Perinatal Mental Health – Addressing Maternal Morbidity & Mortality, Promoting Equity, and Advancing Intergenerational Health

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Lifeline for moms

UMass Chan MEDICAL SCHOOL | UMass Memorial Health

New England Obstetrical and Gynecological Society (NEOGS)
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Conflict of Interest Disclosure

- **Dr. Moore Simas:**
  - Lead Engagement Liaison for the Massachusetts Child Psychiatry Access Program for Moms (MCPAP for Moms, MA DMH, Beacon Health Options)
  - Obstetric Director of Lifeline for Moms, UMass Chan Medical School
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  - Co-Chair, ACOG EWG Perinatal Mental Health
  - Member, ACOG OB CPG Committee
    - Author/Reviewer, ACOG CPGs on Perinatal Mental Health
  - Member/Author, AIM PMHC Patient Safety Bundle
  - Lead Faculty, IHI PMHC Patient Safety Bundle Change Package
  - MPI, CDC, CDC Foundation, NIMH & ACOG Funding
    - PMH Toolkit
    - PMH e-module
    - PMH & OB integration implementation guide

Objectives

The learning objectives are:

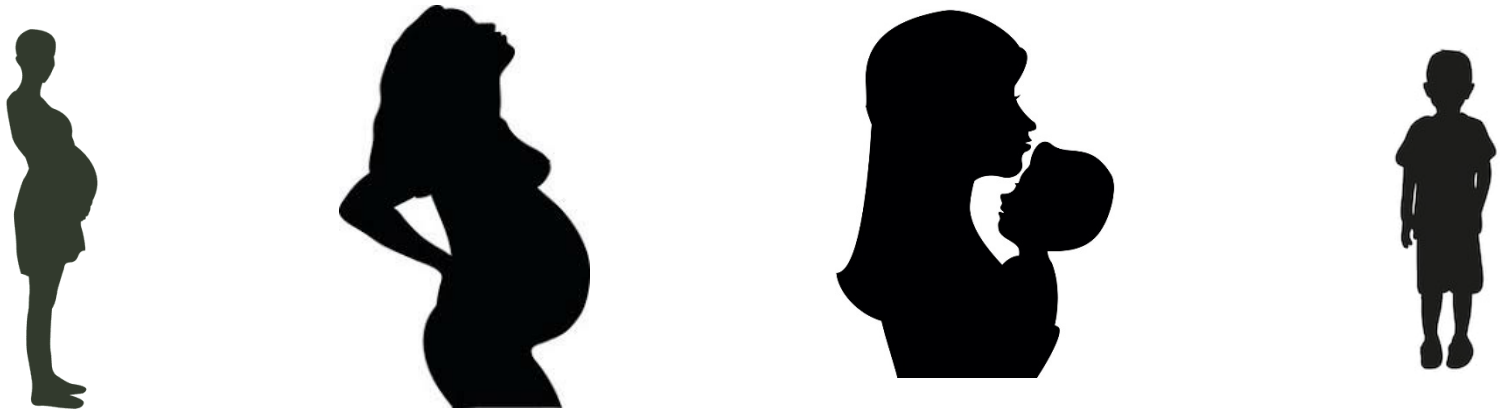
- describe the **Patient Care Pathway** to be followed to address perinatal mental health conditions.
- determine how to **screen and evaluate illness severity**, including how to assess intrusive thoughts and risk of harm to self and/or baby.
- recognize the **risks** of untreated perinatal mental health conditions and the importance of providing evidence-based treatment
- increase awareness of **resources** designed to facilitate obstetric care clinicians in addressing perinatal mental health conditions

Perinatal mental health conditions are one of the most common complications of pregnancy & postpartum

Perinatal mental health affects mom, child, and family

Preterm delivery
Low birth weight
NICU admissions

Cognitive delays
Motor & Growth issues
Behavioral problems
Mental health disorders



Less engagement in medical care
Smoking & substance use

Lactation challenges
Bonding issues
Adverse partner relationships

Mental health conditions are the lead cause of pregnancy related deaths (22.7%)

Causes of Pregnancy-Related Deaths (%)

Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019

MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

Susanna Trost, MPH; Jennifer Beauregard, MPH, PhD; Gyan Chandra, MS, MBA; Fanny Njie, MPH; Jasmine Berry, MPH; Alyssa Harvey, BS; David A. Goodman, MS, PhD

Key Findings

- Pregnancy-related deaths occurred during pregnancy, delivery, and up to a year postpartum.
- The leading cause of pregnancy-related death varied by race and ethnicity.
- Over 80% of pregnancy-related deaths were determined to be preventable.

Maternal Mortality Review Committees (MMRCs) are multidisciplinary committees that convene at the state or local level to comprehensively review deaths during or within a year of pregnancy (pregnancy-associated deaths). MMRCs have access to clinical and nonclinical information (e.g., vital records, medical records, social service records) to more fully understand the circumstances surrounding each death, determine whether the death was pregnancy-related, and develop recommendations for action to prevent similar deaths in the future.

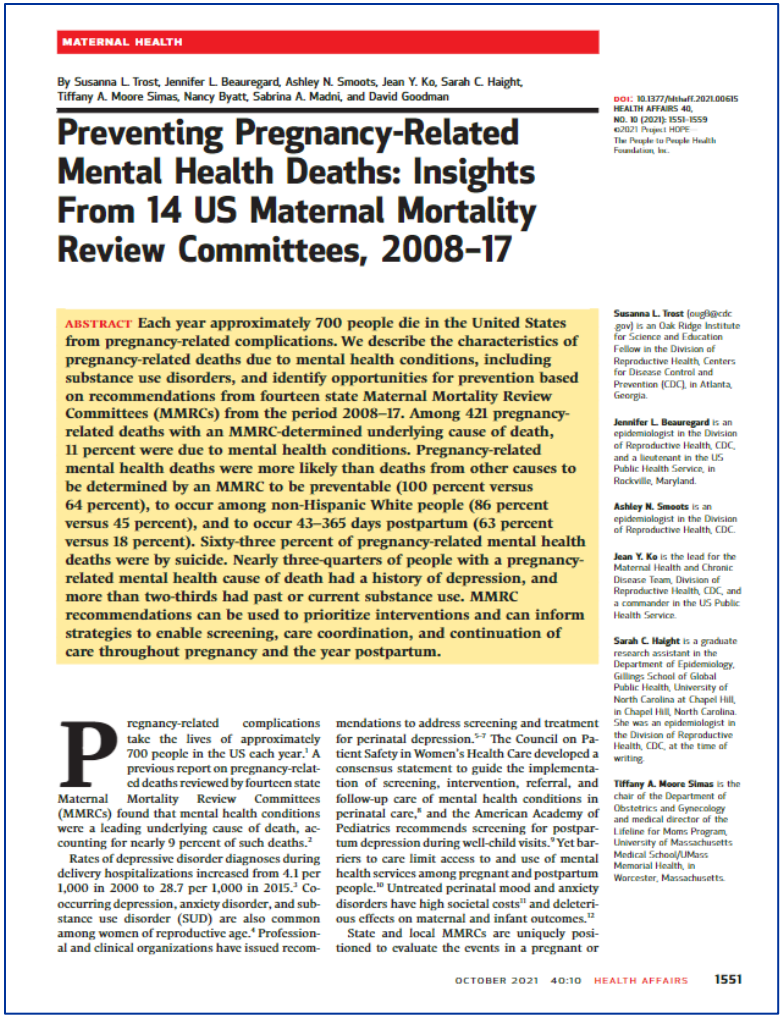
Data on 1,018 pregnancy-related deaths among residents of 36 states from 2017–2019 were shared with CDC through the Maternal Mortality Review Information Application (MMRIA).

Table 1. Characteristics of pregnancy-related deaths, data from Maternal Mortality Review Committees in 36 US States, 2017–2019 (N=1,018)*

	N	%
Race and ethnicity		
Hispanic	144	14.4
non-Hispanic American Indian or Alaska Native	9	0.9
non-Hispanic Asian	34	3.4
non-Hispanic Black	315	31.4
non-Hispanic Native Hawaiian and Other Pacific Islander	6	0.6
non-Hispanic White	467	46.6
non-Hispanic other/multiple races	27	2.7
Age at death (years)		
15–19	29	2.9
20–24	155	15.3
25–29	227	22.4
30–34	297	29.3
35–39	225	22.2
40–44	70	6.9
≥45	10	1.0
Education		
12th grade or less; no diploma	135	13.7
High school graduate or GED completed	396	40.1
Some college credit, but no degree	192	19.4
Associate or bachelor's degree	218	22.1
Advanced degree	47	4.8

*Race or ethnicity was missing for 16 (1.6%) pregnancy-related deaths; age was missing for 5 (0.5%) pregnancy-related deaths; education was missing for 30 (2.9%) pregnancy-related deaths.

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health



MATERNAL HEALTH

By Susanna L. Trost, Jennifer L. Beauregard, Ashley N. Smoots, Jean Y. Ko, Sarah C. Haight, Tiffany A. Moore Simas, Nancy Byatt, Sabrina A. Madni, and David Goodman

Preventing Pregnancy-Related Mental Health Deaths: Insights From 14 US Maternal Mortality Review Committees, 2008–17

DOI: 10.1377/hlthaff.2021.00615
HEALTH AFFAIRS 40,
NO. 10 (2021): 1551–1559

ABSTRACT **Each year approximately 700 people die in the United States from pregnancy-related complications. We describe the characteristics of pregnancy-related deaths due to mental health conditions, including substance use disorders, and identify opportunities for prevention based on recommendations from fourteen state Maternal Mortality Review Committees (MMRCs) from the period 2008–17. Among 421 pregnancy-related deaths with an MMRC-determined underlying cause of death, 11 percent were due to mental health conditions. Pregnancy-related mental health deaths were more likely than deaths from other causes to be determined by an MMRC to be preventable (100 percent versus 64 percent), to occur among non-Hispanic White people (86 percent versus 45 percent), and to occur 43–365 days postpartum (63 percent versus 18 percent). Sixty-three percent of pregnancy-related mental health deaths were by suicide. Nearly three-quarters of people with a pregnancy-related mental health cause of death had a history of depression, and more than two-thirds had past or current substance use. MMRC recommendations can be used to prioritize interventions and can inform strategies to enable screening, care coordination, and continuation of care throughout pregnancy and the year postpartum.**

Pregnancy-related complications take the lives of approximately 700 people in the US each year.[1] A previous report on pregnancy-related deaths reviewed by fourteen state Maternal Mortality Review Committees (MMRCs) found that mental health conditions were a leading underlying cause of death, accounting for nearly 9 percent of such deaths.[2]

Rates of depressive disorder diagnoses during delivery hospitalizations increased from 4.1 per 1,000 in 2000 to 28.7 per 1,000 in 2015.[3] Co-occurring depression, anxiety disorder, and substance use disorder (SUD) are also common among women of reproductive age.[4] Professional and clinical organizations have issued recommendations to address screening and treatment for perinatal depression.[5–7] The Council on Patient Safety in Women's Health Care developed a consensus statement to guide the implementation of screening, intervention, referral, and follow-up care of mental health conditions in perinatal care,[8] and the American Academy of Pediatrics recommends screening for postpartum depression during well-child visits.[9] Yet barriers to care limit access to and use of mental health services among pregnant and postpartum people.[10] Untreated perinatal mood and anxiety disorders have high societal costs[11] and deleterious effects on maternal and infant outcomes.[12]

State and local MMRCs are uniquely positioned to evaluate the events in a pregnant or

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100%

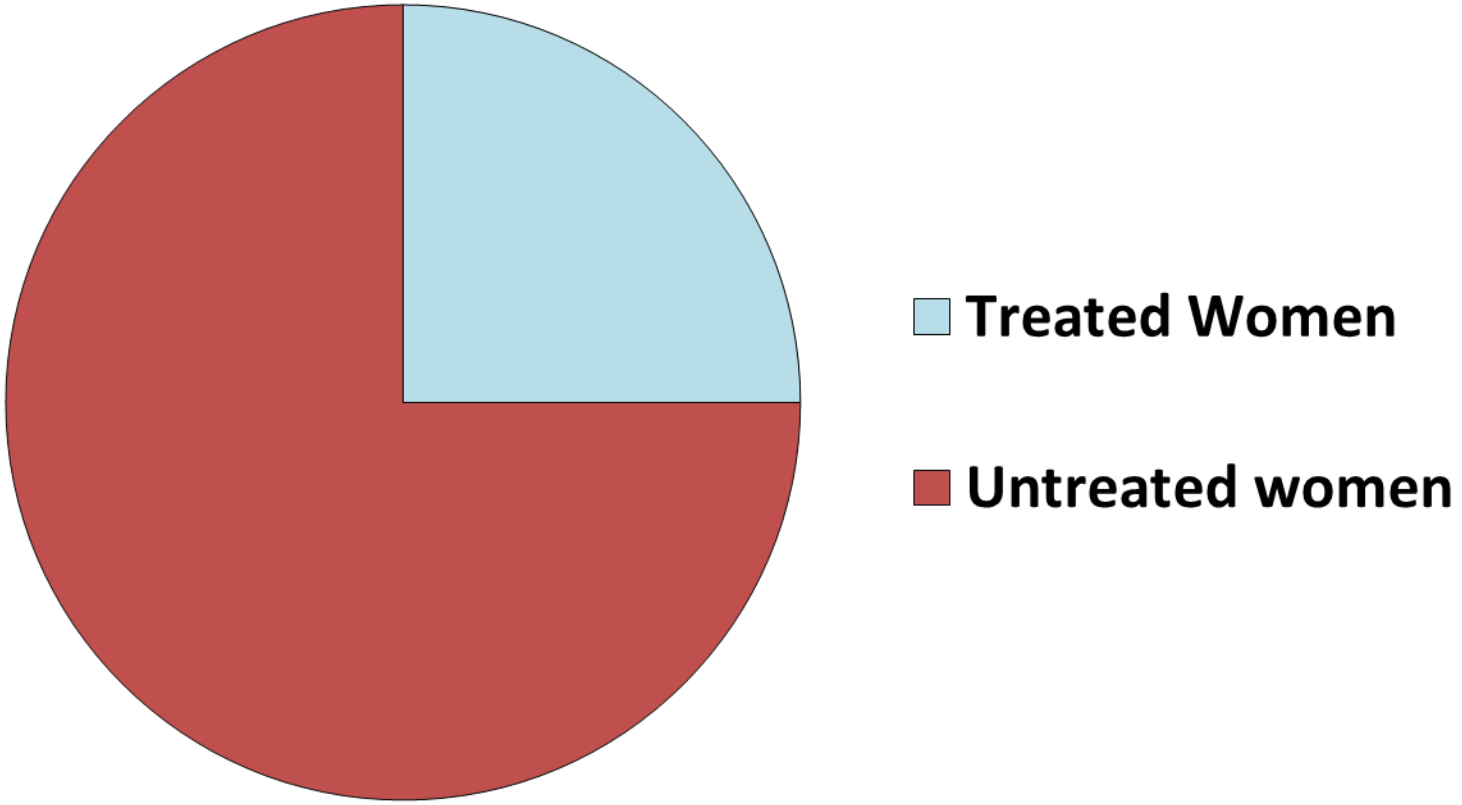
of pregnancy-related mental health deaths were determined to be **preventable**

MMRIA MATERNAL MORTALITY REVIEW INFORMATION APP

ERASE MM

REVIEW to ACTION
WORKING TOGETHER TO PREVENT MATERNAL MORTALITY

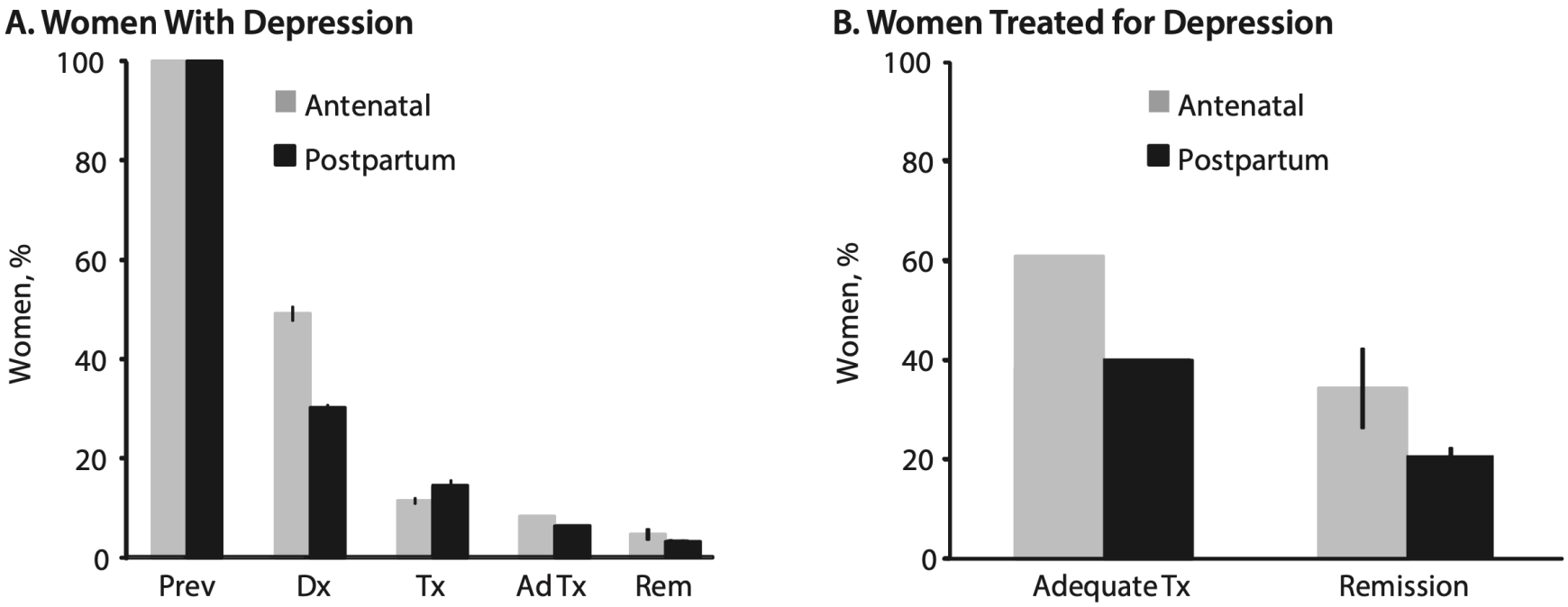
Perinatal mental health conditions are under-detected and under-treated



Depression

Byatt et al. (2015). Ob Gyn.

Percentage of US Women At Each Step of the Perinatal Depression Treatment Cascade

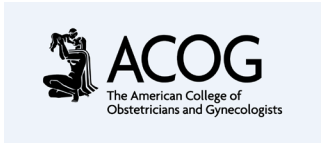


Abbreviations: Ad Tx = adequate trial of treatment, Dx = diagnosis, Prev = prevalence, Rem = remission, Tx = treatment

Cox, E. Q., et al. (2016). "The Perinatal Depression Treatment Cascade: Baby Steps Toward Improving Outcomes." J Clin Psychiatry **77**(9): 1189-1200.

The health care system needs to change to address PMH so perinatal individuals can get the help they need and deserve

Professional Societies and Policy Makers Recognize This as a Significant Public Health Issue



Detection through screening alone is not associated with improved mental health outcomes

Understanding the Patient Care Pathway is critical to addressing PMH conditions

Kelly RH et al. (2001) *Am J Psychiatry.* Byatt et al. (2015). *Ob Gyn.* Byatt et al. (2021). In Prep. Rowan P et al. (2012) *Arch Womens Ment Health.* Byatt et al. *(2019) International Review of Psychiatry.*

Understanding the Patient Care Pathway is critical to addressing PMH conditions

Detection:

- **Screening:** how to detect if a patient has symptoms or is at risk for developing a mental health condition
- **Engagement:** how to focus on patients' interests and needs, using a strengths-based approach, to maximize their participation in care

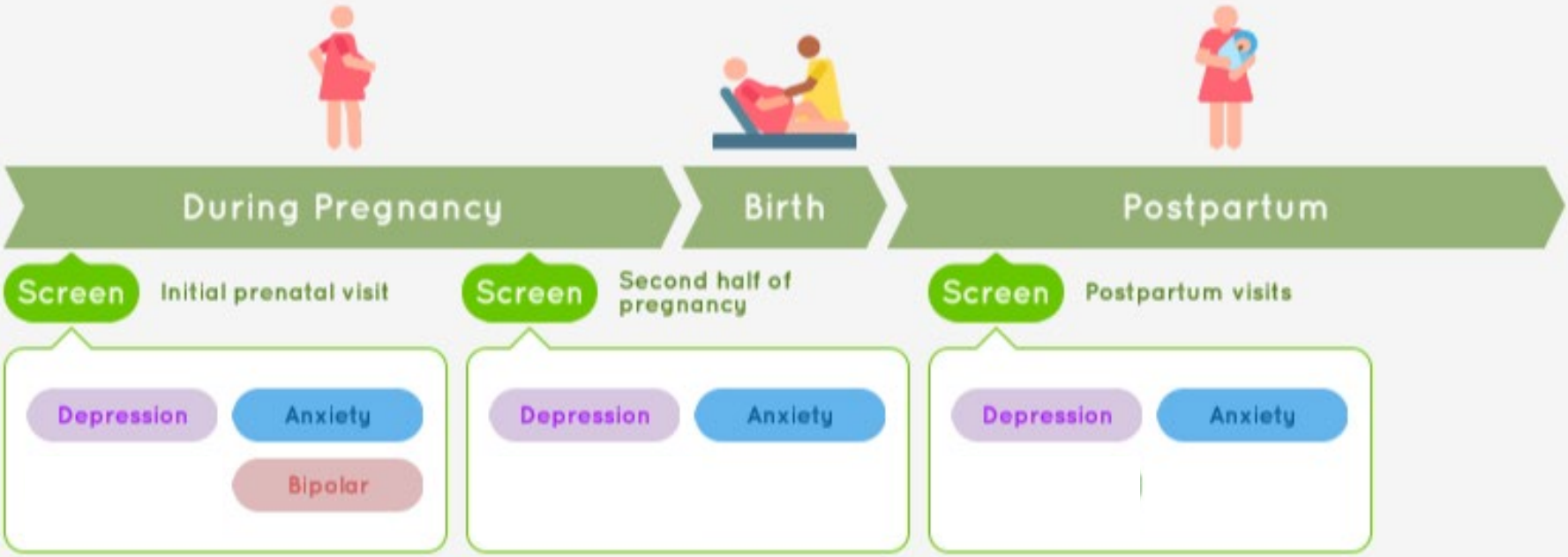
ACOG recommends that everyone receiving well-woman, prepregnancy, prenatal, and postpartum care be **screened for depression and anxiety using standardized validated instruments**.

ACOG recommends that screening for **perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits.**

ACOG recommends that mental health screening be implemented with **systems in place to ensure timely access** to assessment and diagnosis, effective treatment, and appropriate monitoring and follow-up based on severity.

ACOG recommends screening for **bipolar disorder before initiating pharmacotherapy** for anxiety or depression, if not previously done.

When to Screen



Given these recommendations and the prevalence of mental health conditions in the perinatal period, Lifeline for Moms recommend screening for depression, bipolar disorder, anxiety, and PTSD at these time points.

Validated screening instruments exist for perinatal mental health conditions

Depression
PHQ9 or EPDS

Anxiety
GAD7 or EPDS subscale #3-5

PTSD
PC-PTSD

Bipolar Disorder
MDQ or CIDI

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching tele				
8. Moving or speaking so slowly that other people could have noticed. Or, the oppo being so fidgety or restless that you have been moving around a lot more than us				
9. Thoughts that you would be better off d or of hurting yourself in some way				

Add T

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	

e it for you to do your work, take

or assessing generalized anxiety

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.
☐ No, not very often — Please complete the other questions in the same way.
☐ 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
*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

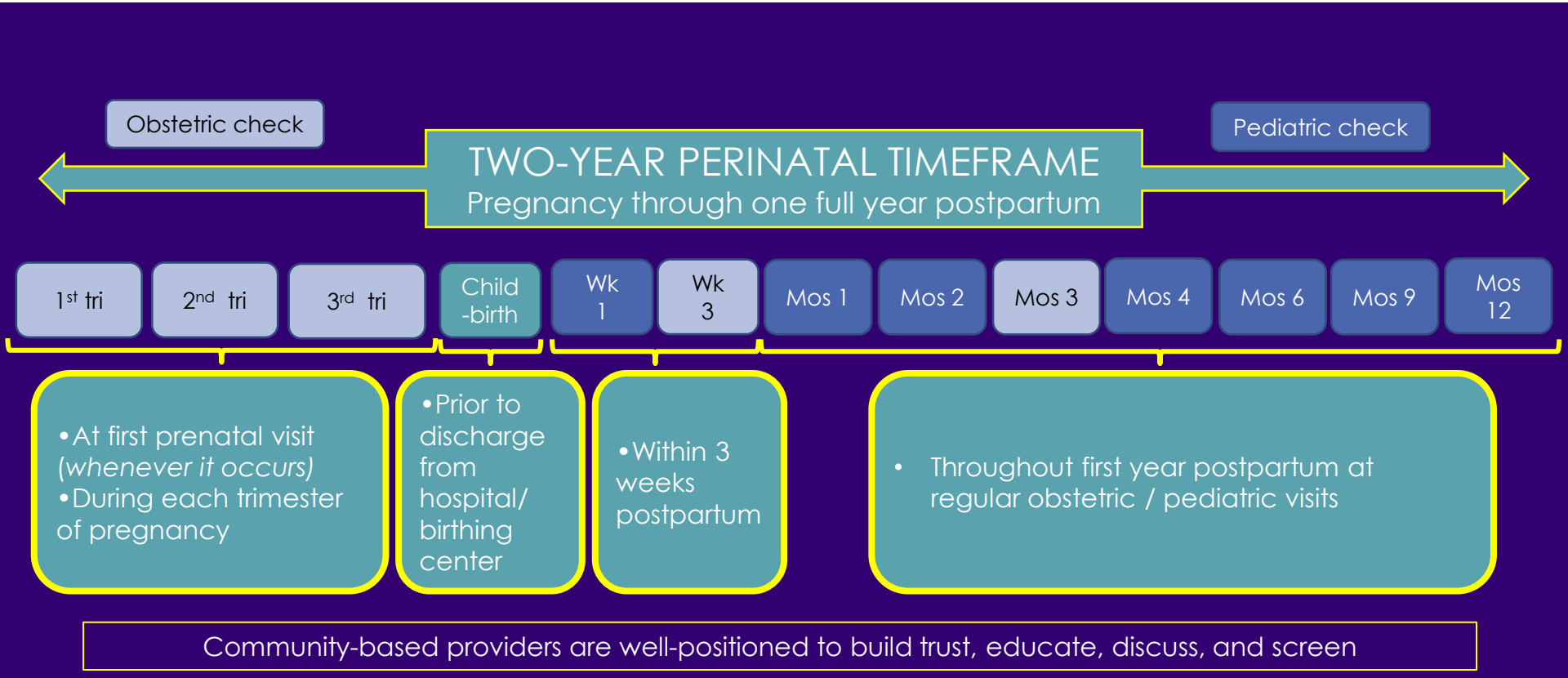
C In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, **in the past month**, you:		
Have had nightmares about it or thought about it when you did not want to?	No	Yes
Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
Were constantly on guard, watchful, or easily startled?	No	Yes
Felt numb or detached from others, activities, or your surroundings?	No	Yes

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○

DRAFT FRAMEWORK FOR PMH EDUCATION & SCREENING



Community-based providers are well-positioned to build trust, educate, discuss, and screen

MMHLA
Maternal Mental Health Leadership Alliance

SCREENING RATIONALE

At first prenatal visit *(whenever it occurs)*	• Obtain baseline • 1/3 of those experiencing PPD enter pregnancy with symptoms
During each trimester of pregnancy	• Build trust, reduce stigma, create safe relationship • 1/3 of those experiencing PPD start symptoms during pregnancy
Prior to discharge from hospital / birthing center	• Birth may be first interaction with medical provider • Opportunity for educating new parents and family members
Within 3 weeks postpartum	• Baby Blues resolve by 2-3 weeks • Peak onset of postpartum psychosis
Throughout first year postpartum	• Peak onset of PMH disorders is 3-6 months postpartum • Peak incidence of suicide is 6-9 months postpartum

MMHLA
Maternal Mental Health Leadership Alliance

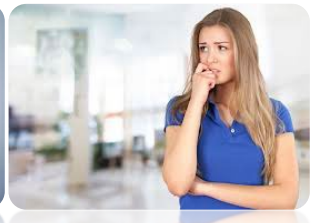
Understanding the Patient Care Pathway is critical to addressing PMH conditions

Assessment:

- **Differential diagnosis:** how to distinguish mood disorders from each other as co-morbid conditions and differentiate them from other medical illnesses
- **Severity and risk:** how to look for the key markers of illness severity and how to assess risks for patient and infant

Considering the differential diagnosis is an important aspect of the assessment

Depression



Anxiety

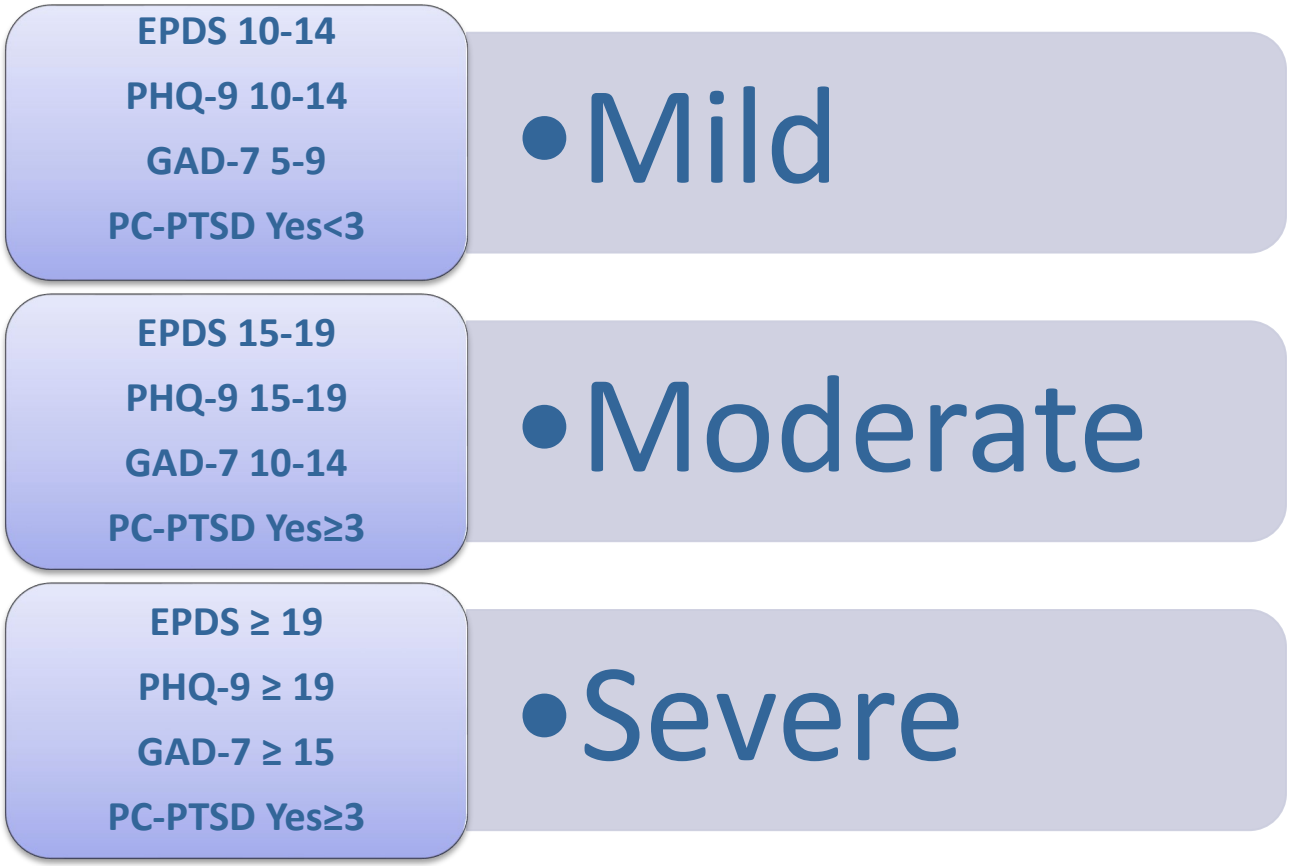
OCD

PTSD

Bipolar D

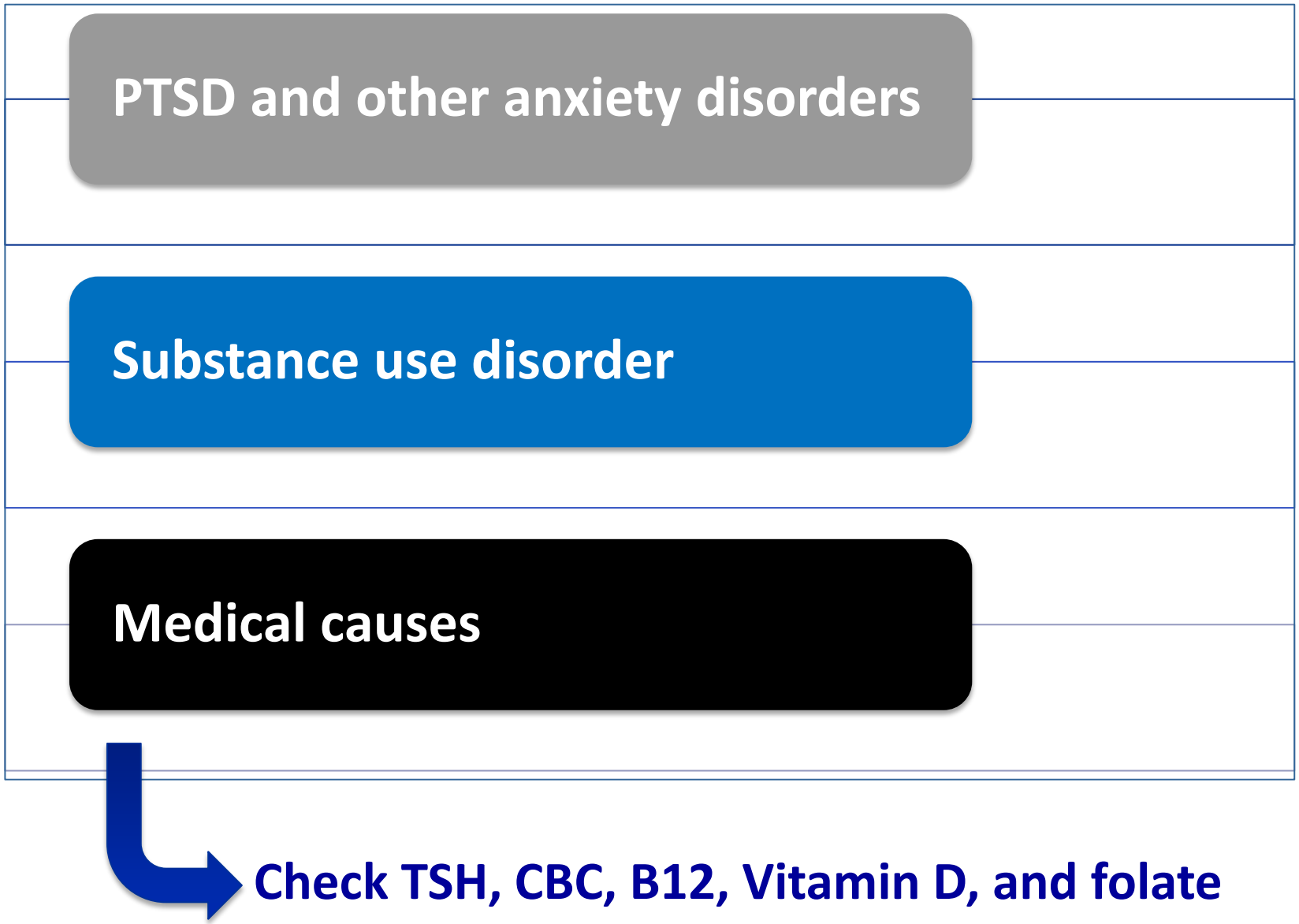
Psychosis

Score on screeners correlates with illness severity however further assessment is needed



Symptom severity directs treatment intensity

Assess for co-morbidities and medical causes



To assess, ask about symptoms and illness severity

- Recent stressors
- Duration of symptoms
- How often symptoms occur
- Feeling of hopeless, helplessness
- Current treatment (medications/therapy)
- Family history
- Prior symptoms
- Previous suicide attempt(s)
- Past psychiatric treatment (medication/therapy)
- Previous psychiatric hospitalizations
- Current suicidal ideation, plan, intent

For depression, symptoms must occur > 2 weeks

DEPRESSED MOOD AND At least 5 of the following must be present for at least 2 weeks:

- **S**leep – increased or decreased
- **I**nterest or pleasure – decreased
- **G**uilt/worthlessness
- **E**nergy – decreased or fatigued
- **C**oncentration/difficulty making decisions
- **A**ppetite and/or weight increase or decrease
- **P**sychomotor activity – increased or decreased
- **S**uicidal ideation

Generalized Anxiety Disorder (GAD) Symptoms

Excessive anxiety and worry

Increased muscle aches or soreness

Impaired concentration

Fatigue

Irritability

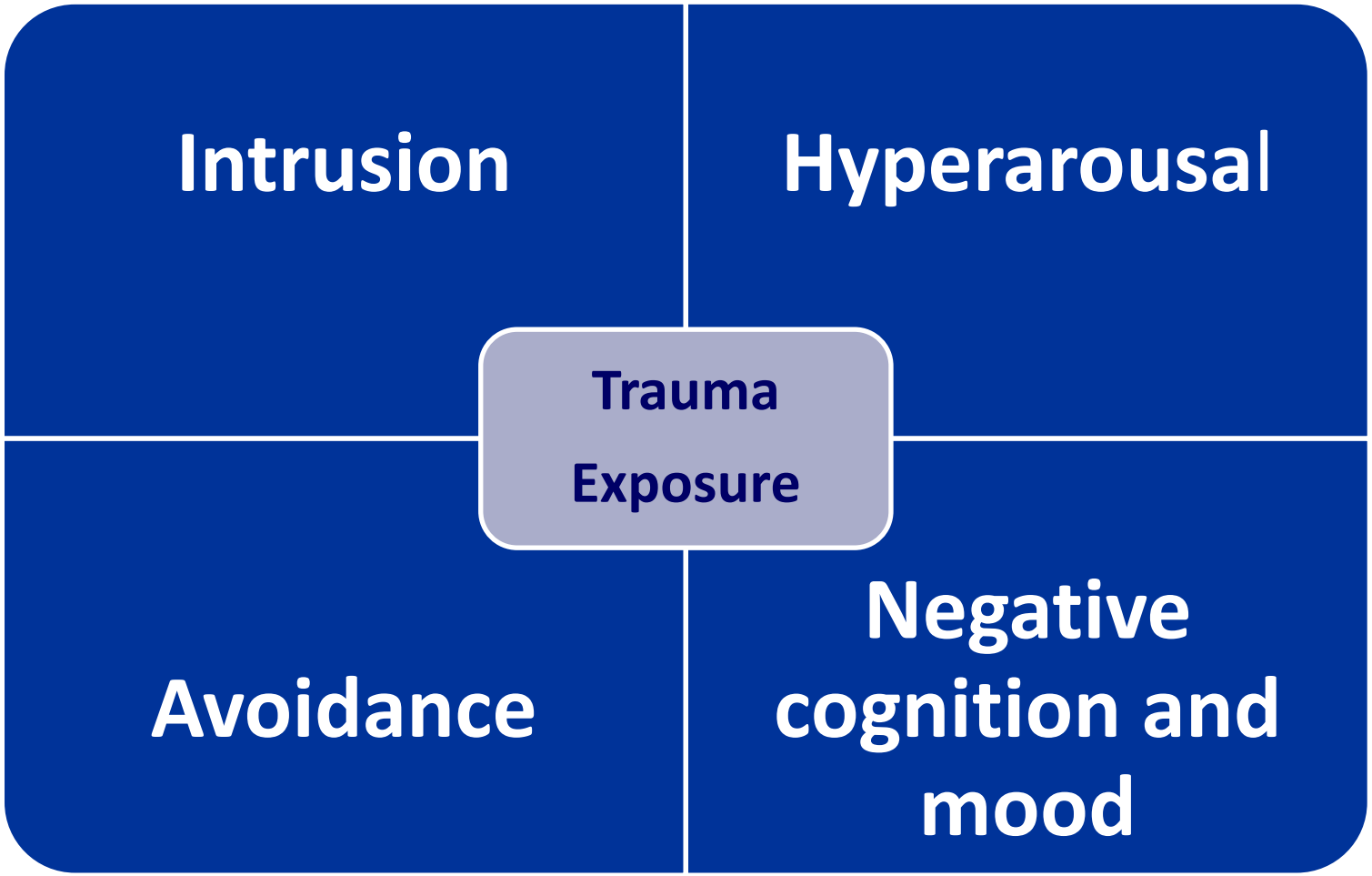
Restlessness

Difficulty sleeping

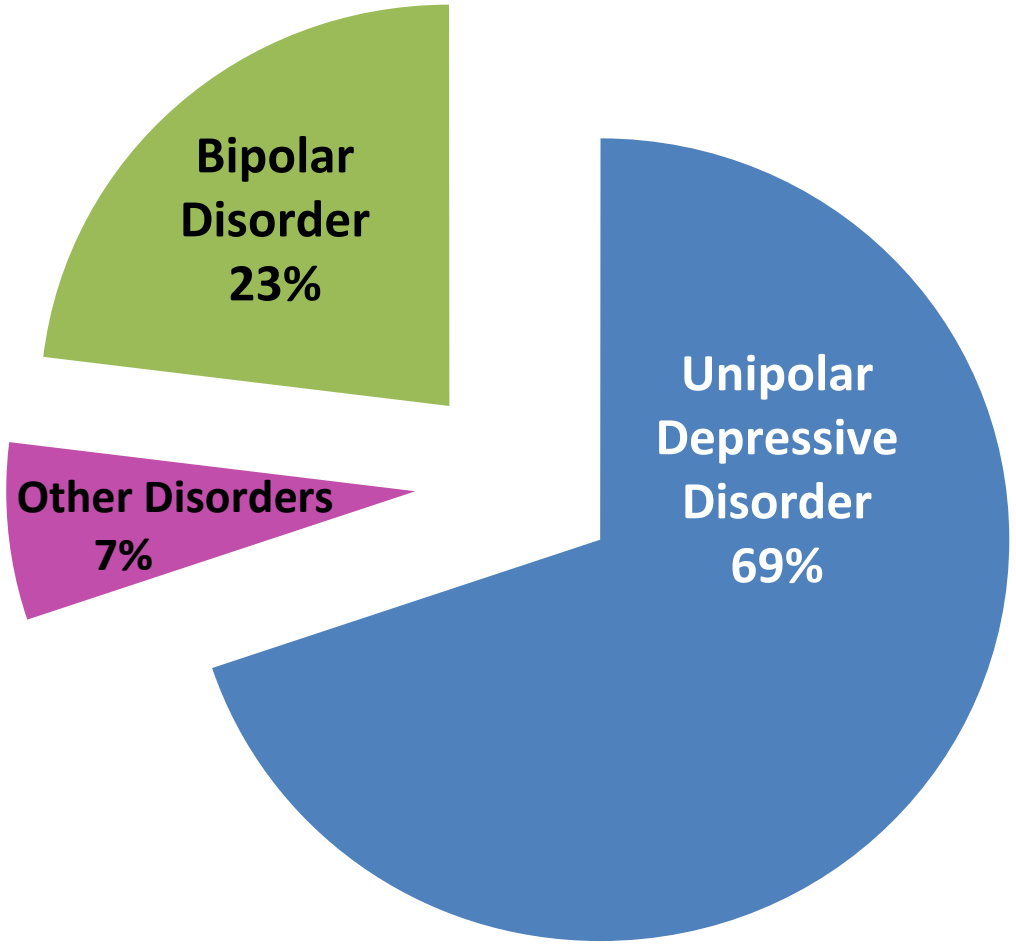
verywell

https://www.verywellmind.com/dsm-5-criteria-for-generalized-anxiety-disorder-1393147

Posttraumatic stress disorder hijacks the natural threat detection and response system



It is imperative to rule out bipolar disorder especially prior to initiating pharmacotherapy



Prescribing unopposed antidepressant can precipitate mania and increase risk of other negative outcomes

Wisner et al. JAMA Psychiatry 2013

Bipolar disorder increases risk of postpartum psychosis

1-2/1000 women

>70% bipolar disorder

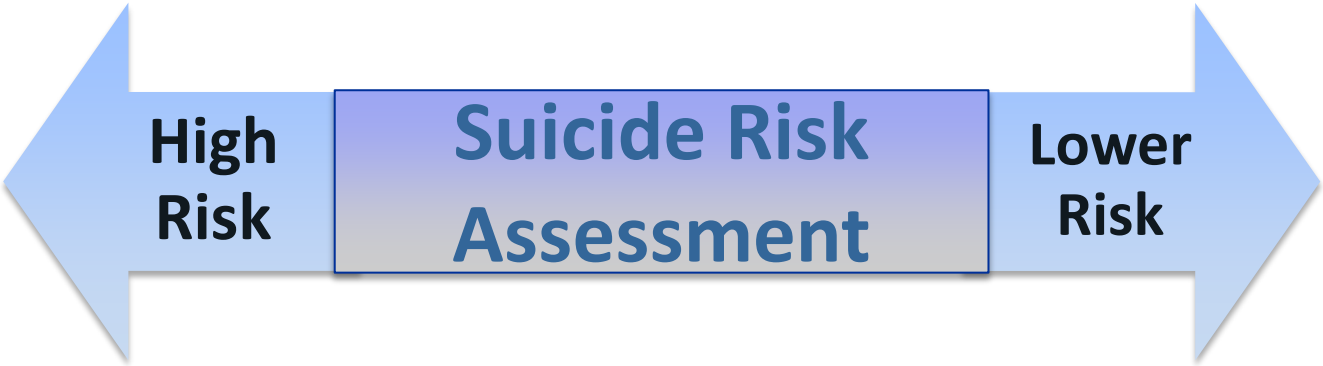
24 hrs – 3 weeks postpartum

Mood symptoms, psychotic symptoms & disorientation

R/o medical causes of delirium

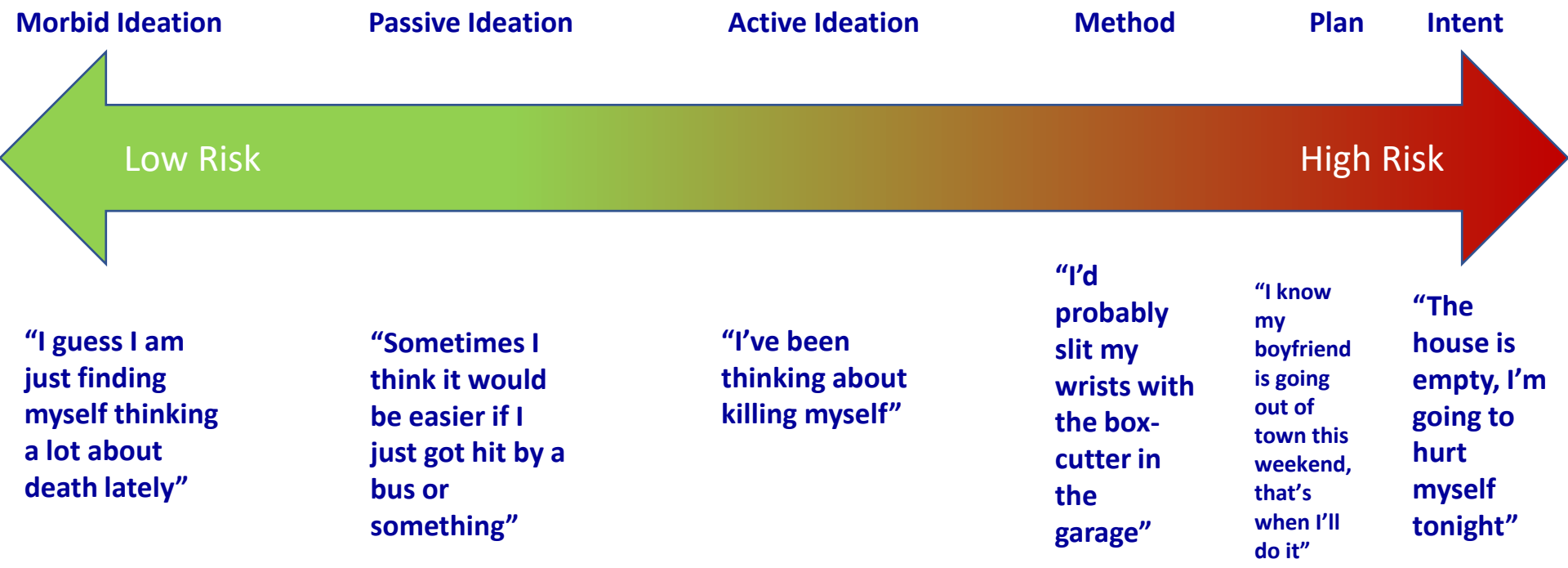
Psychiatric emergency

Increased risk of suicide & infanticide



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

Always assess SLAP: Specificity, Lethality, Access, Previous attempts



Thoughts of harming the baby are not always a psychiatric emergency

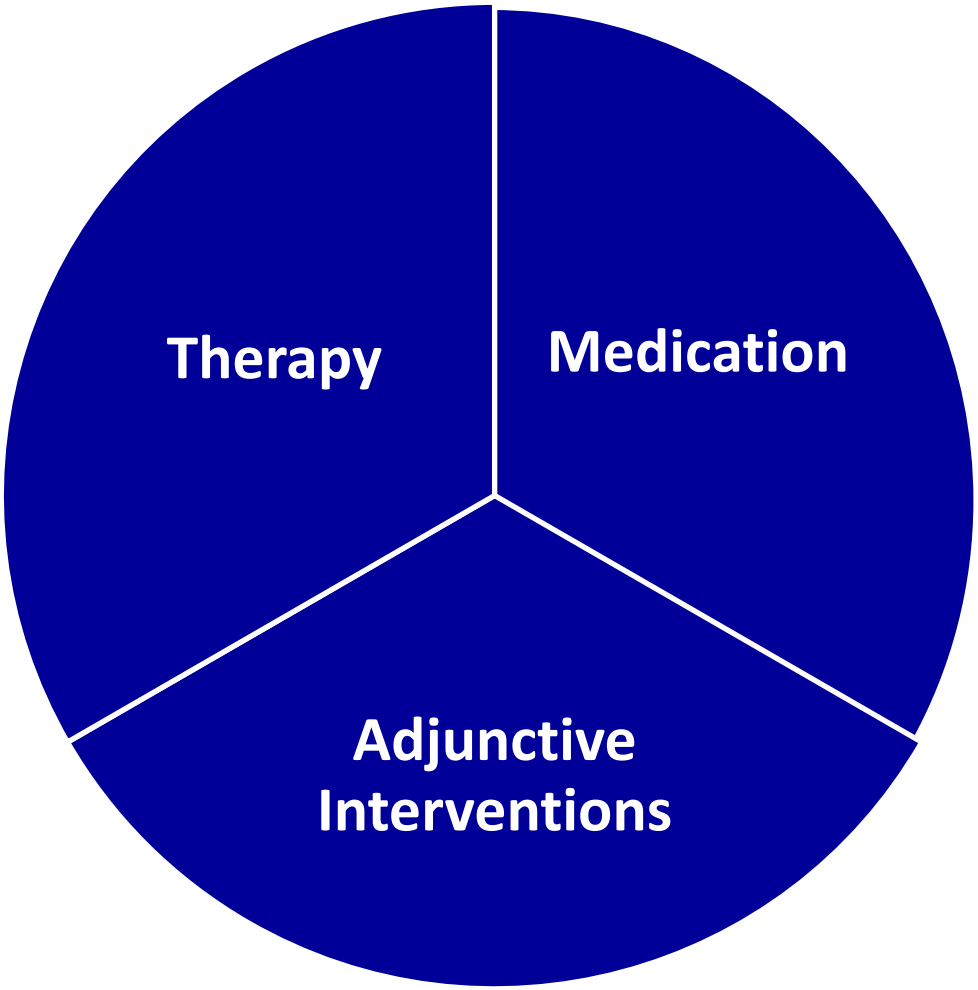
OCD/anxiety/depression	Postpartum Psychosis
• Good insight • Thoughts are intrusive and scary • No psychotic symptoms • Thoughts cause anxiety	• Poor insight • Psychotic symptoms • Delusional beliefs or distorted reality present
↓	↓
Low risk	High risk

Understanding the Patient Care Pathway is critical to addressing PMH conditions

Treatment:

- **Evidence-based treatments:** how to discuss and provide various treatment and support options, including therapy, medication, and adjunctive interventions

Three pillars of treatment for perinatal mental health conditions – elucidate preferences



Individual therapy is first-line treatment for mild illness

Cognitive behavioral therapy

Interpersonal psychotherapy

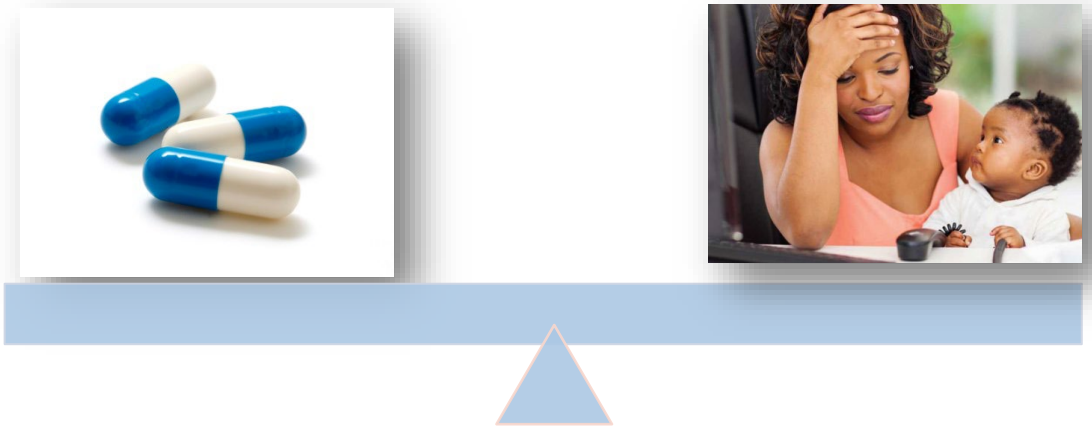
Group, couples, family therapy

ACOG recommends that obstetricians be prepared to **counsel patients** on the benefits and risks of psychopharmacotherapy for perinatal mental health conditions

…and **initiate psychopharmacotherapy** for perinatal depression or anxiety disorders.

There is no such thing as no exposure

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



How to educate patients about treatment with antidepressants	
Antidepressant use during pregnancy:	**Under-treatment or no treatment of perinatal mental health conditions:**
– Does not appear to be linked with birth complications	– Has been linked with birth complications
– Has been linked with small but inconsistent risk of birth defects when taken in the first trimester, particularly paroxetine	– Can increase the risk or severity of postpartum depression
– Has been linked with transient (days to weeks) neonatal symptoms (tachypnea, irritability, insomnia)	– Can make it harder for moms to take care of themselves and their babies
– Has inconsistent, overall reassuring, evidence regarding long-term (months to years) neurobehavioral effects on children	– Can make it harder for moms to bond with their babies
	– Can increase risk of mental illness among offspring
	– Has been linked with possible long-term neurobehavioral effects on children

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

No suicidal ideation

Able to care for self/baby

Engaged in psychotherapy

Depression/Anxiety has improved with psychotherapy in the past

Strong preference and access to psychotherapy

Moderate/severe depression and/or anxiety

Suicidal ideation

Difficulty functioning or caring for self/baby

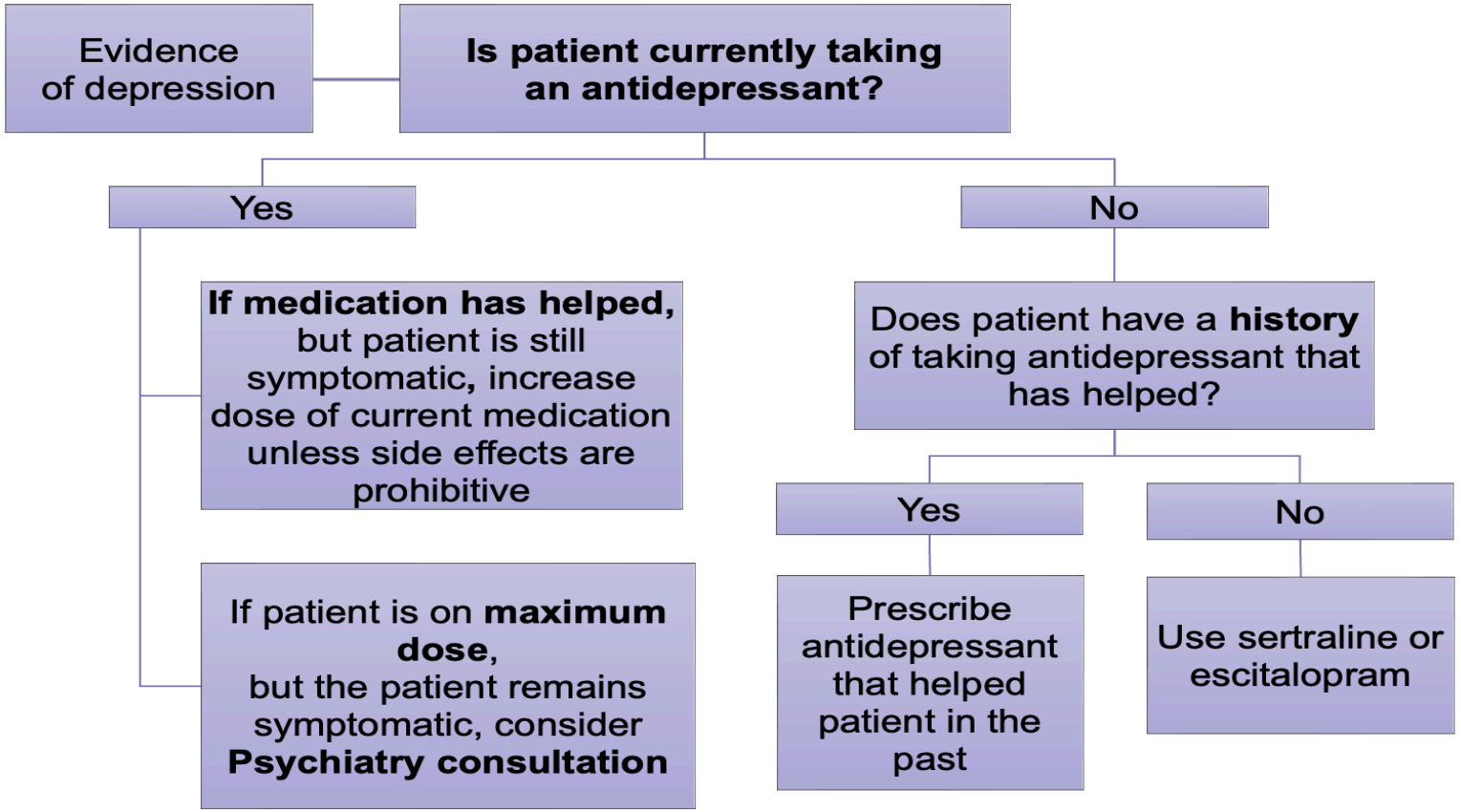
Psychotic symptoms present

History of severe depression/anxiety and/or suicide ideation/attempts

Comorbid conditions (Depr + Anx)

ACOG recommends that **SSRIs be used as first-line pharmacotherapy** for perinatal depression and/or anxiety. SNRIs are reasonable alternatives.

Pharmacotherapy should be **individualized** based on prior response to therapy (if applicable). If there is no pharmacotherapy history, **sertraline** or **escitalopram** are reasonable first-line medications.


Evidence of depression
Is patient currently taking an antidepressant?
Yes
No
If medication has helped, but patient is still symptomatic, increase dose of current medication unless side effects are prohibitive
If patient is on maximum dose, but the patient remains symptomatic, consider Psychiatry consultation
Does patient have a history of taking antidepressant that has helped?
Yes
No
Prescribe antidepressant that helped patient in the past
Use sertraline or escitalopram

Start antidepressants at a low dose and increase in small increments every 4 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

Same prescribing principles apply during preconception, pregnancy and breastfeeding

- Use what has previously worked
- Use EFFECTIVE dose
- Minimize switching
- Monotherapy preferable
- Be aware of need to adjust dose with advancing pregnancy
- Discourage stopping SSRIs prior to delivery

Antidepressants are generally well tolerated

Temporary

Nausea
Constipation/Diarrhea
Lightheaded
Headaches

Long-term

Increase in appetite/weight gain
Changes in sexual interest/experience
Vivid dreams/insomnia

Direct patients to take medication with food to decrease side effects

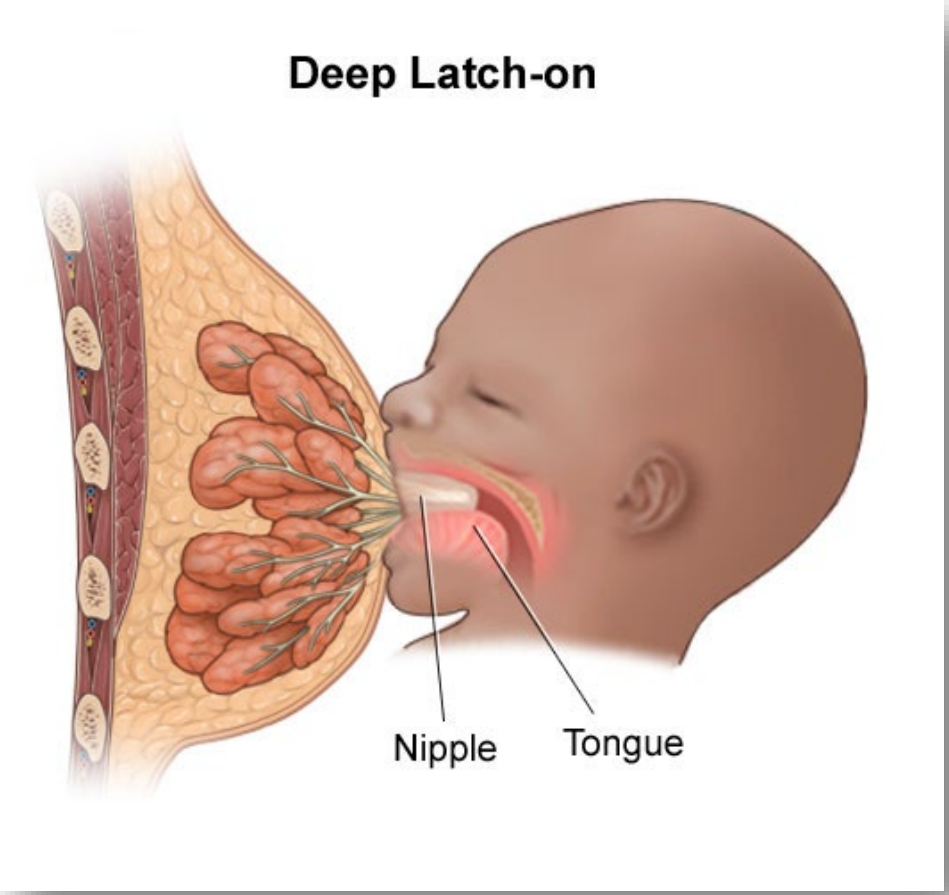
Educate patients about side effects when starting an antidepressant

- Side effects often improve after 2 weeks or so
- Typically takes a month or more for therapeutic effects
- Can take them either in AM or PM depending on effect

Breastfeeding generally should not preclude treatment with antidepressants

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

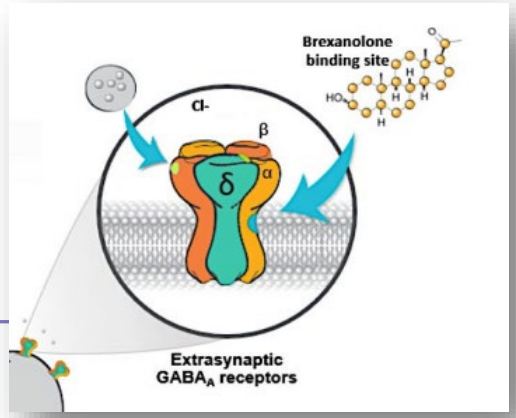
Sertraline, paroxetine, & fluvoxamine have lowest passage into milk



ACOG **recommends against withholding or discontinuing medications** for mental health conditions due to pregnancy or lactation status alone.

ACOG recommends **consideration of brexanolone administration** in the postpartum period for moderate-to-severe perinatal depression with onset in the third trimester or within 4 weeks postpartum.

BREXANOLONE (Zulresso)
Allopregnanolone formulation



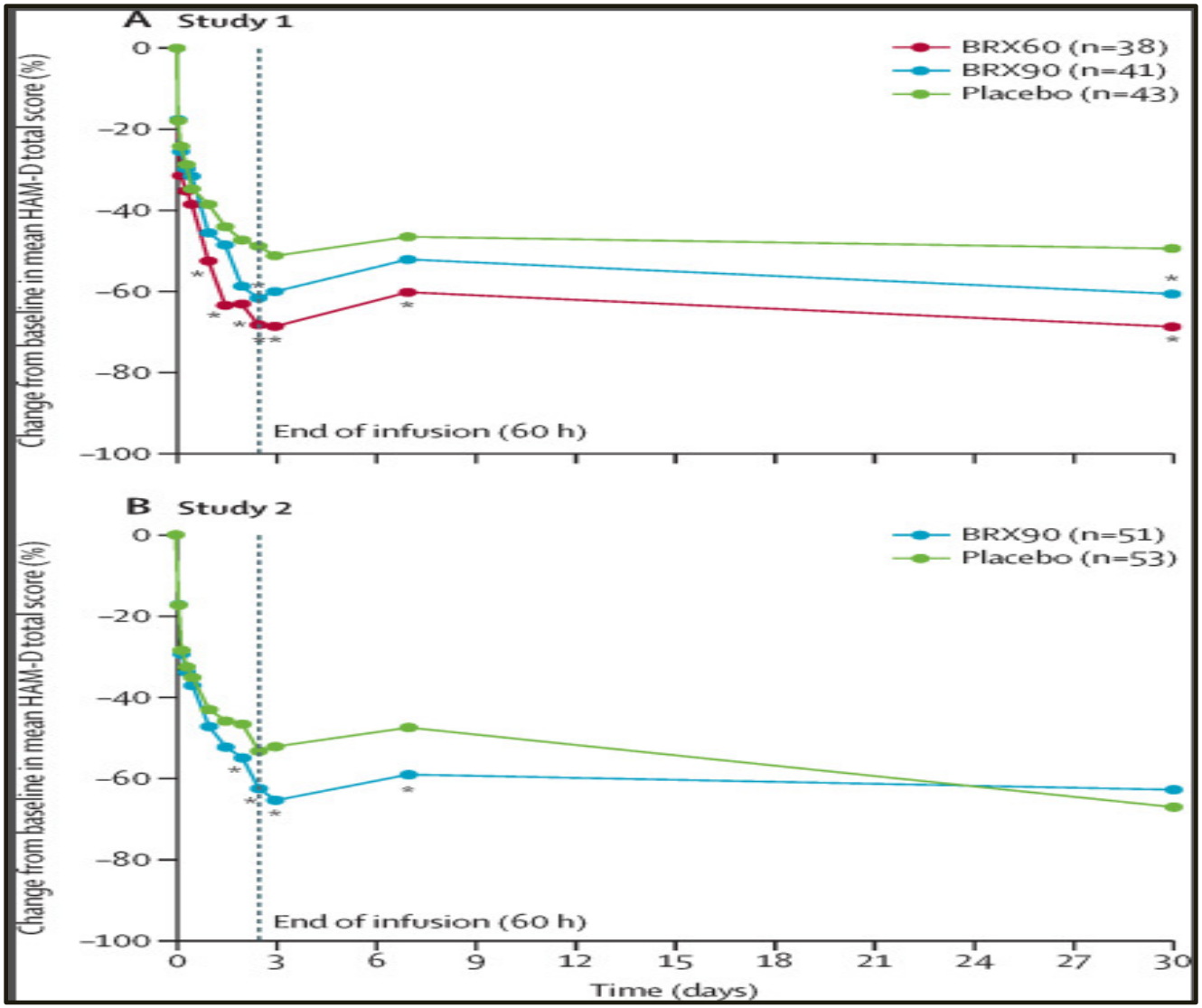
BENEFITS

- Large effect size
- Rapid onset of response and remission of symptoms (1-2 days)

CONSIDERATIONS

- 60-hour infusion
  - Requirement for hospitalization
  - Cost
- Common Side Effects
  - Loss of consciousness
  - Headache
  - Dry mouth
  - Sedation
  - Dizziness
- No published outcomes > 30 days
- Lactation disruption
- No comparative-effectiveness data with SSRIs

3 placebo controlled RCTs showed rapid reduction in depression symptoms, durable at 30 days



Zuranolone for PPD Tx

- FDA approved Aug 2023 for PPD after 2 phase 3 double-blind placebo-controlled RCTs
- $GABA_A$ receptor positive modulator
- **Zuranolone 50 mg PO qPM with fatty meal x 14 day**
  - Decreased to 40 mg with CNS depressant effects
  - Start @ 30 mg with severe hepatic or mod-severe renal impairment
  - Adjustments with CYP3a4 inhibitors
  - Avoid with CYP3A4 inducers
- If miss dose, do not double dose in day; complete 14 doses total
- Can be used with SSRIs and SNRIs
- Use effective contraception for ≥ 1 wk after course
- Precautions reference:
  - Impaired ability to drive or engage in other potentially hazardous activities
    - **No driving until at least 12h after each dose**
    - Avoid other CNS depressants
  - CNS depressant effects including somnolence & confusion
  - Increased suicidal thoughts and behaviors

See ACOG PA Aug 2023

Adjunctive interventions can benefit all patients

Social Engagement (Identify Sources of Support)

- Partner (re)connection is safe
- Friend connection
- Family connection
- Spiritual/religious connection

Personal Engagement (Values congruent activities)

- Self-care
- Pleasurable activities
- Self-kindness
- Meaningful activities

Physical Engagement (Body Positive Approach)

- Balanced Nutrition
- Nourishing movement
- Avoidance of substances (e.g. caffeine, nicotine, EtOH, others0
- Managing medical concerns (not just pregnancy)
- Sleep Hygiene

Offer other adjunctive interventions as indicated

Self-Care Plan

Name:_____DOB / MRN: _____
Provider: _____ Date: _____

Setting goals for things that are within your control has been shown to help women feel emotionally well. Your goals should be fairly easy to start. You do not need to do all of these. Choose one or two to try in the coming weeks.

1. Stay physically active. Make sure you make time to address your basic physical needs, for walking for a certain amount of time each day.

During the week, I will spend at least_____minutes doing (write in activities) _____ _____. I will try to do these for_____(minutes each time).

2. Make time for pleasurable activities. Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activity each day - for example, doing a hobby, listening to music, or watching a video.

Things I find pleasurable include: _____

During the week, I will spend at least_____minutes doing (choose one of more of these to try in the coming week)_____.

3. Talk or spend time with people who can support you. It's tempting to avoid contact with people when you're down, but everyone needs the support of friends and loved ones. Explain to them how you feel if you can. If you can't talk about it, that's OK - just ask them to be with you, maybe joining you for one of your activities. Ask for/accept help from others, especially during nighttime feedings.

People I find supportive and helpful include: _____

During the week, I will make contact with_____(name/s) and try to talk with them_____times.

4. Practice relaxing. For many people, the changes that come with depression - no longer keeping up our usual activities and responsibilities, feeling increasingly sad and hopeless - leads to anxiety. Since physical relaxation can lead to mental relaxation, practicing relaxing is another way to help yourself. Try deep breathing, or a warm bath, or just finding a quiet, comfortable, peaceful place and saying comforting things to yourself (like "It's OK.")

During the next week, I will practice physical relaxation by doing _____ at least_____times, for at least_____ minutes each time.

5. Simple goals and small steps. It's easy to feel overwhelmed when you're depressed. It can be hard to deal with problems when you're feeling sad and have little energy. Try setting a new goal that is different than above. Try breaking things down into small steps and give yourself credit for each step you accomplish.
The problem is:_____ My goal is: _____

Step 1: _____ Step 2:_____

Step 3: _____ Step 4:_____

People who are experiencing symptoms of depression also have thoughts that they might be better off dead or thoughts about harming themselves. Usually, these thoughts go away once treatment has begun but if these thoughts get worse, if you feel unsafe, or feel you cannot resist the urge to act on these thoughts, please call our office or the suicide hotline at 1-800-273-8255.

Adapted from Depression Self-Care Plan developed by……, 2013

Understanding the Patient Care Pathway is critical to addressing PMH conditions

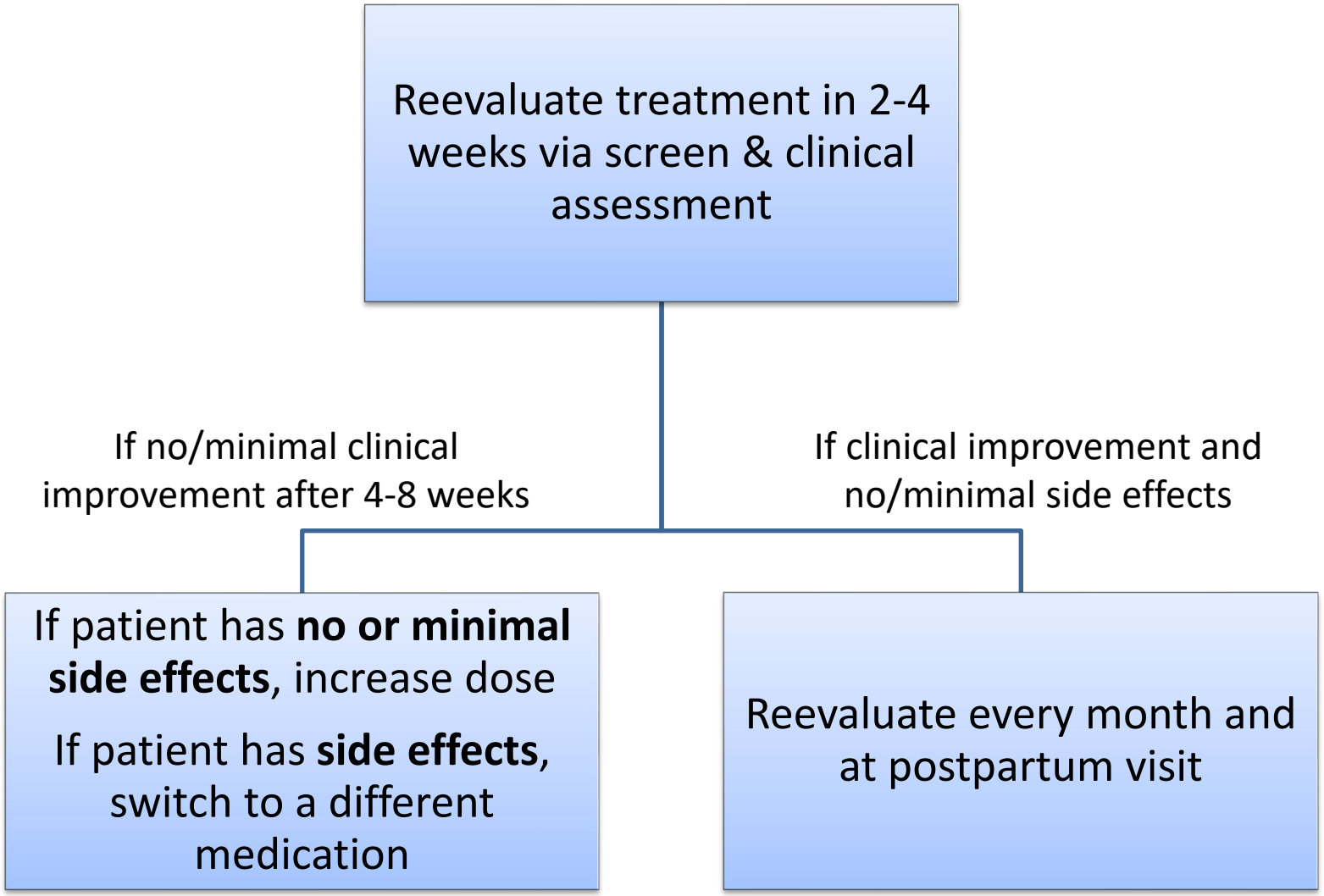
Follow-Up:

- **Follow-up and monitoring:** how to follow up with patients, monitor symptoms, and adjust treatment until full remission of symptoms, in a proactive manner
- **Ongoing treatment versus discontinuation:** how to manage mental health conditions once the illness is in full sustained remission
- **Resources:** guidance documents, toolkits, perinatal psychiatry access lines and apps to help care for perinatal individuals with MH conditions

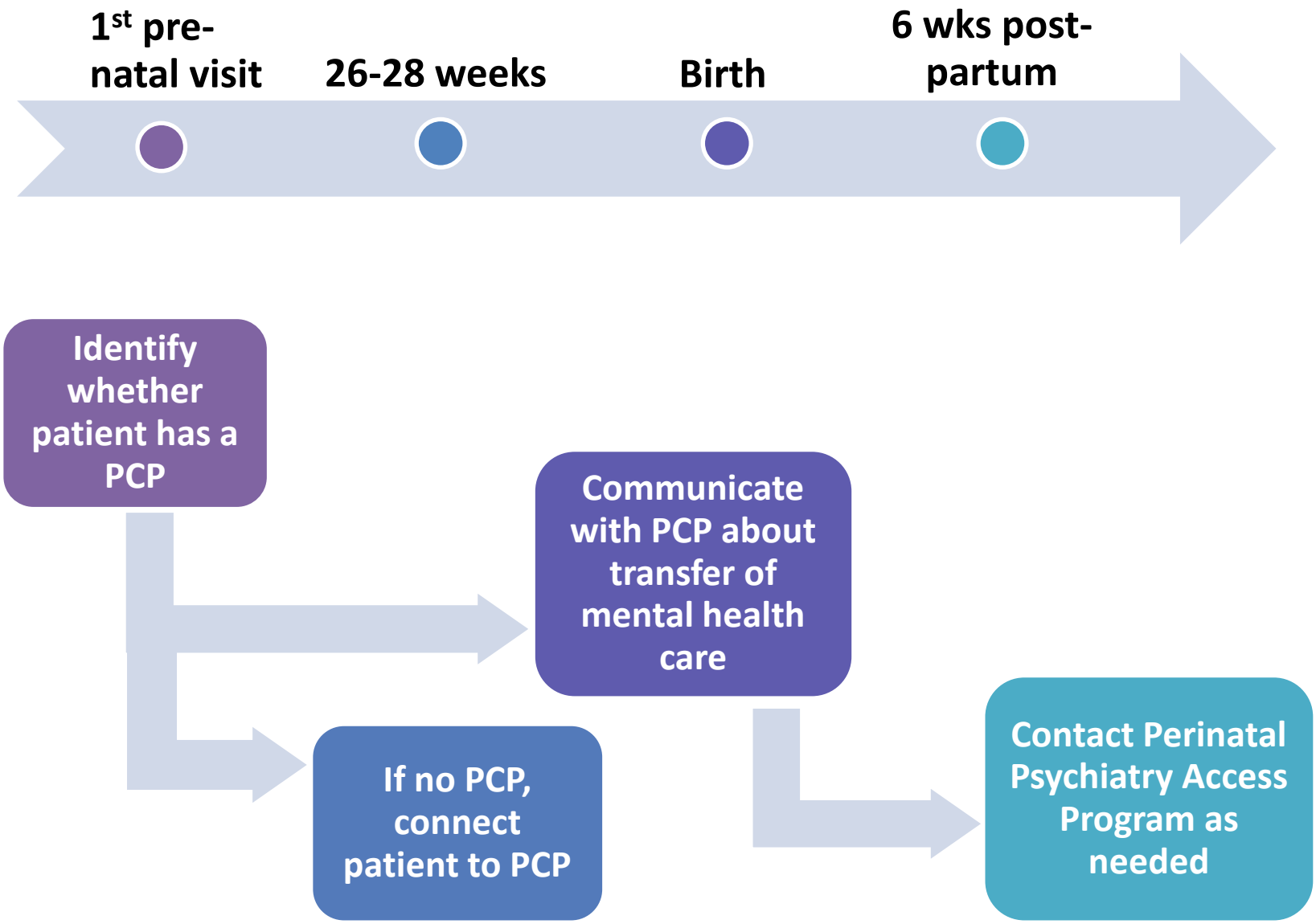
ACOG recommends that a validated screening tool be used to monitor for response to treatment.

If clinically indicated, the pharmacotherapy dosage should be up-titrated, with the goal of remission of depressive and anxiety symptoms.

Titrate antidepressant dose until depression/anxiety remits



Transfer of care if cannot follow-up postpartum



Resources

MS NO: ONG-23-579

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.

PURPOSE: To review evidence on the current understanding of mental health conditions in pregnancy and postpartum, with a focus on mood and anxiety disorders, and to outline guidelines for screening and diagnosis that are consistent with best available scientific evidence. The conditions or symptoms reviewed include depression, anxiety and anxiety-related disorders, bipolar disorder, suicidality, and postpartum psychosis. For information on psychopharmacologic treatment and management, refer to American College of Obstetricians and Gynecologists (ACOG) Clinical Practice Guideline Number 5, "Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum" (1).

TARGET POPULATION: Pregnant or postpartum individuals with mental health conditions. Onset of these conditions may have predated the perinatal period or may have occurred for the first time in pregnancy or the first year postpartum or may have been exacerbated in that time.

METHODS: This guideline was developed using an a priori protocol in conjunction with a writing team consisting of one specialist in obstetrics and gynecology and one maternal–fetal medicine subspecialist appointed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics and two external subject matter experts. ACOG medical librarians completed a comprehensive literature search for primary literature within Cochrane Library, Cochrane Collaboration Registry of Controlled Trials, EMBASE, PubMed, and MEDLINE. Studies that moved forward to the full-text screening stage were assessed by two authors from the writing team based on standardized inclusion and exclusion criteria. Included studies underwent quality assessment, and a modified GRADE (Grading of Recommendations Assessment, Development and Evaluation) evidence-to-decision framework was applied to interpret and translate the evidence into recommendation statements.

RECOMMENDATIONS: This Clinical Practice Guideline includes recommendations on the screening and diagnosis of perinatal mental health conditions including depression, anxiety, bipolar disorder, acute postpartum psychosis, and the symptom of suicidality. Recommendations are classified by strength and evidence quality. Ungraded Good Practice Points are included to provide guidance when a formal recommendation could not be made because of inadequate or nonexistent evidence.

MS NO: ONG-23-580

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.

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.

PURPOSE: To assess the evidence regarding safety and efficacy of psychiatric medications to treat mental health conditions during pregnancy and lactation. The conditions reviewed include depression, anxiety and anxiety-related disorders, bipolar disorder, and acute psychosis. For information on screening and diagnosis, refer to American College of Obstetricians and Gynecologists (ACOG) Clinical Practice Guideline Number 4, "Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum" (1).

TARGET POPULATION: Pregnant or postpartum individuals with mental health conditions with onset that may have predated the perinatal period or may have occurred for the first time in pregnancy or the first year postpartum or may have been exacerbated in that time.

METHODS: This guideline was developed using an a priori protocol in conjunction with a writing team consisting of one specialist in obstetrics and gynecology and one maternal–fetal medicine subspecialist appointed by the ACOG Committee on Clinical Practice Guidelines–Obstetrics and two external subject matter experts. ACOG medical librarians completed a comprehensive literature search for primary literature within Cochrane Library, Cochrane Collaboration Registry of Controlled Trials, EMBASE, PubMed, and MEDLINE. Studies that moved forward to the full-text screening stage were assessed by two authors from the writing team based on standardized inclusion and exclusion criteria. Included studies underwent quality assessment, and a modified GRADE (Grading of Recommendations Assessment, Development and Evaluation) evidence-to-decision framework was applied to interpret and translate the evidence into recommendation statements.

RECOMMENDATIONS: This Clinical Practice Guideline includes recommendations on treatment and management of perinatal mental health conditions including depression, anxiety, bipolar disorders, and acute postpartum psychosis, with a focus on psychopharmacotherapy. Recommendations are classified by strength and evidence quality. Ungraded

Zuranolone for the Treatment of Postpartum Depression

Practice Advisory | **August 2023**

Considerations for zuranolone therapy:

- The daily recommended dose of zuranolone is generally 50 mg. It is taken in the evening with a fatty meal (eg, 400 to 1,000 calories, 25% to 50% fat), for 14 days. Dosage may be reduced to 40 mg if central nervous system (CNS) depressant effects occur. In the case of severe hepatic or moderate to severe renal impairment, dosing should be initiated at 30 mg. Dose adjustments will also be needed if patients are taking medications that are strong CYP3A4 inhibitors and concomitant use with CYP3A4 inducers should be avoided.*
- If an evening dose is missed, take the next dose at the regular time the following evening; do not take extra doses on the same day. Complete 14 days of treatment total.
- Zuranolone can be used alone or as an adjunct to other oral antidepressant therapy like SSRIs and SNRIs.
- Patients should use effective contraception during the 14-day treatment course and for 1-week after the final dose. Zuranolone may cause fetal harm [2]. If pregnancy does occur, there is a registry.**
- Patients should be warned and given precautions about adverse reactions including:
  - Impaired ability to drive or engage in other potentially hazardous activities,
  - CNS depressant effects including somnolence and confusion, and
  - Increased suicidal thoughts and behaviors.
- Patients should not drive or engage in activities requiring complete mental alertness until at least 12 hours after each dose for the duration of the full treatment course. Patients may not be able to accurately assess their own degree of impairment during the treatment cycle.
- Other CNS depressing substances should be avoided (eg, alcohol, benzodiazepines, opioids, tricyclic antidepressants). If unable to avoid, a dose reduction may be necessary.
- The most common side effects include dizziness, fatigue, drowsiness, diarrhea, common cold-like symptoms, and urinary tract infections.
- Zuranolone passes into breast milk, although with a RID lower than that of SSRIs. There are no data on effects on a breastfed infant and limited data on milk production. The patient's clinical need for zuranolone and the developmental and health benefits of breastfeeding should be balanced through a shared decision-making process that considers continuation, pumping and discarding milk through 1-week past treatment completion, and cessation.

AIM PATIENT SAFETY BUNDLES

AIM develops multidisciplinary, clinical-condition specific patient safety bundles to support best practices that make birth safer. LEARN MORE

PERINATAL MENTAL HEALTH CONDITIONS

Perinatal Mental Health Conditions

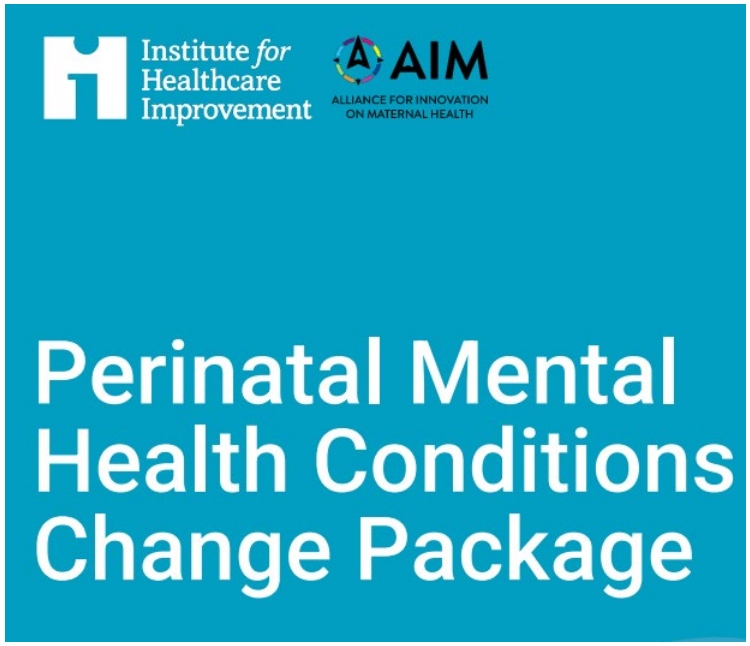
For the purposes of this bundle, perinatal mental health conditions refer to mood, anxiety, and anxiety-related disorders that occur during pregnancy or within one year of delivery and are inclusive of mental health conditions with onset that predates pregnancy. These conditions include and are not limited to depression, anxiety and anxiety-related disorders like posttraumatic stress disorder and obsessive-compulsive disorder, bipolar disorder, and postpartum psychosis.

- READINESS
- RECOGNITION & PREVENTION
- RESPONSE
- REPORTING & SYSTEMS LEARNING
- RESPECTFUL, EQUITABLE & SUPPORTIVE CARE

View the Introduction to Perinatal Mental Health Conditions video HERE.

QUICK LINKS

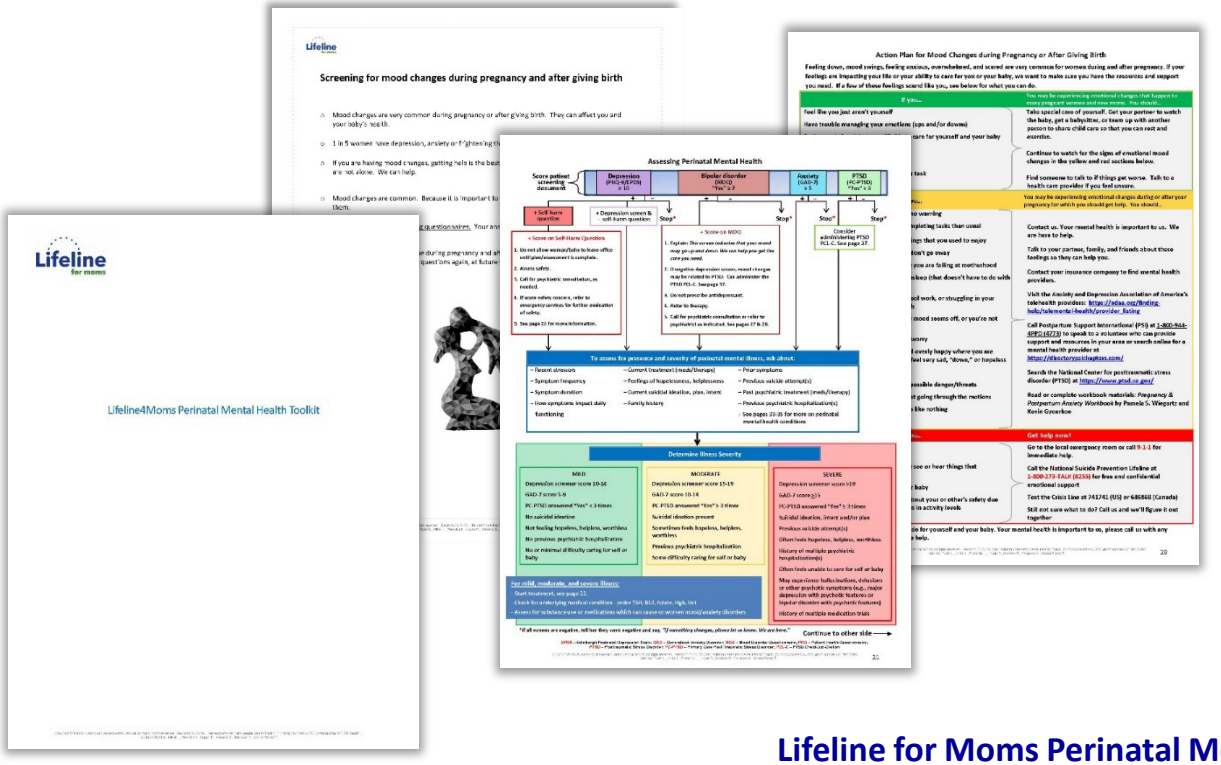
- Printable Bundle (PDF)
- National Maternal Health Hotline
- Perinatal Mental Health Conditions Element Implementation Details (PDF)
- Perinatal Mental Health Conditions Implementation Webinar (Video)
- Perinatal Mental Health Conditions Data Collection Plan (PDF)
- Perinatal Mental Health Conditions Bundle Implementation Resources (PDF)
- COMING SOON: Perinatal Mental Health Conditions Change Package (PDF)



Readiness

Change Concept	Change Idea	Key Resources and Tools
Develop workflows for integrating mental health care into preconception and obstetric care before pregnancy through the postpartum period including provision of pharmacotherapy when indicated	Standardize screening processes and roles. Identify a member of the care team whose role includes screening for mental health conditions *Include mental health screening as part of intake and at regular intervals throughout prenatal care. At a minimum, this schedule should include intake, once in the 3rd trimester, and at the postpartum visit* *	American College of Obstetricians and Gynecologists (ACOG): Perinatal Mental Health: Patient Screening[22]
	Develop a standard process for addressing a positive screen (Who makes the referral? How? When?) and have referral pathways ready	Massachusetts Child Psychiatry Access Program (MCPAP) for Moms: Obstetric Provider Toolkit[23] Orange County (OC) Health Care Agency: Perinatal Mood and Anxiety Disorders: Maternal Screening and Care Pathway[24]
	As feasible, develop a workflow that allows providers to get support from a mental health clinician when a patient screens positive to allow for real-time guidance on appropriate next steps *If access to mental health clinicians is limited in your community, explore alternative pathways such as working with primary care* *	UMass Chan Medical School: Resources for Integrating Mental Health into Obstetric Settings: Sample Workflows (pp. 57 - 58)[25] Maternal Mental Health Leadership Alliance (MMHLA): Psychiatry Access Programs[26] Postpartum Support International (PSI): Perinatal Psychiatric Consult Line[27]
	As feasible, set up mechanisms to pre-schedule mental health care for post-delivery in the event of a positive screen during pregnancy	Increasing Warm Handoffs: Optimizing Community Based Referrals in Primary Care Using QI Methodology[28]

Lifeline for Moms Toolkit provides obstetric clinicians with tools to help them address mental health

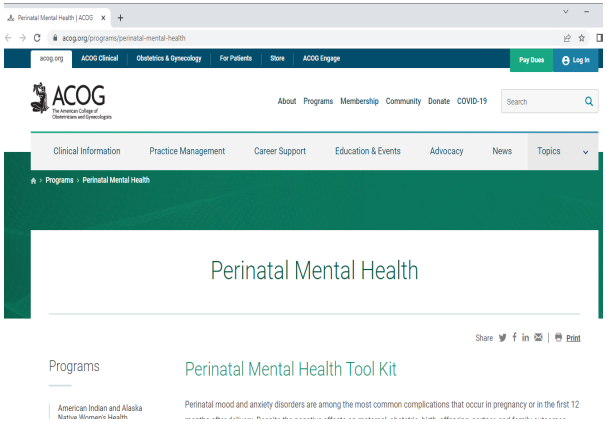


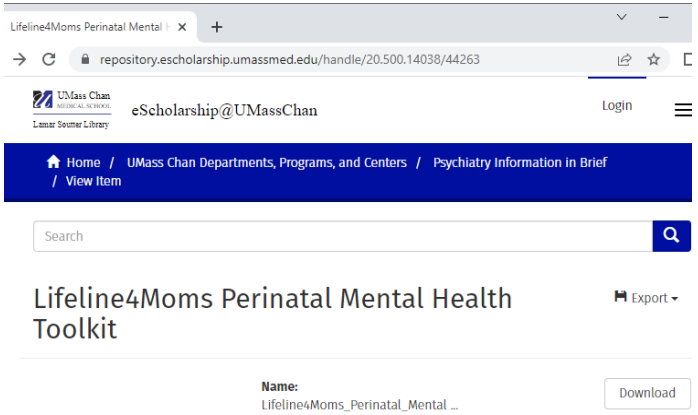
[Lifeline for Moms Perinatal Mental Health Toolkit" by Nancy Byatt, Leena P. Mittal et al. (umassmed.edu)]

Lifeline for Moms Toolkit provides obstetric clinicians with tools to help them address mental health

ACOG
The American College of Obstetricians and Gynecologists

Lifeline for moms





[Perinatal Mental Health | ACOG]

[Lifeline4MomsPerinatal Mental Health Toolkit (umassmed.edu)]

Lifeline for Moms e-Modules provide training in detection, assessment, treatment and follow-up using self-paced, case-based, interactive design

Menu

Resources

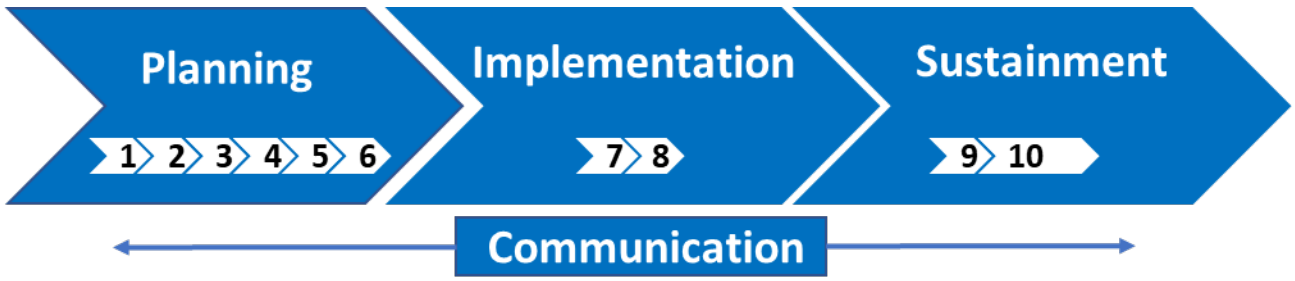
Dr. Silva's treatment across four patients:

Patients	Detect	Assess	Treat	Follow Up
 **Julie** 2nd child 36 weeks GA	EPDS − Self-Harm MDQ GAD-7 PC-PTSD-5	Depression Anxiety	Therapy & Adj. Int.* sertraline	Symptoms improved. Tolerating sertraline. Reevaluate early postpartum.
 **Sofia** 1st child 9 months PP	EPDS − Self-Harm MDQ GAD-7 PC-PTSD-5	Depression with low risk of self-harm	Therapy & Adj. Int.* venlafaxine (previously effective)	At 6 mos. complete symptom remission, venlafaxine tapered with monthly monitoring.
 **Adele** 1st child 26 weeks GA	PHQ-9 − Self-Harm MDQ GAD-7 PC-PTSD-5	Bipolar with depressive symptomatology	Therapy & Adj. Int.* Referral: psychiatric & medication	Scheduled with psychiatric clinician.
 **Olivia** 1st child 6 weeks PP	EPDS − Self-Harm MDQ GAD-7 PC-PTSD-5	Depression PTSD	Therapy & Adj. Int.* Increase citalopram dose	Significant symptom improvement. Transition care to PCP.

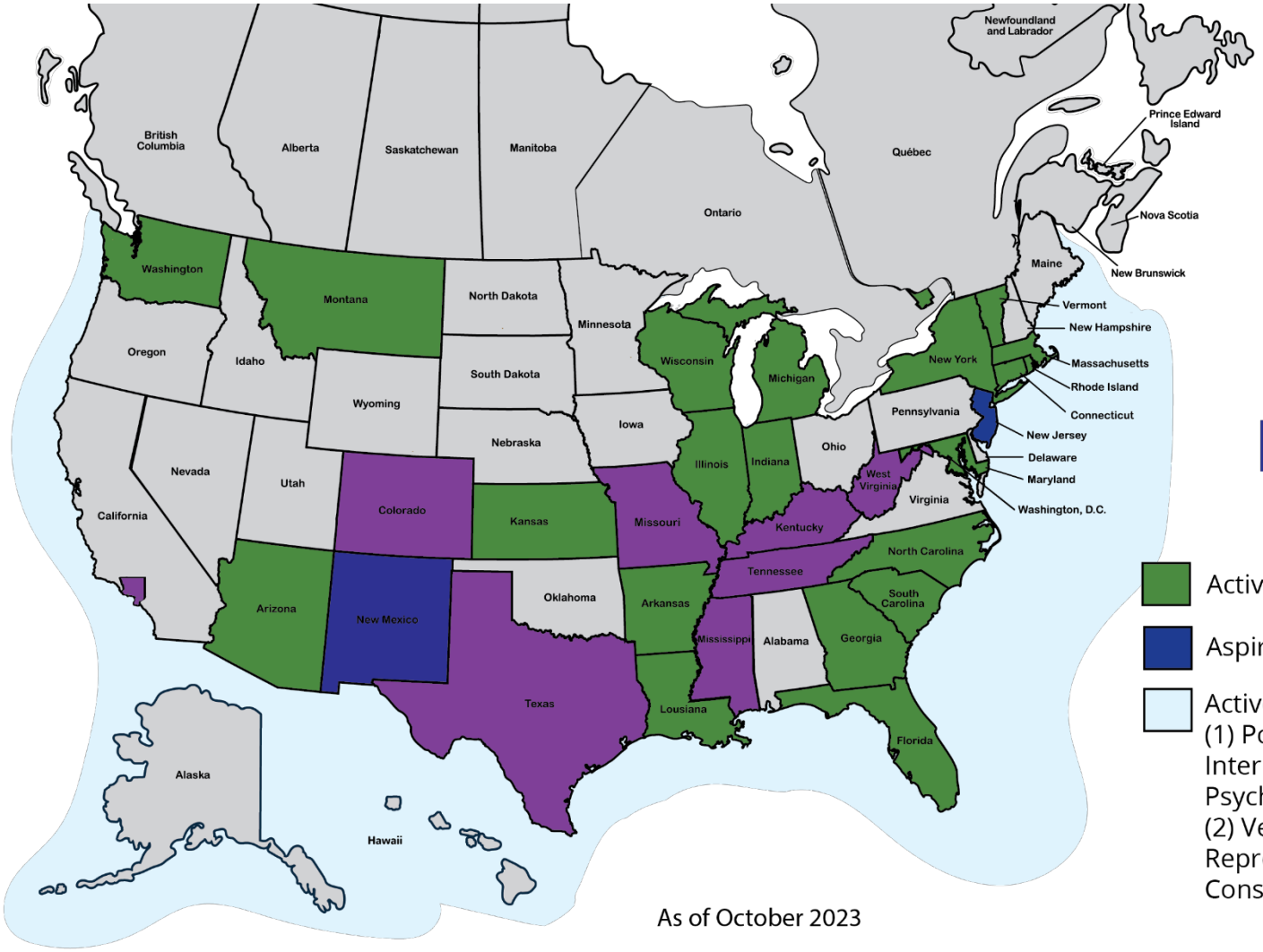
+ Positive − Negative

* Adjunctive Interventions

Implementation Guide for Integrating PMH into OB Practice



Perinatal Psychiatry Access Programs



Lifeline for moms

Active Programs

Aspiring Programs

Active national programs: (1) Postpartum Support International (PSI) Perinatal Psychiatric Consult Line & (2) Veterans Affairs (VA) Reproductive Mental Health Consultation Programs

As of October 2023

The National Maternal Mental Health Hotline is a free and available across the US

1-833-9-HELP4MOMS

(1-833-943-5746)

Patient-facing Hot-Line (24/7)
National Maternal Mental Health Hotline | MCHB (hrsa.gov)

Integrating mental health care into our practices can be transformative for the perinatal individuals, children and families we serve

Thank you!

Lifeline for Moms Teams and Collaborators:

- MCPAP for Moms Team
- Trainees and students
- Massachusetts DMH
- Participating Obstetric Practices
- Participating Perinatal Individuals
- Advisory Council Members
- CDC Collaborators

Funding:

- CDC 1U01 DP006093, 6 U48DP006381-03-01
- CDC Foundation
- The Perigee Fund
- NIMH 1R41 MH113381-01, 2R42 MH113381-02
- PCORI IHS-2019C2-17367, EACB-23288
- ACOG 6 NU380T000287-02-01
- NIH KL2TR000160

www.mcpapformoms.org www.lifeline4moms.org

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Thank you!