

Maternal Mental Health in Utah: Overview and Recommendations

What does “maternal mental health” mean? What happens when someone experiences these health issues? Is this an issue in Utah? What’s missing in our state in order to ensure that care and support is available and accessible, and where are we headed?

These are a few of the questions addressed in this overview of maternal mental health issues in Utah. The goal is to provide a general understanding of what these issues are and how they impact women and families in our state, highlight the current strengths in how Utah responds and what services and support are available to families, and begin to outline the significant gaps and recommendations for meeting unmet needs across the state. This report is not intended to be a detailed, in-depth examination of this issue; but instead offers a shared understanding of an issue that impacts far too many women and families in Utah and provides a starting point for continued conversation and action.

“I have now had 3 pregnancies and 3 babies. It is a little upsetting to me that there isn't enough follow-up care or discussion with the mother's regarding PPD (postpartum depression) here in Utah. I have NEVER filled out a survey or been asked about my thoughts & well being after having a baby. It is difficult, embarrassing, and honestly confusing for mothers and all their hormones & emotions after having a baby. It is hard to bring up yourself and MANY women think they have to just deal with the way they're feeling.

*I would love to see at LEAST a paper survey for the doctor to review at 6 wks. Also a little discussion and concern for the mother. More available & talked about support groups. Moms are exhausted and doing so much for their babies and family. It would be nice if someone was concerned & looking out for mom every once in a while. A lot of women, like myself, don't even know they have PPD. Please help us
Moms!”*

-Utah Pregnancy Risk Assessment Monitoring System Respondent

Defining the Problem

Maternal mental health disorders refer to a range of conditions that new and expectant mothers may experience (including the time period from pregnancy through the first year following childbirth), from depression and anxiety to less common and more severe disorders like postpartum psychosis. “Perinatal mood and anxiety disorders” is the umbrella term most commonly used in clinical and research settings to refer to the range of mental health disorders experienced by childbearing women, while “postpartum depression” and “perinatal depression” are most commonly used by the general

population. This paper uses “maternal mental health challenges” and “perinatal depression” interchangeably.

Maternal mental health challenges often go unidentified and underdiagnosed, and prevalence is therefore believed to be underestimated. We do know, however, that perinatal depression is the number one complication of childbearing—even more common than preterm birth or gestational diabetes. One in seven women experience this type of depression, with nearly 600,000 cases annually in the United States (Patel, Bailey, Jabeen, Ali, & Barker, 2012; Martin, Hamilton, Osterman, Curtin, Matthews, 2015; Ko, Rockhill, Tong, Morro, Farr, 2017).

In one of the largest national studies on perinatal depression, Dr. Katherine Wisner said: “In the United States, the vast majority of postpartum women with depression are not identified or treated, even though they are at higher risk for psychiatric disorders. It’s a huge public health problem” (2013).

Perinatal depression differs from postpartum or “baby blues,” which is experienced by up to 80% of women during the first two weeks after birth. The symptoms of postpartum blues and perinatal depression are similar, but unlike postpartum blues, perinatal depression symptoms can start at any time during pregnancy and/or the first year after giving birth, and are present for greater than two weeks. In fact, without treatment, perinatal depression can last for years. Symptoms range from social withdrawal and mood instability to excessive worry and fear. In some cases, this impacts daily functioning and the ability to care for self and family.

Perinatal depression is associated with adverse outcomes for mother, baby, and family; such as preterm birth, low birth weight, and impaired cognitive development of the child (Bonari, Pinto, Ahn, Einarson, Steiner, Koren, 2004; Deave, Heron, Evans, Emond, 2008). Early breastfeeding cessation and reduced ability to parent are also well-documented consequences (Bonari, Pinto, Ahn, Einarson, Steiner, Koren, 2004). Although rare, suicide and infanticide can be devastating outcomes of perinatal depression (Palladino, Singh, Campbell, Flynn, Gold, 2011). Additionally, there are lifetime economic costs when perinatal depression is left untreated (Bauer, Knapp, Parsonage, 2016). Because of the significant negative impact of perinatal depression, the American College of Obstetricians and Gynecologists (ACOG - 2015), and the United States Preventive Services Task Force (USPSTF - 2016) recommend that all women be screened for detection of perinatal depression during pregnancy and early postpartum. **However, only 44% of providers nationwide are screening for perinatal depression, leaving the majority of women unscreened, perinatal depression undetected, and conditions untreated.**

Examples of the negative costs of leaving maternal mental health issues undetected and untreated—to women, families, communities, and the state—are:

- Mothers experiencing perinatal depression and related symptoms are not able to care for themselves in a healthy way and are at increased risk of substance abuse, smoking, suicide, and long-term depression.
- Babies may not have the opportunity to bond with their mothers in a healthy way. This can cause developmental concerns and may put them at increased risk for learning, social, and behavioral problems/diagnoses when they reach the educational system.
- Maternal mental health challenges within a family cause conflict between parents and puts the stability of the family at risk. This can lead to families relying on publicly-funded programs and resources to support their needs.

Health care providers, who should be on the forefront of this issue, are not provided with consistent, comprehensive, or ongoing training and resources regarding the signs, symptoms, and treatment options for perinatal depression (Patel et al., 2012). In addition, communities lack the appropriate resources and trained professionals to address the specific needs of women and families experiencing maternal mental health issues. Utah is not immune to the impact of allowing these issues to go undetected and untreated. We have reached the point where we must engage state-level policymakers in conversations about this issue, and in efforts to truly support mothers and families statewide who are experiencing unaddressed perinatal depression.

Why Does This Matter to Utah?

Utah has the highest birthrate in the nation with approximately 51,000 births per year. Utilizing the national prevalence estimates, this means that 7,140 childbearing women in Utah—and their babies and families—are negatively impacted by maternal mental health challenges each year. The Utah Department of Health conducts the Pregnancy Risk Assessment Monitoring System, or PRAMS, in order to survey Utah women who have recently delivered a live-born infant (<https://mihp.utah.gov/pregnancy-and-risk-assessment>). From 2012-2014, 11.9% of women reported having symptoms of postpartum depression. By comparison, 7.0% of births in Utah during this time period were low birthweight, 9.1% were born preterm, and 5.7% of pregnancies were complicated by gestational diabetes. See Figures 1-3 on pages 4-5.

In Utah, the greatest predictor of a diagnosis of postpartum depression is depression that spans pre-pregnancy and pregnancy. New mothers with this history of depression are 60 times more likely to be diagnosed with postpartum depression. While only 5.7% of PRAMS respondents reported depression before and during pregnancy, 73% of these same women received a diagnosis of perinatal depression (Latendresse, Wong, Dyer, Wilson, Baksh, Hogue, 2015). These numbers underscore the imperative for detecting and treating perinatal depression long before the actual birth of a baby.

Figure 1. Self-Reported Anxiety Before Pregnancy Among Utah Women with a Live Birth by Selected Maternal Characteristics, Utah PRAMS, 2012-2014

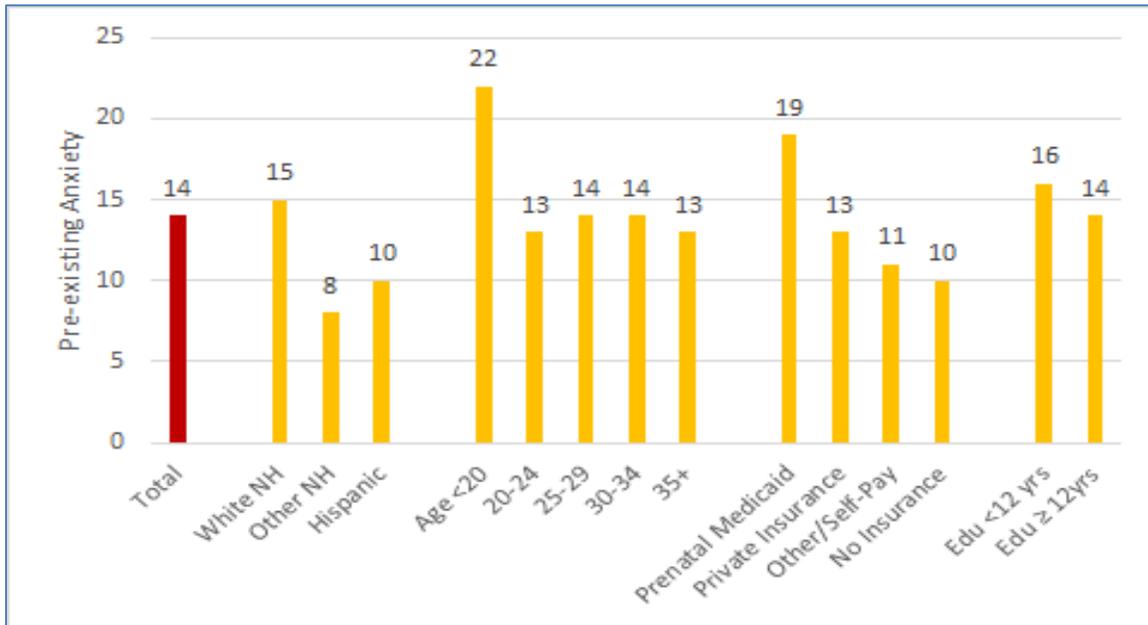


Figure 2. Self-Reported Depression Before Pregnancy Among Utah Women with a Live Birth by Selected Maternal Characteristics, Utah PRAMS, 2012-2014

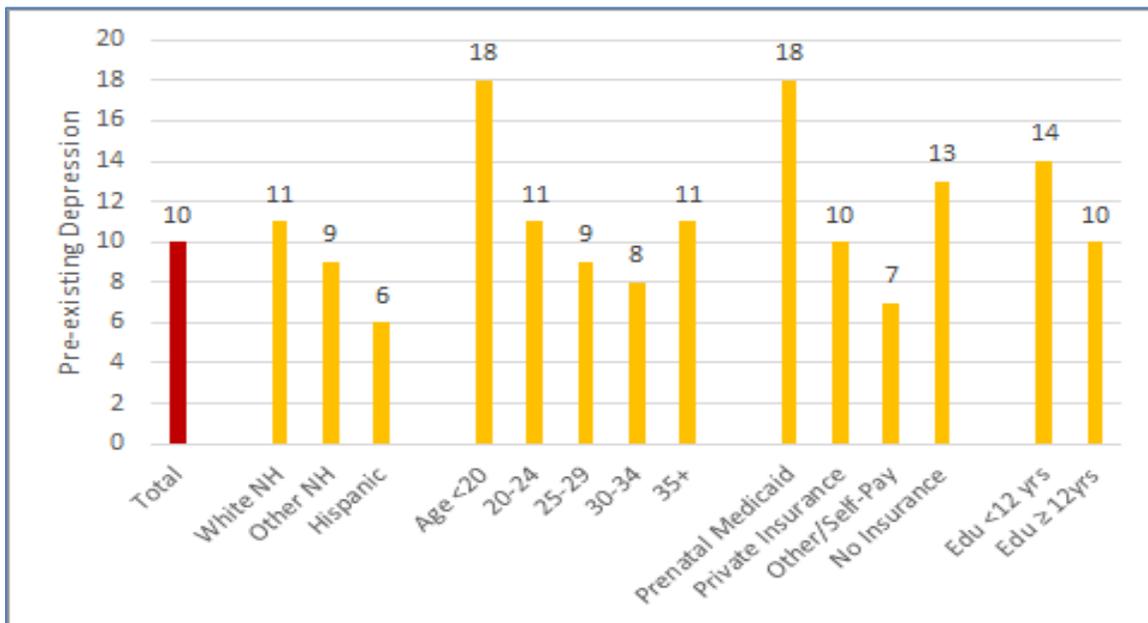
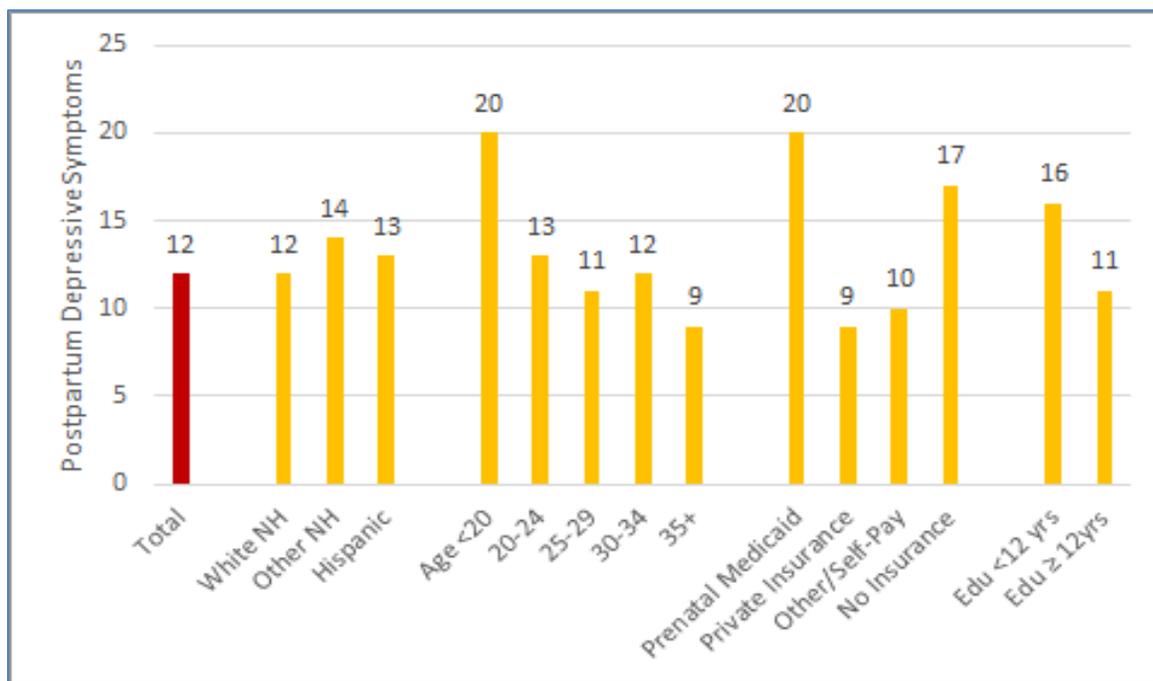


Figure 3. Self-Reported Perinatal Depression Symptoms Among Utah Women with a Live Birth by Selected Maternal Characteristics, Utah PRAMS, 2012-2014



Utah Assessment

Using this understanding of maternal mental health challenges, its estimated prevalence in Utah, and impacts on women and families in our state, we conducted an initial assessment of current strengths and challenges—specific to Utah—in:

- research and data,
- public awareness,
- screening and identification,
- treatment and support,
- financial support and insurance coverage,
- provider education and resources, and
- laws, policies, and regulations.

A broad overview for each is presented below, as well as initial recommendations for improving Utah’s response to this issue.

Research and Data

Strengths

- Utah conducts the Pregnancy Risk Assessment Monitoring System (PRAMS) which asks women who have recently delivered a live birth about anxiety and depression prior to pregnancy, as well as perinatal depression symptoms postpartum.
- Data has been collected in various iterations since 1999.

Challenges

- PRAMS data is self-reported and therefore does not collect information on clinical diagnosis or treatment of perinatal anxiety and mood disorders.
- A new PRAMS question asks women if they were feeling down or depressed at their postpartum visit, but does not assess the use of a valid screening tool for identification or referral for treatment.
- PRAMS data does not include perinatal women who did not experience a live birth.
- The number of questions each state can add to the survey is limited.
- Overall, we do not have reliable data regarding the prevalence and scope of maternal mental health issues in Utah.

Recommendations

- Explore data collection methods that will help us properly assess the Utah-specific prevalence of perinatal mood and anxiety disorders, perinatal depression, screening rates, and treatment. These methods must also include assessment of racial disparities.
- Conduct focus groups with health care providers to assess knowledge gaps around screening and referral.
- Conduct focus groups with mothers and families to gain better understanding of the impact of maternal mental health issues and how they are detected and treated in Utah.

Public Awareness

Strengths

- The Governor designated May 2017 as Maternal Mental Health Awareness Month for the first time.
- The Utah Department of Health has the capacity to leverage existing campaigns, such as Baby Your Baby and Power Your Life, to include more education on maternal mental health issues.
- Other respected media, such as Intermountain Moms, can promote public awareness of these issues.
- “Climb out of the Darkness” campaigns and events are organized in a few Utah communities.
- The National Coalition for Maternal Mental Health sponsors the Blue Dot Campaign to promote international maternal mental health awareness. The Utah Maternal Mental Health Collaborative is part of this national movement.

Challenges

- Maternal mental health challenges are still often kept in secret and too many people do not know the signs or what to do if they suspect that they are experiencing problems.
- There has been no statewide coordinated campaign to educate women about perinatal depression, or maternal mental health issues in general, in recent years.
- The costs of public education campaigns are high and funding is low.

Recommendations

- Develop statewide maternal mental health education messaging that can be shared across entities to educate the public. Coordinated, shared messaging assures that women and families hear consistent and accurate information.
- Adopt and promote these messages within Utah’s public health and behavioral health systems.
- Invest in a campaign through the Utah Department of Health specific to raising maternal mental health awareness across the state.
- Explore text and app programs showing success in other states around raising awareness and providing information directly to women and families. There are models, such as “Speak Up When You’re Down” from the state of Washington, that Utah can utilize.

Provider Education and Resources

Strengths

- Maternal mental health issues are gaining more awareness and attention among healthcare providers, both physical and mental/behavioral healthcare professionals.
- The Utah Maternal Mental Health Collaborative (UMMHC), an all-volunteer organization, was established in 2014 by a mental health clinician and has become a statewide resource for information, national best practice, and training and education for providers in Utah.
- Professional associations and membership organizations, such as the American College of Obstetricians and Gynecologists (ACOG), provide information and resources to practitioners through their Perinatal Health Toolkit.
- Eight of the 13 local health departments across the state include objectives in their annual work plans related to the prevention of maternal depression.
- Overall, comprehensively and effectively addressing maternal mental health issues is beginning to be recognized in Utah as a key component in addressing the health of the whole family.

Challenges

- There remains a general hesitancy among healthcare providers to identify an illness or health concern if there are not sufficient referral resources available in Utah. If providers do not feel confident that they have enough well-trained mental healthcare providers to whom they can refer patients, implementation of widespread screening will continue to be a challenge.
- Once referral resources are in place, and can be accessed across the state, providers need a toolkit and training not only in screening patients, but also in how to most effectively carry out a “warm handoff.”
- For a variety of reasons, even women who are screened and referred for treatment often do not utilize those referrals to seek additional care.
- A pervasive stigma around mental health issues in general, including and perhaps especially maternal mental health, remains an issue among medical providers. General consensus

among healthcare providers that maternal mental health issues are common and serious has not been reached.

- For those who do agree that this must be a priority healthcare issue, widespread training and education around what these issues are, how to identify them, and how to effectively treat them is still missing.
- Many women will not talk to their provider about these concerns because they are concerned, and often rightly so, that their provider's only or primary treatment option is medication.
- There is currently no dedicated funding for specific maternal mental health education for providers through the Utah Department of Health.

Recommendations

- Include maternal mental health issues in continuing education requirements for providers.
- Include non-pharmacological approaches in provider education, as well an emphasis on social support, follow-up, and information on prescribing during pregnancy and lactation.
- Expand behavioral health integration to assist providers in addressing the emotional and mental health needs of pregnant and postpartum patients.
- Educate providers to better treat the women they are already seeing without requiring a referral to a different or additional provider (includes integration of physical and mental/behavioral healthcare services).
- Create a centralized, Utah-specific, multicultural, online provider toolkit.
- Explore the use of community health workers, home visitation, and other navigator-type roles to ease "burden" on providers.
- Utilize Project ECHO (which we have here in Utah) for provider-to-provider consult and training programs.

Screening and Identification

Strengths

- The Utah Maternal Mental Health Collaborative (UMMHC) is working to increase the capacity of health care providers statewide to recognize and treat perinatal mood and anxiety disorders.
- The Utah Department of Health recently established a position within the Maternal and Child Health Bureau to assist with education, awareness, and coordination efforts around these issues.
- Help Me Grow has implemented screening (using Edinburgh Postnatal Depression Scale or EPDS) and referrals for women and families who contact them for resources and support.
- Some health care providers in Utah have begun to implement mandatory depression screenings for every woman in Labor and Delivery, for example, or are working on system-wide screening protocols.
- While not specific to maternal mental health issues, Utah does have an online mental health screening website (healthymindsutah.org).

- The University of Utah is completing a data mining project with all of their hospitals and clinics to assess what is currently happening in regard to maternal mental health screening.

Challenges

- There is no systemic screening protocol or procedure being utilized statewide or across all health care systems and providers. The chances of a new or expectant mother being screened for mental health concerns are left to her (or her child's) individual health care provider and whether or not they believe this is a serious issue and have the capacity to carry out appropriate screening. Screening is even more rare in rural parts of the state.
- There is a lack of statewide data on which providers are providing screening, what tools they are using, and how they are referring to treatment and support services.
- New mothers often prioritize visits to their child's pediatrician over follow-up visits to their own healthcare provider, and many pediatricians do not see the mother as their patient, let alone offer screening and referral services.
- Help Me Grow is struggling with funding cuts which threaten recent expansion of maternal mental health screening and referral services.
- There is currently no dedicated funding for maternal mental health screening through the Utah Department of Health.
- Obstetricians are paid through a global prenatal care fee that offers a payment for a bundled group of services, including the postpartum visit. The lack of separate reimbursement for screening, evaluation, and referral is a disincentive for providing screening.
- The online mental health screening website (healthymindsutah.org) does not specify or differentiate maternal mental health from other forms of depression and anxiety.

Recommendations

- Incorporate home visitors, peer support specialists, and other community health workers into screening education activities. These programs need to be fully funded, and are instead facing cuts statewide. These individuals may be even more important than medical providers and therapists in reaching currently underserved mothers and families for screening and identification of maternal mental health concerns.
- Add a standardized maternal mental health component (e.g., Edinburgh Postnatal Depression Scale) to healthymindsutah.org.
- Stabilize and protect funding for Help Me Grow and other screening and referral services for the general public.

Treatment and Support

Strengths

- There are a few highly qualified maternal mental healthcare providers in Utah. The UMMHC website provides a list of referral resources for the general public as well as for healthcare providers.

- Some healthcare systems, such as Intermountain Healthcare, are working internally and with UMMHC to train their providers on these issues.
- St. Mark's inpatient behavioral health unit offers specific maternal mental health services.
- There are some social media, phone, and in-person support groups in the state. These are usually grassroots and initiated by survivors and/or a few individual providers.

Challenges

- Once screening is implemented, we face the challenge of lack of services and providers to whom we can refer mothers who are experiencing maternal mental health challenges.
- While there is not a comprehensive statewide database, we know that there are not enough specifically-trained maternal mental health care providers in Utah. Some estimate that there are less than 10 providers in Utah who have received comprehensive training on these issues.
- Those who are providing these services do not accept Medicaid. There are no specialized providers in Utah that bill Medicaid.
- The lack of access to treatment and services in rural areas of the state is even greater.
- Utah lacks crisis intervention/emergency care in these situations.
- While local mental health authorities do have some integrated services with physical healthcare, these efforts are inconsistent across the state.
- Home visiting programs in the state that demonstrate success in providing maternal mental health support, including Nurse Family Partnership, are experiencing funding cuts.
- Peer support at different points across the spectrum of maternal mental health issues, including at the crisis level, is not available in any widespread way. Peer support resources are even less available in rural areas of the state.

Recommendations

- Conduct a comprehensive, statewide assessment of current services and resources for maternal mental health detection, treatment, and support.
- Create a comprehensive statewide database of current providers and available services (including peer support resources). Ensure that it is available online and that information is accessible for women and families to directly search for assistance.
- From this centralized database, develop a simple, efficient referral network and process for providers across the state and across health care systems.
- Develop triage protocol to ensure that the severity of the case matches the services provided.
- Explore and expand telehealth and other technology-based services to reach rural and underserved families across the state.
- Train home visitors, peer support specialists, and other community health workers to provide support for women and families in underserved communities and for whom this level of intervention is appropriate.
- Provide more cross-training and awareness of 24/7 mental health crisis intervention programs in Utah.

Financial Support and Insurance Coverage

Strengths

- Utah has a small number of Medicaid accountable care organizations (ACO's) and healthcare systems compared to other states, making coordination across plans potentially more feasible. Moreover, several health care systems and payers in Utah have taken steps to address maternal mental health, and are exploring integrated health models and provider-payment initiatives in different settings.
- University of Utah College of Nursing received a Utah Department of Health grant to pilot a tele-mental-health program that provides mental health services to childbearing women across rural Utah.
- Health care systems in the state are beginning to focus resources on the integration of mental and physical healthcare services in order to treat the whole person.

Challenges

- Insurance coverage is not as available for mental healthcare in general, let alone maternal mental health. The general population cannot afford services. When women do have coverage, it may not include qualified providers in their area.
- Medical and mental health insurance and health delivery systems and providers are not integrated. As a result, most women have to interface with two separate healthcare systems: one for their physical health needs and one for their mental health needs.
- While the Medicaid behavioral health carve-out ensures that some crisis support and other services exist for low-income women, it also further complicates access to care.
- There are no national quality measures, or state-level metrics, for insurance plans or ACO's to incentivize reimbursement or change in provider practice.
- Mothers who are no longer covered by Medicaid are able to receive mental health screening from the pediatrician during a well-child visit through the baby's Medicaid coverage, however the reimbursement rate is very low and many providers do not know this is an option.
- Low reimbursement, coupled with little contractual incentives, makes it difficult to encourage providers to screen, or to identify the practices of providers who are screening.
- Thousands of low-income women cannot afford health insurance. They fall into the Medicaid "coverage gap" because they have incomes between 60% FPL and 100% FPL. If a woman is in this income range and becomes pregnant, she will become eligible for Medicaid (Medicaid covers pregnant women up to 138% FPL), however she will then lose her Medicaid insurance 60 days postpartum. Moreover, her uninsured status prior to pregnancy may increase the likelihood that she has untreated mental or behavioral health conditions.

Recommendations

- Close the coverage gap and treat parents' health as integrated with, rather than separate from, their child's health.

- Continue to pilot and explore integrated physical and behavioral health models. Medical insurers should bring mental health in-house, include mental health benefits in all medical care benefit contracts, and expand medical provider contracts to reimburse for maternal mental health services.
- Insurance companies should reimburse for screening and maternal mental health services, to incentivize providers and begin to gather more data on the scope of the problem in Utah.
- Insurance companies should establish provider-to-provider telehealth consultation.
- Insurance companies should pilot case management or care coordination programs for women from prenatal to postpartum services, especially high-risk women, to ensure that they can be connected with services and care following the birth of their child.
- Insurers can adopt protocols or best practices for providers and ask the questions of providers when a provider joins an insurer's network. Insurers can also designate maternal mental health providers in the provider directory to assist with consumer awareness.

Laws, Policies, and Regulations

Strengths

- Utah lawmakers and decision makers are increasingly aware of maternal mental health. Governor Herbert declared May 2017 as Maternal Mental Health Awareness Month for Utah.
- Small policy changes in the last several years have helped build the base for peer-support and prevention – one-time increases for home-visiting programs and community health worker credentialing efforts.
- The Utah Legislature recently expanded parents' Medicaid eligibility threshold from 40% FPL to 55% FPL, which allows more women to access Medicaid services postpartum.

Challenges

- There remains very limited funding or support for widespread awareness and outreach.
- There is also a lack of funding for mental health resources, particularly for mothers. The opioid crisis highlights the lack of support for co-morbidities among pregnant women and new mothers.
- Utah has not incentivized or directed 'universal screening' for moms and babies, so such efforts are left up to the willing providers and insurers, but are not consistent statewide.
- Home-visiting programs, which provide valuable supportive and preventive treatment services to high-risk women, are facing federal funding cuts.

Recommendations

- Create a statewide system of care for women and families experiencing maternal mental health challenges.
- Establish a statewide stakeholder group to address maternal mental health across state agencies.

- Establish statewide policies to incentivize screening and outcomes and expand resources for maternal mental health data collection.
- Close the coverage gap so that women can receive medical and mental health treatment before their pregnancy and after giving birth (including family planning services).
- Expand and allocate maternal mental healthcare funding to current state-contracted mental health services, as well as require maternal mental health training and education for these providers.
- Increase resources for peer support and home-visiting programs.
- Increase mental health resources and resources for co-morbid treatment.
- Support county-level pilots in the carve-out and ensure such pilots track and monitor effective data to show outcomes.
- Support comprehensive, statewide education and training for mental healthcare providers.

Conclusion

Given the enormous toll on families with mothers who suffer from Perinatal Depression, and the resulting cost to our communities and state, the time is now for focused attention on maternal mental health issues and how to address them in Utah. The women and families experiencing these challenges deserve a statewide system that effectively identifies what they are going through and provides appropriate and comprehensive support, treatment, and resources.

Addressing maternal mental health is the shared responsibility of doctors, hospitals, insurers, policymakers, government agencies, and communities. Together, stakeholders can take steps to prevent maternal mental health disorders and close gaps in care.

–Erik Fernandez y Garcia, et al., 2017

Utah is poised to join other states' pioneering efforts across the country in maternal mental health education, funding, and policies which will create stability in our homes, communities, and state. We can no longer afford the cost of failing to do so.

This report was authored by the Policy Team of the Utah Maternal Mental Health Collaborative (UMMHC), Utah's state chapter of Postpartum Support International (PSI). The UMMHC/PSI-Utah mission is to exchange ideas and form relationships to increase and improve awareness, prevention, detection, and treatment of maternal mental health conditions in Utah. Major contributors: Erin Jemison, YWCA Utah; Jessie Mandle, Voices for Utah Children; Laurie Baksh and Lynne Nilson, Utah Department of Health; Dr. Bill Cosgrove; Gwen Latendresse, University of Utah; Amy-Rose White, UMMHC; Tawna Burton, Soul Solutions.

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