

# PERINATAL Perspectives

FOCUS:  
Perinatal Mood  
Disorders

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IPN Board Chair Chris Sears and Executive Director Larry Humbert present the Member of the Year Award to Joanne Martin.

## Member of the Year:

**Joanne Martin, DrPH, RN, FAAN**

As one of the original members of IPN, Dr. Martin has played a key role in many of IPN's policy and advocacy efforts. She has shown tremendous leadership and innovation with the community-based Doula Project and statewide efforts to address perinatal mood disorders. Dr. Martin is well known throughout the state and the country for her expertise and dedication to young families. Earlier this year Dr. Martin retired from the IU School Nursing where in addition to her teaching duties, she also led the Institute for Action Research in Community Health. "We at IPN are honored to have worked so closely with Dr. Martin over the years, and are grateful for her passion to improve the lives of mothers and babies in Indiana," said IPN Executive Director Larry Humbert.

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## ISDH UPDATE

On February 8, 2011, the federal Health Resources and Services Administration and Association for Children and Families released the second and final portion of the Maternal, Infant and Early Childhood (MIEC) Home Visiting Program funding opportunity. This request asks states and other entities to expand on the first two phases of the application (State Plan and State Needs Assessment) to produce an Updated State Plan to implement and coordinate the State's MIEC Home Visiting Program. The request also identifies seven home visiting models that will be considered evidence-based for the purposes of the application. These models are:

- Early Head Start- Home-Based Option
- Family Check-Up
- Healthy Families America
- Healthy Steps
- Home Instruction Program for Preschool Youngsters (HIPPY)
- Nurse-Family Partnership
- Parents as Teachers

For more information on the selection process and details about each program please see: <http://homvee.acf.hhs.gov/>.

Prior to the submission of the original State Plan, Governor Daniels designated the Department of Child Services and the Indiana State Department of Health as co-lead agencies for the purposes of this funding opportunity. Indiana's State Plan identified processes, resources, and technical needs for completing a state needs assessment. Indiana's Needs Assessment, submitted in September 2010, identified 11 at-risk counties through rigorous data analysis and evaluation of county resources. These counties are:

- Marion
- Lake
- La Porte
- St. Joseph
- Starke
- Owen
- Grant
- Elkhart
- Scott
- Jennings
- Fayette

Currently, ISDH and DCS are working to complete the final portion of the application, which requires a more detailed data and resource analysis at a community level within the identified counties. This process will guide the identification of the most at-risk communities and the evidence-based model(s) that best fit with the needs of each targeted community. The Updated State Plan is due June 8, 2011.

For questions or comments, please contact Indiana State Department of Health Home Visiting Program Coordinator, Mallory Quigley at [mquigley@isdh.in.gov](mailto:mquigley@isdh.in.gov).

## Perinatal Perspectives

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IPN thanks these individuals for their contributions to Perinatal Perspectives and its editorial standards.

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## Member Spotlight

Indiana Perinatal Network has created two new awards, Member of the Year and Member Organization of the Year, to honor the dedication and commitment of our members to improving the health of mothers and babies in our state.



## Member Organization of the Year: MDwise

Since 1994, MDwise has been managing health services for pregnant women, infants and families as part of the Medicaid Hoosier Healthwise, HIP and Care Select Programs. In 2010, the NCOA designated them as the top-ranked Medicaid health plan in Indiana for quality service and member satisfaction. MDwise has been a long-standing partner of IPN and their staff have served on a variety of IPN advisory boards. Over the years they have used many IPN professional and consumer education materials to educate their network providers and their members. "We appreciate the work MDwise does in helping some of our state's most vulnerable populations," said Larry Humbert, "and we look forward to continuing our successful partnership in the years to come."

**Interested in becoming an IPN Member? Visit <http://www.indianaperinatal.org/sections/join.php> for individual, organizational and hospital membership options.**

## Spirit of Service Awards Presented at IPN Forum

Four recipients were honored at Controversies & Innovations in Perinatal Health on March 11, 2011.

### Marilyn Graham Community Service Award

Abby E. Beall, MD, FACOG—Shadeland Family Care Center

The mission of Shadeland Family Care Center is to provide excellent care to underserved families with a focus on pediatric and obstetrical needs, and Dr. Beall is committed to providing compassionate and appropriate care to each and every family she encounters. She strives to provide the most up to date, comprehensive care to mothers and babies with complex medical problems in high risk social settings. Her model of care involves an emphasis on teaching, not just patients, but also the many Family Medicine residents she is training in competency for obstetric care. Through her teaching, Dr. Beall multiplies her positive effect on this often overlooked population. In the words of one coworker, "Dr. Beall works tirelessly and passionately to ensure that all her patients have access to care and are treated well and with dignity by all."

### Advocacy Award

Elaine Cox, MD, FAAP—One Test Two Lives: Prevent HIV Indiana

In 2008, Dr. Cox and her colleagues at the Ryan White Center for Pediatric Infectious Diseases at Riley Hospital for Children recognized a trend of infants infected with HIV being referred to the clinic for care. In response, Dr. Cox convened a group of concerned providers, watchful epidemiologists, and politically powerful advocates to form the One Test Two Lives: Prevent

HIV Indiana Committee. Under the leadership of Dr. Cox, the committee seeks to educate healthcare providers, inform patients and advocates for legislative change about the need for HIV testing during prenatal care, and promote sound clinical practices by offering access to educational materials, innovative resources and training opportunities. Dr. Cox is also highly collaborative in her work, partnering with the Minority Health Coalition, IU Health Partners, Representative Peggy Welch and other legislators to introduce changes to the existing law designed to increase HIV screening during pregnancy. Her passion and commitment to improving the health of moms and babies in Indiana is truly remarkable.

### Julie A. Foster Communication Award

St. Mary's Medical Center

St. Mary's Medical Center has a strong history of using technology and advanced communication methods to provide the highest level of care for their patients. In 2010, after hearing of multiple instances in which parents being discharged did not fully understand their discharge instructions, a project was initiated by patient advocate Guillermo Guevara to find a better way of providing translation services. By collaborating with a local Hispanic advocacy group, St. Mary's Medical Center organized 18 volunteers certified as medical interpreters. In the months since the program has been fully operational, St. Mary's Medical Center has been able to provide live interpretation services to several laboring families as well as in-depth discharge information in their native language. This unique project helped the hospital to improve care for those most at risk in their community.



IPN Board Chair Chris Sears and Executive Director Larry Humbert present the Clinical Care Award to Rene Atkins, RN, IBCLC of St. Francis Hospital.

### Clinical Care Award

Rene Atkins, RN, IBCLC—St. Francis Hospital

As the hospital's Lactation Services Coordinator, Rene Atkins has quadrupled the lactation department in a little over a year. She has developed services that include breastfeeding education and support for postpartum mother-infant dyads as inpatients, as well as ongoing resources after discharge including written information, referrals, telephone support, breastfeeding support groups, and outpatient breastfeeding appointments. Following Rene's vision of an evidence-based standard of care for lactation support, each delivering mother receives the information, hands-on breastfeeding assistance, and empowerment she needs to reach her breastfeeding goals. According to a coworker, "Rene is a unique visionary with the planning and follow-through that allows staff to support mothers and infants and provide the best possible lactation care."

## Legislative and Policy Update

### Indiana News

The 2011 legislative "long session" has been marked by sometimes-contentious dissent on hot button issues, a five week walkout, and efforts to enact sweeping health-related legislation.

The House Democrats returned to the Statehouse at the end of March, and members of the Indiana General Assembly have been moving quickly to wrap up legislative business before the official end of the session on April 29. In light of the delays occurring as a result of the walkout, the deadline for third reading in both the House and the Senate was extended until April 21, shortening the time available for conference committee negotiations at the end.

*Below, IPN highlights developments on a few of the many bills which we have been involved with or are following. To find out more about IPN's legislative efforts this session, visit [http://www.indianaperinatal.org/sections/latest\\_alert.php](http://www.indianaperinatal.org/sections/latest_alert.php). To receive legislative updates from IPN via email, visit [www.indianaperinatal.org](http://www.indianaperinatal.org), and click on "Add me to the email list".*

**SB 581** (Becker)—**HIV testing of pregnant women.** This bill was supported by the One Test, Two Lives committee, of which IPN is a member. Crafted in response to the rise in perinatal HIV transmission occurring in Indiana, the bill requires a pregnant woman's oral or written consent for an HIV test to be documented in her medical chart instead of requiring a written statement of consent. It was amended to require a committee to study issues concerning current laws regarding consent for HIV testing. Status: *The bill passed both chambers and was signed into law by Governor Daniels.*

**SB 245** (Kruse)—**Prenatal substance abuse commission and office of women's health.** Status: The bill, which would reauthorize the prenatal substance use commission and allow the ISDH Office of Women's Health to accept donations, passed the Senate *but was not heard by the House.*

**HB 1018** (Brown, Turner, Candelaria, Reardon, Welch)—**Smoking ban in public places.** Status: heavily amended and approved in the House, the bill was heard by the Senate Committee on Public Policy on April 6th and was *defeated 8-1.*

**HB 1476** (T. Brown)—**Medicaid waiver for family planning services.** Language from this bill was amended into **SB 461** (Miller), **Federal health care matters**, to require the Office of Medicaid Policy and Planning to apply for a federal State Plan Amendment to expand family planning services to women and men, and require OMPP to report on the progress of the plan amendment to the state Medicaid Oversight Committee during its 2011 interim meetings. Among numerous other provisions, the bill also prohibits a state agency from implementing or preparing to implement the federal Patient Protection and Affordable Care Act. *The bill passed both chambers and was signed into law.*

### Federal News

A federal government shutdown has been averted following a last-minute agreement to cut \$39 million in federal spending. The Association of Maternal and Child Health Program reports that although some cuts will be likely, the final bill restores most funding for the Title V Maternal and Child Health Services Block Grant and other key MCH-related programs. Funds for Title X Family Planning programs were cut by \$17 million. Source: *AMCHP, New York Times.* A summary of cuts to other federal agencies is available by going to [http://www.washingtonpost.com/blogs/federal-eye/post/whats-getting-cut-in-the-fy-2011-budget/2011/04/11/AFMlynLD\\_blog.html](http://www.washingtonpost.com/blogs/federal-eye/post/whats-getting-cut-in-the-fy-2011-budget/2011/04/11/AFMlynLD_blog.html).

*For information on these or other issues, please contact Caitlin Priest, MPH, at [cpriest@indianaperinatal.org](mailto:cpriest@indianaperinatal.org) or (317) 924-0825 ext. 4231.*

# FOCUS: PERINATAL MOOD DISORDERS

## Perinatal Mood Disorders—What's the Problem?

- As many as 80% of new mothers will experience mild mood changes during or after the birth of a child.
- 15%–20% of new mothers will experience more severe symptoms of depression or anxiety.
- Perinatal mood disorders often remain undiagnosed due to multiple factors including a new mom not recognizing her symptoms or assuming her feelings are an inevitable part of motherhood; hesitation to admit that there is a problem; lack of awareness by friends or family members; and lack of provider knowledge about screening and treatment.
- Left untreated, perinatal mood disorders can have serious adverse effects on the mother, child and family.
- A variety of effective treatment options are available including medication, counseling or some combination of both.

### IPN's Response

Since 2002, IPN has assumed a lead role in expanding the screening, diagnosis, and treatment of perinatal mood disorders throughout Indiana. Among these efforts, the Indiana Perinatal Network . . .

Convened the **Indiana Perinatal Mood Disorders Task Force** to improve statewide infrastructure and capacity related to PMD prevention, awareness, treatment, and policy

Launched Something's Not Right, a **multimedia public awareness campaign** that includes booklets and posters in both English and Spanish, as well as an online interactive *Edinburgh Postnatal Depression Scale* screening tool

Maintains a list of providers by county who offer **perinatal mood disorder support services**

Developed the **Recognizing Perinatal Depression online training** designed to help home visitors, health care professionals and other care providers recognize perinatal depression and provide support to the new and expectant mothers who experience it

Produced the **Postpartum Depression Consensus Statement**, a comprehensive review of the incidence and significance of depression and other mood disorders women can experience during and after pregnancy

Presented **perinatal mood disorder trainings** to healthcare professionals across the state; offered PMD as a topic in the 2009 and 2011 Regional Workshop Series

*More detailed information about IPN's services can be found in the Resources section.*

## Perinatal Mood Disorders: Key Messages for Providers

Birdie Gunyon Meyer, RN, MA, Coordinator, Perinatal Mood Disorders, IU Health

Although the term **postpartum depression** (PPD) is used and known by most lay and professional people, the term **perinatal mood and anxiety disorders** (PMAD) is a more accurate term.

Perinatal mood disorders refers to a spectrum of mood disorders that can occur anytime during the pregnancy or in the first year postpartum. Categories include:

The **baby blues** (not a diagnosis) affects 50–80% of childbearing women. The blues are generally believed to occur due to rapid changes in hormones, physical and emotional exhaustion following delivery and sleep deprivation. Women may feel irritable, fatigued, cry easily, and feel unsure about new parenting duties. These feelings may last for a few days to 2 weeks.

**Pregnancy or postpartum depression** is characterized by sleep disturbances (too much or too little), eating disturbances (overeating, craving sugar, chocolate, and/or carbs, or lack of appetite), “more bad days than good days”, a sense of hopelessness, worthlessness, difficulty concentrating, feeling irritable or angry, and possible suicidal thoughts.

**Pregnancy or postpartum anxiety** are often described by mothers as “can’t sleep even when the baby is asleep”, “feel like my brain’s burning”, “feel like my skin’s crawling”, “feel nervous”, “excessive worries”, “not hungry, can’t eat”. Women may experience heart palpitations, tingling or numbness in hands and the inability to sleep.

**Pregnancy or postpartum panic disorder** can include all the symptoms of anxiety described above and progress to a full-blown panic attack. Panic attacks can also include shortness of breath, chest pain, or even passing out. Women may go to the emergency room thinking they

are having a heart attack or are dying. Common fears during a panic attack are feeling out of control, going crazy, or feeling like they might die.

### Postpartum obsessive-compulsive disorder:

Obsessive refers to repetitive thoughts. Compulsions refer to behaviors people do to avoid or minimize the anxiety produced by the obsessive thoughts. It may look like excessive worry (checking on the baby frequently), or counting, checking or cleaning. Sometimes women get frightening thoughts or even mental pictures of something bad happening to baby; often the pictures may be about the mom herself hurting the baby. These pictures can seem vivid and horrifying.

**Postpartum posttraumatic stress disorder** (PTSD) is seen in 1–6% of women following a traumatic or disappointing birth experience, or medical complications that occurred for the mom or baby at delivery or postpartum period. It can also be caused by a previous traumatic event earlier in life—physical or sexual abuse or other traumatic event. Symptoms include recurrent nightmares, reliving past traumas, and avoiding reminders of trauma. Women with PTSD often feel they were abandoned, not well cared for, or stripped of their dignity during birth. They felt a sense of powerlessness and lack of protection by their caregivers.

**Postpartum bipolar disorder** (BPD) is often misdiagnosed as depression. It's common for people to suffer for years with an incorrect diagnosis and treatment plan. Women with BPD should be followed closely by a psychiatrist trained in reproductive health throughout pregnancy and postpartum. Many times, women with BPD are told to stop taking their medicines. Unfortunately, up to 80% of women who stop taking their medication will suffer a relapse.

*(continued next page)*

**Postpartum psychosis (PPP)** is considered a medical or psychiatric emergency. It occurs in 1 or 2 women per 1000 births. Symptoms include difficulty relaxing, incoherence, confusion, hallucinations, difficulty sleeping, and inability to sleep. These symptoms may come and go. PPP is associated with a 5% suicide rate and a 4% infanticide rate.

**Risk factors for PMD's can include:**

- Personal or family history of depression, anxiety disorders, psychosis, bipolar, schizophrenia
- History of severe PMS (PMDD)
- Lack of sleep/fatigue
- Previous episode of postpartum depression, anxiety, OCD, PTSD, or psychosis
- History of fertility issues, miscarriage or infant loss
- Thyroiditis
- History of physical or sexual abuse

- Traumatic or disappointing birth experience
- Poor support system, relationship issues, childcare stress
- Life stress or loss

**Treatment options:**

- Getting information and education
- Self-care plan—rest, sleep, good nutrition, mild exercise
- Social support—peer support groups, therapeutic support groups
- Spirituality
- Therapy—personal, couples, family
- Medications if needed
- Hospitalization

Contact Birdie Gunyon Meyer at [BMeyer2@iuhealth.org](mailto:BMeyer2@iuhealth.org).

## PROFILE: *Kathy James, LCSW*

*Perinatal Mood Disorders Program, Family and Children's Center, South Bend*

"It is incredibly rewarding to have a mom who was struggling with postpartum depression come back and tell us how much she is enjoying her baby," says Kathy James, LCSW, Program Director of the Perinatal Mood Disorders program at the Family and Children's Center in South Bend.

A licensed clinical social worker who has worked at Family and Children's Center for six years, James first saw a need for support for families dealing with perinatal issues at her church. She started a support group for women struggling with motherhood, and after the positive reaction she received, decided to expand her mission. James's next step was to approach the executive director and clinical director at the Family and Children's Center and present the idea of expanding perinatal support services. "Their support has been nothing short of phenomenal," James said, including sending therapists to conferences for training and providing access to the center's marketing team. "Our mission is to prevent child abuse, and helping moms with perinatal mood disorders fits perfectly with that mission, said James. "Helping moms be happy and healthy helps to preserve the family and ultimately prevents child abuse."



*Kathy James, LCSW*

Family and Children's Center now offers 11 therapists who are specifically trained in perinatal mood disorders, and has seen the perinatal mood disorders program double over the past year. Referrals to the center come from a variety of sources, including hospitals, OB-GYN offices, the Healthy Families Program, and community agencies. Each mother then has an individual assessment where a therapist can evaluate her

immediate needs and specific symptoms. Therapists always encourage family involvement, whether it's a partner, mother, sister or anyone close to the mom.

Once the initial treatment plan has been made, therapists work to transition moms into support groups. "It's absolutely incredible to see the relationships that the moms develop during the group process," James said. The center has also recently started a mentoring program, pairing women who have survived PMD with women who are recently diagnosed. This approach has helped moms who may not be comfortable sharing their feelings in a group setting. James adds that she has been impressed with how willing the PMD survivors are to provide support to the new moms.

Much of the program's funding comes from United Way, which James credits with seeing a need in the community. The center relies on outside funding to offset costs for women who may lose their Medicaid coverage when they are in the depth of their condition. "We feel a real sense of responsibility to not abandon these women when they are most in need of support," said James.

James says that she has seen positive changes over the past 6 years, with providers becoming more willing to screen women and ask for resources. A common perception is that providers

*"It really helps people to put a face to the issue," James said.*

*"As community awareness increases, it will only help us to provide better support and care to our moms."*

don't screen women for PMD because they aren't sure what to do if the woman needs further help. James's program combats this issue by making the screening and referral process as seamless as possible—providers are given one number to call, all referrals go through one intake coordinator and the woman is scheduled for a follow up appointment within 24 hours of the referral.

James plans to continue to build on the success of the program, with goals of improving lines of communication with nursing staff and becoming more visible in physician's offices. The team of therapists meets monthly for continuing education, and recently held a community conference that drew over 100 people and included a panel of PMD survivors. "It really helps people to put a face to the issue," James said. "As community awareness increases, it will only help us to provide better support and care to our moms."

Contact Kathy James at [KJames@fccin.org](mailto:KJames@fccin.org).

# From the Research

## Postpartum Depression: An Essential Overview for the Practitioner

Postpartum depression (PPD) is a cross-cultural form of major depressive disorder that affects some 13% of women and can have serious health consequences for both the mother and her child. Easy-to-use, reliable, self-administered screening tools are available. PPD may have a variety of etiologies, which include changing plasma levels of estrogen and progesterone, postpartum hypothyroidism, sleep deprivation, or difficult life circumstances. Standard treatments for PPD include psychotherapy and antidepressants. However, treatment of a thyroid condition or insomnia, or even regular exercise or massage may also be beneficial. PPD is underdiagnosed, therefore more screening is needed. Obstetricians and pediatricians have a unique opportunity to screen women for PPD, but general practitioners may also encounter patients with undiagnosed PPD. These physicians could positively impact the lives of depressed mothers and their children by identifying them, then treating or providing referrals for care as appropriate.

Breese McCoy, Sarah J. (2011). Postpartum Depression: An Essential Overview for the Practitioner. *Southern Medical Journal*, 104(2), 128-132.

## American Academy of Pediatrics Statement on Maternal Depression

### *Pediatricians' group urges routine screening, intervention, and referral*

Recognizing the prevalence of perinatal depression as well as the longitudinal relationship pediatricians have with children and families, a new clinical report by AAP recommends that primary care pediatricians incorporate screening for maternal depression into routine well-child care. The AAP's Committee on Psychosocial Aspects of Child and Family Health urges pediatric practices to implement postpartum depression screening and to identify and use community resources for the treatment and referral of the depressed mother and support for the mother-child relationship. The clinical report "Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice" is available online at <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;126/5/1032.pdf>.

Earls, M.F., and the Committee on Psychosocial Aspects of Child and Family Health. (2010). Clinical Report: Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice. *Pediatrics*, 126 (5), 1032-1039.

## New FDA Warning on the Use of Antipsychotic Medications in Pregnancy

The FDA has updated the labels for antipsychotic drugs to include warnings regarding their use during pregnancy. The new drug labels now contain more details on the potential risk for abnormal muscle movements and withdrawal symptoms in newborns exposed during the third trimester of pregnancy. The **FDA Drug Safety Communication** bulletin is available online at <http://www.fda.gov/Drugs/DrugSafety/ucm243903.htm>.

## Diagnosis, Pathophysiology, and Management of Mood Disorders in Pregnant and Postpartum Women

A review in the April issue of *Obstetrics and Gynecology* synthesizes essential information on depressive illness in the perinatal period with a focus on major depressive disorders and bipolar disorder. Authors find that counseling may be sufficient for pregnant and postpartum women who have mild to moderate depression, but women who are severely depressed are likely to require antidepressant treatment. Women with bipolar disorder are at high risk for relapse if mood stabilizer medication is discontinued and are vulnerable to relapse near the time of delivery. Authors urge comanagement of their care with psychiatrists to increase their chances of avoiding a recurrence of illness.

Yonkers, K.A., Vigod, S., and Ross, L.E. (2010). Diagnosis, pathophysiology, and management of mood disorders in pregnant and postpartum women. *Obstetrics and Gynecology*, 117(4), 961-977.

## Preconception Planning to Reduce the Risk of Perinatal Depression and Anxiety Disorders

Women who have depressive and anxiety disorders are at a high risk for recurrence or exacerbation of their psychiatric symptoms during pregnancy or during the postpartum period. This risk can be reduced by implementing preventive measures prior to conception. A systematic preconception clinical assessment can identify factors that may contribute to a woman's risk for developing perinatal depression and/or anxiety. Each of these factors is amenable to interventions that could strengthen a woman's resilience and reduce her likelihood of developing perinatal psychiatric complications. This article reviews the evidence for specific risk factors that can be influenced by preventive interventions, and describes the components of

effective preconception planning for women with depressive and anxiety disorders.

Avni-Barron, O., Hoagland, K., Ford, C., and Miller, L.J. (2010). Preconception Planning to Reduce the Risk of Perinatal Depression and Anxiety Disorders. *Expert Review of Obstetrics and Gynecology*, 5(4), 421-435.

## Prenatal and Postpartum Depression in Fathers and Its Association with Maternal Depression: A Meta-analysis

An analysis published in the *Journal of the American Medical Association* examined studies that documented depression in fathers between the first trimester and the first postpartum year. A review of 43 studies found that prenatal and postpartum depression was evident in about 10% of men and was relatively higher in the 3- to 6-month postpartum period. Paternal depression also showed a moderate positive correlation with maternal depression.

Paulson, J. and Bazemore, S. (2010). Prenatal and Postpartum Depression in Fathers and Its Association with Maternal Depression: a Meta-Analysis. *Journal of the American Medical Association*, 303(19), 1961-1969.



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# Bill Update: Health Care Reform and Perinatal Mood Disorders

The Melanie Blocker Stokes MOTHERS Act was passed as part of the Patient Protection and Affordable Care Act (PPACA). Section 2952 of PPACA, also known as the health care reform legislation, calls for increased support, education, and research for postpartum depression, and encourages (but does not require) federal support for epidemiological studies, improved screening and diagnostic tools, and education programs for providers and the public. Title

V was also amended to include education about postpartum conditions to promote earlier diagnosis and treatment. PPACA called for \$3 million to be appropriated during Fiscal Year 2010 and "such sums as necessary for fiscal years 2011 and 2012".

For more information, visit <http://www.ncsl.org/documents/health/ppaca-consolidated.pdf>.

# Policy Review: What do health groups say about depression screening?

## American Congress of Obstetricians and Gynecologists (ACOG)

### Screening for Depression During and After Pregnancy

At this time there is insufficient evidence to support a firm recommendation for universal antepartum or postpartum screening. There are also insufficient data to recommend how often screening should be done. However, screening for depression has the potential to benefit a woman and her family and should be strongly considered. Women with a positive assessment require follow-up evaluation and treatment if indicated. Medical practices should have a referral process for identified cases. Women with current depression or a history of major depression warrant particularly close monitoring and evaluation.

Committee Opinion Number 453, February 2010

Committee on Obstetric Practice Vol 15 No 2 pp 394-395

## American Academy of Family Physicians Depression, Adults

The AAFP *recommends* screening adults for depression when

staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. "Staff-assisted depression care supports" refers to clinical staff that assist the primary care clinician by providing some direct depression care and/or coordination, case management, or mental health treatment. The AAFP *recommends against* routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient.

Clinical Preventive Services: Depression, 2010.

<http://www.aafp.org/online/en/home/clinical/exam/depression.html>

## Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN)

### The Role of the Nurse in Postpartum Mood and Anxiety Disorders

Health care facilities that serve pregnant women, new mothers

and newborns should have routine screening protocols and educational mechanisms for staff training and client education related to postpartum mood and anxiety disorders.

AWHONN Position Statements: The Role of the Nurse in Postpartum Mood and Anxiety Disorders, 2008.

[http://www.awhonn.org/awhonn/content.do?name=05\\_HealthPolicyLegislation/SH\\_PositionStatements.htm](http://www.awhonn.org/awhonn/content.do?name=05_HealthPolicyLegislation/SH_PositionStatements.htm)

## American College of Nurse Midwives Depression in Women

ACNM supports universal screening, treatment and/or referral for depression in women as a part of routine primary health care. In addition, ACNM recognizes depression as a community problem, requiring a multi-disciplinary, community-based response.

Position Statement: Depression in Women, 2003.

[http://www.midwife.org/siteFiles/position/Depression\\_in\\_Women\\_05.pdf](http://www.midwife.org/siteFiles/position/Depression_in_Women_05.pdf)

## Ask the Expert: How Can Providers Create and Sustain a Postpartum Depression Support Group?

Wendy N. Davis, PhD, Program Director, Postpartum Support International

Most postpartum support groups struggle at some point with low attendance. However, those of us who have led groups continue to feel rewarded, even if the groups are small. We know that a supportive place to gather is essential, even if there are one or two people who come.

The first and most essential step to creating a consistent group is to make good connections in your community -- with OB and pediatric providers, moms' groups, families, public health, faith communities, hospitals, and other childbirth professionals. Find like-minded people who want to develop this network together. Make sure that your own knowledge and support system match your zeal to provide support to other women. Read Jane Honikman's books, "Step by Step" and "I'm Listening", and the companion book, the PSI Guidebook to Developing a Perinatal Support Network in Your Community. The guidebook has lots of ideas about sustaining warmlines and support groups and an appendix with samples from 11 different groups.

One of the most important things I've learned is that no warmline or support group can thrive without being connected with its surrounding community. It is from your own community that you will find supporter, referrals, resources, funds, and of course the families who need you. Sometimes people want to start a group and feel intimidated by "creating a network," but it can be as simple as making calls to introduce yourself, having brief meetings, or bringing your fliers to providers and explaining what you're doing.

### Here are some other tips, once you've connected with others in your area:

1. Create written materials to announce your group, and share them with providers and on bulletin boards. Have a telephone number people can call to ask questions about the group and put them on your written material.
2. Talk to people on the phone before they come to group and after their first one, so they have a personal connection and can discuss concerns.
3. Create group guidelines and follow up procedures so members feel secure about group process. Check in with group members between group meetings.
4. Use online meeting sites and social network sites to advertise your group.

5. Go back out and talk to providers, hospitals, moms' groups, dads' groups, and childbirth educators.
6. Submit an article to your local newspaper or parenting magazine.
7. Offer snacks and drinks at the meetings.
8. Consider finding somebody to donate childcare services where you meet.
9. Provide a link to your group on websites for local parenting resources.
10. Make sure your PSI area coordinator knows about your group.

Finally, anyone who wants to start a support group should feel welcome to contact PSI to get ideas, materials and support. They might also consider becoming a PSI member, or a volunteer, so they can receive training and support, and connect with other people facilitating groups and networks.

Visit the PSI website at [www.postpartum.net](http://www.postpartum.net), or call 1.800.944.4PPD. Find more detailed information about PSI services in the Resources section.

## Postpartum Support International Certificate of Completion Course May 19-20, 2011

Indiana University Health Continuing Education presents the Postpartum Support International 2 day Certification of Completion course. The course is evidence based and includes information concerning assessment and treatment of Perinatal Mood Disorders. The course is designed for nurses, physicians, social workers, mental health professionals or anyone interested in acquiring formal knowledge about the subject.

Visit [http://www.indianaperinatal.org/sections/calendar\\_event.php?id=162](http://www.indianaperinatal.org/sections/calendar_event.php?id=162) for complete details and registration information.



# Perinatal Mood Disorders Resources – Indiana Perinatal Network

## Something's Not Right: Your Feelings During and After Pregnancy

This best-selling booklet explores the differences between 'Baby Blues' and depression during and after pregnancy, and explains how perinatal mood disorders (PMD) can affect the baby. Available in both English and Spanish.

from PPD. Available in English and Spanish. An online self-scoring version of the EPDS is also available to help consumers tally their score and interpret its meaning. Users are cautioned that the screening tool does not diagnose PPD or anxiety and that, regardless of their score, they need to contact their health care provider.

## Recognizing Perinatal Depression Online Training

This interactive online training is designed to help home visitors, health care professionals and other care providers recognize perinatal depression and provide support to the new and expectant mothers who experience it.

## Online Self-Scoring EPDS for Consumers

This version of the EPDS screening tool provides instructions to help consumers tally their score and interpret its meaning. Users are cautioned that the screening tool does not diagnose PPD or anxiety and that, regardless of their score, they need to contact their health care provider.

## Postpartum Depression Consensus Statement

A comprehensive review of the incidence and significance of depression and other mood disorders women can experience during and after pregnancy.

## Statewide Perinatal Mood Disorders

### Service Providers

IPN maintains a statewide list on its website of individuals who offer perinatal mood disorder therapy and counseling. Please note, this list is provided for informational purposes only. IPN does not endorse any of the providers or attest to the accuracy of the information listed.

## Edinburgh Postnatal Depression Scale (EPDS)

A screening tool that can assist primary care health professionals in identifying mothers suffering

Visit [http://www.indianaperinatal.org/sections/perinatal\\_mood\\_disorders.php](http://www.indianaperinatal.org/sections/perinatal_mood_disorders.php) for links to IPN resources.

## Other Resources



## Postpartum Support International

(www.postpartum.net)

International organization dedicated to helping women suffering from perinatal mood and anxiety disorders, including postpartum depression. PSI also works to educate family, friends and healthcare providers so that moms and moms-to-be can get the support they need and recover. The PSI website includes numerous

valuable resources, including:

### PSI Guidebook on Developing a Sustainable Perinatal Support Network in your Community

This 66-page booklet provides practical suggestions and solutions for creating a perinatal support network in your community, including information on developing support organizations, running phone lines, training volunteers, and becoming a not-for-profit organization.

### Chat with an Expert

PSI hosts free, live phone sessions every week, including Wednesday chats for moms and Monday chats for dads. During these sessions you can talk with a PSI expert about resources, symptoms, options and general information about perinatal mood and anxiety disorders from the privacy of your own phone.

### Healthy Mom, Happy Family: Understanding Pregnancy and Postpartum Mood and Anxiety Disorders

This DVD features the stories of four women who have struggled with perinatal mood disorders, plus up-to-date clinical information from experts in the field.

## MedEd PPD (www.MedEdPPD.org)

MedEd PPD is a professional education, peer-reviewed Web site developed with the support of the National Institute of Mental Health (NIMH). The site's goals are to further the education of primary care providers who treat women who have or are at risk for postpartum depression (PPD), and to provide information for women with PPD and their friends and family members. There is also a patient portal with resources and information for consumers and families.

## UIC Perinatal Mental Health Project

Providers can call 1-800-573-6121 for a free consultation to discuss patient issues.

## POSTPARTUM SUPPORT GROUPS

### INDIANAPOLIS:

Birdie Meyer, RN, MA  
Indiana University Health  
Sara Pollard, RN, BS

Indiana Co-Coordinators Postpartum Support International (PSI)

Support groups meet weekly during the day.

317-962-8191 • bmeyer2@iuhealth.org • spollar2@iuhealth.org

Lisa Hill MSW, LCSW, Coordinator  
St Vincent's Hospital

Support group meets weekly in the evening.  
317-415-7676

Marcia Boring, MSW, LCSW, Coordinator  
Community Health Network

Support group meets weekly in the evening.  
317-621-7828 • mboring@community.com

Jean Crane  
St Francis Health Center  
317-782-6426

### BLOOMINGTON:

Bloomington Area Birth  
Services (BABS)  
812-337-8121

### EVANSVILLE:

Candace Landmark  
Mental Health America of  
Vanderburgh County,  
Postpartum Support Group  
812-426-2640

### FORT WAYNE:

JK Wagner, RN, FNP, IBCLC  
Lutheran Hospital  
260-435-7069

### HOBART:

Sarah Fields  
Postpartum Peer Support  
Group of  
Northwest Indiana  
219-947-9646

### LAFAYETTE:

Support group, 2nd and 4th  
Tuesday of every month from  
6-7:30 pm  
Kathryn Weil Center, 415 N.  
26th St, Suite 400  
765-449-5133

### SOUTH BEND:

Kathy James, LCSW,  
Family and Children's Center  
574-232-2255

Linda Meeks, RN, BSN,  
Coordinator

South Bend Memorial Hospital,  
Mother Matters  
574-647-7511

# Ask The Experts



Amy Ricke

By Amy Ricke, MD, Indiana University School of Medicine and Men-Jean Lee, MD, Indiana University School of Medicine



Men-Jean Lee

## What are the risks of psychotropic medication use during pregnancy?

Depression occurs in 10%–20% of pregnant women.<sup>[1]</sup> Depression in pregnancy is associated with the following risks: noncompliance with prenatal care; increased use of drugs, alcohol, and tobacco; poor nutrition; decreased sleep; preeclampsia; preterm birth; low birth weight; low Apgar scores; elevated cortisol and catecholamine levels in the infant; increased risk for postpartum depression; increased risk of sudden infant death syndrome; and suicide and infanticide by the mother.<sup>[2]</sup> Additionally, children born to depressed mothers have a greater risk of insecure attachment and are more likely to experience psychiatric illness. Although there may be risks to the fetus associated with pharmacotherapy, discontinuing a pregnant woman's medication abruptly may put both the mother and fetus at greater risk.<sup>[3]</sup> Thus, the use of psychotropic medications in pregnancy is a complicated clinical situation that requires a careful balancing of the risks and benefits of both medication use and untreated illness, and must take into account a woman's unique beliefs, values, and psychosocial factors. This clinical picture is further complicated by research which for the most part lacks randomized, placebo-controlled clinical trials and has produced conflicting results.

Selective serotonin reuptake inhibitors (SSRIs) are the most common class of antidepressants used to treat women in pregnancy. Two large meta-analyses of SSRIs as a class found no significant associations overall with major congenital malformations. These studies did reveal small, inconsistent associations between specific SSRIs and defects such as omphalocele, septal defects, and anencephaly, however.<sup>[4,5]</sup> Multiple studies report a higher risk of cardiac malformations in neonates with first trimester exposure to paroxetine (Paxil).<sup>[6-8]</sup> In response to these studies, the FDA changed the pregnancy risk category for paroxetine from C to D. Although subsequent studies have questioned the validity of these findings, Paxil is not first line treatment for a pregnant woman with new onset depression in early pregnancy. Prozac is the best studied of the SSRIs. Zoloft has the lowest placental passage according to one study,<sup>[9]</sup> and it is also virtually undetectable in breast milk, making it the often favored SSRI during pregnancy.

There has been much debate regarding persistent pulmonary hypertension of the newborn (PPHN) with late SSRI (particularly Paxil) use (after 20 weeks gestation), although absolute risk is low.<sup>[10]</sup> Recent research has questioned this association, citing other maternal risk factors as significant.<sup>[11,12]</sup> Other studies have revealed that late pregnancy exposure to SSRIs is associated with a higher risk of low birth weight and admission to the neonatal intensive care unit (NICU).<sup>[13]</sup> A recent study found that both continuous SSRI exposure and untreated depression were associated with a 3-fold increased risk of prematurity vs. partial or no exposure.<sup>[14]</sup>

A neonatal distress syndrome is described with exposure to SSRIs in late pregnancy. Symptoms may include insomnia, somnolence, restlessness, irritability, emesis, diarrhea, poor suckling, tremors, jitteriness, and shivering. These symptoms are not life-threatening, but are managed with supportive care and usually resolve within 2 weeks. Although any SSRI can cause these symptoms, they are most often seen with fluoxetine and paroxetine use in late-stage pregnancy.<sup>[15]</sup>

The other classes of antidepressants are considerably less well-studied. A study of venlafaxine (Effexor) in 150 pregnancies found no significant differences in outcomes in the women taking venlafaxine compared to other antidepressants or placebo. The venlafaxine group had a higher incidence of spontaneous abortions, but this did not reach statistical significance.<sup>[16]</sup> A more

recent study revealed that the use of antidepressants, especially paroxetine, venlafaxine, or the combined use of different classes of antidepressants during pregnancy was associated with an increased risk of spontaneous abortion.<sup>[17]</sup>

There are no reported studies on the use of duloxetine (Cymbalta) during pregnancy, only case reports.<sup>[18-20]</sup> Thus far, no reports of major malformations have been reported, although one infant experienced neonatal distress syndrome.<sup>[19]</sup> One recent report suggests a limited transfer of the drug across the placenta.<sup>[18]</sup>

Bupropion (Wellbutrin) exposure in early pregnancy has not been found to increase the risk of major malformations.<sup>[2,21,22]</sup> Early data from the Glaxo Smith Kline Registry were concerning for an increase in cardiac malformations, but subsequent studies failed to confirm this data.<sup>[2]</sup> Although no major malformations are associated with the drug, there is some concern that it may increase the risk of early miscarriage.<sup>[22]</sup>

***“The prescription of psychotropic medications during pregnancy is a complicated clinical decision-making process.”***

With over 40 years of tricyclic antidepressant (TCA) exposure during pregnancy, no major malformations are reported in the infants. Desipramine and nortriptyline are preferred in pregnancy given their lower propensity to cause rebound anticholinergic effects, and appear to be safe in lactation.<sup>[23-25]</sup>

The prescription of psychotropic medications during pregnancy is a complicated clinical decision-making process. The risks of continuing a medication during pregnancy must be considered in the context of the risks of experiencing a relapse of symptoms if medication is discontinued. History of severe psychiatric illness, the number of previous episodes, history of previous instability when medication was discontinued, and current social stressors would tip the balance in favor of continuing the patient's medication throughout the pregnancy. Although all psychotropics can potentially affect the fetus, specific defects are rare and the absolute risks are low, and in many cases, the harmful effects of maternal psychiatric illness on the fetus and infant may be greater.

*Amy Ricke, MD, is a resident in the Department of Psychiatry at Indiana University School of Medicine. Men-Jean Lee, MD, is the Director, Division of Maternal Fetal Medicine at Indiana University School of Medicine.*

## SAVE THE DATE!

2nd Annual Perinatal Hospital Summit:  
Linking Science with Practice

September 23, 2011  
Renaissance Indianapolis North Hotel

*More information coming soon!*

**For a list of references, visit [www.indianaperinatal.org/RickeLeeReferences.pdf](http://www.indianaperinatal.org/RickeLeeReferences.pdf)**

## **FDA Drug Safety Communication: New warnings against use of terbutaline to treat preterm labor**

The FDA is warning the public that injectable terbutaline should not be used in pregnant women for prevention or prolonged treatment (beyond 48-72 hours) of preterm labor in either the hospital or outpatient setting because of the potential for serious maternal heart problems and death. In addition, oral terbutaline should not be used for prevention or any treatment of preterm labor because it has not been shown to be effective and has similar safety concerns. The agency is requiring the addition of a Boxed Warning and Contraindication to the tablet and injection labels to warn against both uses.

For more information, visit <http://www.fda.gov/Drugs/DrugSafety/ucm243539.htm>.

## **Perinatal Continuing Education Program Update**

This year's PCEP (Perinatal Continuing Education Program) participants are quickly approaching the finish line. Staff from Henry County Memorial and St.Vincent Dunn will soon finish the didactic components and testing, and then conclude the Program by participating in the simulation based Neonatal Resuscitation Workshop.

As with any specialized skill, neonatal resuscitation requires practice. Most health care

professionals and hospitals are adopting the stance that it is far better to practice on simulated patients and conduct drills for crisis situations before they arise so teams are ready when they happen in real life. The Neonatal Resuscitation Workshop helps address this need. Facilitated by St.Vincent Women's Hospital staff, multi-disciplinary teams will simulate neonatal resuscitation beginning with difficult birth scenarios such as shoulder dystocia, placental abruption, or postpartum hemorrhage. A neonatal simulator mannequin that features realistic newborn traits and lifelike clinical feedback will enhance their experience. Measuring 21 inches and weighing 7 pounds, SimNewB can simulate a wide range of conditions from a healthy, vigorous, crying infant to a limp, cyanotic newborn with no vital signs.

Anticipation, adequate preparation, effective communication, accurate evaluation and prompt initiation of resuscitation steps are critical to a successful outcome of a neonatal resuscitation. Immersive, simulation-based training results in better retention of cognitive, technical and behavioral skills, and leads to better communication, teamwork and leadership among health care professionals. Henry County and St.Vincent Dunn will be very well prepared for crisis situations in the future.

For more information about the Perinatal Continuing Education Program, contact Tina Babbitt, RN MSN IBCLC at [tbabbitt@indianaperinatal.org](mailto:tbabbitt@indianaperinatal.org).

## Breastfeeding Update



## **Postpartum Mood Disorders and Weaning** **Amanda Ratliff, RLC, IBCLC—St. Francis Hospital**

Most research concerning depression in mothers focuses on symptoms and treatment of postpartum depression (PPD). However, few studies document how breastfeeding women respond to the hormonal changes associated with weaning and how the chemical alterations that occur after weaning can induce depression, anxiety, or elevate symptoms of an underlying mood disorder if a mother is predisposed.

In 1988, the *American Journal of Psychiatry* published an article entitled "Weaning and depression: another postpartum complication" that drew attention to the hormonal base of postpartum mood disorders and discussed four cases of breastfeeding mothers who developed major depressive disorder soon after weaning. They theorized that combining hormonal changes and psychological factors could rapidly stimulate depression. A 2008 *Journal of Human Lactation* article cited research on how the hormones involved with breastfeeding can provide protection against depression. High levels of prolactin and oxytocin were also shown to decrease stress-induced hormonal alterations. The drop in prolactin levels that occurs with weaning may push moms with a history of depression or family history of mood disorders into clinical depression.

Health Psychologist and Researcher Kathleen Kendall-Tackett, PhD, IBCLC, has suggested inflammation as the underlying risk factor for all postpartum mood disorders, including those associated with weaning. Mothers with a personal history of mental illness are at increased risk for inflammation, including mastitis, and high levels of proinflammatory cytokines elevate a weaning mother's potential for depression or other mood disorders. In contrast, she emphasizes that "breastfeeding can protect mothers' mental health" and decrease inflammation; breastfeeding lowers cortisol, the adrenocorticotropic hormone, epinephrine, and norepinephrine. Kendall-Tackett recommends more research on the subject of weaning and depression.

How can health professionals best aid these mothers suffering from not only the loss of a breastfeeding relationship but a significant decrease in the hormones that kept them securely functioning? Perhaps prophylactically treating breastfeeding and weaning moms with a history of mental illness will help lower inflammation and protect against the most devastating symptoms of a hormonal crash. Mindfulness based cognitive therapy, antidepressants, and preventative management such as long-chain omega-3 fatty acids, exercise, and extended breastfeeding and paced weaning are techniques caregivers can implement to assist moms in achieving hormonal and psychological wellness.

# Don't Miss the 2011 Regional Training Series!

These half-day training sessions featuring high-level clinicians are a great way to receive high-quality, low-cost education, close to home. Continuing education credits are available for nurses and social workers.

Registration is FREE to all IPN Members; non-member fees are just \$30 for one session or \$50 for both sessions at a location. Find more information and register at [www.indianaperinatal.org](http://www.indianaperinatal.org).

## June 8 Kosciusko Community Hospital Warsaw



### Sudden Infant Death Syndrome Risk Reduction

9 am – noon

Barb Himes, CLC

Significant progress has been made in decreasing SIDS deaths over the past decade, but SIDS is still the leading cause of death among U.S. infants between one month and one year of age. Racial disparities in SIDS risk factors and rates also remain. This training will provide an overview of the risk factors for SIDS and recommendations to reduce risk, as well as demonstrate how nurses and other healthcare workers can help parents by modeling safe sleep practices.

Barb Himes



### Something's Not Right: Exploring Perinatal Mood Disorders

1 pm – 4 pm

Birdie Gunyon Meyer, RN MA

This session will feature a comprehensive perinatal mood disorders (PMD) presentation, including a review of the types of perinatal mood disorders, available screening tools and how to use them, as well as treatment options. The discussion will include information on medication use and choices for the pregnant and breastfeeding mother, Indiana resources for PMD screening and treatment, and a discussion of the development and use of support groups for treatment. There will also be time for interactive problem solving and dialogue.

Birdie Gunyon Meyer

## June 14 Adams Memorial Hospital Decatur



### Late Preterm Birth: Obstetric and Newborn Practices

9 am – noon

Eric Strand, MD and Marya Strand, MD

Prematurity continues to be one of the leading causes of infant mortality and morbidity in Indiana and the U.S. While "late preterm births" have become one of the biggest contributors to the overall

Eric Strand



Marya Strand

rate of prematurity, many providers and consumers are unaware of the potential complications for both the mother and the infant. This workshop will provide up-to-date clinical information about the short and long term implications of late preterm births, how to best care for these infants and practical suggestions on how hospitals and providers can reduce the incidence.

### Something's Not Right: Exploring Perinatal Mood Disorders

1 pm – 4 pm

Birdie Gunyon Meyer, RN MA

## July 19 Howard Regional Hospital Kokomo



### Opiate Dependence and Addiction in Pregnancy: Implications for Mother and Baby

9 am – noon

James Nocon, MD, JD

Providers throughout the state report a significant increase in opiate dependence among pregnant women, with the potential for serious implications for the short and long term health outcomes for women and their newborns. Despite this increase, many providers have not received adequate training in treating the complex clinical issues associated with these pregnant women and their newborns. This training will provide detailed clinical practice guidelines on how to treat opiate dependent pregnant women and their newborns in the inpatient and outpatient setting.

James Nocon



Men Jean Lee

### Late Preterm Birth: Obstetric and Newborn Practices

1 pm – 4 pm

Men Jean Lee, MD and Bill Engle, MD



Bill Engle

## August 12 St. Mary's Hospital Evansville

### Opiate Dependence and Addiction in Pregnancy: Implications for Mother and Baby

9 am – noon

James Nocon, MD, JD



Tom Ferrara

### Late Preterm Birth: Obstetric and Newborn Practices

1 pm – 4 pm

Tom Ferrara, MD and John Wareham, MD



John Wareham

## August 24 Hendricks Regional Hospital Danville

### Opiate Dependence and Addiction in Pregnancy: Implications for Mother and Baby

9 am – noon

James Nocon, MD, JD

### Something's Not Right: Exploring Perinatal Mood Disorders

1 pm – 4 pm

Birdie Gunyon Meyer, RN MA

## Your Ad Here!

### ADVERTISE IN *PERINATAL PERSPECTIVES*

The Indiana Perinatal Network is now offering ad space in the *Perinatal Perspectives* newsletter distributed to healthcare professionals statewide.

COST \$100/issue or \$250/year (3 issues)

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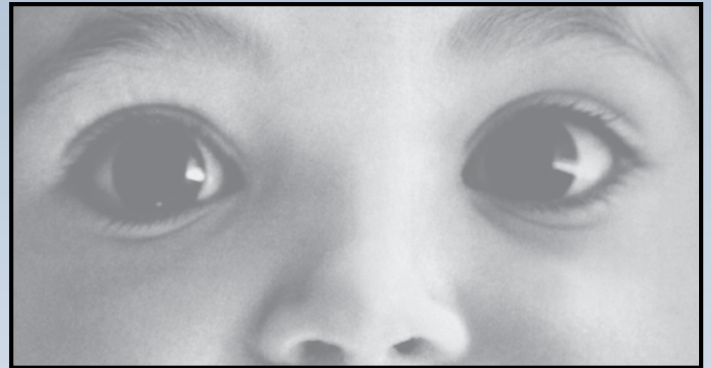
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- Legislative and Policy Update
- Education
- Breastfeeding Update, and more!



*The mission of the Indiana Perinatal Network is to lead Indiana to improve the health of all mothers and babies.*