Perinatal Psychiatric Disorders: Diagnoses, Assessment and Management

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Objectives

- Describe the prevalence of perinatal mood and anxiety disorders.
- Differentiate between postpartum blues, depression, psychosis and anxiety based disorders.
- Understand the risks of untreated perinatal mood and anxiety disorders.
- Describe pharmacologic and non-pharmacologic treatment options for perinatal mood and anxiety disorders, with focus on risks to fetus and breast-feeding infant of psychopharmacologic use.
- Describe advantages for utilization of a provider to provider perinatal psychiatric teleconsultation service, such as The Periscope Project.
Depression in Pregnancy

- Same diagnostic criteria as episode of major depressive disorder
  - > 2 weeks duration of symptoms that impact functioning
  - Onset during pregnancy or up to one year postpartum
- Depression may be overlooked in pregnancy
- Symptoms related to somatic experiences of pregnancy
  - Poor sleep, appetite changes, decreased energy, decreased libido
- Symptoms to guide diagnosis: lack of interest in pregnancy, guilty ruminations, profound anhedonia, suicidal ideation
## Distinguishing Blues from Depression

<table>
<thead>
<tr>
<th><strong>Blues</strong></th>
<th><strong>Depression</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Affects 70-85% of women: NORMAL!</td>
<td>Criteria for major depressive episode need to be met</td>
</tr>
<tr>
<td>Duration of symptoms:</td>
<td>Duration of symptoms:</td>
</tr>
<tr>
<td>&lt;2 weeks</td>
<td>&gt;2 weeks</td>
</tr>
<tr>
<td>Mild symptoms</td>
<td>Tends to have later onset (2-4 weeks)</td>
</tr>
<tr>
<td>Self-limited</td>
<td>Severe symptoms:</td>
</tr>
<tr>
<td>Little to no intervention needed</td>
<td>- Anhedonia</td>
</tr>
<tr>
<td></td>
<td>- Sense of failure</td>
</tr>
<tr>
<td></td>
<td>- Suicidality</td>
</tr>
<tr>
<td></td>
<td>- Psychosis</td>
</tr>
<tr>
<td></td>
<td>Impacts functioning</td>
</tr>
</tbody>
</table>
Somatic Symptoms of Pregnancy
Depression and Anxious Diagnosis vs. Not

<table>
<thead>
<tr>
<th>Somatic Symptom</th>
<th>Depression or Anxiety?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (N=43)</td>
</tr>
<tr>
<td>1. Nausea</td>
<td>93%</td>
</tr>
<tr>
<td>2. Back Pain</td>
<td>88%</td>
</tr>
<tr>
<td>3. Stomach Pain</td>
<td>79%</td>
</tr>
<tr>
<td>4. Headaches</td>
<td>71%</td>
</tr>
<tr>
<td>5. Short of Breath</td>
<td>71%</td>
</tr>
<tr>
<td>6. GI Symptoms</td>
<td>68%</td>
</tr>
<tr>
<td>7. Arm, Leg, Joint Pain</td>
<td>64%</td>
</tr>
<tr>
<td>8. Heart Pounding</td>
<td>58%</td>
</tr>
<tr>
<td>9. Dizziness</td>
<td>54%</td>
</tr>
<tr>
<td>10. Sexual Intercourse</td>
<td>41%</td>
</tr>
<tr>
<td>11. Chest Pain</td>
<td>21%</td>
</tr>
<tr>
<td>12. Fainting</td>
<td>10%</td>
</tr>
</tbody>
</table>

*p<.05   **p<.01    ***p<.001
Bipolar Disorder

• A mood disorder consisting of both depressive symptoms as well as mania (or hypomania).
• Onset: Prior to pregnancy, during pregnancy, or in the postpartum period (often precipitated by disturbed sleep).
• Duration: Persists until treated.
• Signs/Symptoms:
  • May present with depressive symptoms, as previously delineated.
  • Mania characterized by a decreased need for sleep, risk-taking behaviors (e.g., gambling, promiscuity), euphoria or irritability, increased goal-directed activity, grandiosity.
Postpartum Psychosis

• A true psychiatric emergency! Affects 1-2/1000.
• Abrupt onset within 3-14 days postpartum, prodromal signs in 1st three days PP
• Other symptoms: bizarre disorganized behavior, lack of insight, delusions of persecution that revolve around the infant, self neglect, unusual psychotic symptoms
• Bi-directional, strong link with bipolar disorder. Meta-analysis review of 37 articles:
  • If history of bipolar disorder, 37% risk of postpartum relapse
  • If history of postpartum psychosis, 31% risk of relapse
  • Much higher rates (66%) if medication-free during pregnancy, as compared to prophylactic treatment (23%)
• New-onset psychosis work-up needed; 4% may be due to autoimmune encephalitis

Bergink V et al. AJP, 2015; 172(9): 901-8.
Perinatal Anxiety

• Spectrum of anxiety symptoms occurring during pregnancy and/or the postpartum period.
• As common as perinatal depression! Estimated 8.5-13% of women.
• Anxiety may occur in conjunction with perinatal depressive symptoms (usually a more severe illness, and more difficult to treat), or independently of mood disturbances.
• Onset: If anxiety symptoms present during pregnancy, they most commonly present in the first trimester. If onset is postpartum, symptoms may present in the first 2 weeks to 6 months following delivery.
• Symptoms: Persistent and excessive worries, inability to relax, physiological arousal (palpitations/chest pain, air hunger, diaphoresis, dizziness, etc.).
  • Intrusive thoughts are COMMON, often regarding harming infant
    • NO intention of harming infant
    • Will go to great strides to avoid infant
    • Need to differentiate from psychotic symptoms
    • Hesitant to share, fearful of child protection involvement

• Screening of perinatal anxiety disorders
  • Certain items on EPDS scale target anxiety
  • Perinatal Anxiety Screening Scale (PASS)
Obsessive-Compulsive Disorder

- An anxiety spectrum disorder characterized by repeated, intrusive obsessive thoughts that are accompanied by compulsive, sometimes ritualistic behaviors performed to relieve anxiety associated with the intrusive thoughts. Mothers will recognize the thoughts as being irrational and are often fearful of or disturbed by them.
- Onset: Prior to pregnancy, during pregnancy, or up to 1 year postpartum.
- Prevalence: 4% of women.
- Signs/Symptoms:
  - Disturbing repetitive thoughts that are recognized as irrational, including thoughts of harming the baby
  - Compulsive behaviors often involve behaviors dedicated to protecting the baby (e.g., frequent checking, hand washing, etc.)
Post-traumatic Stress Disorder

- Anxiety symptoms precipitated by a traumatic experience (including a history of traumatic birth experience).
  - Preexisting PTSD may also be exacerbated by a traumatic birth experience!
- Onset: May be present prior to pregnancy or result from a traumatic birth experience.
- Prevalence: Affects an estimated 2-15% of women.
- Signs/Symptoms: Syndrome that may include nightmares, hyperarousal, pervasive thoughts or re-experiencing of past trauma, irritable mood, the tendency to avoid disturbing stimuli, physiological arousal symptoms.
Is it Important to Differentiate Between Perinatal Depressive and Anxiety Symptoms?

• Studies have demonstrated that women struggling with perinatal depression will frequently present with significant anxiety symptoms.

  • Nearly half of all women experience obsessions and compulsions postpartum— the majority of which do not represent overt OCD, but may signal significant perinatal depression.

• Detecting comorbid anxiety symptoms will facilitate appropriate and targeted treatment recommendations (SSRIs are effective for both anxiety and depressive symptoms) and confer better outcomes for both mom and baby.
Why is this important?

The prevalence of depression is similar for pregnant and non-pregnant women.

Pregnancy is NOT protective!
COMMITTEE OPINION

• May 2015, American College of OB/GYN guidelines updated
  • “Clinicians screen patient at least once during the perinatal period for depression and anxiety symptoms using a standard, validated tool.”
  • “Coupled with appropriate follow-up and treatment”
  • “Systems should be in place to ensure follow-up for diagnosis and treatment”

U.S. Preventive Services
TASK FORCE

• “Recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.”

• Other issues: Providers need to be cautious regarding misdiagnosis of bipolar disorder (i.e. need to screen for symptoms of mania), and screen for anxiety disorders.
Screening for Perinatal Mood and Anxiety Disorders

- Recommended screening timeline:
  - Initial prenatal visit.
  - 28 weeks gestation.
  - 2-4 weeks postpartum (or at OB 6 week postpartum visit)
  - 12 weeks postpartum.
  - Consider another screening at 9-12 months postpartum

- Utilize a validated screening tool. Most commonly utilized in pregnancy: EPDS and PHQ-9

- Have protocols in places to address:
  - Score above cut-off OR acknowledgement of self-harm (or harm to baby)
  - Local mental health resources
  - Emergent resources (if patient at imminent risk)

- Normalize process; acknowledge that you (or your practice) screens all women for mood and anxiety disorders during pregnancy and postpartum.

- Document as part of OB visit.
<table>
<thead>
<tr>
<th>Screening Tool</th>
<th>Number of Items</th>
<th>Time to Complete (Minutes)</th>
<th>Sensitivity and Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh Postnatal Depression Scale</td>
<td>10</td>
<td>Less than 5</td>
<td>Sensitivity 59–100% Specificity 49–100%</td>
</tr>
<tr>
<td>Postpartum Depression Screening Scale</td>
<td>35</td>
<td>5–10</td>
<td>Sensitivity 91–94% Specificity 72–98%</td>
</tr>
<tr>
<td>Patient Health Questionnaire 9</td>
<td>9</td>
<td>Less than 5</td>
<td>Sensitivity 75% Specificity 90%</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>21</td>
<td>5–10</td>
<td>Sensitivity 47.6–82% Specificity 85.9–89%</td>
</tr>
<tr>
<td>Beck Depression Inventory–II</td>
<td>21</td>
<td>5–10</td>
<td>Sensitivity 56–57% Specificity 97–100%</td>
</tr>
</tbody>
</table>
Why is Screening Important?

• Unfortunately, routine screening for antenatal depression is uncommon!
• 30-50% of women who have postpartum depression had depressive symptoms during pregnancy
• < 20% of women diagnosed with PPD had reported their symptoms to a provider
• When identified, perinatal depression is often not treated or only partially treated
  • < 30% of women with positive screen attend a mental health visit
  • < 10% adhere to full treatment course
How to Talk About Perinatal Mental Health Symptoms with Moms

• If completed a screening tool: Acknowledge and thank mother for doing so. Review score with them. Ask why they chose the answers that they did about certain questions.
• How are you feeling about being pregnant/a mother?
• What things are you most happy about?
• What things are you most concerned about?
• Do you have anyone you can talk to that you trust?
• How is your partner doing?
• Are you able to enjoy your baby?
# Assessing Suicidal Ideation

<table>
<thead>
<tr>
<th><strong>Lower Risk</strong></th>
<th><strong>Higher Risk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No prior attempts</td>
<td>History of suicide attempt</td>
</tr>
<tr>
<td>No plan</td>
<td>High lethality of prior attempts</td>
</tr>
<tr>
<td>No intent</td>
<td>Current plan</td>
</tr>
<tr>
<td>No substance use</td>
<td>Current intent</td>
</tr>
<tr>
<td>Protective factors (what prevents you from acting?)</td>
<td>Substance use</td>
</tr>
<tr>
<td></td>
<td>Lack of protective factors</td>
</tr>
<tr>
<td></td>
<td>(including social support)</td>
</tr>
</tbody>
</table>
Assessing Thoughts of Harming Baby

Thoughts of Harming Baby that Occur Secondary to Obsessions/Anxiety
- Good insight
- Thoughts are intrusive and scary
- No psychotic symptoms
- Thoughts cause anxiety

Suggests not at risk of harming baby

Thoughts of Harming Baby that Occur Secondary to Postpartum Psychosis
- Poor insight
- Psychotic symptoms
- Delusional beliefs with distortion of reality present

Suggests at risk of harming baby
Non-Pharmacologic Management of Perinatal Psychiatric Disorders
Non-Medication Treatment Options

- Use of non-medication options should always be encouraged conjointly
- Avoids any known or unknown risks that might be associated with fetal exposure
- Therapy should always be encouraged!
  - Cognitive behavioral therapy (CBT)
  - Supportive psychotherapy
  - Conjoint therapy with partner
- Appropriate self care is paramount!
Other Non-Medication Treatment Interventions

• Adequate sleep
• Good nutrition
• Elimination of caffeine, nicotine, and alcohol
• Attempts to reduce stressors
• Encouraging saying “yes” to offers of help and support

• Psychoeducation
• Relaxation techniques
  • Mindfulness
• Peer to peer support groups
  • In-person
  • Online
• Bright light therapy
Psychotropic Medication Use in Pregnancy
Pregnancy and Lactation Labeling Rule (PLLR)

- December 2014, the FDA published PLLR with implementation over next three years
- Narrative model for drug labeling and requires that pregnancy-related information be provided under 3 sections on the prescription label:
  1. Pregnancy
  2. Lactation
  3. Females and males of reproductive potential.
- Summarizes risks to the fetus, illness-related clinical considerations, and available safety data
- Replace the “risk” categories, support evidence-based decisions
Medication Use During Pregnancy

- % taking 4 or more medications at any time during pregnancy
- % taking 4 or more medications at any time during the first trimester

About 1 in 7 women of reproductive age take an antidepressant. Talk to your doctor about medication use before and during pregnancy.
Fewer than 10% of medications have enough information to determine fetal risks.

Some women need to take medication during pregnancy.

www.cdc.gov/pregnancy/meds
SSRI: Serotonin Specific Reuptake Inhibitors

- Represent over 60-70% of new prescriptions for depression
- Easy to use and dose
- High therapeutic index
- Common side effects:
  - Headaches
  - GI upset
  - Weight gain dependent on anticholinergic activity
  - Sexual dysfunction
  - Withdrawal syndrome

- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Fluvoxamine (Luvox)
Potential Risks of SSRIs in Pregnancy: General Outcomes

• Poor pregnancy outcomes, controversial?
  • Meta-analysis failed to find statistically significant and/or clinically relevant
differences between antidepressant-exposed and non-exposed infants:
birth weight, length of gestation and APGAR scores
  • Increased risk of spontaneous abortion
• Increased risk of NICU admission
• Poor neonatal adaptation
Poor Neonatal Adaptation

- Occurs in 30% late-pregnancy exposed infants
- Most COMMON effect of SSRI use in pregnancy
- Begins minutes to hours after birth
- Lasts usually 1-4 days, inconsistent reports of signs > 1 week
- Can occur with any antidepressant
- NOT dose dependent
- Supportive treatment only

- Symptoms may include:
  - Jitteriness
  - Constant crying
  - Feeding/Sleeping problems
    - Desaturation with feeding
  - Autonomic instability
  - Tachypnea
  - Hyperreflexia/hypertonia
  - Seizures
  - Lower quality of movement
  - More CNS-stress abstinence signs
  - Poorer self-regulation, higher arousal levels at day 14 post-delivery

Salisbury AL. AJP. 2015 Oct 30
Congenital Anomalies

- None in prospective, controlled studies
- None in meta-analyses of those studies
- Retrospective case-control studies
  - Some have not demonstrated increased risk
  - Increased risk of anencephaly (RR 2.4), craniosynostosis (RR 2.5), omphalocele (RR 2.8)
    - Need to put in terms of absolute risk!
- Retrospective database reviews
  - Controversial! Increased risk of septal heart defects
  - “Worst” data = 1.5% risk of cardiac defects (general population = 1%)

<table>
<thead>
<tr>
<th>Study</th>
<th>Publication Date</th>
<th>Journal</th>
<th>Key Details</th>
</tr>
</thead>
</table>
| **Furo et al. May 2015. BMJ.** | | | • Nation-wide health register. 5 Nordic countries.  
  • 2.3 million births.  
  • Sibling-controlled discordant analysis  
    • Able to adjust for confounding factors (genetics, family-related concerns)  
  • N=36,772 exposed to SSRIs  
  • Not associated with increased risk of any malformations |
  • Case control.  
    • N=17,952 with defects  
    • N=9,857 without defects  
    • N=1,285 exposed to SSRIs  
  • Compared to previously identified birth defects categories  
  • Increased risk of malformations in children exposed to fluoxetine, paroxetine |
Other Concerns with SSRI Use in Pregnancy

• Persistent pulmonary hypertension of the newborn (PPHN)
  • 2014 meta-analyses demonstrated late term use had increased risk of PPHN (OR = 2.5) Did NOT control for known risk factors of PPHN (smoking, obesity, prematurity, C-section)
  • FDA revised warning, cannot make conclusions based on evidence
  • Large cohort study utilized Medicaid enrollees, OR= 1.28, may be due to residual confounding factors

• Neurodevelopmental outcomes
  • Current thought that exposure to untreated severe maternal depression in utero and during early childhood is associated with worse cognitive and behavioral outcomes than antidepressant medications

Huybrechts KF. Antidepressant Use late in Pregnancy and Risk of PPHN. JAMA 2015;2; 313(21): 2142-2151
Nulman I. Neurodevelopment of children exposed in utero to antidepressant drugs. NEJM 1987; 316(4): 258-62.
Grigoriadis S. Prenatal exposure to antidepressants and persistent pulmonary hypertension of the newborn: systematic review and meta-analysis. BMJ. 2014 Jan 14.
Autism Spectrum Disorder

• Several epidemiologic studies demonstrated an association with prenatal exposure of SSRIs and ASDs
• Increased risk may be all, or least in part, due to confounding factors, primarily maternal psychiatric disorder itself
  • Studies unable to distinguish between effects of drug exposure and consequences of underlying maternal psychiatric illness
  • Studies attempt to control for maternal mental illness, no reliable measures of severity
• Data at face value = 87% risk.
  • Average child = 1% risk, then child exposed to SSRIs = 1.87% risk.

SNRIs in Pregnancy: Venlafaxine, Desvenlafaxine, and Duloxetine

- October 2015 systematic review, risk of major congenital malformations after first-trimester exposure to venlafaxine or duloxetine.
  - Eight cohort studies were identified
  - N = 3186 exposed to venlafaxine and N = 668 exposed to duloxetine.
  - Venlafaxine-exposed group = 107 major malformations
    - 3.36% risk of major malformations. RR = 1.12. 95% CI = 0.92-1.35.
  - Duloxetine-exposed infants and observed 16 major malformations
    - 2.33% risk of malformations. RR = 0.80. 95% CI = 0.46-1.29.

- Possible increase in miscarriage
- Possible increased risk of hypertension
  - Monitor BP closely with initiation
  - Concern if patient becomes pre-eclamptic

- No behavioral studies

Lassen D. First-trimester pregnancy exposure to venlafaxine or duloxetine and risk of major congenital malformation: a systematic review. Basic Clin Pharmaco Toxicol. 2016; 118(1): 12-6
Bupropion

- No increased risk of congenital anomalies
- Decreased birth weight at higher doses
- Elevated rate of spontaneous miscarriage (p=0.009)
- Lowers seizure threshold – possible risk in women with pre-eclampsia
- Bupropion registry: [http://pregnancyregistry.gsk.com/bupropion](http://pregnancyregistry.gsk.com/bupropion)

Mirtazapine

- Recent case series, n = 56
  - None with major malformations
  - N = 14 (25%) risk of poor neonatal adaptation
- If add to previous cases, n = 300, no clear signal increasing malformation risk
- Side effect considerations:
  - Nausea less likely than with SSRIs; may be used with hyperemesis gravidarum
  - Weight gain can increase obstetric complications
    - 40% patients have >7% increase in body weight in one year
  - Sedation may be difficult to tolerate in pregnancy and postpartum, however can be helpful in patients struggling with insomnia

Breast-feeding and Psychotropic Medication Use
General Principles

• All psychotropic agents are secreted into breast milk, but concentrations may vary considerably

• Amount of exposure dependent on:
  • Maternal dosage, frequency of dosing, rate of maternal metabolism, frequency and timing of feedings
  • Typical peak concentrations into breast milk = 6-8 hours

• Whether infant experiences toxicity dependent on:
  • Amount of medication ingested, rate of metabolism
  • Neonate metabolism 1/3 to 1/5 that of adult
  • Concern for infants w/ hepatic compromise (hyperbilirubinemia)
General Principles, cond.

• Considering measuring medication level in infant’s serum
  • Must remember to measure metabolites.
  • Ask laboratory to use highest level of sensitivity.
• American Academy of Pediatrics: “safe” breast-feeding ratio of infant dose exposure to maternal dose < 10%.
• If taking antidepressants in pregnancy, continue the same medication during lactation to limit the infant’s exposure to a single medication
Potential Risks of Psychopharmacology Postpartum

• Sedation
  • Reduces energy to parent
  • May sleep too soundly to awaken for baby
• Reduction in restful sleep
• Weight gain may be less tolerable postpartum
• Sexual dysfunction may be less tolerable postpartum
• Effects on breast feeding infant
<table>
<thead>
<tr>
<th>Antidepressant</th>
<th>Estimated % Ingested by Infant</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>1.2-12.0%</td>
<td>crying, fussiness, drowsiness</td>
</tr>
<tr>
<td>Sertraline</td>
<td>0.4-2.3%</td>
<td>No ADRs noted</td>
</tr>
<tr>
<td>Paroxetine</td>
<td>0.1-4.3%</td>
<td>1 case: SIADH</td>
</tr>
<tr>
<td>Citalopram</td>
<td>0.7-9.4%</td>
<td>poor sleep, weight loss, irritability</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>7.9%</td>
<td>No ADRs noted</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>3.8-9.2%</td>
<td>decreased wt gain</td>
</tr>
<tr>
<td>Bupropion</td>
<td>2%</td>
<td>1 case: seizure</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>1.5%</td>
<td>No ADRs noted</td>
</tr>
</tbody>
</table>
Benzodiazepines

- May accumulate secondary to immature liver enzymes
- Transfer rate typically < 2-3%
- Some case reports of sedation, lethargy, irritability, impaired respiration
- Pooled data suggest a relatively low incidence of adverse events, particularly when used at a low dosage or on as needed basis
Clinical Pearls
Pre-conception Planning!

• 50% of pregnancies are unplanned in the US
• ASK: “Would you like to become pregnant in the next year?”
  • www.onekeyquestion.org
• DOCUMENT about birth control and/or conception planning
• Discussion of risks at time of administration of medications, rather than awaiting conception
• Encouragement of women to contact mental health provider upon learning of their pregnancy prior to discontinuation of any medication
Return to previous effective medication if appropriate.

Monotherapy if possible.

Utilize lowest effective dose of medication.

Majority of risks NOT dose dependent.

Avoid exposure to patient/fetus of symptoms and medication.

Appropriate monitoring of fetus and mother based on drug regimen utilized.

Vast majority of psychotropic medications can be safely utilized during breastfeeding.
The Periscope Project is **free resource** for health care providers caring for **perinatal women** who are struggling with **mental health** or **substance use disorders**.

**Providing health care professionals access to:**

1. Real time provider-to-provider psychiatric teleconsultation
2. Education
3. Community resource information
TELECONSULTING WITH PERINATAL PSYCHIATRIST

How to access psychiatrist:
- **Monday – Friday, 8am – 4pm**
- **Call:** 877-296-9049 or **Email:** theperiscopeproject@mcw.edu
- Program Coordinator to triage call, connected to Psychiatrist **within** 30 minutes
When to utilize teleconsultation services:

- Psycho-pharmacology or substance use treatment
  - Preconception, during pregnancy or while breastfeeding
- Screening tools
- Diagnostic clarification
- General questions on behavioral health during perinatal period
PROVIDER EDUCATION AND TOOLS

Available online:
www.the-periscope-project.org

Toolkit
- Downloadable PDFs
- www.the-periscope-project.org
- Evaluation guides
- Screening tools
- Treatment algorithms
PROVIDER EDUCATION AND TOOLS

Presentations

- **In-Person**
  - Grand rounds, faculty or staff meetings

- **Online:** [www.the-periscope-project.org](http://www.the-periscope-project.org)
  - Antidepressant Use in Pregnancy
  - Anxiolytic and Hypnotic Use in the Perinatal Period
  - Management of Opioid Use Disorders in the Perinatal Patient
  - Perinatal Psychiatric Disorders
  - Psychotropic Medication Use in Breast-feeding
COMMUNITY RESOURCE INFORMATION

- Access through Program Coordinator
  - 877-296-9049 or theperiscopeproject@mcw.edu
  - Monday – Friday 8am – 4pm

- Types of resource information
  - Support
  - Psychotherapy
  - AODA
  - Therapy

Focused on greater Milwaukee area
WHY ENROLL?

- Build your capacity to treat patients
- Specialty consultations with no added cost
- More robust care for perinatal patients
- Demonstrates need and utilization for funding
- Initial steps towards making teleconsultation a reimbursable service
“The experience was extremely valuable and timely as the phone call was received as the patient was completing her therapy session that had been prescheduled. I learned a number of new items regarding the medications and what to expect in the perinatal time. We did make medication adjustments consistent with the recommendations. I am encouraging colleagues to use this service.”

Luke Warpinski, M.D.
Family Medicine
QUESTIONS & CONCERNS

Christina Wichman, Medical Director
Shelby Borchardt, Program Coordinator
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414-955-8972

Visit us online: www.the-periscope-project.org
Thank you!

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