Postpartum Mental Health Screening is one of twenty Maternal and Child Health (MCH) **National Performance Measures (NPMs)** for the Title V MCH Services Block Grant to States Program. This NPM is focused on increasing the percent of women* who were screened for depression or anxiety following a recent live birth.

For Postpartum Mental Health Screening, there are 14 evidence-based strategies from MCHbest and 6 field-based practices from Innovation Hub (see page 3)

The **What Works Evidence Accelerators** provide background information and a summary of effective strategies to advance each of the NPM topic areas. The strategies highlight timely access to postpartum screening for both anxiety and depression and the resources, knowledge, and skills needed by interprofessional teams that support pregnant and postpartum women. See also: Postpartum Visit | Postpartum Contraception Use Accelerators.

Overview.

In the United States (U.S.), mental health disorders are one of the most common medical conditions that occur during pregnancy and the postpartum period.[1] The impacts of postpartum depression and anxiety disorders include withdrawal from social networks, poorer relationships with their newborns, poor self-esteem, inappropriate guilt, feeling overwhelmed, hopeless, or excessively sad, self-harm, suicidal ideation, and thoughts of harming the child.[1,2] Factors contributing to the development of postpartum depression and anxiety include brain structure and functioning, genetics, and family history as well as socioeconomic and other triggers.[1,3]

Validated screening tools should be administered both during pregnancy and at the postpartum visit.[3] There are several validated screening tools that have shown to be successful in the clinical setting, all with varying question length, symptoms focus, and languages available for administration. There are several treatment recommendations for women who screen positive for postpartum depression and anxiety with equity considerations that include access to high-quality care.[1,2,4]

In 2018, the American College of Obstetricians and Gynecologists (ACOG) issued the ACOG Committee Opinion No. 757: Screening for Perinatal Depression, which recommends that health care providers screen patients at least once during the perinatal period for depression and anxiety as well as during the postpartum visit.[5] Screening for depression and anxiety alone is not sufficient; follow-up care and support are paramount.[6] It is important to assess how mothers of newborns perceive their level of support to help identify specific indicators to better support women who are transitioning to motherhood.[6]

It is also important to recognize that stigma and fear may prevent pregnant and postpartum women from seeking, initiating, and continuing to access mental health treatment services.[7,8,9,10] In one study, women of color noted they may not disclose postpartum depression symptoms out of fear that their children would be taken away by social services.[9] Some provider behaviors, use of language, attitudes, and beliefs can lead to stigmatizing interactions as well.[10] To foster open conversations, clinicians need to pose questions in a non-threatening way so women are not fearful of the repercussions of truthful responses.[8,9]

Data.

This NPM is measured through data collected from the Pregnancy Risk Assessment Monitoring System (PRAMS). Overall, in the U.S., 87.4% of women report being screened for depression during a postpartum care visit; however, this percentage varies widely with only about 50% of women being screened in some states and jurisdictions.[11]

Social Determinants of Health (SDOH).

ACOG stresses the influence that social risk factors have on the health of pregnant and postpartum women, along with the role obstetricians-gynecologists have in improving them. Strategies affecting social risk that have demonstrated effectiveness include:

- Addressing SDOH triggers of postpartum depression and anxiety, such as cultural stigmas, socioeconomic stressors, lack of paid leave, and gender discrimination.
- Screening for individual-level social risk factors that impact mental health at prenatal and postpartum visits, such as stable housing, enough food for mom and baby, enough diapers, and a safe place for baby to sleep.

- Addressing barriers, such as lack of clinician time or awareness of resources, that prevent postpartum women from accessing timely, affordable, and high-quality mental health care.
- Establishing interdisciplinary teams to support postpartum women and screen for postpartum depression and anxiety.[1,2,4]

Health Equity.

While postpartum anxiety and depression impact women of all backgrounds, traditionally marginalized individuals are impacted at a higher rate. Postpartum women from low socioeconomic status or of racial/ethnic minorities (especially Black, Latina, Native American and Alaska Native or Indigenous individuals) have a higher likelihood of not only developing postpartum anxiety and depression, but are also less likely to receive adequate or culturally-competent care.[12,13] Women from these groups also have lower rates of follow up and continued mental health care.[13] Overall, compared to white women, identification of postpartum depression and anxiety remains lower in non-white women.[2,14]

Health equity can be improved for postpartum depression and anxiety by:

- Focusing on systems-level, institutional, and community-level strategies that build on culturally-appropriate strengths for the identification and treatment of postpartum depression and anxiety.
- Educating practitioners, including doctors, nurses, midwives, doulas, and lactation consultants, to treat the whole patient – this includes principles of integrated behavioral care.
- Valuing and investing in the community voice – centering on the opinion and expertise of the women being cared for.[15]

Impact of Postpartum Depression and Anxiety on Newborns and Children.

There are numerous negative outcomes that postpartum depression and anxiety could potentially impact the health and well-being of infants and children such as poor cognitive motor and language development, behavioral disorders and poor academic performance, higher risk of preterm birth, low birth weight, and poor physical growth.[1,16] Research also indicates that infants of mothers with postpartum depression and/or anxiety were less likely to be placed in the recommended back-to-sleep position.[16] These impacts highlight the importance of resources for screening and follow-up care.[1]

Key Resources.

The National Maternal Mental Health Hotline | MCHB provides 24/7, free, confidential support before, during and after pregnancy. The Blue Dot Project raises awareness on maternal mental health disorders and aims to combat stigma around mental health. Clinician training/education, patient education, and collaboration between care providers are strategies shown to be effective in increasing screening rates.[12] Although universal mental health screening might be beneficial, ethical factors such as the presence, or lack of, a systematic referral process should be considered.[4,16,17]

Search the Established Evidence database for peer-reviewed research articles related to strategies for improving postpartum mental health screening.

Find field-based resources focused on improving postpartum mental health screening relevant to Title V programs in the MCH Digital Library.

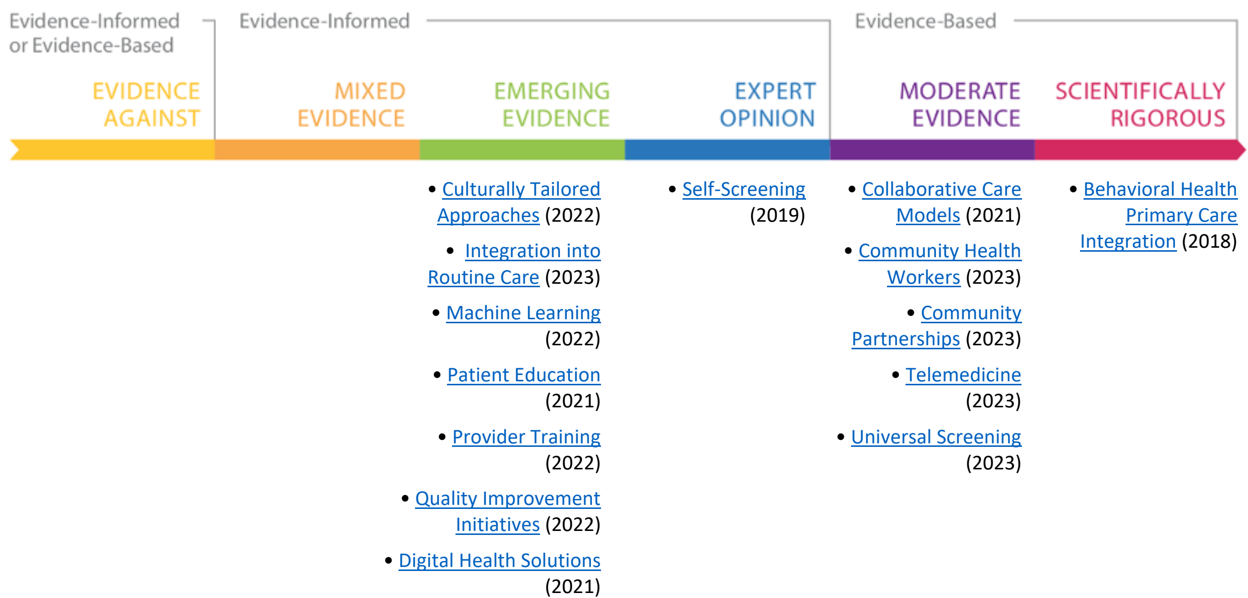
Partnership and the Role of Title V.

Title V has a role to play in improving rates of screening for postpartum depression and anxiety including:

- Partnering with community-led organizations to dismantle stigma surrounding mental health screening and provide educational opportunities for women about the importance of postpartum depression and anxiety screening.
- Partnering with Home Visiting and other programs to address social isolation and create support groups for new mothers.
- Supporting the expanded use of telehealth and/or community health workers to increase access to mental health services in maternity care deserts.
- Establishing statewide or regional networks that provide real-time psychiatric consultation to improve providers' capacity to screen, assess, treat, and refer for maternal mental health issues.
- Participating in interagency collaboration to ensure perinatal women are being cared for in a system that is effective in detecting and treating postpartum depression and anxiety.[1,12,18,19]

Postpartum Mental Health Screening Strategies. This page summarizes the latest strategies and practices that have emerged as potential approaches for increasing the percent of women who receive postpartum depression or anxiety screening following a recent live birth. It provides a framework to identify, understand, and implement "what works" in creating new Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this NPM.

Evidence-Based/Informed Strategies. 14 strategies have emerged from studies in the scientific literature as being effective in advancing the NPM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center's MCHbest database.



Field-Based Practices. 6 practices from state-/community-based programs have emerged as potential approaches for advancing the NPM for specific communities or populations. They can be used as models to meet your program needs. More information can be found in the Association of Maternal and Child Health Program's (AMCHP's) Innovation Hub.

Key Findings.

The following are key findings emerging from the literature:

1. Integrating screening into multidisciplinary care such as during prenatal visits, pediatric well visits, and pediatric emergency department visits has been shown to not only be successful, but also decrease logistical barriers associated with screening including cost, transportation, and childcare issues.[20-24]
2. Mothers caring for infants in the neonatal intensive care unit (NICU) are at a higher risk of screening positive for postpartum depression. Strategies that employ routine screening for mothers of babies in the NICU have shown to be successful in identifying individuals in an at-risk population. A referral resource packet can also be given to mothers in the NICU to help facilitate treatment and follow-up care.[25-27]
3. Technology-based screening approaches such as text-message based strategies, smartphone app strategies, and machine learning strategies are particularly successful in identifying positive screens for individuals who are often difficult to reach during the postpartum period.[28-30]
4. Strategies integrating screening into routine care for populations at a higher risk for developing postpartum mental health disorders such as women with pre-existing mental health conditions, mothers eligible for the Women, Infants, and Children program and incarcerated mothers have shown to be effective.[30,31,32]

Discussion: Research, Practice, Partnership.

Research. Multiple strategies are emerging as potential approaches to advance this NPM, but they have not been studied with enough rigor to be included in the evidence-based continuum. Additional research is needed to verify outcomes, but initial studies have shown promise of these strategies in MCH settings:

- Partnering with Medicaid to promote expansion of Medicaid benefits and reduce barriers to Medicaid enrollment.[33,34]
- Promoting partner involvement to assist new parents in identifying the signs and symptoms of postpartum mental health disorders.[35]
- Engaging with community leaders to promote postpartum mental health screening.[36]
- Establishing peer support programs to decrease stigma attached to postpartum depression.[37]

Practice. The following tools can be used to translate evidence to action to advance this NPM:

- Postpartum Depression Toolkit (AAFP). This toolkit includes materials to assist in the identification/care of postpartum depression.
- Maternal Depression-Making a Difference Through Community Action: A Planning Guide (MHA). This guide strengthens the capacity of communities to mobilize around postpartum depression.

Partnership. The following organizations focus efforts on Postpartum Depression Screening:

- Postpartum Support International. Provides information, resources, and education to support perinatal mental health.
- March of Dimes Postpartum Depression. Outlines postpartum depression and links to resources.
- ACOG: Postpartum Depression. Provides clinical resources around postpartum depression screening, support, and follow-up.

Frameworks and Tools for "What Works."

Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- MCH Evidence Framework
- Blueprint for Change for CYSHCN
- Maternal Health Toolkit
- Life Course and Social Determinants Brief

Need More Help?

Contact us for training and technical assistance customized to your needs.

Cite As. Monge A, Le L, Watson K, Richards J. *Postpartum Mental Health Screening: What Works Evidence Accelerator. Summarizing Effective Strategies for MCH.* Strengthen the Evidence for MCH Programs. National Center for Education in Maternal and Child Health, Georgetown University, Washington DC. May 2024.

*** Note.** Throughout this document, we use terms such as woman, women, and mother to describe people who have the biological capacity to become pregnant. We acknowledge that some pregnant and/or birthing people do not identify with these terms. However, we use these terms as a reflection of language used in the peer-reviewed research that predominantly refers to study participants as "women." Our findings are not meant to be exclusive of individuals who do not identify as female. Read more in [NCEMCH's Gender Identity Statement](#).

References

[1] Waqas A, Koukab A, Meraj H, et al. Screening programs for common maternal mental health disorders among perinatal women: report of the systematic review of evidence. *BMC Psychiatry*. Jan 24 2022;22(1):54. doi:10.1186/s12888-022-03694-9

[2] Garthus-Niegel S, Radoš SN, Horsch A. Perinatal Depression and Beyond—Implications for Research Design and Clinical Management. *JAMA Network Open*. 2022;5(6):e2218978-e2218978. doi:10.1001/jamanetworkopen.2022.18978

[3] The American College of Obstetricians and Gynecologists. Perinatal Mental Health Toolkit. https://www.acog.org/programs/perinatal-mental-health

[4] Cedars-Sinai. Moms With Postpartum Depression Benefit From Improved Screening. https://www.cedars-sinai.org/newsroom/moms-with-postpartum-depression-benefit-from-improved-screening/

[5] American College of Obstetricians Gynecologists. ACOG Committee Opinion No. 757: screening for perinatal depression. *Obstet Gynecol*. 2018;132(5):e208-e212.

[6] Corrigan, C. P., Kwasky, A. N., & Groh, C. J. (2015). Social Support, Postpartum Depression, and Professional Assistance: A Survey of Mothers in the Midwestern United States. *The Journal of perinatal education*, *24*(1), 48–60. https://doi.org/10.1891/1058-1243.24.1.48

[7] Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37-70.

[8] Modak, A., Ronghe, V., Gomase, K. P., Mahakalkar, M. G., & Taksande, V. (2023). A Comprehensive Review of Motherhood and Mental Health: Postpartum Mood Disorders in Focus. *Cureus*, *15*(9), e46209. https://doi.org/10.7759/cureus.46209

[9] Tully, K. P., Stuebe, A. M., & Verbiest, S. B. (2017). The fourth trimester: a critical transition period with unmet maternal health needs. *American journal of obstetrics and gynecology*, *217*(1), 37-41.

[10] Agency for Healthcare Research and Quality. Pregnant and Postpartum Women and Behavioral Health Integration. https://integrationacademy.ahrq.gov/products/topic-briefs/pregnant-postpartum-women

[11] Kuehn BM. Postpartum Depression Screening Needs More Consistency. *JAMA*. 2020;323(24):2454-2454. doi:10.1001/jama.2020.9737

[12] O'Connor E, Senger CA, Henninger M, Gaynes BN, Coppola E, Weyrich MS. Interventions to Prevent Perinatal Depression: A Systematic Evidence Review for the US Preventive Services Task Force [Internet]. 2019;

[13] Maternal Health Technology Transfer Center Network. Perinatal Mental Health. https://mhttcnetwork.org/centers/global-mhttc/perinatal-mental-health

[14] Iturralde E, Hsiao CA, Nkemere L, et al. Engagement in perinatal depression treatment: a qualitative study of barriers across and within racial/ethnic groups. *BMC Pregnancy and Childbirth*. 2021/07/16 2021;21(1):512. doi:10.1186/s12884-021-03969-1

[15] Matthews K, Morgan I, Davis K, Estriplet T, Perez S, Crear-Perry JA. Pathways To Equitable And Antiracist Maternal Mental Health Care: Insights From Black Women Stakeholders. *Health Affairs*. 2021;40(10):1597-1604. doi:10.1377/hlthaff.2021.00808

[16] Slomian J, Honvo G, Emonts P, Reginster JY, Bruyère O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Womens Health (Lond)*. Jan-Dec 2019;15:1745506519844044. doi:10.1177/1745506519844044

[17] O'Connor E, Rossom RC, Henninger M, Groom HC, Burda BU. Primary Care Screening for and Treatment of Depression in Pregnant and Postpartum Women: Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA*. 2016;315(4):388-406. doi:10.1001/jama.2015.18948

[18] Bauman BL, Ko JY, Cox S, et al. Vital signs: postpartum depressive symptoms and provider discussions about perinatal depression—United States, 2018. *Morbidity and Mortality Weekly Report*. 2020;69(19):575.

[19] March of Dimes. Maternity Care Deserts Report. Nowhere to go: Maternity care deserts across the U.S. (2022 Report) https://www.marchofdimes.org/maternity-care-deserts-report

[20] James SJ. Maternal Postpartum Depression Screening in a Federally Qualified Health Care Center: An Evidence-Based Pilot Project. *Pediatric Nursing*. 2023;49(2):59-63.

[21] Puryear LJ, Nong YH, Correa NP, Cox K, Greeley CS. Outcomes of implementing routine screening and referrals for perinatal mood disorders in an integrated multi-site pediatric and obstetric setting. *Maternal and child health journal*. 2019;23:1292-1298.

[22] Jarvis LR, Breslin KA, Badolato GM, Chamberlain JM, Goyal MK. Postpartum depression screening and referral in a pediatric emergency department. *Pediatric Emergency Care*. 2020;36(11):e626-e631.

[23] Coffman MJ, Scott VC, Schuch C, et al. Postpartum depression screening and referrals in special supplemental nutrition program for women, infants, and children clinics. *Journal of Obstetric, Gynecologic & Neonatal Nursing*. 2020;49(1):27-40.

[24] Russomagno S, Waldrop J. Improving postpartum depression screening and referral in pediatric primary care. *Journal of Pediatric Health Care*. 2019;33(4):e19-e27.
[25] Berns HM, Drake D. Postpartum depression screening for mothers of babies in the neonatal intensive care unit. *MCN: The American Journal of Maternal/Child Nursing*. 2021;46(6):323-329.
[26] Brownlee MH. Screening for postpartum depression in a neonatal intensive care unit. *Advances in Neonatal Care*. 2022;22(3):E102-E110.
[27] Vaughn AT, Hooper GL. Development and implementation of a postpartum depression screening program in the NICU. *Neonatal Network*. 2020;39(2):75-82.
[28] Lawson A, Dalfen A, Murphy KE, Milligan N, Lancee W. Use of text messaging for postpartum depression screening and information provision. *Psychiatric services*. 2019;70(5):389-395.
[29] Vanderkruik R, Raffi E, Freeman MP, Wales R, Cohen L. Perinatal depression screening using smartphone technology: Exploring uptake, engagement and future directions for the MGH Perinatal Depression Scale (MGHPDS). *Plos one*. 2021;16(9):e0257065.
[30] Zhang Y, Wang S, Hermann A, Joly R, Pathak J. Development and validation of a machine learning algorithm for predicting the risk of postpartum depression among pregnant women. *Journal of affective disorders*. 2021;279:1-8.
[31] Giron K, Noe S, Saiki L, Kuchler E, Rao S. Implementation of Postpartum Depression Screening for Women Participating in the WIC Program. *Journal of the American Psychiatric Nurses Association*. 2021;27(6):443-449.
[32] Meine K. Pregnancy unshackled: Increasing equity through implementation of perinatal depression screening, shared decision making, and treatment for incarcerated women. Wiley Online Library; 2018:437-447.
[33] Burak EW, Dwyer A, Mondestin T, Guest. *State Medicaid Opportunities to Support Mental Health of Mothers and Babies During the 12-Month Postpartum Period*. 2024.
[34] Sidebottom A, Vacquier M, LaRusso E, Erickson D, Hardeman R. Perinatal depression screening practices in a large health system: identifying current state and assessing opportunities to provide more equitable care. *Archives of women's mental health*. 2021;24:133-144.
[35] Sampson M, Villarreal Y, Padilla Y. Association between support and maternal stress at one year postpartum: Does type matter? *Social Work Research*. 2015;39(1):49-60.
[36] Lewis Johnson TE, Clare CA, Johnson JE, Simon MA. Preventing perinatal depression now: a call to action. *Journal of Women's Health*. 2020;29(9):1143-1147.
[37] Dennis C-L. The process of developing and implementing a telephone-based peer support program for postpartum depression: evidence from two randomized controlled trials. *Trials*. 2014;15:1-8.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC31613, MCH Advanced Education Policy, $3.5 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.