

# Maternal Mental Health

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Webinar will begin at 12:33 PDT

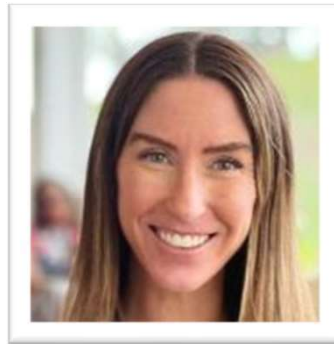
2024

The information provided in this training is not intended as treatment advice. Individualized diagnosis and treatment plans can only be rendered by a treating provider.

## Facilitators



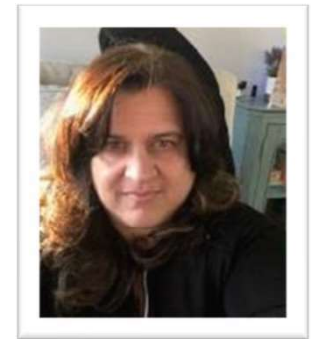
George Hawley  
Training Specialist



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# House Keeping

- **Webinar Format**

Participants Pre-Muted

Limits Distractions



- **Chat Box**

Ask Questions

Answered during and after presentation



- **Presentation Availability**

A pdf version of the slide and the recording

will be emailed to all attendees after the presentation



# Maternal Mental Health Disorder: Prevalence and Impact



## What are Maternal Mental Health Disorders?

- Any behavioral, emotional, or mental illness that affects a perinatal woman
- Perinatal = conception through one year postpartum
- Can be new-onset, chronic, or worsened
- On a spectrum: mild – moderate - severe



# Maternal Depression

## Symptoms may include but are not limited to:

- Feelings of anxiety, depression, guilt, isolation, and/or inadequacy that do not resolve
- Crying more often than usual or for no apparent reason
- Oversleeping, or being unable to sleep even when baby is asleep
- Having trouble concentrating, remembering details, and making decisions
- Experiencing anger or rage
- Losing interest in activities that are usually enjoyable
- Suffering from physical aches and pains, including frequent headaches, stomach problems, and muscle pain
- Eating too little or too much
- Withdrawing from or avoiding friends and family
- Having trouble bonding or forming an emotional attachment with one's baby
- Thinking about harming oneself or one's baby



## Maternal Depression Incidence

- The rates of depressive disorders during hospitalizations for delivery in the U.S. increased from **4.1 diagnoses per 1000** hospitalizations in 2000 to **28.7 per 1000** in 2015
- Highest rates in 2015 were seen in:
  - Women 35yo or older
  - Women on public insurance
  - Non-Hispanic white women

Haight, Sarah C. MPH; Byatt, Nancy DO, MS; Moore Simas, Tiffany A. MD, MPH; Robbins, Cheryl L. PhD, MS; Ko, Jean Y. PhD. Recorded Diagnoses of Depression During Delivery Hospitalizations in the United States, 2000–2015. *Obstetrics & Gynecology* 133(6):p 1216-1223, June 2019. | DOI: 10.1097/AOG.0000000000003291



# Postpartum Psychosis

- Most severe form of postpartum psychiatric illness
- Impacts approximately 1 to 2 in 1,000 women after childbirth
- Onset can occur as early as 48 to 72 hours up to two weeks after delivery
- Early signs: restlessness, irritability, and insomnia
- Looks similar to a manic episode of Bipolar Disorder
- Delusional ideas as well as auditory hallucinations can occur
- Research indicates 5% suicide rate and 4% infanticide rate

<https://www.postpartum.net/learn-more/postpartum-psychosis/>

<https://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders>





## Maternal PTSD

- An Australian study of 400 women who gave birth found that 10.5% experienced “significant distress related to childbirth” and demonstrated many symptoms of PTSD
- Their findings also demonstrated high rates of co-morbidity of depression, anxiety, and PTSD
- A positive postpartum screen for depression, anxiety, or PTSD should prompt further assessment of the other 2 conditions

Howard, S., Witt, C., Martin, K. et al. Co-occurrence of depression, anxiety, and perinatal posttraumatic stress in postpartum persons. *BMC Pregnancy Childbirth* 23, 232 (2023). <https://doi.org/10.1186/s12884-023-05555-z>



# OCD in Pregnancy

- Often called Perinatal OCD or Postpartum OCD
- Pregnancy up until 12 months after delivery is considered an especially vulnerable time for the emergence of OCD symptoms—either a recurrence of prior symptoms that may have been in remission or a new onset
- One study found that more than 40% of women with postpartum depression also experience repeated, intrusive thoughts of harm coming to their infants—consistent with OCD symptomatology
- Possible causes:
  - Significant hormonal shifts that occur in pregnancy and postpartum period also affecting brain activity
  - Rise in oxytocin causing an exaggerated “protective” response that presents as obsessions and compulsions
  - Psychological factors related to increased sense of responsibility and enhanced awareness of threats



# OCD in Pregnancy

- **Examples of obsessions:**
  - What if I drown the baby in the bathtub?
  - What if the baby stops breathing when I'm not watching?
  - What if I drop the baby down the stairs?
  - Intrusive images of death, injury, physical or sexual harm being inflicted on baby
- **Examples of compulsions:**
  - Excessive checking
  - Excessive cleaning / washing
  - Seeking reassurance about health of baby (i.e., repeated trips to the pediatrician)



## OCD in Pregnancy

- Important to distinguish OCD from postpartum psychosis, especially as it relates to risk of harm to baby or mother
  - Mothers with OCD are distressed and horrified by their obsessions and are fearful of what the thoughts might mean
  - Mothers with psychosis are not typically conflicted over their abnormal thoughts and are not able to identify that such thoughts are unwanted or unnatural
  - Mothers with OCD may be overly attached to their infants, trying to protect them and not allowing others to help care for their babies. Or they may be avoidant, fearing that they will unintentionally do something to cause them harm.
- In either case, attachment and bonding between mother and baby can be disrupted, as well as causing stress in the woman's other relationships.

<https://iocdf.org/expert-opinions/perinatal-ocd-what-research-says-about-diagnosis-and-treatment/>



## Additional Observations & Trends Related to Maternal Mental Health

A serial cross-sectional study using the National Inpatient Sample database looked at 73,109,791 delivery hospitalizations during the period from 2000 to 2018. The authors noted 4 main findings:

- (1) The proportion of delivery hospitalizations with at least 1 mental health diagnosis increased more than 10-fold during the study period.
  - Most of the increase was due to higher rates of anxiety and depressive disorders, but diagnoses of bipolar & schizophrenia spectrum disorders also increased significantly throughout this period.
- (2) Mental health diagnoses were associated with a modestly increased risk of negative maternal & obstetrical outcomes.
- (3) Mental health diagnoses were associated with chronic physical health conditions.
  - Almost 40% of hospitalizations with a MH diagnosis had a co-morbid diagnosis of pregestational diabetes, obesity, hypertension, asthma, or substance abuse by the end of the study period
- (4) Underlying physical health conditions in the context of a MH diagnosis were associated with a higher risk of severe maternal morbidity.



## Risk of Suicide in Postpartum Period

Maternal suicide is the 2<sup>nd</sup> most common cause of death in the postnatal period

- 13% to 36% of maternal deaths are attributed to suicide

In a study published in *JAMA* in January 2024, the authors looked at the association between perinatal depression and suicidal behavior, using the national registry data in Sweden (population-based matched cohort, followed by a sibling comparison)

86,551 women with perinatal depression in the study

- 47,642 affected in the antenatal period
- 38,909 affected in the postnatal period

Compared with matched women without perinatal depression, women with perinatal depression were more likely to:

- Live alone
- Have lower levels of education & income
- Smoke 3 months before pregnancy



## Risk of Suicide in Postpartum Period

Follow-up period was 18 years. Compared with matched women without perinatal depression, those with affected women had a 3 times higher risk of suicidal behavior.

- The excess risk was greatest during the 1 year following the perinatal depression diagnosis
- Even though the risk decreased over time, it remained twice as high 5 or more years later

**Excess risk did not depend on the women's history of psychiatric disorders**

- Suggests that perinatal depression is associated with an additional risk of suicidal behavior beyond the risk associated with psychiatric diagnoses that existed before the perinatal period
- However, it is possible that women with perinatal depression AND a prior psychiatric diagnosis may be more likely to receive treatment during the perinatal period, which could decrease the risk of suicidal behavior



## Risk of Suicide in Postpartum Period

**Consider:** study was done in Sweden, which has universal health care and a high average national income

Results may differ in countries with different socioeconomic situations & different health care access

At any rate, this study emphasizes the need for close clinical monitoring and follow-up for any woman with perinatal depression, regardless of whether there is a prior history of psychiatric diagnoses





## Risk Factors for MMH Disorders

- Symptoms of depression during or after a previous pregnancy
- Previous experience with depression or bipolar disorder at another time in her life
- A family member who has been diagnosed with depression or other mental illness
- A stressful life event during pregnancy or shortly after giving birth
- Medical complications during childbirth, including premature delivery or having a baby with medical problems
- Mixed feelings about the pregnancy, whether it was planned or unplanned
- A lack of strong emotional support from her spouse, partner, family, or friends
- Alcohol or other drug abuse problems



## Impact of MMH Disorders

- Less adherence to prenatal care regimens
- Preterm delivery
- Reduced breastfeeding
- Increased crying and irritability in newborn
- Long-term risks of anxiety / depression in child
- Increased risk of delays in communication and personal-social development
- Increased risk of child abuse and neglect
- Suicidality

Netsi E, Pearson RM, Murray L, Cooper P, Craske MG, Stein A. Association of Persistent and Severe Postnatal Depression With Child Outcomes. *JAMA Psychiatry*. 2018;doi:10.1001/jamapsychiatry.2017.4363

<https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.3a11>



## Economic Impact of MMH Disorders

- Study published in June 2020: Authors developed a mathematical model using a cost-of-illness approach in order to estimate the economic impact of untreated perinatal mood and anxiety disorders
  - Used cohort of mothers and babies born in 2017
  - Projection from time of conception through the 1<sup>st</sup> 5 years of the babies' lives
- Based on their model and projections, they estimated that untreated perinatal mood and anxiety disorders cost \$14 billion for this 2017 cohort
  - Average cost per affected mother-child: \$31,800
  - Mothers: 65% of the costs / Children: 35% of the costs



Luca DL, Margiotta C, Staatz C, Garlow E, Christensen A, Zivin K. Financial Toll of Untreated Perinatal Mood and Anxiety Disorders Among 2017 Births in the United States. *Am J Public Health*. 2020 Jun;110(6):888-896. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7204436/>

## Economic Impact of MMH Disorders

- Primary sources of the costs:
  - Decreased economic productivity among mothers (lost income due to inability to work or decreased performance at work)
  - Increased preterm births
  - Increased health expenditures among mothers
- Costs in children related primarily to medical, behavioral, and developmental conditions

Luca DL, Margiotta C, Staatz C, Garlow E, Christensen A, Zivin K. Financial Toll of Untreated Perinatal Mood and Anxiety Disorders Among 2017 Births in the United States. *Am J Public Health*. 2020 Jun;110(6):888-896. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7204436/>



## Postpartum in New Fathers

- New fathers can also have postpartum depression, sometimes called Paternal Postpartum Depression
- Fathers who are young and who have a history of depression or stressful life events most at risk
- Can have the same negative impact on partner relationships and child development
- Recent systematic review and meta-analysis of 7 million father-child dyads from 16 observational studies found that depression in fathers was associated with a 42% higher risk of depression in the children

<https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617>

[https://www.consultant360.com/exclusive/paternal-depression-increases-risk-depression-offspring?hmpid=amVzc2xhbmdlMDVAZ21haWwY29t&utm\\_medium=email&utm\\_source=enewsletter&utm\\_content=1908754650](https://www.consultant360.com/exclusive/paternal-depression-increases-risk-depression-offspring?hmpid=amVzc2xhbmdlMDVAZ21haWwY29t&utm_medium=email&utm_source=enewsletter&utm_content=1908754650)



## Possible Effects of the End of Roe v. Wade

- Consider 2018 study led by M. Antonia Biggs, PhD, and published in *American Journal of Psychiatry*, looking at 5-year suicidal ideation trends among women who either received or were denied an abortion
- Long-held argument is that women who have had an abortion experience significant mental health issues, including suicidal ideation
- However, based on the study, no statistically significant differences in suicidal ideation outcomes were observed between the 2 groups of women
- Another study found that women who had been denied an abortion (compared with those who had received an abortion) reported:
  - Increased anxiety
  - Poorer self-esteem
  - Lower life satisfaction



## Unmet Treatment Needs

- A retrospective cohort study of women (ages 15 & older) who delivered a live birth in the Kaiser Permanente Northern California system between October 2012 and May 2017 found that 13,637 women were given a new diagnosis of depression:
  - Prenatal: 51.6%
  - Postpartum: 48.4%
- Initiation of treatment was defined as being prescribed at least 1 antidepressant medication or receiving a therapy visit up to 90 days after the diagnosis
- 31.4% of the pregnant women initiated treatment
- 73.1% of the postpartum women initiated treatment
- Women with Latino or Asian backgrounds were less likely than Caucasian women to start treatment in the postpartum period

Avalos LA, Nance N, Iturralde E, Badon SE, Quesenberry CP, Sterling S, Li DK, Flanagan T. Racial-Ethnic Differences in Treatment Initiation for New Diagnoses of Perinatal Depression. *Psychiatr Serv.* 2023 Apr 1;74(4):341-348. doi: 10.1176/appi.ps.20220173



## Unmet Treatment Needs

- Looking at data from the 2011-2016 National Survey on Drug Use and Health (NSDUH):
  - 51% of pregnant women with a major depressive episode did not receive any MH treatment
  - 40% of pregnant women with a major depressive episode “perceived an unmet need” for their mental health, whether or not they had actually received any MH treatment
  - A significant percentage of pregnant women with major depression reported using opioids, using THC, or drinking ETOH in the past 30 days
- Also, for both pregnant and non-pregnant women with depression, the #1 reason cited for unmet MH treatment was financial issues, which could include:
  - Inability to afford cost of treatment
  - Insurance did not cover treatment
  - Insurance was not sufficient to cover the costs of treatment





## Pregnancy Loss

Consider also the mental health needs of women who have experienced miscarriages or stillbirths.

In the U.S., a miscarriage is defined as the loss of a baby before the 20<sup>th</sup> week of pregnancy. Stillbirth describes the death of a baby at 20 weeks of pregnancy or later, or death during delivery.

Per CDC data for the U.S.:

- Approximately one pregnancy in 100 at 20 weeks of gestation or later is affected by stillbirth.
- Every year, about 24,000 babies are stillborn.

In addition to grief, women who experience pregnancy loss may experience feelings of anger, guilt, disappointment, and frustration, as well as negative views toward their bodies. They may also experience symptoms of PTSD.



Pregnancy and Infant Loss. Centers for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/stillbirth/features/pregnancy-infant-loss.html>

Emotional Healing After a Miscarriage: A Guide for Women, Partners, Families, & Friends. Georgetown University School of Nursing. [Emotional Healing After a Miscarriage: A Guide for Women, Partners, Family, and Friends - Nursing@Georgetown](#)

# Maternal Mental Health: Substance Use Disorders



## Perinatal Substance Use: Overview

- Tobacco, alcohol, and marijuana are the most common substances used during pregnancy, followed by cocaine and opioids
- Other factors associated with perinatal SUD:
  - Poor nutrition
  - Needle-sharing
  - Lack of safe housing
  - Financial insecurity / poverty
  - Low educational level
  - Partner violence
- Higher rates of alcohol and drug use in urban areas and in communities that have higher proportions of teens/young adults and immigrants



## Perinatal Substance Use: Statistics

Between 2005 and 2014:

- 11.5% of teen and 8.7% of adult pregnant women reported consuming alcohol
- 23% of teen and 14.9% of adult pregnant women reported using tobacco

A 2012 U.S. national survey found:

- 5.9% pregnant women reported using illicit drugs
- 8.5% pregnant women reported consuming alcohol
- 15.9% pregnant women reported smoking cigarettes

Similar rates have been reported in Europe and in Australia.

**Also: retrospective reviews have shown that 2.5% of all pregnant women and approximately 20% of those with Medicaid insurance received at least 1 opioid prescription during pregnancy.**

**Most pregnancies in patients with Opiate Use Disorder (OUD) are unplanned.**



## Perinatal Substance Use: Associated Risks

Sharing drug paraphernalia and multiple partners, leading to increased risks of:

- HIV
- Hepatitis B & C
- TB
- Other STI's

Homelessness

Increased incarceration rates

Avoidance of prenatal care due to concerns about revealing SUD / consequences

Fears of arrest / prosecution, social services involvement, loss of custody



## Perinatal Substance Use: Mortality

Based on data from 2017-2019 collected by Maternal Mortality Review Committees (MMRCs), the leading underlying causes of pregnancy-related death include:

- Mental health conditions: 23%
  - This includes deaths by suicide as well as deaths via overdose or poisoning related to substance use
- Excessive bleeding / hemorrhage: 14%
- Cardiac/coronary conditions: 13%
- Infection: 9%

Also, according to a National Institute on Drug Abuse (NIDA) study, deaths by drug overdose rose markedly between January-June 2018 and July-December 2021 among 10 to 44-year-old girls and women who were pregnant or pregnant with the prior 12 months

- Death by overdose more than tripled among women aged 35-44 during the study period:
  - 4.9 deaths per 100,000 mothers aged 35-44 with a live birth in the 2018 period
  - 15.8 deaths per 100,000 mothers aged 35-44 with a live birth in the 2021 period

Four in 5 pregnancy-related deaths in the U.S. are preventable. September 19, 2022: <https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html>

Overdose deaths increased in pregnant and postpartum women from early 2018 to late 2021: [https://www.nih.gov/news-events/news-releases/overdose-deaths-increased-pregnant-postpartum-women-early-2018-late-](https://www.nih.gov/news-events/news-releases/overdose-deaths-increased-pregnant-postpartum-women-early-2018-late-2021#:~:text=Drug%20overdose%20deaths%20rose%20markedly,the%20National%20Institutes%20of%20Health)

[2021#:~:text=Drug%20overdose%20deaths%20rose%20markedly,the%20National%20Institutes%20of%20Health](https://www.nih.gov/news-events/news-releases/overdose-deaths-increased-pregnant-postpartum-women-early-2018-late-2021#:~:text=Drug%20overdose%20deaths%20rose%20markedly,the%20National%20Institutes%20of%20Health)



## Perinatal Substance Use: Mortality

Females who died from a drug overdose during pregnancy, compared to those who died from obstetric causes, were more likely to be:

- 10 to 34-years-old (75.4% versus 59.5%)
- Non-college graduates (72.1% versus 59.4%)
- Unmarried (88.0% versus 62.1%)
- In “non-home, non-healthcare settings” at the time of death (25.9% versus 4.5%)

Four in 5 pregnancy-related deaths in the U.S. are preventable. September 19, 2022: <https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html>

Overdose deaths increased in pregnant and postpartum women from early 2018 to late 2021: <https://www.nih.gov/news-events/news-releases/overdose-deaths-increased-pregnant-postpartum-women-early-2018-late-2021#:~:text=Drug%20overdose%20deaths%20rose%20markedly,the%20National%20Institutes%20of%20Health>



## Recommendations for SUD Screening

American College of Obstetricians & Gynecologists (ACOG) recommends early and universal screening for substance use as part of comprehensive prenatal care. If screening is only performed when a clinician suspects alcohol or drug use, many patients with SUD will be missed.

- Screening does NOT mean drug or alcohol testing.
- Except in life-threatening situations, maternal consent is needed before drug testing can be performed during pregnancy. (Exception: Mandated testing may be necessary for women in treatment programs or those involved in the legal system.)





## Recommendations for SUD Screening

3 free screening tools are:

- NIDA Quick Screen: [https://nida.nih.gov/sites/default/files/pdf/screening\\_qr.pdf](https://nida.nih.gov/sites/default/files/pdf/screening_qr.pdf)
- 4 P's (Parents, Partners, Past, Present): <https://oasas.ny.gov/system/files/documents/2019/09/4Ps.pdf>
- CRAFFT (for women under 27yo): [https://njaap.org/wp-content/uploads/2018/03/COMBINED-CRAFFT-2.1-Self-Admin\\_Clinician-Interview\\_Risk-Assess-Guide.pdf](https://njaap.org/wp-content/uploads/2018/03/COMBINED-CRAFFT-2.1-Self-Admin_Clinician-Interview_Risk-Assess-Guide.pdf)

Also, the T-ACE is specific for alcohol use screening in pregnancy:

[https://www.mirecc.va.gov/visn22/t-ace\\_alcohol\\_screen.pdf](https://www.mirecc.va.gov/visn22/t-ace_alcohol_screen.pdf)



## Approach to Treating SUD in Pregnancy

- Comprehensive prenatal care
- Counseling, education, encouragement to reduce/stop use
  - Motivational interviewing
  - Peer support
- Referral to mental health & substance use providers



# Nicotine Use During Pregnancy

Increases risk of:

- Stillbirth & sudden unexplained infant death
- Fetal growth restriction
- Low birth weight
- Premature birth

May be linked to ADHD developing in child, but no studies to date to establish causation

Behavioral counseling is preferred treatment approach

- Varenicline & Bupropion: lack of safety data for use during pregnancy
- Nicotine replacement: lack of safety data, plus has not been shown to lead to long-term smoking cessation



## Alcohol Use During Pregnancy

Alcohol is a known teratogen, and any amount of alcohol is considered unsafe during pregnancy

Fetal Alcohol Syndrome (FAS) is the leading cause of preventable intellectual disability in the U.S.

Alcohol withdrawal is potentially life-threatening, with a risk of seizures and delirium tremens (DTs), in any patient population, and pregnant patients going through alcohol withdrawal should receive inpatient detoxification management



## Cocaine Use During Pregnancy

Associated with maternal hypertension, placental abruption, & premature birth

In the baby, cocaine use is associated with:

- Low birth weight
- Small for gestational age (SGA)
- Growth deceleration



## Amphetamine Use During Pregnancy

Associated with increased morbidity and mortality in mothers and babies, including:

- Maternal hypertension / preeclampsia
- Placental abruption
- Fetal & neonate death



## Opioid Use During Pregnancy

Can lead to **Neonatal Opioid Withdrawal Syndrome (NOWS)**, previously known as Neonatal Abstinence Syndrome (NAS)

Effects on newborn's nervous, respiratory, & GI systems:

- Irritability
- Poor feeding
- Unstable body temperature
- Poor sleep

Also increases risks of being small for gestational age & low birthweight



## Opioid Use During Pregnancy: Statistics

**From the CDC:** based on 2019 self-reported data, about 7% of women reported using prescription opioid pain medications during pregnancy.

Of these, 1 in 5 reported misuse of those prescriptions:

- Obtaining them from a non-healthcare source
- Using them for reasons other than to relieve pain

From 2010 to 2017, the number of women with opioid-related diagnoses documented at delivery increased by 131%

Based on 2020 data from the Healthcare Cost and Utilization Project (HCUP), about 6 newborns were diagnosed with NAS (NOWS) for every 1,000 newborn hospital stays.

This translates to 1 baby diagnosed with NOWS every 24 minutes in the U.S.

Or: more than 59 newborns diagnosed every day

From 2010 to 2017, the number of babies in the U.S. with NOWS increased by 82%

Increases were seen for almost all states and demographic groups





## Management of Opioid Use During Pregnancy

Medication-assisted treatment (MAT) with Methadone or Buprenorphine is considered the standard of care

- Higher risk of relapse during pregnancy in women who choose to go through opiate withdrawal management versus those who opt for MAT
- MAT can decrease the severity of NOWS in the newborn
  - Some studies have shown that newborns exposed to Buprenorphine fare better than those exposed to Methadone
    - Require less medication
    - Shorter hospitalizations
    - Slightly higher birthweights
- MAT is associated with low risk of congenital malformations
- MAT has shown no/minimal long-term negative neurodevelopmental effects in the babies exposed to prenatal MAT



# Management of Opioid Use During Pregnancy

Study published in January 2024 in *JAMA Internal Medicine* compared risk of congenital malformations in babies exposed to in utero buprenorphine versus methadone.

- Population-based cohort study
- Based on health care utilization data from Medicaid beneficiaries in the U.S. from 2000 to 2018

A total of 13,360 pregnancies:

9514 pregnancies with 1<sup>st</sup> trimester buprenorphine exposure

3846 pregnancies with 1<sup>st</sup> trimester methadone exposure

Risk of overall malformations was 50.9 per 1000 pregnancies for buprenorphine & 60.6 per 1000 pregnancies for methadone

- After adjusting for confounding factors, buprenorphine was associated with a lower risk of malformations compared to methadone, with RR 0.82



## Management of Opioid Use During Pregnancy

Buprenorphine was associated with lower risk of:

- Cardiac malformations (RR, 0.63; 95% CI, 0.47-0.85)
- Oral clefts (RR, 0.65; 95% CI, 0.35-1.19)
- Clubfoot (RR, 0.55; 95% CI, 0.32-0.94)

Could not assess fully for risks of neural tube defects due to low event counts.

With secondary analyses, buprenorphine, compared with methadone, was associated with:

- Decreased risk of central nervous system, urinary, and limb malformations
- Greater risk of gastrointestinal malformations

**For malformations overall, there was an 18% relative risk reduction with buprenorphine versus methadone—or 1 less event per 100 patients**



## Management of NOWS in Infants Exposed to Opioids In Utero

Traditionally (for the past 50 years), the Finnegan Neonatal Abstinence Scoring Tool (FNAST) has been used to assess and manage infants who have been exposed to opioids in utero and are at risk of NOWS

However, a more recent study on the hospital outcomes of a large and geographically diverse group of infants exposed to opioids has looked at the use of the “Eat, Sleep, Console” (ESC) approach, which focuses on non-pharmacological approaches to infant care:

- Low-stimulation environment
- Swaddling
- Skin-to-skin contact
- Breastfeeding
- Parental involvement in the assessment & care of the babies



[“Eat, Sleep, Console” reduces hospital stay and need for medication among opioid-exposed infants | National Institutes of Health \(NIH\)](#)

# Management of NOWS in Infants Exposed to Opioids In Utero

ESC assessments are based on the ability of the baby to eat, to sleep, and to be consoled

Study findings included that newborns cared for with the ESC approach, compared to those cared for with FNAST:

- Were medically stable for discharge 6.7 days earlier (8.2 versus 14.9 days)
- Were 63% less likely to receive medication as part of their treatment (19.5% versus 52% received medication)
  - Concerns have been raised that the FNAST approach overestimates the need for opioid medication

Safety outcomes at 3 months were similar between the 2 groups

["Eat, Sleep, Console" reduces hospital stay and need for medication among opioid-exposed infants | National Institutes of Health \(NIH\)](#)



## Outcomes of Perinatal Substance Use Treatment

With an integrated treatment approach, behavioral counseling, psychosocial support, and MAT when applicable, women can maintain sobriety until delivery.

However, the risk of postpartum relapse is high, especially for tobacco, marijuana, and alcohol—possibly as high as 80% in the 1<sup>st</sup> postpartum year

Consider additional risk-factors/triggers:

- Hormonal changes
- Sleep deprivation
- Caring for a new baby

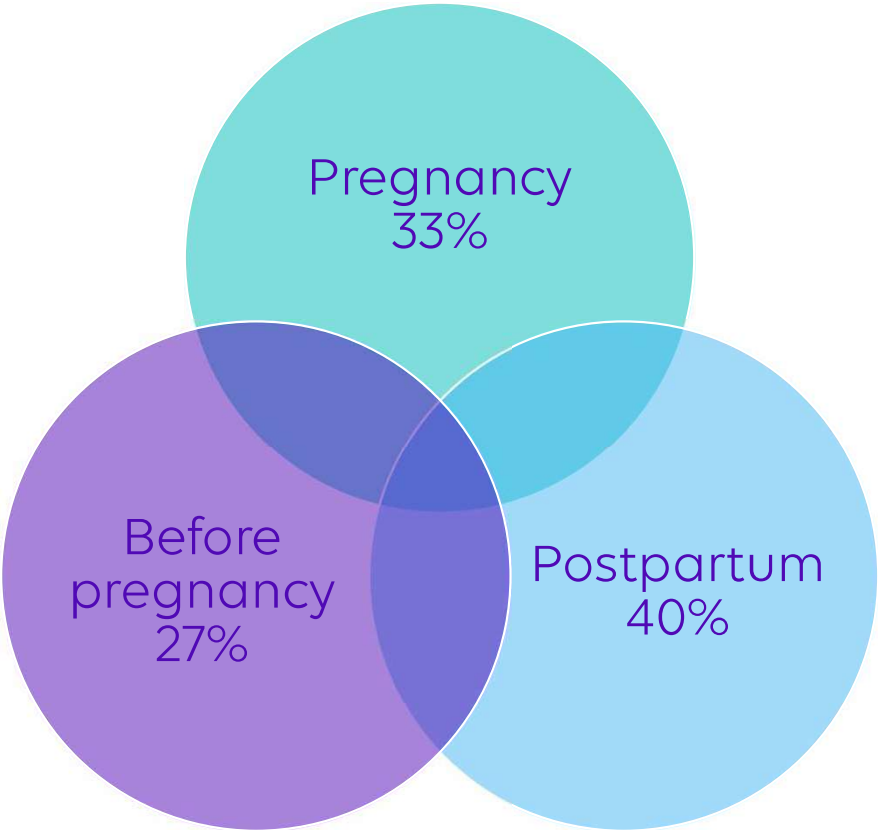
The risk of unintentional overdoses also exists, and so it is imperative that women continue to receive monitoring and support during the postpartum period



# Maternal Mental Health: Solutions



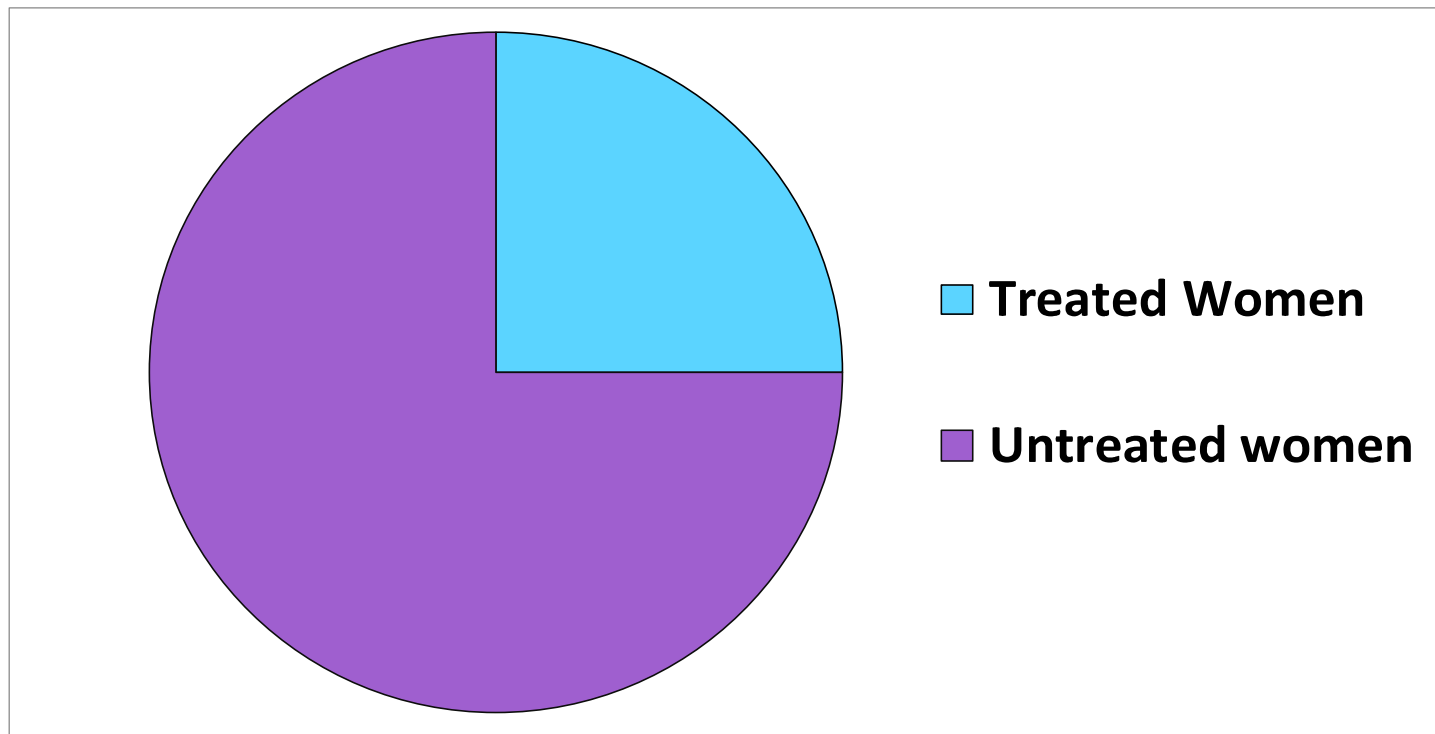
# Expand our Focus Beyond Postpartum Depression





## Expand our Focus Beyond Postpartum Depression

- The vast majority of perinatal depression is unrecognized and untreated



## Addressing Guilt and Shame

- One of the barriers to maternal mental health care is addressing the guilt and shame that many women feel when they start to experience these symptoms
- Reasons they may not want to share their symptoms:
  - Expectations that birth/pregnancy is supposed to be a joyous time
  - Fears that they won't be considered a "good mother"
  - Fears that they will appear "crazy" (especially in cases of OCD)
  - Lack of recognition of symptoms (mostly in cases of psychosis)
  - Belief that no other mothers feel the way they are feeling
- Therefore: need to screen, to educate, to provide reassurance, to offer support and resources (including peer support / support groups)



## The Universal Message

You are not  
alone

You are not to  
blame

With the right  
help, you will  
get better



## Screening

- Studies have indicated that only 1 in 4 providers report using validated tools when assessing postpartum women for mental health conditions
- Screening is the first step toward accurate diagnosis and treatment

Howard, S., Witt, C., Martin, K. et al. Co-occurrence of depression, anxiety, and perinatal posttraumatic stress in postpartum persons. *BMC Pregnancy Childbirth* 23, 232 (2023). <https://doi.org/10.1186/s12884-023-05555-z>



## Screening Tools

- Universal screening recommended for the presence of prenatal or postpartum mood and anxiety disorders, using evidence-based tools
  - Edinburgh Postnatal Depression Screen (EPDS) – addresses anxiety, depressive and suicidal symptoms (<https://psychology-tools.com/test/epds>)
  - Patient Health Questionnaire (PHQ-9) (<https://www.phqscreeners.com/>)
  - Generalized Anxiety Disorder 7-item (GAD-7) (<https://www.hiv.uw.edu/page/mental-health-screening/gad-7>)
  - Post-traumatic Stress Disorder Checklist (PCL-5) (<http://traumadissociation.com/pcl5-ptsd>)
  - Obsessive-Compulsive Inventory-Revised (OCI-R) (<https://psychology-tools.com/test/obsessive-compulsive-inventory-revised>)

<http://www.postpartum.net/professionals/screening/>



## Screening

- Screen for anxiety and depression multiple times through pregnancy and during baby's pediatric visits
  - First prenatal visit
  - At least once in second trimester
  - At least once in third trimester
  - Six-week postpartum obstetrical visit (or at least first postpartum visit)
  - Repeated screenings at 6 and/or 12 months in OB and primary care settings
  - 3, 9, and 12 month pediatric visits
- Train providers in recognizing and treating MMH Disorders
- **Create mechanism of reproductive psychiatry support for perinatal care providers**



# MMH Treatment

- **Counseling/Talk Therapy**

- Cognitive behavioral therapy (CBT), which helps people recognize and change their negative thoughts and behaviors
- Interpersonal therapy (IPT), which helps people understand and work through problematic personal relationships.
- Exposure and Response Prevention therapy (ERP), which specifically addresses obsessions and compulsions of OCD

- **Medication**

- Conventional antidepressant medications have shown efficacy
- Specific SSRIs used as first-line agents
- A woman should talk to her health care provider about the risks and benefits to both herself and her baby

- **These treatment methods can be used alone or together.**

<https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml>

<https://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/>



## Psychotropic Medications During Pregnancy

- Data suggest some medications may be used safely during pregnancy; however, knowledge regarding risks of prenatal exposure to psychotropic medications is incomplete
- Understanding of the risks associated with fetal exposure to a particular medication while taking into consideration the risks related to untreated psychiatric illness in the mother
- A woman should speak to her health care provider about her options for psychotropic medications. Best approach is coordination between OB-GYN and a psychiatrist.
- Need to account for fact that antidepressants take 4-6 weeks to take effect

<https://womensmentalhealth.org/specialty-clinics/psychiatric-disorders-during-pregnancy/>





## Psychotropic Medications During Pregnancy

- Antidepressants: SSRI's such as Prozac, Zoloft, or Lexapro (except Paxil) and tricyclic antidepressants (TCA's) generally safe. SSRI use later in pregnancy may lead to transient infant withdrawal symptoms after birth although these seem to be benign and short-lived (resolve within 1 to 4 days after birth)
- Anti-anxiety: Use of benzodiazepines discouraged due to possible association with oral cleft development, neonatal toxicity, and withdrawal symptoms
- Most mood stabilizers have some sort of risk associated: Lithium – congenital cardiac malformation, Depakote – neural tube defects; craniofacial, limb, and cardiovascular issues
- Typical antipsychotics: Poses minimal risk of teratogenicity, specifically Haldol. Seroquel and Zyprexa also often used during pregnancy.



## Psychotropic Medications and Lactation

- Antidepressants: Zoloft has been considered 1<sup>st</sup>-line antidepressant if mother is breastfeeding
  - Low levels of Zoloft detected in breastmilk, plus very low number of adverse effects reported
  - However, if mother has been taking Prozac or Lexapro during pregnancy, recommend continuation of agent that has been helpful for her
- If mother has symptoms that are exacerbated in the postpartum period and needs to start an agent that is considered contraindicated with breastfeeding, need to weigh risks versus benefits in terms of mother's mental health and benefits of breastfeeding for the infant
- With any medication during breastfeeding: goal is to maintain stability with minimally effective dose

Pinheiro E, Bogen DL, Hoxha D, Ciolino JD, Wisner KL. Sertraline and breastfeeding: review and meta-analysis. *Arch Womens Ment Health*. 2015 Apr;18(2):139-146.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4366287/>



# Medications Specific for Postpartum Depression

## Zulresso (Brexanolone):

- Approved for the treatment of postpartum depression in women 15yo & older
- Is a neuroactive steroid that acts on the GABA-receptor
  - No clear effects on serotonin
- Is administered via continuous IV infusion over 60 hours (2.5 days)
  - Patient needs to be hospitalized for treatment
- Risks include extreme sedation, sudden loss of consciousness, and hypoxia
  - REMS program
  - Under constant supervision with continuous pulse oximetry monitoring and assessment for sedation every 2 hours
- Benefits include:
  - Rapid reduction in depressive symptoms, based on HAM-D that was used in clinical trials
  - Depressive symptoms did not return to baseline when followed up at Day 30



## Medications Specific for Postpartum Depression

### Zurzuvae (Zuranolone):

- Recently approved (8/4/23) by FDA for Postpartum Depression
- Oral medication, taken once/day x14 days (in the evening, with a fatty meal)
- Synthetic neurosteroid – supplements drop in progesterone & allopregnanolone that occurs after giving birth
- Benefits seen as early as 2 days with median response rate of 9 days
- Benefits last 45 days
  - Expectation: take along with SSRI, so effects of traditional antidepressant will take effect at the point at which Zurzuvae's effects are wearing off

<https://www.uclahealth.org/news/new-pill-treat-postpartum-depression-could-be-game-changer>



# Medications Specific for Postpartum Depression

## Zurzuva (Zuranolone), continued:

- Main side-effects = dizziness, sedation
- Effects in terms of breastmilk not yet known
- Was NOT studied during pregnancy
- Hope is that it will enhance adherence, due to its fast onset or effects
- Same approach/mechanism as Zulresso, but much more accessible in terms of convenience, cost, time
- However, the price is still \$15,900 for a 14-day course of treatment

<https://www.uclahealth.org/news/new-pill-treat-postpartum-depression-could-be-game-changer>

<https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2023/08/zuranolone-for-the-treatment-of-postpartum-depression>



## Risk versus Benefit Analysis for Treatment of MMH Disorders

Consider that babies born to women with untreated depression are at risk of:

- Premature birth
- Low birth weight
- Intrauterine growth restriction
- Childhood development challenges
  - Impulsivity
  - Poor social interactions
  - Cognitive, behavioral, and emotional difficulties

Chan J, Natekar A, Einarson A, Koren G. Risks of untreated depression in pregnancy. *Can Fam Physician*. 2014 Mar;60(3):242-3. PMID: 24627378; PMCID: PMC3952758.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3952758/>



## Risk versus Benefit Analysis for Treatment of MMH Disorders

Consider that mothers with untreated depression are at higher risk of:

- Suicidality
- Hospital admissions
- Pregnancy complications (ex: preeclampsia)
- High-risk behaviors
  - Smoking
  - Substance & alcohol use
  - Poor nutrition

After delivery, maternal depression may also have ill effects on family relationships, negatively impacting bonding with the newborn

Chan J, Natekar A, Einarson A, Koren G. Risks of untreated depression in pregnancy. *Can Fam Physician*. 2014 Mar;60(3):242-3. PMID: 24627378; PMCID: PMC3952758.  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3952758/>

Murray L, Cooper PJ, Wilson A, Romaniuk H. Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression: 2. Impact on the mother-child relationship and child outcome. *British Journal of Psychiatry*. 2003;182(5):420-427. doi:10.1192/bjp.182.5.420



# Treatment Delivery for Maternal Mental Health

- Integrated health care delivery between primary care, OB-GYN, and behavioral health
- Mental health screening during pregnancy and in postpartum period
- Telepsychiatry services to improve access to care
- Increased partner involvement in perinatal check-ups

Maria X. Sanmartin, Mir M. Ali, Jie Chen and Debra S. Dwyer. Mental Health Treatment and Unmet Mental Health Care Need Among Pregnant Women With Major Depressive Episode in the United States. *Psychiatric Services*: Volume 70, Issue 6 June 01, 2019. Pages 441-534. <https://ps.psychiatryonline.org/doi/epdf/10.1176/appi.ps.201800433>

Chauhan A, Potdar J (October 25, 2022) Maternal Mental Health During Pregnancy: A Critical Review. *Cureus* 14(10): e30656. doi:10.7759/cureus.30656





## Resources

Online registries for women who are pregnant and taking psychotropic medications

- ✓ Can obtain information regarding medications during pregnancy
- ✓ FDA has a list of links available from independent organizations (none of them are specifically endorsed by the FDA)
- ✓ MGH Center for Women's Mental Health appears to have the most comprehensive registry, as well as overall resources for patients and providers:

<https://womensmentalhealth.org/research/pregnancyregistry/>



## Resources

Perinatal OCD: <https://iocdf.org/perinatal-ocd/for-clinical-providers/>

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

- ✓ Offer HelpLine, certification opportunities for providers, educational materials, & other resources

Moms' Mental Health Matters: <https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms>

- ✓ Educational materials for patients and for providers



# Resources

## Books

- For patients
  - ✓ *This Isn't What I Expected: Overcoming Postpartum Depression* by Karen Kleiman
  - ✓ *The Mother-to-Mother Postpartum Depression Support Book: Real Stories From Women Who Lived Through It and Recovered* by Sandra Poulin
- For Providers
  - ✓ *Therapy and the Postpartum Women: Notes on Healing Postpartum Depression for Clinicians and the Women Who Seek Their Help* by Karen Kleiman



# Resources

## Podcasts:

- ✓ Mom and Mind (Dr. Kat-psychologist and specialist in perinatal mental health)
- ✓ Momwell (Erica Djossa-psychotherapist)
- ✓ Maternal Health 911 (Dr. Jill Baker-community health researcher and fertility coach)
  - Also looks at health disparities in black and brown mothers/babies



## Resources Related to Pregnancy Loss

- Postpartum Support International:  
<https://www.postpartum.net/get-help/loss-grief-in-pregnancy-postpartum/>
- March of Dimes:  
<https://www.marchofdimes.org/find-support/topics/miscarriage-loss-and-grief>
- The Mother Baby Care Center:  
<https://www.themotherbabycenter.org/blog/2022/09/perinatal-loss-what-you-need-to-know-and-how-you-can-get-help/>
- The American College of Obstetricians & Gynecologists:  
<https://www.acog.org/womens-health/experts-and-stories/the-latest/finding-emotional-support-after-pregnancy-loss>



# Carelon's Maternal Mental Health Supports



# Overview of Carelon MMH Services

## Screening & Outreach

Call Center:

- Provide screening via Standardized Screening Tools for member calls
- Refer members needing SMHS to the county
- Refer members with MMH concerns needing NSMHS to Carelon CM

Case Manager:

- Social Determinants of Health
- PHQ-9
- Edinburgh Postnatal Depression Scale

## Linkage

Case Managers will:

- Assist members with obtaining mental health services
- Follow-up with member to ensure connection with a provider and/or other resources
- Assist with resources for housing, food, county supports, transportation
- Provide comprehensive resources via email or mail, based off members' preference

## Education

Case Managers will provide education related to understanding:

- Maternal Mental Health program & coverage of Doulas
- The importance of attendance at perinatal follow-up appointments with OB/GYN and all pediatrician appointments for newborn infants
- Support available to moms with premature births and caring for infants in the Neonatal Intensive Care Unit (NICU)

## Collaboration

Case Managers will collaborate with:

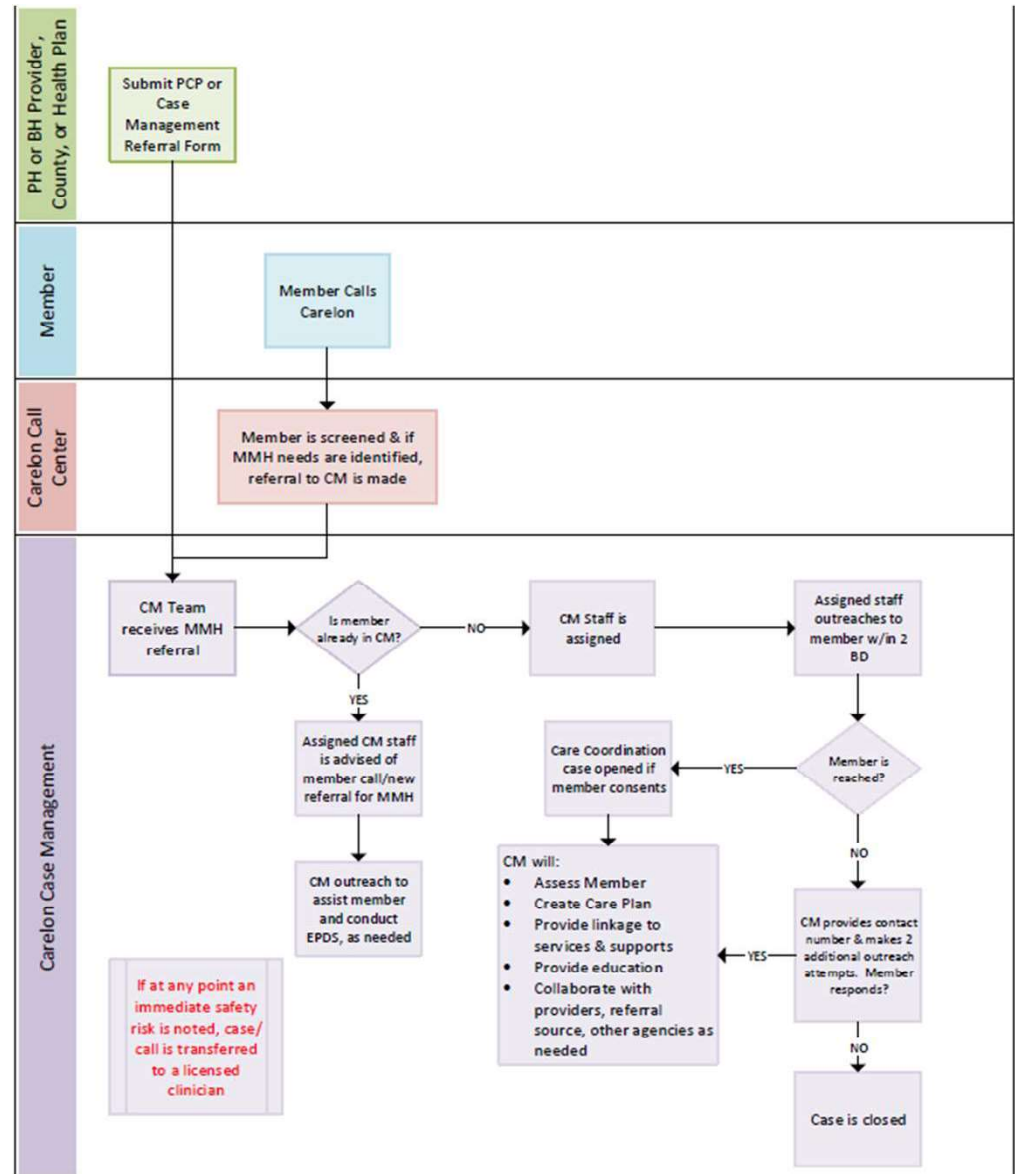
- Health Plan, Counties and/or Medical Case Managers
- Members' current practitioners (&/or coordinate care for the member and baby, as needed)
- Community providers to meet the members where they are, provide whole person care, support & resources
- Community & faith-based organizations to reach underserved communities



# Getting Members Connected to Care

## Referral to Carelon

- Physical Health, Behavioral Health, County, and Health Plan providers/staff can refer a member to Carelon via the PCP or CM Referral Forms. Submit to:
  - PCP Referral: email to [med-cal.referral@carelon.com](mailto:med-cal.referral@carelon.com)
  - CM Referral: see submission information on health plan specific form
- Members may call Carelon for self-identified behavioral or maternal mental health needs.
  - Members will be identified through Carelon Member Services and/or our call center
  - Staff will assist in providing appropriate network referrals and complete a referral to CM for care coordination service





# PCP/Provider and Case Management Referral Forms



Carelon Behavioral Health / [Click or tap here to enter text.](#)  
Behavioral Health Care Management Referral Form

Referral Date: \_\_\_\_\_ Member Name: \_\_\_\_\_ Medi-Cal CIN ID#: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
 Phone: \_\_\_\_\_ (home); \_\_\_\_\_ (parent/guardian's cell); \_\_\_\_\_ (member's cell)  
 Member address: \_\_\_\_\_  
 Member notified of this referral:  Yes  No Parent/guardian notified of this referral:  Yes  No  
 If the member is a minor 12 and older, who is requesting MH care management and services?  
 Member only (parent/guardian is unaware)  Parent/guardian only  Both member and parent/guardian  
 Does the minor 12 and older have capacity to give consent to services?  Yes  No If no, please explain \_\_\_\_\_  
 Best day/time to reach the member: \_\_\_\_\_ Best day and time to reach the parent/guardian: \_\_\_\_\_  
 PCP Clinic/Agency: \_\_\_\_\_ Name of PCP: \_\_\_\_\_ PCP Phone #: \_\_\_\_\_

**REFERRAL SOURCE:**

Health Plan  PCP  Behavioral Health Provider  Specialty Provider  Community Partner  Hospital  
 Referring Clinic/Agency/Location: \_\_\_\_\_ Referring Provider: \_\_\_\_\_  
 Email: \_\_\_\_\_ Contact Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_

**Referral for Care Management:** Local behavioral health care coordination services to link members to mental health providers, engage members with history of non-compliance and/or link them to community support services, and assist with coordination between multiple agencies

Requested Services:  Individual/Group Therapy  Family Therapy  Medication Management  Other: \_\_\_\_\_

**Referral Reason** (check all that apply):

<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Suicidal or Homicidal Ideation: If yes, Current <input type="checkbox"/> History <input type="checkbox"/>
<input type="checkbox"/> Poor self-care due to mental health	<input type="checkbox"/> Response Given on HRA: _____
<input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusional)	<input type="checkbox"/> Difficulties Maintaining Relationships
<input type="checkbox"/> PTSD/Trauma	<input type="checkbox"/> Gender Identity
<input type="checkbox"/> Violence/Aggressive Behavior	<input type="checkbox"/> Legal, Child or Elder Abuse
<input type="checkbox"/> Difficult/Unable to Complete ADLs	<input type="checkbox"/> Adverse Childhood Experiences (ACEs): Score _____
<input type="checkbox"/> Difficult/Unable to go to work/school	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Perinatal Depression and/or Anxiety	<input type="checkbox"/> Other: _____

Step-down from County SMHS: Yes  No

Substance Use: If yes, Current  History  Substance Use (type): \_\_\_\_\_

Mental health and medical diagnoses: \_\_\_\_\_

Medications (list below or send medication list with this form): \_\_\_\_\_

Additional Information: \_\_\_\_\_

**Member Motivation for Services:**

Member wants services for self (or dependent)  
 Member is unsure or ambivalent about services for self (or dependent)  
 Member does not want services or does not believe they are needed  
 Member has not been informed of this referral to Beacon



Carelon Behavioral Health, Inc.  
Primary Care Primary Care Provider (PCP) Referral Form

Referral Date: \_\_\_\_\_ Member Name: \_\_\_\_\_ Medi-Cal CIN ID#: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
 Phone: \_\_\_\_\_ (home); \_\_\_\_\_ (parent/guardian's cell); \_\_\_\_\_ (member's cell)  
 Member address: \_\_\_\_\_  
 Does the minor 12 and older have capacity to give consent to services?  Yes  No If no, please explain \_\_\_\_\_  
 Best day/time to reach the member: \_\_\_\_\_ Best day and time to reach the parent/guardian: \_\_\_\_\_  
 PCP Clinic/Agency: \_\_\_\_\_ Name of PCP: \_\_\_\_\_ PCP Phone #: \_\_\_\_\_  
 Please check to confirm member eligibility was verified

**PCP Request (one request per referral form)**

**PCP Decision Support:** obtain a mental health educational conversation with a Carelon Behavioral Health psychiatrist related to psychiatric diagnoses/medications. Contact the National Peer Advisor line. **Office Hours:** 6am-5pm PST Monday – Friday

**Please call phone number:** 877-241-5575

**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Carelon Behavioral Health's network of providers when their needs are outside the PCP scope of practice. Carelon Behavioral Health can coordinate member care with county mental health. *Fax: OR secure email:*

**Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) Services:** Specialty services for youth under 21 years old with established diagnosis of Autism Spectrum Disorder (ASD).

\*\*Include Progress Note with diagnosis of ASD and physician order requesting ABA services. *Fax:*

**Request Reason** (check all that apply):

**Symptoms:**

<input type="checkbox"/> Depression	<input type="checkbox"/> Perinatal depression/anxiety	<input type="checkbox"/> PTSD/Trauma
<input type="checkbox"/> Poor self-care due to mental health	<input type="checkbox"/> Violence/Aggressive behavior	<input type="checkbox"/> Abuse/CPS
<input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusional)	<input type="checkbox"/> Psychological testing	<input type="checkbox"/> Chronic Pain
<input type="checkbox"/> Adverse Childhood experiences (ACEs)	<input type="checkbox"/> Neuropsychological testing	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Substance use type: _____		
<input type="checkbox"/> Other BH symptoms: _____		

**Impairments:**

Difficult/Unable to complete ADLs  Difficulties maintaining relationships  Legal/CPS  
 Difficult/Unable to go to work/school  Other: \_\_\_\_\_  
 Medications (list below or send medication list with this form): \_\_\_\_\_

**Motivation for Services** (check all that apply)

Member (or guardian) has been informed for referral to Carelon Behavioral Health  
 Member wants services for self (or dependent)  
 Member is unsure or ambivalent about services for self (or dependent)  
 If applicable, Patient has completed a PHQ-2/PHQ-9, Score \_\_\_\_\_

*For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.*

# Resources & Contacts

## Additional Carelon Resources

- Interdisciplinary Rounds with medical case management teams to review complex cases, such as SUD during pregnancy, and ensure care is coordinated and integrated
- Case consultation and decision support from a Carelon licensed psychiatrist through our National Peer Advisor Line (877-241-5575)
- Provision of training to medical & behavioral health providers to increase awareness of maternal mental health issues, appropriate screening and referral

Carelon Contacts		Health Plan(s)
Mandy Kullar, Director BH Services	<a href="mailto:Mandeep.Kullar@carelon.com">Mandeep.Kullar@carelon.com</a>	CCAH, HPSJ, PHPC, SFHP
April Myers, Manager BH Services	<a href="mailto:April.Myers@carelon.com">April.Myers@carelon.com</a>	CCAH
Regina Kendall, Manager II BH Services	<a href="mailto:Regina.Kendall@carelon.com">Regina.Kendall@carelon.com</a>	PHPC
Doris Doss, Director BH Services	<a href="mailto:Doris.Doss@carelon.com">Doris.Doss@carelon.com</a>	LA Care, GCHP
Vacindra Benson, Manager II BH Services	<a href="mailto:Vasundhara.Benson@carelon.com">Vasundhara.Benson@carelon.com</a>	LA Care
Chantel Martinez, Manager II BH Services	<a href="mailto:Chantel.Martinez@carelon.com">Chantel.Martinez@carelon.com</a>	GCHP





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# Questions?

The information provided in this training is not intended as treatment advice. Individualized diagnosis and treatment plans can only be rendered by a treating provider.



# Thank you!

