PARTICIPANT HANDOUTS

CHAMPS Perinatal Mental Health Series: Treatment, Continuum of Care, and Integrated Practice

Thank you for attending today's training. By doing so, you are strengthening the ability of your community-based and patient-directed health center to deliver comprehensive, high-quality primary health care services.

Presented by:
Celeste St. John-Larkin, MD, PMH-C, Colorado Perinatal Mental Health Project

Live Event Date/Time:
Thursday, June 4, 2026
12:00–1:00PM Mountain Time /1:00–2:00PM Central Time

Target Audience:
This series is intended for Region VIII health center medical and behavioral health providers as well as nurses, care coordinators, other clinical roles, and those who support the mental health and wellbeing of pregnant and postpartum individuals and their families.

Event Overview:
This session covers evidence-based treatment approaches for perinatal mental health conditions, including psychotherapy, psychopharmacology, and peer support. Participants will learn how integrated and collaborative care models can improve continuity of care. The session also highlights the important role of family and community-based supports.

Learning Objectives:
At the end of this session, participants will:

1. Describe evidence-based treatment approaches for perinatal mental health conditions, including psychotherapy, psychopharmacology considerations, and peer support models.
2. Apply principles of integrated and collaborative care — including warm handoffs and co-located behavioral health — to improve continuity of perinatal mental health services in primary care settings.
3. Articulate the importance of community and family-level interventions as part of a comprehensive continuum of care for perinatal mental health.

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CHAMPS Archives

This event will be archived online. This online version will be posted within two weeks of the live event and will be available for at least one year from the live presentation date. For information about all CHAMPS archives, please visit https://champsonline.org/events-trainings/distance-learning/online-archived-champs-distance-learning-events.

Description of CHAMPS

Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII federally-designated Community Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. Staff and board members of CHAMPS Organizational Members receive targeted benefits in the areas of business intelligence, networking and peer support, recognition and awards, recruitment and retention, training discounts and reimbursement, and more.

For over 40 years, CHAMPS has been an essential resource for Community Health Center training and support! Be sure to take advantage of CHAMPS' programs, products, resources, and other services. For more information about CHAMPS, please visit www.CHAMPSonline.org. The Happenings box in the middle of the CHAMPS home page highlights the newest CHAMPS offerings, while the CHAMPS Membership box on the lower part of the home page lists current benefits for CHAMPS Organizational Members.

Description of The Birth Squad/CO PMHP

The Birth Squad/Colorado Perinatal Mental Health Project (CO PMHP) is a Colorado-based nonprofit dedicated to improving access to comprehensive perinatal mental health care for prenatal and postpartum individuals and their families. Through clinical training, community outreach, and cross-sector partnerships, CO PMHP works to close the gap between screening and care by building a robust perinatal support network that meets families where they are.

Speaker Biography

Celeste St. John-Larkin, MD is a double board-certified psychiatrist based in Aurora, Colorado, specializing in child, adolescent, and perinatal mental health. She is an Associate Professor at the University of Colorado School of Medicine and holds an endowed chair in Perinatal Mental Health at Children's Hospital Colorado. Dr. St. John-Larkin focuses on integrated mental health and maternal-infant relationships, serving as the Medical Director of the Healthy Expectations Perinatal Mental Health Program. She also serves as Project Director for Colorado PROSPER, providing statewide resources for perinatal psychiatry and substance use disorders. Additionally, she has worked for over 12 years as an integrated psychiatrist with Project CLIMB in the Child Health Clinic and serves on the Board of Directors for the American Board of Psychiatry & Neurology (ABPN).

Perinatal Mental Health PROJECT

CHAMPS

PERINATAL MENTAL HEALTH SERIES: EVIDENCE-BASED PRACTICE ACROSS THE CONTINUUM OF CARE

May 28: Perinatal Mood Disorders and Screening
Emely Romero, LCSW, IBCLC, PMH-C

June 4: Treatment, Continuum of Care, and Integrated Practice
Celeste St. John-Larkin, MD, PMH-C

June 11: Trauma, Loss, Family Systems, and Resources
Tatiana Turo-Handy, PsyD, PMH-C

The AAFP has reviewed Perinatal Mental Health Series: Evidence-Based Practice Across the Continuum of Care and deemed it acceptable for up to 3.00 Live AAFP Prescribed credit(s). Term of Approval is from 05/28/2026 to 06/11/2026. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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CHAMPS Perinatal Mental Health Series: Evidence-Based Practice Across the Continuum of Care

Treatment, Continuum of Care, and Integrated Practice

Celeste St. John-Larkin, MD, PMH-C

6/4/2026

About Me:

- Child/Adolescent, Adult and Perinatal Psychiatrist
- Associate Professor at the CU School of Medicine, Department of Psychiatry
- Anschutz Chair in Perinatal Mental Health at Children's Hospital Colorado
- Medical Director for Healthy Expectations Perinatal Mental Health Program, Colorado Women's Behavioral Health and Wellness
- Project Director for Colorado PROSPER
- Integrated mental health in primary care and consultation to community primary care providers through CoPPCAP and she worked as an integrated psychiatrist with Project CLIMB in the Child Health Clinic pediatric training program for 12 years.
- Grew up in small town in Upper Peninsula of Michigan, studied history at Northwestern University, and attended Michigan State University, College of Human Medicine in the Rural Physician Program.
- Residency and child psych fellowship at the University of Colorado
- Mother of three boys - NICU twins→ college students
- No financial conflicts or additional disclosures.

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Disclosures & Acknowledgements:

- Colorado PROSPER is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award to the Regents of the University of Colorado totaling $3,750,000 over 5 years with 10% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.
- Funding awarded to the Regents of the University of Colorado, as a state entity; renewable for five years (Sept 2023-2028).
- See website for full Land & Labor Acknowledgements: CU Anschutz acknowledges the unceded Arapaho lands and the enduring presence of diverse Indigenous peoples, honoring their stewardship and recognizing the historical injustices, while also acknowledging the exploited labor of enslaved and indentured people, primarily of African descent, and the ongoing contributions of marginalized laborers. www.coloradoprosper.org/access

Learning Objectives:

1. Describe evidence-based treatment approaches for perinatal mental health conditions, including psychotherapy, psychopharmacology considerations, and peer support models.
2. Apply principles of integrated and collaborative care — including warm handoffs and co-located behavioral health — to improve continuity of perinatal mental health services in primary care settings.
3. Articulate the importance of community and family-level interventions as part of a comprehensive continuum of care for perinatal mental health.

#1 Poll Question

How confident are you in your ability to discuss treatment for perinatal mental health conditions, including medications:

- 1 - Not at all confident
- 2 - Slightly confident
- 3 - Moderately confident
- 4 - Very confident
- 5 - Extremely confident

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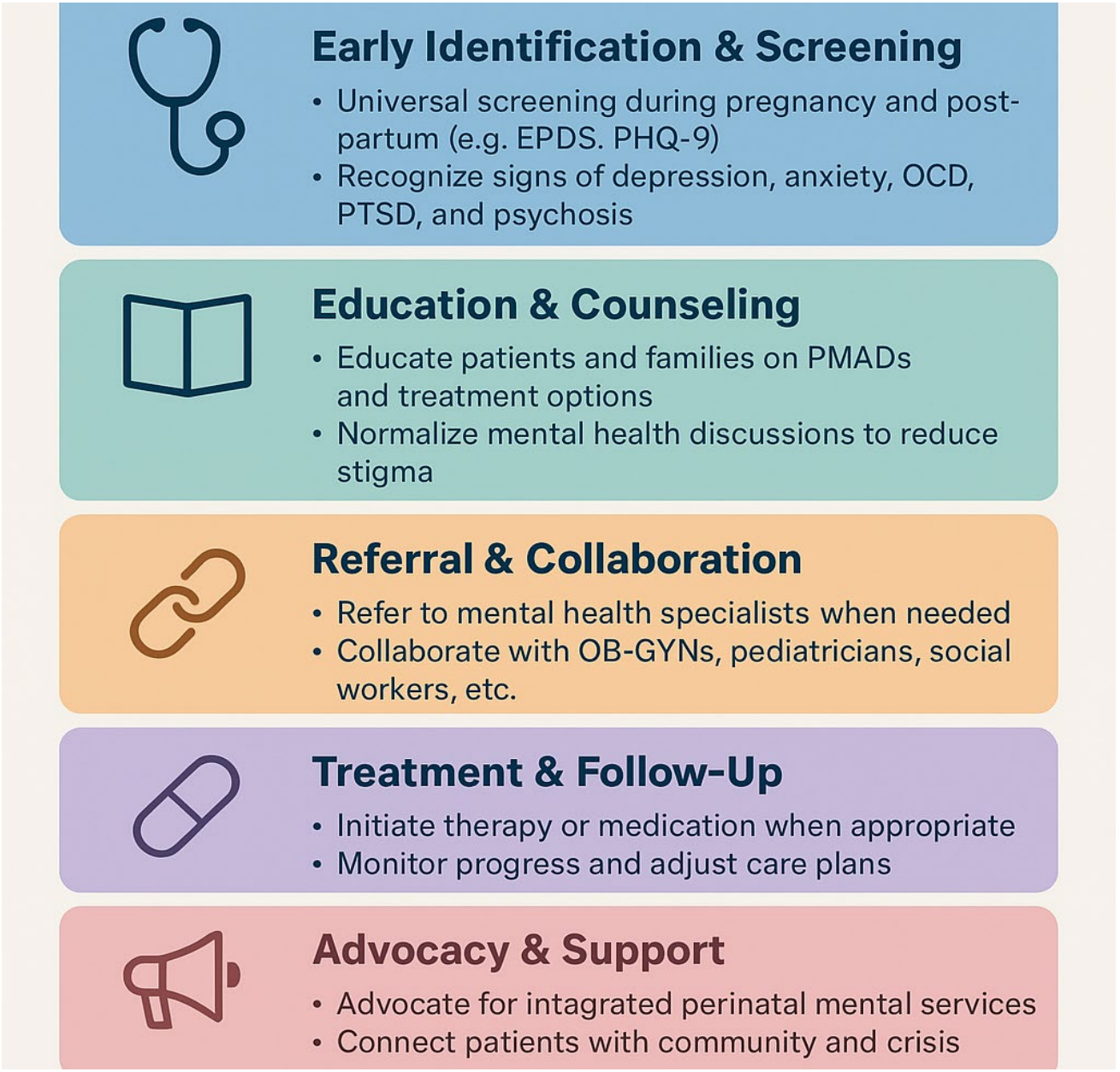
"...the amazing thing is that throughout all of this...I looked rather well at most times. This, I believe, hindered me from receiving the help from the professionals I needed..."

"The most significant factor in the duration of the postpartum depression is the length of delay to adequate treatment"

Cheryl Tatano, 2002

Empowering Advocates in Community Programs



Resource:

[1] Perinatal Mental Health Advocacy Toolkit

Models of Perinatal Mental Health Care

- **Consultation**
  - Real time telephone consultation and care coordination or resource/referral support
- **Collaborative Care**
  - Evidence-based Case Coordination and treatment with MH and Primary Care providers working together
- **Co-Located**
  - Mental Health and Primary Care clinics operating in the same location, but independently scheduled visits
  - Mental Health providers integrated into the operation of the clinic

Collaborative Care Flow Example

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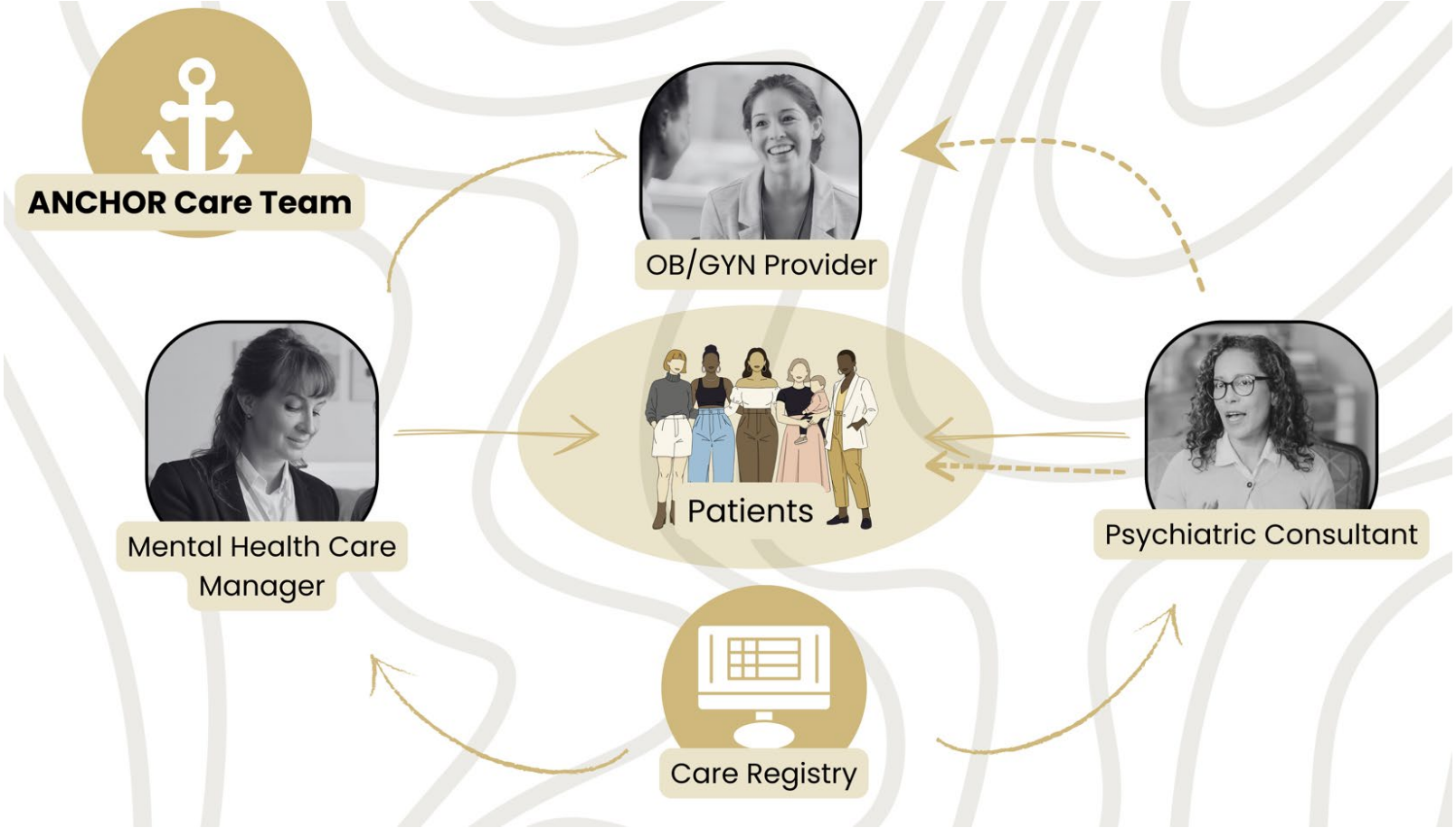
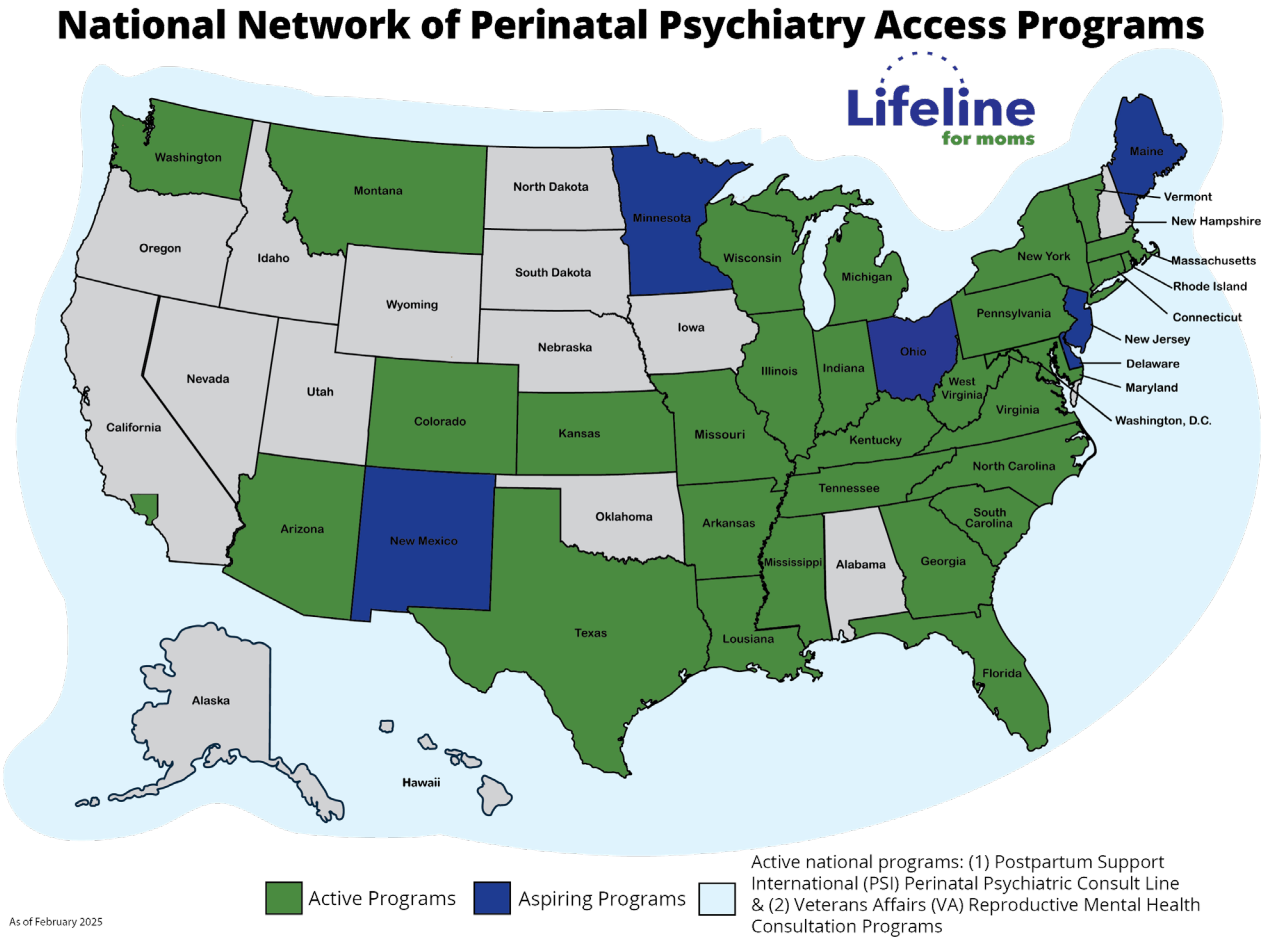


Psychiatry Access Program Model

- Originated in child psychiatry in the early 2000s to address workforce shortages.
- Now expanded to perinatal populations and nationwide, with 45+ state-based programs
- Evidence-Based Intervention:
  - Improves provider confidence & screening rates
  - Increases access to mental health treatment
  - Impactful in rural and underserved areas
- Supported by HRSA, SAMHSA, & multiple state agencies

Colorado PROSPER is part of this national movement- tailored to meet perinatal mental health and substance use needs across the state.



Health Care Clinician Resources

Montana's HRSA MCHB funded Perinatal Psychiatry Access Progr

Montana Psychiatric Access Line (MTPAL)

https://www.mtpal.org/perinatal
1-844-406-8725

Montana Healthy Moms, Healthy Babies Program:

https://hmhb-mt.org/

National:

Postpartum Support International (PSI) Perinatal Psychiatric Consult Line
1-877-499-4773

https://postpartum.net/professionals/perinatal-psychiatric-consultation/

Veterans Affairs Women's Mental Health Consultation Program
Email: ReproMHConsult@va.gov

Perinatal Mental Health IOP Programs

North Dakota: Fargo – Sagent Behavioral Health Mother Baby Intensive Outpatient Program

Utah: Riverton and Provo – Serenity Recovery and Wellness Maternal Mental Health IOP

Utah: South Jordan – Reach Counseling Postpartum Intensive Outpatient Program

PSI Directory:

https://postpartum.net/get-help-2/intensive-perinatal-psych-treatment-in-the-us/

sagent Behavioral Health

We offer high and low intensity group options. Our high-intensity group meets in-person or virtually for 3 hours a day, 4 days a week and our low-intensity group meets virtually for 60 minutes, twice per week.

Mother Baby Program

Your body and mind go through many changes during and after pregnancy. A multitude of emotions are experienced and many mothers may experience depression, anxiety, changes in mood, or notice an increase of worry and concern. We explore these emotions in our Mother Baby Program.

Utah Maternal MH Unit- Now Open!

Opening soon

The Maternal Mental Health Unit at Alta View Hospital will open on **June 1, 2026.** Find out more about the department below.

24/7 dedicated BH inpatient unit provides compassionate care, separate from other units, where moms receive support and resources to promote healing and resilience. The Maternal Mental Health Unit serves pregnant and post-partum women, up to one year.

After hours, enter through the Emergency Department.

intermountainhealthcare.org/locations/alta-view-hospital/maternal-mental-health-unit

Patient/Family Resources

- **National Maternal Mental Health Hotline:** https://mchb.hrsa.gov/national-maternal-mental-health-hotline
- **Call or Text: 1-833-TLC-MAMA (833-852-6262)**

  (Can be for new parents just to talk or get support- even if not fully in crisis)

- **Parents Thrive Colorado**: https://parentsthrive.org/resources/

- **Postpartum Support International** - online groups, peer support and resources for specific situations/illnesses:
  - https://postpartum.net/get-help-2/specialized-support-resources/
  - **Doula Resources:** https://postpartum.net/get-help-2/doulas/

Perinatal Mental Health Affects our Patient, their Child(ren) & Family

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Less engagement in medical care
Smoking & substance use

Lactation challenges
Bonding issues
Adverse partner relationships

Preterm delivery
Low birth weight
NICU admissions

Cognitive delays
Motor & Growth issues
Behavioral problems
Mental health disorders

What are risks of untreated perinatal mental health disorders?

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- Increased risk of suicide
- Increased risk of substance use
- Low adherence with prenatal care, poor nutrition
- Loss of interpersonal and financial resources
- Increased rates of miscarriage, low maternal weight gain, preeclampsia, gestational HTN, preterm birth, low birth weight, postpartum hemorrhage
- Increased rates of c-sections and NICU admissions
- Impaired attachment with infant
- For child: cognitive and motor delays, emotional and behavioral problems
- For family: increased rates of parental separation

Curry et al 2019

Postpartum Symptoms that Need Attention

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Monitor	Treatment	Emergency
▪ Crying spells for more than 2 weeks	▪ New or intense feelings of guilt, worthlessness	▪ Suicidal thoughts, plan, or attempts
▪ Persistent loss of appetite	▪ Intense urges to run away	▪ Thoughts or images of harming baby
▪ Ongoing, unexplained exhaustion	▪ Aversion to the baby	▪ Delusions
▪ Difficulty concentrating		▪ Hallucinations
		▪ Disorientation

Non-Pharmacologic Treatment

- Consider first when a patient presents with **mild to moderate symptoms without significant impairment**
- Includes: CBT, interpersonal psychotherapy, peer support, exercise as tolerated, and sleep

MOMS AND MOODS SUPPORT GROUP	BLACK MAMAS CIRCLE SUPPORT GROUP	MAMAS CONNECT THERAPY GROUP	BEARING HOPE THERAPY GROUP
Moms and Moods (M&Ms) is a free, weekly peer support group for individuals seeking support in the perinatal period, but aren't able to attend a therapy group due to insurance or scheduling conflicts. It is also open to individuals before or after they complete a therapy group to maintain social support and connection with other caregivers.	Black Mamas Circle is a free, weekly mental health support group guided by community members and a Black perinatal psychiatrist. This group provides weekly support sessions with the primary goals of increasing access and support around perinatal mental health care for Black moms and babies. It is uniquely inclusive to Black women and their babies.	For caregivers experiencing depression or anxiety in the first year after delivery to come together to connect, learn, and find support as they navigate parenthood. The topic-based group sessions utilize a modified version of the Mother-Infant Therapy Group curriculum. Babies are encouraged to attend along with their parents.	For those experiencing depression or anxiety during the second or third trimester of pregnancy. Topic-based psychotherapeutic group where pregnant people can connect, learn and find support as they navigate the complex path toward parenthood.

Treatment + Intervention Options

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- Psychotherapy
  - Individual (next slide)
  - Couples
  - Dyadic Infant Mental Health – Parent-Infant Psychotherapy
  - Group –
    - Therapeutic Group models
    - Psychoeducational and Peer Support Groups
- Psychosocial Supports
  - Sleep (At least 4 hours of uninterrupted sleep for reduction of risk or PMHD's)
  - Peer Mentoring and Recovery Support Coaching
  - Postpartum Doula or night nurse support
- Integrative/Wholistic Practices
- Integrated Mental Health in Primary Care

Adult Focused Interventions

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- Self-care
  - **NEST-S**
    - **N**utrition, **E**xercise, **S**leep and rest, **T**ime for self, **S**upport
- Best Evidence for:
  - Cognitive behavioral therapy (CBT)
  - Interpersonal therapy (IPT)
  - Emerging Evidence: (Behavioral Activation, Acceptance & Commitment Therapy, Mindfulness Based Cognitive Therapy, Dialectical Behavior Therapy)
- Bright light therapy

Adapted from: BC Reproductive Mental Health Program & Perinatal Services BC. (2014). *Best Practices for Mental Health Disorders in the Perinatal Period.*

There is no baby without a mother

(D.W. Winnicott)

No such thing as a mother without a baby (D. Stern)

Repair & Healing are Possible

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- Activities to promote attunement: Infant Massage, Music Groups, Reading
- Peer Support & Caregiver Community Gatherings
- Dyadic Therapy
  - Perinatal Child-Parent Psychotherapy (P-CPP)
  - Attachment and Biobehavioral Catch-up (ABC)
- Group Therapy
  - Mother-Infant Therapy Group (M-ITG)
  - Circle of Security Intensive (COS-I)
- Intensive Outpatient Programs (40+ programs in U.S.)
- Perinatal Inpatient Psychiatric Units (AK, LA, NC, NY, CA)
  - Now Utah!

Healthy Expectations Perinatal Mental Health Program

- Offer a continuum of care utilizing evidence-based interventions to meet the varied needs of pregnant and postpartum people experiencing PMADs from peer support to a perinatal intensive outpatient program (IOP)
- Provide two-generation intervention to enhance the relationship between caregivers and their infants

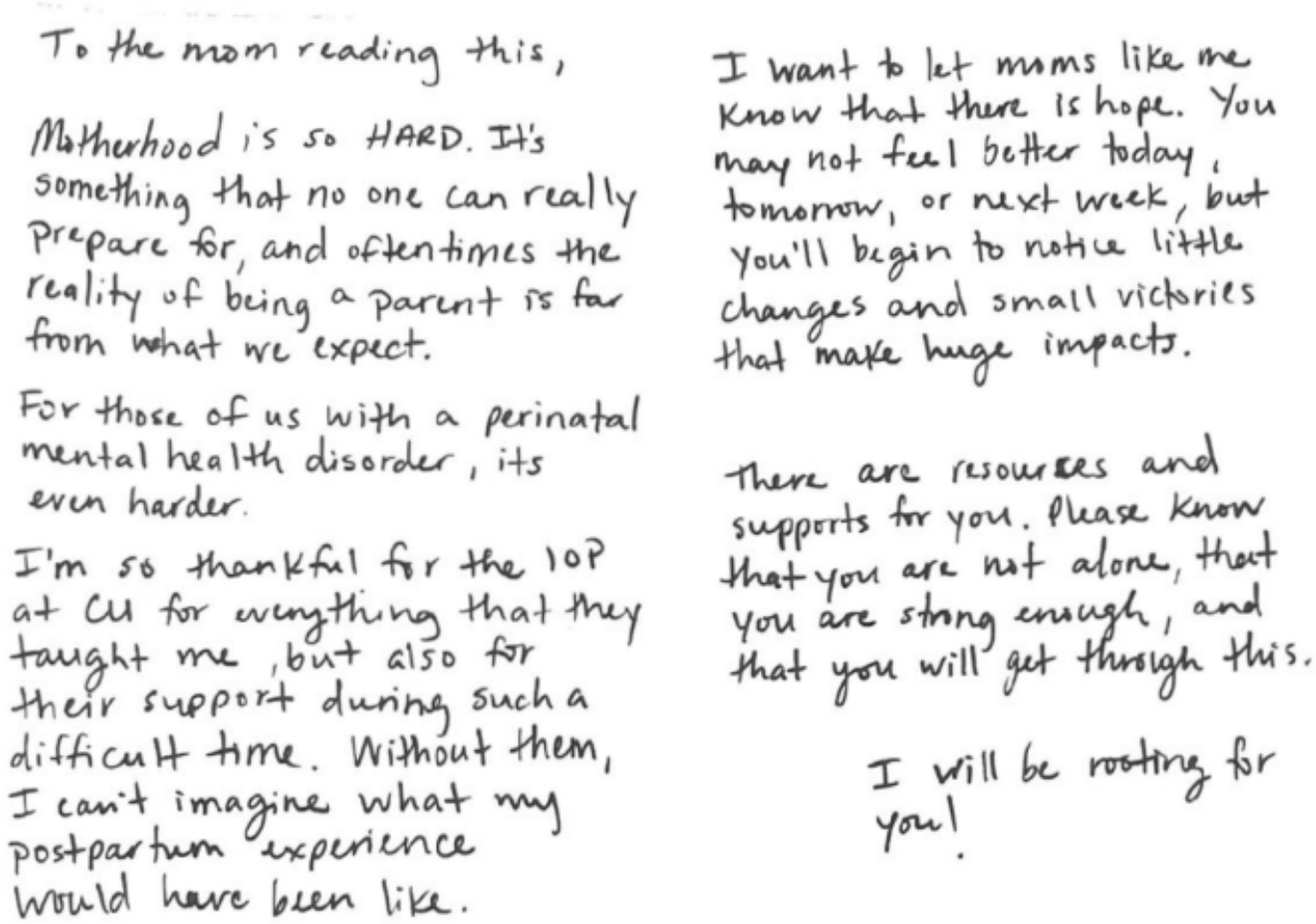
Black Mamas Circle

- Perinatal peer-to-peer mental health support group that is culturally responsive, safe, welcoming, and uniquely inclusive to Black women and their babies.
- Drop-in, free virtual group.
- Co-facilitated by an African American licensed medical provider and an African American peer mentor mom.
- Care coordination is provided by an African American care coordinator.

Healthy Expectations PIPER (Parent Infant Program for Emotional Resilience) Perinatal MH IOP

- Intensive Outpatient Program for pregnant and postpartum individuals and their babies
- Families attend 3 days a week for 3 hours a day
- Integrates ACT, COS-P, M-ITG, and wellness/movement groups as well as individual therapy and medication management
- University of Colorado Women's Behavioral Health and Wellness Outpatient Clinic and Services

Letter to a future patient...



To the mom reading this,

Motherhood is so HARD. It's something that no one can really prepare for, and oftentimes the reality of being a parent is far from what we expect.

For those of us with a perinatal mental health disorder, its even harder.

I'm so thankful for the IOP at CU for everything that they taught me, but also for their support during such a difficult time. Without them, I can't imagine what my postpartum experience would have been like.

I want to let moms like me know that there is hope. You may not feel better today, tomorrow, or next week, but you'll begin to notice little changes and small victories that make huge impacts.

There are resources and supports for you. Please know that you are not alone, that you are strong enough, and that you will get through this.

I will be rooting for you!

University of Colorado Anschutz Medical Campus

Children's Hospital Colorado

When are Medications Indicated in the Perinatal Period?

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- Moderate-severe symptoms
  - (~ EPDS 14+, PHQ9 10+)
- Suicidal ideation
- Psychotic symptoms / Postpartum Psychosis
- Bipolar Disorder
- Worsening symptoms
- Prior benefit from medication or recent stabilization
  - Less than 6 months of stability on current med
- Symptom relapse off medication (prior hx or current)
- History of severe depression or suicidal ideation/suicide attempts
- Unable to access therapy or Poor response to psychotherapy
- Functional impairment
  - Inability to care for self/baby
  - Inability to return to work, if needed
- Patient Preference

Perinatal Prescribing Principles

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- **RISK-RISK** Discussion
  - *No such thing as non-exposure* – given risks of exposure to untreated mental illness during pregnancy and postpartum
- Prior to starting med for first time screen with MDQ or RMS to rule out bipolar disorder: https://www.coloradoprosper.org/screening-tools
- No benefit to taper SSRI in 3rd Trimester or prior to delivery
- Follow Up with EPDS/PHQ9/GAD7 after starting an SSRI
- SSRIs/SNRIs are compatible with breastfeeding (RID<10%)

Medication Adjustment During Pregnancy

- Hormonal Changes – Increase in Progesterone and E2
- Fluid Changes- Increase in Plasma Volume
- Renal Clearance Increases
- Changes in Regional Blood Flow
- Hepatic Metabolism and Protein Binding also affected
- Ex: Lamotrigine and Lithium metabolism both increased during pregnancy → need higher doses
  - Decrease dose rapidly postpartum
  - May need higher SSRI doses in 3rd Trimester

When prescribing SSRIs…

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Use SSRIs at lowest EFFECTIVE dose

Sertraline is good first line choice for SSRI-naive patients

Do NOT switch to sertraline if patient already stable on another SSRI/SNRI

Monotherapy ideal- maximize dose of 1 med before adding another

Medication Considerations - Pregnancy

- Antidepressants
  - Generally best to continue med that is working or worked previously
    - Paroxetine some association with Cardiac Defects
- Antipsychotics (if indicated for psychosis, mania)
  - Typical (first generation)
  - Atypical (second generation)- most data for quetiapine
- Lamictal – Bipolar II, or Bipolar Depression
- Lithium can be used with caution/monitoring
- Benzodiazepines – last resort if needed for severe anxiety, panic, anxiety related sleep disturbance
- Stimulants – may be continued if severe symptoms- preg + PP
- **<u>Medications to avoid during pregnancy:</u>**
  - valproic acid, carbamazepine

Breastfeeding and Medication

- Consider cultural and family factors (e.g., emphasis on “breast is best,” historical meaning)

- Recent Data: Mothers on SSRIs were more likely to breastfeed through 6 months of age, vs. those who stopped SSRI or who had untreated depression

University of Adelaide. "Antidepressants and breastfeeding can mix, study suggests." Science Daily, 2014.

Breastfeeding and Medication

- Most antidepressants are present in breastmilk
  - Small amounts - **Sertraline has lowest levels**
  - Minimal adverse effects generally
  - Generally lower than 10% threshold for Relative Infant Dose
- Reassurance from:
  - Low levels of medication in asymptomatic infants
  - Prenatal exposure not related to negative long term outcomes
- Breastfeeding often still recommended with other meds

Kendall-Tackett & Hale, 2010; Chad et al, 2013

#2 Discussion Question

How many of you have heard of Zuranolone (Zurzuvae) – the only FDA approved medication for postpartum depression?

Has anyone prescribed it?

Anyone known a patient who has taken it?

Which hormone is it similar to that drastically decreases at the end of pregnancy?

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Zuranolone Overview

- Synthetic form of allopregnanolone that recreates a third trimester like neuroactive steroid environment, giving the GABA -A receptor time and stability to recalibrate
- Available as a pill and is taken for a 14-day course.

FDA NEWS RELEASE

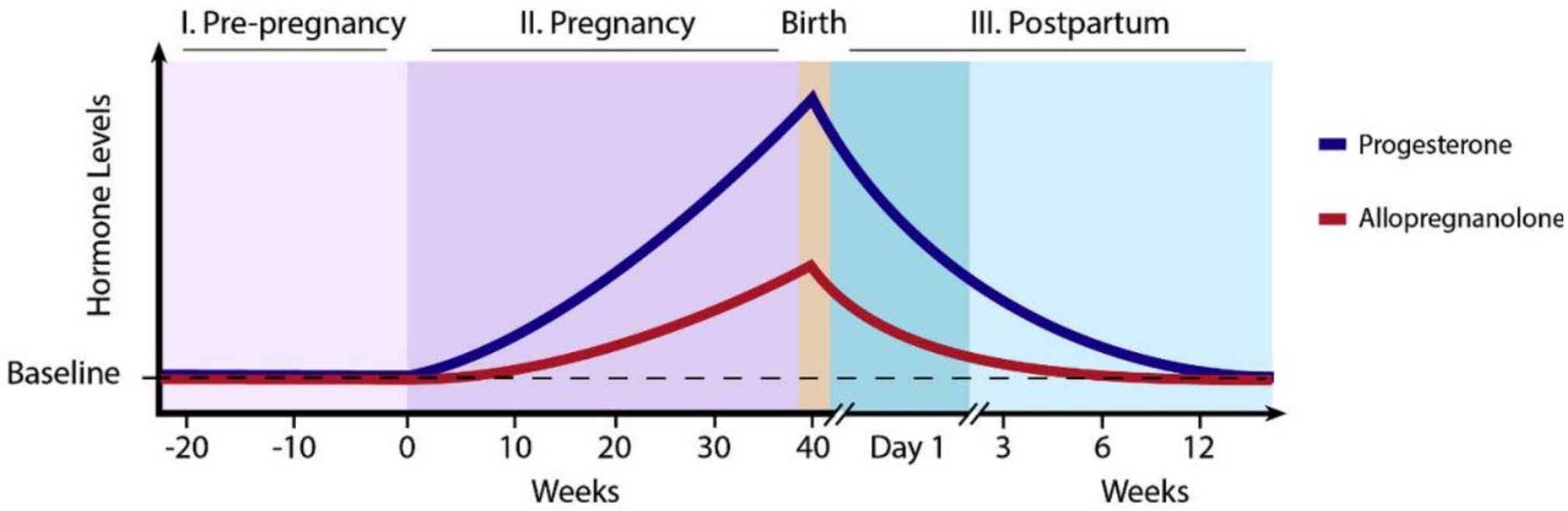
FDA Approves First Oral Treatment for Postpartum Depression

For Immediate Release: August 04, 2023

Spanish

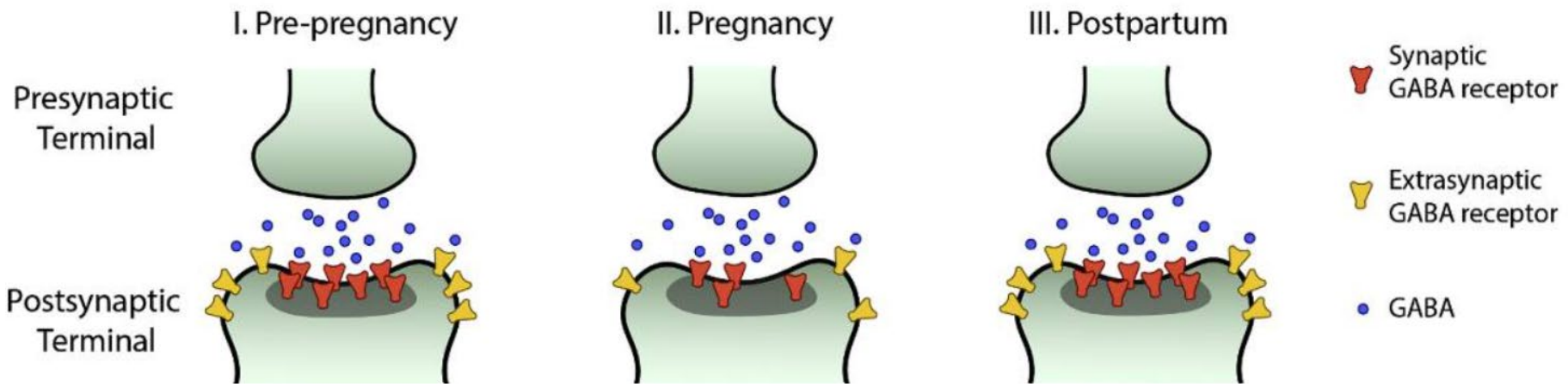
Today, the U.S. Food and Drug Administration approved Zurzuvae (zuranolone), the first oral medication indicated to treat postpartum depression (PPD) in adults. PPD is a major depressive episode that typically occurs after childbirth but can also begin during the later stages of pregnancy. Until now, treatment for PPD was only available as an IV injection given by a health care provider in certain health care facilities.

Hormonal Fluctuations in Pregnancy and the Postpartum Period



- Allopregnanolone acts as a positive allosteric modulator of synaptic and extra synaptic GABA-A receptors and is thought to have a calming anxiolytic effect.

Allopregnanolone and the GABA-A Receptor



- Women who go on to develop PPD in the early postpartum period may have dysregulation of this system that may begin in pregnancy, interferes with normal receptor plasticity, and contributes to their risk for PPD.
- This is **NOT a hormone deficiency but rather a sensitivity to hormonal fluctuation.**

Efficacy of Zuranolone

- Zuranolone has demonstrated efficacy as both an add on or monotherapy for PPD.

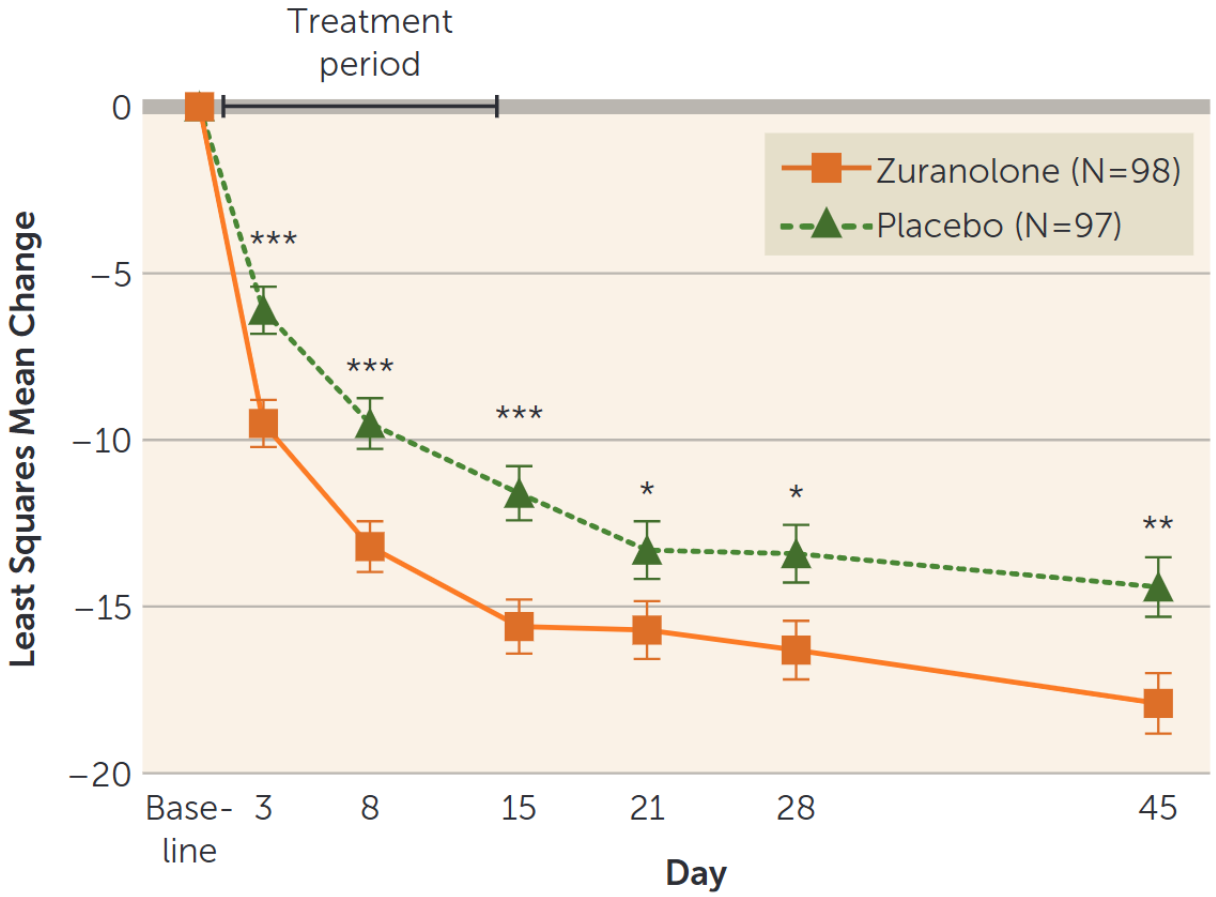


FIGURE 2. Change from baseline in HAM-D score in a placebo-controlled trial of zuranolone 50 mg/day for postpartum depression (full analysis set)[a]

- Women had an improvement in mood scores at day 3 with benefits ongoing at day 45

Prescribing Considerations for Zuranolone

- Due to the **sedating effects** of Zuranolone, patients cannot drive/operate heavy machinery. Since zuranolone can likely the affect the ability to safely care for an infant, we strongly recommend **planning for back up support at night while taking zuranolone**.

- Zuranolone **should not be used during pregnancy**

- Zuranolone **should be taken with food**

Zuranolone and Breastfeeding

- **A dose of 50mg Zuranolone likely has an RID < 1%.**
- However, the currently available studies are small and we do not yet have long term outcome data so **shared decision making is essential.**

Factors to Consider in Medication Management

- Traditional antidepressants and zuranolone can be used **sequentially or together** depending on the clinical situation and the patient's goals.

1. **Diagnostic clarity**
2. **Timing of symptom onset**
3. **Severity of symptoms**
4. **Practicalities**
5. **Prior treatment response**
6. **Breastfeeding goals**
7. **Comorbidities**

Additional Slides

- Discussion of Safety Assessment
- Substance Use Screening and Treatment examples
- Prescribing Sleep to support postpartum mental health
- Details on Psychiatry Access Programs

Suicide & Drug Overdose: Leading causes of Perinatal Deaths in the US

- Critical Periods of Prenatal and Early Childhood Brain Development
- Relationships with caregivers shape emotional experience and self-regulation capacity
- Can we prevent the loss of a parent and mitigate ACEs for infants and families?

CDPHE, Maternal Mortality Report, 2023

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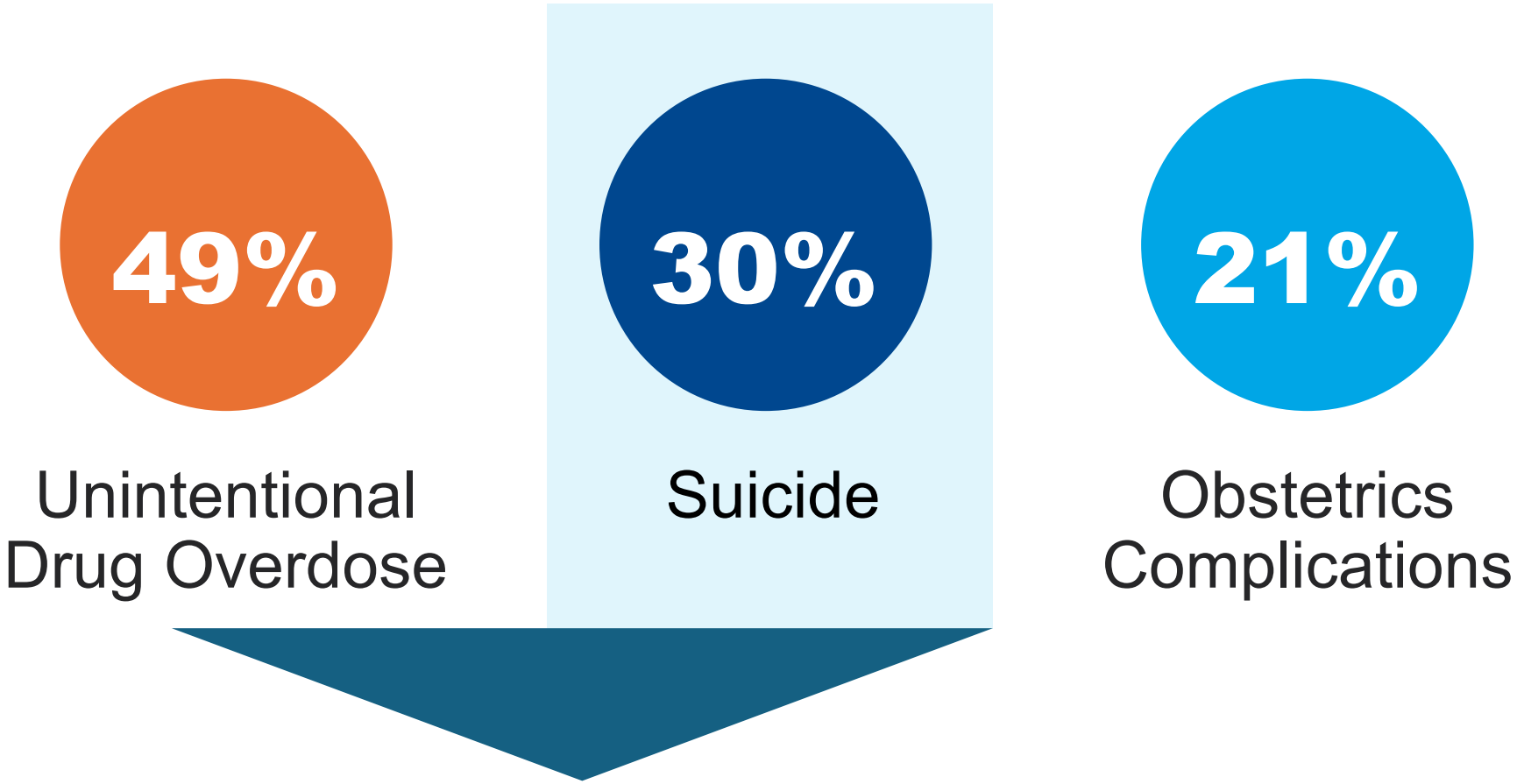
Leading Causes of Maternal Deaths in the Perinatal Period



Postpartum Psychosis + Emergencies

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- 1-2 per 1000 births
- Bipolar disorder increases risk of PPP
- Highest risk in first 1-3 months postpartum, often onset in first few weeks
  - Anger and agitation
  - Insomnia
  - Confusion and disorientation
  - Thoughts of harming self (suicide) or baby (infanticide)
    - vs. OCD - in psychosis thoughts may make sense to the mother; desire/plan/intent to act on thoughts may happen
  - Hallucinations and delusions
  - Paranoia
  - Strange thoughts or statements

* ***POSTPARTUM PSYCHOSIS IS A MEDICAL EMERGENCY AND A FAMILY CRISIS***
* *Treatment often requires hospitalization and medication*

Treatment – or lack of…

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- **Half** of the women in one sample who died by suicide were **on psycho-pharmacotherapy at conception**, and about **half of this group discontinued medications for psychiatric disorders** during pregnancy
- Overall, 71% had a documented psychiatric illness in their medical chart, with 48% having ≥2 psychiatric illnesses.
- However, **only a third** of these patients had documentation of taking psychotropic medication for their illness

Metz, T. D., Rovner, P., Hoffman, M. C., Allshouse, A. A., Beckwith, K. M., & Binswanger, I. A. (2016). Maternal deaths from suicide and overdose in Colorado, 2004–2012. *Obstetrics and gynecology*, *128*(6), 1233.
Kountanis, J. A., Roberts, M., Admon, L. K., Smith, R., Cropsey, A., & Bauer, M. E. (2023). Maternal deaths due to suicide and overdose in the state of Michigan from 2008 to 2018. *American Journal of Obstetrics & Gynecology MFM*, *5*(2), 100811.

Contributing Factors and Healthcare Utilization

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- More than half involved **intimate partner conflict**.
- Are more likely to have had a **perinatal loss**.
- They are disproportionally insured by **Medicaid** vs. those who died by other causes (63 vs 56%).
- More than half **did not attend a postpartum visit** with their obstetrics clinician.
- Most (74%) had at least one **ED or hospital visit** in between delivery and death.

Colorado Maternal Mortality Prevention Program Legislative Report 2014–2016. Colorado Department of Public Health and Environment. 2020.

Trost, S. L., *Health Affairs*, *40*(10), 1551-1559. Goldman-Mellor, S., & Margerison, C. E. (2019). *American journal of obstetrics and gynecology*, *221*(5), 489-e1.
Chin, K., Wendt, A., Bennett, I. M., & Bhat, A. (2022). Suicide and maternal mortality. *Current psychiatry reports*, *24*(4), 239-275.

Screening: Edinburgh Postnatal Depression Scale

EPDS 3A = Anxiety - Q's 3,4,5 >=6 positive for likely Anxiety Disorder.

Q 10 = Clarify if Self-Harm vs. SI, w/ or w/ out plan?

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In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have copied quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Example of Further Assessment

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SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity (If question 2 is "no" you may skip 3, 4 and 5)	**Month**
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might do this?*	
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*	

https://www.coloradoprosper.org/screening-tools

IMMEDIATE INTERVENTIONS

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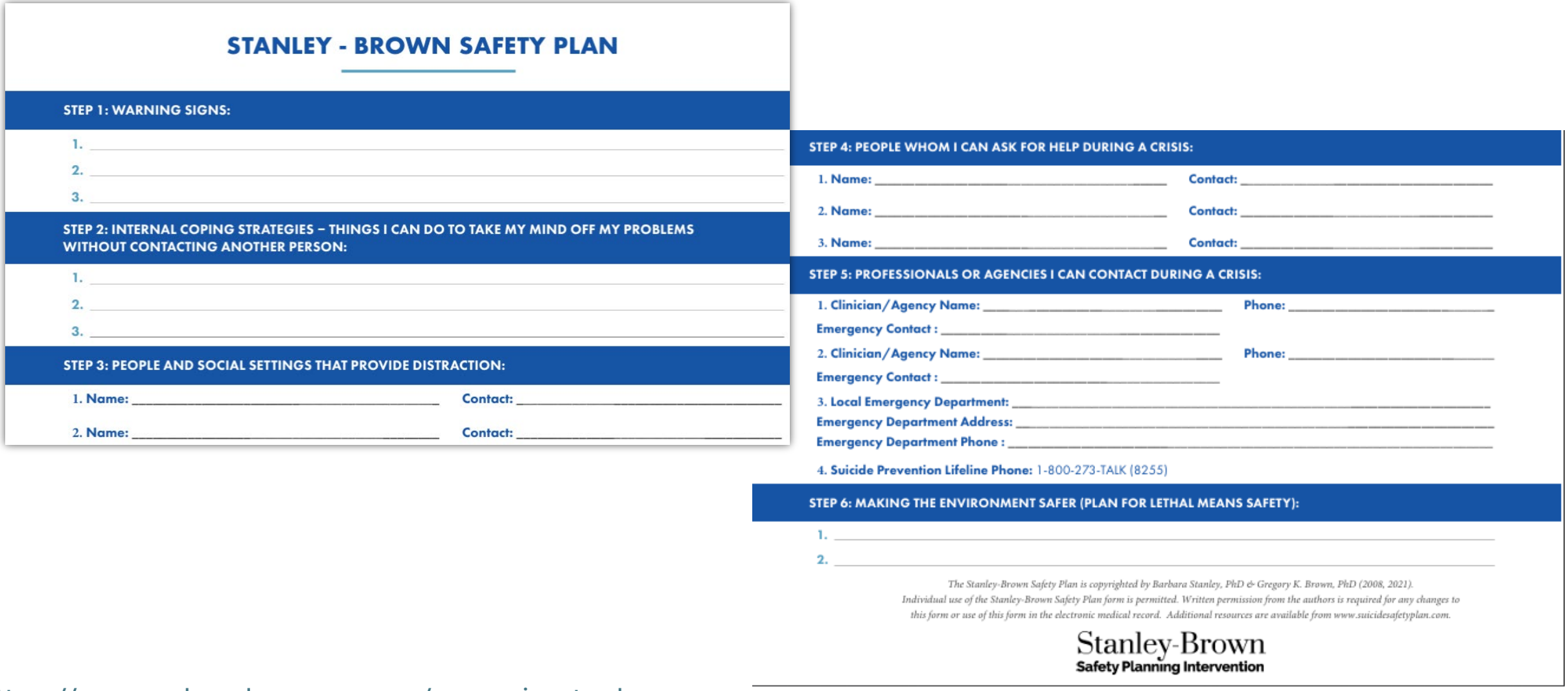
- Name what's happening and provide education
  - "I think you're experiencing postpartum _____." "Other women have this experience too."
  - There is treatment that works – therapy, medications, peer and community support.

- Offer reassurance
  - "I know you love your baby and want to keep baby safe."

  - "You are not a bad mother."
  - "Your baby and family need you and you will recover from this."

Stanley Brown Safety Plan



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

https://www.coloradoprosper.org/screening-tools

Substance Use Screening

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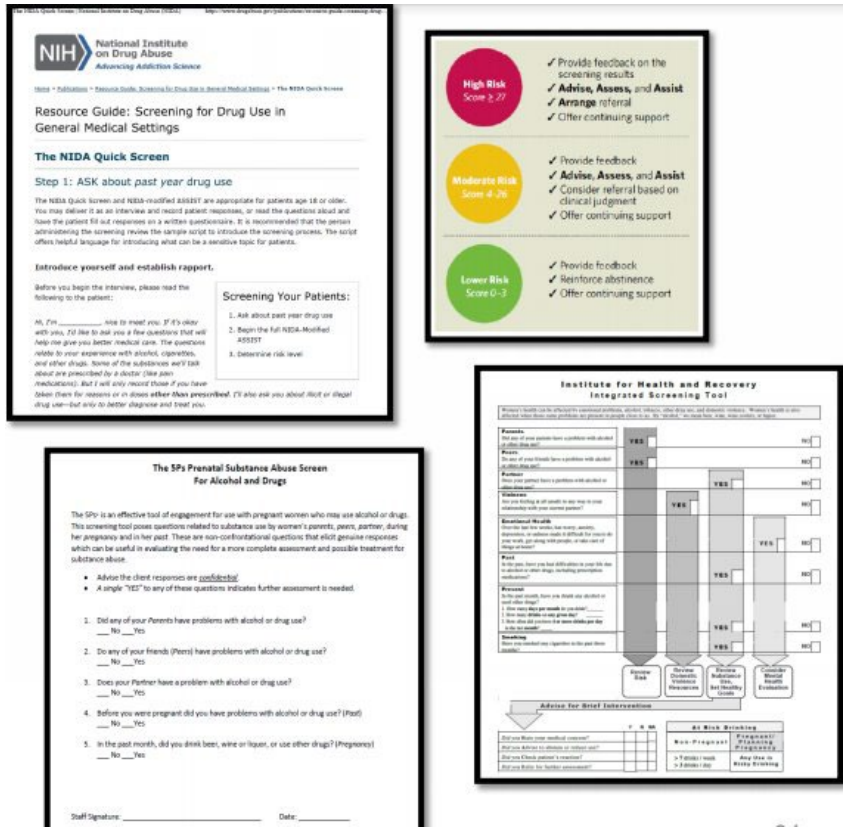
- **Who?** Universally, everyone, every pregnancy
- **What?** Validated, evidenced-based screening tools - e.g. 5P's, NIDA Quick Screen, available at: www.coloradoprosper.org/screening-tools
- **When?** As early as possible (1st prenatal visit – ACOG; every trimester – WHO)
- **Why?** Determine risk, screening associated w/decreased use, context for use and often high motivation to change during pregnancy/postpartum.
- **How?** *"We are working as a clinic/unit/team, etc to take better care of our patients as whole people. This includes asking questions about physical and emotional health, including substance use."*



Free Screeners Available

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- Drug Abuse Screening Test (DAST-10)
- 5P's Substance Use Disorder Screening Tool
- The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool
- Brief Negotiated Interview (BNI)
- The Alcohol Use Disorders Identification Test (AUDIT)
- The Cannabis Use Disorder Identification Test Revised (CUDIT-R)
- The PROMOTE Prenatal Screener
- NIDA Quick Screen

Instead of . . .	Please use . . .
Addict, Substance or drug abuser or user	Person with a substance use disorder or patient
Substance abuse	**For illicit drugs:** Use **For prescription medications:** Misuse Used other than prescribed
Junkie	Person in active use; use the person's name, and then say "is in active use."
Alcoholic	Person with alcohol use disorder
Drunk	Person who misuses alcohol/engages in unhealthy/hazardous alcohol use
Former or reformed addict	Person in recovery or long-term recovery
Habit	Substance use disorder; drug addiction
Clean/Dirty	**For toxicology screen results:** Testing negative/testing positive **For non-toxicology purposes:** Being in remission or recovery/Person who uses drugs
Addicted baby	• Baby born to mother who used drugs while pregnant • Baby with neonatal opioid withdrawal/neonatal abstinence syndrome • Newborn exposed to substances
Opioid substitution replacement therapy Medication-assisted treatment (MAT)	Medication for a substance use disorder Medication for opioid use disorder (MOUD)

https://nida.nih.gov/nidamed-medical-health-professionals

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Helpful Language

What if my patient screens positive?

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- Curiosity, Motivational Interviewing Approach + Counseling
- Assess reason(s) for use: *"What does it do for you?"*
- Non-judgmental, neutral phrasing
    - Pattern of use: frequency, quantity, last use, route of admin, triggers
    - Functional impairment
    - Hx of SU treatment,
    - Any periods of abstinence
    - Partner use? And use patterns others around the patient

- Check PDMP (or make sure prescribing providers are doing so)

Helpful Language - Breastfeeding

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- *"THC is stored in body fat. A baby's brain and body are made with a lot of fat. Since your baby's brain and body may store THC for a long time, you should not use marijuana while you are breastfeeding."*

- *"Because of the potential risks to the baby, the American Academy of Pediatrics states that marijuana should not be used while breastfeeding."*

CPDHE guidance

Pearls: Breastfeeding

BREASTFEEDING MEDICINE
Volume 18, Number 10, 2023

DOI: 10.1089/bfm.2023.29256.abm

ABM Protocol

Open camera or QR reader and scan code to access this article and other resources online.

Academy of Breastfeeding Medicine Clinical Protocol #21: Breastfeeding in the Setting of Substance Use and Substance Use Disorder (Revised 2023)

Miriam Harris,[1,2] Davida M. Schiff,[3,4] Kelley Saia,[2,5] Serra Muftu,[3,4] Katherine R. Standish,[6] and Elisha M. Wachman[2,7]

MOUD (methadone, buprenorphine, naltrexone) are safe for breastfeeding at any dose!

Breastfeeding significantly reduces incidence and severity of NOWS.

Non-prescription opioids, stimulants, alcohol not safe. Cannabis (THC) not recommended.

Medications first, but not ONLY medications:

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Primary Care + Perinatal Care

Individual counseling

Group therapy

Peer Recovery Specialist

Embedded or referrals for psychiatric care, primary care, dental care, etc

Assistance with education, housing, transportation, utilities, legal concerns, social services, etc.

Slide from Kaylin Klie, MD

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Substance Use Continuum of Care

Support groups, educational classes (DUI, DWAI)	AA, NA, CA, LifeRing, SMART recovery, Celebrate Recovery, Women for Sobriety, etc	Medically Managed Withdrawal	Outpatient
Intensive Outpatient	Residential Treatment	Sober living	Connection to Recovery Communities

Slide from Kaylin Klie, MD

Health Care Clinician Resources

MOMS+ (Maternal Overdose Matters): www.momsplus.us/videos

Suicide screening tools: https://zerosuicide.edc.org/toolkit/identify/screening-options

MGH Women's Mental Health: https://womensmentalhealth.org/about/

Mother to Baby- Fact Sheets for Meds in Pregnancy: https://mothertobaby.org/

Infant Risk Center- Lactation Pharmacology Resource and Helpline: https://www.infantrisk.com/

Strategies for Supporting Sleep: Intro to Prescribing Sleep in the Postpartum

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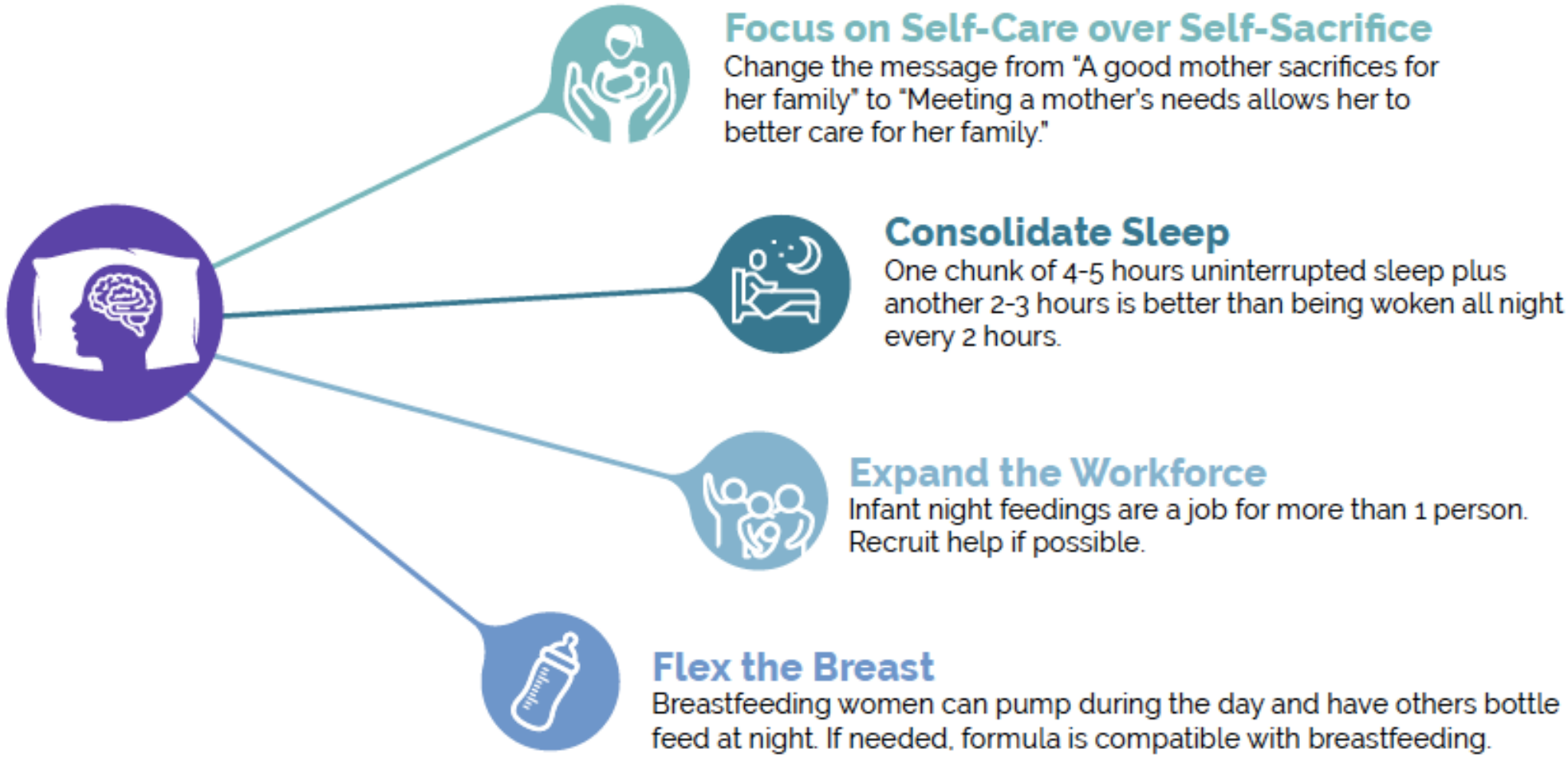
Sleep is a modifiable risk factor for PPD and virtually all PMHDS

- 3,619 patients who were not depressed during pregnancy
- Endorsement of sleep disturbance on PHQ 9 (Q3) predicted postpartum depressive symptoms (aOR 3.43)

- Felder JN, Roubinov D, Zhang L, Gray M, Beck A. Endorsement of a single-item measure of sleep disturbance during pregnancy and risk for postpartum depression: a retrospective cohort study. Arch Womens Ment Health. 2023 Jan 12.

Prescribing Sleep



Focus on Self-Care over Self-Sacrifice

Change the message from "A good mother sacrifices for her family" to "Meeting a mother's needs allows her to better care for her family."

Consolidate Sleep

One chunk of 4-5 hours uninterrupted sleep plus another 2-3 hours is better than being woken all night every 2 hours.

Expand the Workforce

Infant night feedings are a job for more than 1 person. Recruit help if possible.

Flex the Breast

Breastfeeding women can pump during the day and have others bottle feed at night. If needed, formula is compatible with breastfeeding.

Prescribing Sleep- Initial Steps

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- Taking a detailed history to understand the specific sleep situation within a particular family
- Looking for opportunities where chunks of sleep could be possible with the right intervention
- Collaborating with the patient to help them to consider changing
  - roles, expectations, and routines
- Goal: 4- 5 hour block of consolidated sleep becomes possible- ideally for each parent

Sleep Planning

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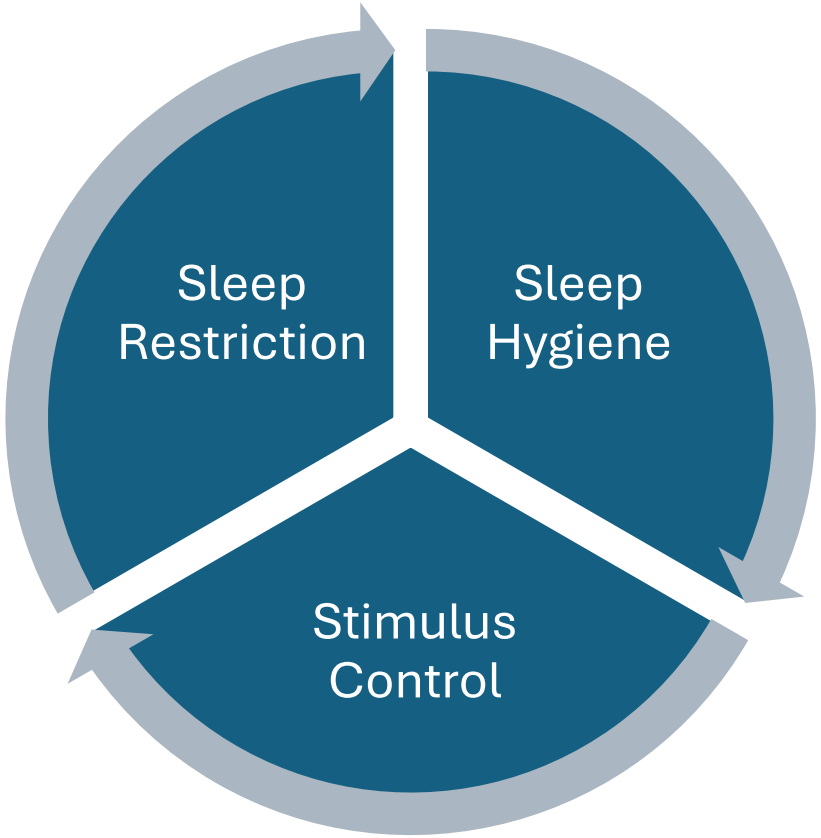
Prescribing sleep:

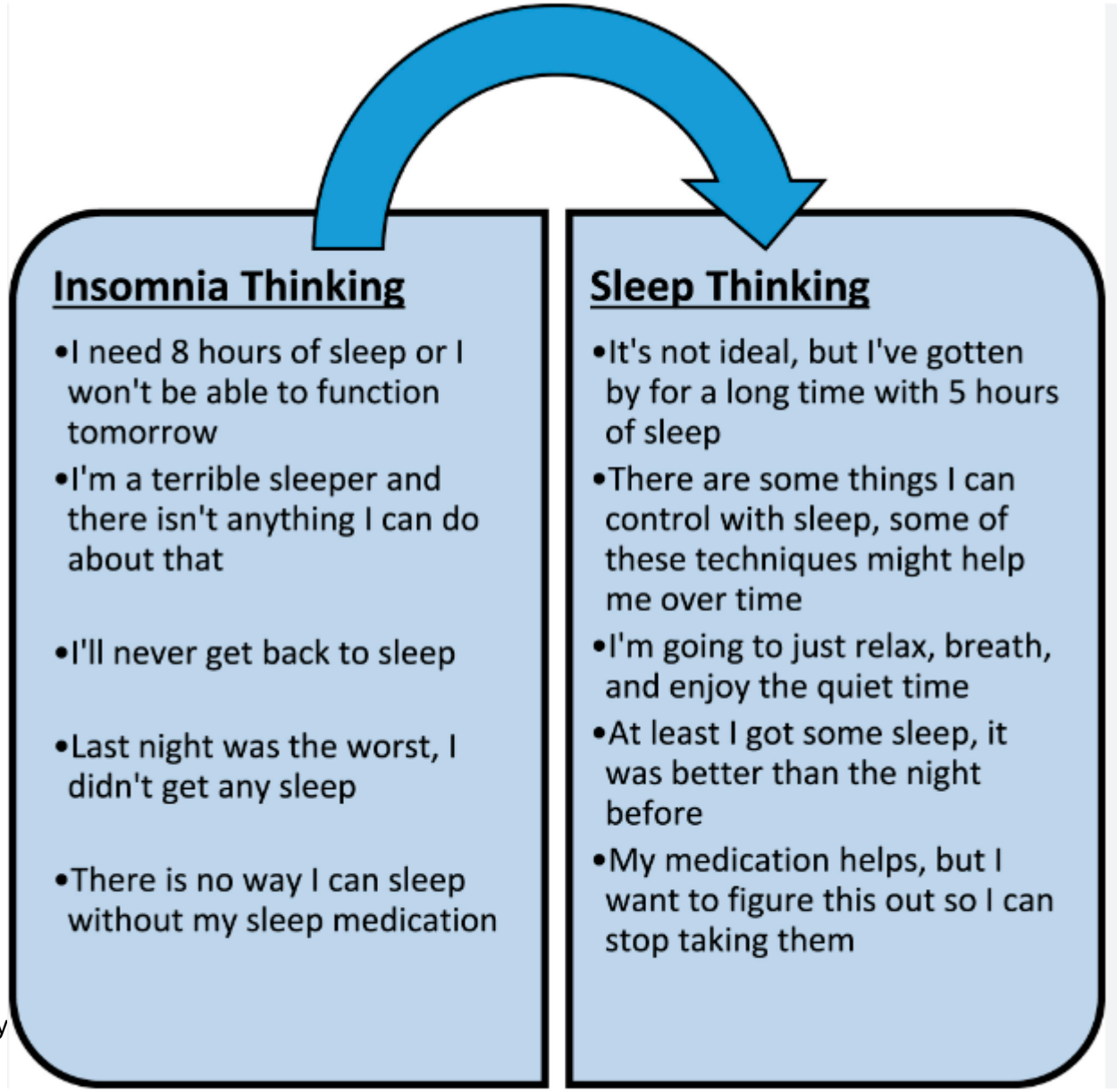
- Treats postpartum sleep as a **shared family resource and responsibility**, something that CAN be changed with a plan and benefits the whole family, rather than a burden to be placed on one individual who is blamed for failure or lack of effort
- Requires **partner, family, or other adult involvement** whenever available
- Often requires **explicit permission from a clinician** to override cultural pressure toward self-sacrifice in the postpartum in favor of a focus on maternal self-care that is good for babies

Postpartum Sleep Strategies

- Proactive planning
- Team approach
- Prioritize opportunities for consolidated sleep
- Feeding flexibility
- Separate space

CBT I





Traupman, E. K., & Dixon, M. A. (2022). Cognitive-behavioral therapy for insomnia for primary care: Review of components and application for residents in primary care. The International Journal of Psychiatry in Medicine, 57(5), 423–433. https://doi.org/10.1177/00912174221112466

Mindfulness Based Stress Reduction

- Aims to help individuals understand their physical/mental reactions to stress and learn to self-regulate
- In the general population, MBSRI has parallel effectiveness to CBT I
- Not studied in perinatal populations

Info on Psychiatry Access Programs:

1. Consultation

Target Audience:

Any Healthcare professional seeing Pregnant and Postpartum women across Colorado

Free + Payor-Blind

Consultation Approach:

- **NO WRONG DOOR! – All inquires welcome**
- Practice registration is encouraged but not required
- Available to assist with both simple and complex clinical questions
- Provide diagnostic clarification and medication recommendations
- Dedicated to improving access for Rural Coloradans
- Our team was intentionally built to address Health Disparities for moms and babies!
- Now Available!
  - One-time Treatment Planning Visit for patient with reproductive psychiatrist
  - E-Consults – within UCH system first

2. Resource & Referral Component:

PROSPER Resource & Referral Specialist (RRS) answers calls:

- Facilitates **referrals** to group, individual or dyadic therapy, psychiatrists, and more.
- Provides **resources** to improve screening, early intervention, inform decision-making, and increase provider efficiency.

Peer support groups reduce isolation and increase social connection:

- **Alma Program (**www.colorado.edu/crowninstitute/alma**)**
  - English- and Spanish-speaking Peer Mentors for new mothers
  - Existing Partnerships in Rural Counties
- **Hard Beauty (**www.hardbeauty.life/**)**
  - Lived Experience Coaches for mothers with Substance Use Disorders
  - Program located in Castle Rock & Colorado Springs

Recommendations for higher level of care when needed, such as:

- Healthy Expectations Perinatal MH Intensive Outpatient Program
- https://medschool.cuanschutz.edu/psychiatry/Healthyexpectationsiop

3. Education & Training Component

Meeting Patients Where They Are: Trauma Informed Care and Cultural Humility	Perinatal Mental Health Emergencies	Strategies to Support Sleep
Screening: Mood, Anxiety, and Substance Use	Screening and Initiating Treatment for Perinatal Bipolar Disorder	Guidance around Cannabis Use
Treatment of Depression and Anxiety	Perinatal Obsessive-Compulsive Disorder and Intrusive Thoughts	Opioid and Alcohol Use Disorders

- Asynchronous learning modules on perinatal mental health foundational topics coming soon!
- Future plans for drop-in communities of practice sessions.
- Every consultation is an educational opportunity
- Each conversation builds provider confidence and strengthens their ability to manage more complexity

CO-MAP

Three Access Programs, One Seamless Pathway: CO-MAP (Office of Colorado Mental Health Access Programs) brings together three psychiatric access programs—pediatric (CoPPCAP), perinatal (PROSPER), and adult (EASY)—to form a coordinated, statewide model of support across the lifespan.
(scan QR code above for website)

- **Integrated Across All Ages:** A single, coordinated system supporting mental health care from childhood through geriatric ages
- **Statewide Reach:** Designed to serve providers in urban, rural, and frontier communities across Colorado
- **Data-Driven:** Focused on reducing barriers and expanding access for all Coloradans
- **No Wrong Door:** One phone number for all programs—call us, and we'll route you to the right team for your patient's needs: **1-888-910-0153**
- **A Strong Commitment to Colorado Providers**

EASY

Effective Access and Support from psychiatrY
Primary Care Consult Line

Scan QR Code with phone camera

Phone: 1-888-910-0153, option #2
Email: easyconsultation@cuanschutz.edu

Free & Payor-Blind

Psychiatric Consultation:

- Access line for peer-to-peer consultation; medically complex, geriatric & SUD expertise
- Additional focus on nursing home support
- E-consults; asynchronous contact

Education:

- ECHOs and other educational forums
- Website/Toolkits for resources

Referral & Support:

- Curated mental health resources and resources for other community supports

Questions?

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PERINATAL MENTAL HEALTH & SUBSTANCE USE CONSULTING + ACCESS PROGRAM

Contact Us:

Phone: 1-888-910-0153

Email: prosper@ucdenver.edu

Website: www.coloradoprosper.org

Thank you for joining us for the second session in the Perinatal Mental Health Series!

To view the **event archive** of this and other past CHAMPS events, visit: http://champsonline.org/events-trainings/distance-learning/online-archived-champs-distance-learning-events

To learn about other **upcoming CHAMPS events**, visit: http://champsonline.org/events-trainings/distance-learning/upcoming-live-distance-learning-events

You must evaluate today's session to receive Continuing Medical Education (CME) Credits. CME will be awarded at the conclusion of the series.

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