



## Postpartum Depression

Maternal depression often goes unrecognized and untreated because pregnant and postpartum women are not universally screened for depression. Additionally, there are concerns about the safety of treating women for depression with medication during pregnancy. Universal screening and funding for research into safe and effective treatments are needed for this important population.

Depression is common during pregnancy and in the postpartum period. Although screening pregnant women for depression is not universal, estimates of depression during pregnancy range from 14% to 23%; estimates of maternal depression in the first year postpartum range from 5% to 25% (ACOG, June 2010). There are many programs at the federal, state, and local levels that support maternal and child health; these programs may indirectly contribute to maternal mental well-being. However, these programs do not have depression screening requirements or built in support for mental health services. Despite enactment of provisions in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, Section 2952) that support mothers throughout the perinatal period, funding for provisions that specifically address postpartum depression research, screening, and treatment has not materialized.

The American Psychological Association (APA) supports universal screening for depression in the perinatal period, as well as full funding of the postpartum depression provisions in the ACA. This fact sheet provides background information on postpartum depression, as well as APA's recommendations for PPD funding in the FY2015 budget cycle and beyond.

### **PPD is Common in the First Year Postpartum.**

- ❖ Research shows that 20% women with PPD experience suicidal thoughts; almost two-thirds experience comorbid anxiety disorders, and more than one in five had bipolar disorders (JAMA 2013).
- ❖ PPD disproportionately affects low-income and minority women (JAMA 2013).
- ❖ Women with a history of alcohol abuse, depression, or a family history of depression have an increased risk of perinatal depression (AAP 2010).

### **Screening and Access to Care are Limited.**

- ❖ Nationally, there is no screening for PPD despite recommendations and mandates in several states.
- ❖ Several major organizations, including the American Academy of Pediatrics and the Association College of Obstetricians and Gynecologists (ACOG Committee Opinion #453) have encouraged screening of all pregnant and postpartum women for signs of depression.
- ❖ Although some may need medication, this is not always feasible during pregnancy or the postpartum period. Behavioral interventions that focus on parent engagement and social support have shown success in decreasing symptoms of PPD (NCCP 2008).

### **Maternal Depression and Psychosis has Lasting Effects on Mothers, Fathers, and Children**

- ❖ Rates of paternal depression are higher when the mother has PPD (AAP 2010).
- ❖ PPD is associated with negative pregnancy outcomes, including preeclampsia, preterm birth, and low birth weight.
- ❖ PPD has lasting effects on children, including discontinuation of breastfeeding, family dysfunction, and child abuse and neglect (AAP 2010).

## PPD Provisions in the Affordable Care Act

The ACA increased access to maternity health care by expanding insurance coverage and ensuring maternity coverage in all insurance plans. The law also included key provisions of the Melanie Blocker Stokes MOTHERS Act, an initiative to combat perinatal mood disorders. The Act established a comprehensive federal commitment to combating postpartum depression through new research, education initiatives, and voluntary support service programs. However, Congress has not appropriated funds to carry out the activities authorized in these provisions.

Specifically, the ACA provisions authorize research at the National Institute of Mental Health (NIMH) to conduct and support 1) basic research on the symptoms and causes of PPD and postpartum psychosis; 2) epidemiological studies; 3) development of improved screening and diagnostic techniques; 4) development of new treatments; 5) information and education programs for health care providers and the public. The legislation encourages, but does not require, NIMH to conduct a 10-year study on the mental health consequences of pregnancy. Additionally, the legislation authorizes the Health Resources and Services Administration (HRSA) to award grants for the establishment, operation, and coordination of effective and cost-efficient services to women with or at risk of postpartum conditions and their families. The legislation allows these services to be integrated with other programs, such as Healthy Start (which is also administered by HRSA). Finally, the ACA required the Department of Health and Human Services to conduct a study on the benefits of screening for postpartum conditions. This study was conducted by the Agency for Healthcare Research and Quality at HHS and completed in 2013, but failed to recommend universal screening for depression in pregnant and postpartum women.

## APA Recommendations

- ❖ **Provide funding for the research and service provisions of the Melanie Blocker Stokes MOTHERS Act.** These provisions were authorized in the health reform law, but have not been funded.
- ❖ **Encourage universal screening of pregnant and new mothers for depression.** The perinatal period is one of increased connection with healthcare systems for most women, and an opportune time to screen for the symptoms of depression.
- ❖ **Increase access to mental health services for low-income mothers.** Coordination and access to appropriate services can be supported by existing programs (such as Maternal, Infant, and Early Childhood Home Visiting Programs and Early Head Start) that connect low-income mothers to services in their communities.

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American Academy of Pediatrics (AAP). (2010). Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics*, 126(5). Pp. 1032-1039.

American College of Obstetricians and Gynecologists (ACOG). ACOG Today (June 2010); Health Care Reform: What it means for you and your patients. Pp 8-9.

ACOG Committee Opinion #453.

Centers for Disease Control and Prevention. (2008). Prevalence of self-reported postpartum depressive symptoms—17 states, 2004-2005. *MMWR Morbidity and Mortality Weekly Report*, 57(14), 361-366. Retrieved from <http://www.cdc.gov/mmwrR/preview/mmwrhtml/mm5714a1.htm>.

National Center for Children in Poverty (NCCP), Columbia University. 2008. Reducing maternal depression and its impact on young children: Toward a responsive policy framework.

Wisnew, K., et al. (2013) Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA* 70(5). Pp. 490-498.