PERINATAL OUD AND CO-OCCURRING DISORDERS

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I HAVE NO DISCLOUSURES

PERINATAL SUD IS COMPLICATED!

- In general population:
  - Cigarette smoking decreases from 23% pre-pregnancy to 15% during pregnancy
  - Alcohol declines from 55% pre-pregnancy to 10% during pregnancy
- Among women with OUD however change is more complicated (Terplan, 2015)
  - High drop-out rates
  - Need for intensive psychosocial support
  - Late entrance into prenatal care and lower rates of prenatal care follow-up
  - High rates of polysubstance use

CO-OCCURRING SUD

- Alcohol
- Cannabis
- Stimulants – methamphetamine and cocaine
- Benzodiazepines
- Tobacco
- All need to be assessed and addressed along with the OUD
- Remember multiple substance use disorders are the rule not exception

PSYCHIATRIC COMORBIDITIES

- Range of rates of pregnant women with OUD and a psychiatric co-morbidity was broad 21%-72%
- Mood Disorders were most commonly reported with rangers of 28—58% of samples
  - Mostly Depressive Disorders
  - Bipolar was reported as 6% in one study
  - Hypomanic Episodes 30% in one study
- Anxiety Disorders next most common with rages from 40—42% of samples
- PTSD diagnosis ranged from 3%-26%
  - These women more likely to have a second Axis I (50% vs. 27%)
- Personality disorders
  - 23% in one study (Moylan)
  - Much more studies are needed
- Treatment of OUD/SUD can actually increase symptoms of underlying psychiatric illnesses

“When this picture was taken I was suffering through severe postpartum depression. You can’t tell by looking, but just hours before this picture was taken, I tried to kill myself. I had been sobbing for two weeks. An hour after this picture was taken, I got up on stage and performed for a church talent show like everything was fine.” ~ Adrienne Feldmann

http://www.postpartumprogress.com/cant-tell-mom-postpartum-depression-looking

SCREENING TOOLS IN TREATMENT

- Using screening tools, for example PHQ-9, in a repeated fashion in treatment can be an effective way to track progression of symptoms
- Research from Cara Lewis, PhD (Formerly of IU Bloomington)
- Showed significant correlation between use of measurements of symptoms and improvement of the symptoms
- Urine drug screens are used in this way in addiction treatment
- Carbon Monoxide monitoring as well for tobacco smoking cesation
- Tools to track life changes such as employment, decrease in involvement with criminal justice, custody of children

https://www.kpwashingtonresearch.org/our-research/our-scientists/lewis-cara-c/

Baby Blues

- Mood lability
- High emotionality

Depression

- Guilt, feeling worthless
- Suicidal thoughts
- Impacts functioning

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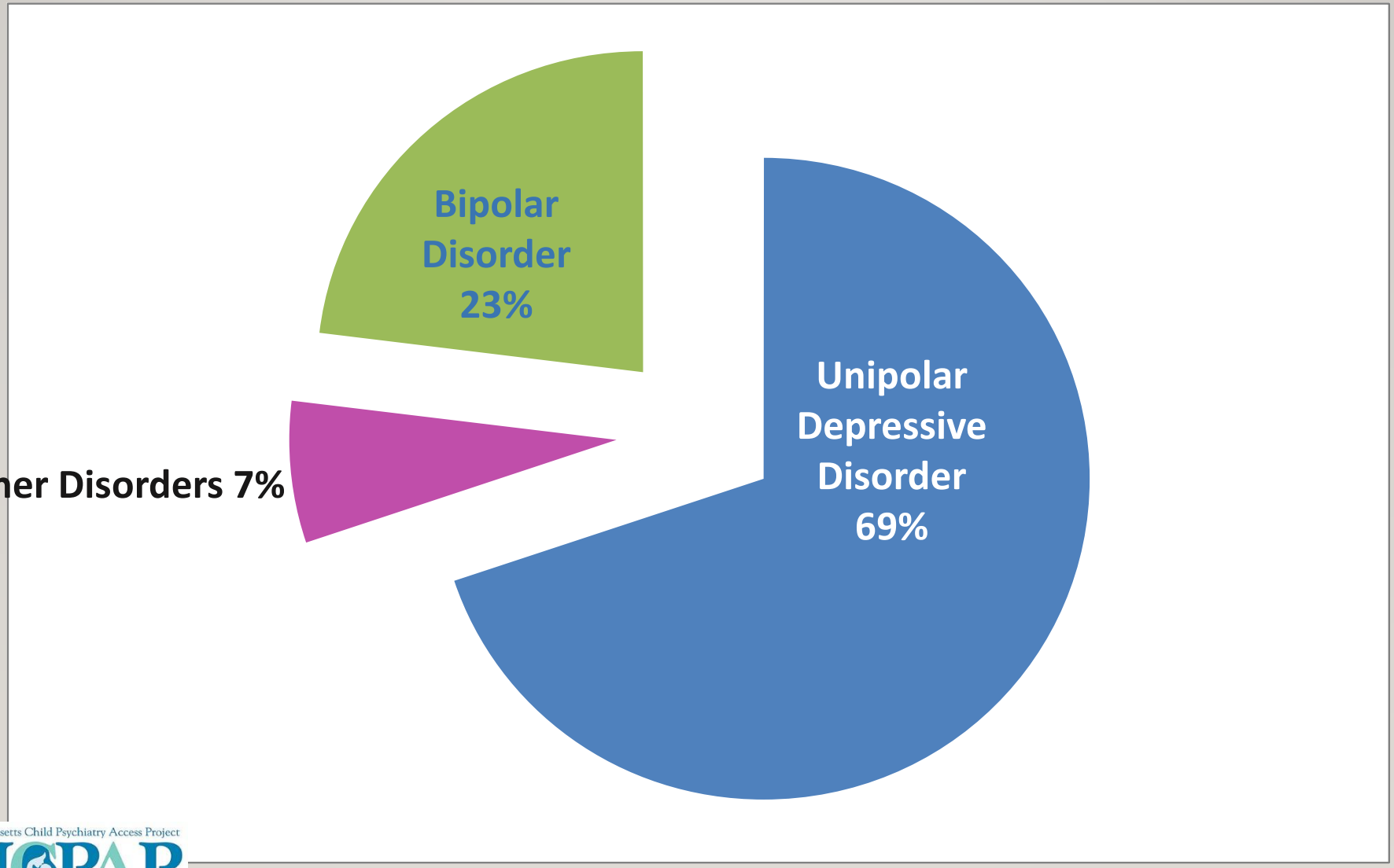
Imperative to address bipolar disorder



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Wisner et al. *JAMA Psychiatry*. 2013

Bipolar disorder increases risk of postpartum psychosis

1-2/1000 women

>70% bipolar disorder

24 hrs – 3 weeks postpartum

Mood symptoms, psychotic symptoms & disorientation

R/o medical causes of delirium

Psychiatric emergency

4% risk of infanticide with postpartum psychosis

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Bipolar Disorder Screen

This algorithm can be used when treatment with antidepressants is indicated, in conjunction with the **Depression Screening Algorithm for Obstetric Providers.**

In this algorithm, the provider *speaks the italicized text* and summarizes other text.

Screen for bipolar disorder[1]

1. *Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period liked this lasting several days or longer?*
2. *Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?*

If yes to questions 1 and/or 2

Continue screen for bipolar disorder[1]

3. *People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in ways they would normally think are inappropriate. Did you ever have any of these changes during your episodes of being (excited and full of energy/very irritable or grouchy)?*

If yes to question 3

The screen suggests the patient may have bipolar

If you have questions or need telephone consultation with a psychiatrist call MCPAP for Moms: 855-Mom-MCPAP (855-666-6272)

If no to question 3

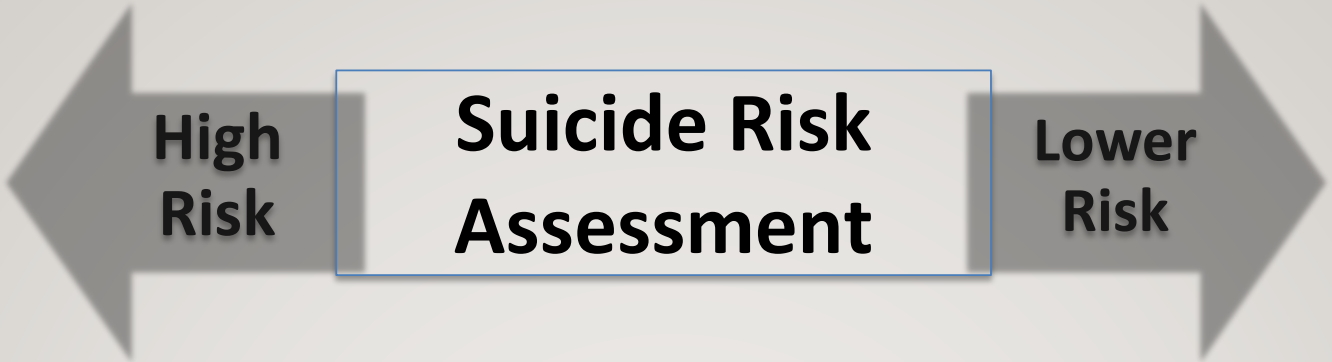
Refer to the **Recommended Steps before Beginning Antidepressant Medication Algorithm**

If no to both questions 1 & 2

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT 855-666-6272

[1]Taken from the Composite International Diagnostic Interview-Based Bipolar Disorder Screening Scale (Kessler, Akiskal, Angst et al., 2005)

Psychosis	*Intrusive thoughts*
Pt is convinced the belief is true	Pt knows the thought is not true
Pt is bothered by other people's response to the belief	Pt is bothered by the belief
Pt may feel compelled to act on thoughts	Pt does everything to avoid acting on thoughts



History of suicide attempt	No prior attempts
High lethality of prior attempts	If prior attempts, low lethality & high rescue potential
Recent attempt	
Current plan	No plan
Current intent	No intent
Substance use	No substance use
Lack of protective factors (including social support)	Protective factors

THERAPY

- Harm Reduction Focused
- Motivational Enhancement Therapy
- Trauma Informed crucial
- Psychodynamic Psychotherapy
- Behavioral Therapies (CBT manuals for cocaine, opioids, benzo's)
- Group and individual can both be helpful
- Research supports the treatment of women in women only settings
- Individualized care that takes into consideration diagnosis and setting
- In our review article, Dr. Andraka-Christou and I found that adherence to treatment was linked to treatments being appropriately geared toward the population

There is no such thing as no exposure

Need to balance and discuss the risks and benefits of medication treatment and risks of untreated depression

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Mild depression

No suicidal ideation

Able to care for self/baby

Engaged in psychotherapy

Depression has improved with psychotherapy in the past

Strong preference and access to psychotherapy

Moderate/severe depression

Suicidal ideation

Difficulty functioning caring for self/baby

History of severe depression and/or suicide ideation/attempts

Intrusive thoughts

Comorbid anxiety

ANTI-DEPRESSANT MEDICATIONS

- SSRI most commonly prescribed psychiatric med during pregnancy
- Much concern in recent years about safety
- Hundreds of articles published
- Definitive answers on whether they increase risk for different outcomes remain illusive
- Confounders particularly of depression itself have been difficult to control for
  - High quality studies have tried to address this
  - Measures used for diagnosing depression in the studies are variable
  - Rate of smoking and alcohol use are higher in women with mental illness, but many studies do not properly control for this

Absolute risk of birth defects when antidepressants taken in first trimester is small

Data is inconsistent, paxil has most been controversial

Byatt et al. *Acta Psych Scand* 2013.

Possible transient neonatal symptoms with exposure to antidepressants

Transient and self-limited syndrome that may occur in up to 30% of neonates

No data to support taper in third trimester

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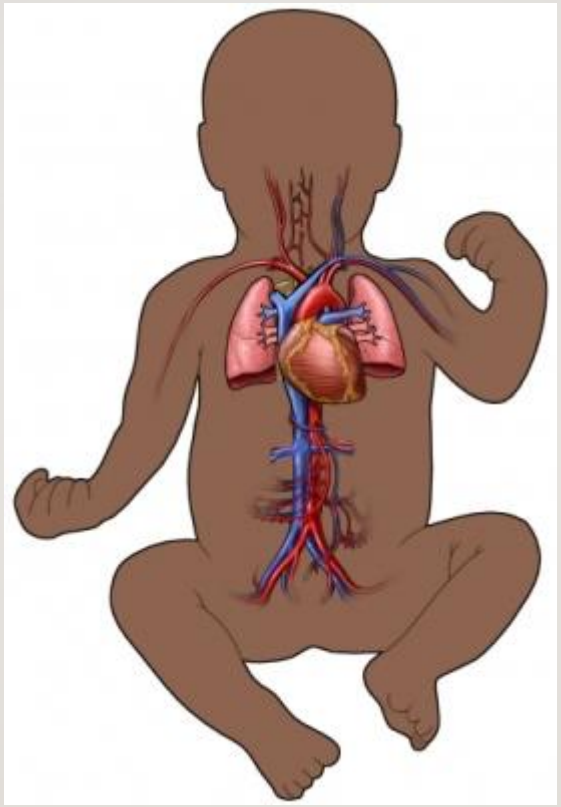
Moses-kolko et al JAMA 2005, Warburton et al. *Acta Psychiatr Scand* 2010.

Absolute risk of persistent pulmonary hypertension (PPHN) appears small



Baseline rate of 1-2 per 1000 births, may increase to 3-4 in 1000 births

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Chambers et al. *NEJM* 2006, Kallen et al. *Pharmacoepidemiol Drug Saf* 2008, Andrade et al. *Pharm Drug Saf* 2009.

Small increase risk of preterm labor & low birth weight

Depression can also increase risk of preterm labor and low birth weight

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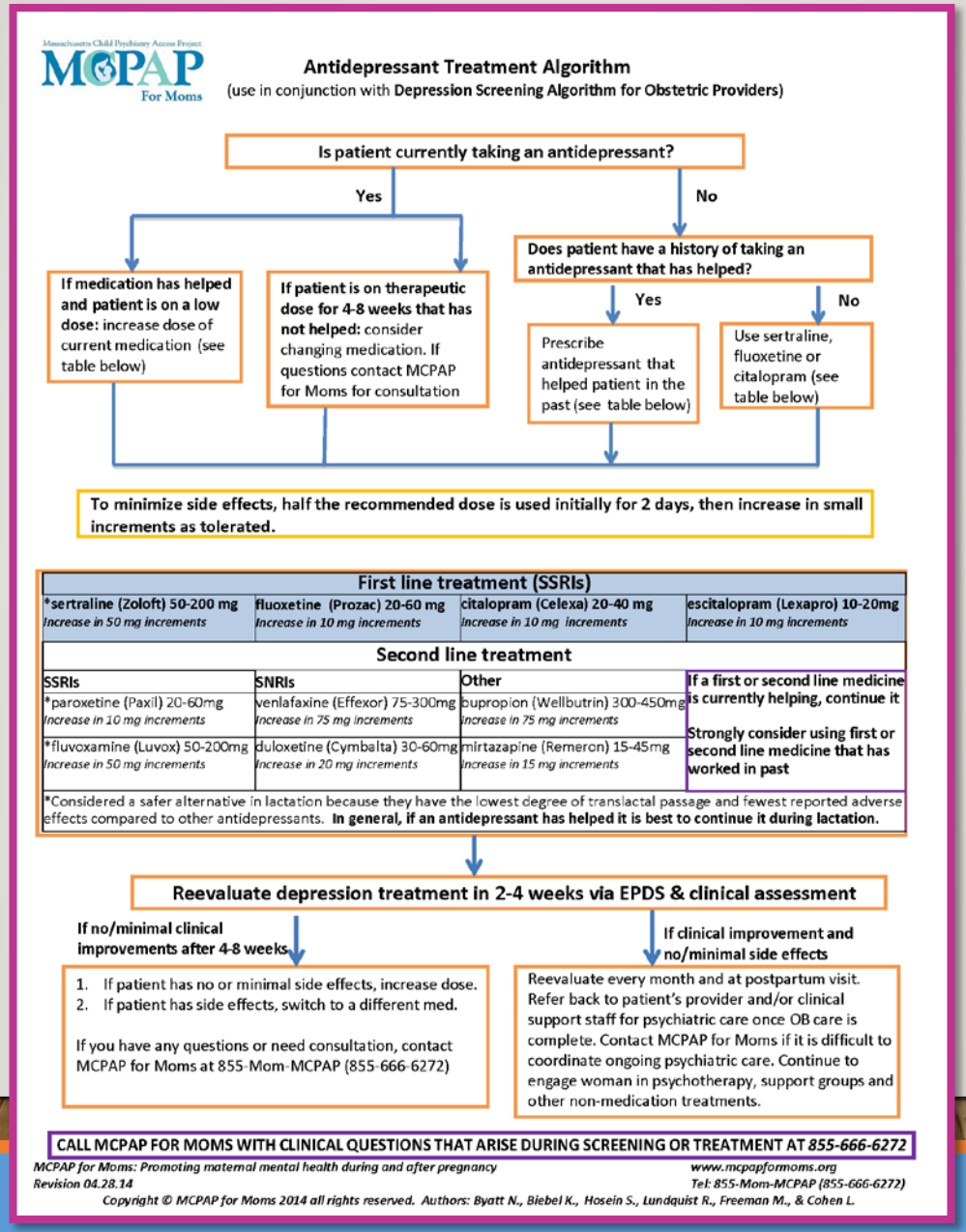
Huybrecht et al. *PLoS ONE*. 2014

Treatment - Antidepressant Treatment Algorithm



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Antidepressant Treatment Algorithm
(use in conjunction with **Depression Screening Algorithm for Obstetric Providers**)

Is patient currently taking an antidepressant?

Yes

If medication has helped and patient is on a low dose: increase dose of current medication (see table below)

If patient is on therapeutic dose for 4-8 weeks that has not helped: consider changing medication. If questions contact MCPAP for Moms for consultation

No

Does patient have a history of taking an antidepressant that has helped?

Yes

Prescribe antidepressant that helped patient in the past (see table below)

No

Use sertraline, fluoxetine or citalopram (see table below)

To minimize side effects, half the recommended dose is used initially for 2 days, then increase in small increments as tolerated.

First line treatment (SSRIs)

*sertraline (Zoloft) 50-200 mg	fluoxetine (Prozac) 20-60 mg	citalopram (Celexa) 20-40 mg	escitalopram (Lexapro) 10-20mg
Increase in 50 mg increments	*Increase in 10 mg increments*	*Increase in 10 mg increments*	*Increase in 10 mg increments*

Second line treatment

SSRIs	SNRIs	Other	
*paroxetine (Paxil) 20-60mg *Increase in 10 mg increments*	venlafaxine (Effexor) 75-300mg *Increase in 75 mg increments*	bupropion (Wellbutrin) 300-450mg *Increase in 75 mg increments*	**If a first or second line medicine is currently helping, continue it**
*fluvoxamine (Luvox) 50-200mg *Increase in 50 mg increments*	duloxetine (Cymbalta) 30-60mg *Increase in 20 mg increments*	mirtazapine (Remeron) 15-45mg *Increase in 15 mg increments*	**Strongly consider using first or second line medicine that has worked in past**

*Considered a safer alternative in lactation because they have the lowest degree of translactal passage and fewest reported adverse effects compared to other antidepressants. **In general, if an antidepressant has helped it is best to continue it during lactation.**

Reevaluate depression treatment in 2-4 weeks via EPDS & clinical assessment

If no/minimal clinical improvements after 4-8 weeks

1. If patient has no or minimal side effects, increase dose.
2. If patient has side effects, switch to a different med.

If you have any questions or need consultation, contact MCPAP for Moms at 855-Mom-MCPAP (855-666-6272)

If clinical improvement and no/minimal side effects

Reevaluate every month and at postpartum visit. Refer back to patient's provider and/or clinical support staff for psychiatric care once OB care is complete. Contact MCPAP for Moms if it is difficult to coordinate ongoing psychiatric care. Continue to engage woman in psychotherapy, support groups and other non-medication treatments.

CALL MCPAP FOR MOMS WITH CLINICAL QUESTIONS THAT ARISE DURING SCREENING OR TREATMENT AT *855-666-6272*

MCPAP for Moms: Promoting maternal mental health during and after pregnancy *www.mcpapformoms.org*
Revision 04.28.14 *Tel: 855-Mom-MCPAP (855-666-6272)*

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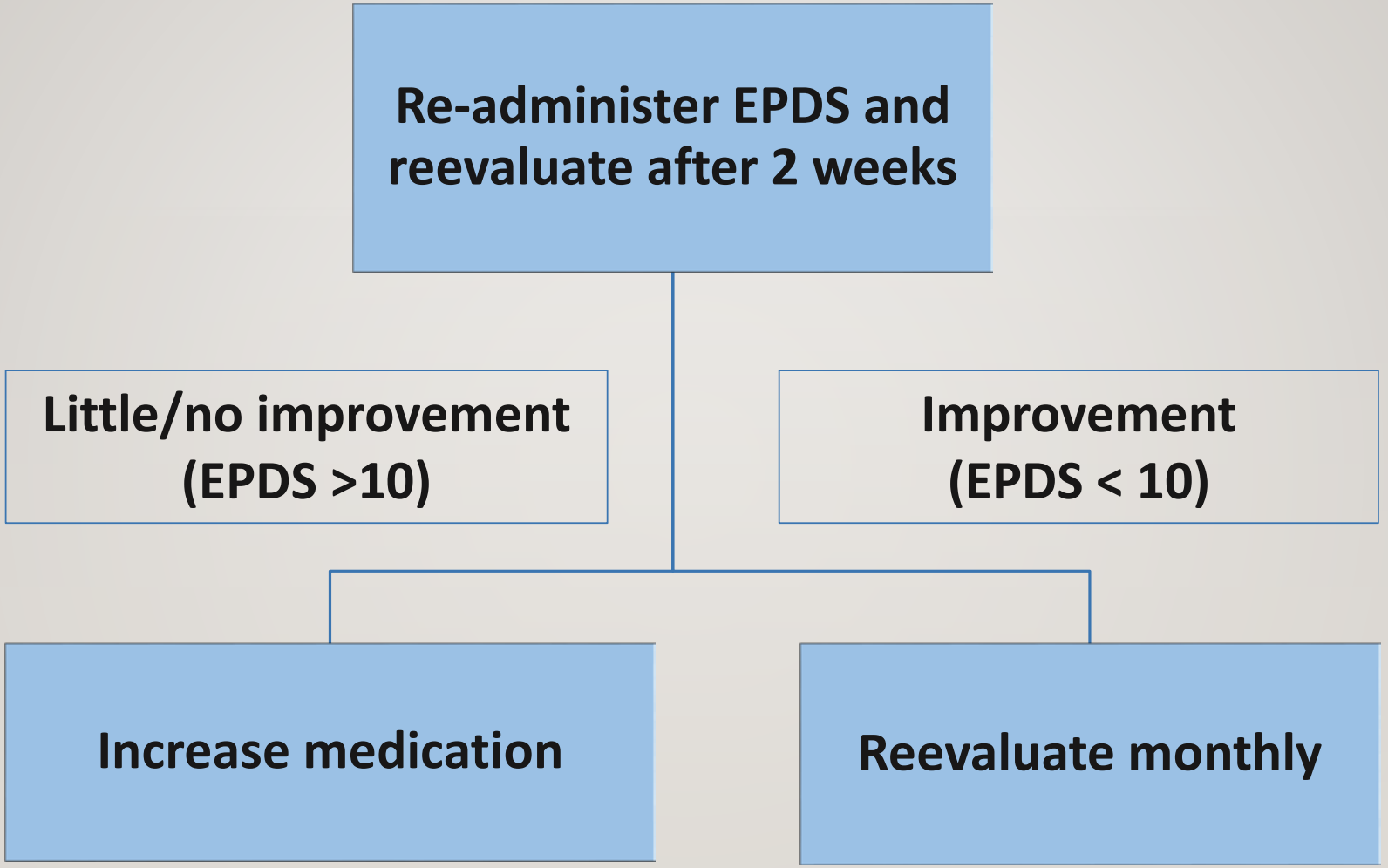
After starting antidepressant re-administer EPDS



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Prescribing principles for pregnancy and breastfeeding

- Use what has worked (considering available reproductive safety information)
- Use lowest EFFECTIVE dose
- Minimize switching
- Monotherapy preferable
- Be aware of need to adjust dose
- Discourage stopping SSRIs prior to delivery

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MOOD STABILIZERS

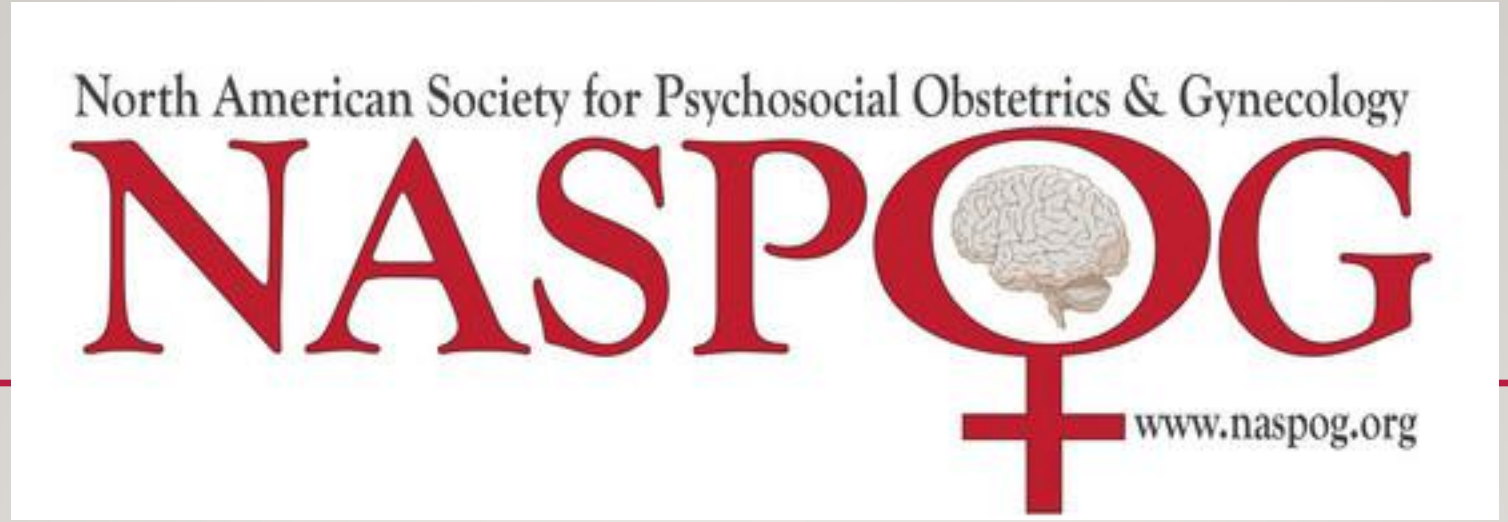
- Lamotrigine
  - Anti-epileptic
  - In pregnancy must follow levels and adjust accordingly
  - Risk for Stevens-Johnsons rash low if started low and increased slowly
  - Relatively safe in breastfeeding
  - Excellent article on dosing (Clark et al 2013)
- Lithium
  - Risk of Ebsteins' anomaly not as high as originally believed
  - Dosing adjustments and levels also needed
  - Dose decrease at delivery very important
- Second generation Anti-psychotics

ANTI-PSYCHOTICS

- Used to control mania and psychosis during pregnancy
- Risk of untreated **Psychosis** leads to poor prenatal care, inability to care for self, increased risk of violence, increased substance use, premature birth, low birth weight, fetal demise (Croicu et el, 2016)
- Risks of **Anti-psychotics:**
  - Haloperidol most repro data (no evidence teratogenesis, EPS in newborn possible)
  - More limited datat on 2nd Gen, but no evidence of teratogenesis thus far
  - Except risperidone were small risk of increase in cardiac malformations
  - (Cohen et atl 2016) and (Huybrechts et al 2016)
- MGH Registry for Atypical Antipsychotics particularly needs pregnant women from mid-western states
  - https://womensmentalhealth.org/research/pregnancyregistry/atypicalantipsychotic/
  - **TO PARTICIPATE CALL TOLL-FREE: 1-866-961-2388**

WANT TO LEARN MORE?

- North American Societu for Psychocosial Obs and Gyn (NASPOG)
- Perinatal Mental Health Society
- MCPAP For Moms
- Postpartum Support International (PSI)



- Formed in 1971
- Interdisciplinary group of clinicians and researchers
- Interested in mental health of women throughout the lifespan
- Biennial Meetings in April of even years
- Outstanding line-up of leaders in the field

Can refer moms to www.mcpapformoms.org

CONCLUSION

- Women receiving MAT have higher rates of success if psych and other SUD diagnoses are treated together
- Many co-occurring diagnoses are missed because you can't tell by looking
- Screening for additional SUD and general psychiatric diagnoses allows identification of other diagnoses and their treatment
- Alcohol and Tobacco in particular lead to pregnancy complications and are often missed by those treating women with OUD
- Integration of Ob-Gyn and psychiatric care has evidence for improved outcomes

QUESTIONS?