Last session of the series!

- **Post series evaluation Survey (required for CME)**
  - Will be emailed out tomorrow July 7
  - Required to receive CME credits, certificates will be emailed in 1-3 months
  - Survey due by 11:59pm on July 20
  - We value your input and take your feedback very seriously!
- **MAP ECHO Equity, Diversity, & Inclusion Survey**
  - Anonymous survey, unless you decide to enter your name
  - Link is in the chat and will also be emailed out to you tomorrow along with the post-series evaluation survey
- **Questions?** Please email mcmh@uw.edu
- **Stay in touch!** Feel free to call our consultation line for providers

UW Perinatal Psychiatry Consultation Line (Perinatal PCL)

WEEKDAYS 9:00 – 5:00PM | 877-725-4666 (PAL4MOM) | PPCL@UW.EDU

- Who can call? Any provider who cares for pregnant/postpartum patients
- What kind of questions? Any behavioral health-related questions for patients who are pregnant, in the first year postpartum, or who have pregnancy-related complications (e.g. pregnancy loss, infertility). Topics may include:
    - **Co-morbid substance use and mental health conditions (*new*)**, depression, anxiety, other psychiatric disorders (e.g., bipolar disorder, post-traumatic stress disorder), or co-occurring disorders
    - Pregnancy loss, complications, or difficult life events
    - Weighing risks and benefits of psychiatric medication, non-medication treatments
    - Local resources & referrals
- Staffed by UW perinatal psychiatrists
- Learn more https://www.mcmh.uw.edu/ppcl

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Co-occurring Disorders in the Perinatal Period

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Didactic Speaker Disclosures

- I have no conflicts of interest to disclose
- I will be discussing some off-label uses of medications

Learning Objectives

- Characterize the comorbidity between substance use and mental health among women/perinatal population
- Name at least three principles of treating co-occurring disorders
- Describe the general approach to medication treatment of co-occurring disorders in the perinatal period

Let's start with some cases

- Jennifer is a 28 year old cisgender woman (she/they pronouns), G2P0, currently at 14 weeks gestation referred after her initial prenatal visit for depressive symptoms
- Jennifer tells you that this pregnancy was unexpected but desired
- She has been struggling with feeling down, overwhelmed, at times hopeless, has been isolating and not enjoying her usual hobbies, sleeping poorly
- She also tells you that prior to finding out about this pregnancy she was a "partier" and used cocaine and alcohol heavily, stopped when she found out she is pregnant, struggling with cravings
- In addition, she describes a history of periods lasting up to a week of decreased need for sleep, increased goal-directed activity, hyper sexuality, impulsivity, and overspending

Case 2

- Mary is a 33-year-old G2P1 cisgender woman (she/her pronouns) at 21 weeks gestation who was referred for methamphetamine use in pregnancy and interest in quitting
- Mary has an extensive trauma history and grew up in foster care, she was diagnosed with many psychiatric disorders as an adolescent including bipolar disorder, ADHD, depression, anxiety, etc
- She recalls doing well in high school and college when she was prescribed Adderall for ADHD
- She had a tough time in college due to being in abusive relationship, started using substances including cocaine and later methamphetamines, had to drop out, has been using on and off since
- She wonders if she should restart Adderall or something similar

Case 3

- Quinn is a 25-year-old nonbinary person (they/them pronouns) G1P0 at 14 weeks gestation with a history of alcohol use disorder who presents to discuss recent anxiety.
- Quinn completed a 28 day treatment program upon discovering they are pregnant and has been abstaining from alcohol since, they are prescribed Naltrexone 50 mg daily.
- They have been struggling with significant anxiety, particularly in any kind of social situation. They were told in the treatment program that this is like protracted withdrawal (PAWS) and should get better over time, but it is only getting worse.
- Quinn mentions that they struggled with anxiety prior to alcohol becoming an issue. In fact, they think alcohol helped with this and this is part of the reason it became an issue.

Co-Occurring Disorders

- About half of individuals with a substance use disorder will also meet criteria for a mental health condition and vice versa
  - Common risk factors
  - Self-medication
  - Substance use can lead/contribute to mental health condition
- Stronger correlation among adolescents and women
- Trauma (particularly childhood and adult sexual trauma in women) is a common risk factor

Sex Differences

- Adverse outcomes including medical and psychiatric complications and functional impairment more severe in women
  - Women develop alcohol-related heart and liver disease as well as brain disorders earlier in the course of alcohol use disorder
  - Women who inject substances are at a higher risk of contracting HIV than men
- Women who use substances are more likely to cite family responsibilities, mental health, and perceived stigma as barriers to care
- Among women seeking treatment for SUD diagnoses of PTSD, anxiety disorder, eating disorders, mood disorders more prevalent than among men
- Similar treatment outcomes

McHugh et al 2017, Agterberg et al 2020

What about pregnancy?

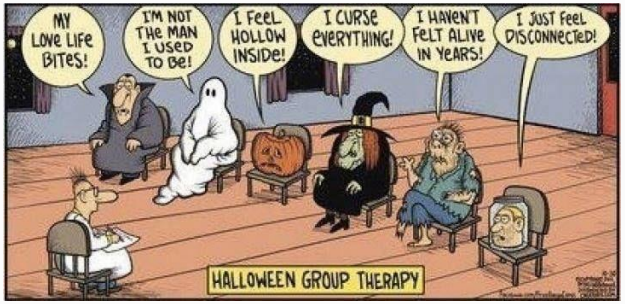
- Substance Use, Depression, IPV
  - People who screened positive for depressive symptoms in pregnancy (EPDS>10) were more likely to report substance use problems and IPV than those who screened negative
- Patients with comorbid SUD and psychiatric disorders less likely to get prenatal care than either alone
- Among pregnant patients with OUD
  - Up to 70% have a comorbid psychiatric disorder (although varies by study)
  - Depression most common
  - Psychosocial impairment higher in those with comorbid psychiatric disorders than OUD alone
    - OUD and PTSD associated with greatest impairment
  - OUD and comorbid psychiatric illness associated with lower treatment retention than OUD alone

Connelly et al 2013, Arnaudo et al 2017

Approach to Treating Co-occurring Disorders in the Perinatal Period

- Integrated treatment of both substance use and mental illness consistently found to be more effective than treating either alone
- Less than half of addiction treatment facilities in the US reported having programming tailored to those with co-occurring disorders
- Guiding Principles in Treating Clients With CODs
  - 1. Use a recovery perspective.
  - 2. Adopt a multi-problem viewpoint.
  - 3. Develop a phased approach to treatment.
  - 4. Address specific real-life problems early in treatment.
  - 5. Plan for the client's cognitive and functional impairments.
  - 6. Use support systems to maintain and extend treatment effectiveness.

Models of Care



- Integrated Dual Diagnosis Treatment
  - Evidence-based model
  - Multiple components including multidisciplinary team, stages of intervention, comprehensive services, motivational interventions, counseling for substance use and mental health issues, group treatment, family psycho-ed, etc
- Seeking Safety
  - integrated counseling model for individuals with trauma and substance use disorder that incorporated, but does not require patients to disclose their trauma narrative
- Integrated Group Therapy
  - an evidence-based providing treatment for adults with co-occurring bipolar and substance use disorders.

Medications and Co-Occurring Disorders in the Perinatal Period

- Less evidence exists for medications in populations with co-occuring disorders
- Medications don't tend to work as well without psychosocial interventions in this population, should be offered and discussed
- "Rational polypharmacy" – pt needs MAT and medication for anxiety
- Some medication can treat multiple issues
  - Bupropion – depression, nicotine use, some evidence for reducing meth use
  - Gabapentin – may help with anxiety, insomnia, cannabis withdrawal, alcohol withdrawal (including protracted withdrawal symptoms)
  - Mirtazapine – depression, anxiety, insomnia, nausea/slack of appetite, some evidence for reducing meth use (evidence primarily in cis men and trans women)

ADHD and Substance Use

- Untreated ADHD is a risk factor for substance use including non-prescribed stimulant use
- Diagnosis is difficult in the context of substance use
  - Under and over-diagnosis risk
  - When did symptoms begin?
  - Is collateral available?
- ADHD should be treated
  - No evidence treating ADHD with stimulants worsens SUD
  - Treatment of ADHD with stimulants has been shown to reduce substance use (results mixed)
  - Using extended release formulation lowers misuse potential
  - Chronic substance use ->dysregulation of dopamine system ->may need higher doses of stimulants for ADHD
  - Recommend involving psychiatry in these cases

Iqbal et al 2019

Prescribing in the Perinatal Period

- Consider possibility of pregnancy for all patient that may become pregnant
  - Substance use is a risk factor for unplanned pregnancy
- Discuss pregnancy planning with patients, ideally medications optimized prior to pregnancy
- What has worked in the past for a particular issue?
- Risks vs risks discussion (or benefit)
- Consider risks of relapse and recurrence/worsening of mental illness if reducing of stopping medication (and call us)
- Reducing polypharmacy when possible (may be more difficult in COD population)
- Optimize non-medication treatment
- Patient-centered multidisciplinary approach

Disparities in Co-Occurring Disorder Treatment

- Lack of services, difficult to access
- Rates of under-identification (identifying one and not the other) particularly high in adolescents and racial/ethnic minorities
- Lack of childcare consistently cited as a barrier to access care by parents who identify as women
- In a study of correctional facilities white inmates were more likely to have been diagnosed with a COD and have treatment as part of their sentence than non-white inmates despite similar rates of substance use
- In a study of parents involved with child welfare services, Native American parents were less likely to be assessed for mental illness and be referred to treatment and more likely to be assessed for substance use than other groups

Priester et al 2015

Key Takeaways

- Co-Occurring Disorders are the norm, not the exception
- View both issues as “primary”
- Integrated treatment
- Rational polypharmacy when needed
- Don’t forget about ADHD
- Psychosocial interventions are key
- Systemic issues – different patients get different care

Return to Cases

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