Welcome to the Webinette!

January 10, 2017

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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.

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Substance Abuse and Mental Health Services Administration
SAMHSA
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Pregnant &Post-Partum Women With Co-Occurring Disorders: Implications for Treatment Providers

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CoE PPW Webinette #7

January 10, 2017

toolsfortreatment | Family-Centered Behavioral Health Support for Pregnant & Postpartum Women

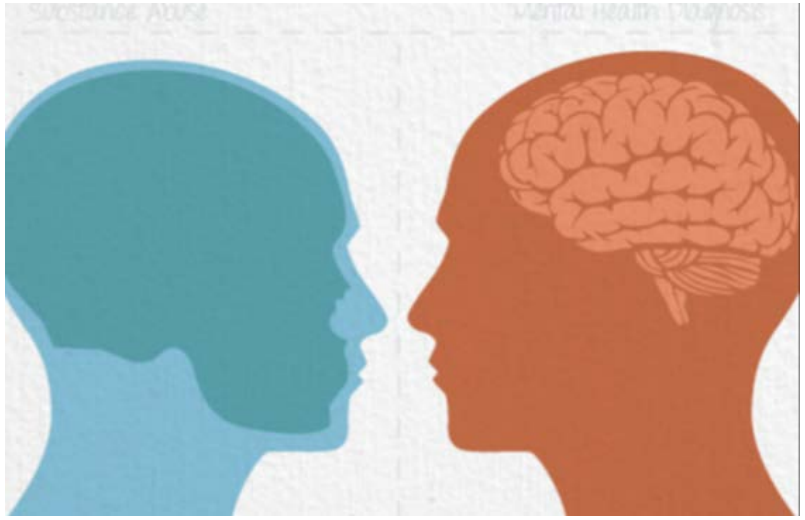
Webinette Overview

- 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

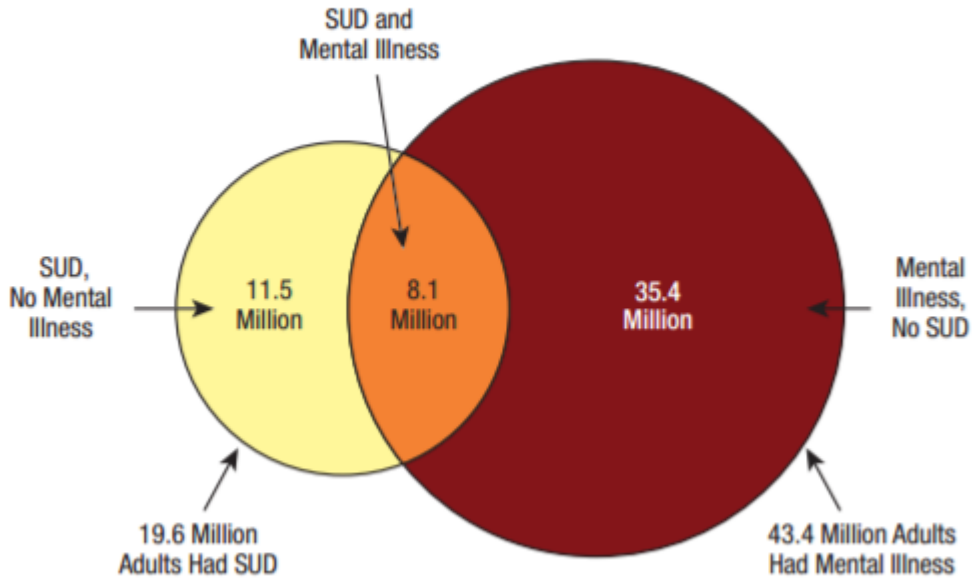
Co-occurring Disorders Defined

- 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



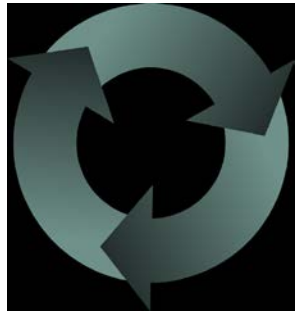
Reprinted from: Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/

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

Disorder	Illness	Estimated prevalence (%)	Ref.
Depressive disorders	Major depression	13-20	[10,87]
	Bipolar disorder	Unknown	
Anxiety disorders	General anxiety disorder	8.5	[25,28]
	Panic disorder	1-2	
	Post-traumatic stress disorder	3.5	
	Obsessive-compulsive disorder	0.2-1.2	
Eating disorders	Anorexia only	1.4	[43]
	Bulimia only	1.6	
	Both anorexia and bulimia	0.7	
Personality disorders		6.4	
Psychotic disorders		Unknown	[35]

Source: Gold, K.J., & Marcus, S. M. (2008). Effect of maternal mental illness on pregnant women's health care. Expert Review of Obstetrics & Gynecology, 3(3), 391-401.

Condition	Fetal Effect	Maternal Effect
MDD	PTD, LBW, miscarriage	Bleeding during pregnancy, miscarriage, higher uterine artery resistance
Bipolar	More research needed, placental abnormalities	Antepartum hemorrhage, placental abnormalities,↑ chance of risky behavior, higher SUD risk
Panic Disorder	Polyhydramnios, premature L& D	
PTSD	PTD	Ectopic pregnancy, miscarriage, hyperemesis, higher SUD risk
Schizophrenia/ schizoaffective	PTD, LBW, placental abnormalities, cardiac defects	↓rate of live births, ↑ rate of losing pregnancy, ↑ rates of gestational DM, SUD's, seeking less medical care (psych & prenatal)
Eating d/O	Miscarriage, PTD, LBW	Gestational DM, hyperemesis gravidum

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

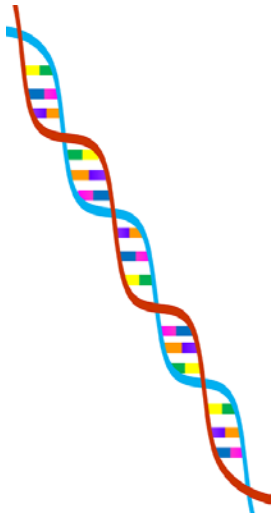
Why the Co-Morbidity? (cont.)

Kindling

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

Why the Co-Morbidity? (cont.)

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 **T**reatment: 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

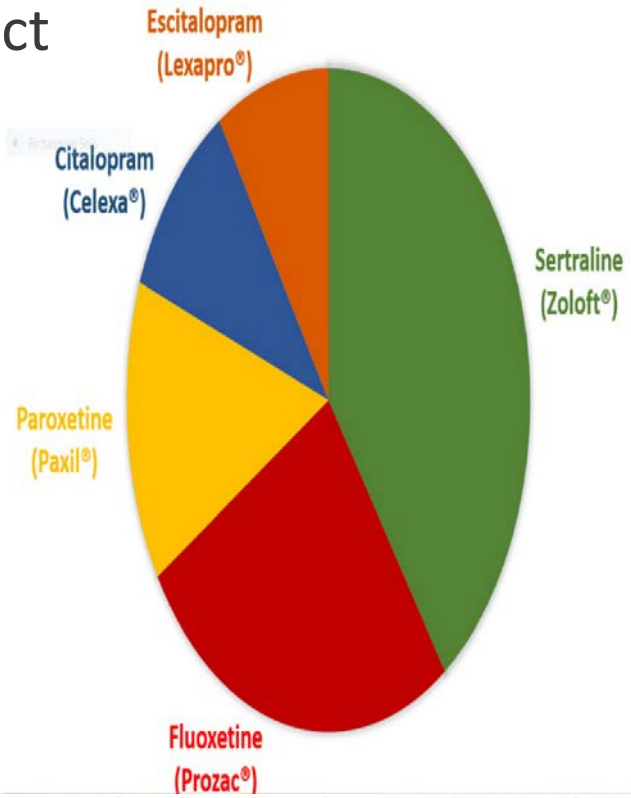
SSRI's

Depression, anxiety, PTSD

Fluoxetine: heart & skull defects

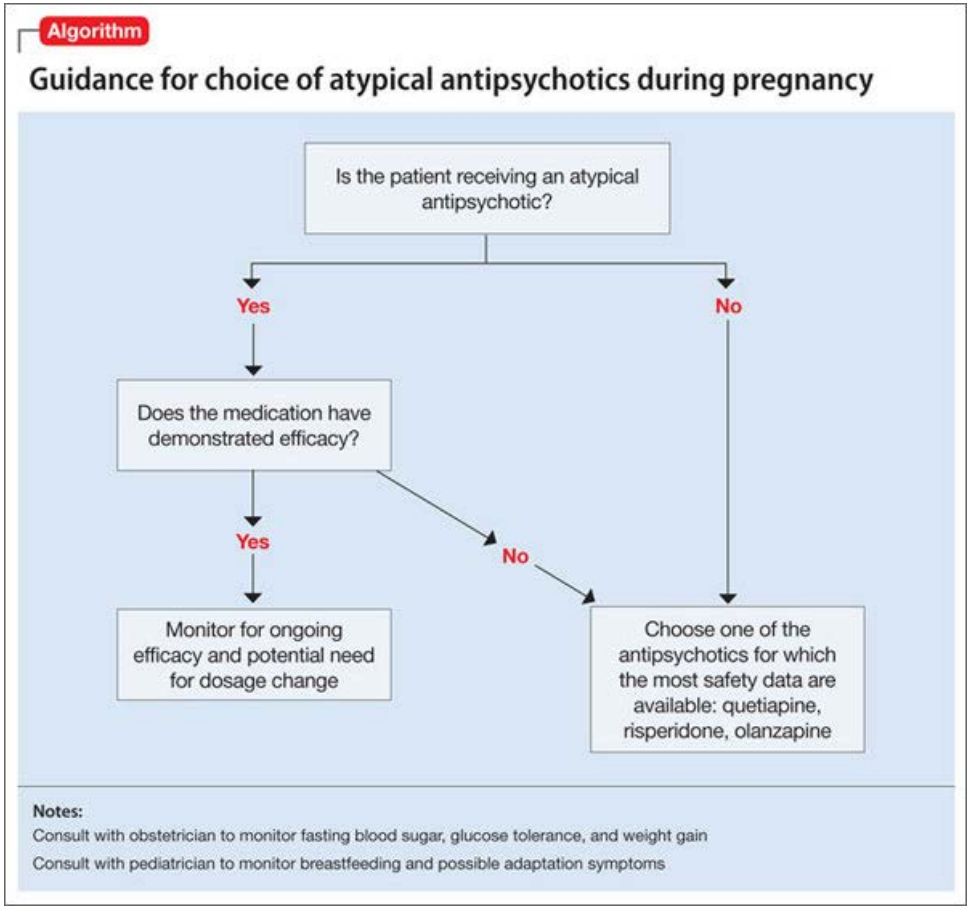
Paroxetine: brain, skull, heart, abdomen

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



Source:Robakis, T, Williams K. Atypical Antipsychotics during Pregnancy (2013). Current Psychiatry. 12(7), 12-18

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Generally Avoided in PPW's

- Benzodiazepines
- Valproic acid
- Lithium
- Carbamazepine

Resource

Practice Guidelines: ACOG Guidelines on Psychiatric Medication Use During Pregnancy and Lactation - American Family Physician

View/Print Table

Table 1

Safety of Psychiatric Medications During Pregnancy and Lactation

DRUG	FDA PREGNANCY CATEGORY*	AAP RATING	LACTATION RISK CATEGORY†
Anxiolytics and hypnotics			
Benzodiazepines			
Alprazolam (Xanax)	D	Unknown, of concern	L3
Chlordiazepoxide (Librium)	D	NA	L3
Clonazepam (Klonopin)	D	NA	L3
Clorazepate (Tranxene)	D	NA	L3
Diazepam (Valium)	D	Unknown, of concern	L3; L4 if used chronically
Estazolam (Prosom)‡	X	NA	L3
Flurazepam (Dalmane)	X	NA	L3

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

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