Children's Hospital of Philadelphia
PolicyLab

The Case for Monitoring Mom's Mental Health at the Pediatrician's Office

Family & Community Health

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Image

Earlier this year, the United States Preventive Services Task Force (USPSTF) released guidelines recommending depression screening for pregnant and postpartum women. About 10% to 12% of women are depressed during pregnancy and after birth, and evidence shows that young children of depressed mothers are more likely to exhibit developmental delays and behavioral problems like anxiety or acting out as compared to children of non-depressed mothers.

If screening is a necessary first step to diagnosis and treatment, how does the health care system implement these guidelines? We believe any strategy must include pediatricians. Postpartum women have many appointments with their infant's pediatrician in the first months after birth. Up to five infant visits are common in the first two months of life and, by recent counts, more than 80% of infants in the U.S. receive care from pediatricians. Therefore, the pediatrician's office may be the best place for new mothers to get connected to the care they need.

Fragmented Care for Families

Despite having access to postpartum women, it is difficult for pediatricians to adopt comprehensive and global screening for postpartum depression. Screening efforts have shown benefits for families primarily when they are linked to immediate mental health interventions or strong referral systems. However, many pediatricians are not trained to screen adults. Pediatric practices may lack systems to connect mothers to adult mental health services, and training and licensing requirements limit the ability of pediatricians to provide direct treatment to parents.

Research from 2011 found that when New Jersey adopted mandates for postpartum depression screening in 2005, there was no increase in treatment for postpartum depression among Medicaid recipients. This was attributed in part to lack of integration between prenatal and postnatal care, and isolation of mental health services from routine obstetrical or pediatric services.

At The Children's Hospital of Philadelphia (CHOP), when newborns present for pediatric care, paperwork from the hospital at which they were born comes with them. These papers contain details of their delivery and many prenatal screening tests. The paperwork does not, however, contain information about prenatal mental health screening. Similarly, when we identify postpartum depression in our pediatric clinics, pediatric social workers are available to triage and refer families back to their own adult clinicians. These professional and institutional barriers to more immediate provision of care are a disservice to families.

Strategies for Screening and Treatment

The new USPSTF recommendations may provide an opportunity for change. The Affordable Care Act of 2010 requires health plans to cover USPSTF-recommended services with no cost sharing. In addition, the federal "Bringing Postpartum Depression Out of the Shadows" bill was introduced in both the House and the Senate in 2015. This bill, which was endorsed by the American Academy of Pediatrics (AAP) and the March of Dimes, would provide grants totaling up to $25 million to at least three states to establish, expand or maintain postpartum depression screening and treatment.

So how can pediatricians play a role? Communication and care coordination should be enhanced between prenatal and postpartum care. Ideally, coordination between prenatal and postnatal systems would also reach organizations such as Women, Infants, and Children (WIC), which provides services to 53% of all infants born in the U.S. each year, and home visiting programs, which serve a disproportionate share of mothers with mental health diagnoses.

Pediatricians can also seek new ways to treat parents in the pediatric setting. Large research trials in adult medicine have shown that interventions using social workers, nurses and case managers can treat depression in the primary care setting. Though pediatricians face restrictions to treating adults, social workers, nurses and case managers do not face the same restrictions. Indeed, neither do psychiatrists, even those who have chosen to subspecialize in child psychiatry. Some health systems like the Vermont Blueprint for Health and Massachusetts Child Psychiatry Access Project are now embedding psychiatrists in pediatric primary care and developing protocols for them to treat both children and parents.

The new USPSTF guidelines are a reminder that taking care of parents is a critical aspect of taking care of children, and yet their recommendations do not go far enough. Evidence suggests that screening alone will not be sufficient to achieve improved outcomes for depressed mothers and their children. We must do more to connect mothers and families with the treatment and care they need. Moving beyond screening will require systems-level changes, such as renegotiation of payment contracts and institutional policies to allow providers and other staff members to bill for treating parents in a pediatric setting. Establishing health care infrastructure that crosses the prenatal to postnatal divide may be the most critical component to providing evidence-based, family-centered care to the newest families.

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