(a Brief Overview of) Peripartum Psychiatry

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Think beyond "**post**partum"

- Pregnancy and having a baby are time periods of HIGH contact with healthcare
- Most patients (young and generally healthy) will have had limited contact with the healthcare system in adulthood
- Most psychiatric disorders have onset in women in mid 20s-30s (corresponding with reproductive activity)
- More and more studies demonstrate symptoms begin during pregnancy, are stable through pregnancy, and then continue (at same intensity) into the postpartum period
- ACOG recently advised increased screening for psychiatric symptoms earlier in the pregnancy
- Bottom line: ***Pregnancy and postpartum may be the first time a patient is seeking regular healthcare as an adult. This is also the time frame for the onset of most psychiatric disorders. Most of psychiatric disorders affecting pregnancy begin <u>during</u> the pregnancy and continue into the postpartum period. Screening for and addressing psychiatric disorders during the pregnancy are becoming the standard of care.***

Think beyond “depression”

- Anxiety disorders are as prominent, possibly more so, than depressive disorders in pregnancy
- The rate of OCD diagnosis in the postpartum period is double that of non-postpartum women
- The postpartum period may also be the first onset of bipolar disorder
- Patients may also experience PTSD from the pregnancy and birthing experience
- Validated screening tools are available for peripartum anxiety (Perinatal Anxiety Screening Scale, PASS)
- Bottom Line: Maintain a broad view and avoid the tendency to over-focus on depressive symptoms.

”Are you planning to become pregnant in the next year? What are you doing to prevent pregnancy if pregnancy is not desired?”

- Medication management begins PRECONCEPTION
- Begin talking with your patients about their reproductive health to advise risk vs risk assessment of medications
- Not just psychiatric medications, but also medications used to treat endocrine, rheumatologic, neurologic, etc. disorders
- For your patients planning pregnancy, review first trimester safety data before pregnancy and as you select a medication

First trimester safety considerations

- For all medications (not just psychiatric) – we primarily think about the risks of increased congenital malformations, spontaneous abortion
- What is the ***individualized*** risk?
- Every patient may have a different threshold for tolerating risks, and this will likely change through time. **Reassess** where they stand often.
- The FDA has released a new labeling rule. The old "Category …" labeling is no longer in use. Now, we have the Pregnancy and Lactation Labeling Rule. Provides:
  - Safety data in pregnancy and lactation
  - Risk vs risk assessment for men and women of reproductive potential
  - Goal is to inform a more nuanced and individualized discussion of known and theoretical risks of accepting vs rejecting treatment

Psychotropic medication quick points

- Psychotropics are safe in pregnancy and in lactation with few exceptions
- The best medication is the medication that we know works. ***Pregnancy is not a time for experimentation***
- Use the lowest **EFFECTIVE** dose: ***do not expose the fetus to the drug and to untreated symptoms***
- **Minimize exposure to multiple agents**. Maximize each agent before transitioning to another (unless intolerable side effects)
- Due to physiologic changes, some patients **may need dose increases in 3rd trimester** to maintain serum levels. They may present complaining of medication "wearing off"
- ***No evidence to reduce doses or discontinue agents at time of delivery to avoid neonatal discontinuation syndromes***
  - ***Do not discontinue SSRIs around the time of delivery to avoid neonatal serotonin withdrawal***
  - ***Lithium does need dose reduction during delivery (please call Psychiatry!)***

Medication tid bits

- Hesitant to use venlafaxine if history of hypertensive disorders
- Hesitant to use bupropion if higher risk of pre-eclampsia
- Mirtazapine can treat hyperemesis and comes in an ODT formulation (7.5-15mg)
- Medications with high antihistamine activity (Benadryl, hydroxyzine) can reduce breastmilk supply and are not first line as PRN for anxiety in a lactating patient
- Quetiapine does not really cross the placenta or transfer into breastmilk, making it favored for treatment of sleep and anxiety for a short period of time

Risk vs Risk assessment: There are few “Absolutes”

- Try to break down the data to an individual risk, keeping in mind there is baseline risk of adverse neonatal and maternal outcomes for the general population
- There are a few medications where we have more caution:
  - **paroxetine** with higher incidence of congenital malformations compared to other SSRIs.
  - **Depakote** is the Devil: neural tube defects and very significant effects on IQ in children exposed to valproate in utero
  - **Lithium**: used in pregnancy with relative safety compared to old data. NOT recommended in lactation
  - **Benzodiazepines**: Safe in lactation (very low, <1%, transfer rate into breastmilk). In pregnancy, probably safe if used ***truly as a PRN (<4 times per week)***
  - **Stimulants**: women with severe ADHD are recommended to continue. Lowest effective dose and “drug holidays” are encouraged
  - Breastfeeding is contraindicated with **clozapine**

Cannabis in pregnancy and lactation

- Suggest treating it the same as alcohol use in pregnancy: No amount of cannabis in pregnancy is safe
- Studies that examine this consistently show diffuse cognitive impairments in children who were exposed to cannabis in utero, including problems in memory formation and executive dysfunction
- If cannabis is smoked, it carries the same risks of exposure to cigarettes during pregnancy
- Ask the patient why they are using cannabis. Most are using during pregnancy to relieve physical or psychological symptoms, not necessarily recreationally. If they are using to relieve symptoms, ask if they're open to pursuing safer treatment options for these
- Data about cannabis exposure from breastmilk is very limited. All professional societies recommend sobriety or very minimal use if lactating for the same risks above.
  - No indication to "pump and dump" due to very long half-life
  - Cannabis is fat soluble and is suspected to accumulate in fetal and infant brains

After delivery: Support plan for home

- Before delivery, consider engaging patient and their supports to create a plan to support once home with a newborn. Think about:
  - Self care challenges - focus on basics of hydrate, eat, sleep, get fresh air, etc
  - Sleep plan for mom
- What are their plans for lactation? How do they feel about pumping, formula supplementation, etc?
  - Do they know the resources to find help once they're home?
- If mom is taking medication that may be sedating, can someone be available to monitor for the first few doses in case she cannot wake up to attend to baby?

Postpartum anxiety vs OCD vs Psychosis

- "intrusive thoughts" are common and may variant of "normal" – anxiety disorder – OCD – Psychosis
- Prior to exploring, attempt to normalize that intrusive thoughts are common and provide reassurance about the limits of confidentiality (only obligated to report if credible, imminent threat to safety)

Common Symptom	OCD (obsessive compulsive disorder)	Psychosis
Thoughts/beliefs	Unwanted and intrusive thoughts, mental images, or urges	Hallucinations (visual, auditory, olfactory) or delusions (false beliefs, often bizarre)
Response to thoughts	Thoughts are distressing (ego-dystonic). Attempts to prevent harm, increase certainty, or alleviate distress in the form of compulsions (actions or ritualized behaviors)	Not always bothersome (ego-syntonic). May lack insight into the delusions and act on delusions or command hallucinations
Repetitive behaviors	Compulsions to alleviate distress or uncertainty, or to prevent a feared catastrophe	May be represent as a result of the delusions or hallucinations and not be performed with the goal of relieving any kind of distress
Reality testing	Insight present	Insight lacking
Symptoms over time	Typically persistent	May wax/wane. Some may have periods of appearing as if in a stupor or delirious

Helpful resources to give to patients

- Postpartum Support International: Postpartum Support International - PSI
- MGH Center for Women's Mental Health Welcome to the MGH Center for Women's Mental Health - MGH Center for Women's Mental Health (womensmentalhealth.org)

Resources for clinicians

- MGH: Welcome to the MGH Center for Women's Mental Health - MGH Center for Women's Mental Health (womensmentalhealth.org)
- Medication Fact Sheets (helpful to print out for patients, if requested) from MotherToBaby: Home Page - MotherToBaby
- Periscope project: The Periscope Project
- Project ECHO on Perinatal Substance Use through Hennepin Project ECHO - Hennepin Healthcare

What do we have for you in CentraCare at this time?

- Chart reviews
  - Dr. Drom will review patient's chart and give recommendations based on generalities and history available in the EMR
  - When to use:
    - patient considering pregnancy and taking psychotropics with questions about safety in pregnancy and lactation
    - Patient pregnant and taking medications who has questions about safety
    - Patient with worsening symptoms who does not have a psychiatric clinician and may benefit from medication adjustments
  - How to Order: AMB Consult Behavioral Health > Psychiatry > Perinatal Consult w/Recommendations
    - Or message Dr. Drom directly with patient chart and specific request
  - This may be replaced by an E-Consult in the near future
- Psychotherapy: Angeal Williams Schroden MS, LADC, LPCC
  - Psychotherapy available during pregnancy, on Family Birthing, and to all families with children in the NICU
  - To schedule psychotherapy, send a request to: P Perinat Appointment Scheduling, or reach out to Angela Williams directly

Future plans for CentraCare

- Actively recruiting members for a coalition within the organization to focus on the multiple dimensions of maternal mental health
- Peripartum psychiatric clinic (Pilot phase)
  - Hoping to have appointments opening in very early 2024
  - Dr. Drom will have 4-hr of appointments per month to follow women through pregnancy and up to 6 months postpartum
  - patients should not already be established with a psychiatric clinic
  - Submit a referral through the chart review order

- Please reach out if you want to be a part of this work or have suggestions for things you would like to see offered!
- Claire.drom@centracare.com

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