NH DIVISION OF Public Health Services

HRSA Health Resources & Services Administration

CDC

NH AIM/ERASE Monthly Webinar

January 9, 2025

Welcome!

- We will begin shortly
- Reminder, we will be recording this session
- Your line will be muted upon entering. Please enter comments or questions in the chat
- Julie Bosak & Maggie Coleman will monitor the chat box and call on you to unmute yourself
- If you have trouble connecting, please email **Margaret.A.Coleman@hitchcock.org**

To Receive CME/CNE Credit for Today's Session

Text: 833-884-3375

Enter Activity Code: 148176

Need help?

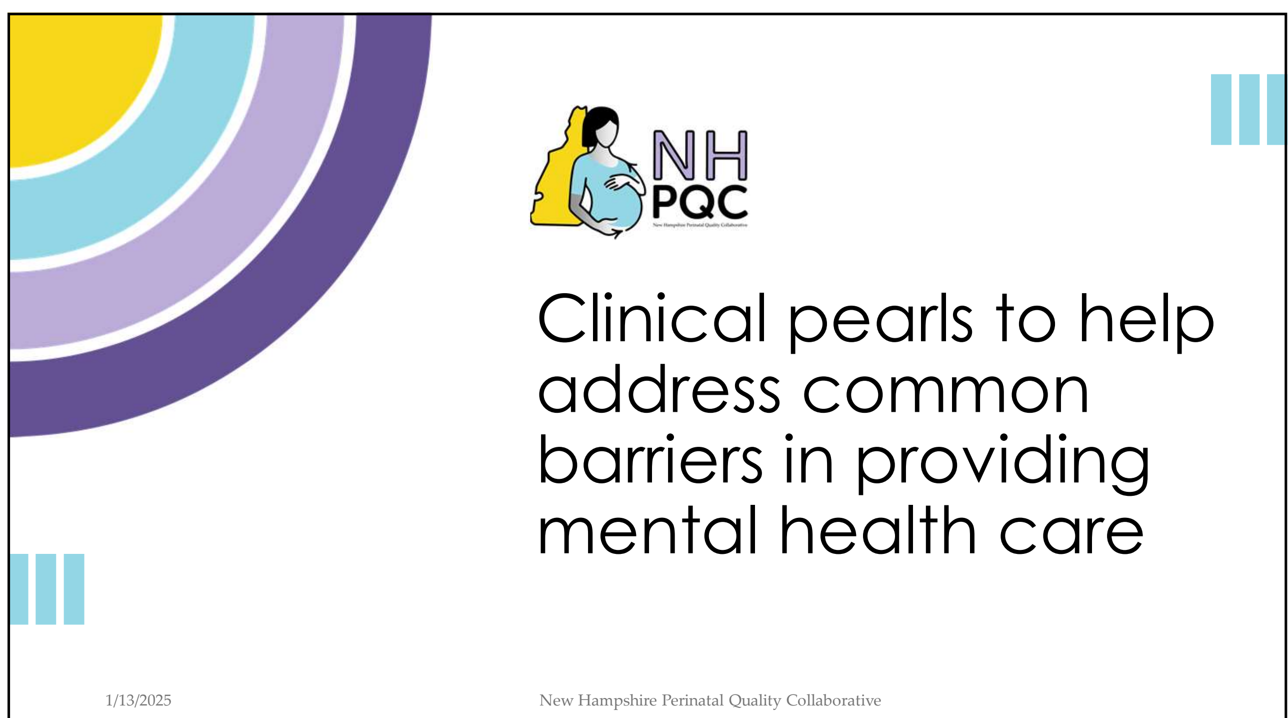
clpd.support@hitchcock.org

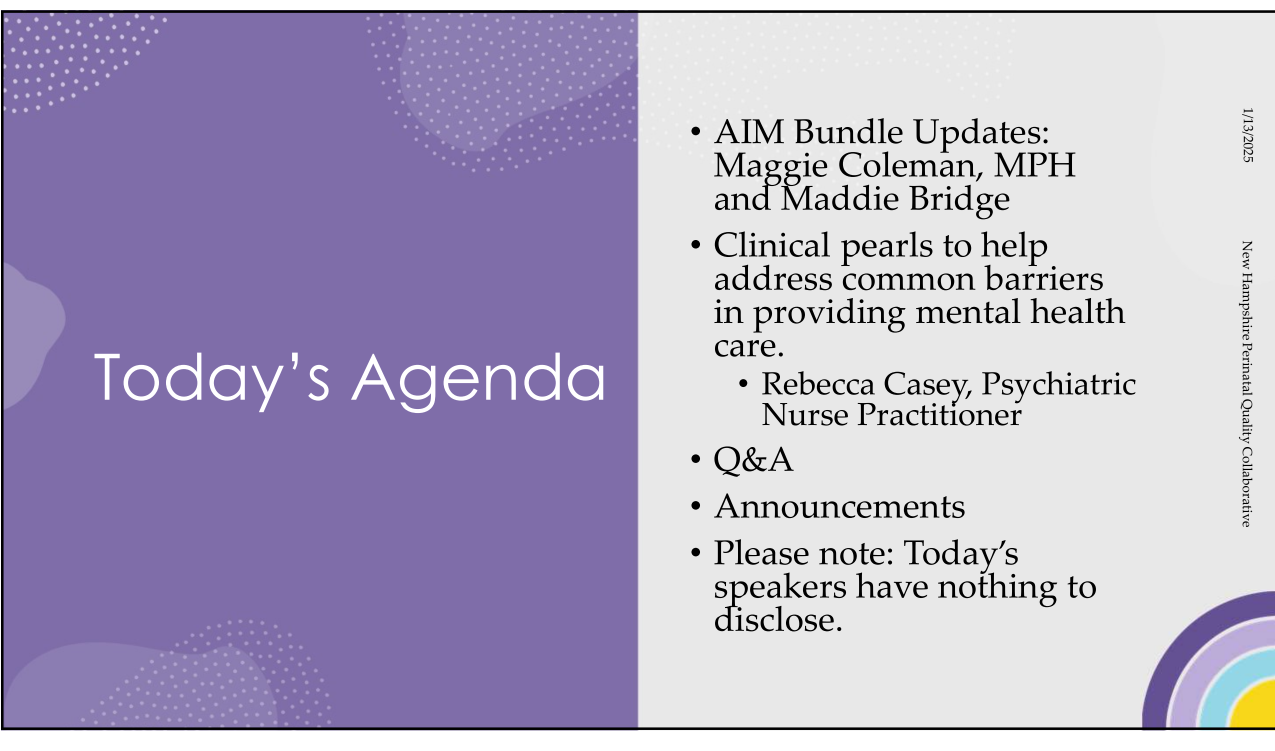
CE is ONLY available for live attendance.

REMINDERS:
Please feel free to share the recording with colleagues and those you feel would benefit if they are unable to attend @ **www.NNEPQIN.org**: Educational Offerings | NNEPQIN

We HIGHLY value your input. Please be sure to **complete the evaluation** that Maggie Coleman will send to you immediately following the webinar. It takes less than 5 minutes to complete.

1/13/2025 New Hampshire Perinatal Quality Collaborative





Today's Agenda
• AIM Bundle Updates: Maggie Coleman, MPH and Maddie Bridge
• Clinical pearls to help address common barriers in providing mental health care.
• Rebecca Casey, Psychiatric Nurse Practitioner
• Q&A
• Announcements
• Please note: Today's speakers have nothing to disclose.
1/13/2025
New Hampshire Perinatal Quality Collaborative

NH PQC
Gender Statement: We recognize that pregnant people have a variety of gender identities. There may be gendered language in this presentation, especially when citing other sources but the content of this presentation is applicable to all pregnant people.
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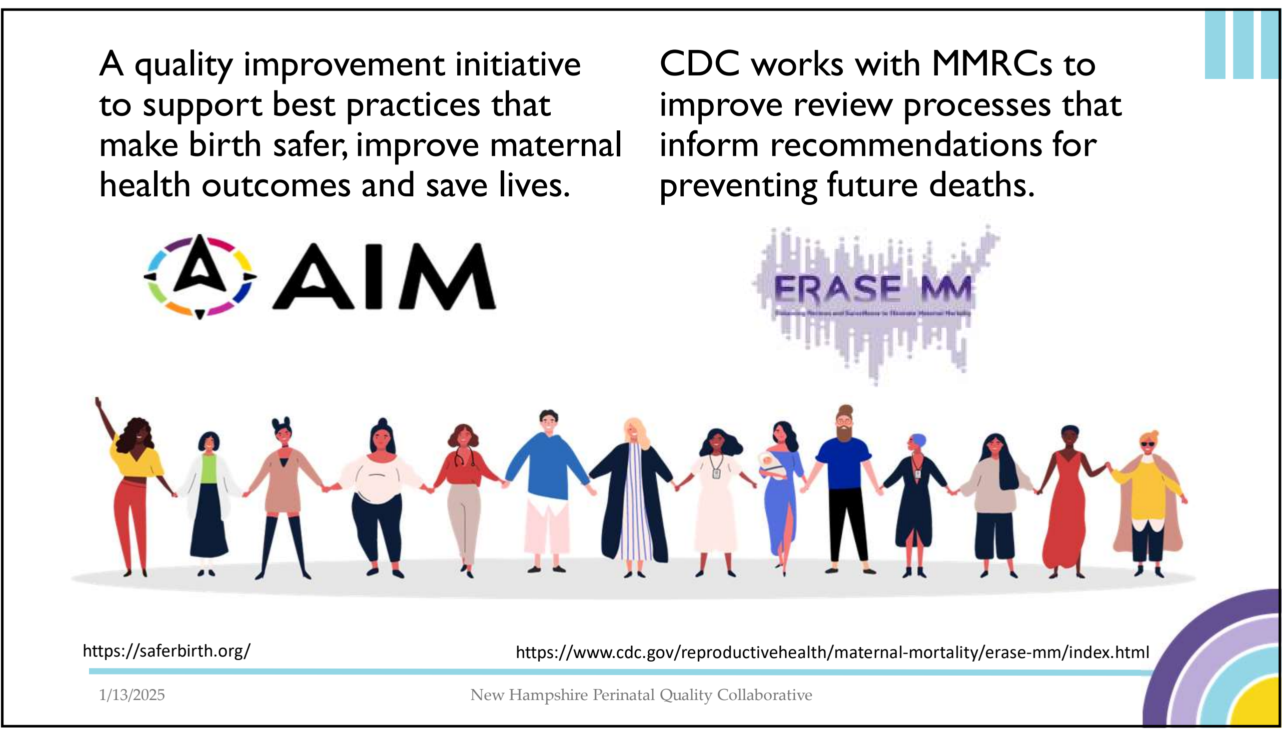
A quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes and save lives.
CDC works with MMRCs to improve review processes that inform recommendations for preventing future deaths.
AIM
ERASE MM
https://saferbirth.org/
https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/index.html
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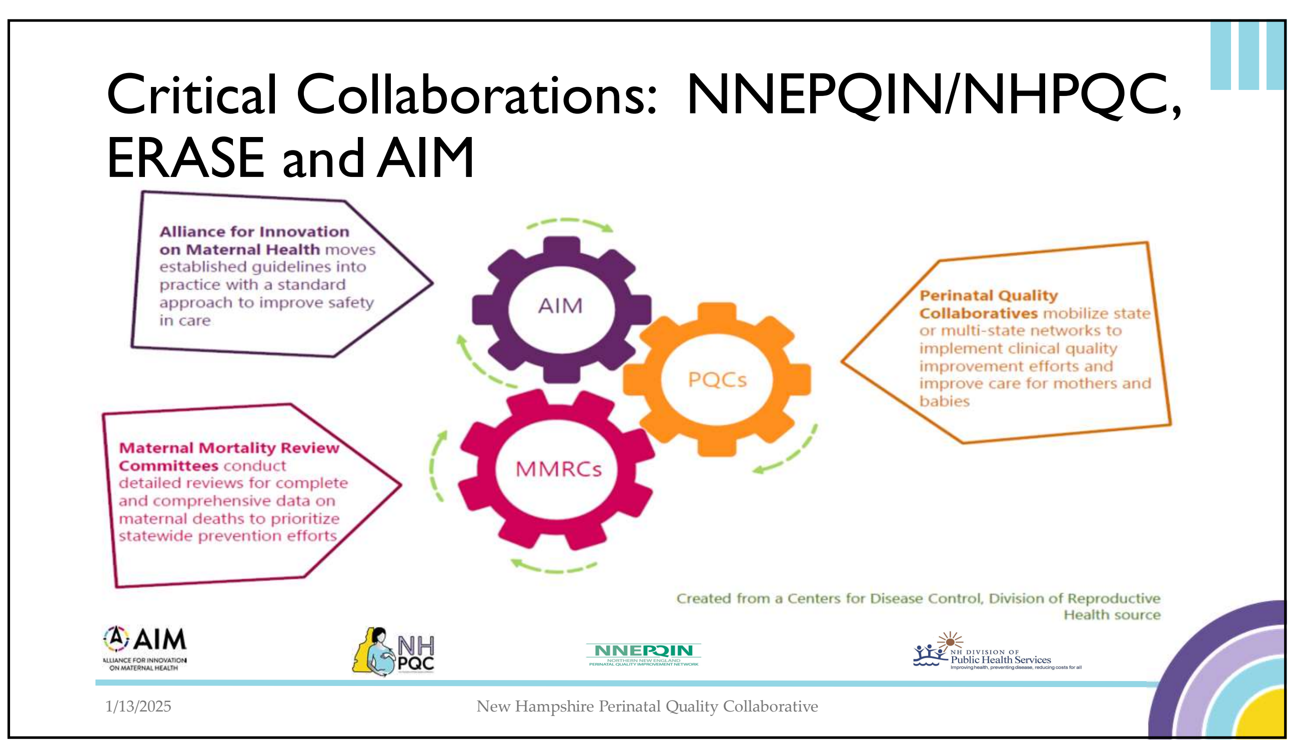
Critical Collaborations: NNEPQIN/NHPQC, ERASE and AIM
Alliance for Innovation on Maternal Health moves established guidelines into practice with a standard approach to improve safety in care
AIM
PQCs
MMRCs
Perinatal Quality Collaboratives mobilize state or multi-state networks to implement clinical quality improvement efforts and improve care for mothers and babies
Maternal Mortality Review Committees conduct detailed reviews for complete and comprehensive data on maternal deaths to prioritize statewide prevention efforts
Created from a Centers for Disease Control, Division of Reproductive Health source
AIM
ALLIANCE FOR INNOVATION ON MATERNAL HEALTH
NH PQC
NNEPQIN
NH DIVISION OF Public Health Services
1/13/2025
New Hampshire Perinatal Quality Collaborative

Critical Collaborations: NNEPQIN/NHPQC, ERASE and AIM

Provide Perinatal Mental Health & Suicide screening, interventions and documentation education to all healthcare settings and wrap-around services/programs involved in perinatal care.

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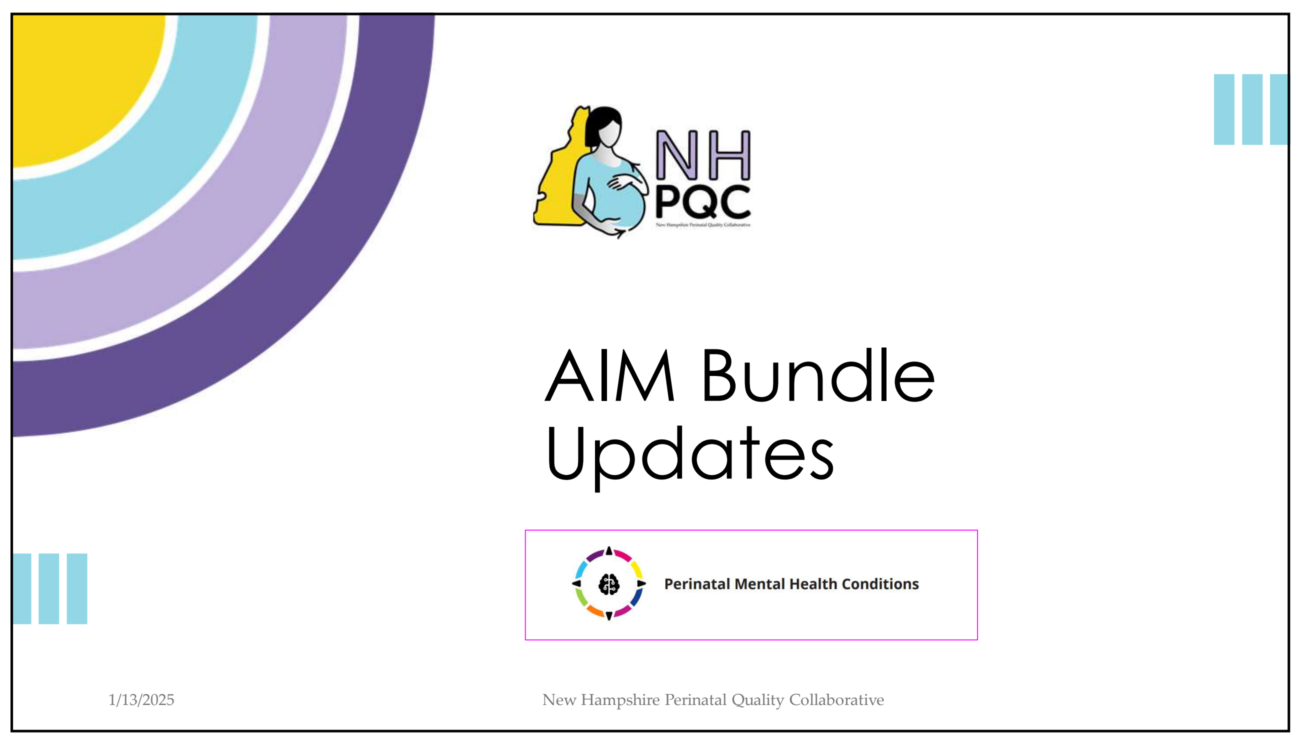


Rebecca Casey, APRN – Case Consultation and Education Opportunities for all AIM Participants

- **Weekly open office hours on Mondays from 12:45-1:45pm virtually**.
  - Bring specific case management questions (no PHI), typical challenges, or come hear what other sites are encountering.
- **Becca is also able to hold tailored lunch and learn, education, and discussion sessions for your team**.
  - Postpartum depression, psychosis, and medication management, "What do I do when Zoloft fails?"
- **January 27, 2025** special session on postpartum OCD with Q&A opportunity. Please join through weekly open office hour Webex link.

Please contact Maddie Bridge at Madalynne.M.Bridge@hitchcock.org if you would be interested in scheduling a tailored learning session or want office hours Webex calendar invite!

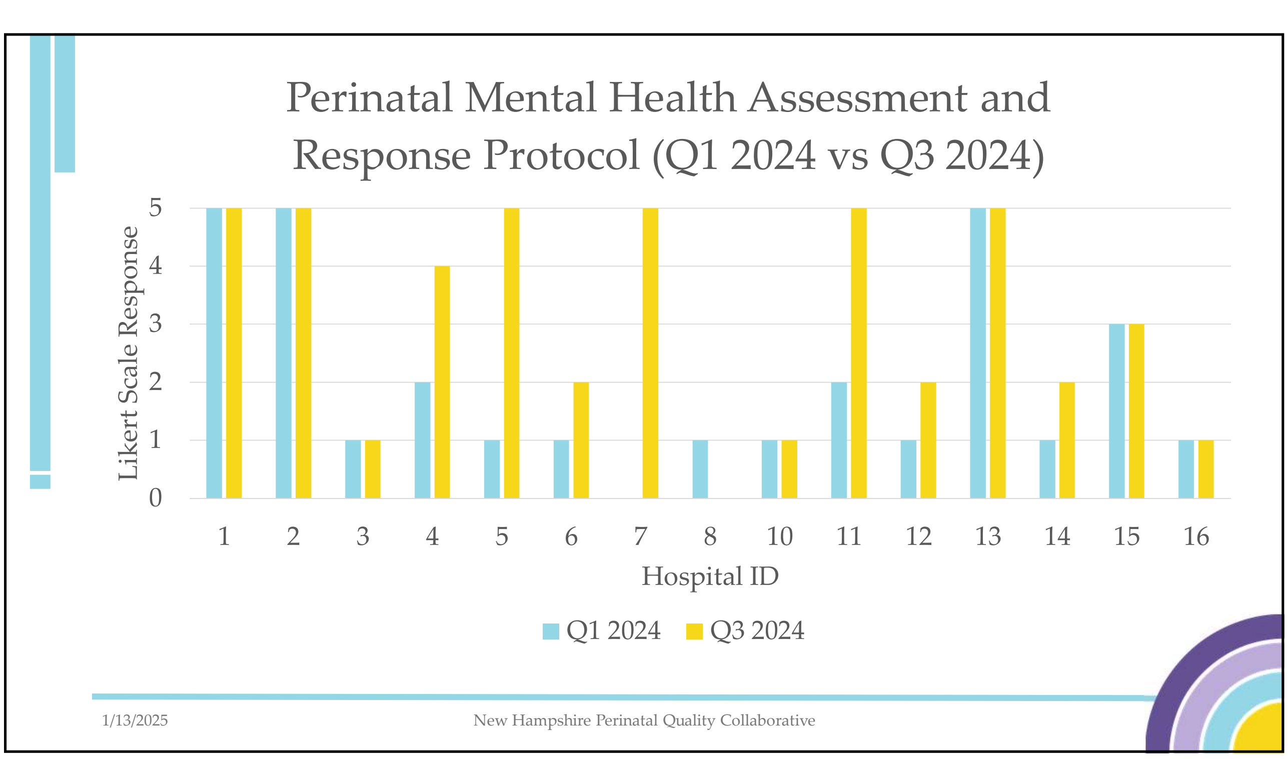
"Toxic" Film Screening for Respectful and Equitable Care Education Measure

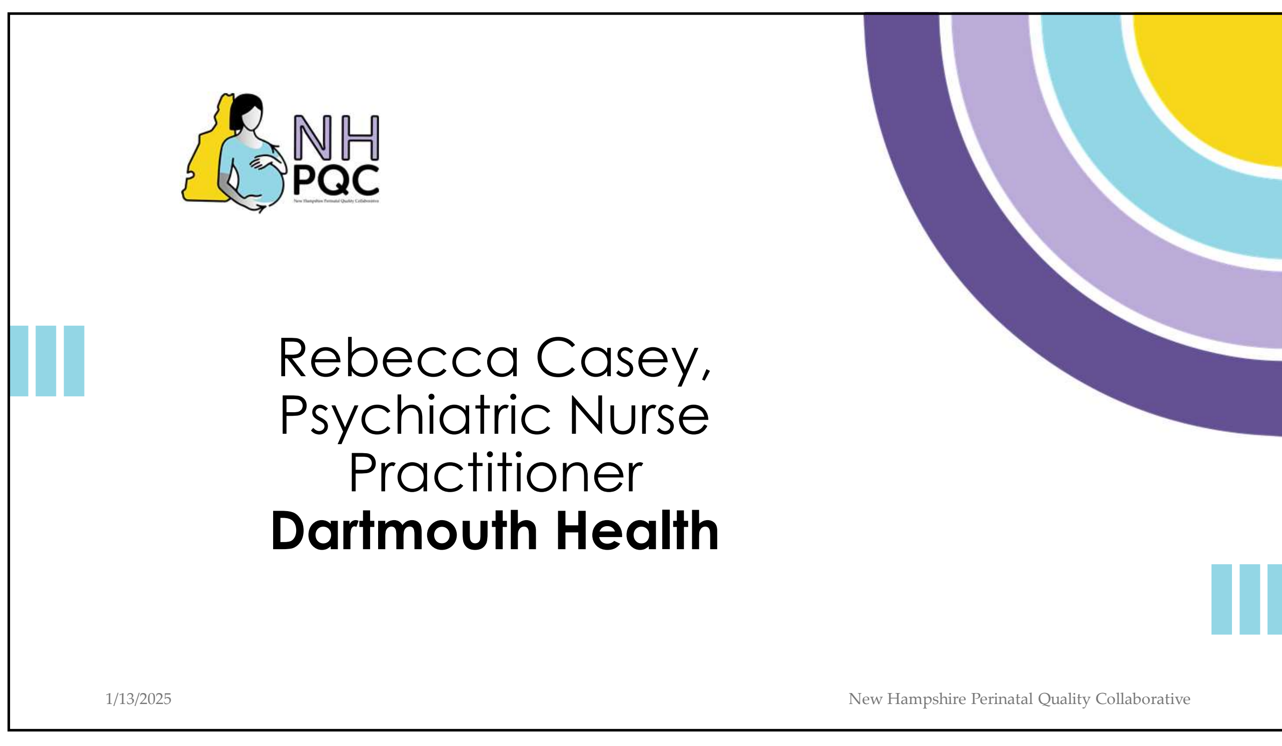
- "Toxic" is a short film (~25 minutes) about a day-in-the-life of a pregnant Black woman, and the racism and injustices that she faces.
- We can provide film screenings for your team with a facilitated group discussion (CEUs should be available)
- Click HERE for the film website and trailer
- "The facilitated discussion after the film was enlightening and respectful." – Recent participant

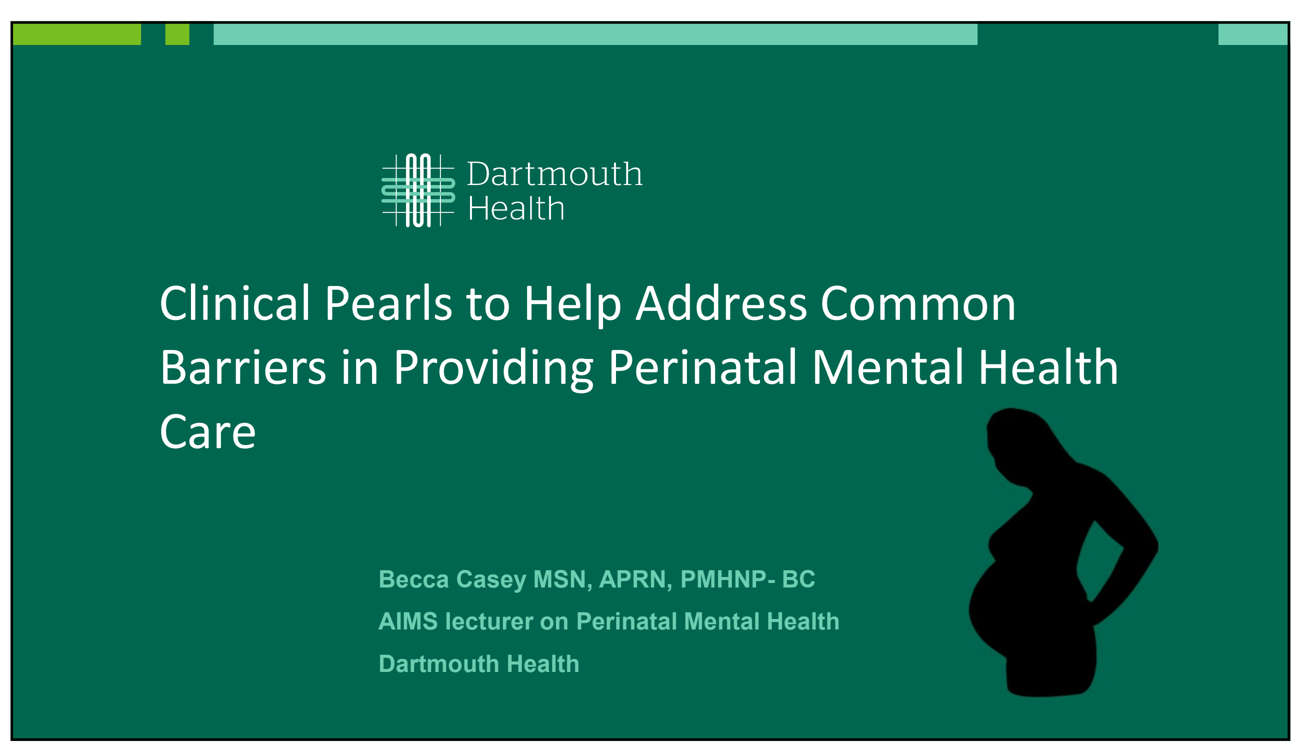
Please contact Maddie Bridge at Madalynne.M.Bridge@hitchcock.org if you are interested in scheduling a session for your group.

Patient Safety Bundle Q4 Check Ins

- End of Year summary reports were sent to AIM site contacts on December 30
- We have reached out to schedule Q4 2024 check ins
- We will review the AIM Data Portal and End of Year reports at the Q4 check in meetings




NH
PQC
Rebecca Casey,
Psychiatric Nurse
Practitioner
Dartmouth Health
1/13/2025
New Hampshire Perinatal Quality Collaborative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Health
Clinical Pearls to Help Address Common Barriers in Providing Perinatal Mental Health Care
Becca Casey MSN, APRN, PMHNP- BC
AIMS lecturer on Perinatal Mental Health
Dartmouth Health

Dartmouth Health

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What's calling you here today?

- My goal is reduce your anxiety in treating perinatal mental health conditions.
- I want you to feel empowered at the end of this talk to provide evidenced based care for PMADS.
- The opportunity to help birthing people thrive has many downstream effects. We don't want to miss that moment because we were afraid of our capacity to actually help.

Dartmouth Health

Department / Program Name, Hospital / Member Name

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Many birthing people with depression don't receive treatment!

https://www.umassmed.edu/lifeline4moms/why-perinatal-mental-health/

Pre-Session Scenario:

Molly is 32yo woman who works in finance. She is 10 weeks gestation with no medical complications. This is her first pregnancy. She is tearful during her initial prenatal intake. She tells you since she was a teenager she has been a "worrier". She tends to ruminate and lose sleep during periods of stress. She has always managed this with exercise but her nausea has made this hard. Currently, her anxiety feels much worse during pregnancy. She is agitated with her partner and worrying about her health and the health of her baby non-stop. She calls the OB office a lot looking for reassurance everything is okay. She is "very sensitive" to medications and worries about it's impact on her fetus. Her PCP told her to avoid medications as it's unsafe in pregnancy.

What would you do?

Pre-Session Scenario:

Sarah is 30yo who is 2 months post partum with her first child. She is pumping to provide breastmilk as her baby had challenges with latching. Her pregnancy was complicated by pre- term labor and delivery at 34 weeks. Her baby had a long NICU stay. Her partner works long hours and isn't able to help her much. She shares she is overwhelmed with the needs of her infant. Her sleep has been poor often awakening every two hours to feed and soothe her newborn. Sarah cries during the day, forgets to eat, feels disconnected from her baby, has fleeting thoughts her family would be better without her, and can't seem remember what it's like to enjoy a good book or a phone call from a friend. She doesn't think she will ever feel better. Of note, she has family history of maternal aunt who has bipolar disorder.

What would you do?

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Is there a guide to help me optimize my patients' mental health?

- Yes!
- "The MCPAP for Moms Obstetric Provider Toolkit, was created to assist front-line perinatal care providers in the prevention, identification and treatment of depression, other mental health and/or substance use concerns in pregnant and postpartum women."
- It can be found here: AdultProviderToolkit_2019.pdf

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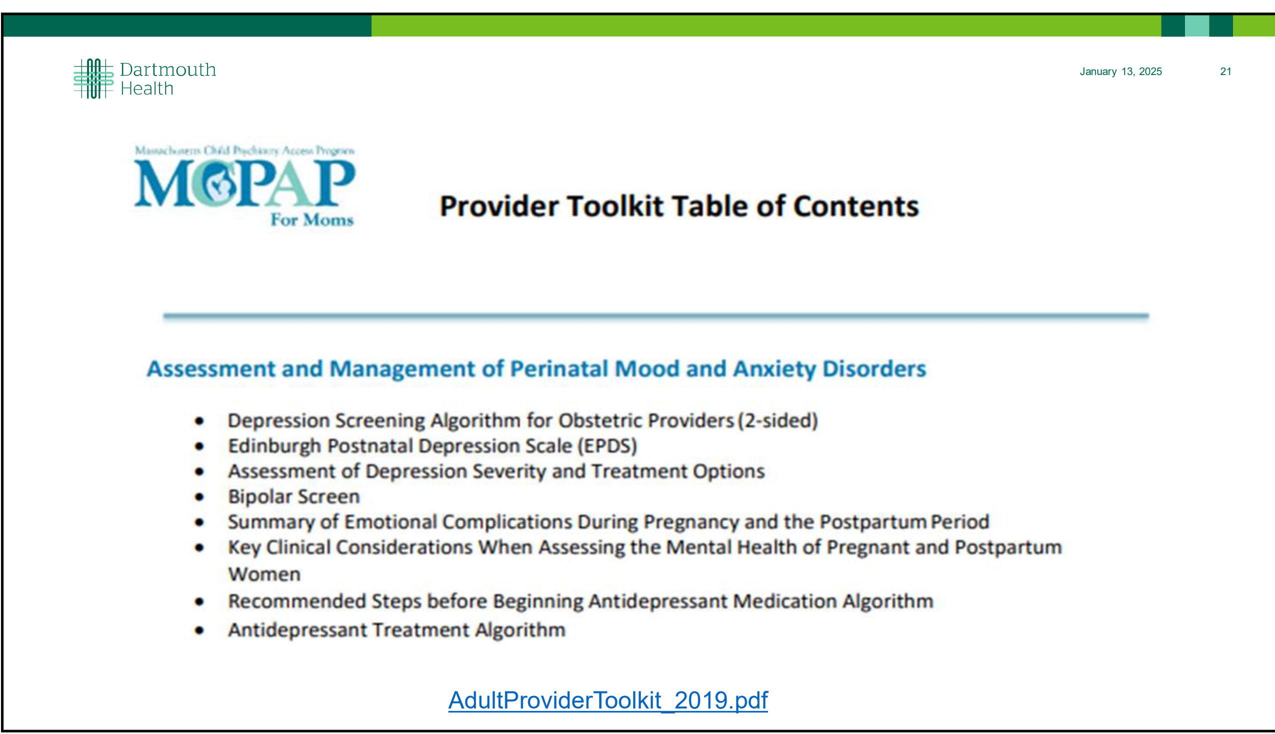
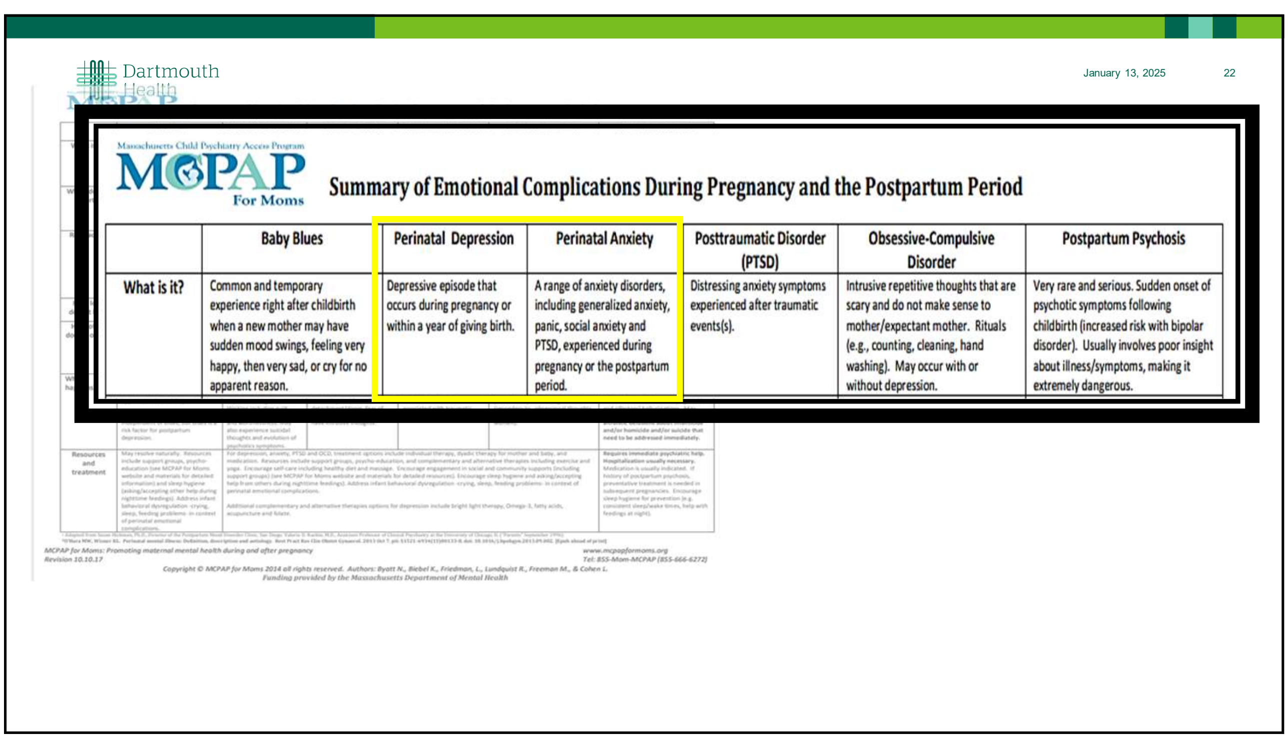
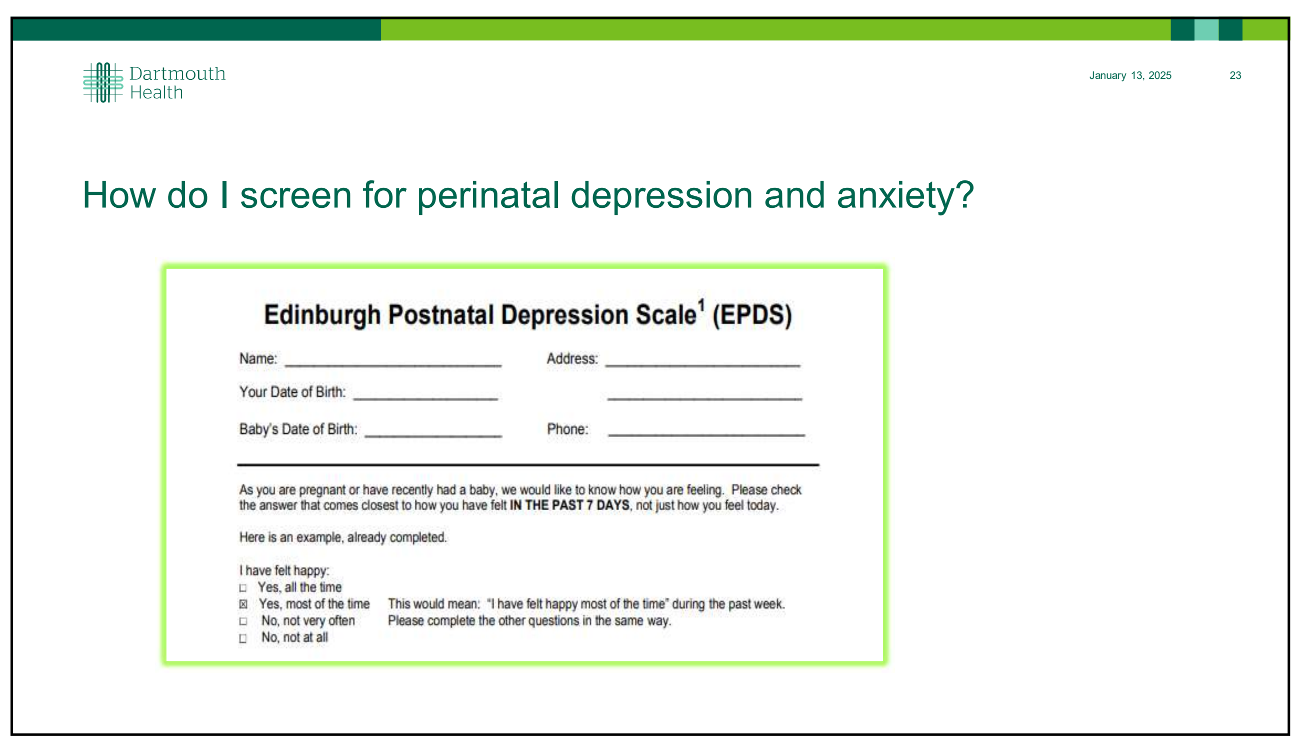




	Baby Blues	Perinatal Depression	Perinatal Anxiety	Posttraumatic Disorder (PTSD)	Obsessive-Compulsive Disorder	Postpartum Psychosis
What is it?	Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason.	Depressive episode that occurs during pregnancy or within a year of giving birth.	A range of anxiety disorders, including generalized anxiety, panic, social anxiety and PTSD, experienced during pregnancy or the postpartum period.	Distressing anxiety symptoms experienced after traumatic events(s).	Intrusive repetitive thoughts that are scary and do not make sense to mother/expectant mother. Rituals (e.g., counting, cleaning, hand washing). May occur with or without depression.	Very rare and serious. Sudden onset of psychotic symptoms following childbirth (increased risk with bipolar disorder). Usually involves poor insight about illness/symptoms, making it extremely dangerous.



Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ______________ Address: ______________

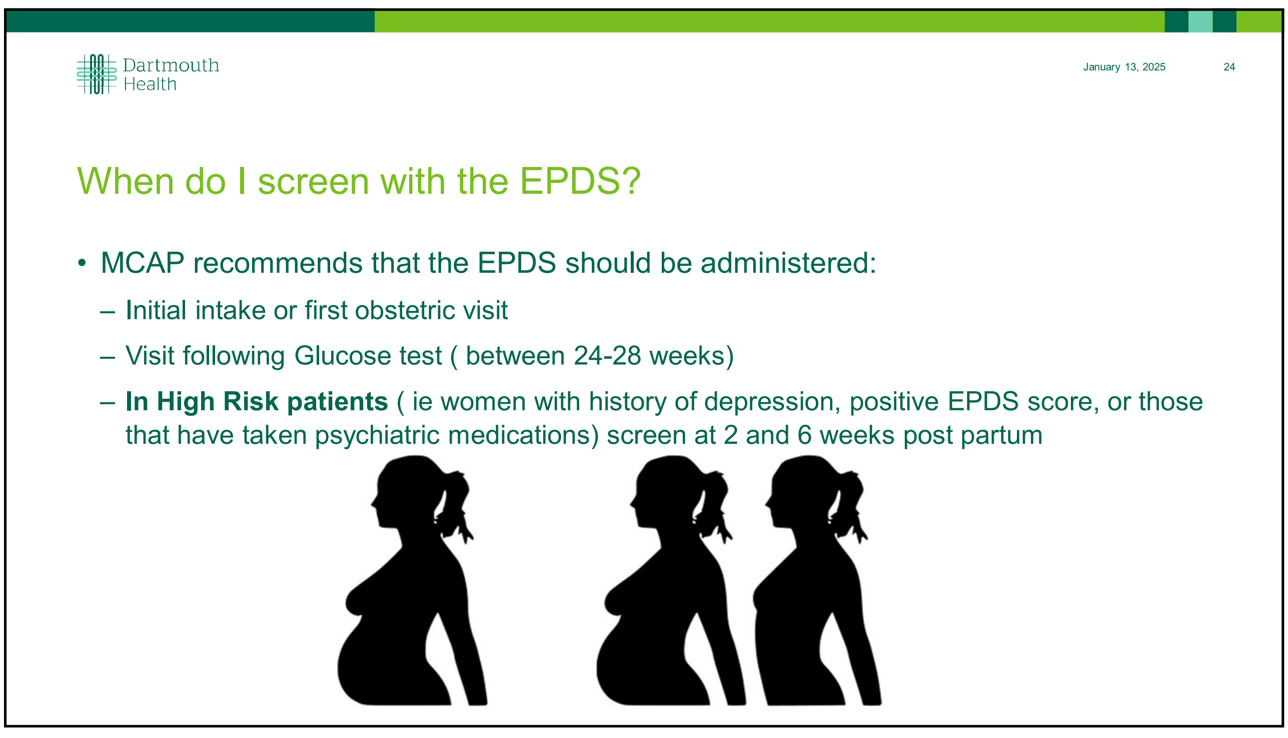
Your Date of Birth: ______________ ______________

Baby's Date of Birth: ______________ Phone: ______________

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

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.
- ☐ No, not very often
- ☐ No, not at all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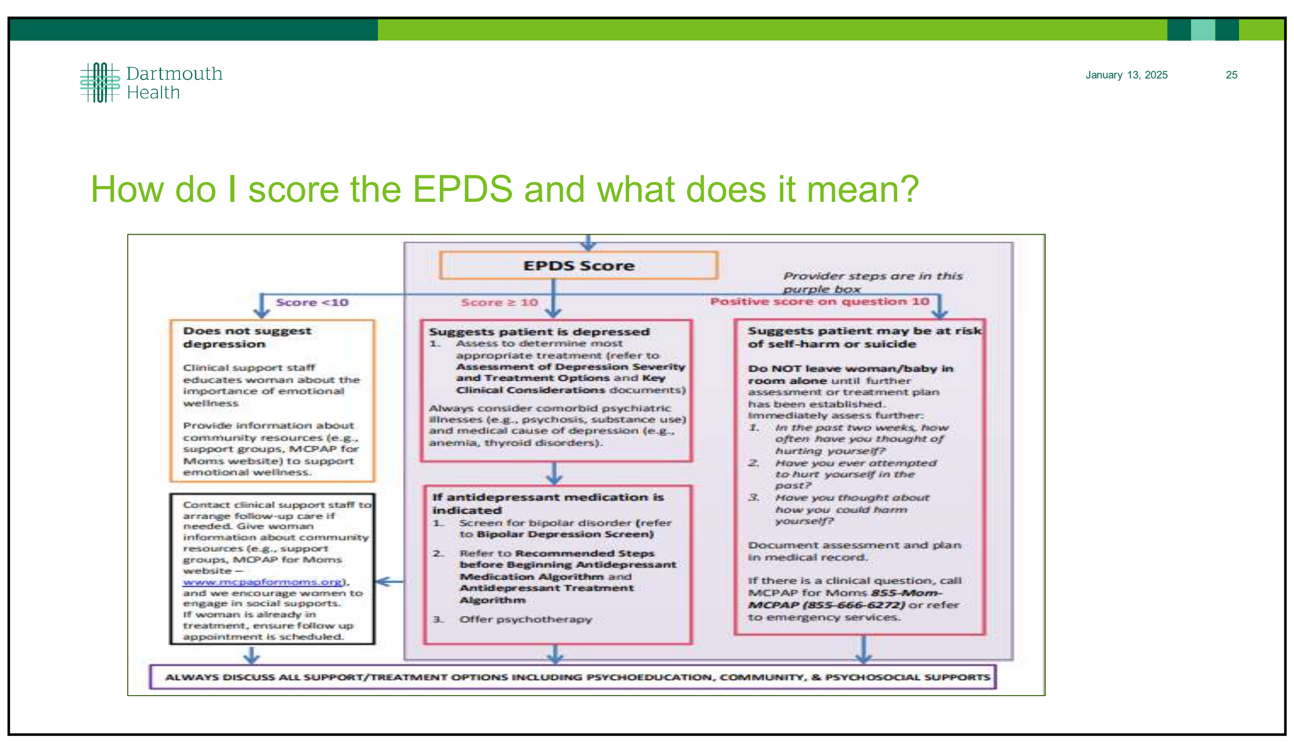
When do I screen with the EPDS?
MCAP recommends that the EPDS should be administered:
– Initial intake or first obstetric visit
– Visit following Glucose test (between 24-28 weeks)
– In High Risk patients (ie women with history of depression, positive EPDS score, or those that have taken psychiatric medications) screen at 2 and 6 weeks post partum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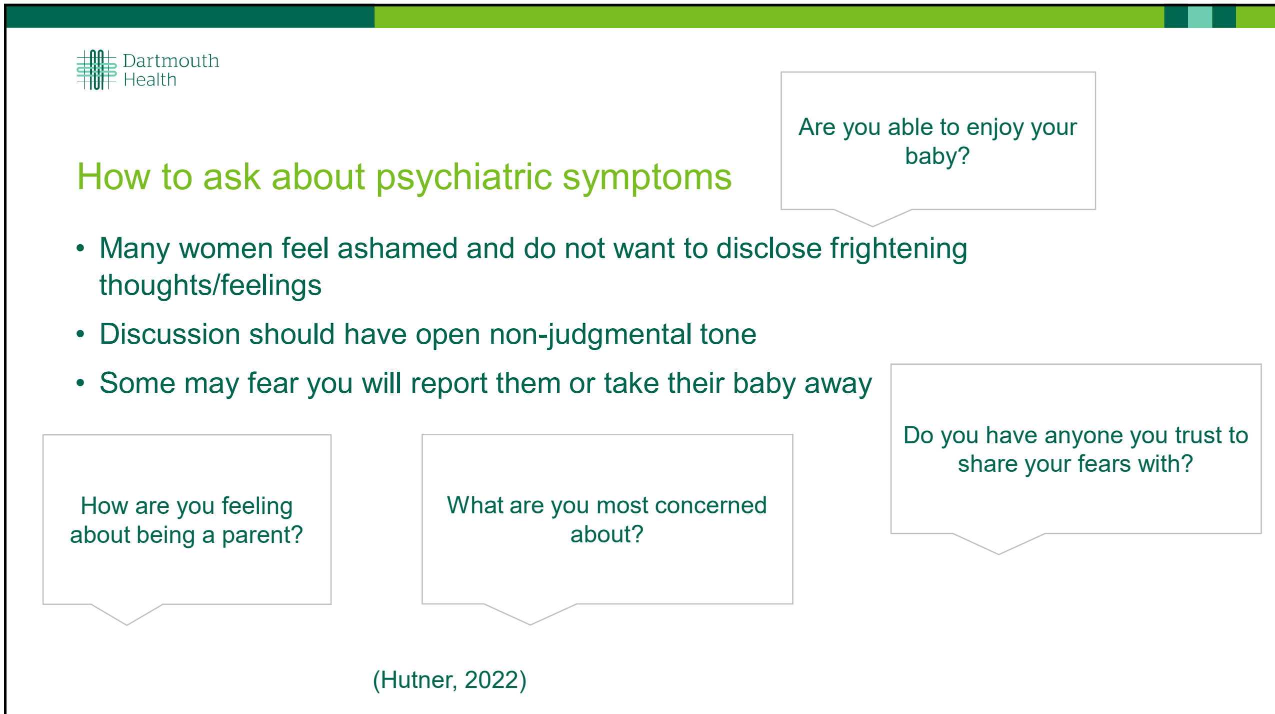
How do I score the EPDS and what does it mean?
EPDS Score
Provider steps are in this purple box
Score <10
Score ≥ 10
Positive score on question 10
Does not suggest depression
Clinical support staff educates woman about the importance of emotional wellness
Provide information about community resources (e.g., support groups, MCPAP for Moms website) to support emotional wellness.
Contact clinical support staff to arrange follow-up care if needed. Give woman information about community resources (e.g., support groups, MCPAP for Moms website – www.mcpapformoms.org), and we encourage women to engage in social supports. If woman is already in treatment, ensure follow up appointment is scheduled.
Suggests patient is depressed
1. Assess to determine most appropriate treatment (refer to Assessment of Depression Severity and Treatment Options and Key Clinical Considerations documents)
Always consider comorbid psychiatric illnesses (e.g., psychosis, substance use) and medical cause of depression (e.g., anemia, thyroid disorders).
If antidepressant medication is indicated
1. Screen for bipolar disorder (refer to Bipolar Depression Screen)
2. Refer to Recommended Steps before Beginning Antidepressant Medication Algorithm and Antidepressant Treatment Algorithm
3. Offer psychotherapy
Suggests patient may be at risk of self-harm or suicide
Do NOT leave woman/baby in room alone until further assessment or treatment plan has been established.
Immediately assess further:
1. In the past two weeks, how often have you thought of hurting yourself?
2. Have you ever attempted to hurt yourself in the past?
3. Have you thought about how you could harm yourself?
Document assessment and plan in medical record.
If there is a clinical question, call MCPAP for Moms 855-Mom-MCPAP (855-666-6272) or refer to emergency services.
ALWAYS DISCUSS ALL SUPPORT/TREATMENT OPTIONS INCLUDING PSYCHOEDUCATION, COMMUNITY, & PSYCHOSOCIAL SUPPORTS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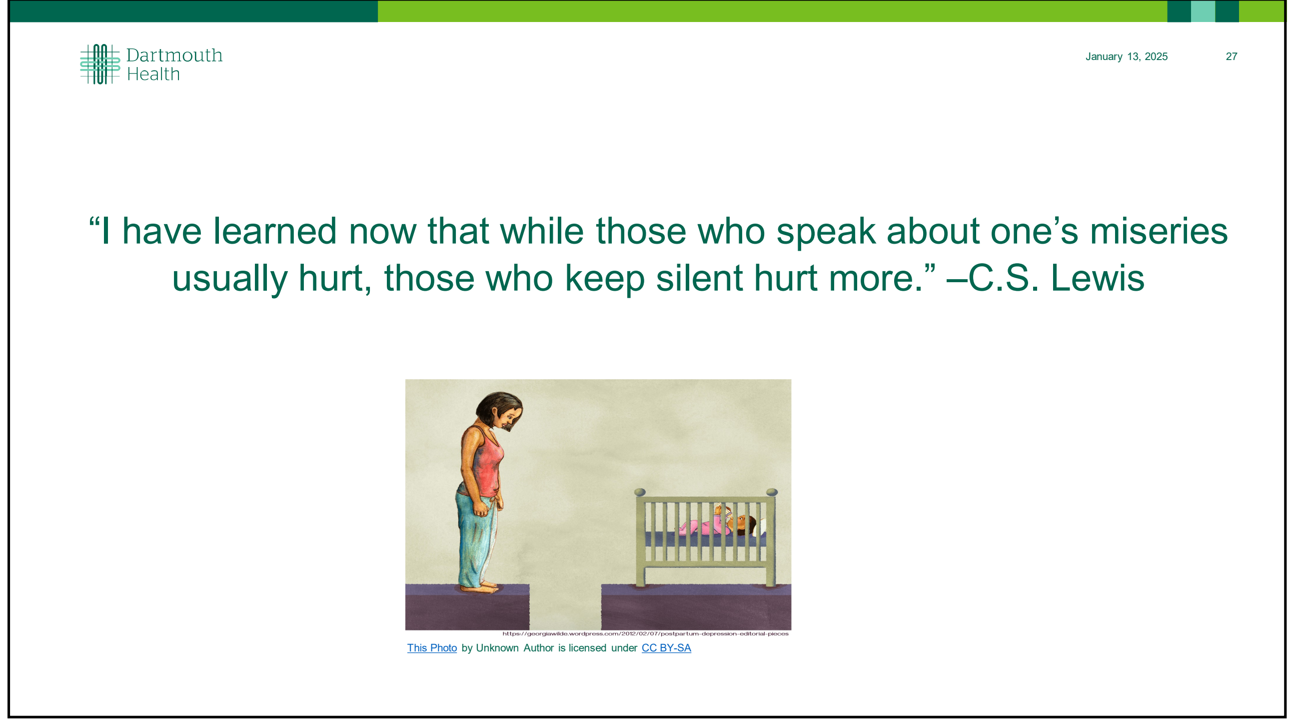
How to ask about psychiatric symptoms
Are you able to enjoy your baby?
• Many women feel ashamed and do not want to disclose frightening thoughts/feelings
• Discussion should have open non-judgmental tone
• Some may fear you will report them or take their baby away
How are you feeling about being a parent?
What are you most concerned about?
Do you have anyone you trust to share your fears with?
(Hutner, 2022)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"I have learned now that while those who speak about one's miseries usually hurt, those who keep silent hurt more." –C.S. Lewis
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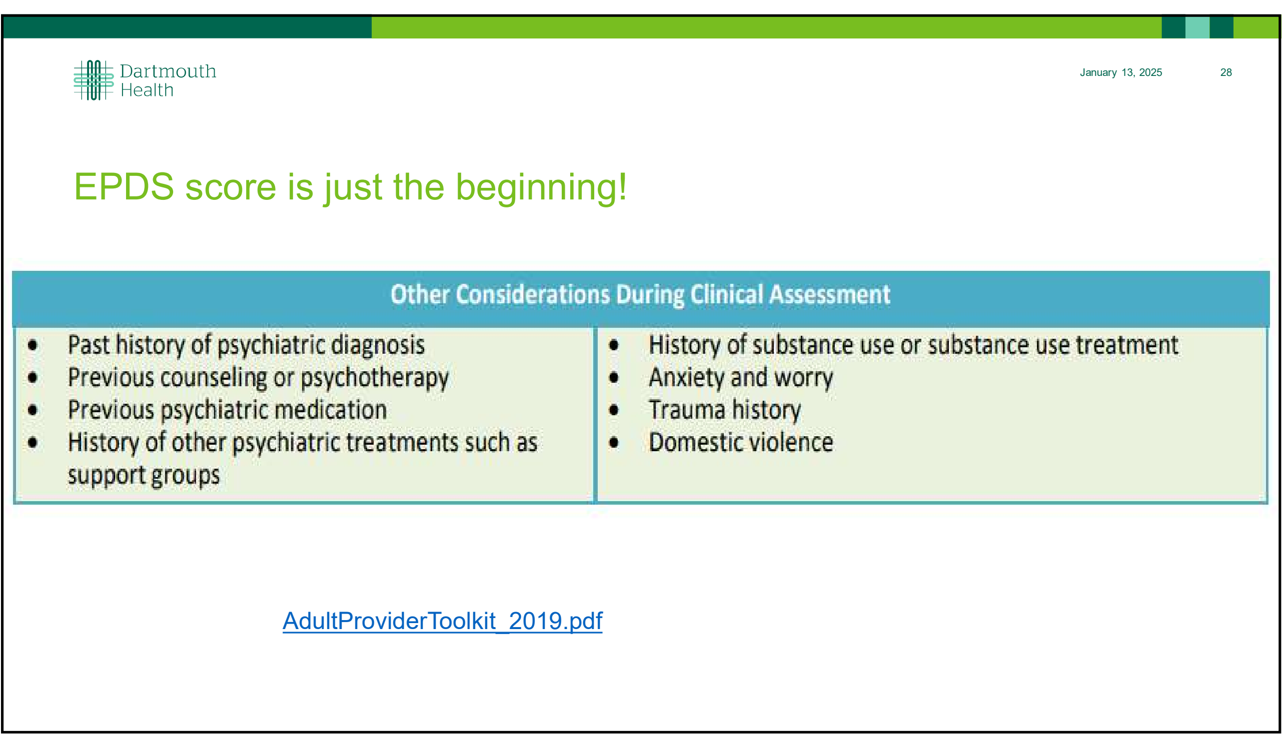

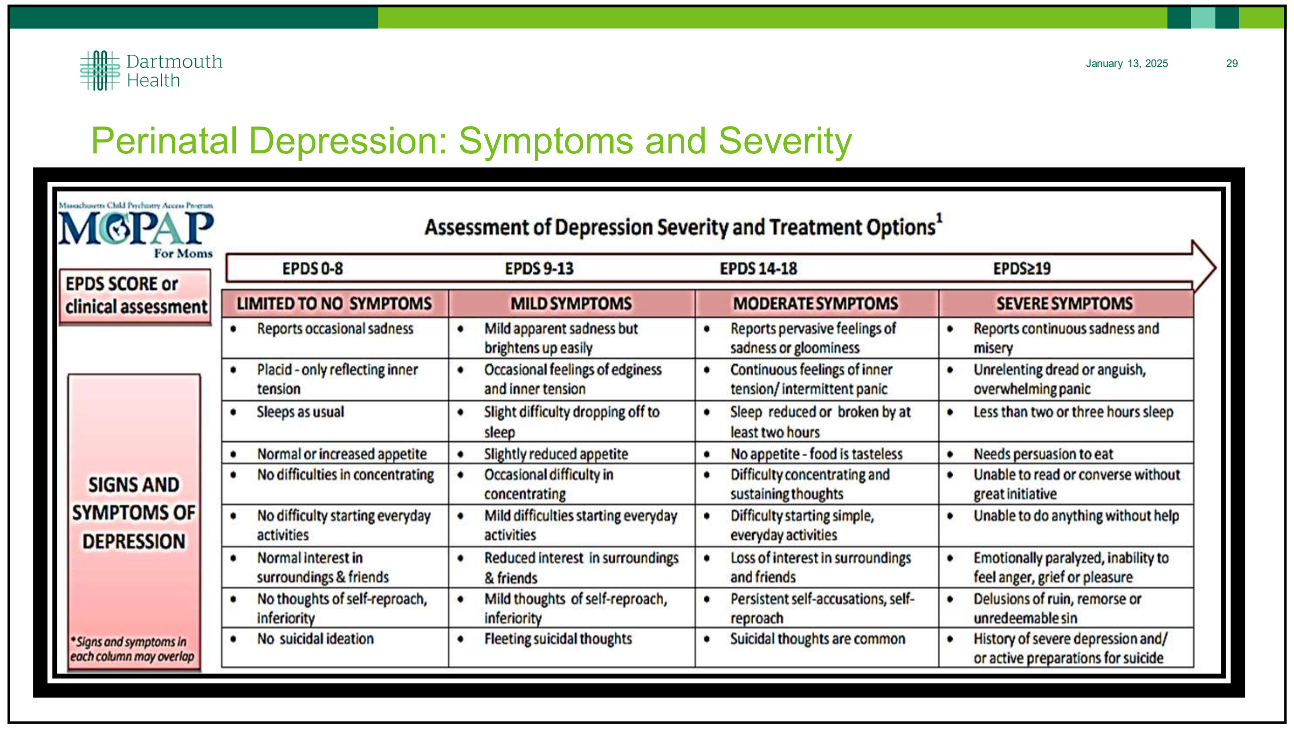

EPDS 0-8	EPDS 9-13	EPDS 14-18	EPDS≥19
LIMITED TO NO SYMPTOMS	MILD SYMPTOMS	MODERATE SYMPTOMS	SEVERE SYMPTOMS
Reports occasional sadness	Mild apparent sadness but brightens up easily	Reports pervasive feelings of sadness or gloominess	Reports continuous sadness and misery
Placid - only reflecting inner tension	Occasional feelings of edginess and inner tension	Continuous feelings of inner tension/ intermittent panic	Unrelenting dread or anguish, overwhelming panic
Sleeps as usual	Slight difficulty dropping off to sleep	Sleep reduced or broken by at least two hours	Less than two or three hours sleep
Normal or increased appetite	Slightly reduced appetite	No appetite - food is tasteless	Needs persuasion to eat
No difficulties in concentrating	Occasional difficulty in concentrating	Difficulty concentrating and sustaining thoughts	Unable to read or converse without great initiative
No difficulty starting everyday activities	Mild difficulties starting everyday activities	Difficulty starting simple, everyday activities	Unable to do anything without help
Normal interest in surroundings & friends	Reduced interest in surroundings & friends	Loss of interest in surroundings and friends	Emotionally paralyzed, inability to feel anger, grief or pleasure
No thoughts of self-reproach, inferiority	Mild thoughts of self-reproach, inferiority	Persistent self-accusations, self-reproach	Delusions of ruin, remorse or unredeemable sin
No suicidal ideation	Fleeting suicidal thoughts	Suicidal thoughts are common	History of severe depression and/ or active preparations for suicide

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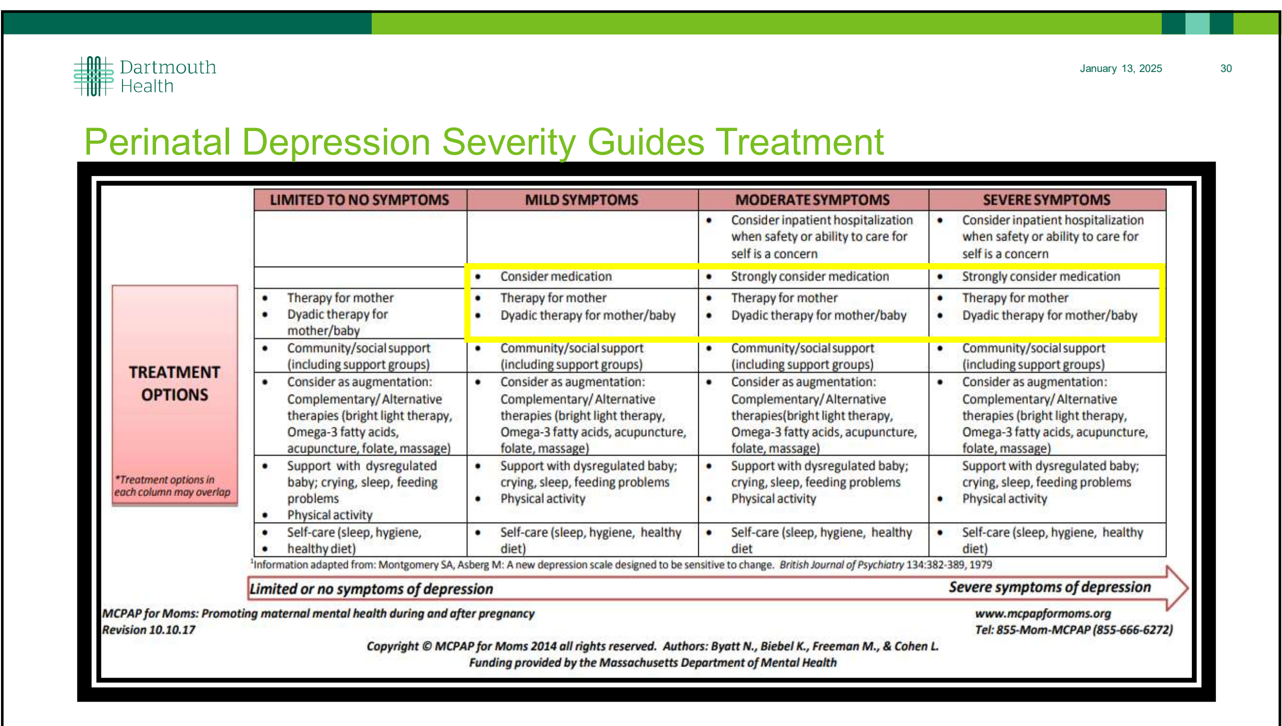
Perinatal Depression Severity Guides Treatment



	LIMITED TO NO SYMPTOMS	MILD SYMPTOMS	MODERATE SYMPTOMS	SEVERE SYMPTOMS
TREATMENT OPTIONS			• Consider inpatient hospitalization when safety or ability to care for self is a concern	• Consider inpatient hospitalization when safety or ability to care for self is a concern
		• Consider medication	• Strongly consider medication	• Strongly consider medication
	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby	• Therapy for mother • Dyadic therapy for mother/baby
	• Community/social support (including support groups)	• Community/social support (including support groups)	• Community/social support (including support groups)	• Community/social support (including support groups)
	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies(bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)	• Consider as augmentation: Complementary/ Alternative therapies (bright light therapy, Omega-3 fatty acids, acupuncture, folate, massage)
	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	• Support with dysregulated baby; crying, sleep, feeding problems • Physical activity	Support with dysregulated baby; crying, sleep, feeding problems • Physical activity
	• Self-care (sleep, hygiene, • healthy diet)	• Self-care (sleep, hygiene, healthy diet)	• Self-care (sleep, hygiene, healthy diet	• Self-care (sleep, hygiene, healthy diet)

*Treatment options in each column may overlap

[1]Information adapted from: Montgomery SA, Asberg M: A new depression scale designed to be sensitive to change. *British Journal of Psychiatry* 134:382-389, 1979

Limited or no symptoms of depression → *Severe symptoms of depression*

MCPAP for Moms: Promoting maternal mental health during and after pregnancy
Revision 10.10.17

www.mcpapformoms.org
Tel: 855-Mom-MCPAP (855-666-6272)

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Funding provided by the Massachusetts Department of Mental Health

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Complementary Treatments

- Yoga
- Exercise
- Acupuncture
- Bright light therapy (seasonal depression)

(Reza et al, 2018)

- Meditation
  - Mindful birthing trainings showed reduction in fear of childbirth/stress (Francisca et al, 2023)

*Consider financial cost as potential barriers

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Prescribe Sleep!

- One of the most important questions I ask is about the *quality* and *quantity* of sleep during pregnancy and post partum
- 4 hours of interrupted sleep can make a big difference on mood/anxiety in the post partum period
  - Work with partners to support birthing person to protect sleep
  - Breastfeeding is important but sleep should be prioritized if woman is struggling with symptoms of PMADs
- Cognitive behavioral therapy for insomnia is gold standard

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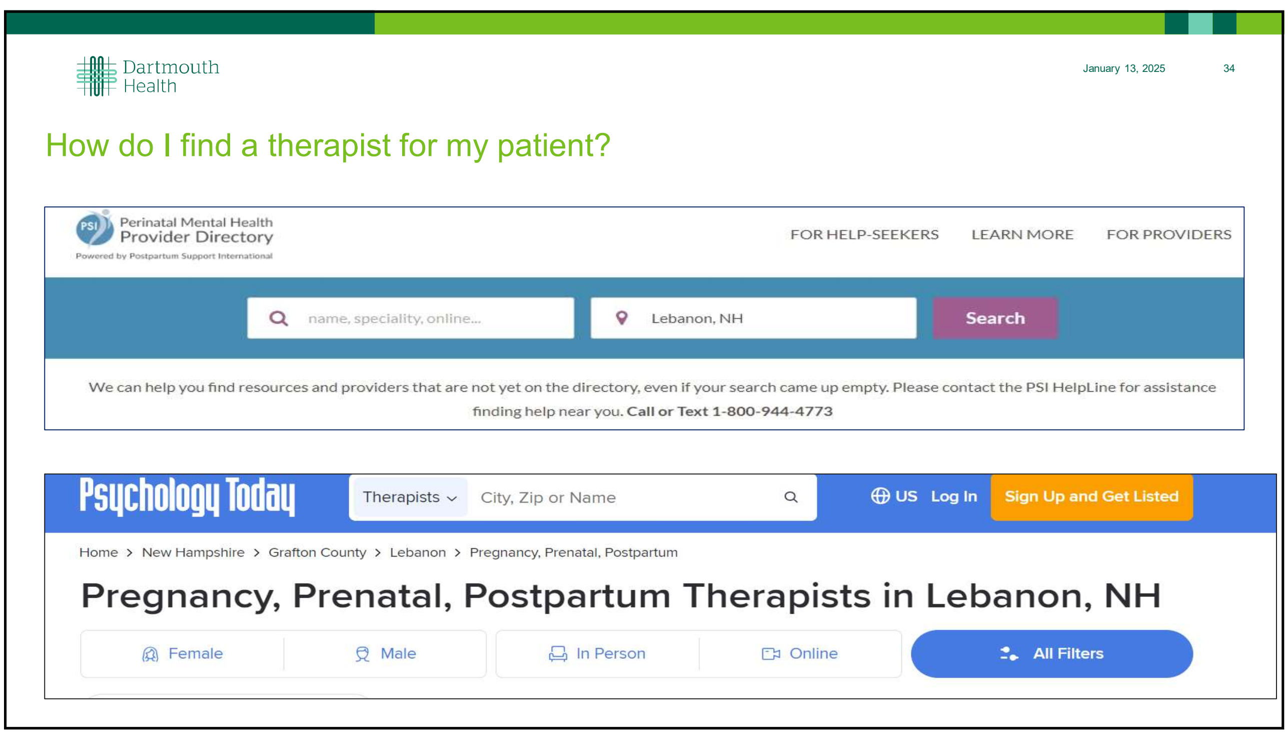
Psychotherapy: what works in the perinatal population?

Interpersonal Psychotherapy

- Focus is on improving interpersonal relationships during big life transition (e.g., pregnancy). Evidence shows can improve mood/reduce anxiety (Sokol, 2018)

Cognitive Behavioral psychotherapy

- Challenging negative thoughts which can influence emotions and behavior



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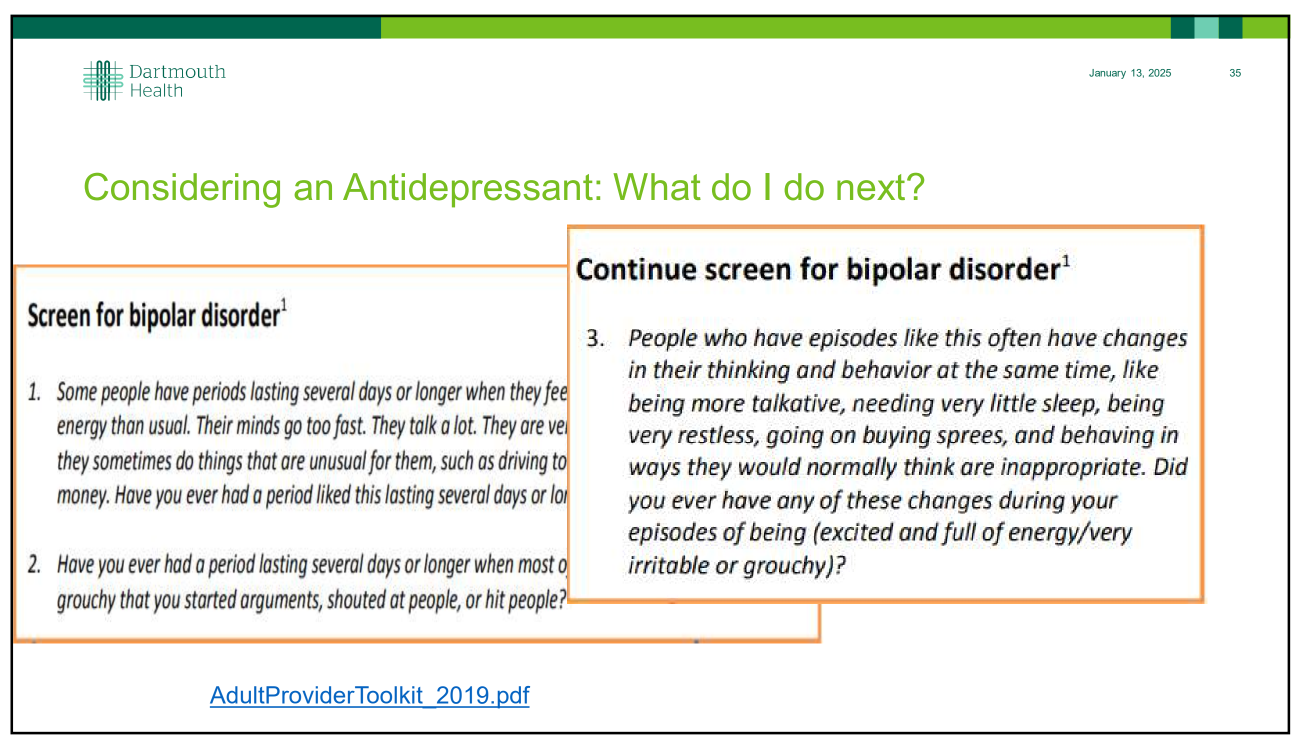
How do I find a therapist for my patient?
Perinatal Mental Health Provider Directory
Powered by Postpartum Support International
FOR HELP-SEEKERS
LEARN MORE
FOR PROVIDERS
name, speciality, online...
Lebanon, NH
Search
We can help you find resources and providers that are not yet on the directory, even if your search came up empty. Please contact the PSI HelpLine for assistance finding help near you. Call or Text 1-800-944-4773
Psychology Today
Therapists
City, Zip or Name
US
Log In
Sign Up and Get Listed
Home > New Hampshire > Grafton County > Lebanon > Pregnancy, Prenatal, Postpartum
Pregnancy, Prenatal, Postpartum Therapists in Lebanon, NH
Female
Male
In Person
Online
All Filters



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Considering an Antidepressant: What do I do next?
Screen for bipolar disorder1
1. Some people have periods lasting several days or longer when they fee
energy than usual. Their minds go too fast. They talk a lot. They are ve
they sometimes do things that are unusual for them, such as driving to
money. Have you ever had a period liked this lasting several days or lo
2. Have you ever had a period lasting several days or longer when most o
grouchy that you started arguments, shouted at people, or hit people?
Continue screen for bipolar disorder1
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)?
AdultProviderToolkit_2019.pdf

Bipolar Disorder: considerations

- Bipolar disorder is a rare disorder but is frequently missed
  - "The aggregate lifetime prevalence of BD-I = 0.6%, BD-II = 0.4%" (Jain et al, 2023)
  - PP depression is common in bipolar disorder
  - Risk of post partum psychosis increases in those with hx of bipolar disorder
- **If positive screen/interview do not prescribe an antidepressant**
  - This can increase risk of hypomania/mania and mood cycling
  - Recommend referral to psychiatric consultant or call perinatal consult line for support (PSI consult line: https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/)

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The Risk-Risk Analysis (untreated illness)

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- **Risks of psychiatric illness in pregnancy have long been underestimated:**
  - "Depression during pregnancy has been associated with pre-term delivery, low birth weight, higher rates of preeclampsia, gestational diabetes, decreased infant motor tone and activity, higher infant cortisol levels, poor reflexes, and overall worse infant health status" (Hutner et al., 2022)
  - Post partum depression impacts infants and children development including lowered IQ, slower language development, higher rates of behavioral problems, increased rates of ADHD, depression & anxiety (Hutner et al., 2022)
  - Anxiety during pregnancy is an independent risk factor for postpartum depression
  - Most importantly; there is increased suffering for mothers and families collectively

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The Risk-Risk Analysis (antidepressant use in pregnancy)

- Associated with small increased risk of pre-term labor
  - Depression itself carries this risk (Hutner et al., 2022)
- Associated with small increased risk of pulmonary hypertension in a newborn
  - Absolute risk is small and conflicting studies (Huybrechts et al., 2016)
- Risk of poor neonatal adaption syndrome
  - Self limited & mild
  - Usually lasting 24-48 hours
  - Symptoms include: irritability, jitteriness, tremor, harder to soothe, increased muscle tone, rapid breathing

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The Risk-Risk Analysis

Important to communicate to patients:

Psychiatric Medication = Exposure

Psychiatric illness = Exposure

Goal: Mitigate risk of both!

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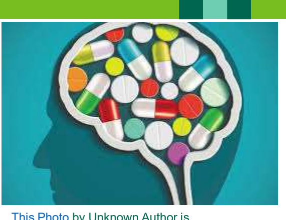
Pregnancy is not a time to stop psychiatric treatment

- Many women are counseled to stop psychiatric treatment to avoid risk to their fetus.
- This is not without risk, when a women with pre-existing depression stops treatment for pregnancy, relapse is as high as 65% (Cohen, 2006)
- Women should be counseled about the risks of stopping treatment vs continuing treatment carefully

Tips for success: SSRIs/SNRIS in the perinatal period



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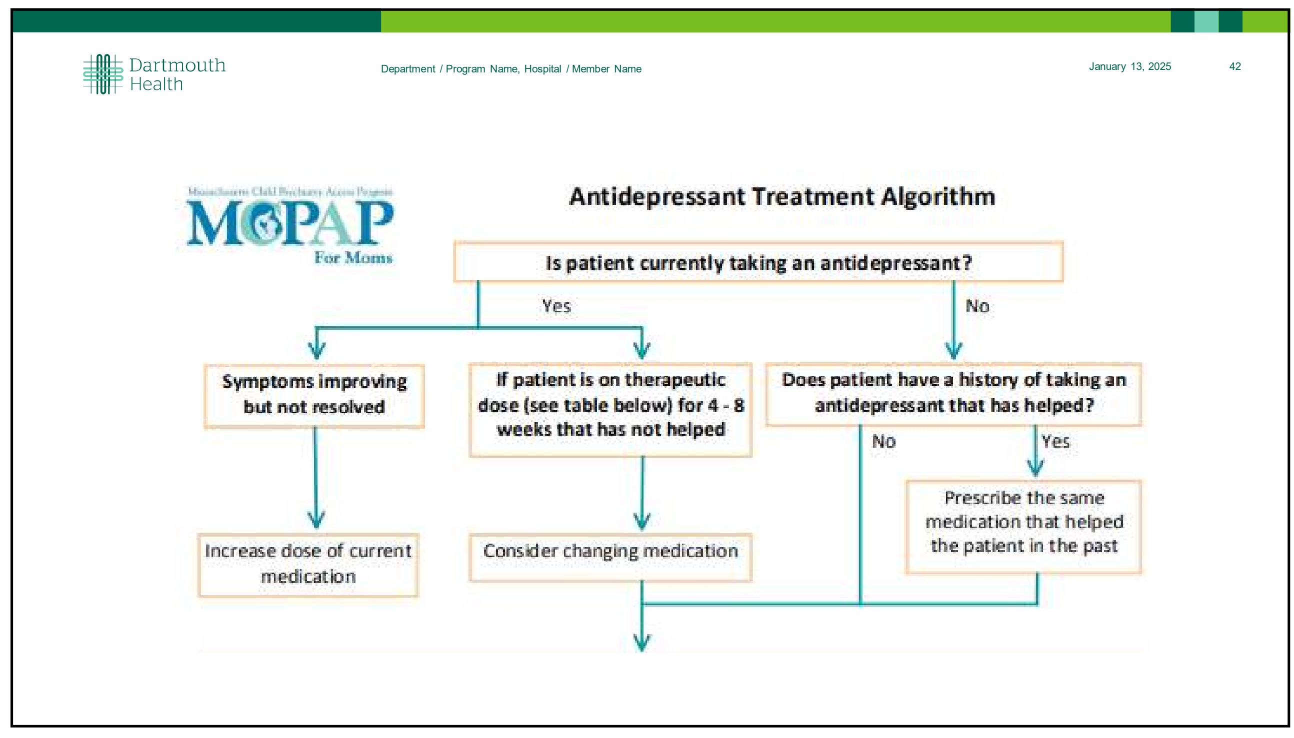
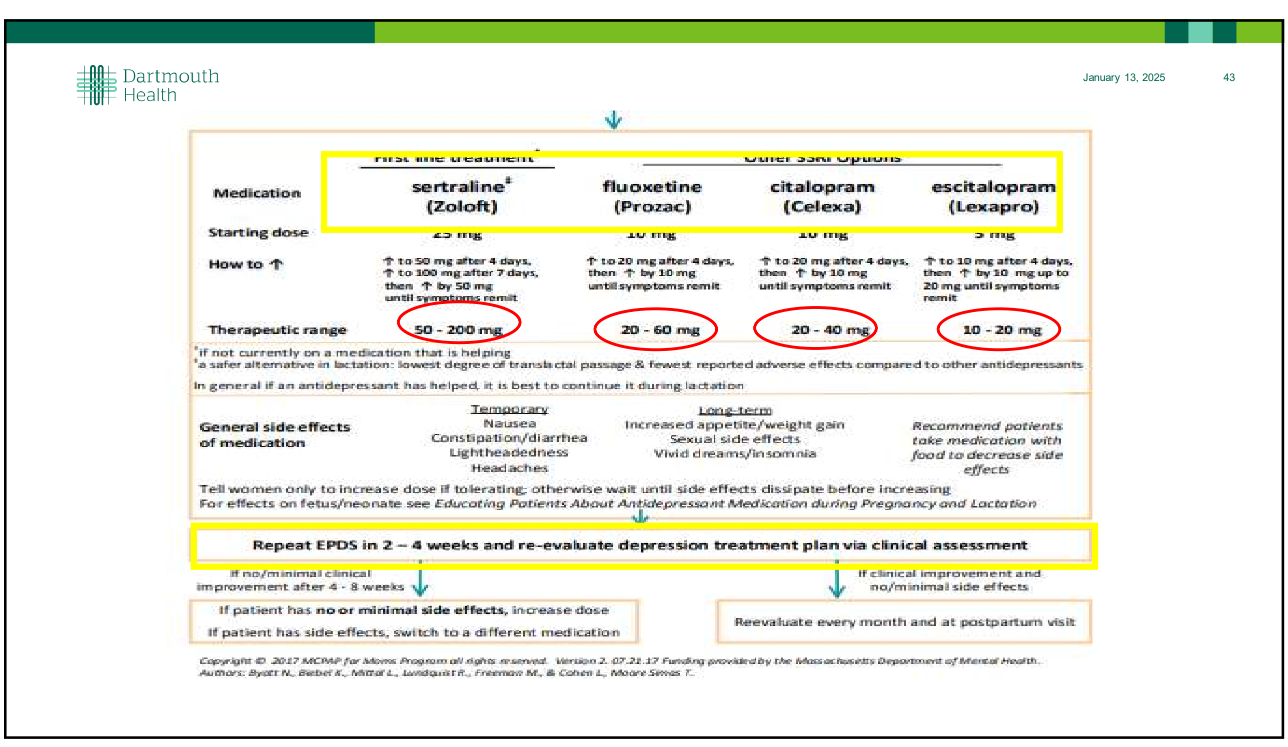
- Ask patient if they have had good experience with medications in the past, start with what *has worked*
- Continue medications that are working and taper/discontinue medications that are ineffective
  - Limit fetus exposure to multiple psycho-tropic medications where possible
  - This is ideal to complete *prior to conception*
- In later pregnancy, often need to increase dose of medication to higher then typical maximum dosing (e.g, Sertraline 250mg or Fluoxetine 100mg)
  - Due to increase in blood volume, changes in glomerular filtration rate and liver metabolism. Plasma antidepressant concentrations can drop by 40% to 50%. (Hutner et al., 2022)


Dartmouth Health
Department / Program Name, Hospital / Member Name
January 13, 2025
42
MCPAP For Moms
Antidepressant Treatment Algorithm
Is patient currently taking an antidepressant?
Yes
No
Symptoms improving but not resolved
If patient is on therapeutic dose (see table below) for 4 - 8 weeks that has not helped
Does patient have a history of taking an antidepressant that has helped?
No
Yes
Prescribe the same medication that helped the patient in the past
Increase dose of current medication
Consider changing medication


Dartmouth Health
January 13, 2025
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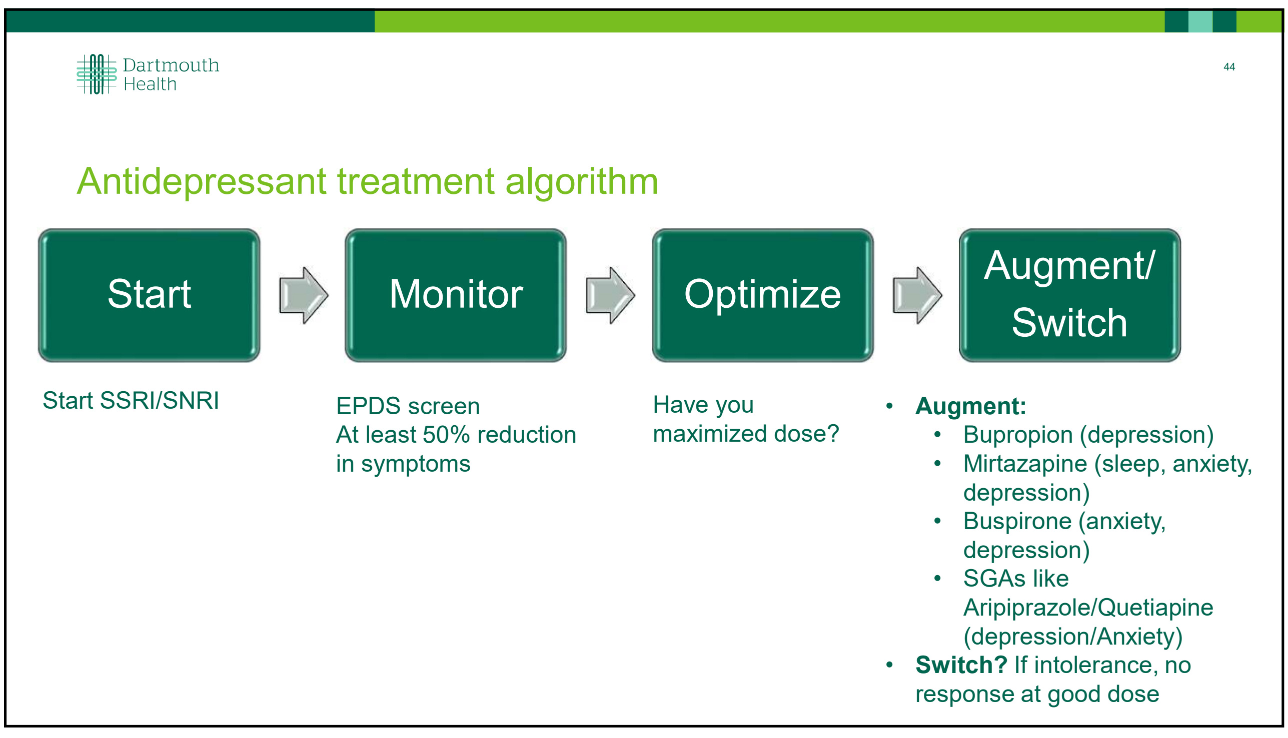
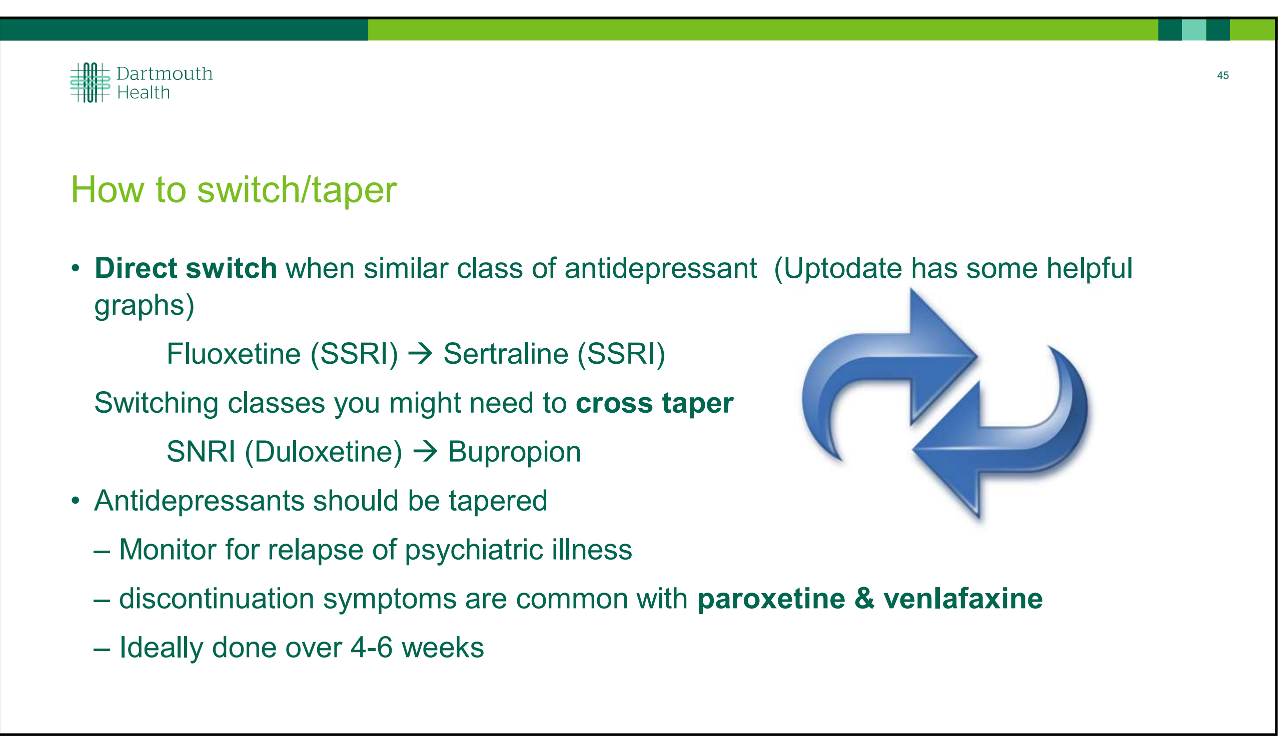
Medication
sertraline[‡] (Zoloft)
fluoxetine (Prozac)
citalopram (Celexa)
escitalopram (Lexapro)
Starting dose
25 mg
10 mg
10 mg
5 mg
How to ↑
↑ to 50 mg after 4 days, ↑ to 100 mg after 7 days, then ↑ by 50 mg until symptoms remit
↑ to 20 mg after 4 days, then ↑ by 10 mg until symptoms remit
↑ to 20 mg after 4 days, then ↑ by 10 mg until symptoms remit
↑ to 10 mg after 4 days, then ↑ by 10 mg up to 20 mg until symptoms remit
Therapeutic range
50 - 200 mg
20 - 60 mg
20 - 40 mg
10 - 20 mg
*if not currently on a medication that is helping
‡a safer alternative in lactation: lowest degree of translactal passage & fewest reported adverse effects compared to other antidepressants
In general if an antidepressant has helped, it is best to continue it during lactation
General side effects of medication
Temporary
Nausea
Constipation/diarrhea
Lightheadedness
Headaches
Long-term
Increased appetite/weight gain
Sexual side effects
Vivid dreams/insomnia
Recommend patients take medication with food to decrease side effects
Tell women only to increase dose if tolerating; otherwise wait until side effects dissipate before increasing
For effects on fetus/neonate see Educating Patients About Antidepressant Medication during Pregnancy and Lactation
Repeat EPDS in 2 – 4 weeks and re-evaluate depression treatment plan via clinical assessment
If no/minimal clinical improvement after 4 - 8 weeks
If clinical improvement and no/minimal side effects
If patient has no or minimal side effects, increase dose
If patient has side effects, switch to a different medication
Reevaluate every month and at postpartum visit
Copyright © 2017 MCPAP for Moms Program all rights reserved. Version 2. 07.21.17 Funding provided by the Massachusetts Department of Mental Health.
Authors: Byatt N., Biebel K., Mittal L., Lundquist R., Freeman M., & Cohen L., Moore Simas T.


Dartmouth Health
44
Antidepressant treatment algorithm
Start
Monitor
Optimize
Augment/ Switch
Start SSRI/SNRI
EPDS screen
At least 50% reduction in symptoms
Have you maximized dose?
• Augment:
• Bupropion (depression)
• Mirtazapine (sleep, anxiety, depression)
• Buspirone (anxiety, depression)
• SGAs like Aripiprazole/Quetiapine (depression/Anxiety)
• Switch? If intolerance, no response at good dose


Dartmouth Health
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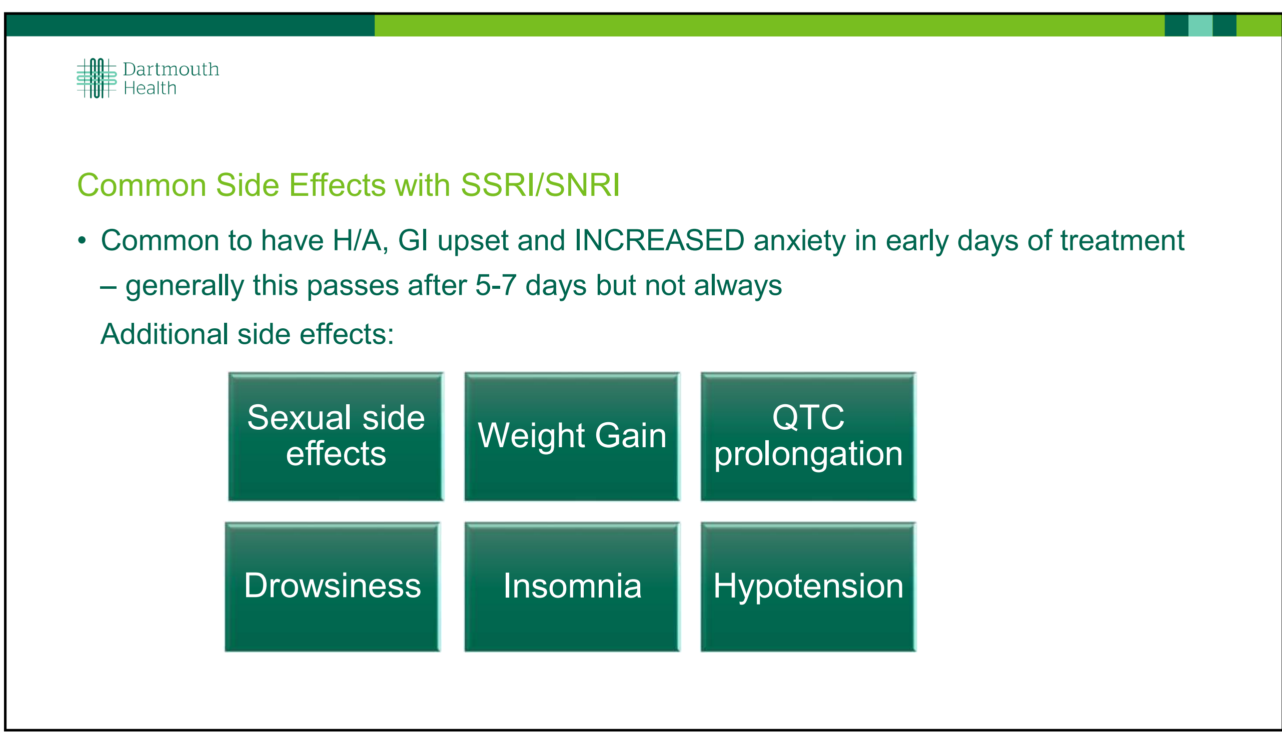
How to switch/taper
• Direct switch when similar class of antidepressant (Uptodate has some helpful graphs)
Fluoxetine (SSRI) → Sertraline (SSRI)
Switching classes you might need to cross taper
SNRI (Duloxetine) → Bupropion
• Antidepressants should be tapered
– Monitor for relapse of psychiatric illness
– discontinuation symptoms are common with paroxetine & venlafaxine
– Ideally done over 4-6 weeks



Dartmouth Health

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Drug	Anticholinergic	Drowsiness	Insomnia/ agitation	Orthostatic hypotension	QTc prolongation*	Gastrointestinal toxicity	Weight gain	Sexual dysfunctio
Selective serotonin reuptake inhibitors[¶]								
Citalopram	0	0	1+	1+	2 to 3+[Δ]	1+[¶]	1+	3+
Escitalopram	0	0	1+	1+	2+	1+[¶]	1+	3+
Fluoxetine	0	0	2+	1+	1+	1+[¶]	0	3+
Fluvoxamine	0	1+	1+	1+	1+	1+[¶]	1+	3+
Paroxetine	1+	1+	1+	2+	1+	1+[¶]	2+	4+
Sertraline	0	0	2+	1+	1+	2+[¶◊]	1+	3+
Atypical agents								
Agomelatine[§] (not available in United States)	0	1+	1+	0	0	1+	0	0 to 1
Bupropion	0	0	2+ (immediate release) 1+ (sustained release)	0	0 to 1+[¥]	1+	0	0
Mirtazapine	1+	4+	0	0	1+	0	4+	1+
Serotonin-norepinephrine reuptake inhibitors[¶‡]								
Desvenlafaxine[†]	0	0	1+	0	0	2+	Unknown	1+
Duloxetine	0	0	1+	0	0	2+[¶]	0 to 1+	1+
Levomilnacipran[†]	0[**]	0	0 to 1+	0 to 1+	0	2+[¶]	0	1+

https://www.uptodate.com/contents/image?imageKey=PC/62488

Breastfeeding considerations

- Generally SSRI/SNRIs are in low levels in breastmilk
  - No need to stop antidepressant if mother chooses to breastfeed
  - Infant serum levels less then 10% maternal levels
    - Fluoxetine is exception and in higher levels in breastmilk
  - All can increase prolactin and cause galactorrhea
- Lactmed and Mothertobaby great resources to consult

Know your local resources!

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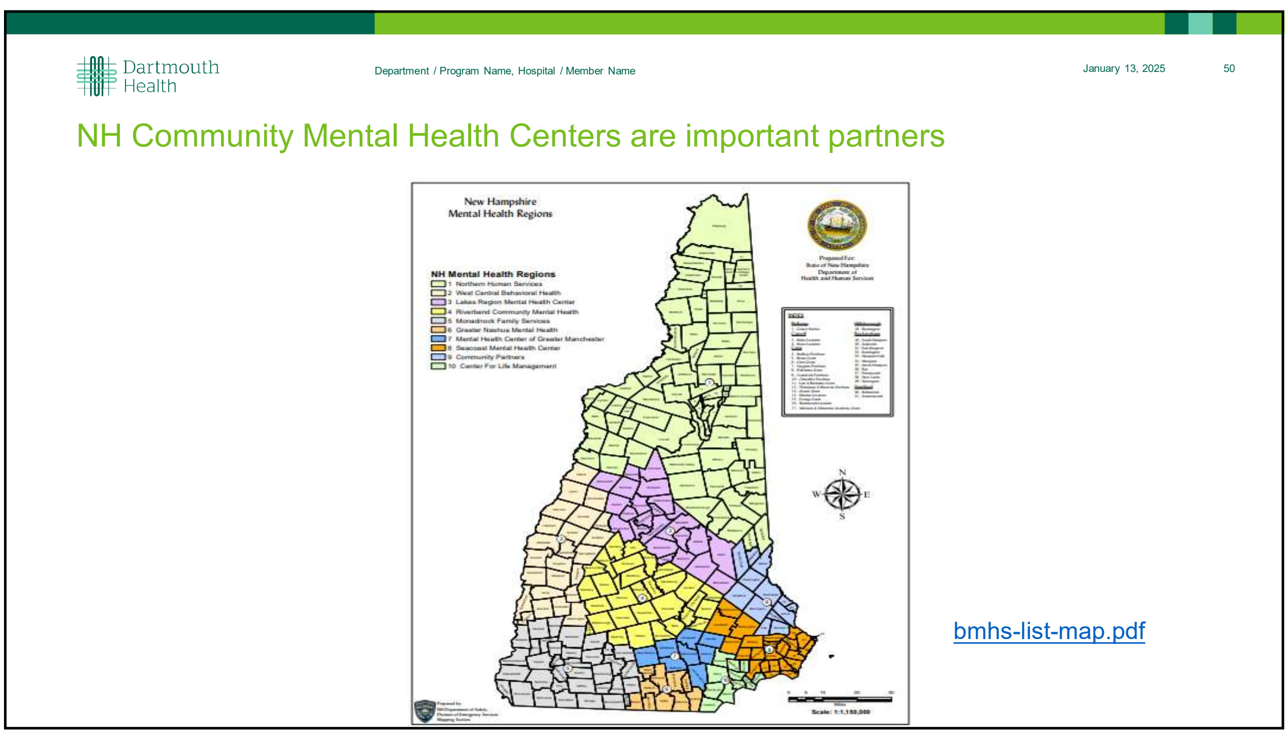
- Help your patient find their local family resource center: https://www.fsnh.org/community-connections.html
- Help your patient find their local community mental health center:

https://www.dhhs.nh.gov/sites/g/files/ehbemt476/files/documents2/bmhs-list-map.pdf

  - They typically can offer wrap around services for both baby and parents



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Helpful perinatal mood and anxiety disorder resources:

- **MGH Reproductive Psychiatry:** https://womensmentalhealth.org/ - MGH Reproductive Psychiatry site with up to date, evidence-based information for patients and providers as well as opportunities to participate in research studies
- **Postpartum Support International:** https://www.postpartum.net/ - Postpartum Support International--grass roots organization providing information and support for perinatal mood and anxiety disorders, including provider directory and online support groups
- **Postpartum Support International Support Groups:** https://www.postpartum.net/get-help/psi-online-support-meetings/ - online support groups
- **UK Teratology Information Service:** https://www.medicinesinpregnancy.org/ -Best Use of Medicines in Pregnancy: UK Teratology Information Service site regarding safety of medications in pregnancy
- **MotherToBaby:** https://mothertobaby.org/- provides free and uptodate evidence-based information on the benefit or risk of medications and other exposures during pregnancy and while breastfeeding. Also, great patient handouts

Helpful perinatal mood and anxiety disorder resources:

- **Birth Trauma Resource Website**: https://www.birthtraumaassociation.org/ - Support birthing people who identify traumatic birth experiences. Serves to educate health care professions
- **LactMed**: https://www.ncbi.nlm.nih.gov/books/NBK501922/ - Contains information on drugs and other chemicals to which breastfeeding mothers may be exposed. It includes information on the levels of such substances in breast milk and infant blood, and the possible adverse effects in the nursing infant
- **Reprotox**: https://reprotox.org/login - Contains summaries on the effects of medications, chemicals, biologics, and physical agents on pregnancy, reproduction, lactation, and development. Subscription only access
- **NCRP**: https://ncrptraining.org/ - "The mission of the National Curriculum in Reproductive Psychiatry is to advance knowledge about the diagnosis and treatment of psychiatric disorders throughout the reproductive life span. To build a common foundation for education and training in this emerging field, and to inspire lifelong learning about reproductive psychiatry, particularly during pregnancy and the postpartum period."

When you need additional help:

PSI provider line is a national perinatal psych consult service for medication questions: https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

PSI patient/family helpline is not for emergencies, but helps patients find PMADS resources: https://www.postpartum.net/get-help/psi-helpline/

PSI POSTPARTUM SUPPORT INTERNATIONAL

-**The National Maternal Mental Health Hotline** is a patient hotline connecting people to crisis counselors, resources, etc. It *does not* provide med recommendations for providers : https://mchb.hrsa.gov/programs-impact/national-maternal-mental-health-hotline

National Maternal Mental Health Hotline HRSA

-**CALL 988** for any mental health emergency or use the crisis text Line: https://www.crisistextline.org/

988 LIFELINE

Post-Session Scenario:

Molly is 32yo woman who works in finance. She is 10 weeks gestation with no medical complications. This is her first pregnancy. She is tearful during her initial prenatal intake. She tells you since she was a teenager she has been a “worrier”. She tends to ruminate and lose sleep during periods of stress. She has always managed this with exercise but her nausea has made this hard. Currently, her anxiety feels much worse during pregnancy. She is agitated with her partner and worrying about her health and the health of her baby non-stop. She calls the OB office a lot looking for reassurance everything is okay. She is “very sensitive” to medications and worries about it’s impact on her fetus. Her PCP told her to avoid medications as it’s unsafe in pregnancy.

Now, what would you do?

Post-Session Scenario:

Sarah is 30yo who is 2 months post partum with her first child. She is pumping to provide breastmilk as her baby had challenges with latching. Her pregnancy was complicated by pre- term labor and delivery at 34 weeks. Her baby had a stressful NICU stay. Her partner works long hours and isn’t able to help her much. She shares she is overwhelmed with the needs of her infant. Her sleep has been poor- awakening every two hours to feed and soothe her newborn. Sarah cries during the day, forgets to eat, feels disconnected from her baby, has fleeting thoughts her family would be better without her, and can’t seem remember what it’s like to enjoy a good book or a phone call from a friend. She doesn’t think she will ever feel better. Of note, she has family history of maternal aunt who has bipolar disorder.

Now, what would you do?

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Thank you!

Questions?
Join my AIMS PMADS office hours, Mondays between 12:45-1:45PM!

Email: Rebecca.A.Casey@hitchcock.org

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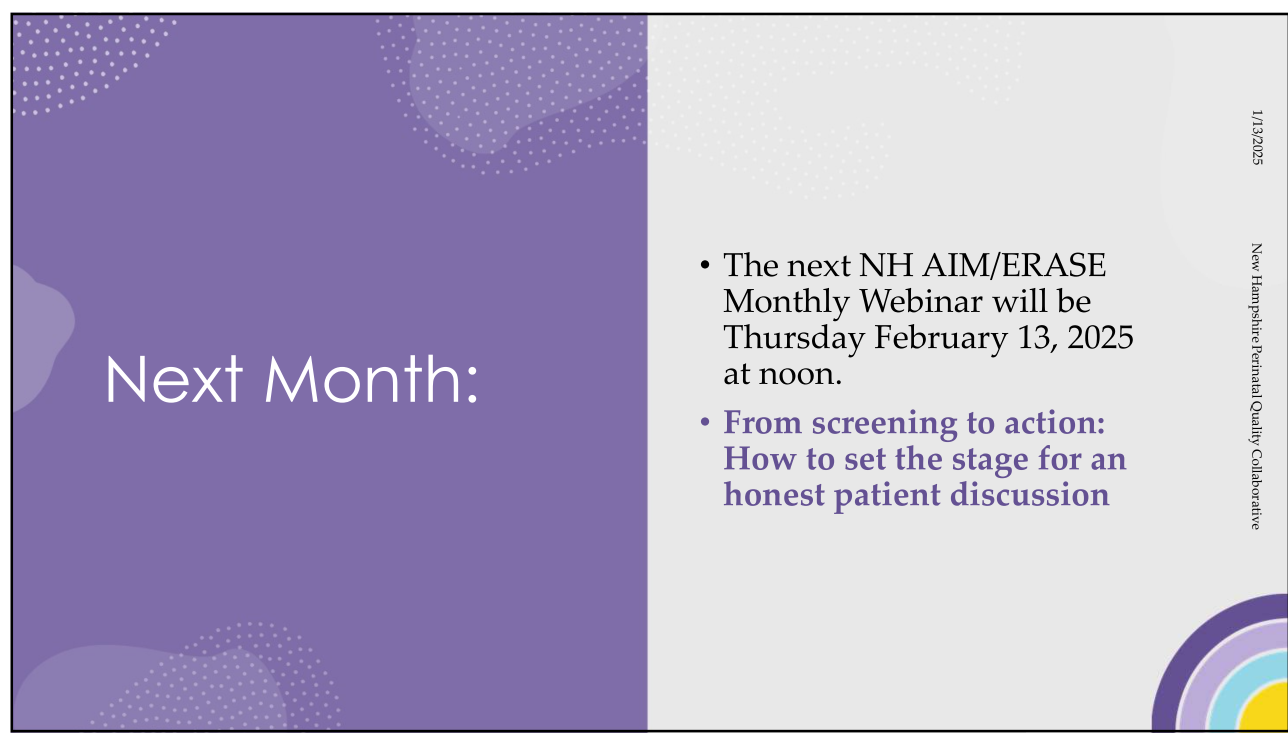

Important Links

- Becca Casey Monday Open Office Hours (12:45-1:45pm) Webex Link HERE

1/13/2025 New Hampshire Perinatal Quality Collaborative

Announcements
• Saturday February 8 – NH BLM Women's Health Conference at St. Anselm's College in Manchester, NH. Please contact NHPQC staff for more information.
1/13/2025
New Hampshire Perinatal Quality Collaborative