Postpartum Psychosis

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Massachusetts Child Psychiatry Access Project MCPAP For Moms

UMass Chan MEDICAL SCHOOL

Lifeline for families

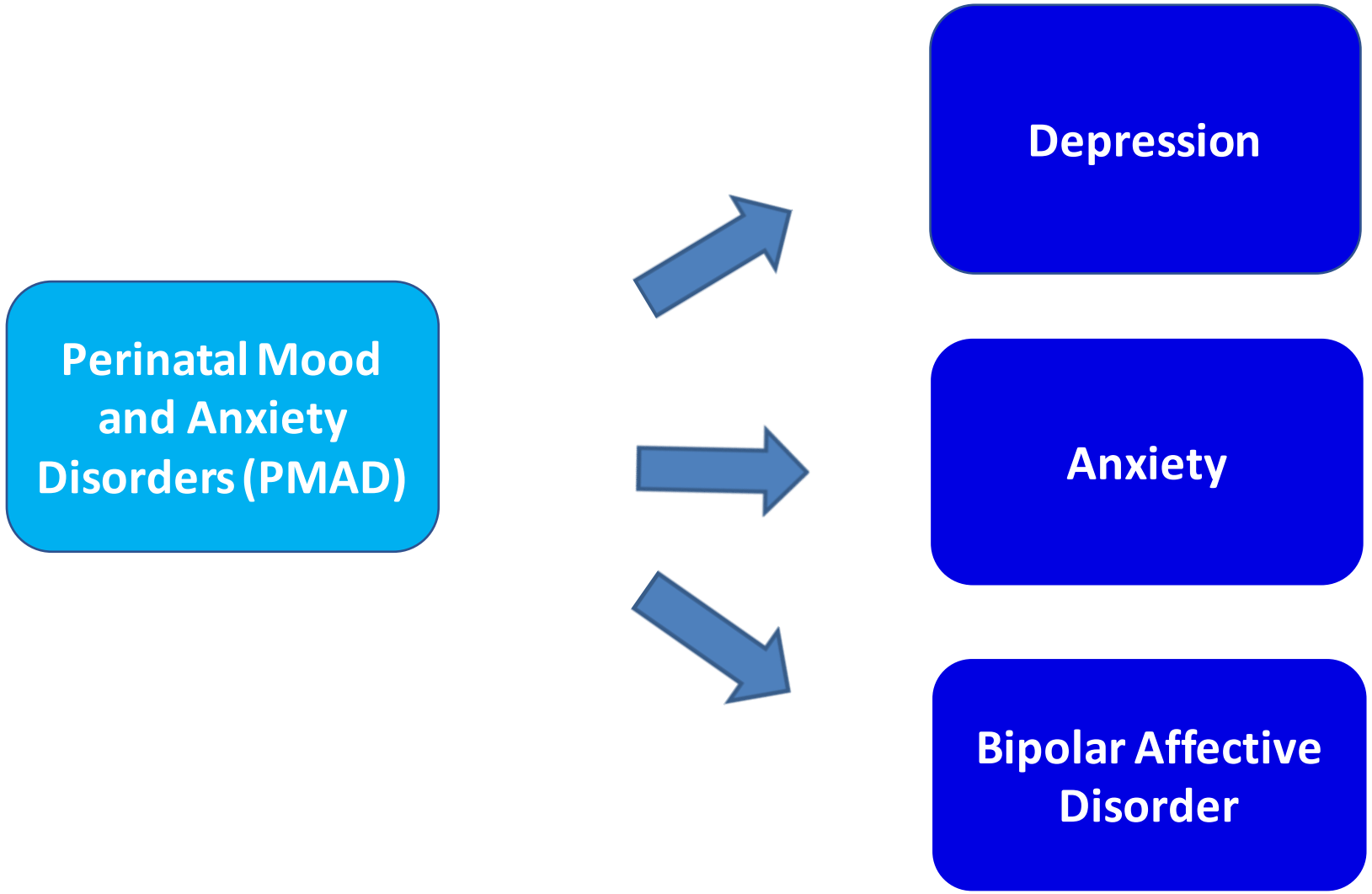
I have no disclosures: Uruj Kamal Haider MD

Post Partum Psychosis: Objectives

- Risk factors
- Clinical features
- Differential diagnosis
- Evaluation of postpartum psychosis
- MCPAP for Moms role in supporting providers

Massachusetts Child Psychiatry Access Project
MCPAP
For Moms

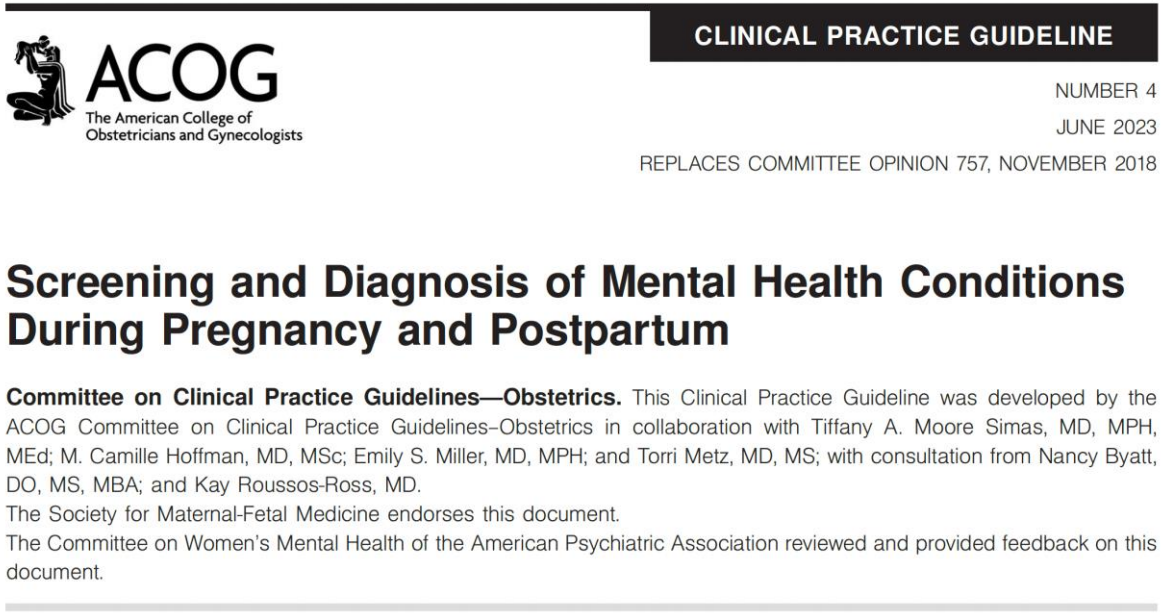
Perinatal mental health affects all of us



Health care systems need to change to help promote perinatal mental health

Perinatal mood and anxiety disorders are recognized as a major public health problem

The perinatal period is ideal for the detection and treatment of mood and anxiety disorders



ACOG
The American College of Obstetricians and Gynecologists

CLINICAL PRACTICE GUIDELINE

NUMBER 4

JUNE 2023

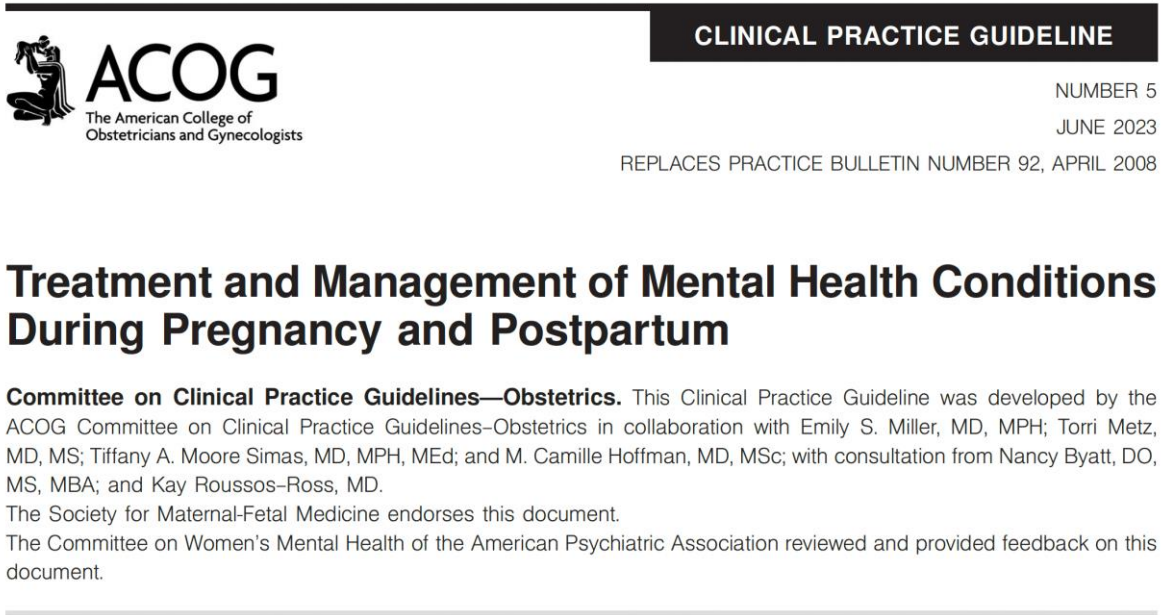
REPLACES COMMITTEE OPINION 757, NOVEMBER 2018

Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum

Committee on Clinical Practice Guidelines—Obstetrics. This Clinical Practice Guideline was developed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics in collaboration with Tiffany A. Moore Simas, MD, MPH, MEd; M. Camille Hoffman, MD, MSc; Emily S. Miller, MD, MPH; and Torri Metz, MD, MS; with consultation from Nancy Byatt, DO, MS, MBA; and Kay Roussos-Ross, MD.

The Society for Maternal-Fetal Medicine endorses this document.

The Committee on Women's Mental Health of the American Psychiatric Association reviewed and provided feedback on this document.



ACOG
The American College of Obstetricians and Gynecologists

CLINICAL PRACTICE GUIDELINE

NUMBER 5

JUNE 2023

REPLACES PRACTICE BULLETIN NUMBER 92, APRIL 2008

Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum

Committee on Clinical Practice Guidelines—Obstetrics. This Clinical Practice Guideline was developed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics in collaboration with Emily S. Miller, MD, MPH; Torri Metz, MD, MS; Tiffany A. Moore Simas, MD, MPH, MEd; and M. Camille Hoffman, MD, MSc; with consultation from Nancy Byatt, DO, MS, MBA; and Kay Roussos-Ross, MD.

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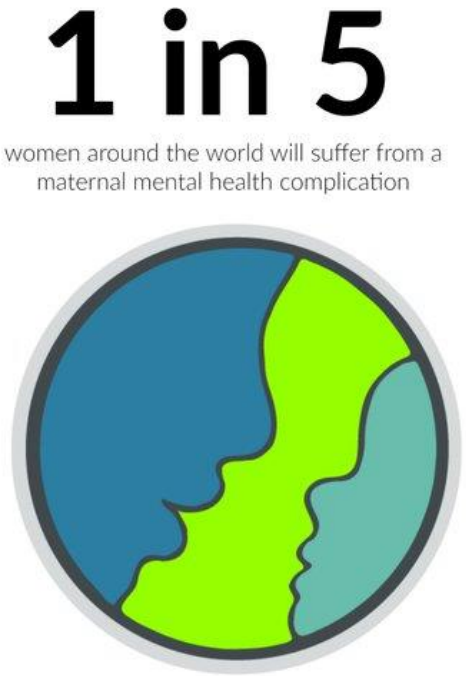
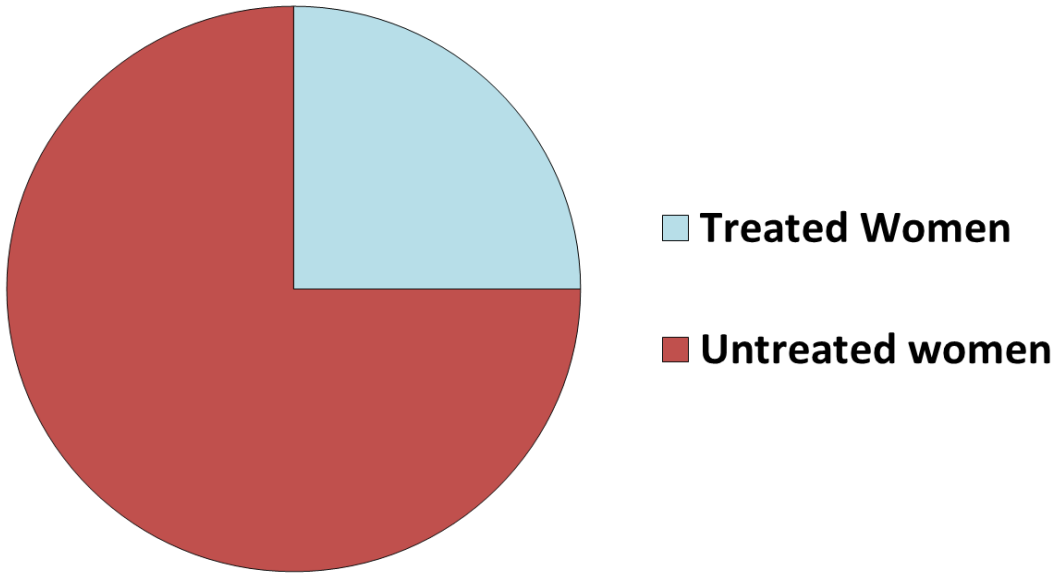
Perinatal mental health and substance use disorders are common, undertreated, and the leading cause of maternal death in the US

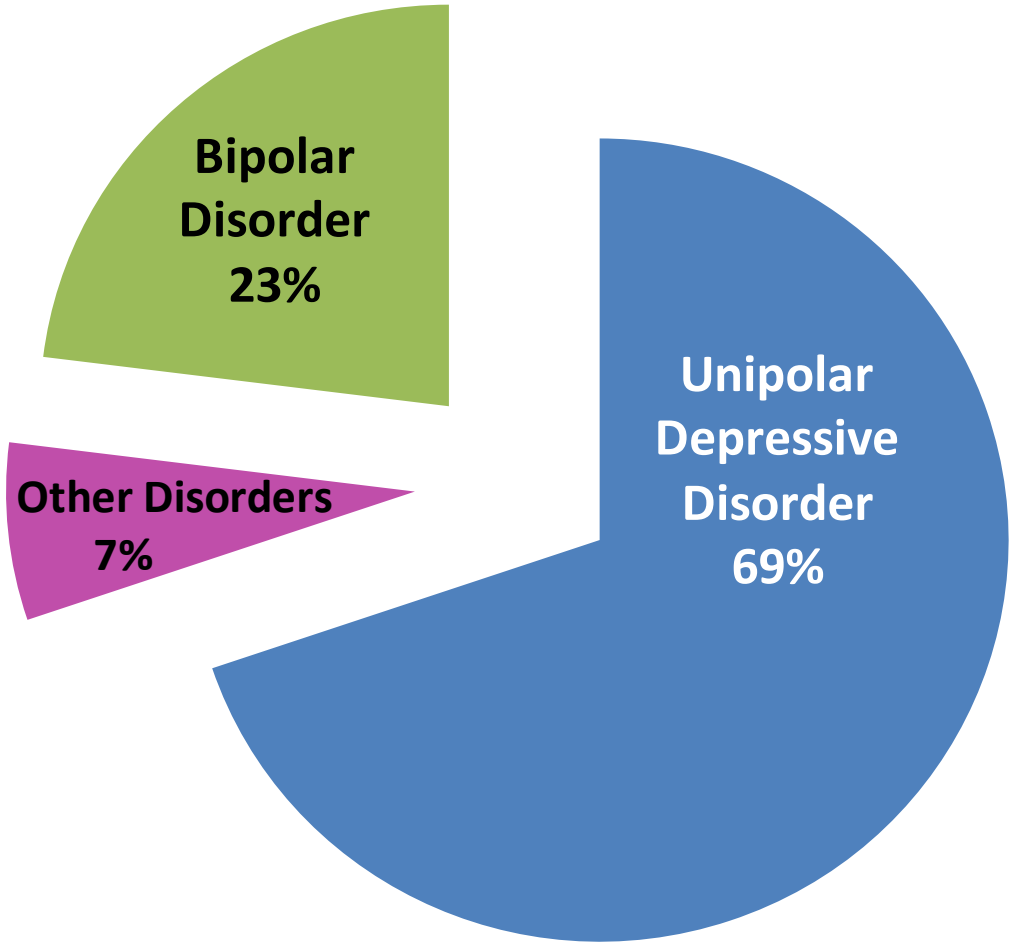




Mental health conditions are the underlying cause of 23% of maternal deaths in the US

Trost S, et al. (2022) *CDC MMRC Report*. https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html (2022).

Bipolar disorder is particularly common during the perinatal time period as compared to other time periods

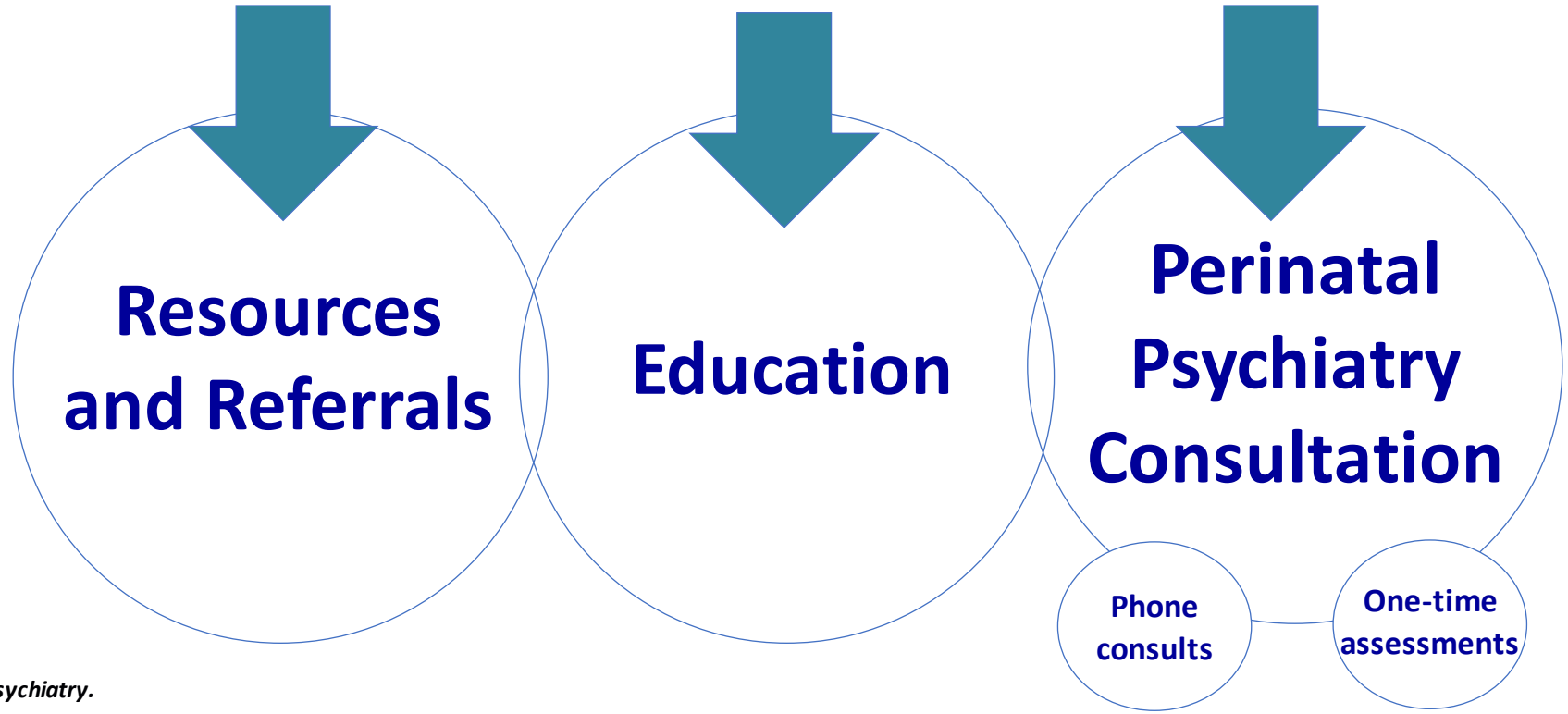


Wisner et al (2013). JAMA Psychiatry.

MCPAP for Moms can help provide a solution by building the capacity of perinatal care settings to provide mental health care

Massachusetts Child Psychiatry Access Program

MCPAP For Moms



Byatt et al. (2016). *General Hospital Psychiatry*.

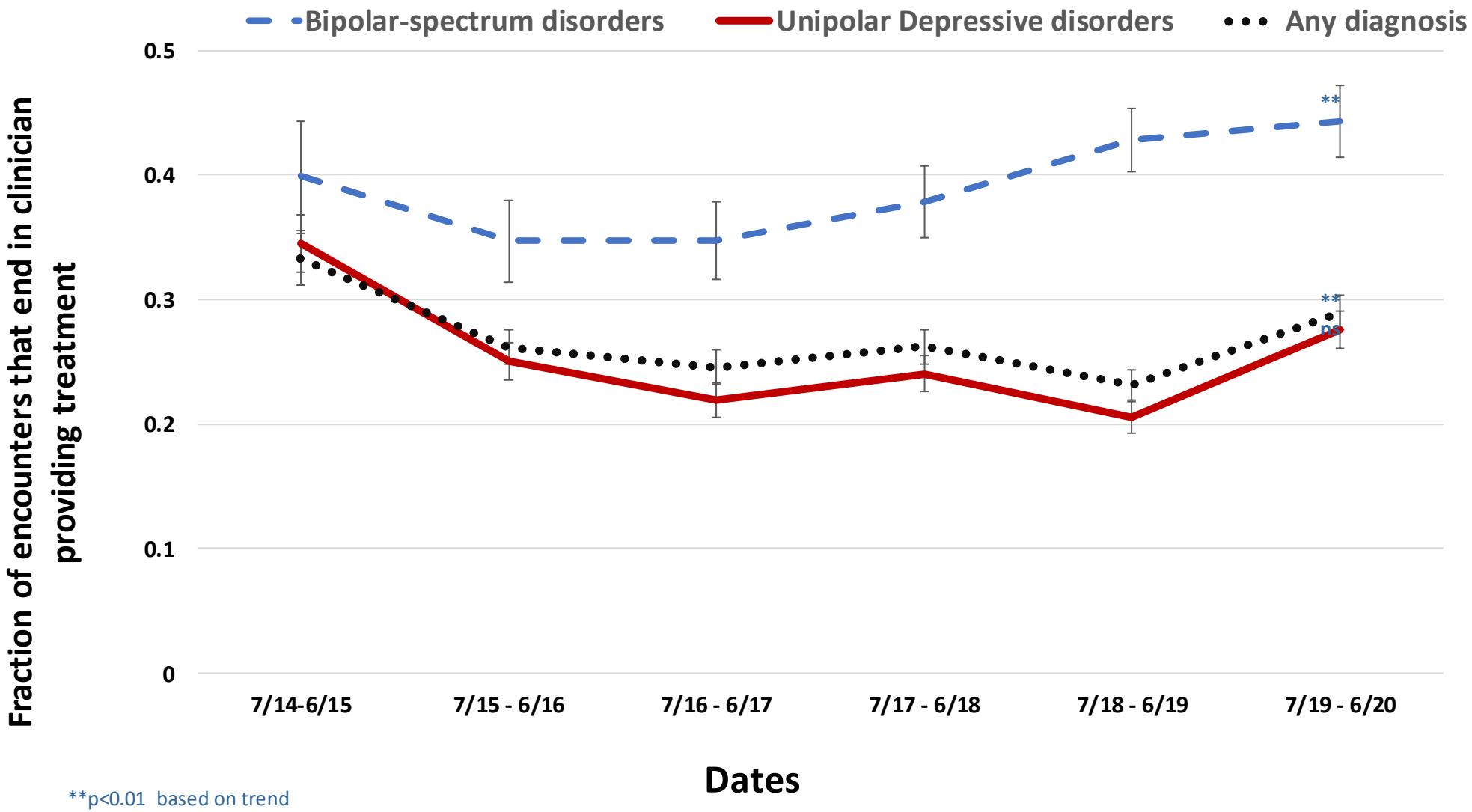
The consultation is the “engine” of MCPAP for Moms

- Discuss potential management strategies
- Recommend a Face-to-Face Evaluation
- Refer to the community

18, 428 encounters total

Byatt et al. (2016). *General Hospital Psychiatry*.

Treatment trends suggest that MCPAP for Moms helps clinicians treat more complex illness over time

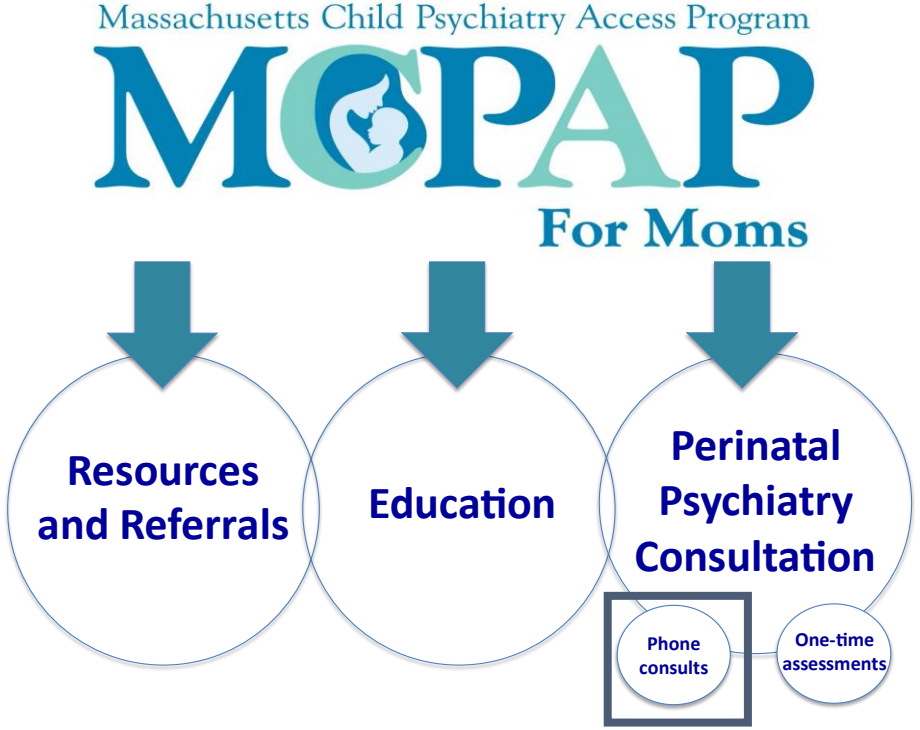


**p<0.01 based on trend

Masters et al. (2023). *Archives of Women's Mental Health*.

Increased utilization of phone consults was significantly associated with the rates at which clinicians provided direct mental healthcare for any diagnosis

Utilization of phone consultations

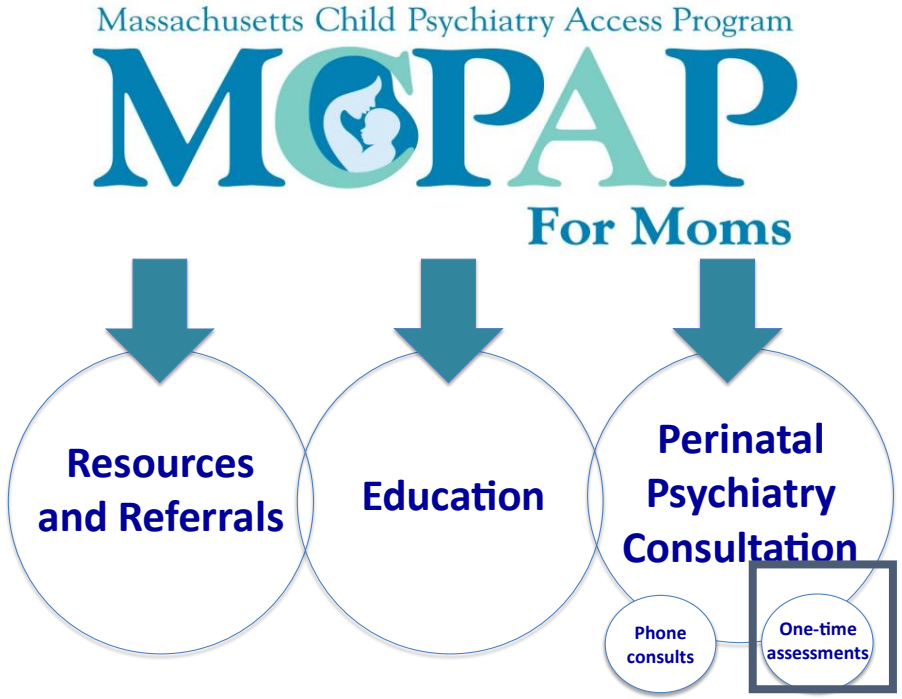


	Any diagnosis		Unipolar depressive disorders		Bipolar-spectrum disorders	
	IRR	*95% CI*	*IRR*	*95% CI*	*IRR*	*95% CI*
Utilization of phone consults	**1.30**	**1.28 to 1.33**	**1.31**	**1.28 to 1.34**	**1.25**	**1.20 to 1.29**

Masters et al. (2023). *Archives of Women's Mental Health*.

Increased utilization of one-time assessments was significantly associated with the highest rates at which clinicians provided direct mental healthcare for any diagnosis, *especially* BD

Utilization of one-time assessments



	Any diagnosis		Unipolar depressive disorders		Bipolar-spectrum disorders	
	IRR	*95% CI*	*IRR*	*95% CI*	*IRR*	*95% CI*
Utilization of one-time consults	**1.70**	**1.60 to 1.81**	**1.66**	**1.53 to 1.79**	**2.12**	**1.86 to 2.41**

Masters et al. (2023). *Archives of Women's Mental Health.*

Participants with support see addressing perinatal bipolar disorder as an important part of their role as obstetric professionals

"I'm a lot less scared to prescribe medications than I was probably four years ago because I see [that] the benefit outweighs the risks. So, I won't start somebody on a bipolar medication if I think they're bipolar. But if they've been on it and I call and I talk to [MCPAP psychiatrist] and we [talk through] the case and they think it's appropriate, then I will happily prescribe it."

- Provider exposed to MCPAP for Moms

Masters et al. (2022). *General Hospital Psychiatry*.

Clinical Case

- **Hour 4**
  - speaking rapidly and pacing around the house in an agitated fashion
- **Hours 10-12**
  - locked her husband out of her house and gripping the baby in a bizarre way
- **Hours 15**
  - paced up and down the stairs with the baby refusing to let the husband in
- **Hours 24-48**
  - showering with clothes, washing/drying rocks and pebbles, filling cabinets with water

Bipolar Disorder in pregnancy is associated with negative outcomes

Pregnancy does not protect against mood episodes

Bipolar (like depression) is associated with

- **low birth weight,**
- **preterm <37wks**
- **small for gestational age**

Increased rate of C-section

Mood elevation can lead to behaviors with known perinatal risk (eg substance use, high risk driving, hypersexuality)

Mei-Dan et al, AM J OB Gyn 2015, Boden Et al, BMJ 2012

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, 5% risk of suicide with postpartum psychosis

Wesseloo et al AJP 2016, Manic Depression Illness, Goodwin and Jamison, 2007

Preventing decompensation among women with bipolar disorder is critical

- Prophylaxis with mood stabilizer
- A birth plan
- Close monitoring
- Collaboration with newborn medicine
- Plan for infant feeding
- Support adequate sleep
- Limit stress
- Support maternal-infant bonding

Pathogenesis

Genetic, immunologic and hormonal factors

Sleep deprivation

National Sleep Foundation

What are the risk factors for postpartum psychosis?

- History of postpartum psychosis
- History of BPAD, Schizophrenia or Schizoaffective Disorder
- Family history of postpartum psychosis or BPAD
- First pregnancy
- Discontinuation of psychiatric medications for pregnancy
- Perinatal or neonatal loss
- Sleep deprivation

cdc.Gov

Risk of harm to baby when mother has thoughts of harming baby

OCD/anxiety/depression	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**

What are the signs and symptoms?

Rapid clinical deterioration

Shifting mental status, psychotic thoughts, hallucinations, delusions, disorganized behavior, thought disorganization

Irritability, anxiety, psychomotor agitation, manic/depressed mood

Usually within 2 weeks

A medical emergency

Requires rapid intervention and hospitalization

Clinical Features

Thought content: thought broadcasting, ideas of reference, persecutory, jealous, paranoid, delusions of grandiosity

Thought process: Disorganized thinking, flight of ideas

Perceptions: Hallucinations: command auditory, visual, olfactory, tactile

What are the thoughts?

- ***The individual can have both scary thoughts and be horrified by them***
  - ***Upon assessment, psychotic thoughts tend to be more bizarre***

Impaired sensorium, at times can appear to be normal

Clinical Features

What does the patient look like?

- **ADLs, limited self care**

Do family members think patient is acting differently? Has patient been acting differently since baby was born?

Clinical Questions

Have you had periods of increasing energy lasting at least 4 days?

Were these episodes accompanied by high mood, less need for sleep, rapid speech, racing thoughts, productivity?

Have others noticed in the past if you were very active, unusually happy, talking too fast, needed to slow down?

Collateral from family members

How can we detect postpartum psychosis?

Early recognition + secondary prevention

Screening: screen as early as possible for current mental health problems, history of psychiatric treatment, a family history of mental illness

- EPDS, MDQ, PHQ-9, GAD-7

Enhancing mental health and emotional support

Psychoeducation, sleep, exercise, diet

911, CRISIS, MA Behavioral Health Helpline (BHHL), don’t leave mom alone with baby, MCPAP for Moms, get immediate help

Reducing Risk

- Women with BPAD should remain on medication during pregnancy to avoid postpartum relapse
- Initiate treatment immediately in women with a history of postpartum psychosis
- SLEEP
- With help, patients with PPP achieve full remission and functional recovery
- Plan: partner, family, sleep

Harvardhealth.edu

What do I do if there is a psychiatric emergency?

Suicide or PPP: take the baby away from the mom and call 911, BHHL, CRISIS

BHHL: Call, text or chat 833-773-2445, 24/7, 365 days, free

- **Anyone can call, even family members**
- **Staffed by trained clinicians who will stay online with you until you get the support you need**
- **Connects to crisis support or Community Behavioral Health Centers (CBHC)**

Imminent risk vs non-imminent

Call MCPAP for Moms at any point – we can guide you

Mass.gov

Postpartum psychosis during delivery hospitalizations and postpartum readmissions, 2016-2019

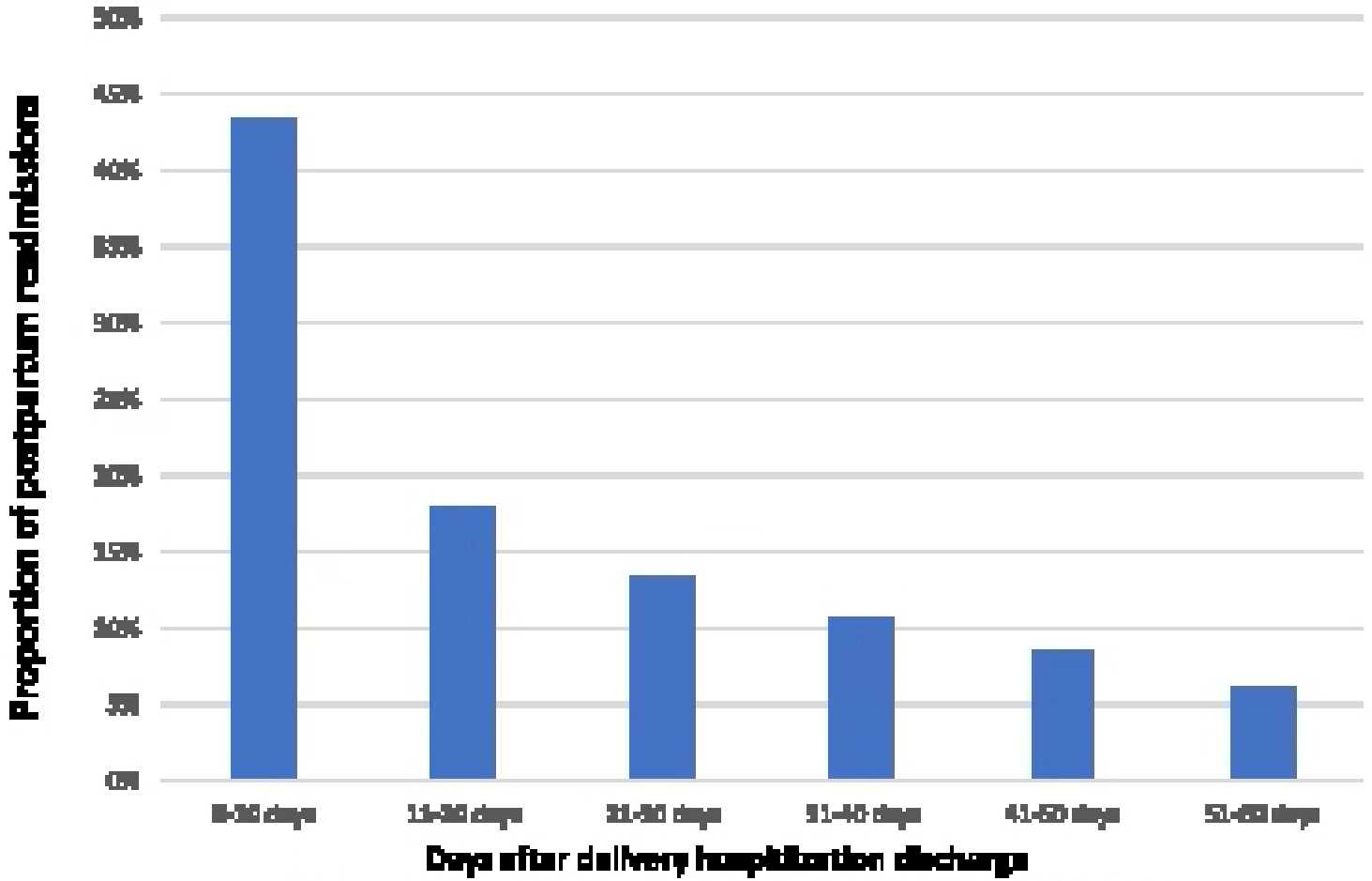
Aimed to determine trends in and risk factors for postpartum psychosis during delivery hospitalizations and postpartum readmissions

Retrospective, cross sectional analysis

American Journal of Obstetrics & Gynecology, Feb 2023

Most readmissions with a post partum diagnosis occurred in 0-10 days (43% of readmission)

FIGURE 1
Time to readmission for postpartum psychosis after delivery hospitalization discharge

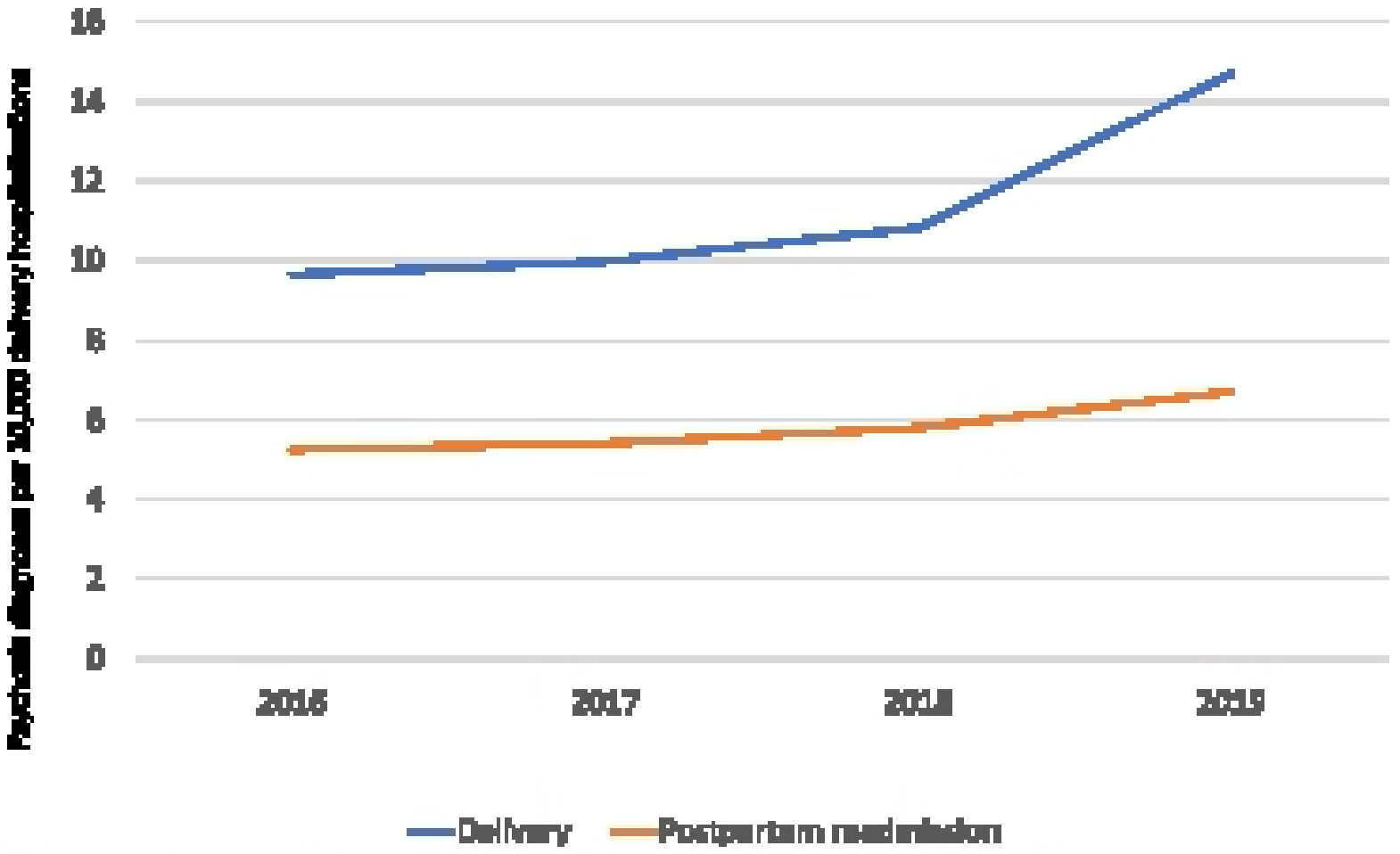


The figure demonstrates the proportion of deliveries occurring at each 10-day interval after delivery hospitalization discharge.

Albert. Postpartum psychosis during delivery hospitalizations and postpartum readmissions. Am J Obstet Gynecol MFM 2023.

Both delivery hospitalizations and postpartum readmissions with postpartum psychosis increased

FIGURE 2
Trends in delivery and postpartum readmissions with postpartum psychosis



The figure demonstrates trends of delivery and postpartum readmissions with postpartum psychosis diagnoses.

Albert. Postpartum psychosis during delivery hospitalizations and postpartum readmissions. Am J Obstet Gynecol MFM 2023.

Demographic characteristics associated with increased risk of readmission with postpartum psychosis included Medicare and Medicaid vs. commercial insurance

TABLE 2
Unadjusted and adjusted analyses for postpartum psychosis diagnoses during delivery and postpartum readmissions

Variable	Delivery hospitalization				Postpartum readmission				Postpartum readmission (sensitivity)	
	Unadjusted model		Adjusted model		Unadjusted model		Adjusted model		Adjusted model	
	OR	95% CI	aOR	95% CI	OR	95% CI	aOR	95% CI	aOR	95% CI
Maternal age (y)										
15–19	1.02	0.89–1.16	1.05	0.92–1.20	1.65	1.41–1.93	1.51	1.29–1.78	1.53	1.3–1.79
20–24	1.16	1.08–1.24	1.15	1.07–1.24	1.42	1.29–1.57	1.34	1.21–1.48	1.35	1.22–1.49
25–29	Reference		Reference		Reference		Reference		Reference	
30–34	0.98	0.91–1.04	0.99	0.93–1.06	0.93	0.84–1.03	0.98	0.89–1.09	0.98	0.89–1.09
35–39	1.04	0.96–1.13	1.01	0.93–1.10	1.21	1.08–1.35	1.20	1.07–1.34	1.19	1.06–1.33
40–44	1.02	0.88–1.17	0.94	0.81–1.08	1.50	1.25–1.78	1.33	1.11–1.59	1.32	1.1–1.58
Payer status										
Medicare	2.10	1.66–2.66	1.19	0.94–1.50	5.12	4.11–6.36	2.42	1.94–3.02	2.43	1.94–3.05
Medicaid	1.44	1.36–1.53	1.25	1.18–1.33	1.75	1.63–1.89	1.43	1.31–1.55	1.42	1.31–1.55
Commercial insurance	Reference		Reference		Reference		Reference		Reference	
Self-pay	1.08	0.86–1.35	1.04	0.83–1.31	1.25	0.89–1.74	1.23	0.88–1.72	1.24	0.89–1.74
No charge	1.05	0.34–3.21	0.96	0.31–2.96	NA	NA	NA	NA	NA	NA
Other	1.22	1.02–1.46	1.16	0.97–1.37	1.17	0.94–1.45	1.10	0.88–1.37	1.11	0.89–1.38
Median income Quartile by zip code										
Income quartile 1 (the lowest)	1.34	1.21–1.48	1.00	0.99–1.22	1.76	1.57–1.97	1.29	1.14–1.46	1.28	1.14–1.45
Income quartile 2	1.24	1.14–1.36	1.08	0.99–1.18	1.63	1.45–1.82	1.32	1.17–1.49	1.32	1.18–1.49
Income quartile 3	1.15	1.06–1.26	1.06	0.97–1.15	1.31	1.17–1.47	1.15	1.03–1.29	1.15	1.02–1.29
Income quartile 4 (the highest)	Reference		Reference		Reference		Reference		Reference	

Risk factors associated with highest odds for postpartum psychosis diagnoses at delivery were Schizophrenia and anxiety

	Delivery Hospitalization				Postpartum readmission			
	Unadjusted		Adjusted		Unadjusted		Adjusted	
Clinical factors	OR		aOR		OR		aOR	
Pregestational diabetes mellitus	2.03	1.73–2.38	1.24	1.05–1.47	2.90	2.41–3.48	1.35	1.11–1.65	1.36	1.11–1.65
Chronic hypertension	1.45	1.26–1.68	1.09	0.94–1.26	2.52	2.17–2.92	1.89	1.62–2.21	1.86	1.59–2.18
Hypertensive disorders of pregnancy	1.50	1.40–1.61	1.25	1.17–1.35	2.25	2.07–2.45	1.75	1.6–1.91	1.75	1.60–1.92
Asthma	1.83	1.67–1.99	1.24	1.13–1.36	1.99	1.77–2.24	1.15	1.01–1.30	1.15	1.02–1.30
Obesity	1.47	1.36–1.59	1.09	1.01–1.18	1.84	1.68–2.02	1.16	1.05–1.28	1.15	1.05–1.27
Autoimmune conditions	1.72	1.41–2.1	1.37	1.12–1.68	1.62	1.26–2.09	1.15	0.88–1.51	1.12	0.86–1.45
Anxiety disorder	5.20	4.87–5.56	3.86	3.51–4.23	5.05	4.61–5.53	2.06	1.81–2.35	2.07	1.81–2.36
Depression disorder	3.08	2.81–3.37	1.25	1.11–1.41	6.52	5.97–7.13	3.71	3.29–4.2	3.78	3.34–4.28
Bipolar spectrum disorder	4.64	4.04–5.34	1.81	1.55–2.13	6.04	5.07–7.20	2.87	2.33–3.54	2.97	2.41–3.66
Schizophrenia spectrum disorder	7.99	6.15–10.39	2.54	1.91–3.38	12.75	9.66–16.81	2.89	2.12–3.96	2.88	2.10–3.95
Substance use disorder	3.01	2.73–3.32	1.74	1.56–1.93	3.15	2.75–3.60	1.49	1.29–1.72	1.49	1.30–1.72
Multiple pregnancy	1.84	1.61–2.11	1.35	1.18–1.56	1.87	1.53–2.29	1.12	0.91–1.37	1.12	0.91–1.38
Stillbirth	3.90	3.38–4.51	3.63	3.13–4.2	2.36	1.82–3.05	1.95	1.50–2.52	2.03	1.57–2.64
Preterm delivery	1.84	1.67–2.02	1.47	1.33–1.62	2.30	2.04–2.59	1.70	1.50–1.92	1.67	1.48–1.89

Clinical Case

- **Hour 4**
  - speaking rapidly and pacing around the house in an agitated fashion
- **Hours 10-12**
  - locked her husband out of her house and gripping the baby in a bizarre way
- **Hours 15**
  - paced up and down the stairs with the baby refusing to let the husband in
- **Hours 24-48**
  - showering with clothes, washing/drying rocks and pebbles, filling cabinets with water

MCPAP for Moms aims to promote maternal and child health by building the capacity of front line providers to address perinatal mental illness

Resources

- **MCPAP for Moms**
  - **Mcpapformoms.org**
- **MGH Center for Women's Mental Health**
  - **Womensmentalhealth.org**
- **Reprotox**
  - **Reprotox.org**
- **Postpartum Support International**
  - **Postpartum.net**
- **Lactmed**
  - **toxnet.nlm.nih.gov/newtoxnet/lactmed.htm**

Acknowledgements

MCPAP for Moms Team

Leadership

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MCPAP for Moms Users

We need your help!

ROADMAP Study

Roadmap Aims: Perinatal Psychiatry Access Programs (PPAP)

- Understand how PPAPs serve perinatal professionals and their patients
- Develop a tool to evaluate PPAPs across the nation

Participation Criteria: Obstetric care providers

- who have used MCPAP for Moms
- who can prescribe medication

Click on the QR code to access the study link