Promoting Maternal Mental Health During and After Pregnancy

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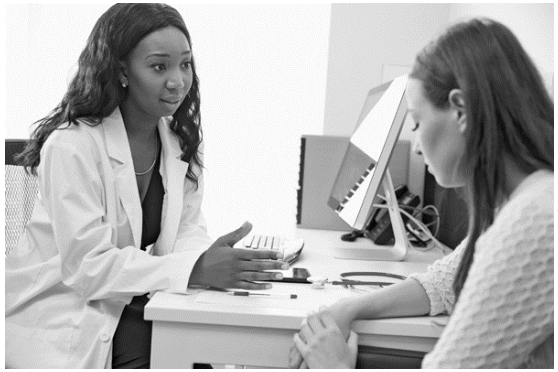
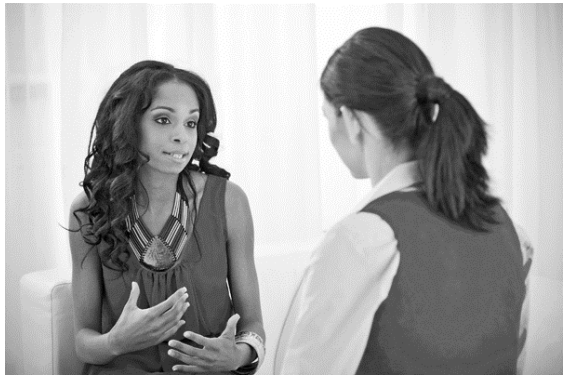
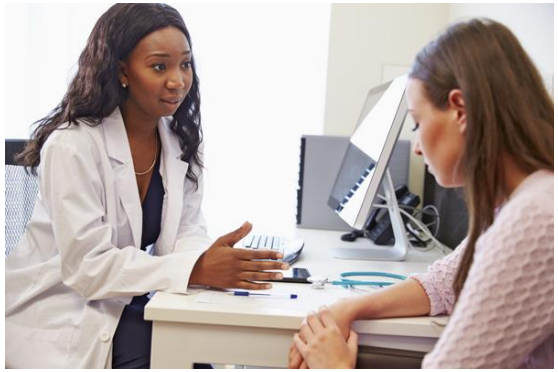
MCPAP For Moms



MCPAP
For Moms





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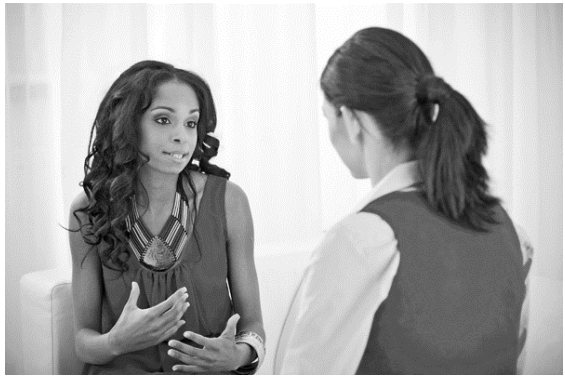

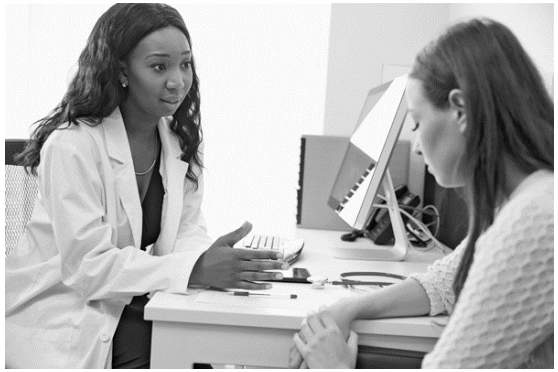

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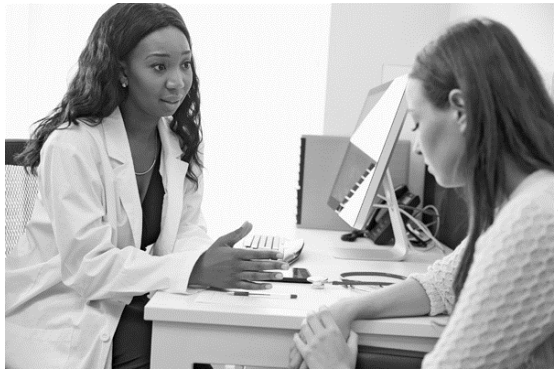

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1 in 7 women suffer from perinatal depression

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

Perinatal depression is twice as common as gestational diabetes

Depression
10 – 15 in 100

Diabetes
3 -7 in 100

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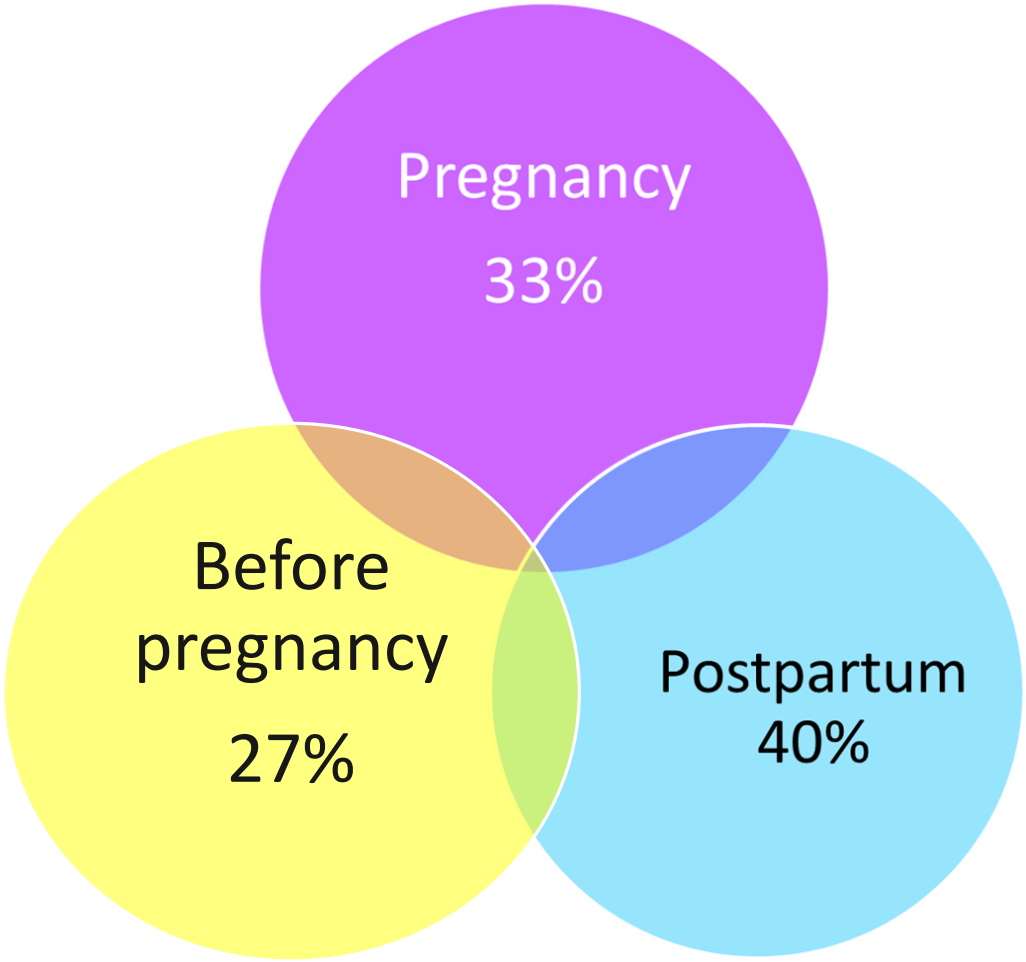
Gavin et al. *Ob Gyn* 2005, Vesga-Lopez et al. *Arch Gen Psychiatry* 2006. *ACOG Practice Bulletin* 2013.

Two – thirds of perinatal depression begins before birth



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Wisner et al. *JAMA Psychiatry* 2013

Optimizing perinatal mental health could break the transgenerational impact of maternal depression

Generation 0 Childhood impact
Maternal depression

Generation 1
Childhood impact

Maternal depression

Generation 2
Childhood impact

Maternal depression

Generation 3
Childhood impact

Maternal depression

Generation 4
Childhood impact

Maternal depression

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Adapted from slide created by Allain Gregoire, DRCOG, MRCPsych

Perinatal depression affects mom, child & family

Poor health care
Substance abuse
Preeclampsia
Maternal suicide

Low birth weight
Preterm delivery
Cognitive delays
Behavioral problems

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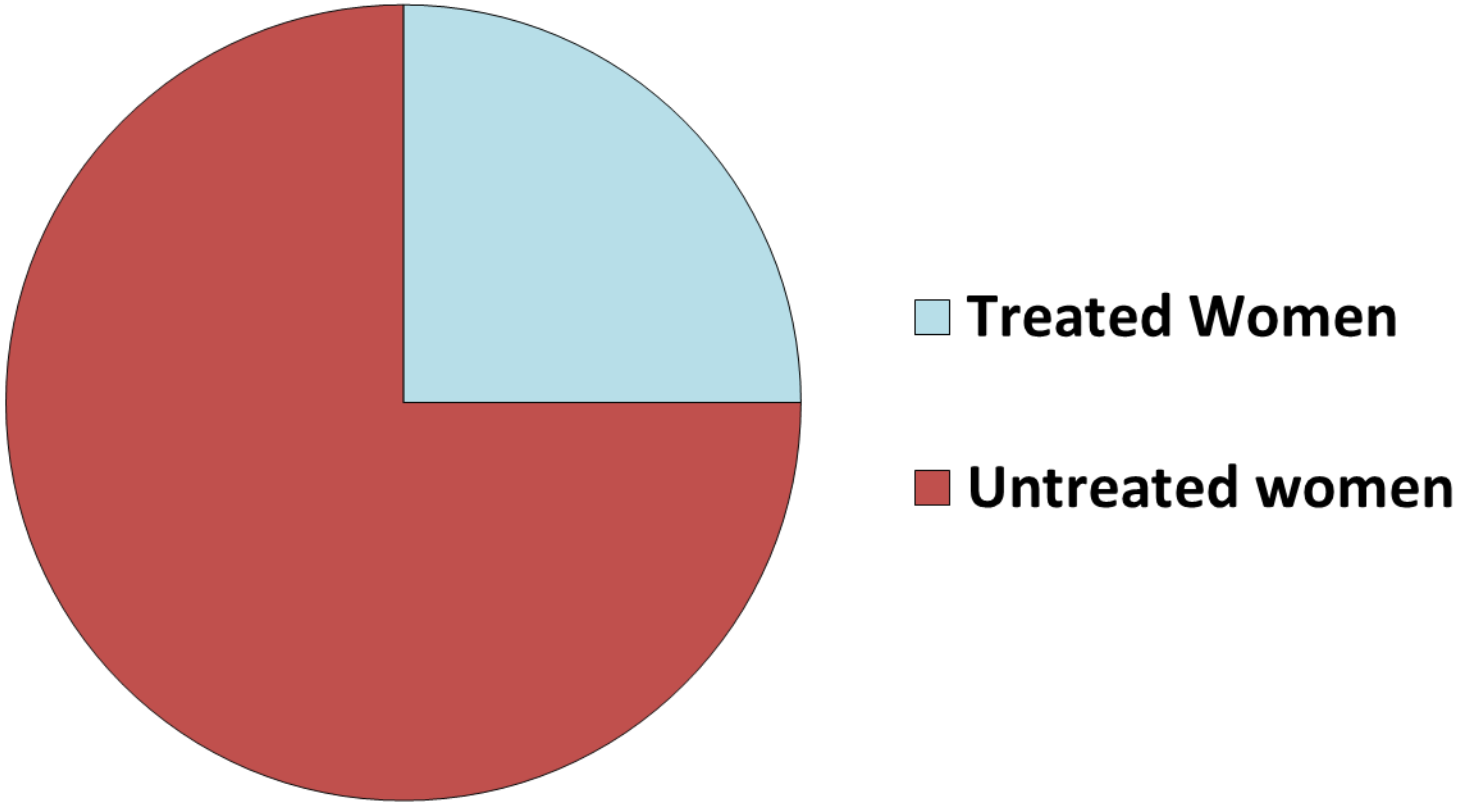
Bodnar et al. *The Journal of clin psych* 2009. Cripe et al. *Pedi and perinatal epidemiology* 2011. Forman et al. *Dev and psych* 2007

Perinatal depression is under-diagnosed and under-treated



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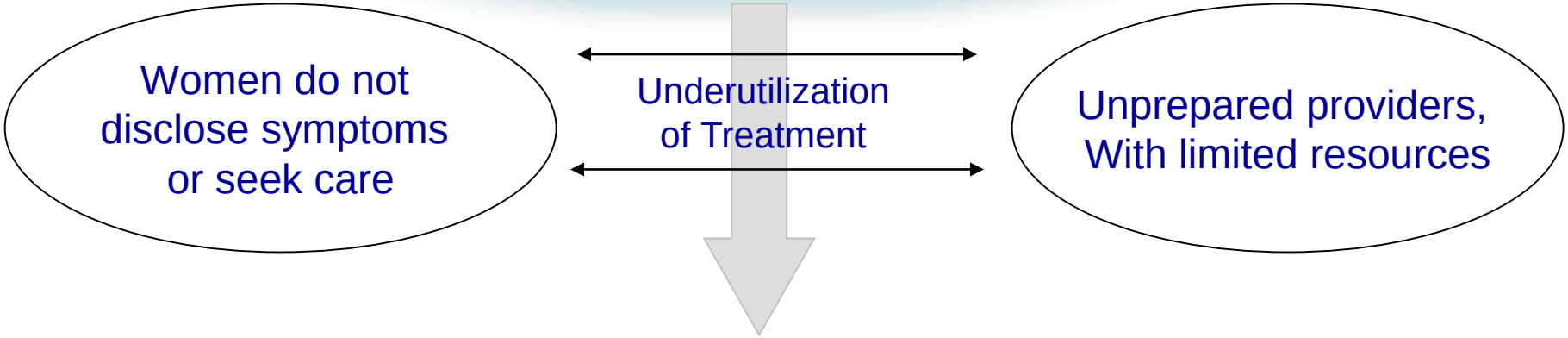
Byatt et al. *Obstetrics and Gynecology*.2015

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



Poor Outcomes

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www.chroniccare.org

The perinatal period is ideal for the detection and treatment of depression

80% of depression is treated by primary care providers

Regular opportunities to screen and engage women in treatment

Front line providers of all types have a pivotal role

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Transforming obstetrical and pediatric practice to include depression care could provide a solution

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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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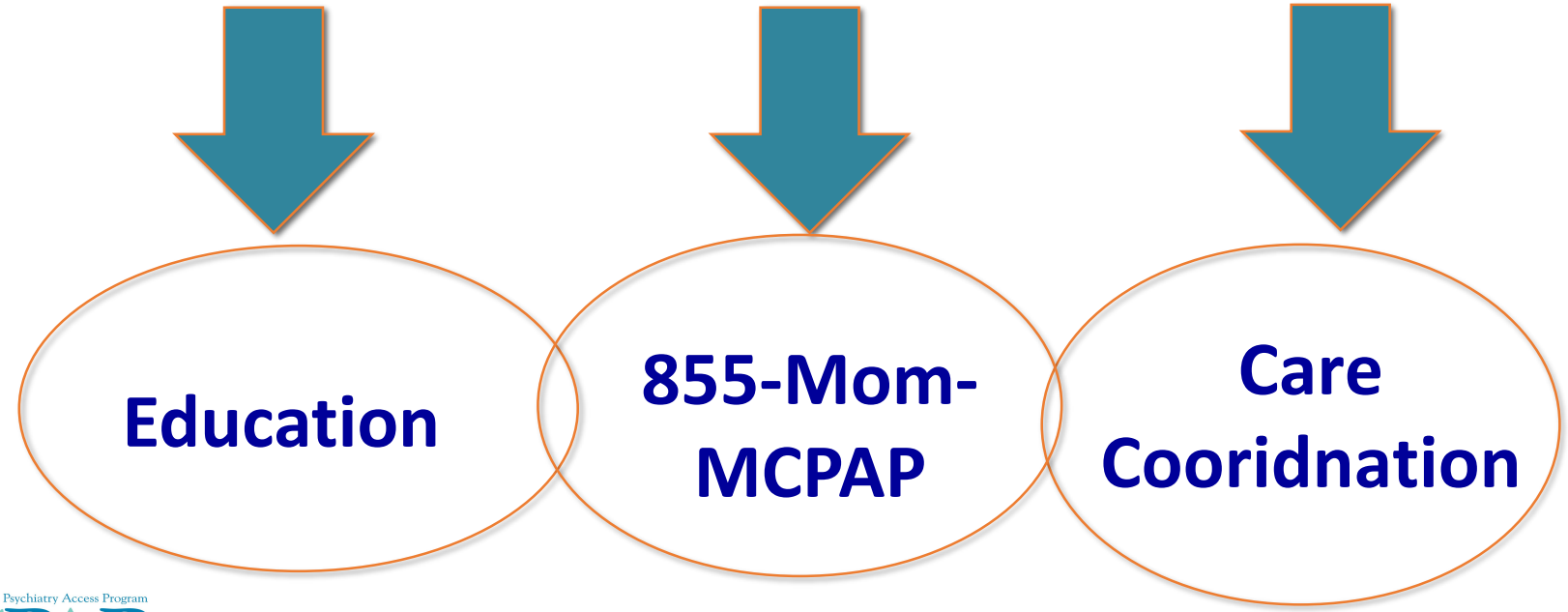

Telephone Consultation

Obstetric providers/ Midwives	**Family Medicine**	**Psychiatric providers**	**Primary care providers**	**Pediatric providers**

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1-855-Mom-MCPAP

Telephone Consultation

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

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1-855-Mom-MCPAP

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

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Care coordination is based on acuity, severity and need

Resources to Provider

Resource and Referral specialist will identify 2-3 targeted resources to deliver via phone or email

Does not involve speaking with mom

Outreach to Patient

Resource and Referral specialist will contact mom and work with her to schedule appointment

Resource and Referral specialist will follow up after 1 month

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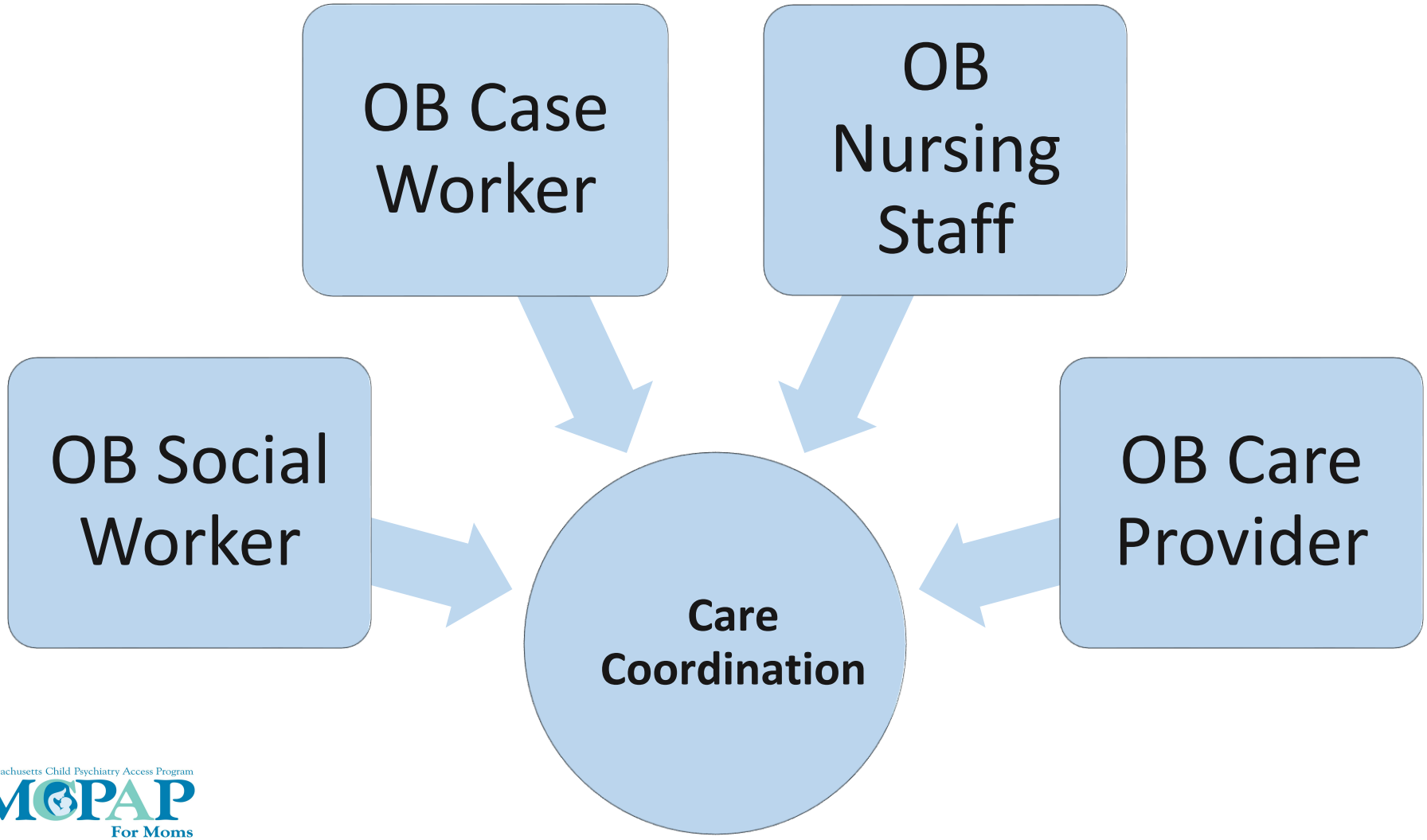
Enrolled practices can call for resources to provider without a telephone consult with a psychiatrist



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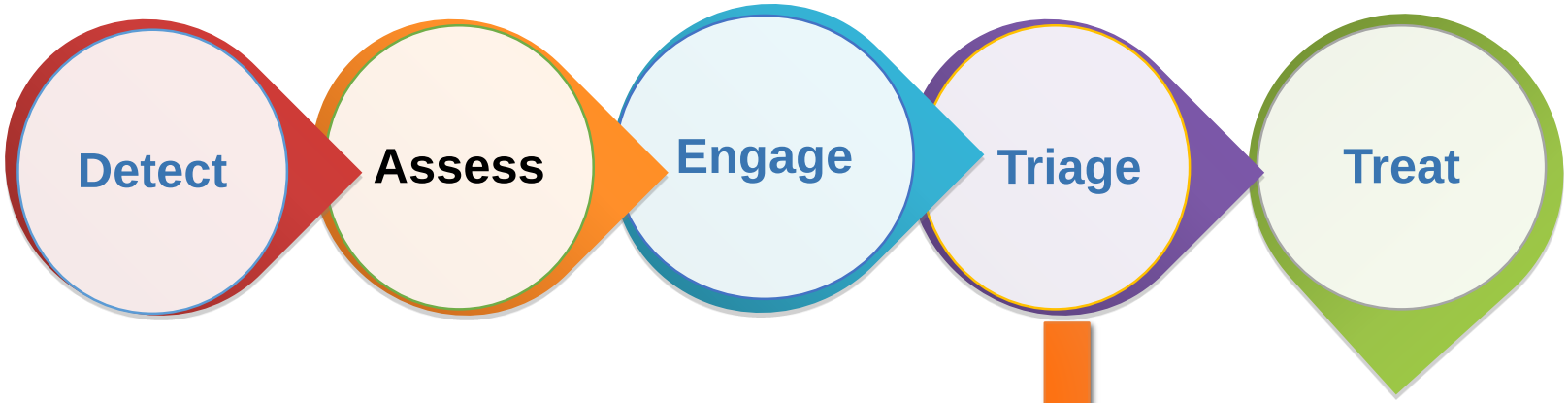

Obs 80%

&

Psychiatrists 20%

Improved outcomes

for moms, babies and families

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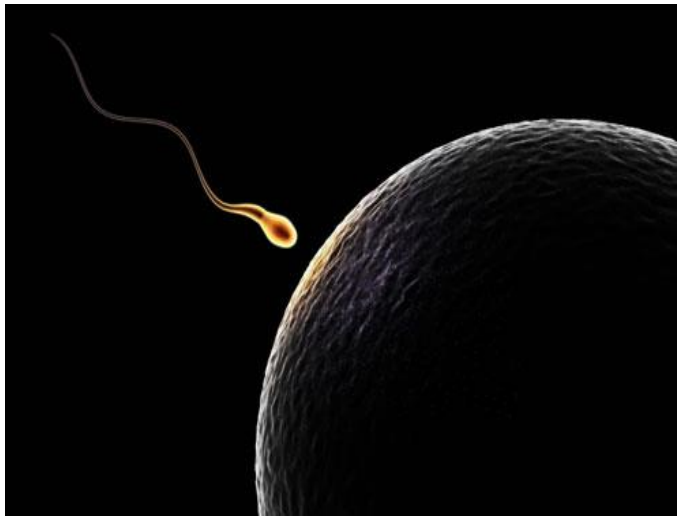
Bidirectional relationship between depression and infertility likely exists



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Freeman et al. *Annals of Clinical Psychiatry* 2013

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

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Administer Edinburgh Postnatal Depression Scale

Administer EPDS for high-risk patients

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Steps after a positive screen

- ☑ Assess severity and comorbidities
- ☑ Consider all treatment and support options
- ☑ Consider patient preference
- ☑ Rule out bipolar disorder
- ☑ Consider treatment risks/benefits

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Steps after a positive screen

- ☑ **Assess severity and comorbidities**
- ☑ Consider all treatment and support options
- ☑ Consider patient preference
- ☑ Rule out bipolar disorder
- ☑ Consider treatment risks/benefits

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EPDS scores range 0 - 30

< 10	• Depression unlikely
≥10	• Possible depression
≥ 13	• Probable depression

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Cox et al. *British Journal of Psych* 1987. Wisner et al.*Postpartum Depression N Engl J Med* 2002.

Screening is reimbursed once during pregnancy and once postpartum for MassHealth patients

Use Code S3005

- Behavioral health need is identified

Modifier U3

Use Code S3005

- No Behavioral health need is identified

Modifier U4

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Baby Blues

≤ 2 wk

Mood lability

High emotionality

Depression

≥2 wks

Guilt, feeling worthless

Suicidal thoughts

Impacts functioning

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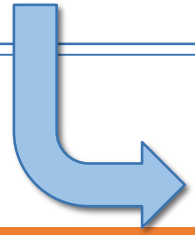
Assess for other comorbidities and medical causes

- PTSD and other anxiety disorders
- Eating disorders
- Substance abuse
- Medical causes



Check TSH, CBC, B12, Vitamin D, and folate

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Risk of harm to baby

OCD/anxiety

- Good insight
- Thoughts are intrusive and scary
- No psychotic symptoms
- Thoughts cause anxiety

Low risk

Postpartum Psychosis

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

High risk

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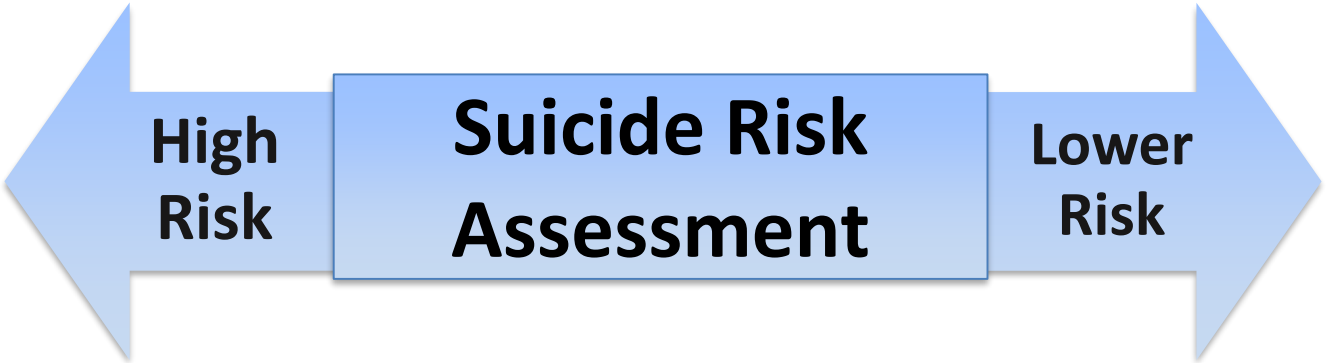

High Risk	Lower Risk
History of suicide attempt	No prior attempts
High lethality of prior attempts	If prior attempts, low lethality & high rescue potential
Recent attempt	
Current plan	No plan
Current intent	No intent
Substance use	No substance use
Lack of protective factors (including social support)	Protective factors

Key clinical considerations after a positive screen

- ☑ Severity
- ☑ **Consider all treatment and support options**
- ☑ Patient preference
- ☑ Bipolar vs. unipolar depression
- ☑ Consider treatment risks/benefits

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Education about various treatment and support options is imperative

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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

Psychotic symptoms present

History of severe depression and/or suicide ideation/attempts

Comorbid anxiety

Linkages with support groups and community resources

Support the wellness and mental health of perinatal women

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Can refer moms to www.mcpapformoms.org

Steps after a positive screen

- ☑ Assess severity and comorbidities
- ☑ Consider all treatment and support options
- ☑ **Consider patient preference**
- ☑ Rule out bipolar disorder
- ☑ Consider treatment risks/benefits

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Ask women what type of treatment they prefer

There are effective options for treatment during pregnancy and breastfeeding.

Depression is very common during pregnancy and the postpartum period.

There is no risk free decision.

Women need to take medication during pregnancy for all sort of things.

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Steps after a positive screen

- ☑ Assess severity and comorbidities
- ☑ Consider all treatment and support options
- ☑ Consider patient preference
- ☑ **Rule out bipolar disorder**
- ☑ Consider treatment risks/benefits

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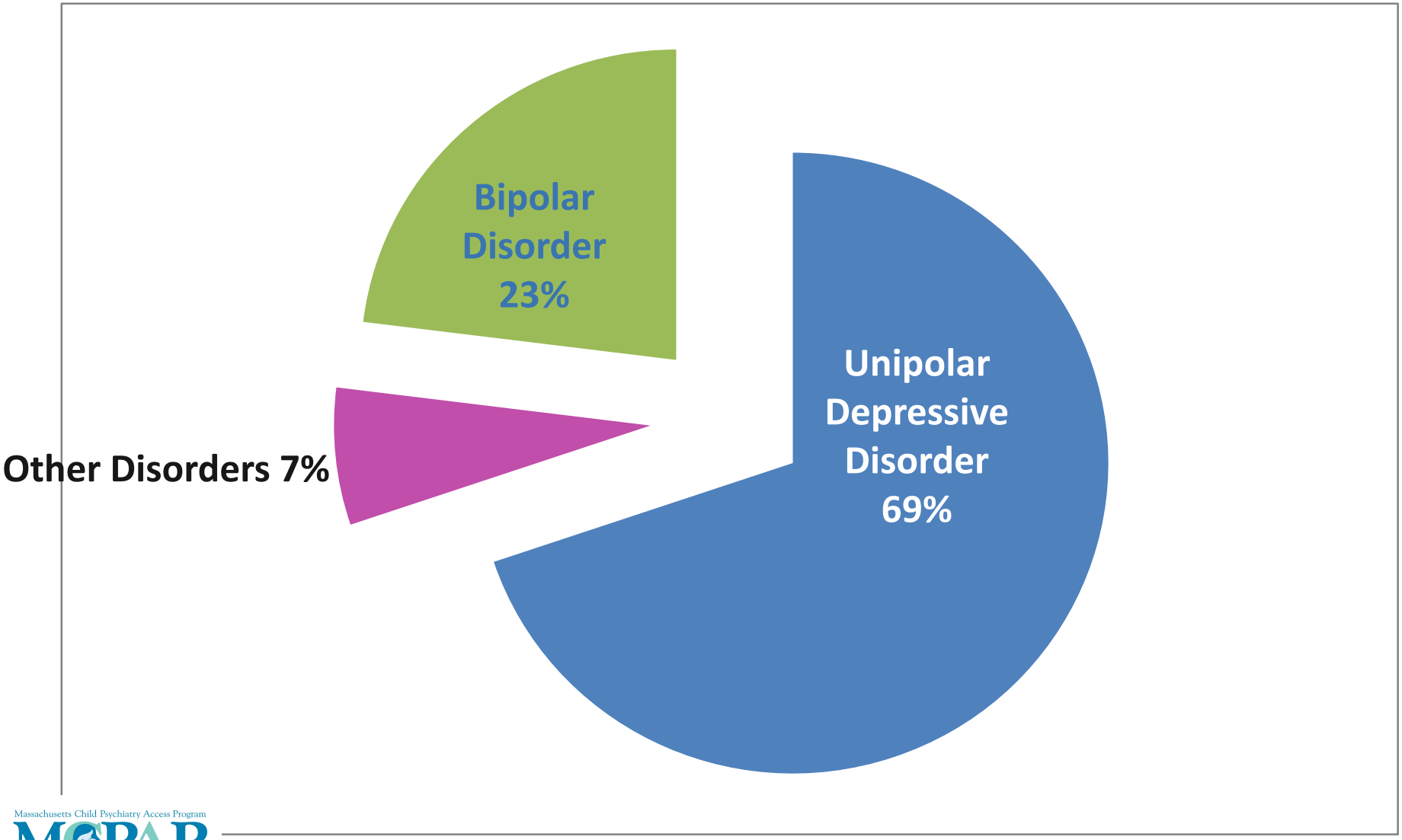
Imperative to address bipolar disorder



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Wisner et al. *JAMA Psychiatry.* 2013

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

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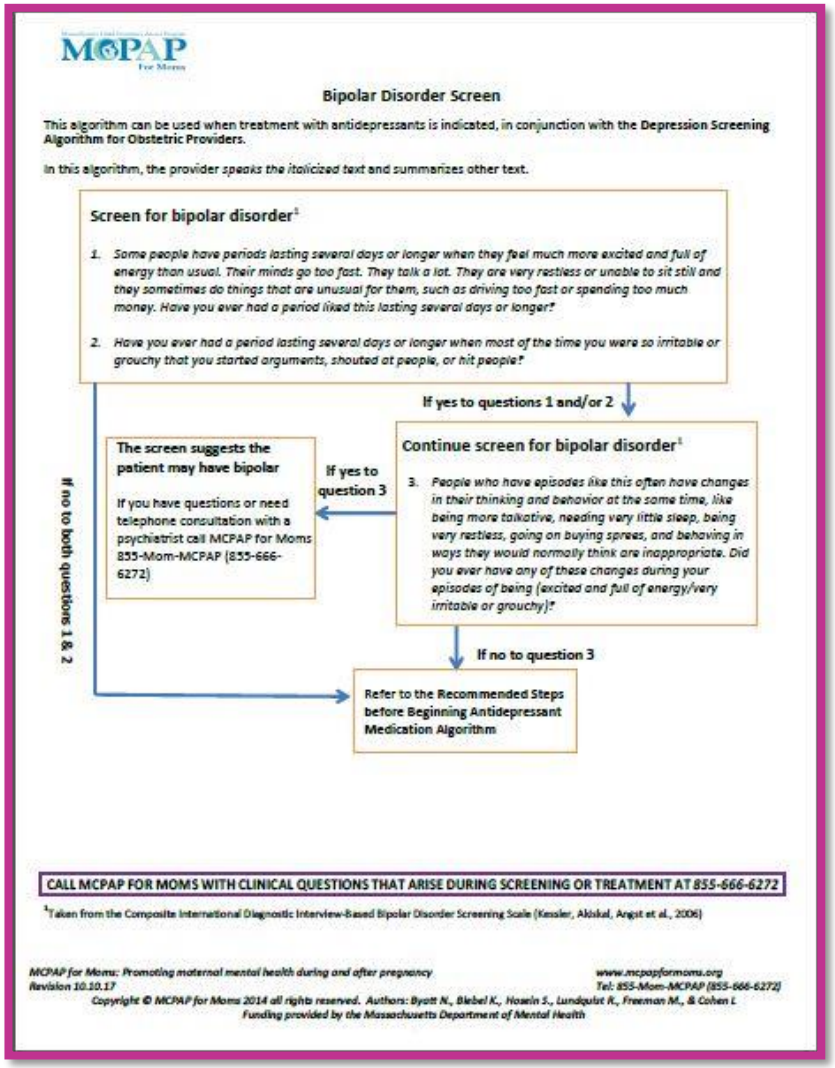
Bipolar Disorder Screen



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Bipolar Disorder Screen

This algorithm can be used when treatment with antidepressants is indicated, in conjunction with the **Depression Screening Algorithm for Obstetric Providers.**

In this algorithm, the provider *speaks the italicized text* and summarizes other text.

Screen for bipolar disorder[1]

1. *Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period liked this lasting several days or longer?*
2. *Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?*

If yes to questions 1 and/or 2

Continue screen for bipolar disorder[1]

3. *People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in ways they would normally think are inappropriate. Did you ever have any of these changes during your episodes of being (excited and full of energy/very irritable or grouchy)?*

If yes to question 3

The screen suggests the patient may have bipolar

If you have questions or need telephone consultation with a psychiatrist call MCPAP for Moms 855-Mom-MCPAP (855-666-6272)

If no to both questions 1 & 2

If no to question 3

Refer to the Recommended Steps before Beginning Antidepressant Medication Algorithm

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

[1]Taken from the Composite International Diagnostic Interview-Based Bipolar Disorder Screening Scale (Kessler, Akiskal, Angst et al., 2006)

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Tel: 855-Mom-MCPAP (855-666-6272)

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Steps after a positive screen

- ☑ Assess severity and comorbidities
- ☑ Consider all treatment and support options
- ☑ Consider patient preference
- ☑ Rule out bipolar disorder
- ☑ **Consider treatment risks/benefits**

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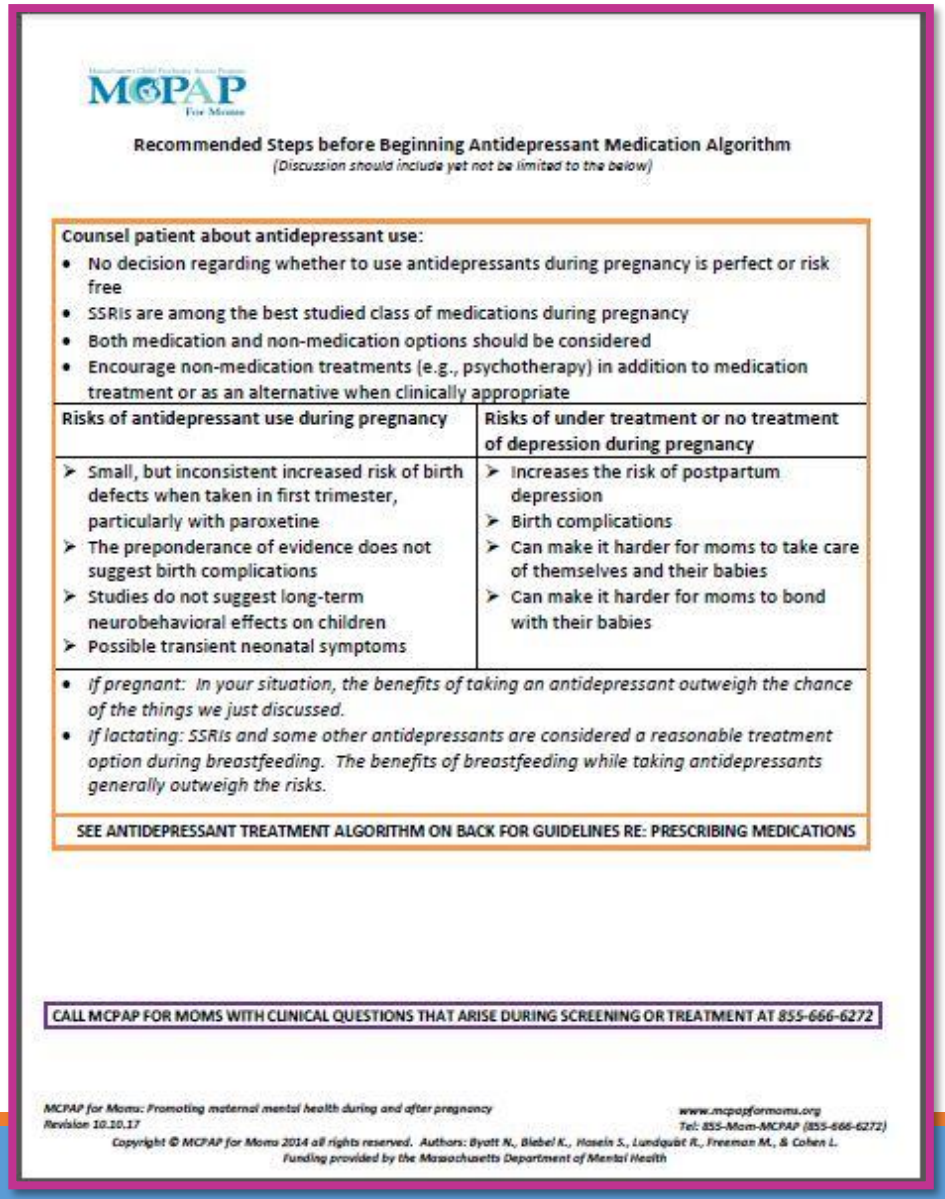
Treatment - Recommended Steps Before Beginning Antidepressant Treatment



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Recommended Steps before Beginning Antidepressant Medication Algorithm

(Discussion should include yet not be limited to the below)

Counsel patient about antidepressant use:

- No decision regarding whether to use antidepressants during pregnancy is perfect or risk free
- SSRIs are among the best studied class of medications during pregnancy
- Both medication and non-medication options should be considered
- Encourage non-medication treatments (e.g., psychotherapy) in addition to medication treatment or as an alternative when clinically appropriate

Risks of antidepressant use during pregnancy	Risks of under treatment or no treatment of depression during pregnancy
➢ Small, but inconsistent increased risk of birth defects when taken in first trimester, particularly with paroxetine ➢ The preponderance of evidence does not suggest birth complications ➢ Studies do not suggest long-term neurobehavioral effects on children ➢ Possible transient neonatal symptoms	➢ Increases the risk of postpartum depression ➢ Birth complications ➢ Can make it harder for moms to take care of themselves and their babies ➢ Can make it harder for moms to bond with their babies

- *If pregnant: In your situation, the benefits of taking an antidepressant outweigh the chance of the things we just discussed.*
- *If lactating: SSRIs and some other antidepressants are considered a reasonable treatment option during breastfeeding. The benefits of breastfeeding while taking antidepressants generally outweigh the risks.*

SEE ANTIDEPRESSANT TREATMENT ALGORITHM ON BACK FOR GUIDELINES RE: PRESCRIBING MEDICATIONS

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No decision is risk free

Vs.

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

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Byatt et al. *Acta Psych Scand* 2013.

Case of Ms. Y

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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.

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

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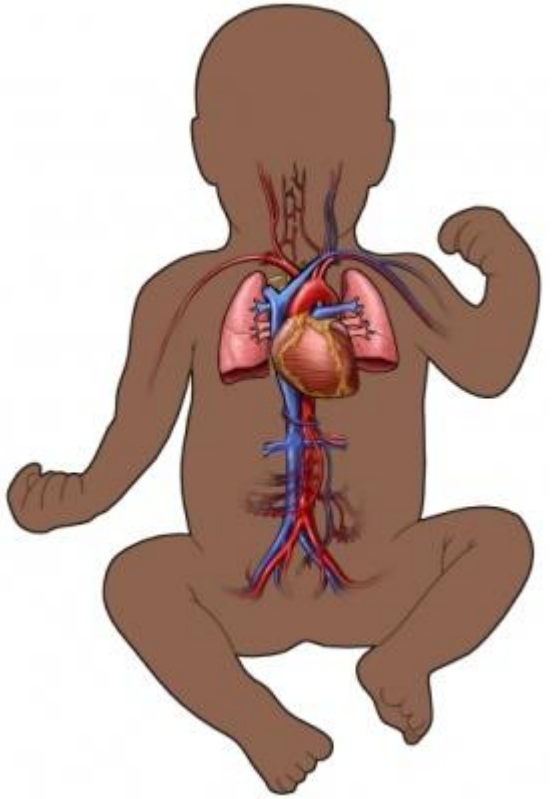
Moses-kolko et al JAMA 2005, Warburton et al. *Acta Psychiatr Scand* 2010.

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

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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

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Huybrecht et al. *PLoS ONE*. 2014

Studies do not suggest long-term neurobehavioral effects on children

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

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

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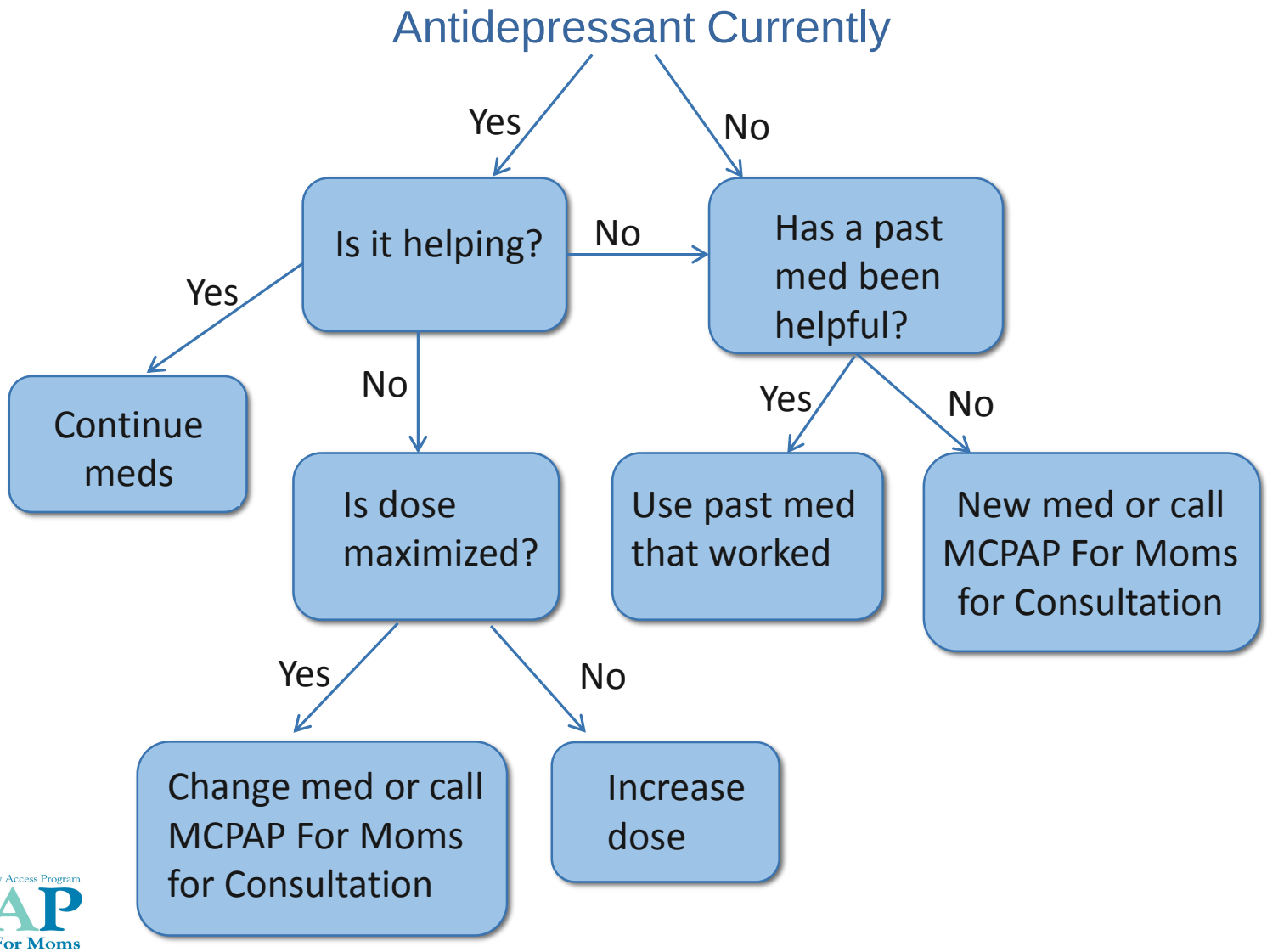
Antidepressants treatment algorithm



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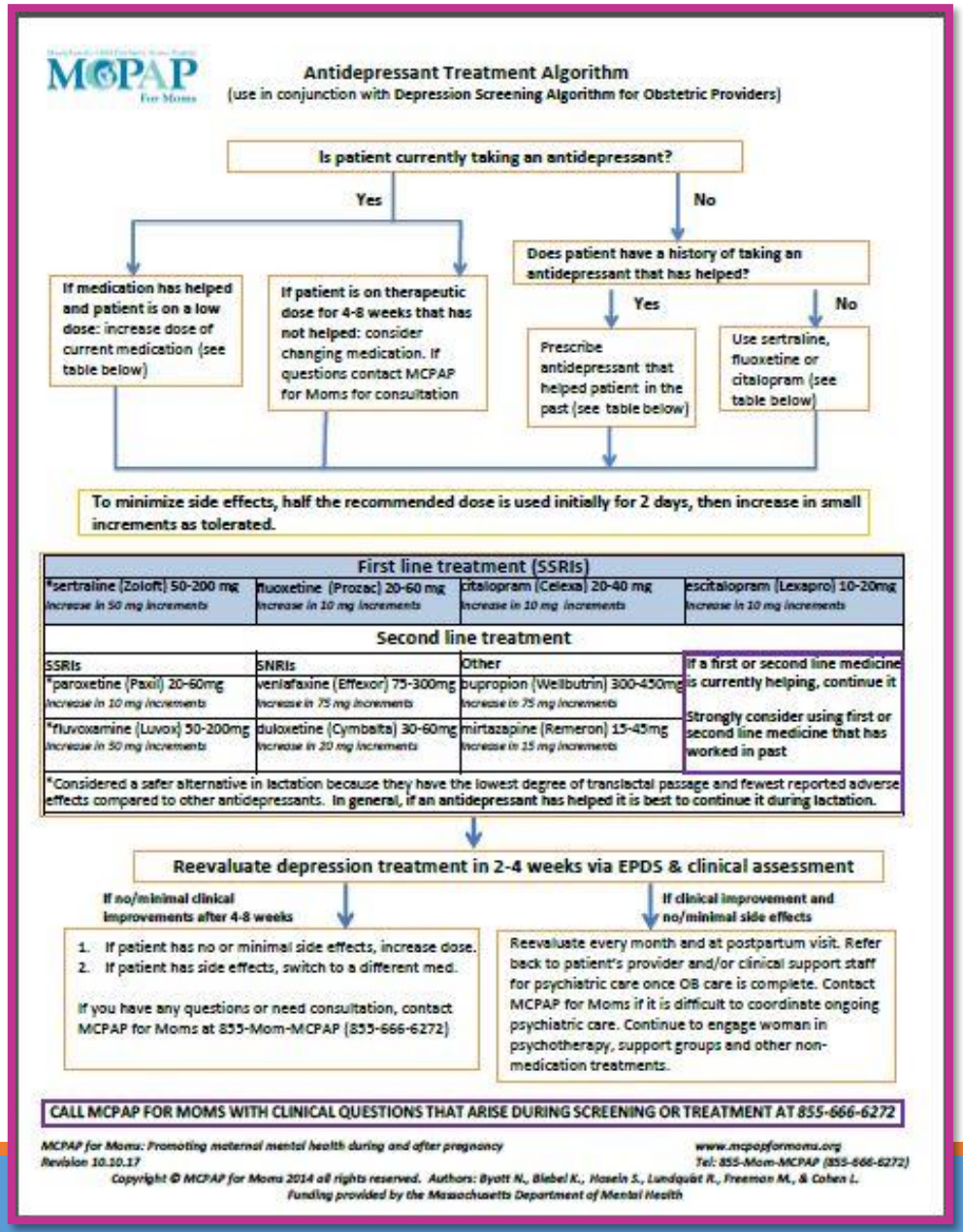
Treatment - Antidepressant Treatment Algorithm



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Antidepressant Treatment Algorithm
(use in conjunction with Depression Screening Algorithm for Obstetric Providers)

Is patient currently taking an antidepressant?

Yes

- If medication has helped and patient is on a low dose: increase dose of current medication (see table below)
- If patient is on therapeutic dose for 4-8 weeks that has not helped: consider changing medication. If questions contact MCPAP for Moms for consultation

No

Does patient have a history of taking an antidepressant that has helped?

- **Yes** → Prescribe antidepressant that helped patient in the past (see table below)
- **No** → Use sertraline, fluoxetine or citalopram (see table below)

To minimize side effects, half the recommended dose is used initially for 2 days, then increase in small increments as tolerated.

First line treatment (SSRIs)

*sertraline (Zoloft) 50-200 mg	fluoxetine (Prozac) 20-60 mg	citalopram (Celexa) 20-40 mg	escitalopram (Lexapro) 10-20mg
Increase in 50 mg increments	*Increase in 10 mg increments*	*Increase in 10 mg increments*	*Increase in 10 mg increments*

Second line treatment

SSRIs	SNRIs	Other
*paroxetine (Paxil) 20-60mg *Increase in 10 mg increments*	venlafaxine (Effexor) 75-300mg *Increase in 75 mg increments*	bupropion (Wellbutrin) 300-450mg *Increase in 75 mg increments*
*fluvoxamine (Luvox) 50-200mg *Increase in 50 mg increments*	duloxetine (Cymbalta) 30-60mg *Increase in 20 mg increments*	mirtazapine (Remeron) 15-45mg *Increase in 15 mg increments*

If a first or second line medicine is currently helping, continue it

Strongly consider using first or second line medicine that has worked in past

*Considered a safer alternative in lactation because they have the lowest degree of transfactal passage and fewest reported adverse effects compared to other antidepressants. **In general, if an antidepressant has helped it is best to continue it during lactation.**

Reevaluate depression treatment in 2-4 weeks via EPDS & clinical assessment

If no/minimal clinical improvements after 4-8 weeks

1. If patient has no or minimal side effects, increase dose.
2. If patient has side effects, switch to a different med.

If you have any questions or need consultation, contact MCPAP for Moms at 855-Mom-MCPAP (855-666-6272)

If clinical improvement and no/minimal side effects

Reevaluate every month and at postpartum visit. Refer back to patient's provider and/or clinical support staff for psychiatric care once OB care is complete. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.

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Start antidepressants at a low dose and increase in small increments every 2 days

SSRIs	Starting & Increment Dose (mg/day)	Target Dose (mg/day)
sertaline (Zoloft)	25	75-200
citalopram (Celexa)	10	20-40
escitalopram (Lexapro)	5	10-20
fluoxetine (Prozac)	10	20-80

Tell women only to increase dose if tolerating

Otherwise, wait until side effects dissipate before increasing

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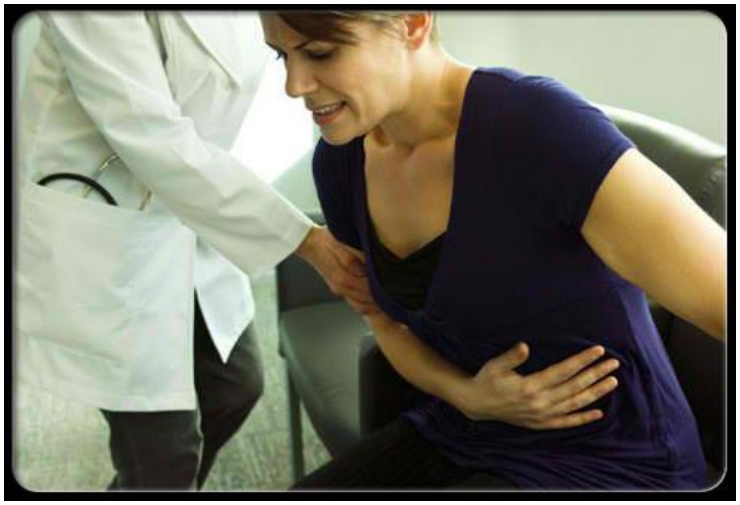
General side effects of antidepressants

Temporary

- Nausea
- Constipation/Diarrhea
- Lightheaded
- Headaches



Long-term

- Increase in appetite/weight gain
- Sexual side effects
- Vivid dreams/insomnia

Direct patients to take medication with food to decrease side effects

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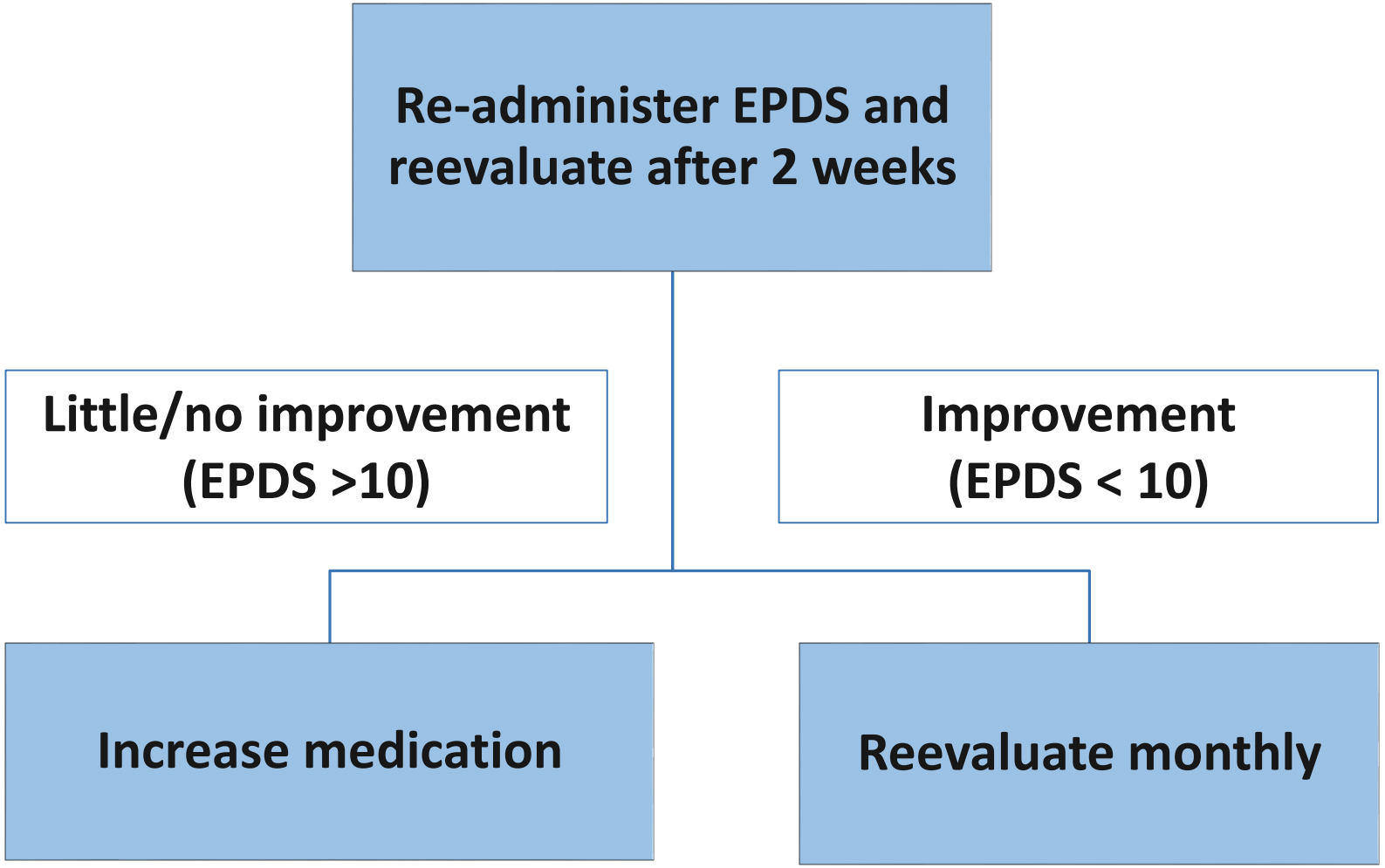
After starting antidepressant re-administer EPDS



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Prescribing principles for 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

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Breastfeeding generally should not preclude treatment with antidepressants

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

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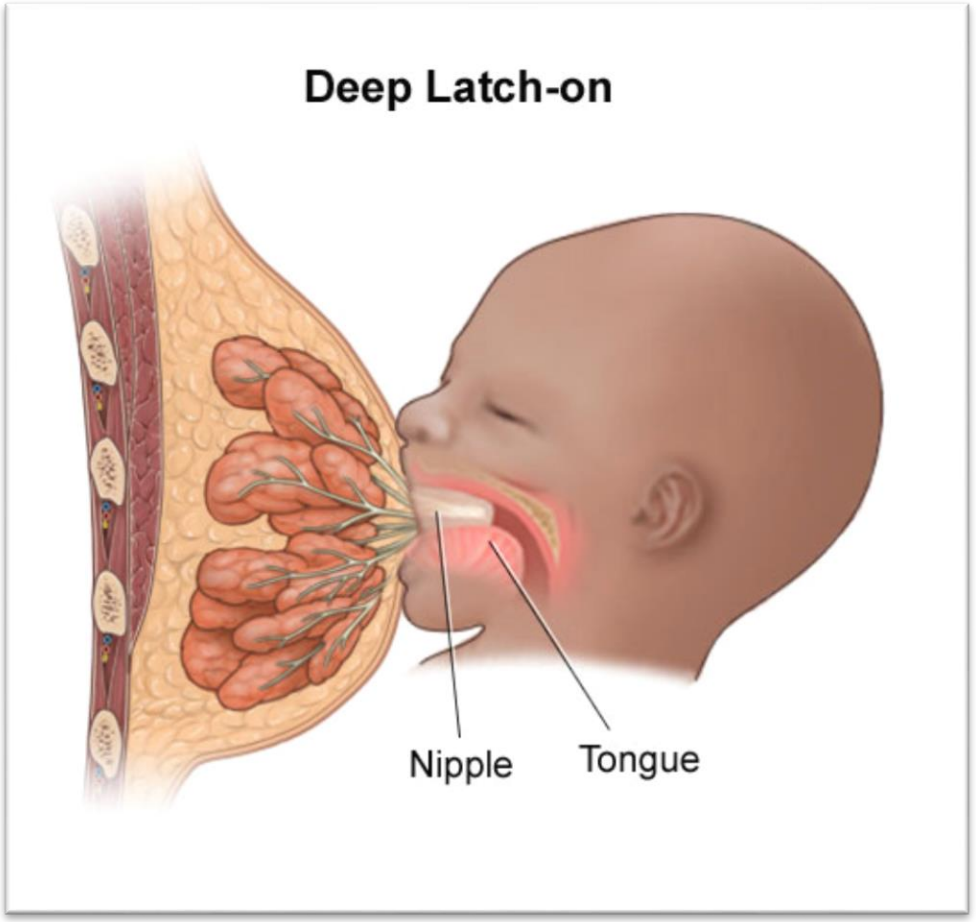
Sertraline, paroxetine, & fluvoxamine have lowest passage into milk



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Steps after a positive screen

- ☑ Assess severity and comorbidities
- ☑ Consider all treatment and support options
- ☑ Consider patient preference
- ☑ Rule out bipolar disorder
- ☑ Consider treatment risks/benefits

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

1-855-Mom-MCPAP

www.mcpapformoms.org

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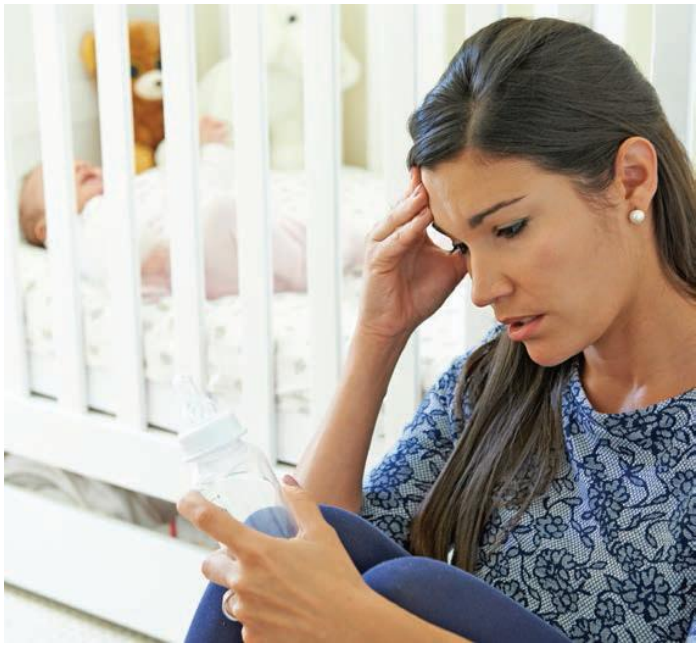
In summary, our aim is to promote maternal and child health by building the capacity of front line providers to address perinatal depression



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Thank you!