APSAC ALERT

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Special Points of Interest:

- *An estimated 10% to 15% of women experience postpartum depression.*
- *Maternal depression is one of the most common adverse childhood experiences.*
- *Postpartum depression screening and referral are essential and evidence-based practices that serve as a buffer against possible toxic stress, adverse childhood experiences, and various risk factors for child abuse and neglect.*
- *The American Academy of Pediatrics recommends routine screening for postpartum depression in mothers during well-infant visits by 1, 2, 4, and 6 months of age.*

A Strategy to Prevent Child Abuse and Neglect: Screening and Referrals for Perinatal Depression at Pediatric Primary Care Settings

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In 2010, the American Academy of Pediatrics (AAP) published a report describing the rationale and need for screening for postpartum depression (PPD) in pediatric primary care settings (Earls & Committee on Psychosocial Aspects of Child and Family Health, 2010). However, a periodic review of AAP members conducted in 2013 showed that less than half of pediatricians screened mothers for depression. The AAP then published a policy statement in January 2019 reiterating the need for incorporating PPD screening and referrals into pediatric primary care settings to improve child health outcomes (Earls, Yogman, Mattson, Rafferty, & Committee on Psychosocial Aspects of Child and Family Health, 2019). The AAP policy statement highlighted how pediatric primary care clinicians (PCCs) such as physicians, nurse practitioners, and physician assistants are in an ideal position to screen for maternal depression due to their provider-caregiver relationship and frequent contact with parents and infants. The U.S. Preventative Services Task Force (USPSTF) also recognizes that screening for PPD is an evidence-based recommendation, and the Centers for Medicare and Medicaid Services (CMS) support coverage of PPD screening by PCCs (Siu et al., 2016; Wachino, 2016). In addition, according to a study by the

Centers for Disease Control and Prevention (CDC), PPD is one of the most common adverse childhood experiences (ACEs) (Felitti et al., 1998). Therefore, the AAP emphasized that now is the time to close the gap in screening rates for PPD and appropriately connect mothers to mental health evaluation and treatment through pediatric primary care settings.

Perinatal depression (PND) is the most common obstetric complication in the United States affecting women during pregnancy and the first 12 months after delivery (O'Hara & Wisner, 2014). PPD, a subset of PND, is a spectrum that includes milder symptoms of "postpartum blues," PPD, and postpartum psychosis (PPP). Postpartum blues symptoms begin a few days after birth and can last up to 2 weeks and affects an estimated 50% to 80% of all mothers. PPD is considered a major depressive disorder and affects approximately 10% to 15% of women who give birth each year. It is also commonly accompanied by anxiety (Wisner et al., 2013). PPP is the least common mood disorder but the most severe, affecting about 1 to 2 per 1000 women after childbirth (Cohen, 1998). It is considered a psychiatric emergency as both the mother and her child's lives may be at risk.

Wisner et al. *JAMA Psychiatry*. 2013; 70(5), 490-498.

Maternal depression has detrimental consequences for the entire family. An infant living in an environment with significant maternal depression may experience toxic stress. Prolonged toxic stress puts infants at risk for impairment in language, cognitive, and social-emotional development. Untreated PPD can contribute to child abuse and neglect. Depressed mothers more often fail to comply with injury prevention recommendations such as car seat and electrical plug safety, to implement preventative health practices such as those recommended by the Back to Sleep campaign, and to manage chronic health conditions such as asthma or disabilities (Earls et al., 2019). PPD has the potential to impair parenting and erode protective factors against child abuse and neglect. Data suggests that PPD can disrupt the mother-child relationship, with effects including: hindered bonding; distorted perceptions of infant behavior; mothers becoming less sensitive, indifferent, or more controlling towards the infant; and mothers' attention to and judgment of infant health and safety becoming impaired (Earls et al., 2019). Timely response to PPD is crucial, as the negative consequences on the infant can last a lifetime.

Screening to identify PPD and coordinating access to mental health evaluation and treatment in pediatric primary care settings are both essential and evidence-based practices that buffer against possible toxic stress and ACEs. Two validated screening tools for PPD screening are the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ-9). For a more complete list of reliable and valid screening tools, see Table 1 of the Committee on Obstetric Practice's opinion on screening for perinatal depression (2015). It is important to note that screening is not diagnostic, and a positive screen result only indicates a possibility that depression exists. To ensure PPD screening and referrals reach their intended goals, the AAP policy statement outlines the following key considerations:

1. PCCs should consider the mother-infant dyad relationship as the primary concern. PPD screening is directed at the mother, but its intent is to benefit the infant, since the health of an infant is inextricably linked to the well-being of the mother.
2. When screening reveals a concern, PCCs should communicate results of the screen, demystify any guilt or shame regarding PPD, provide appropriate supportive resources, and refer mothers with the warmest of handoffs to a reliable mental health professional for further evaluation and treatment if needed.
3. Regardless of referral method, a key component is following up with mothers at subsequent well-child visits to ensure they are receiving the

appropriate care and support to manage their depressive symptoms.

PPD is recognized by AAP, USPSTF, and CMS as a measure of risk in an infant's environment. Therefore, screening and referrals are considered a billable service at an infant's well-child visit with the infant as the patient.

Women, families, and advocates can also take part in ensuring that the best care is available for infants at their pediatric primary care visits. The National Institute for Children's Health Equity (NICHQ) recently published an issue brief with guidance to help mothers and babies thrive amidst maternal depression. Key recommendations include encouraging mothers to request a PPD screening during their children's well-infant visits, and advocating for state Medicaid and policies that make it easier for mothers to access PPD screening and referral to evaluation and treatment through pediatric primary care settings (NICHQ, 2019).

Recognition and management of PND at pediatric primary care settings are garnering national recognition as an important strategy to prevent toxic stress, ACEs, and various risk factors for child abuse and neglect. Focusing on the mother-child dyad for pediatric care benefits the infant, and may contribute to improving overall child health outcomes.

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