Welcome to the Webinette!
January 10, 2017

Information on how to obtain your no-cost .5 NAADAC contact hour provided at conclusion of this live webinar.

operators for treatment
Family-Centered Behavioral Health Support for Pregnant & Postpartum Women

ATTC | Center of Excellence

www.attcppwtools.org
ATTC Center of Excellence on Behavioral Health for Pregnant and Postpartum Women and Their Families
www.attcppwtools.org

ATTC Regional Center Partners:
- Great Lakes ATTC
- Mid-America ATTC
- New England ATTC
- Southeast ATTC

Purpose:
The Center was established to develop a family-centered national curricula, web-based toolkit, and provide support for national training and resource dissemination.
• COD’s occur frequently & can impact mother & child

• There are multifactorial risk factors

• Repeat screening, appropriate referral, & coordinated treatment are key

• Safety profile of meds for mother & fetus must be considered along with appropriate therapy measures
SIGNIFICANCE
Co-occurring Disorders Defined

- Previously referred to as dual diagnosis
- SAMHSA: coexistence of both a mental health d/o and a SUD
How Many Affected?

Figure 46. Past Year Substance Use Disorder (SUD) and Mental Illness among Adults Aged 18 or Older: 2015

Impact

- Persons w/MH d/o’s more likely than those without to have SUD’s
- Co-occurrence complicates severity & treatment of each individual disorder
- One condition can exacerbate the other
Impact

- Symptoms often overlap

- Often only 1 of the 2 disorders are treated, sometimes neither

- Untreated/undertreated disorders → ↑homelessness, dysfunctional relationships, incarceration, mortality
Unique issues for women

• Unique risk: higher prevalence of anxiety, MDD in women

• Psych disorders & SUD during pregnancy → adverse outcomes for mothers & offspring

• PPW with psych d/o less likely to report good overall health
Unique issues for women (cont.).

- Most women with a current psych d/o did not receive any mental health care in the preceding 12 mo. regardless of pregnancy status

- Lifetime & past-yr. treatment rates for psych d/o significantly lower for past-year pregnant than non-pregnant women w/psych d/o
Common Co-Morbidities

- MDD
- Anxiety disorders
- PTSD
- Bipolar
- Eating disorders
### Prevalence of Psych Disorders

**Table 1. Estimated Prevalence of Selected Psychiatric Illness During Pregnancy**

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Illness</th>
<th>Estimated prevalence (%)</th>
<th>Ref.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive disorders</td>
<td>Major depression</td>
<td>13-20</td>
<td>[10, 87]</td>
</tr>
<tr>
<td></td>
<td>Bipolar disorder</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>General anxiety disorder</td>
<td>8.5</td>
<td>[25, 28]</td>
</tr>
<tr>
<td></td>
<td>Panic disorder</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-traumatic stress disorder</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obsessive-compulsive disorder</td>
<td>0.2-1.2</td>
<td></td>
</tr>
<tr>
<td>Eating disorders</td>
<td>Anorexia only</td>
<td>1.4</td>
<td>[43]</td>
</tr>
<tr>
<td></td>
<td>Bulimia only</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Both anorexia and bulimia</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Personality disorders</td>
<td></td>
<td>6.4</td>
<td></td>
</tr>
<tr>
<td>Psychotic disorders</td>
<td></td>
<td>Unknown</td>
<td>[35]</td>
</tr>
<tr>
<td>Condition</td>
<td>Fetal Effect</td>
<td>Maternal Effect</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>MDD</td>
<td>PTD, LBW, miscarriage</td>
<td>Bleeding during pregnancy, miscarriage, higher uterine artery resistance</td>
<td></td>
</tr>
<tr>
<td>Bipolar</td>
<td>More research needed, placental abnormalities</td>
<td>Antepartum hemorrhage, placental abnormalities, ↑ chance of risky behavior, higher SUD risk</td>
<td></td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>Polyhydramnios, premature L&amp; D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>PTD</td>
<td>Ectopic pregnancy, miscarriage, hyperemesis, higher SUD risk</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia/schizoaffective</td>
<td>PTD, LBW, placental abnormalities, cardiac defects</td>
<td>↓ rate of live births, ↑ rate of losing pregnancy, ↑ rates of gestational DM, SUD’s, seeking less medical care (psych &amp; prenatal)</td>
<td></td>
</tr>
<tr>
<td>Eating d/O</td>
<td>Miscarriage, PTD, LBW</td>
<td>Gestational DM, hyperemesis gravidum</td>
<td></td>
</tr>
</tbody>
</table>

PTD: preterm delivery; LBW: low birth weight; L&D: labor & delivery
UNDERSTANDING CO-MORBIDITY
Why the Co-Morbidity?

Self-Medicating:

• Depression leading to drinking to cope with mood

• Bipolar disorder leading to cocaine use to mimic pleasurable manic state, avoid “crash” into depression

• Schizophrenia leading to marijuana use to silence AH
Kindling

- Drugs sensitize neurons
- Leads to more frequent and intense drug use
- MH disorders similarly become more symptomatic, shorter periods between episodes
Genetics

- Families w/ SUD’s more likely to have members with mood d/o & vice versa

- Genes may cause brain to respond to initial drug exposures in ways that promote chronic use → drugs lead to changes causing MH disorders
Other Risk Factors

- Age
- Marital status
- Health status
- Stressful life events
- History of traumatic experiences
DIAGNOSIS & TREATMENT
How do I Identify

- Screen, screen, screen
  - during initial intake
  - again throughout the program
  - end of program

- Woman’s self ID
Screening Tools

General: SCL-90

Depression: Edinburgh Postnatal Depression Scale (postpartum) (EPDS)*, Postpartum Depression Screening Scale (PDSS), PHQ-9, BDI, HAM-D

Anxiety: GAD-7, BAI, HAM-A

Bipolar disorder: MDQ
**SBIRT**

**Screening:** assess for disorder

**Brief Intervention:** HCP engages person to understand & ↓ risks

**Referral to Treatment:** Refers if additional services are needed

*Source: Indiana SBIRT*
Brief Intervention

• Normalize MH treatment as part of the recovery process

• Destigmatize

• Engage woman as a partner in her recovery
Refer to Treatment

• Screening ≠ diagnosis

• Lack of disorder ≠ lack of symptoms

• Consider referral even if sx & no positive screen

• Engage psychiatry, therapist, ob/gyn, pediatrician
Treatment Goals

- Specialized, integrated care

- ↓ substance use in mother & exposure for child

- ↓ health risks (physical & mental) & sx for mother & child
Treatment Goals (cont.)

- Improving sleep habits
- Improving communication & parenting skills
- Improving nutritional & eating behaviors
- Working on family relationships
Treatment Approaches

• Provide support, linkage to care

• Incorporate non-pharmacologic tx: therapy

• Risk /benefit of medicine vs risk /benefit of untreated psych condition

• Support groups: double trouble

• Avoid punitive tone
MEDICINES
SSRI’s

Depression, anxiety, PTSD

Fluoxetine: heart & skull defects

Paroxetine: brain, skull, heart, abdomen

Distribution of specific SSRIs used among women whose baby did not have a birth defect

Source: Key Findings—A Closer Look at the Link Between Specific SSRIs and Birth Defects. https://www.cdc.gov/pregnancy/meds/treatingfortwo/features/ssrisandbirthdefects.html
Antipsychotics

Generally Avoided in PPW’s

- Benzodiazepines
- Valproic acid
- Lithium
- Carbamazepine
Table 1
Safety of Psychiatric Medications During Pregnancy and Lactation

<table>
<thead>
<tr>
<th>DRUG</th>
<th>FDA PREGNANCY CATEGORY*</th>
<th>AAP RATING</th>
<th>LACTATION RISK CATEGORY</th>
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</thead>
<tbody>
<tr>
<td>Benzodiazepines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alprazolam (Xanax)</td>
<td>D</td>
<td>Unknown, of concern</td>
<td>L3</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librium)</td>
<td>D</td>
<td>NA</td>
<td>L3</td>
</tr>
<tr>
<td>Clonazepam (Klonopin)</td>
<td>D</td>
<td>NA</td>
<td>L3</td>
</tr>
<tr>
<td>Clorazepate (Transax)</td>
<td>D</td>
<td>NA</td>
<td>L3</td>
</tr>
<tr>
<td>Diazepam (Valium)</td>
<td>D</td>
<td>Unknown, of concern</td>
<td>L3, L4 if used chronically</td>
</tr>
<tr>
<td>Estazolam (Procomilla)</td>
<td>X</td>
<td>NA</td>
<td>L3</td>
</tr>
<tr>
<td>Flurazepam (Dalmane)</td>
<td>X</td>
<td>NA</td>
<td>L3</td>
</tr>
</tbody>
</table>

http://www.aafp.org/afp/2008/0915/p772.html
References


