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Spotlight on Perinatal Mental Health

Issue Brief from New York State Maternal Mortality Review Board

The audience for this issue brief is psychiatrists and other mental health providers, emergency medicine (EM) providers, addiction medicine providers, internists, family medicine providers, obstetrician-gynecologists (Ob-Gyn), midwives, nurse practitioners, physician assistants, social workers, and other health care providers.

Introduction

The New York State (NYS) Maternal Mortality Review Board (MMRB or Board) is releasing the first in a series of issue briefs that is designed to offer multi-disciplinary providers an in-depth examination of a key recommendation from a comprehensive review of 2018 pregnancy-associated[1] deaths in NYS.

According to the data recently released in the report "NYS Pregnancy Associated Deaths in 2018," mental health conditions represent the third leading cause of pregnancy-related[2] deaths statewide, and the Board determined that these deaths were potentially preventable. All pregnancy-related deaths attributed to mental health conditions occurred post-pregnancy, with the majority occurring between 42 and 365 days after the end of pregnancy. Mental health conditions were considered contributing factors in nearly one in five (19.5%) pregnancy-related deaths.

This issue brief uses a composite case of a fictitious patient to incorporate key aspects of mental health-related conditions that were identified in actual cases during the Board's review of 2018 pregnancy-related deaths. Specific recommendations follow the case description.

Composite Case

The patient was a 28-year-old gravida 1 who died 82 days postpartum with cause of death "asphyxia due to hanging." The patient had a long history of mental illness and was diagnosed with both depression and anxiety 10 years prior to the index pregnancy. Her pregnancy was complicated by gestational diabetes and chronic hypertension. She had been seeing a psychiatrist and was receiving medications that included quetiapine, hydroxyzine, sertraline, and trazodone. Records indicated that she filled her prescriptions routinely.

She stopped taking psychiatric medications upon learning she was pregnant at 9 weeks gestation. She was experiencing significant vomiting and was concerned about the effects the medications may have on her baby. On the advice of her psychiatrist, at 11 weeks gestation, she did not restart the medications.

No documentation of any depression screening tool could be found in the prenatal medical records.

Her first prenatal visit was at 15 weeks, and she attended 4 subsequent visits, with several prenatal appointments not attended. An ultrasound performed at 22 weeks demonstrated normal fetal anatomy and confirmed her dates.

She also had 3 emergency room visits with a variety of concerns, including headache, difficulty sleeping, and abdominal pain. On two of these occasions, she left before the medical evaluations could be completed.

She presented to her local hospital in active labor at 5 cm and had an uncomplicated labor. She delivered a 3200-gram male infant that had a normal neonatal course. A follow-up appointment was scheduled with an Ob-Gyn provider in 6 weeks. She was also advised to see her psychiatrist.

1 Pregnancy-associated death: A death during pregnancy or within one year of the end of pregnancy.

2 Pregnancy-related death: A death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

She did not return for a postpartum follow-up visit. There is no record of any provider contacting her.

At 82 days postpartum, her partner, the father of the baby, found her dead in her apartment due to hanging. Her baby was crying in his crib.

Discussion and Recommendations

The presence of a mental illness represents a significant risk factor for adverse maternal health outcomes, as evidenced by mental health conditions being the third-leading cause of pregnancy-related deaths in NYS. All 2018 pregnancy-related deaths caused by mental health conditions occurred in the period following the end of pregnancy. Pregnant patients with a mental health history require individualized, person-centered management of their mental health conditions during pregnancy, and their care should always include close coordination between the prenatal care and mental health providers. Further, continuity of care after delivery is essential, as patients are particularly vulnerable to complications during the postpartum period. Shared decision making regarding the appropriate course of treatment before, during, and after pregnancy is recommended.

Recommendation 1

Psychiatric medications should not be automatically discontinued just because a patient is pregnant.

- Mental health providers should be aware that the use of psychiatric medications during pregnancy is not automatically contraindicated. For each pregnant person with a mental health history, careful consideration of the risks and benefits of medications should be undertaken prior to change or withdrawal of such medications.
- If the prenatal care provider identifies the abrupt discontinuation of psychiatric medications, they should contact Project TEACH or the patient's mental health provider to discuss.
- Mental health practitioners may consider consulting with another provider to get a second opinion or reach out to Project TEACH which offers a consultation line for providers (see more details below).
- For patients of reproductive age, all providers are encouraged to ask: "Would you like to become pregnant in the next year?" If the patient confirms their intention to become pregnant, they should be referred to preconception counseling. If they are uncertain or do not intend to become pregnant, contraceptive counseling should be delivered.

Recommendation 2

Screening for depression should be conducted during all pregnancies and is considered the standard of care.

NYS Pregnancy Risk Assessment Monitoring System 2020 data shows that 10% of pregnant individuals indicated they had depression during their pregnancy and 10.1% of postpartum individuals reported experiencing depressive symptoms.[3]

- Screening for depression, utilizing a standardized tool, should be done in all pregnancies at least once during both the prenatal and postpartum periods by the individual's healthcare provider.[4] Early recognition is key. For patients with a history of mental health diagnoses, prenatal care providers should continue to screen for worsening of their disease over the course of their pregnancy.
- When a prenatal care provider identifies a patient with a positive screen, treatment and counseling may be needed. If a provider needs consultative support, they can access Project TEACH for consultation and to discuss treatment options. If a referral is needed, an appointment should be made and confirmed for the patient; the consultant who received the referral should close the loop by sending the visit notes resulting from the referral back to the sending provider.

3 NYS Department of Health, Pregnancy Risk Assessment Monitoring System Reports, 2020

4 Screening for Perinatal Depression | ACOG

Recommendation 3

Enhanced coordination of care between prenatal care providers and mental health providers is needed.

- Coordination between prenatal care providers and mental health providers is recommended for patients with mental health disorders, both during the pregnancy and the postpartum period.
- After delivery, care coordination is necessary to ensure postpartum mental health treatment needs are met. Simply advising the patient to seek a mental health appointment is insufficient during this time of increased stress and risk. A closed-loop referral should be made, and an appointment confirmed, prior to discharging patient.
- Ensuring on-going connection to care and a warm handoff to psychiatric treatment is essential.[5]
- Consider referral to community-based programs that provide home visiting and care coordination services. Visiting nurses, community health workers, and patient navigators can ensure successful linkage with healthcare and community resources, assist with navigating barriers to care, and provide ongoing monitoring and support.

Recommendation 4

Enhance knowledge and awareness among emergency medicine providers regarding perinatal mental health conditions.

Emergency medicine providers should be aware that pregnant people who present frequently, offer vague symptoms, and/or display challenging behaviors, should be assessed for mental health conditions.

It has been shown that when pregnant people return to the emergency room after prior Emergency Department discharge, mental health diagnoses are common and should be considered and pursued, especially when there are no alternative diagnoses.[6]

Provider Resources

American Congress of Obstetricians and Gynecologists (ACOG) Guidance:
Screening for Perinatal Depression | ACOG

NYS Report on Pregnancy-Associated Deaths in 2018:
https://health.ny.gov/community/adults/women/docs/maternal_mortality_review_2018.pdf

Project TEACH and other Referral Resources:
https://projectteachny.org/maternal-mental-health/

To enhance care of patients with mental health involvement, providers caring for pregnant and postpartum patients can utilize NYS Project TEACH to obtain direct access to reproductive psychiatrists for information and case consultation. Visit www.projectteachny.org or call (855) 227-7272.

Patient Resources

ACOG Depression During Pregnancy:
https://www.acog.org/womens-health/faqs/depression-during-pregnancy

Centers for Disease Control and Prevention Depression During and After Pregnancy:
https://www.cdc.gov/reproductivehealth/features/maternal-depression/index.html

NYS Department of Health:
Perinatal Mood and Anxiety Disorders | NYSDOH

NYS Office of Mental Health:
Help for Maternal Depression | OMH

5 Warm Handoff: Intervention/ Agency for Healthcare Research and Quality (https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html)

6 Gabayan et al. Short-term Bounce-Back. Annuals of Emergency Medicine. August 2013.

NYS Home Visiting Programs:
NYS Child Care, After School, and Parent Support Programs Locator (arcgis.com)

To find a home visiting program, click on “Locate Parent Support Programs”. A listing of home visiting programs by county is provided. Click on the home visiting program name for eligibility and contact information.

Postpartum Resource Center: A Toll-Free State-wide Helpline 1-855-631-0001:
https://postpartumny.org/

Postpartum Support International:
https://www.postpartum.net