Utah Women Stats
Research Snapshot

UTAH WOMEN & LEADERSHIP Project

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Maternal Mental Health Among Utah Women

Setting the Stage

Pregnancy, giving birth, and caring for a newborn are challenging. Most mothers[1] naturally experience the "baby blues" during the first two weeks after delivery, when they report feeling anxious, irritable, overwhelmed, or weepy.[2] Usually, these symptoms resolve on their own within two weeks.

Some women, however, experience mental health concerns beyond the baby blues, such as postpartum depression or postpartum anxiety. It is estimated that one in eight women in the US report postpartum depression symptoms.[3] Symptoms of depression interfere with daily life and can include feeling sadness, guilt, or hopelessness; loss of interest in activities; changes in energy, sleep, and appetite; irritability; difficulty concentrating; withdrawing from social relationships; and, sometimes, thoughts of hurting oneself or others.[4]

Perinatal Mood and Anxiety Disorders (PMADs) is a term used to encompass a range of disorders that can occur during pregnancy or up to one year postpartum.[5] Mood disorders include depression or bipolar disorder. Anxiety disorders include generalized anxiety and obsessive-compulsive disorder. Post-traumatic stress disorder may also occur. Combined, these disorders are common complications of pregnancy, affecting up to 20.0% of mothers.[6] More rarely—one to two women among 1,000—women can experience perinatal psychosis.[7] While PMADs are more likely in women with a history of mental illness, women with no history can also develop PMADS.[8]

A 2017–2019 report found that 42.8% of Utah women who delivered a live infant reported depression and/or anxiety before pregnancy, while pregnant, or shortly after giving birth.

PMADs often remain underdiagnosed and undertreated.[9] Leaving these conditions untreated can have negative effects on maternal health (e.g., decreased quality of life) and increase societal costs (e.g., reduced economic output, higher health care costs).[10] Untreated PMADs can also affect the mother-infant relationship and the ongoing health and development of the child.[11] In the most severe form, PMADs is associated with maternal suicide, the second leading cause of death of postpartum women in the US.[12] Early screening and treatment of PMADs is thus critical for the well-being of mothers and children.

This research snapshot summarizes data about PMADs in Utah, reviews relevant information for patients and healthcare providers, and aims to raise awareness about this issue so that more women receive appropriate screening and care. The snapshot is organized in the following areas:

1) Overview of US and Utah data,
2) Screening recommendations,
3) Treatment and resources, and
4) What Utahns can do.

Overview of US and Utah Data

In a 2018 report about the Pregnancy Risk Assessment Monitory System survey (PRAMS), the national average of women experiencing depression symptoms *after* the birth of a baby was 13.0%; Utah's average was similarly estimated to be 13.0–15.0%.[13] However, the most recent Utah data available, from 2021, suggests the rate of postpartum depression symptoms has risen to 16.2%.[14] Furthermore, Utah has a higher rate of self-reported lifetime depression (24.2%) than the national percentage (20.1%).[15]

Utah's 2019–2021 PRAMS data provided estimates of postpartum depression symptoms among subgroups of mothers. The rate of postpartum depression symptoms was 15.0% for Hispanic/Latino mothers; 15.3% for White, non-Hispanic/Latino mothers; and 18.0% for other, non-Hispanic/Latino mothers.[16] Younger mothers reported postpartum depression symptoms more than older mothers did.[17] For example, 32.9% of mothers who were 18–19 years old reported postpartum depression symptoms compared to 15.3% and 8.4% of mothers who were 35–39 and over 40 years old, respectively.

Mood and anxiety disorder estimates are higher when mental health is documented over the *entire* perinatal period. Utah's Department of Health and Human Services published a report based on 2017–2019 PRAMS data that found 42.8% of Utah women who delivered a live infant reported depression and/or anxiety symptoms before pregnancy, during the prenatal period, or during the postpartum period.[18] Of these women, 45.1% experienced depression or anxiety symptoms before pregnancy, 44.3% experienced

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depression or anxiety symptoms during the prenatal period, and 14.8% reported symptoms of postpartum depression.[19] Among women who experienced depression or anxiety symptoms before or during pregnancy, 25.8% experienced postpartum depression symptoms. Among women who had not experienced depression or anxiety symptoms before or during pregnancy, 8.3% reported experiencing depression symptoms during the postpartum period.

Similar to national data about risk factors, Utah data shows that PMAD risk factors include the mother being unmarried, living at or below 100.0% of the federal poverty level, being enrolled in Medicaid, having no college education, receiving WIC services during pregnancy, having an unintended pregnancy, or feeling ambivalence towards pregnancy.[20] Other known risk factors include lack of partner support, multiple life stressors, chronic disease, history of physical abuse, and experiencing a difficult or traumatic pregnancy, labor, or delivery.[21]

The Utah Department of Health and Human Services analyzed 40 maternal deaths in 2015 and 2016.[22] The leading causes of maternal deaths were accidental drug-related deaths (25.0%) and suicide (20.0%). A significant proportion of the women (75.0%) had current or prior mental health conditions, such as depression and anxiety. In terms of timing, 17.5% of the deaths occurred during pregnancy, 17.5% occurred between birth and 42 days postpartum, and 65.0% occurred between 43 and 365 days postpartum.

According to 2021 Utah data from the Behavioral Risk Factor Surveillance System, adult Utah women have a higher lifetime prevalence of clinically diagnosed depression (32.1%) than adult men in the state (16.3%).[23] And while 42.8% of Utah mothers with a recent live birth were affected by depression or anxiety,[24] it is important to note that systematic and meta-analytic reviews suggest one in ten fathers will also experience symptoms of depression or anxiety in the postpartum period.[25] Fathers are twice as likely to experience paternal postpartum depressive symptoms if their partner has PMADs.[26] Other risk factors for fathers include previous paternal mental health illness, financial instability, low education level, lack of social support, and low parenting self-efficacy.[27]

Screening Recommendations

Table 1 provides Utah screening rates from the 2017–2019 PRAMS survey[28] and unpublished 2020–2021 PRAMS data.[29] Between the two time points, screening rates increased during the 12 months before pregnancy, during the prenatal period, and during the postpartum period. Screening rates were highest during the postpartum period and lowest before pregnancy. Overall, the data suggest that Utah screening rates need to improve, particularly as women seek healthcare prior to becoming pregnant.

Table 1: Proportion of Utah Women with Live Infant Delivery Who Were Screened for Depression

Time Frame of Healthcare Visit	2017–2019	2020–2021
Before Pregnancy	43.7%	53.0%
Prenatal Period	68.9%	75.0%
Postpartum Period	85.9%	89.0%

The American College of Obstetricians and Gynecologists (ACOG) recommends the following:[30]

- Screening patients at least once during the perinatal period with a validated measure of mood and emotional well-being.
- Closely monitoring, evaluating, and assessing women with previous depression, anxiety, suicidal thoughts, or increased risk factors for PMADs.
- Referring patients to appropriate behavioral health resources or initiating medical therapy, or both.
- Ensuring systems are in place to confirm follow-up for diagnosis and treatment.

Various organizations throughout the state are working to increase the number of women screened during the perinatal period, including the Utah Women and Newborns Quality Collaborative, which recently developed a provider toolkit for clinicians with recommendations about screening for PMADs. The toolkit includes validated screening tools and local patient resources in Utah. Accompanying training videos are also helpful.

For providers, some evidence-based screening tools include the Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire-9 (PHQ-9), Center for Epidemiologic Studies Depression Scale, and the Beck Depression Inventory.[31] When individuals screen positive for depression, it is important for the provider to rule out bipolar disorder through another validated screening tool. It is also important to screen for substance use risk and other potential comorbidities, such as eating disorders.[32] Providers should use harm reduction strategies and non-stigmatizing language when screening for substance use disorders in pregnancy, with an emphasis on building trust and connecting the mother to appropriate resources.

Treatment and Resources

Individuals who screen positive should be fully assessed for a diagnosis and then should discuss treatment options with their provider.[33] Treatment is based on severity of illness and may include conservative measures, therapy, and/or medications.[34] Conservative measures include sleep, exercise, and discussing social support. Patients and providers should use risk/benefit assessments to select treatment plans. For mothers who have several risk factors, the United States Preventative Task Force recommends preventative therapy and support groups.[35]

Women concerned they are experiencing symptoms of PMADs should talk with their obstetrics provider if they are pregnant or within the first six weeks postpartum; they may also talk with their primary care provider for an evaluation and a discussion of treatment options. The obstetrics or primary care provider can screen, diagnose, and discuss treatment options. If needed, they may refer women to a specialist in maternal mental health.

The Utah Maternal Mental Health Referral Network (UMMHRN), created by the Maternal and Infant Health Program under the Utah Department of Health and Human Services, is a directory of Utah providers and support groups with specialized training in maternal mental health. The MMHRN allows searching by provider type and specialty, insurance, and location (including in-person or online). Specialties listed in the MMHRN include providers who help parents with PMADs, men's mental health, birth trauma, miscarriage and infant death, substance abuse, and other emotional challenges related to pregnancy and childbirth. Services can be sought through local mental health authorities as well; each local mental health authority has at least one therapist trained in maternal mental health. Utah patients with Medicaid must receive services through a Prepaid Mental Health Plan (PMHP) provider, which are based on an individual's county of residence. A list of providers can be found in the Utah Medicaid Member Guide.[36]

Several major hospitals in Utah operate specialized clinics that serve women with PMADs. The University of Utah's Perinatal Mental Health Services, in addition to providing outpatient psychiatric care, offers free weekly meetings with a postpartum support group. The University of Utah also runs maternal mental health clinics through the Huntsman Mental Health Institute at locations in Salt Lake and Farmington. Serenity in Riverton and Provo, and Reach Counseling in South Jordan offer intensive outpatient programs for individuals experiencing PMADs. The University of Utah also houses the Substance Use in Pregnancy Recovery Addiction Dependence Clinic (SUPeRAD) for mothers who have substance use disorder. This clinic, which opened in 2017, combines maternal-fetal medicine, addiction medicine, social work, advocacy, and peer support for prenatal and postpartum care.

There are many organizations, both national and local, working to support maternal mental health in Utah. Nationally, there is a maternal mental health hotline (1-833-943-5746). Individuals can call or text and communicate with someone in English or Spanish. Utah's Maternal and Infant Health Program (MIHP) provides information about maternal health, including links to their social media pages that regularly share educational resources. The MIHP also has a guide with community resources. As mentioned earlier, the Utah Women and Newborns Quality Collaborative is a network of Utah providers, community-based organizations, healthcare systems, and community members dedicated to promoting maternal and infant health. The Mother to Baby Hotline (1-800-822-2229) is a resource for medication and substance questions. Comunidad Materna offers resources for the Spanish-speaking population.

The Utah chapter of Postpartum Support International (PSI) lists local providers, including hotlines and online support groups, provides educational material and crisis resources, and links to professional training and certification opportunities in perinatal mental health. Of note is a two-day certification training that prepares obstetric and primary care providers to assist those with PMADS through screening, diagnosing, treating, and making appropriate referrals. PSI also has a Perinatal Psychiatric Consult Line, a free consulting service for medical providers seeking advice for diagnosis and treatment of PMADs. Women may also request help from local PSI volunteers who answer questions and help identify mental health services.

Finally, the Emily Effect is a Utah foundation created to raise awareness about PMADs and organize local resources to support maternal mental health. The foundation has a platform where women can share their stories with one another through videos and Letters of Light, which are written accounts posted on their website.

What Utahns Can Do

Many play a role in supporting individuals experiencing PMADS and ensuring positive outcomes.[37] *Policymakers* can remain informed about state statistics and support screening and treatment programs. Two recent examples include the Telehealth Project and S.B. 133—a bill passed during Utah's 2023 legislative session that extends Medicaid coverage from 60 days to 12 months for certain postpartum women.[38] *Providers* can implement strategies to improve their screening rates of mothers and also of partners if they are present. Providers should ensure that mental health resources are consistently shared with mothers and that follow-up about diagnosis and treatment occurs.[39] *Women* and *partners* can speak up and ask for help. To create safety for mothers who feel they may be experiencing PMADs, it is particularly important to reduce stigma surrounding maternal mental health. *Friends* and *extended family* can understand symptoms, advocate for mothers, and offer emotional and practical support.

Utah's Perinatal Mortality Review (PMR) committee is comprised of medical, mental health, and public health professionals who meet monthly to review cases of infant and maternal mortality.[40] The committee discusses how to improve health systems and prevent future deaths. In their 2018 PMR report, the committee offered specific recommendations for improving maternal mental health and decreasing maternal mortality.[41] They called for increased

access to services and screening and called on pediatric providers to implement more screening initiatives. They noted the need to improve coordination of care between hospitals and providers (e.g., through communication, record sharing). They commended the SUPeRAD program, encouraged funding of similar programs, and emphasized improving access to substance use treatment and detox facilities, especially in rural Utah. They proposed developing in-home services for women at risk of pregnancy or postpartum complications, including online options such as virtual daily check-ins. Finally, they recommended educating the public about indicators of postpartum complications, including signs of suicidality and prevention strategies such as removing firearms and drugs from the home.

Conclusion

Given the high rates of perinatal mood and anxiety disorders, continued research is crucial to inform both policy and practice and to help new mothers most at risk. Through evidence-based policy adjustments, Utah can improve PMADs screening rates and access to quality care. As Utahns become educated about specific risk factors of PMADs, and as individuals seek appropriate care and treatment, more Utah mothers and their families will thrive.

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[1] We recognize that not all people who are pregnant or have given birth identify as female, but we use "mother" or "woman" instead of "person" to highlight the role of gender in this issue and contextualize the way being perceived as female affects mental health and treatment.

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