

HEALTH AND HUMAN SERVICES

From Pregnancy to Postpartum

The Effects of Maternal Depression on Mothers, Infants and Toddlers



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Introduction

Maternal depression, which includes depression before, during and after pregnancy, can have serious consequences for mothers and their children, especially infants and toddlers. Risks include preterm birth, low birth weight and cognitive and developmental delays. Postpartum depression is linked to hormonal and chemical changes in the mother's body after giving birth and can be exacerbated by a number of factors, including economic stressors and lack access to treatment and services.

The negative effects of maternal depression on mother and child are well researched and clear. Scientific research confirms that infants need engaged, attentive and nurturing caregivers to thrive, and when mothers are unable to engage in a loving and nurturing way, their children's health and development suffer.

Science clearly points to the need for early identification and treatment of maternal depression. While racial or ethnic minorities are less likely to be depressed, those who are depressed experience worse health outcomes and are less likely to receive care and treatment.³

This brief provides an overview of maternal depression, its effects on mothers and infants, and state legislative options to address the issue.

Depression in the U.S.

One in five adults in the United States—nearly 44 million people—experience a mental health disorder each year.¹ Depression is one of the most common forms. Symptoms range from mild to serious. They include feelings of sadness and/or loss of interest in everyday activities lasting more than two weeks and the inability to engage in normal activities.²

Biological and environmental factors both contribute to a person's mental health and depressive disorders.

Maternal Depression

ANTEPARTUM DEPRESSION: DEPRESSION DURING PREGNANCY

While postpartum depression receives the lion's share of public attention, depression during pregnancy, clinically known as antepartum depression, remains an issue for many women. Fourteen to 23 percent of women suffer from some type of depression during pregnancy, according to the [American Congress of Obstetricians and Gynecologists](#).⁴

Antepartum depression is the greatest predictor of postpartum depression. [Nearly 73 percent](#) of women who report antepartum depression also experience postpartum depression, compared to 38 percent of women who did not experience antepartum depression but later experienced it postpartum.⁵

Depression during pregnancy can significantly affect mothers and developing babies. Several studies have linked antepartum depression with [preterm birth and low birth weight](#).⁶ Preterm births (births that occur before 37 weeks) are both more costly than a full-term birth and [increase the likelihood of physical and intellectual developmental delays](#).

The cost of preterm births, during and after delivery, is also concerning. According to the [March of Dimes](#), caring for a preterm baby in the first year of life costs approximately \$50,000, whereas care for a baby born without complications costs about \$5,000.⁷ Approximately half of all births in the U.S. are paid for by Medicaid,⁸ which covers a greater share of preterm births than private insurance.⁹ Together, these facts are evidence of the effect of poverty on health and well-being.

POSTPARTUM DEPRESSION

Postpartum depression disorders range from "baby blues" to postpartum depression and, in rare cases, postpartum psychosis. An estimated 50 to 80 percent of women experience baby blues, or feelings of sadness, that last only a few weeks immediately after birth, according to the [American Academy of Pediatrics](#).¹⁰ Postpartum depression lasts longer than a few weeks and occurs in [approximately 10 to 12 percent](#) of women.¹¹ Postpartum depression generally occurs about six weeks after birth, but it can happen as late as one year after birth. [Postpartum psychosis](#),¹² the rarest of these three conditions, typically has a sudden onset within the first two weeks after birth. Symptoms include paranoia, hallucinations, delusions, hyperactivity and mood swings. Postpartum psychosis occurs in only 0.1 to 0.2 percent of all births. Women who have personal or family history of bipolar disorder or a previous psychotic episode are at highest risk.

Postpartum depression is [linked to delays in cognitive](#), linguistic, and social and emotional development in infants and toddlers.¹³ In the first few years of life, a child's brain develops [a million new neural connections every second](#).¹⁴ These connections are influenced by many environmental factors, most significantly child-adult interactions. Scientists describe healthy interactions between infants and adults as a “[serve and return](#)” relationship.¹⁵ This is the give-and-take interaction between infants and adults. For example, an adult makes a silly face at the baby, the baby laughs in response to the silly face, and the adult smiles back at the baby. This back-and-forth interaction provides much-needed stimuli for babies' developing brains and is needed for a healthy bond to form between caregiver and child. Postpartum depression can [interfere with the serve and return relationship](#).¹⁶ Babies consistently deprived of this interaction can experience levels of stress that are constant to the point that it affects their developing brain.¹⁷ This is known as [toxic stress](#).

Breastfeeding and Maternal Depression

The relationship between maternal depression and breastfeeding is complicated. Mothers who are depressed are [less likely to breastfeed](#), and when they do, it generally is for a shorter duration than non-depressed mothers.¹⁸ Breastfeeding [may reduce postpartum depression](#) symptoms.¹⁹ According to the Centers for Disease Control and Prevention (CDC) breastfeeding is beneficial for both mother and baby. [Breastfeeding reduces the risk of heart disease, Type 2 diabetes, ovarian cancer and breast cancer for the mother.](#) The benefits of breastfeeding for a newborn include a reduction in the risk of asthma, obesity, Type 2 diabetes, ear and respiratory infections and sudden infant unexpected death syndrome (SUIDS).



The Interaction Between Adverse Childhood Experiences (ACEs) and Maternal Depression

The interaction between adverse childhood experiences and maternal depression is multifaceted. Between 1995 and 1997, the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente surveyed more than 17,000 male and female adults to explore whether there was a [connection between childhood trauma and health outcomes](#).²⁰ This research, known as the Adverse Childhood Experiences (ACE) Study, concluded that potentially traumatic events that occur before the age of 18 can increase an individual's risk of disease and behavioral challenges throughout his or her life.

The study measured 10 adverse childhood experiences: parental separation and divorce; parental incarceration; domestic violence; substance misuse or mental illness in the home; emotional, physical and sexual abuse; and emotional and physical neglect. Later research on ACEs included metrics on [additional traumatic experiences](#), such as [community violence, homelessness, economic hardship and the death of a parent](#).^{21, 22}

Research indicates that people with four or more ACEs are about [four times more likely](#) to develop depression. Research also found that depressed mothers are more likely to neglect their children,²³ which itself is one of the [10 original](#) adverse childhood experiences.²⁴ In addition to ACEs potentially having negative lifelong consequences for children, they may contribute to maternal depression.²⁵ Ultimately, reductions in rates of maternal depression [may support improvements in a child's health](#) and [disrupt the intergenerational transmission](#) of adverse childhood experiences.^{26, 27}

State Policy Options

COVERAGE AND ACCESS FOR DEPRESSION SCREENINGS

Some health care providers screen their patients to identify women suffering from maternal depression and use that information to connect patients with treatment. Screenings generally are written questionnaires that patients fill out or brief interviews conducted by a health care provider. The [Edinburgh Postnatal Depression Scale](#) (EPDS)²⁸ and the [Patient Health Questionnaire-9](#) (PHQ-9)²⁹ are two of the most commonly used standardized and validated screening tools; however, screening for depression is neither uniform nor universal, and in fact, varies greatly.

In recent years, state legislators examined increases in coverage and access to screenings for pregnant women and new mothers. [Thirty-seven](#) states allow, require or recommend that Medicaid cover maternal depression screenings at well-child visits.³⁰ [At least 13 state Medicaid programs](#) cover maternal depression screenings, including Colorado, Delaware, Iowa, Illinois, Maryland, Massachusetts, Nevada, New York, North Dakota, Ohio, South Carolina, Virginia and Washington.³¹

Some states allow the child's insurance to reimburse for the mother's depression screening. The American Academy of Pediatrics (AAP) publishes the [Bright Futures Guidelines](#)³² for health care providers, specifically pediatricians, to improve care and address infant and toddler health care needs. The guidelines are a resource for providers and family members and include information on when children should have well-child visits and which screenings and services to provide at those appointments. In these guidelines, AAP recommends pediatricians conduct maternal depression screenings as a part of well-child visits at ages 6 months, 1, 2 and 4 because of the strong relationship between the mother's and child's health.

The [Centers for Medicare & Medicaid Services](#) (CMS) stressed a similar point in a 2016 report, stating that "since a maternal depression screening is for the direct benefit of the child, state Medicaid agencies may allow such screenings to be claimed as a service for the child as part of the [Early and Periodic Screening, Diagnostic and Treatment, (EPSDT)] benefit."³³ EPSDT is part of a federal Medicaid requirement that mandates coverage of a wide range of preventive and treatment services for children under 21 who are covered by Medicaid.

Colorado, Illinois, North Dakota and Virginia cover maternal depression screenings under the child's insurance when they are covered by the [Children's Health Insurance Program \(CHIP\)](#).³⁴ Each state provides this coverage in slightly different ways, but most stipulate that screenings be billed under the child's Medicaid coverage when the parent is not otherwise insured.

Illinois, Massachusetts, New Jersey and West Virginia went further by mandating that providers screen all women for prenatal and postpartum depression. [West Virginia](#) enacted legislation in 2008 that requires women receiving prenatal care be screened to evaluate risk of depression.³⁵ [New Jersey](#) enacted legislation in 2006, making it the first state to require health care providers to administer postpartum depression screenings to all new mothers.³⁶

Home visiting programs are another tool to screen for maternal depression. Not all home visitors are trained to address maternal depression, but most can identify a depressed mother and provide a referral. Maryland developed a statewide training and certification program to train home visitors to identify signs of maternal depression, substance abuse, domestic violence and child behavior issues. All home visitors funded through Maryland's Maternal, Infant and Early Childhood Home Visiting (MIECHV) program must complete the training.

COVERAGE AND ACCESS FOR TREATMENT

While screenings can indicate a woman's risk of depression, additional services are needed to treat maternal depression. Many states are working to increase access and coverage for treatment related to behavioral health overall, and in some states, this includes treatment for women during pregnancy and in the postpartum period.

New York became the first state to enact legislation to recognize pregnancy as a "life qualifying event" in 2015, triggering a special opportunity for people to enroll in state health exchanges.

States also are looking at ways to extend coverage after pregnancy. [Missouri](#) enacted legislation in 2018 that supports the governor’s plan to apply for a [Medicaid 1115 demonstration waiver](#).³⁷ that, if accepted by the Centers for Medicare and Medicaid Services (CMS), will cover behavioral health services for women up to one year postpartum.³⁸ Without this waiver, women not otherwise covered by insurance will lose access to behavioral health services 60 days postpartum. With [increasing rates of maternal mortality](#) across the country, sometimes due to untreated behavioral health conditions, states are examining ways to provide continued coverage and care for this population.³⁹

Along with ensuring coverage of maternal depression treatment, states continue to make efforts to increase access to treatment. Massachusetts created the [Massachusetts Child Psychiatry Access Program](#) (MCPAP) to address severe shortages of child psychiatrists in the state. MCPAP offers a phone number that a child’s primary care provider can call to connect with a behavioral health professional who can provide information and referrals for the patient.⁴⁰ The MCPAP model was so successful in increasing access for children in Massachusetts that more than 30 other states created programs based on this model. In recent years, MCPAP expanded to include consultations for maternal depression and postpartum depression.

States also have passed legislation that requires increased access to information on postpartum depression and treatment options. [Virginia](#) enacted legislation in 2003 that requires hospital staff to provide information on postpartum depression to women and their families. It also requires hospital staff to discuss postpartum depression with maternity patients before discharge.⁴¹ In a similar effort to increase access to treatment and services, New York enacted [AB 8953](#) in 2018, which requires its department of mental health to provide information on its website regarding how to locate behavioral health providers who treat maternal depression.⁴²

STATE-FEDERAL PARTNERSHIP ON DATA COLLECTION

States are using data to track, analyze and assess maternal depression; however, information limited to prevalence and severity is incomplete.

[The Pregnancy Risk Assessment Monitoring System](#) (PRAMS) is a project run by the CDC in conjunction with state health departments. PRAMS is the only database that tracks the number of women screened for postpartum depression across states. It tracks state-specific information on pregnancies and babies through a questionnaire sent randomly to women who have recently given birth.⁴³ All information is confidential and is used to track and analyze health patterns over time and across states. PRAMS tracks maternal drug and alcohol use, breastfeeding, mental health, obesity, preconception health, pregnancy history, prenatal care, sleep behavior, tobacco use and other health-related topics.

Almost [83 percent of all U.S. births](#) are tracked in the database; however, PRAMS provides an incomplete picture in several important ways.⁴⁴ First, not all states use it, and second, PRAMS tracks only the occurrence of screenings, not screening results, referrals or treatment. Acknowledging these limitation, PRAMS has the best available data on rates of maternal and postpartum depression screenings.

PUBLIC EDUCATION AND AWARENESS

Public education and awareness campaigns can serve a variety of functions, including educating the population as a whole, educating people in a specific population, and raising awareness and attention among lawmakers.

States have increased awareness and understanding of maternal depression in various ways. [California](#) passed a resolution in 2010 declaring May “Perinatal Depression Awareness Month.”⁴⁵ Several states, including [Colorado](#), created public awareness campaigns about postpartum depression.⁴⁶

Other states more narrowly target their education efforts. For example, [Minnesota](#) enacted legislation in 2005 that required its state health commissioner to work with health care stakeholders to create and disseminate information on postpartum depression.⁴⁷ The state further required health care professionals who provide prenatal care to make this information available to women and their families.



Conclusion

Depression before, during and after pregnancy can have lasting negative effects on new mothers and their young children. A mother's ability to care for and form an attachment with her young child can affect the child's long-term social, emotional, physical and cognitive development. Access to maternal depression screening, services and treatment is important to a healthy start for infants and toddlers. State legislators play a critical role in determining policies and funding options related to maternal depression screening and treatment, improved data tracking, and public awareness and education. While there is no silver bullet for maternal depression, many states are ensuring better health and developmental outcomes for infants and toddlers by supporting their mothers' emotional well-being.

Strategies to Address Maternal Depression

- Increase coverage of and access to depression screenings during pregnancy and in the postpartum period.
- Increase coverage of and access to treatment for maternal depression.
- Improve data tracking on the number of women screened for postpartum depression at the state and national levels through PRAMS and other data tracking programs.
- Expand public education and awareness campaigns.
- Utilize home visiting programs as a tool to screen and make referrals to qualified professionals.

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