PARTICIPANT HANDOUTS

Region VIII Maternal Health Summit
Session Two
Perinatal Mental Health: From Maternal Mortality to Meaningful Support

Addressing maternal health is a federal priority area, and many community, state, and federal partners are actively engaging in a variety of initiatives throughout Region VIII (CO, MT, ND, SD, UT, WY) aimed at improving maternal health outcomes. This online convening of health center and maternal health experts is intended to foster efficient cross-program collaborations and to share evidence-based models or promising practices that support improved maternal health.

Facilitated by:
Sharon Talboys, PhD, MPH, University of Utah

Featuring Speakers:
Robin Landwehr DBH, LPCC, Spectra Health
Marcella Smid, MD, SUPeRAD Clinic at the University of Utah

Live Session Date & Time:
Thursday, January 22, 2026
10:00–10:45PM Mountain Time | 11:00–11:45PM Central Time

Session Overview:
This session will discuss maternal mortality, perinatal mental health and substance use disorder, and will feature best and promising practices for screening, referral, and wraparound support systems. Region VIII health center clinical and enabling services staff, state and local health officials, and individuals from maternal health community organizations are encouraged to attend.

Maternal Health Landscape in RVIII Summary of Findings:
CHAMPS partnered with the University of Utah to conduct an environmental scan of maternal health programs in Region VIII. View the Summary of Preliminary Findings that will serve as the basis for Summit discussion.

Contents

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. The Happenings box in the middle of the CHAMPS home page highlights the newest CHAMPS offerings. 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. Be sure to take advantage of CHAMPS' programs, products, resources, and other services. For more information about CHAMPS, please visit www.CHAMPSonline.org.

Speaker Biographies

Sharon Talboys

Sharon Talboys, PhD, MPH is an Associate Professor in the Division of Public Health at the University of Utah. As a 'pracademic' for over 25 years, her focus is on accelerating the implementation of best practices in public health and healthcare to improve health outcomes and address upstream drivers of health. She has expertise in maternal and child health, health workforce, community health needs assessments, strategic planning, and policy development. She has worked extensively with communities in Utah, Ghana, India, and Latin America. She is a former president of the Utah Public Health Association and received her public health training at Emory University and the University of Utah.

Robin Landwehr

Robin J. Landwehr, DBH, LPCC, is a Licensed Professional Clinical Counselor in North Dakota and is also licensed in Florida and Oregon. She serves as the Integrated Care Director at Spectra Health, where she supports integrated behavioral health services in an FQHC setting using the Primary Care Behavioral Health model. While at Spectra, she helped establish a Medication-Assisted Treatment (MAT) program for individuals with opioid use disorder. She works with the University of North Dakota delivering trainings on perinatal mental health. Her clinical experience includes supporting individuals experiencing trauma, depression, anxiety, health behavior concerns, and substance use disorders. She is a certified instructor in QPR (Question, Persuade, Refer) and CALM (Counseling on Access to Lethal Means) suicide prevention programs, and is especially proud of her service as a Disaster Mental Health volunteer with the American Red Cross - Dakotas Region.

Marcela Smid

Marcela Smid MD, MA, MS is an Associate Professor and board certified Maternal Fetal Medicine, Complex Family Planning and Addiction Medicine physician at the University of Utah. She is the Director of Perinatal Addiction Services and the medical director of the Substance Use & Pregnancy – Recovery, Addiction, Dependence (SUPeRAD) specialty prenatal clinic, a multi-disciplinary clinic

for pregnant and postpartum individuals with substance use disorder. She also serves as the medical director of University of Utah's OBAirMed and the Chair of the Utah Maternal Mortality Committee. Her research focus is on perinatal addiction, interventions for pregnant and postpartum women with substance use disorders, maternal mortality and maternal mental health.

The views and opinions expressed in this program are solely those of the speakers, based on their individual expertise, and do not necessarily reflect the views of CHAMPS.

REGION VIII MATERNAL HEALTH SUMMIT

Thursday January 22, 2026

Perinatal Mental Health: From Maternal Mortality to Meaningful Support

Featured Panelists:

Robin Landwehr, DBH, LPCC, Spectra Health &

Marcela Smid, MD, SUPeRAD Clinic, University of Utah

HEALTH
UNIVERSITY OF UTAH

CHAMPS

About our panelists

Moderator: Sharon Talboys, PhD, MPH, University of Utah

Robin Landwehr, DBH, LPCC,
Spectra Health

SOUTH DAKOTA

Marcela Smid, MD, SUPeRAD
Clinic University of Utah

UTAH

Key Findings from Environmental Scan

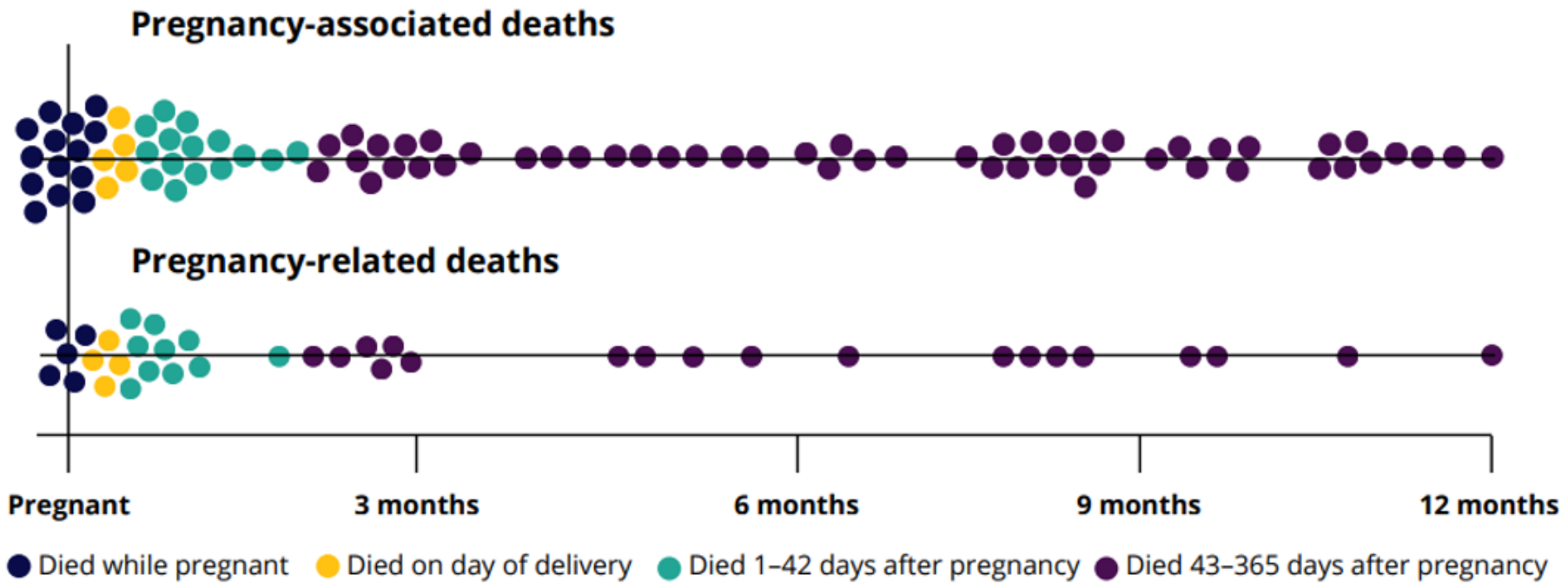
- Substance Use Disorder (SUD), and perinatal depression are the main drivers of maternal mortality
- Opportunities are often missed to screen and link women to mental health care
- Mental health services are in short supply and providers want and need more training in perinatal mental health
- Barriers to adequate perinatal mental health care include limited availability of providers, especially in rural areas, stigma, and health literacy gaps

Pregnancy-related maternal mortality findings from Region VIII Maternal Mortality Review Committee Reports published from 2019-2024

State	Pregnancy-Related Mortality Ratio*	Leading Causes	Key Disparities
Colorado	**25.1** per 100,000	Suicide, Overdose	Native Americans 4.8x higher risk
Montana	**32.5** per 100,000	Mental health, SUD, postpartum suicide	American Indian populations disproportionately affected
North Dakota	**50.07** per 100,000	Trauma, Sepsis, Cardiac arrest, overdose	American Indian mothers ~30% of deaths
South Dakota	**68.7** per 100,000	Mental health, Substance misuse	American Indian mothers up to 184.6 per 100,000
Utah	**20.2** per 100,000	Suicide, Overdose	American Indian/Alaska Native overrepresented
Wyoming	**35.5** per 100,000	Mental health, SUD	Rural access barriers, Native populations

*Timespan varies from 3 to 15 year periods
Pregnancy-related maternal mortality includes deaths during pregnancy and up to one year postpartum

Timing of pregnancy-associated (n=87) and pregnancy-related (n=38) deaths, Utah 2017-2020



Source *Maternal Mortality in Utah* https://mihp.utah.gov/wp-content/uploads/Maternal-mortality-in-Utah-2017-2020.pdf

Environmental scan quotes:

"It's overwhelming how many women in the postpartum period die by suicide. I had no idea before I was on that committee" *(Maternal mortality review committee member)*

"sometimes I feel like people could be falling through the cracks" *(Provider discussing perinatal mental health)*

Today's topics

PERINATAL MENTAL HEALTH NEEDS + FQHC BEST PRACTICES

EXPANDING CARE FOR PREGNANT AND POSTPARTUM PEOPLE WITH SUBSTANCE USE DISORDER

Perinatal Mental Health Needs + FQHC Best Practices

A behavioral health consultant's overview for family practice (pregnancy → 12 months postpartum)

15-minute briefing

Robin Landwehr, DBH, LPCC
Integrated Care Director
Spectra Health

What we'll cover

GOALS

By the end, you should be able to:

- Describe common perinatal mental health conditions, risk factors, and red flags
- Implement a simple, repeatable screening → brief assessment → stepped-care workflow
- Use integrated behavioral health tactics that fit FQHC reality (warm handoffs, registries, follow-up)
- Build referral pathways that keep patients engaged through the first postpartum year

Family practice is a high-leverage place for universal screening and follow-up.

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Key sources: ACOG (2023)

Perinatal = pregnancy through 12 months postpartum | FQHC = Federally Qualified Health Center

Why perinatal mental health belongs in primary care

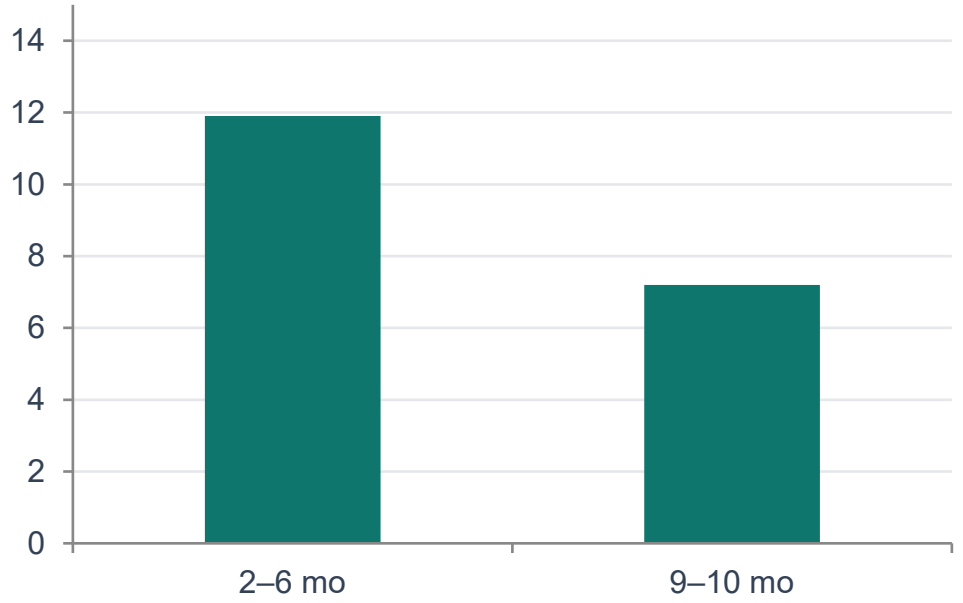
High prevalence — and not just at 6 weeks

- About 1 in 8 women report postpartum depressive symptoms in the U.S.
- Symptoms can emerge later: in one study, 57% of women with symptoms at 9–10 months did NOT report symptoms at 2–6 months.

High stakes

- Untreated perinatal depression is linked to poorer maternal and infant health outcomes.
- CDC MMRC data show mental health conditions are a major underlying cause of pregnancy-related deaths.

Postpartum depressive symptoms can appear later



Implication: screening + follow-up needs to extend through the first year.

Key sources: Bauman et al., 2020 Robbins et al., 2023; Chen et al., 2025.

Data snapshot: 2–6 months vs 9–10 months postpartum (population-based study in 7 U.S. states).

What we're screening for (and what can be missed)

Common perinatal presentations

- Depression, anxiety, panic, trauma/PTSD
- Obsessive / intrusive thoughts (ego-dystonic vs psychosis)
- Bipolar disorder relapse (sleep loss + mood activation)
- Substance use disorders (including opioids) and co-occurring MH

Red flags → same-day action

- Suicidal thoughts/plan, inability to maintain safety
- Postpartum psychosis symptoms: hallucinations, delusions, confusion, severe insomnia
- Mania/hypomania, severe agitation, or escalating substance use
- Intimate partner violence or immediate safety concerns

Risk & protective factors (quick scan)

Risk ↑

- Prior depression/anxiety or bipolar disorder
- Trauma history, IPV, housing/food insecurity
- Preterm birth/NICU, pregnancy complications
- Low social support, language barriers

Protective ↑

- Trusted, continuous primary care team
- Partner/family/peer support
- Concrete supports (WIC, home visiting, case management)
- Accessible therapy + medication management when indicated

Spectra HEALTH

Key sources: ACOG (2023); Friedman et al. (2023)

Tip: If the story sounds "off" (rapid onset, disorganization, paranoia), think bipolar/psychosis — not just depression.

Perinatal substance & alcohol use: stigma + primary care's role

Conceptual guide (not diagnostic). Pregnancy → 12 months postpartum: treat as a health condition, not a moral failing.

Stigma is a clinical barrier

- Fear of judgment, CPS/legal concerns, and loss of trust can reduce disclosure and care-seeking
- Stigma is reinforced by language—use person-first, non-stigmatizing terms (e.g., "substance use disorder," not "abuser")
- Trauma-informed, culturally responsive, harm-reduction approaches improve engagement and retention

Clinical framing to reduce stigma

- Validate and reduce shame: "Many people use substances to cope—our goal is to keep you and your baby healthy"
- Ask permission, offer choices, and avoid labels; use person-first language
- Focus on safety, recovery, and connection to care (harm reduction + relapse-prevention planning)

What primary care can do (FQHC-ready)

- Screen universally and repeatedly across pregnancy and the postpartum year; normalize with "We ask everyone"
- Use brief, nonjudgmental interventions (motivational interviewing / SBIRT) and shared goal-setting
- Provide warm handoffs to treatment (including MOUD where available) and coordinate with OB, pediatrics, and behavioral health
- Address barriers (transportation, housing, safety, food, insurance) with integrated social services
- Be transparent about confidentiality and mandated reporting limits; prioritize trust and engagement

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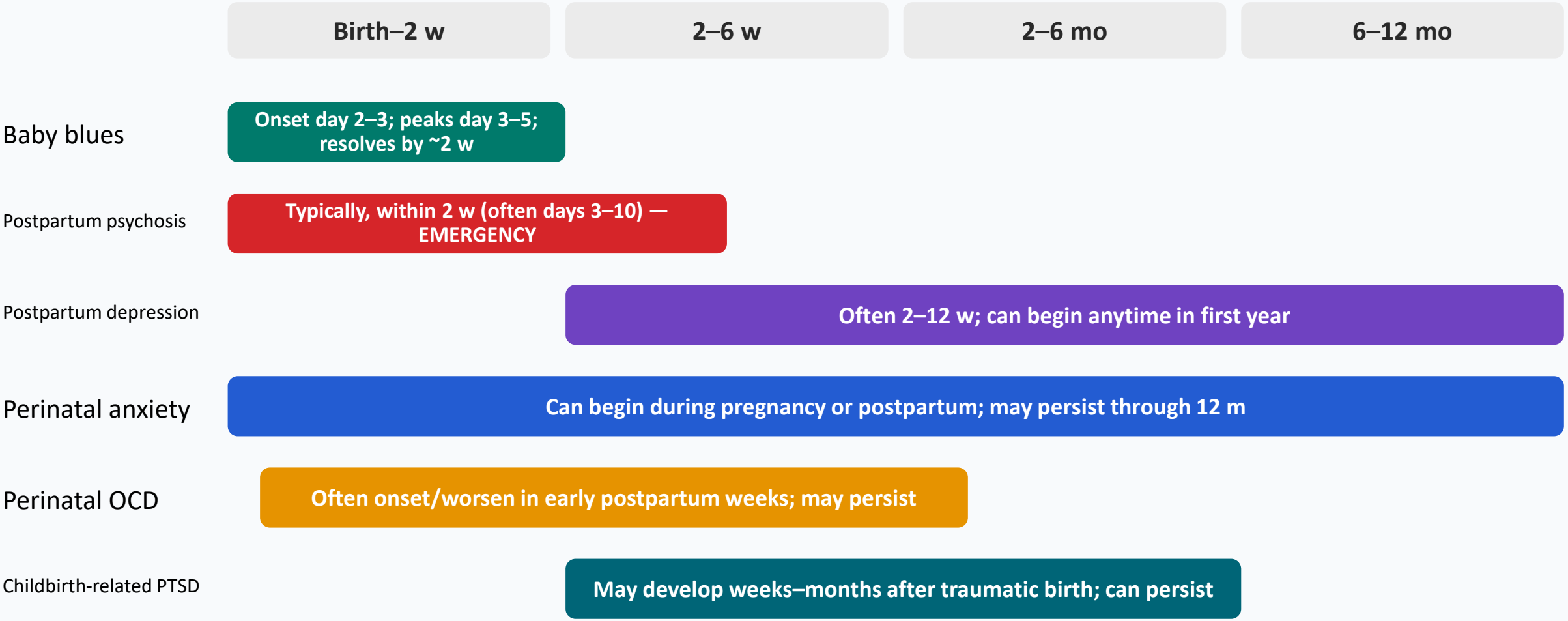
Key sources: Weber et al. (2021); Stone (2015); Work et al. (2023); Martino et al. (2018); Ellis et al. (2023).

Postpartum timing: when symptoms commonly emerge

Conceptual guide (not diagnostic). Onset varies—screen repeatedly through 12 months postpartum.



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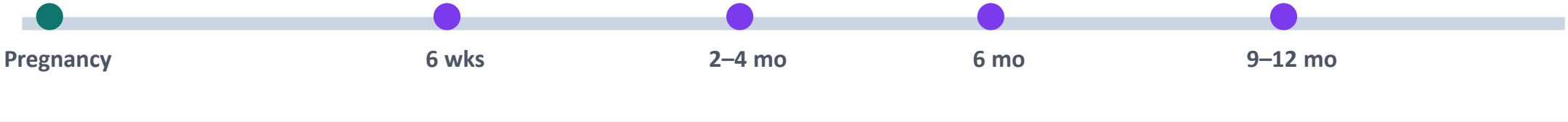
Sources: Tosto et al., 2023; Sit et al., 2006; O'Hara & Wisner, 2014; Robbins et al., 2023; Silverwood et al., 2022; Fairbrother et al., 2021; Dekel et al., 2017; Horsch et al., 2024.

Family practice is a fantastic home for the first postpartum year

The opportunity: multiple touchpoints beyond the 6-week visit



Where family practice adds leverage:

- Continuity: chronic disease + postpartum recovery + contraception
- Co-visits with infant care (many FQHCs provide both)
- Trusted relationships reduce stigma and improve engagement
- Integrated BHC can deliver brief therapy and care coordination on-site

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Key sources: O'Hara & Wisner, 2014; Slomian et al., 2019; Tosto et al., 2023.

Practical takeaway: build a postpartum mental health touchpoint into existing visit patterns (not a separate program).

Screening in FQHC family practice: simple and repeatable

When to screen (minimum viable schedule):

Timing

- Initial prenatal visit
- Later in pregnancy (e.g., 28–32 weeks)
- Postpartum: 0–3 months AND again in the later postpartum period (6–12 months)

Tools that fit primary care

- Depression: EPDS or PHQ-9 (choose ONE and standardize)
- Anxiety: GAD-7 (or EPDS anxiety subscale)
- Safety: a brief suicide screen when indicated (e.g., item-level follow-up)
- Consider: substance use (SBIRT), IPV, and social needs screening

Make it work in clinic flow

- MA gives tool at check-in (paper or tablet)
- Score before provider enters the room
- Positive screen triggers: (1) safety check (2) warm handoff to BHC when available
- Document score + plan; schedule follow-up before patient leaves

Standardize roles: who screens, who scores, who follows up.

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Key sources: Cox et al. (1987); Kroenke et al. (2001); Spitzer et al. (2006); ACOG (2023).

Evidence-based cadence: ACOG recommends screening at initial prenatal, later pregnancy, and postpartum visits.

After a positive screen: brief assessment + risk stratification

Aim for a 5–10 minute, structured follow-up (BHC or PCP):

1) Clarify symptoms

Duration, impairment, worry/intrusions, sleep, supports

→

2) Safety + bipolar screen

Suicide risk, psychosis/mania, substance use, IPV

→

3) Severity → plan

Mild: brief tx

Mod: therapy/meds

Severe: urgent specialty

Stepped response (example)

Mild	Moderate	Severe / safety
• Brief therapy (BA/CBT skills) • Sleep + social support plan • Follow-up in 2–4 weeks	• BHC therapy + PCP med discussion • Measurement-based follow-up • Care coordination / community supports	• Same-day safety plan and escalation • Urgent psych consult / ED if needed • Close follow-up + outreach within 24–72h

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Key sources: ACOG (2023); Byatt et al. (2016).

Document: score, brief assessment, safety determination, plan, and follow-up date.

Treatment in integrated primary care (what good looks like)

Behavioral interventions (BHC-friendly)

- Brief, skills-based therapy: behavioral activation, CBT, IPT-informed support
- Problem-solving around sleep, feeding stress, role transition, and identity shifts
- Partner/family engagement when appropriate

Medication support (PCP + consult when needed)

- SSRIs are commonly first-line when pharmacotherapy is indicated; individualize by history and lactation considerations
- Rule out bipolar disorder before starting antidepressants when history suggests it

Care model mechanics

- Measurement-based care (repeat PHQ-9/EPDS over time)
- Brief follow-ups (in-person, phone, portal)
- Registry to track who is overdue
- Psychiatric consultation line or tele-psych when possible

Equity lens

- Use interpreters and culturally responsive framing
- Reduce friction: same-day access, childcare-friendly scheduling, text reminders
- Co-locate concrete supports (WIC, case management) whenever possible

Spectra HEALTH

Key sources: ACOG (2023); Deligiannidis et al. (2023); Meltzer-Brody et al. (2018).

Scope note: This slide summarizes evidence-based care; follow local protocols and consult perinatal psychiatry when available.

Referral pathways that keep patients connected

Design for “warm handoffs” and closed-loop follow-up

Tier 1: In-house (best-case)

BHC brief therapy • PCP med management • Case management + social needs • Group visits / peer support

Tier 2: Partnered specialty care

Perinatal psychiatry (tele-psych, consult line) • Community mental health / CCBHC • SUD treatment programs • Home visiting / doula programs

Tier 3: Crisis & urgent escalation

988 Suicide & Crisis Lifeline • Mobile crisis / ED • Safety planning and means-restriction counseling • Domestic violence resources

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Key sources: ACOG (2023); HRSA (n.d.); PSI (n.d.); SAMHSA (n.d.); 988 Suicide & Crisis Lifeline (n.d.).

“Closed loop” = we confirm the referral happened, we track outcomes, and we keep outreach if the patient disengages.

A sample screening → treatment → referral workflow (BHC perspective)

A clinic-ready model you can adapt (start small and iterate):

Check-in / MA	**Screen + score** EPDS/PHQ-9 GAD-7 as needed Flag positives	**Warm handoff trigger** MA alerts PCP/BHC (as available)	**Document** Score entered Problem list updated
PCP	**Normalize + engage** “We ask everyone.” Ask permission to talk.	**Brief assessment** Safety, bipolar, SUD, function, supports	**Start stepped care** Brief tx / meds Follow-up plan
BHC / Care Team	**BHC intervention** Skills + coping Safety plan if needed	**Care coordination** Referrals + benefits Transportation/childcare	**Tracking + outreach** Registry Repeat measures No-show follow-up

Spectra HEALTH

Key sources: Miller et al. (2020); Byatt et al. (2016); ACOG (2023); Schaefer et al. (2024)

Key build: a single “positive screen” pathway that reliably triggers safety assessment + follow-up scheduling.

FQHC best practices (what sustains the work)

High-yield implementation moves

1) Standard work

- One tool set
- One positive-screen pathway
- Standing orders for who does what

2) Track and follow

- Registry of active patients
- Repeat measures
- No-show outreach

3) Reduce friction

- Same-day BHC slots
- Text reminders
- Warm handoffs over “here's a number”

4) Build community links

- PSI + peer support
- Home visiting/WIC
- Perinatal psychiatry consult access

5) Team practice

- Micro-huddles for positives
- Case review (weekly)
- Cross-training for coverage

6) Billing/documentation basics

- Document tool + score + plan
- Use payer-allowed screening codes
- Don't let billing drive clinical care

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Key sources: Byatt et al. (2016); Miller et al. (2020); Schaefer et al. (2024)

If you can't do everything: start with universal screening + a reliable follow-up appointment + outreach for no-shows.

Resources + takeaways

Clinical quick resources

- National Maternal Mental Health Hotline: 1-833-TLC-MAMA (24/7; English/Spanish)
- 988 Suicide & Crisis Lifeline (call/text/chat)
- Postpartum Support International (PSI) HelpLine: 1-800-944-4773 (4PPD)
- FindTreatment.gov (mental health/SUD treatment locator)

3 takeaways for FQHCs

- Screen universally — then do something reliable with positives
- Extend follow-up through 12 months (late-onset symptoms are common)
- Use integrated care tactics: warm handoffs, tracking, and closed-loop referrals

Questions?

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Key sources: HRSA (n.d.); PSI (n.d.); SAMHSA (2023); SAMHSA (n.d.); 988 Suicide & Crisis Lifeline (n.d.).

Thank you — adapt this workflow to your clinic's staffing and community resources.

Contact

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Expanding Care for Pregnant and Postpartum People with Substance Use Disorder

University of Utah Health

Substance Use and Pregnancy—Recovery, Addiction, Dependence Clinic (SUPeRAD)

Marcela Smid MD MA MS
Maternal Fetal Medicine
Addiction Medicine

Illustration: Dung Hoang

Leading contributing factor for maternal deaths in Utah

- Substance use disorder (SUD) affects pregnant people from **all walks of life**.
- In Utah, SUD is a **leading contributing factor for maternal deaths** (n=87) during pregnancy and after birth/postpartum from 2017-2020.

Accidental overdose and suicide are the leading causes of pregnancy-associated deaths in utah.

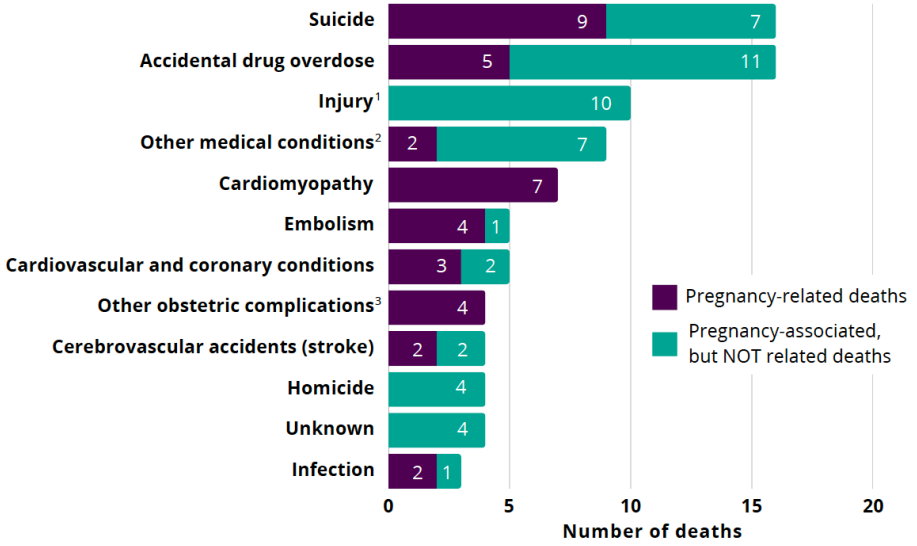
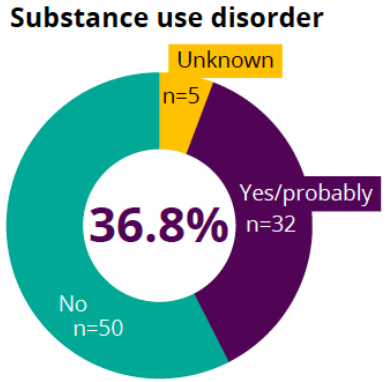


Figure 8. Causes of pregnancy-associated and pregnancy-related deaths, Utah 2017–2020.[4]



Maternal mortality in Utah

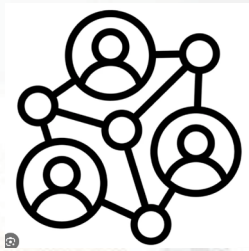
Utah Department of Health & Human Services

2017–2020

Utah Maternal Mortality Review Committee Recommendations

- Screening all pregnant and postpartum people for substance use and mental health

- Connect those with SUD with prenatal care, perinatal addiction services and SUD treatment, including peer recovery services.



- Medication for opioid use disorder (MOUD) is life-saving and should be recommended in pregnancy and postpartum for those with OUD.

- Naloxone should be readily available for all people with SUD or those with opioid use/exposure (prescribed or not prescribed)

Chain of Risk: Shame and delayed care

- Pregnant people with SUD often **put off prenatal care for fear of being stigmatized and shamed for past or current use**

"I'll never go to that hospital again. They treated me so bad that I would have to really think "if I don't go in now, I am going to die. And then when I was pregnant, I finally went in to prenatal care and all they talked to me about was that the suboxone was going to make my baby withdraw and I would get reported to CPS."

—Mandy

Illustration: Dung Hoang

Chain of Risk: Delayed care and complications

- Delayed care places individuals at risk of severe complications, including severe maternal morbidity and mortality.
  - 1:10 for OUD or methamphetamine use disorder
  - 1:5 for OUD and methamphetamine use disorders

Reference: Smid MC, Charron E, Allshouse AA, Campbell K, Metz TD, Debbink MP, Cochran G. Co-occuring opioid and methamphetamine use disorder and severe maternal morbidity and mortality. Am J Obstet Gynecol MFM.

Integrated care leads to better outcomes

- Substance Use and Pregnancy—Recovery, Addiction, Dependence **(SUPeRAD) Clinic opened in 2017**
- The clinic takes a **multidisciplinary, trauma-informed, judgement-free approach** to care
- From pregnancy through the first year of postpartum, the SUPeRAD clinic provides **integrated care** with wrap-around services

To date, SUPeRAD has served more than 1,500 dyads in Utah.

Illustration: Dung Hoang

SUPeRAD Services

- **Integrated** prenatal, mental health, and **addiction care**
- **Research opportunities**
- **Peer recovery** support and coaching
- Neonatal opioid withdrawal syndrome **education**
- Pediatric and anesthesia care consultations for **tailored pediatric and pain management**
- **Rooming-in** with eat, sleep, console approach for infants after delivery
- **Care coordination** with residential **treatment** program, outpatient treatment providers ("methadone clinics"), Division of Child and Family Services
- **Contraceptive** care in reproductive justice framework

Community Partners

- Home visiting services
- House of Hope
- Odyssey House
- Utah Support
- Advocates for Recovery Awareness
- Project Reality
- Bay Area Addiction Research & Treatment Center (BAART)
- Tranquility Place
- Soap2Hope
- Utah Harm Reduction Coalition
- Utah Naloxone
- *ValleyPhoenix* | Valley Behavioral Health

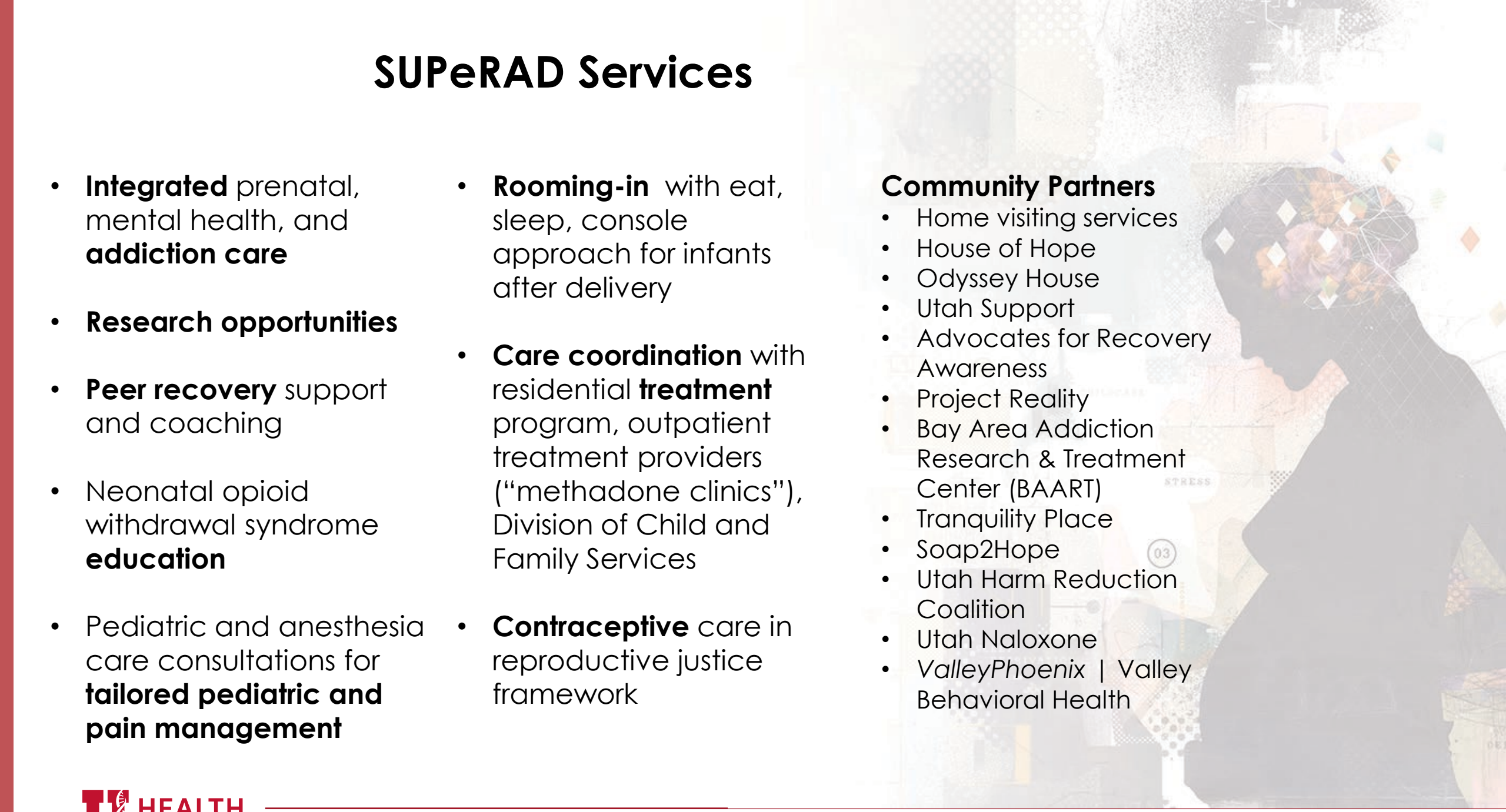


Illustration: Dung Hoang

SUPeRAD University of Utah Clinic Locations

- **University of Utah South Jordan**
  - First location – August 2017
- **Ambulatory Care Center**
  - Second location – September 2019
- **Population Health Center**
  - Supported by Utah and Salt Lake County Opioid Settlement Funds
  - March 2025

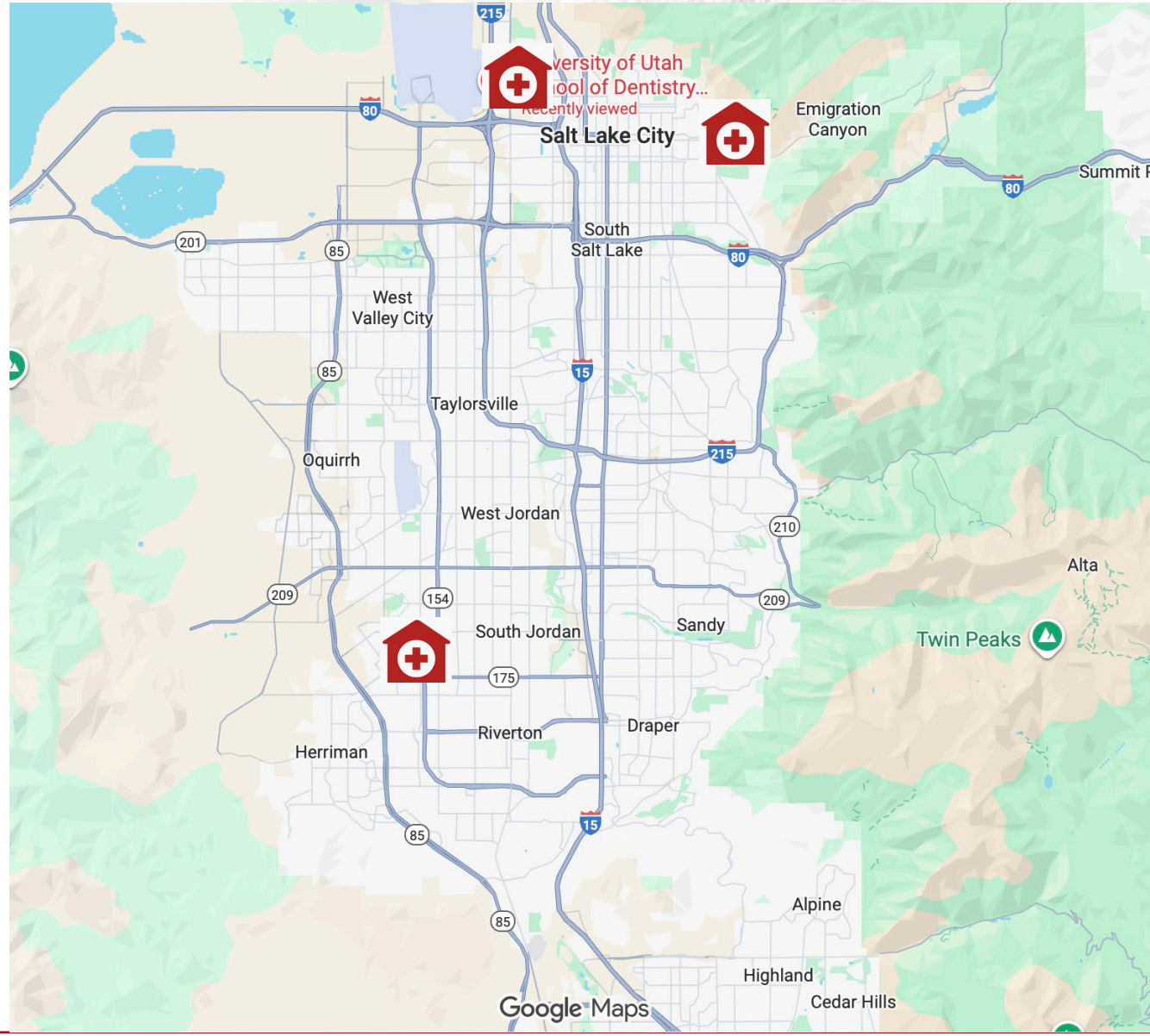
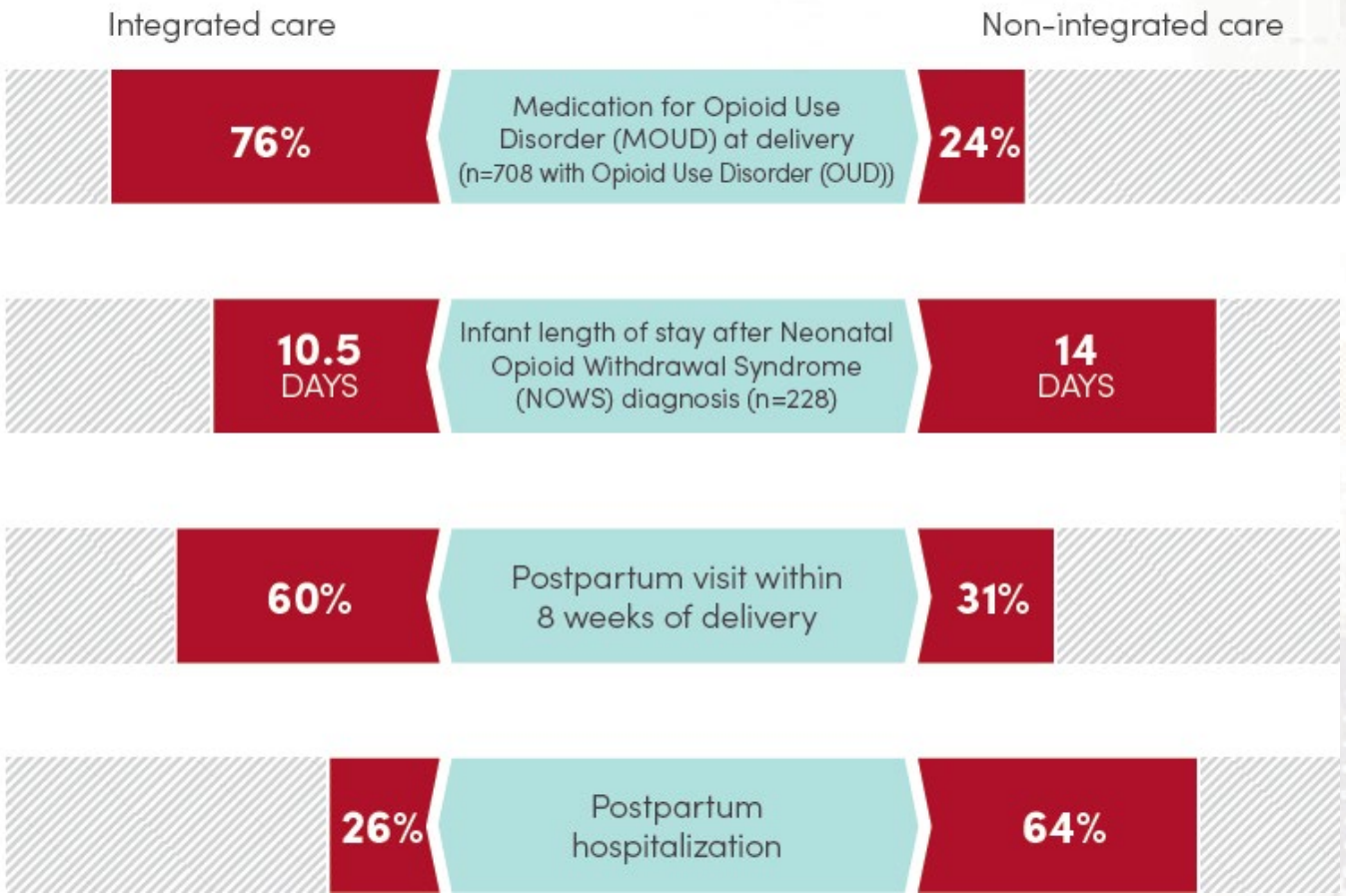


Illustration: Dung Hoang

Integrated vs. non-integrated care



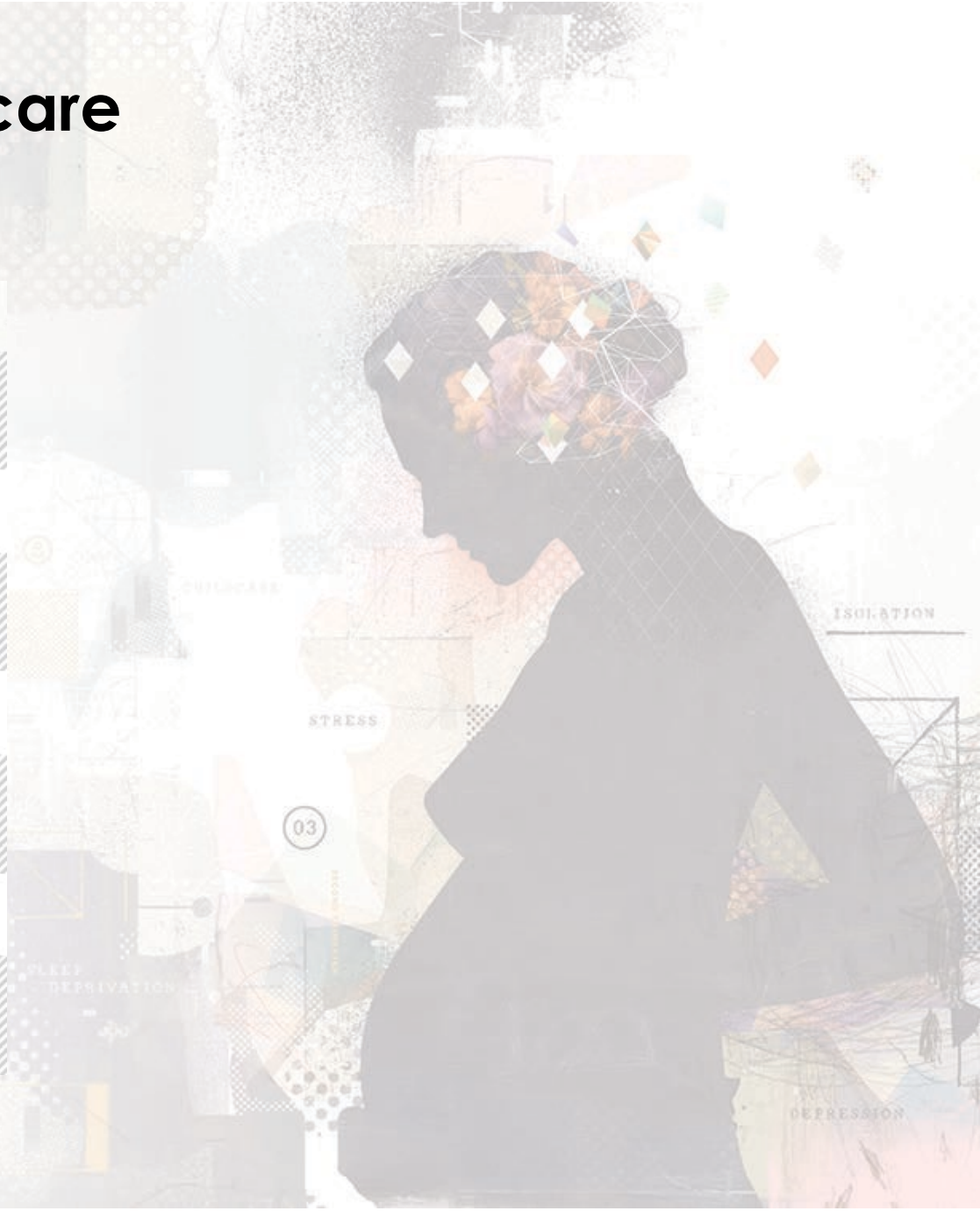


Illustration: Dung Hoang

Integrated SUPeRAD model

- **Increases** the number of pregnant people on medication for opioid use disorder.
- **Shortens** neonatal hospital stay.
- **Decreases** need for neonatal intensive care.
- **Increases** postpartum visits.
- **Decreases** postpartum admission.

Saving millions of dollars in Medicaid expenses every year.

Illustration: Dung Hoang

Postpartum Services

- **Care for a year postpartum**
- **Referral (or reconnection) with primary care**
  - MOUD
  - Methadone Clinics
  - Hepatitis C Treatment
  - Mental health
  - Mammograms
  - Colposcopy
- **Door is always open**
  - Long acting injectable medications
    - Brixadi
    - Sublocade
    - Vivitrol

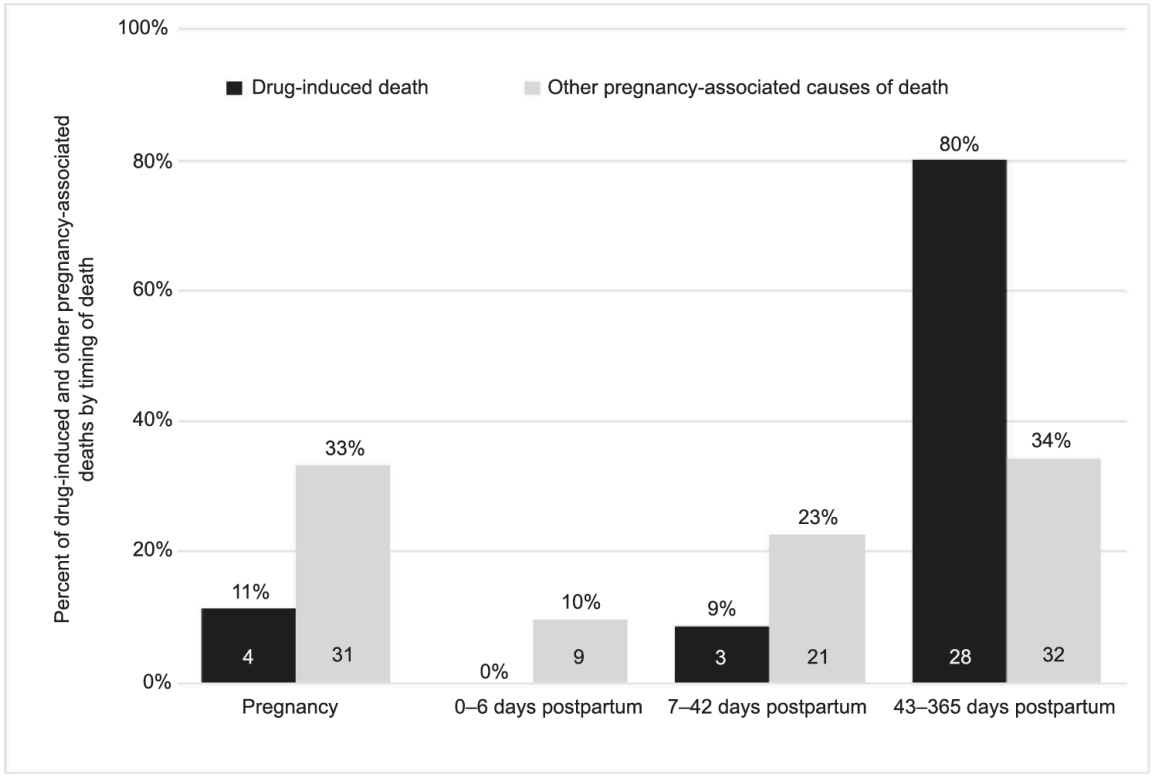


Fig. 1. Proportion of pregnancy-associated, drug-induced deaths vs all pregnancy-associated deaths 2005–2014 (N=136).
Smid. Pregnancy-Associated Drug-Induced Deaths in Utah. Obstet Gynecol 2019.

Grateful patient: they showed me I was worth saving

"Becoming pregnant isn't what got me out of my addiction and an abusive relationship. But it led me to the SUPeRAD clinic at the University of Utah. They showed me I was worth saving.

I kept showing up and relapsing again and again and they never gave up on me. I got sober at four months pregnant and have been clean ever since.

If you or someone you know is pregnant and struggling with addiction, I promise you, there is a way out. There is help at the SUPeRAD clinic." —Kelsey

HEALTH UNIVERSITY OF UTAH

Illustration: Dung Hoang

Q&A Discussion

What are some practical steps toward **integrated care and/or stronger collaboration** with public health and social care entities?

"This is supposed to be this happy, joyful time". Can you speak to common beliefs, or mental models, that sustain **stigma** about perinatal depression - among providers, patients, society? What alternative narrative can we promote?

What knowledge gaps have you come to recognize with your patients who struggle with mental health or SUDs? What can be done to improve **health literacy?**

What **training or resources** do you recommend to improve provider competency around maternal mental health?

If you could implement one change tomorrow to strengthen maternal mental health, what would it be and why?

Thank you for participating!

Join us at the top of the hour for the next session, Primary Care and Public Health Collaboration: Integrating Title V and Community Partnerships

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Please evaluate today's session:

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