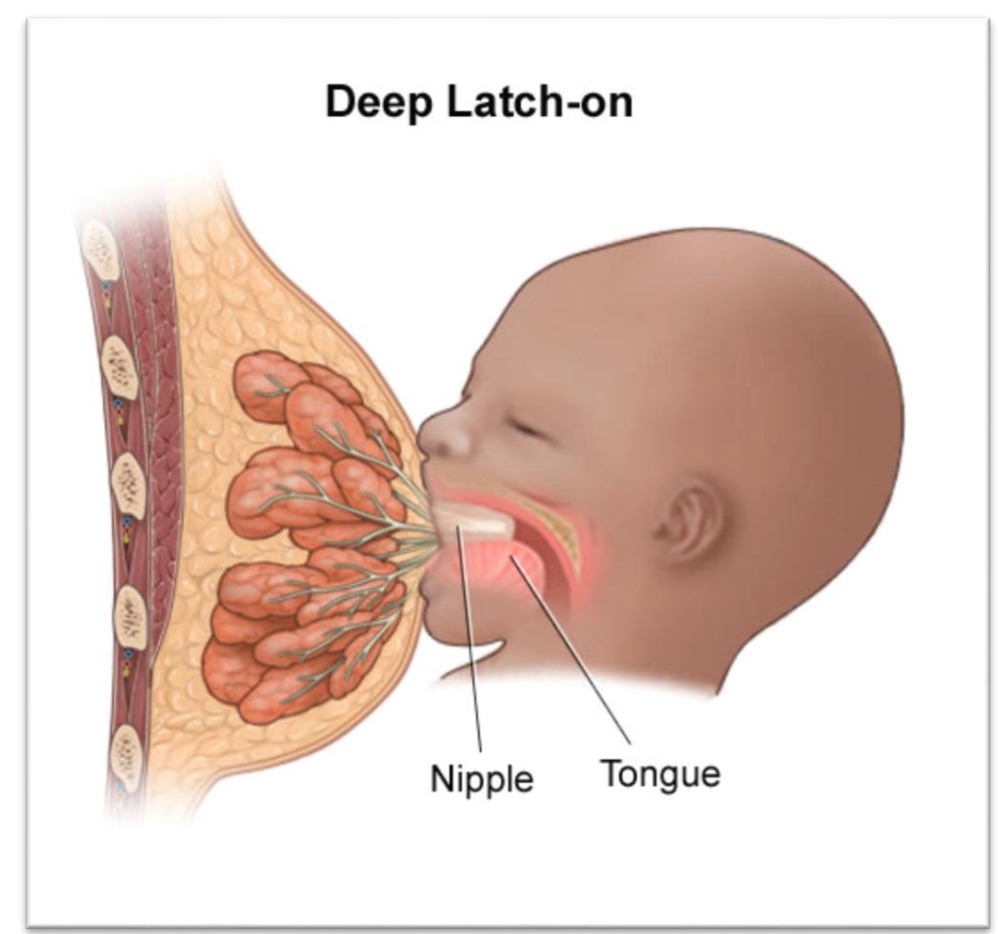
Postpartum

Breastfeeding generally should not preclude treatment with antidepressants



SSRIs and some other antidepressants are considered a reasonable option during breastfeeding

Sertraline, paroxetine, & fluvoxamine have lowest passage into milk



All psychotropic meds are excreted through breastmilk

Medication	AAP
Buproprion	Unknown, but may be of concern
Carbamazepine	Usually compatible with breastfeeding
Valproic acid	Usually compatible with breastfeeding
Lamotrigine	Unknown, but may be of concern
Lithium	Significant side effects, should be used with caution
Olanzapine	Not rated
Risperidone	Not rated
Quetiapine	Not rated

Infant monitoring is needed during lactation for certain medications

Drug	Infant Monitoring
Carbamazepine	CBZ level, CBC, liver enzymes
Valproic acid	VPA level (free and total), liver enzymes, platelets
Lamotrigine	Rash, liver enzymes, lamictal level
Lithium	BUN, CRE, TSH, CBC
Typical antipsychotics	Stiffness, CPK
Atypical antipsychotics	Weight, blood sugar

LactMed website: http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

In summary, psychiatric disorders affect mom, baby and family

Mom	Fetus/Pregnancy	Child/Family
• Suffering • Poor self-care • Suicide	• Preterm birth • LBW • HTN & Preeclampsia	• ↑ risk of depression • Child development • Marriage • Siblings

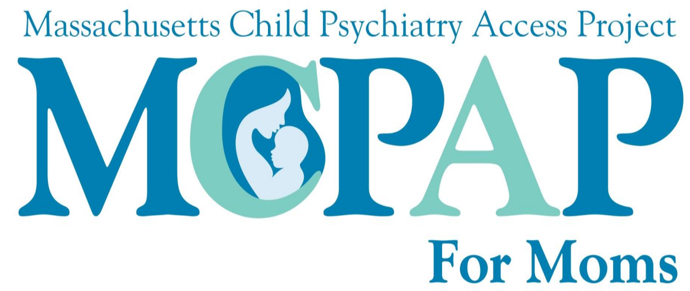
No decision is risk-free

In summary, our aim is to promote maternal and child health by building the capacity of front line providers to address perinatal depression

Please call us with any questions as we are to here to help you

1-855-Mom-MCPAP

www.mcpapformoms.org



Call 1-855-Mom-MCPAP

www.mcpapformoms.org

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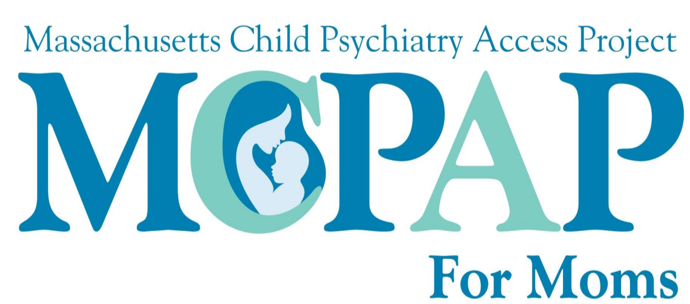

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Thank you!