

1.2.1 Maternal Depression: Screening

Percentage of pregnant and/or postpartum women screened for depression

Purpose

Maternal depression has demonstrated negative impacts on not only the mother herself but also on her child and the family overall. The identification of this condition through universal screening is a key contribution that the early childhood system can offer beyond what an individual sector can do. In selecting maternal behavioral health with a focus on depression over other mental health conditions, the intent is not to exclude paternal mental health or other serious mental health conditions; rather, the intent is to align the measure to existing practices, which are typically focused maternal depression screening due to the strong link to child outcomes.

Definition

This measure seeks to track whether all pregnant and/or postpartum mothers are screened for depression at least once, but ideally at recommended intervals over time. Data availability is likely to be a challenge for communities. In the absence of the ideal source—unduplicated patient case records documenting prenatal and postpartum depression screening at the local level—this measure offers alternatives for measurement. An acceptable alternative is a representative self-report survey that asks postpartum mothers whether their health care provider asked them if they were experiencing prenatal or postpartum depression symptoms. While there are representative surveys that ask retrospectively about prenatal care depression screens, as of publication, a reliable survey asking about postpartum screens appears elusive.

Given the lack of universal case data and low availability of population-level data, program-level data provide the most likely source of data for early childhood systems, although these data are likely to be limited. A population-level assessment of maternal depression screening coverage will not be possible with program-level data. When program-level data are sourced to several different programs or practices, and may be duplicated, communities can focus on trend analysis instead of coverage rate.

There are a variety of maternal depression screening approaches which may be included in this performance measure. Localities may use: evidence-based screening tools; screening, brief intervention, referral to treatment (SBIRT) processes; a single question on a provider questionnaire; or a question/brief conversation between providers and patients. We encourage communities to work along two axes in making progress in maternal depression screening: 1) increasing the rigor of the screening tool/process; and 2) increasing the reach of the depression screening tool/process. This measure looks specifically at the reach of screening tools/processes.

The Data Sources and Limitations sections provide more information about the varying data sources.

Implementation

Summary of Steps

1. **Set intention:** Consider community goals, recent efforts, and constraints related to this area.
2. **Assess data availability:** Investigate whether there are maternal depression screening population-level data available

in your state or at the local level. If not, consider collecting and pooling data from service providers in your early childhood system. Since duplication is an issue with program-level data from various agencies, data sharing agreements that enable a unique identifier will reduce issues of duplication and greatly improve the value of the results. Since data from private providers or insurance companies are difficult to obtain, the data are likely to be limited to the participating agency's service population. Data may be available from Medicaid.

3. **Engage stakeholders:** For communities that will be using program-level data to measure system performance, engage with agencies from whom you would like to obtain data. Confirm and refine intentions/goals with stakeholders.
4. **Define parameters:** For communities that will be seeking program-level data from a variety of providers, quality results will depend on collectively determining what will count as a screen (e.g., use of a formal tool or a simple question about symptoms), at what intervals, and how to address potential for duplication.
5. **Retrieve or compile data:** From population-level sources, retrieve data. From program-level sources, request data. Request five years of data to enable a trend analysis.
6. **Interpret:** Analyze and interpret the data, considering data limitations such as duplication. Think about data trends and how they may be impacted by related interventions or landscape factors in your community. Consider health equity factors in your analysis if able to access disaggregated data.
7. **Plan:** Determine what action should be taken as a result of the analysis and record in action planning guide.

Stakeholders

Stakeholder engagement may not be necessary for communities that have easily accessible population-level data. For communities which seek to collect program-level data, outreach to the agencies conducting screens will be needed.

Data Sources

► Population-level

- **PRAMS:** [PRAMS](#) is a CDC sponsored, population-based random sample survey of women who have recently given birth. It provides state-level data on many topics, including maternal depression. The Phase 8 (2016) Standard PRAMS questionnaire asks, "During your postpartum checkup, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?" Options include, "What to do if I feel depressed during my pregnancy or after my baby is born." This question is not on the Core PRAMS questionnaire. Consequently, not all states ask this question. Furthermore, the data are only at the state level and tend to fall short of a screen; this is because PRAMS measures whether a health care worker talked with a mother during a prenatal care visit about what she should do if she feels depressed during or after pregnancy, not whether the health care worker asked if she was

experiencing depression symptoms at the time of the survey (post-partum).

- California’s Maternal and Infant Health Assessment (MIHA) or similar: [MIHA](#)—an annual statewide representative survey of postpartum women in California—asks whether a health care worker ever asked the mother during a prenatal care visit if she felt depressed. This data source stopped asking this question as of 2014 but added it back in the 2018 survey questionnaire, along with questions about connection to services when indicated by screening or assessment. Non-California based early childhood systems can investigate whether their state or region has a similar survey.
- ▶ **Program-level:** Client data from programs, agencies/ organizations, or systems that conduct maternal depression screens. Program-level data will be more readily available for states implementing the U.S. Department of Health and Human Services, Health Resources & Services Administration’s Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program (FL, KS, LA, MT, NC, RI, and VT).

Limitations

While some states will continue to have state-level population-level maternal depression screening data going forward, data at the local level is likely to remain problematic in many states. Current characteristics of data quality include the following:

- ▶ Program-level data is likely to be duplicated.
- ▶ Programs included in program-level data may vary across years due to changes in funding, service delivery, and reporting.
- ▶ Definitions of what constitutes a “depression screen” may vary, from a single question to an entire assessment.
- ▶ Population-level data use slightly different questions and are mostly only available at the state level.
- ▶ Population-level data may not offer reliable results, as mothers surveyed after the birth of their child may forget whether they were asked about mental health during a prenatal care visit.

Opportunities

Additional opportunities include the following:

- ▶ Analyze program data from Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program grantee states.

- ▶ Research recommended intervals (e.g., prenatal, in-hospital, postnatal to 6 months, etc.) and/or intervals for which there are commonly data. Use this research to define the measurement timeframe. The Bright Futures/AAP Periodicity Schedule recommends maternal depression screening during well baby checks by 1 month and at 2, 4, and 6 months (see Resources above).
- ▶ Consider whether prenatal screens should be included in the measure, or if the measure should focus on postpartum screening.
- ▶ In a growing number of states, postpartum maternal depression screening may be conducted and covered under the child’s Medicaid, regardless of the mother’s insurance status; in these states, Medicaid data may provide a rate of screening for mothers, though it would be for lower-income women only.
- ▶ Test adding postpartum depression screening questions to the Ages and Stages Questionnaire (ASQ), or otherwise connect maternal screening to well-baby checks.
- ▶ Advocate for local level depression-screening data, such as adding maternal screens to existing immunization or developmental screening registries.
- ▶ Research which states or localities have maternal and infant health survey’s similar to the MIHA, which ask about depression screening based on PRAMS or similar surveys.

Resources

- ▶ [Screening for Perinatal Depression](#), the American College of Obstetricians and Gynecologists
- ▶ [Patient Health Questionnaire \(PHQ-9\)](#), Substance Abuse and Mental Health Services Administration
- ▶ [Bright Futures/AAP Recommendations for Preventative Pediatric Health Care \(Periodicity Schedule\)](#), which includes recommended intervals for maternal depression screening.
- ▶ Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice, Earls, MF. and The Committee on Psychosocial Aspects of Child and Family Health. Pediatrics, November 2010, volume 216, issue 5.