COPE
Centre of Perinatal Excellence

Applied Skills in Perinatal Mental Health Assessment and Care

LESSON NOTEBOOK

Module 2 | Lesson 5

Pharmacotherapy and Management of Severe Perinatal Mental Illness

COPE Accredited Program

Module 2: Lesson 5
Pharmacotherapy & Management of Severe Perinatal Mental Illness

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Medication – related Challenges

- Lack of understanding about the role of medications
- Patients told to come off medications
  - Can increase the rates of relapse
- Important to balance the risks and benefits on a case-by-case basis

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Lesson 5 Overview

1. Moderate to severe PMH illness
2. Research findings
3. Psychotropic medication
4. Risk-benefit analysis of medication
5. Somatic interventions

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Moderate to Severe Anxiety and Depression

Influencing Factors on Clinical Presentations

Possible supportive factors

- Increased sleep
- Access to support (practical / emotional)
- Increasing parenting confidence

Possible inhibitive factors

- Sleep deprivation
- Breast-feeding challenges
- Birth complications
- Unmet expectations
- Increased isolation

Moderate to Severe Depression and Anxiety

In Pregnancy:

- Consider the use of **selective serotonin reuptake inhibitors (SSRIs)** as first-line treatment for moderate to severe depression and/or anxiety in pregnant women.

Moderate to Severe Depression and Anxiety

In Pregnancy:

- Before choosing a particular antidepressant for pregnant women, consider the woman's **past response** to antidepressant treatment, **obstetric history** (eg. other risk factors for miscarriage, preterm birth or postpartum haemorrhage) and any factors that may increase risk of adverse effects.

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Moderate to Severe Depression and Anxiety

Postpartum:

- Use **SSRIs as first-line treatment** for moderate to severe depression in postnatal women.
- Before prescribing antidepressants to women who are breastfeeding, consider the infant's health and gestational age at birth.

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Moderate to Severe Depression and Anxiety

- Consider the **short-term use of benzodiazepines** for treating moderate to severe symptoms of anxiety while awaiting onset of action of an antidepressant in pregnant or postnatal women.
- **Use caution** in repeated prescription of long-acting benzodiazepines around the time of birth.

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Moderate to Severe Depression and Anxiety

- **Use caution** in prescribing **non-benzodiazepine hypnotics (z-drugs)** to pregnant women for insomnia.
- **Doxylamine**, a Category A drug in pregnancy, may be considered for use as a first-line hypnotic in pregnant women who are experiencing moderate to severe **insomnia**.

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Moderate to Severe Depression and Anxiety

- Advise women with moderate to severe anxiety and depressive disorders **that psychological interventions are a useful adjunct**, usually once medications have become effective.

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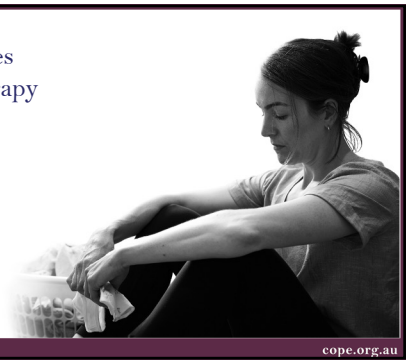
Guiding Principles for Pharmacotherapy



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Guiding Principles - Pharmacotherapies

- Discuss the potential **risks and benefits** of pharmacological treatment in each individual case with the woman and, where possible, her significant other(s).

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Guiding Principles - Pharmacotherapies

- Ensure that women are aware of the **risks of relapse** associated with stopping medication and that, if a medication is ceased, this needs to be done gradually and with advice from a mental health professional.

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Management of Suicide Risk

- When a woman is identified as at risk of suicide (through clinical assessment and/or the EPDS), manage immediate risk, arrange for urgent mental health assessment and consider support and treatment options.

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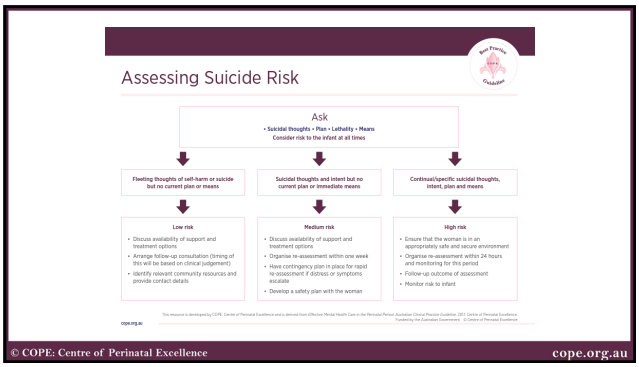

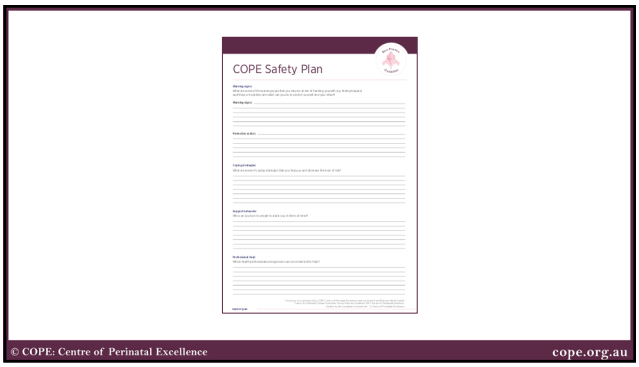

Mother-Infant Interaction Difficulties

- For women who have or are recovering from postnatal depression and are experiencing mother-infant relationship difficulties, consider provision of or referral for individual **mother-infant** relationship interventions.

Clinical Considerations

- Case-by-case basis
- Weighing up the risks versus the benefits
- Referring to best practice guidelines

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Management of Severe Mental Illness

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Guiding Principles - Pharmacotherapies

- Ideally, treatment with psychoactive medications during pregnancy would involve close liaison between a treating psychiatrist or, where appropriate, the woman's GP, and her maternity care provider(s).
- In more complex cases, it is advisable to seek a second opinion from a perinatal psychiatrist.

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Guiding Principles - Pharmacotherapies

- When exposure to psychoactive medications has occurred in the first trimester - especially with anticonvulsant exposures - pay particular attention to the 18-20 week ultrasound due to the increased risk of major malformation.

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Guiding Principles - Pharmacotherapies

- Plan for pharmacological review in the early postpartum period for women who cease psychotropic medications during pregnancy.
- Arrange observation of infants exposed to psychoactive medications in pregnancy for the first three days postpartum.

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Antipsychotic Medications

- Use antipsychotics for treating psychotic symptoms in pregnant women.
- Use caution when prescribing metabolic-inducing antipsychotics to pregnant women, due to the increased risk of gestational diabetes.

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Antipsychotic Medications - Clozapine

- If considering the use of clozapine in pregnant women, seek specialist psychiatric consultation.
- Use clozapine with caution in women who are breastfeeding and monitor the infant's white blood cell count weekly for the first six months of life.

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Antipsychotic Medications

- If women commence or continue antipsychotic treatment during pregnancy, monitor them for excessive weight gain and the development of gestational diabetes and refer them for advice on weight management as required.

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Antipsychotic Medications - Preconception

- Given their teratogenicity, only consider prescribing anticonvulsants (especially valproate) to women of child-bearing age if effective contraception is in place.

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Anticonvulsant Medications - Preconception

- Once the decision to conceive is made, if the woman is on valproate wean her off this over 2-4 weeks, while adding in high-dose folic acid (5 mg/day) which should continue for the first trimester.

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Anticonvulsant Medications

- **Use great caution** in prescribing anticonvulsants as mood stabilisers for pregnant women and seek specialist psychiatric consultation when doing so.
- If prescribing lamotrigine to a woman who is breastfeeding, arrange **close monitoring of the infant** and specialist neonatologist consultation where possible.

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Anticonvulsant Medications - Lithium

- If lithium is prescribed to pregnant women, ensure that maternal blood levels are **closely monitored** and that there is specialist psychiatric consultation.
- If lithium is prescribed to a pregnant woman, reduce the dose just prior to the onset of labour and aim to recommence treatment immediately after the birth at a pre-pregnancy dose.

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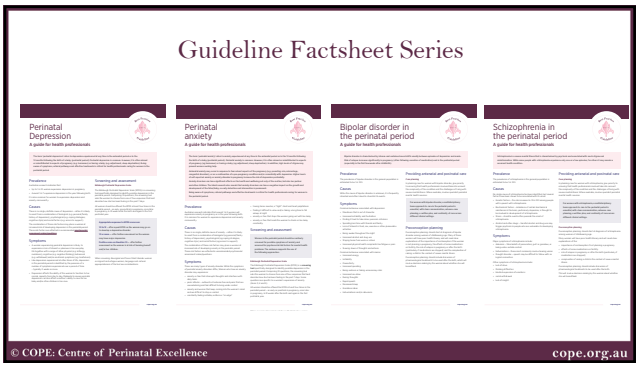

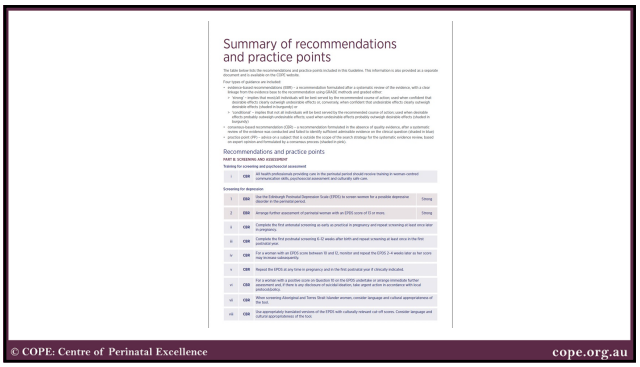

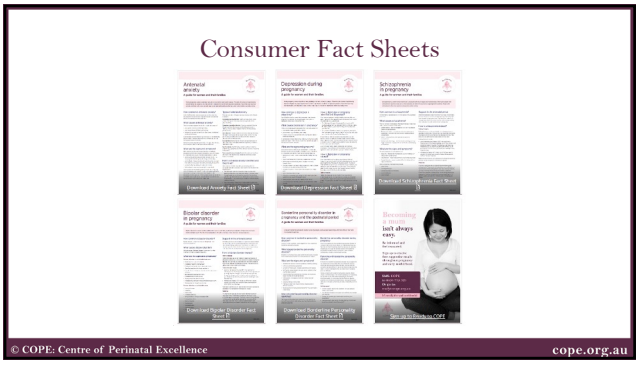

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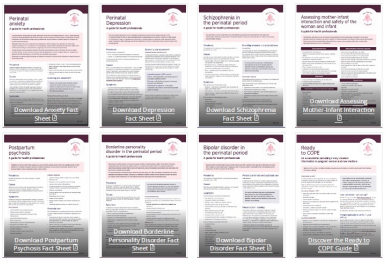
Health Professional Fact Sheets



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Electroconvulsant Therapy - Antenatal

- In pregnant women, ECT should be only be undertaken in conjunction with close fetal monitoring (using cardiotocography to monitor fetal heart rate) and access to specialist maternal-fetal medical support.

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Electroconvulsant Therapy - Postnatal

- Consider electroconvulsive therapy (ECT) when a postnatal woman with severe depression has not responded to one or more trials of antidepressants of adequate dose and duration.

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Electroconvulsant Therapy - Postnatal

- Consider electroconvulsive therapy (ECT) as a first-line treatment where there is a high risk of suicide or high level of distress; when food intake is poor; and in the presence of psychotic or melancholic symptoms.

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Transcranial Magnetic Stimulation

- Non-invasive procedure that uses magnetic fields to stimulate nerve cells in the brain to improve symptoms of depression.

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Early Warning Signs

- What are they
- Who identifies and how is this communicated
- Plans for action
- Who needs to be involved/engaged

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Pharmacotherapy & Management of Severe Perinatal Mental Illness

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Lesson 5: Recap

1. Consider SSRIs for moderate to severe anxiety and/or depression
2. Benzodiazapines - short-term use only
3. Non-Benzodiazapines - use cautiously in pregnancy

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Lesson 5: Recap

4. Use antipsychotic medications with caution in pregnancy
5. Do not initiate clozapine in pregnancy and monitoring infant in breastfeeding women without specialist advice
6. Do not prescribe sodium valproate in pregnancy
7. Use great caution when prescribing anticonvulsants and lithium (avoid lithium in breastfeeding women)

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