

UVM Project ECHO

Perinatal Mental Health

Preconception Through the First Year Postpartum

January 11, 2022

Course Co-Directors: Katherine Mariani, MD, MPH
Jill Davis, MA

ECHO Director: Elizabeth Cote

Series Faculty: Sandy Wood, CNM, PMHNP
Sayida Peprah, PsyD
Amy Wenger, RN
Elizabeth Gilman
Carol Lang-Godin, BA
Maria Rossi, CLC, CLD, BS
Sarah Guth, MD
Fiona Griffin, LCMHC
Kathryn Wolfe, LICSW, LADC



- RECORDING OF SESSION TO BEGIN

Agenda

- Introductions
- Objectives
- Didactic Presentation (~20-30 min)
- Case presentation
 - Clarifying questions
 - Participants – then faculty panel
- Discussion
- Recommendations
- Summary
- Closing Announcements
 - Submission of new cases
 - Completion of evaluations



Series Objectives

Learning objectives for this ECHO series include the ability to:

- Explain clinical knowledge about presentation of perinatal mental health complications
- Discuss treatment and management approaches
- Apply appropriate diagnostic and treatment strategies for the perinatal population, with an emphasis on diversity, equity, and inclusion
- Describe statewide resources that can assist patients who may experience perinatal mood and anxiety



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This activity was planned by and for the healthcare team, and learners will receive 1 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.



CME Disclosures

Interest Disclosures: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

Meeting Disclaimer: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.

Depression and Anxiety in the Prenatal Period

Sandra G Wood, APRN, CNM, PMHNP

University of Vermont Medical Center

Burlington, VT

Sandra.wood@uvmhealth.org

[I have no conflicts to disclose.]

Depression and Anxiety in the Prenatal Period

Session Objectives:

1. Understand the diagnostic considerations for mental health disorders in pregnancy.
2. Describe treatment strategies in pregnancy
3. Apply the principles of prescribing psychotropic medications in pregnancy.



Perinatal Mood and Anxiety Disorders

- Perinatal:
 - Preconception
 - Pregnancy
 - The first year post partum
- Spectrum of Emotional Distress
 - Depression
 - Anxiety
 - Obsessive Compulsive Disorder
 - Post Traumatic Stress Disorder
 - Bipolar disorder
 - Psychosis



Maternal Mental Health Complications

- Perinatal Mood and Anxiety Disorders are one of the most common complications of the perinatal period.
- PMADs have a powerful impact on Maternal Child health.
- Pose serious risks to the woman, the pregnancy and fetus, the infant, the partner, and the family.
- Substance Use Disorder in pregnancy often co-occurs with mental health conditions and is common.
- Overdose and Suicide are leading causes of maternal death.

<http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression>



Incidence:

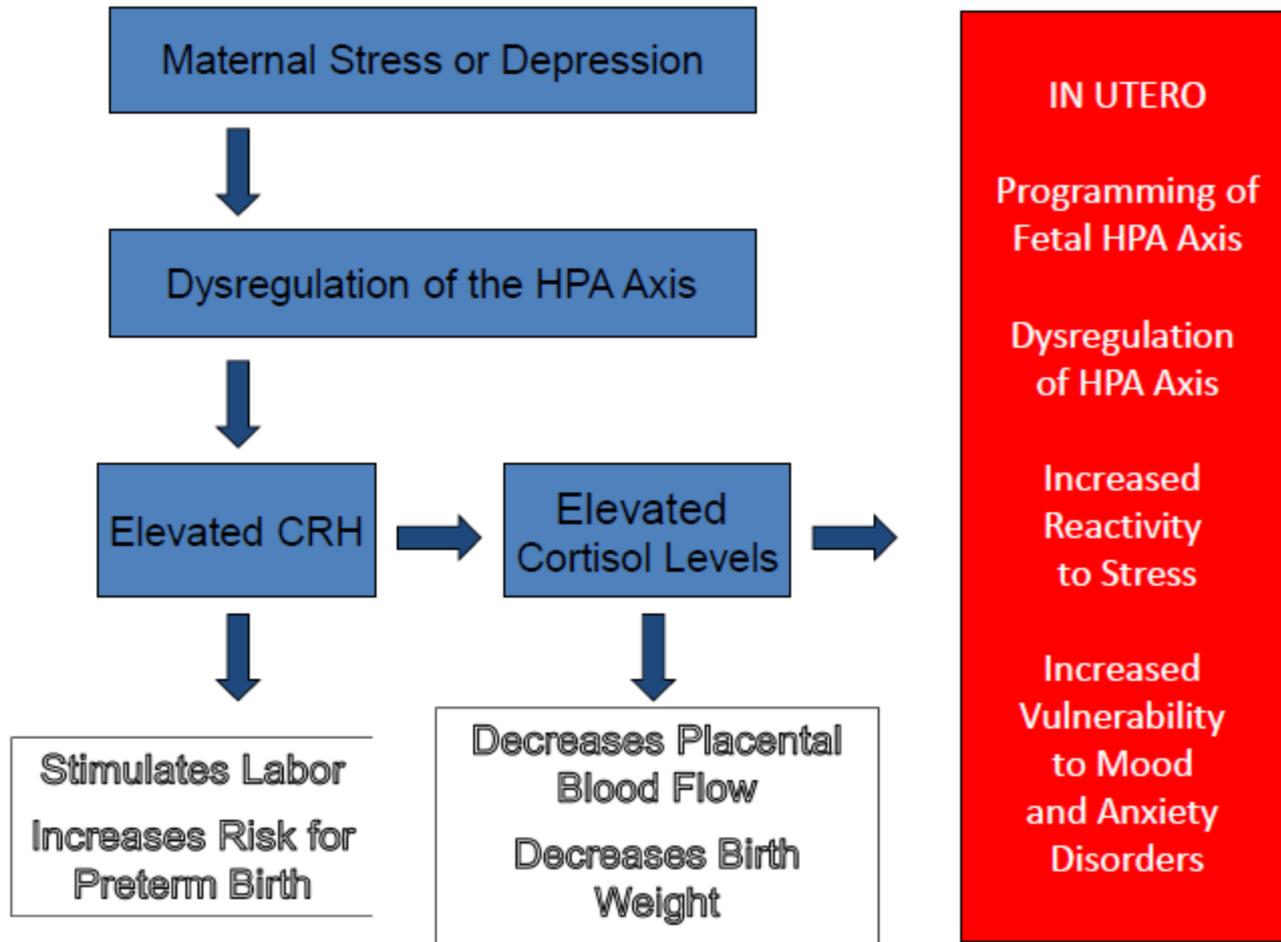
The most common complication of pregnancy

- Up to 1 in 5 women suffer from perinatal mood or anxiety symptoms
- More common than Gestational Diabetes or Preeclampsia in pregnancy
- Two thirds of PMADs begin before birth
 - 27% onset prior to pregnancy
 - 33% onset in pregnancy
 - 40% onset postpartum with a common peak at 3 months postpartum



Underdiagnosed and Undertreated

- Less than 86% of women with a diagnosis are treated.
- 50% of women being treated are still symptomatic suboptimal treatment.
- Requires broad interdisciplinary approaches and solutions.



“One Key Question” initiative

“Would you like to become pregnant in the next year?”

- Folic Acid supplementation
- Abstinence from nicotine, alcohol and recreational substances
- Update vaccinations
- Avoidance of environmental teratogens
- Stabilize any preexisting chronic diseases (ex Hgb A1C < 7)
- Movement and nutrition to promote optimal BMI
- Medication changes or discontinuation
- Optimize Mental Health and diversify tools
- [One Key Question Support 2021 | Power to Decide](#)



Diagnostic considerations for mental health disorders in pregnancy.



Depression and Anxiety in the Prenatal Period

- PMADs behave somewhat differently
- Normal symptoms of pregnancy can mimic the neurovegetative symptoms of depression and the physiologic symptoms of anxiety.
- The changes/stresses of the pregnancy may uncover biological risks
- In pregnancy symptoms may include:
 - Multiple and severe physical complaints
 - Excessive Worries that lead to
 - Insomnia
 - Prevent the pregnant person from accessing tools
 - Isolating self
 - Inability to enjoy the pregnancy/parenthood.



Causes

- Biological
- Psychological
- Social
 - Women have a greater risk for anxiety and depression
 - Exposed to more stress and more likely to be victim of abuse or poverty
- Pregnancy, birth, and the transition to parenthood are potent stressors



Biological Risk Factors

- Personal or family history of psychiatric disorders
- Previous episode of perinatal onset of mood or anxiety disorder
- Symptoms of anxiety or depression during pregnancy
- History of mood symptoms related to hormonal changes
 - PMDD
 - Contraceptives
 - Infertility treatment
- Chronic medical condition
 - Endocrine dysfunction
 - Diabetes, thyroid, infertility
 - Autoimmune disorders



Psychosocial Risk Factors

- Unplanned/unwanted/mistimed pregnancy
- Prior infertility, pregnancy conceived via assisted reproductive technologies, and multiples
- Prior losses: miscarriages, neonatal deaths, stillbirths
- Interpersonal violence (current or past)
- History of sexual abuse or trauma
- Young maternal age, especially adolescence
- Relationships/Lack of social support, especially from the partner
- Recent stressful life events within 2 years of pregnancy



Factors that compound risk

- Pregnancy complications or health challenges
- Seasonal stressors
- Perfectionism or high expectations
- Insomnia/Sleep deprivation



Maternal Mental Health During Covid-19 Pandemic

- Family planning
- Loss of coping tools and support systems
- Significant impact on the Social Determinants of Health
- Increasing numbers of women with risk factors for mental health complications.
- Increased symptoms of Anxiety and Depression
- Telemedicine and implications for pregnancy and postpartum period
- Infertility treatment and the pandemic



Universal Screening

- Prevalence warrants screening
- Essential for early detection and treatment
- Opportunity to uncover prior undiagnosed mental illness
- Opportunity for education and referral
- Reduce the duration and severity of symptoms and may prevent a crisis
- Treatment can reduce the impact of maternal mental health complications on the pregnant person, children, and family.



Effective Screening

- Universal screening Essential for early detection and treatment
 - Appearances can be deceiving
 - Normalizes/Reduces stigma
 - Consider mental health as any other health indicator (BP, weight)
- Standardized tool
 - Opportunity to discuss emotional health during the visit
 - Gives the patient language to use with the clinician
 - Alerts the clinician to potential concerns that can be addressed during the visit
- Standardized Process
 - Established roles, consistency, Scoring cutoffs
 - Can be integrated into routine visits
 - Simplifies workflow
- Validated tool
 - Screening questionnaire that has been tested for
 - Reliability, sensitivity and specificity
 - Consider validation in the perinatal period as normal symptoms can confound the results.
- Valuable tool for preexisting diagnosis or treatment
 - Track course of symptoms or efficacy of treatment



Diagnostic and Statistical Manual of Mental Disorders: DSM-V criteria for Major Depressive Episode

- Depressed mood
- Anhedonia
- Significant increase or decrease in appetite/weight
- Insomnia/hypersomnia
- Psychomotor agitation/retardation
- Fatigue/loss of energy
- Feelings of worthlessness/inappropriate guilt
- Diminished ability to think, concentrate, or make decisions
- Recurrent thoughts of death or suicide



Patient Health Questionnaire (PHQ-9)

- 10-item scale designed to compare depressive symptoms against DSM criteria items in a healthcare setting
- Sensitivity: 75-88% Specificity: 88-90%
- 5 minutes to complete
- Validated for use in the perinatal period
- Can be used to assess and track treatment response
- Free
- Not diagnostic, despite reflecting diagnostic criteria
- Not specific to PMADs and does not capture anxiety



PHQ-9 — Nine Symptom Checklist

- Over the last 2 weeks, how often have you been bothered by any of the following problems?
 - Not at all /Several days /More than half the days /Nearly every day
 - Little interest or pleasure in doing things
 - Feeling down, depressed, or hopeless
 - Trouble falling asleep, staying asleep, or sleeping too much
 - Feeling tired or having little energy
 - Poor appetite or overeating
 - Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
 - Trouble concentrating on things such as reading the newspaper or watching television
 - Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
 - Thinking that you would be better off dead or that you want to hurt yourself in some way
- If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
 - Not Difficult at All /Somewhat Difficult /Very Difficult /Extremely Difficult



Anxiety

- General Anxiety
 - 6% in pregnancy
 - 10% postpartum
 - Twice incidence in general population
 - PP onset greater than the rate of depression
- Panic
 - 1.4%



Diagnostic and Statistical Manual of Mental Disorders: DSM-V criteria for Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

- Restlessness or feeling keyed up or on edge.
- Being easily fatigued.
- Difficulty concentrating or mind going blank.
- Irritability.
- Muscle tension.
- Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).



General Anxiety Disorder Scale (GAD 7)

- 7-item scale designed to compare anxiety symptoms against DSM criteria items in a healthcare setting
- *is also sensitive to severity of symptoms of social phobia, post-traumatic stress disorder, and panic disorder.*
- Sensitivity: 89% Specificity: 82%
- < 5 minutes to complete
- Can be used to assess and track treatment response.
- Free
- Not diagnostic, despite reflecting diagnostic criteria



GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it's hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

0 Not at all 1 Several days 2 Over half the days 3 Nearly every day

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____



Edinburgh Postnatal Depression Scale (EPDS)

- Designed to detect PMAD in healthcare settings, this 10-question screen can be completed in about 5 minutes.
- Sensitivity: 78% Specificity: 99%
- Validated for use with PPD
- Most widely studied
- Available in more than 20 languages
- Free
- No parenting-specific questions
- Self-report measures subject to woman's perceptions



Edinburgh Postpartum Depression Scale EPDS

1. I have been able to laugh and see the funny side of things
2. I have looked forward with enjoyment to things
- 3. I have blamed myself unnecessarily when things went wrong**
- 4. I have been anxious or worried for no good reason**
- 5. I have felt scared or panicky for not very good reason**
6. Things have been getting on top of me
7. I have felt sad or miserable
8. I have been so unhappy that I have difficulty sleeping
9. I have been so unhappy that I have been crying
10. The thought of harming myself has occurred to me

Most of the time/ sometimes/ not often/ not at all



SUD Screening

- Substance Use Risk Profile-P
 - Substance Use Risk Profile-Pregnancy
- ASSIST
 - Alcohol, Smoking, and Substance involvement Screening Test
- 4-Ps
 - Parents
 - Peers
 - Partner
 - Past
 - Plus=Present
 - [03.-SBIRT-for-Substance-Use-During-Pregnancy REV-03.15.18.pdf \(nnepqin.org\)](#)



Are you interested in implementing, increasing or improving screening for perinatal depression or anxiety at your practice?

- The Vermont Child Health Improvement Program, VCHIP, is working with the Vermont Department of Health through the STAMPP grant (Screening, Treatment & Access for Mothers and Perinatal Partners) to assist practices with screening, referral and treatment workflow optimization.
- Please contact Jill Davis for additional information.

Jill.davis@med.uvm.edu

Other diagnostic considerations

- Comorbidity
 - Substance abuse
- Medical
 - Thyroid disorders (TSH)
 - Anemia (CBC)
 - Nutritional/Vitamin deficiencies (B12, Vitamin D, folate)
 - Diabetes, Autoimmune, or other medical disorders
- Medication Side effects
 - antiemetics



Depression and Anxiety during pregnancy is the strongest predictor of postpartum depression and anxiety



Vermont Resources

- Vermont Department of Health
 - <https://www.healthvermont.gov/family/pregnancy/PMADs>
- Department of Mental Health
 - <https://mentalhealth.vermont.gov/services/children-youth-and-family/perinatal-mood-anxiety-disorders-pmads>



Treatment strategies in pregnancy

Primary Prevention Model

- Population in contact with health care providers and community partners
- Clear markers and a defined period of risk
- Detectable
- Treatable
- Opportunity to help women with prior undiagnosed mood and anxiety disorders



Prevention and Treatment

- Maximize social supports
 - Psycho education of family members
- Peer support and groups
- Group therapy
- Interpersonal Therapy
- Cognitive Behavioral Therapy
 - Mindfulness based Cognitive Behavioral Therapy
- Targeted therapy for OCD or PTSD



Steps to Wellness

- Education
- Sleep
- Nutrition
- Exercise and time for self
- Nonjudgmental sharing
- Emotional support
- Practical support
- Referrals and other resources

<https://janehonikman.com/steps-to-wellness/>



Barriers to Care

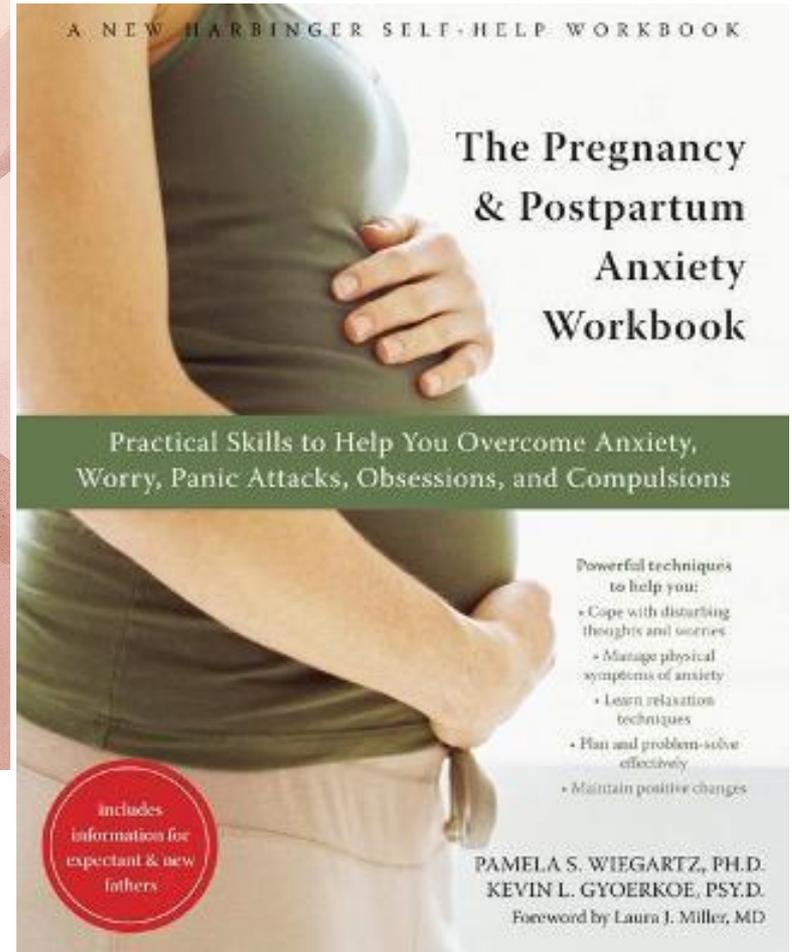
- Stigma
- Practical barriers
 - Financial
 - Time
 - Transportation/access to telehealth
 - childcare
- Need for
 - adequate and appropriate screening
 - Evidence based care
 - Trauma informed care
 - Culturally sensitive care
 - Addressing disparities
 - Integrated and collaborative care



THE PREGNANCY WORKBOOK

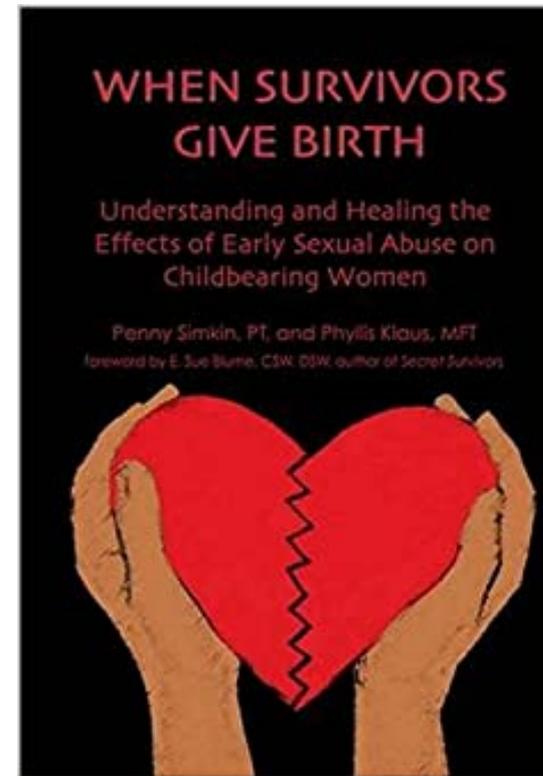
KATAYUNE KAENI, PSY.D., PMH-C

MANAGE ANXIETY AND WORRY WITH CBT AND MINDFULNESS TECHNIQUES



Trauma Informed care

- Systemic Racism
- Childhood Sexual Abuse
- Prior emotionally or medically traumatic birth
- [Previous Traumatic Birth: An Impetus for Requested Cesarean Birth \(nih.gov\)](#)



Principles of prescribing psychotropic medications in pregnancy.



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The Golden Rules of Treatment

- Every baby deserves a healthy parent
- Psychiatric illness and psychiatric medication each pose a risk to the mother and fetus/newborn
- Treatment decisions are always a risk benefit analysis on a case by case basis
- There is no one medication that is safest or best for use during pregnancy or breastfeeding
- The best treatment strategy is to minimize or eliminate one of the exposures whenever possible
- No single study tells the whole story, all of the literature must be read in context.



Decisions about medication

- Important factors in decision making and counseling a woman on psychotropic medications in pregnancy
 - Psychiatric history including prior medication trials and efficacy
 - Risks of mood and anxiety disorders to the woman, pregnancy, and child
 - Medication risks and benefits through out the perinatal period
 - Collaborative, patient-centered approach required



Risks/Benefits of Medications

- Risks
 - Effectiveness
 - Comparison to placebo or therapy
 - It is Complicated!!!
 - Medication effects
 - Mental health diagnosis
 - Heredity
 - Social
 - Environmental
 - Nutrition
 - Substance exposure
- Benefits
 - Effectiveness
 - Prevent Relapse or Reoccurrence
 - Severe disease



Perinatal Pharmacodynamics

- 1st trimester
 - Miscarriage
 - Teratogen
- 2nd and 3rd trimester
 - Short term: pregnancy complications
 - Long term: infant outcome
- Birth transition
 - Withdrawal/adaptation
- 4th trimester
 - Infant exposure during Lactation



Congenital Abnormalities

- SSRIs are the most studied medication in pregnancy and there have been NO consistent fetal malformations or abnormalities documented with any SSRIs.
- Baseline risk of congenital abnormalities is 3% in general population(CDC). SSRIs do not increase this baseline risk.
- In review of the literature as a whole, SSRIs/SNRIs are not teratogens.
- No association in prospective, controlled studies.
- No association in meta-analyses.



Choosing Medication

- Consider safety throughout the perinatal period.
- Ideal to choose one medication to use from conception to lactation with the goal of minimizing exposure to the child and prevent relapse in the mother
- Integrate good psychopharmacology principles with what is known about medications in pregnancy and lactation.
- Monotherapy is best
- Start with lowest dose
- Use lowest effective dose and be aware of need to adjust dose
- Discourage stopping SSRIs prior to birth.
- The “safest” medication may not be the one that works best for your individual client. Use what has worked.
- Use **current up to date** resources.



Don't Switch Don't Stop



Preconception decision making

- Risk of relapse during pregnancy with discontinuing antidepressants preconception
 - Continuing medication has 25% relapse
 - Discontinuing medication has a 65% relapse
- If tapering or discontinuing medication prior to conception, continue to follow women during pregnancy



Counseling about antidepressant use

- There are effective options for treatment during pregnancy and breast feeding
- Depression and Anxiety are common in the pregnancy and postpartum
- Women need to take medications in pregnancy and lactation for all kinds of things.
- No decision during pregnancy is risk free
- Most studies during pregnancy have examined SSRIs
- SSRIs are the best studied class of medications during pregnancy
- Medication and non medication options should be considered and encouraged as an alternative or in addition if clinically appropriate.



Counseling on Risks

Antidepressant use in pregnancy

- The bulk of the evidence does not suggest teratogenicity
- Preterm labor
- Low birth weight
- Transient neonatal symptoms
- Persistent pulmonary hypertension of the newborn (PPHN) low absolute risk
- Long term neurodevelopmental effects. Data are mostly reassuring

Untreated/Undertreated depression and anxiety in Pregnancy

- Preterm labor
- Low birth weight
- Preeclampsia
- Poor self care
- Substance abuse
- Suicide
- Impaired bonding
- High risk for Postpartum depression
 - Strong associations with negative outcomes for mother, infant, and family.



Documentation

- All prescribed, over-the-counter drug, environmental and substance exposures during the pregnancy.
- Previous pregnancy outcomes for preterm birth, birth defects, and other complications.
- Risks of the medication and risks of the psychiatric disorders on pregnancy outcomes.
- The patient's decision or understanding of the information in her own words.
- Plan to monitor symptoms and side effects across pregnancy.



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Psychotropic Treatment During Pregnancy: Research Synthesis and Clinical Care Principles

Hannah K. Betcher, MD^{1,2} and Katherine L. Wisner, MD, MS^{1,3}

Abstract

Background: Psychiatric illnesses are common in women of childbearing age. The perinatal period is a particularly high-risk time for depression, bipolar, and anxiety disorders.

Methods: The scope of the public health problem of perinatal mental disorders is discussed followed by an examination of the specific research methods utilized for the study of birth and developmental outcomes associated with maternal mental illness and its treatment. The evidence on exposure to common psychotropics during pregnancy and breastfeeding is reviewed.

Results: Selective serotonin reuptake inhibitors or serotonin–norepinephrine reuptake inhibitor medications are not associated with higher rates of birth defects or long-term changes in mental development after adjustment for confounding factors associated with underlying psychiatric illness. Lithium exposure is associated with an increased risk for fetal cardiac malformations, but this risk is lower than previously thought (absolute risk of Ebstein's anomaly 6/1,000). Antipsychotics, other than risperidone and potentially paliperidone, have not been associated with an increase in birth defects; olanzapine and quetiapine have been linked with an elevated risk of gestational diabetes. Due to the dramatic physiological changes of pregnancy and enhanced hepatic metabolism, drug doses may need to be adjusted during pregnancy to sustain efficacy. Untreated maternal psychiatric illness also carries substantial risks for the mother, fetus, infant, and family.

Conclusions: The goal of perinatal mental health treatment is to optimally provide pharmacotherapy to mitigate the somatic and psychosocial burdens of maternal psychiatric disorders. Regular symptom monitoring during pregnancy and postpartum and medication dose adjustments to sustain efficacy constitutes good practice.



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Benzodiazepines

- Most studies show no increase in malformations, no consistent pattern of defects
- Ongoing and regular use in pregnancy is associated with symptoms of toxicity or withdrawal
 - more likely to occur in women taking higher dosages of medication.
 - hypothermia, lethargy, poor respiratory effort, feeding difficulties, irritability, sleep disruption, and seizures. Although this risk is still low, the infant should have follow up and be. Prolonged symptoms may be linked to higher dosages of medication.
- Lorazepam is a preferred agent as it accumulates less in fetal tissues.
- Consideration must be given to the client's risk for relapse when the decision is made to discontinue medication as this may increase the risk for depression and anxiety. Taper is suggested to take a month.



Stimulants in Pregnancy

- Current data suggest that none of the medications used for the treatment of ADHD are a major human teratogens.
- May increase the risk of preeclampsia. The absolute risk is still low.
- Limited Long-term neurodevelopmental studies
- Methylphenidate, Amphetamine and Bupropion have more reproductive safety data.
- Consideration must be given to the clients underlying diagnosis and risk for relapse when making decisions



Cannabis and Pregnancy/Lactation

- Risks:
 - Associated with increased risk of preterm births
 - Drop in IQ and cognitive abilities
 - Animal studies show disruption in brain development
 - Possibility of slowing down of fast dividing cells such as a fetus
 - prenatal marijuana exposure is associated with decreased attention span and behavioral problems
- Presents challenges with psychiatric diagnosis and treatment planning in Mood and anxiety disorders, attention deficit disorder.
 - Why is the client using cannabis? Anxiety, insomnia, nausea/vomiting.
 - Offer alternative evidence based researched treatment or treatments with known safety profiles
- <https://cdphe.colorado.gov/marijuana-health-care-provider-resources>

Metz TD, Borgelt LM. Marijuana Use in Pregnancy and While Breastfeeding. *Obstet Gynecol.* 2018;132(5):1198-1210. doi:10.1097/AOG.0000000000002878



Medication Resources

- Product label (PLLR updated by FDA)
<https://www.cdc.gov/pregnancy/meds/treatingfortwo/index.html>
- <https://dailymed.nlm.nih.gov>
- <https://www.infantrisk.com/>
- Mother To Baby (Organization of Teratology Information Specialists)
www.mohtertobaby.org
- <http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>
- www.ibreastfeeding.com
- MGH Center for Women's Mental Health
www.womensmentalhealth.org
- <http://www.breastfeedingonline.com/meds.shtml>



MGH Center for Women's Mental Health

Reproductive Psychiatry Resource and Information Center

- [Center for Women's Mental Health at MGH \(womensmentalhealth.org\)](http://womensmentalhealth.org)
- [Virtual Rounds at the CWMH - MGH Center for Women's Mental Health \(womensmentalhealth.org\)](http://womensmentalhealth.org)
- [National Pregnancy Registry for Psychiatric Medications © \(womensmentalhealth.org\)](http://womensmentalhealth.org)



Sandra Wood APRN, CNM, PMHNP

University of Vermont Medical Center
Women's Services: Perinatal Mental Health

Vermont Department of Health
Vermont Perinatal Mood and Anxiety Consultation
Service

802-847-4758

Sandra.wood@UVMHealth.org



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Postpartum Support International

- Trainings for Professionals
- Provider directory
- Helpline
- Online Support Groups
- Vermont Chapter <https://psichapters.com/vt/>
 - Local coordinators
- National Perinatal Psychiatric Consult Line
 - 1-877-499-4773
 - <https://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/>



Toolkits for maternal mental health

MCPAP For Moms (Massachusetts Child psychiatry Access Program)

- <https://www.mcpapformoms.org/Docs/AdultProviderToolkit12.09.2019.pdf>
- Includes SUD

Lifeline4Moms

- <https://escholarship.umassmed.edu/cgi/viewcontent.cgi?article=1140&context=pib>





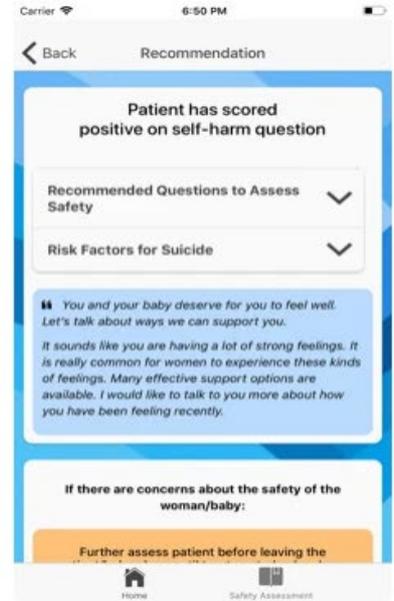
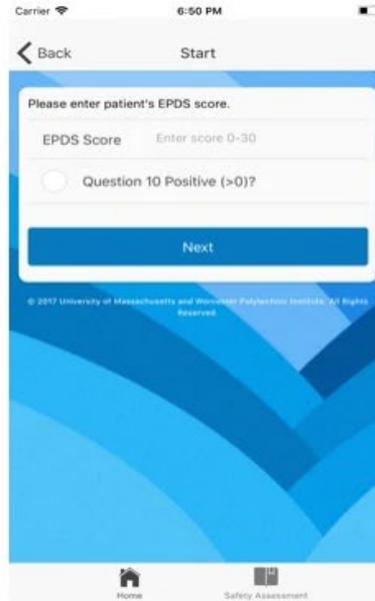
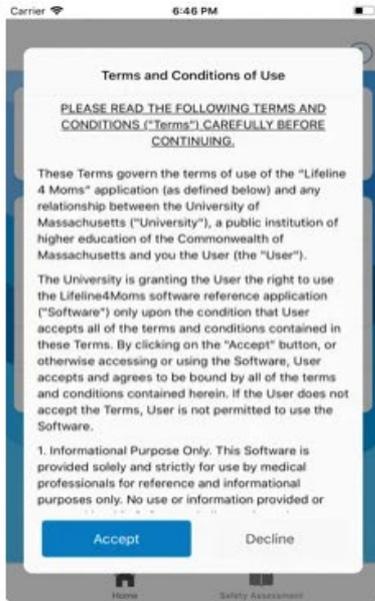
Lifeline4Moms 17+

Worcester Polytechnic Institute

★★★★★ 4.7 • 3 Ratings

Free

Screenshots [iPhone](#) [iPad](#)



Discussion and Q & A

Cases/HIPAA

DO NOT INCLUDE:

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #



The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.



Case Presentation Format

Case presentation from a participant (*a real-world case, from the field*)

Then

Clarifying questions about the case from group to case presenter

Then

Ideas, suggestions, recommendations from participants

Then

Ideas, suggestions, recommendations from ECHO faculty team

Then

Additional discussion, if any (All)

Then

Summary of case discussion

(course co-directors: Katherine Mariani, MD, MPH and Jill Davis, MA)

- RECORDING TO BE STOPPED FOR CASE PRESENTATION



Prep for Next Session

Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

SESSIONS ARE ON TUESDAYS FROM 12:00PM TO 1:00PM		
DATES	SESSION	DIDACTIC TOPICS (in addition to case review)
Jan 11	TeleECHO Session 1	Depression & Anxiety in the Prenatal Period (Sandy Wood, CNM, PMHNP)
Feb 8	TeleECHO Session 2	Cultural Considerations in Perinatal Mental Health (Sayida Peparah, PsyD)
Mar 8	TeleECHO Session 3	Depression & Anxiety in the Postpartum Period (Sandy Wood, CNM, PMHNP)
Apr 12	TeleECHO Session 4	Resources & Referrals (Amy Wenger, RN, Elizabeth Gilman, Carol Lang-Godin, BA, and Maria Rossi, CLC, CLD, BS)
May 10	TeleECHO Session 5	Bipolar Disorder in the Peripartum (Sarah Guth, MD)
May 31	TeleECHO Session 6	Postpartum Psychosis (Sarah Guth, MD)
June 14	TeleECHO Session 7	Birth Trauma/Perinatal Grief & Loss (Fiona Griffin, LCMHC)



Conclusion

- Slides are posted at www.vtahec.org
- Volunteers to present cases (this is key to the Project ECHO model)
 - Please submit cases to Katherine.Mariani@uvmhealth.org
- Please complete evaluation survey after each session
- Once your completed evaluation is submitted, CE information will be emailed to you.
- Please contact us with any questions, concerns, or suggestions
 - Katherine.Mariani@uvmhealth.org
 - Elizabeth.Cote@uvm.edu

