



Invited Commentary | Pediatrics

Moving From Depression Screening Mandates to Systems of Care

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During the perinatal period, up to 20% of women and birthing people (hereafter women or mothers) experience mental health disorders such as anxiety and depression.¹ Such conditions are also the leading cause of preventable maternal death during pregnancy and in the first year after giving birth. Maternal and infant health are inseparable. Thus, it should not be surprising that growing evidence links adverse maternal mental health with infant mortality. In this issue, Woofter and colleagues² report on a population-based retrospective cohort study of 414 890 linked birth and death records from 2016 to 2021. The authors leveraged New Jersey legislation, first enacted in 2000, mandating birthing facilities screen mothers for postpartum depression prior to discharge. Woofter and colleagues found that infants born to mothers screening positive on the Edinburgh Postnatal Depression Scale (EPDS) before hospital discharge had 2.9 times the adjusted risk of death within the first year of life compared with infants whose mothers screened negative. The association persisted across strata of maternal race and ethnicity, insurance, education, and infant preterm birth, and for each of the 4 leading causes of infant death, including sudden infant death syndrome.

This study illustrates how state-level policies and mandates can be leveraged into rigorous population health and policy research. Because New Jersey law requires near-universal EPDS screening of delivering mothers, the investigators could characterize depressive symptoms across the full birthing population rather than the—often inequitably—selected group of pregnant and postpartum people who can access prenatal and/or postnatal maternal care and postpartum depression screening. Equally important is the granularity with which the authors chose the exposure and outcome: EPDS scores analyzed as binary thresholds and as continuous measures, screening anchored temporally before discharge to mitigate reverse causality, a secondary outcome window of 8 to 364 days to strengthen confidence that exposure preceded death, and cause-specific mortality analyses rather than a single aggregate endpoint. Population health research of this rigor is possible when policy standardizes clinical practice and generates population-level data. Woofter's team's work reminds us that policy can create not just clinical touchpoints but also the data infrastructure needed for rigorous scientific exploration.

While New Jersey was the first, it is not the only state that has created the opportunity for quasi-experimental policy research on maternal depression screening. The authors cite 7 other states with similar universal provider-directed screening mandates: West Virginia, California, Florida, Oklahoma, Illinois, Louisiana, and Arkansas. Our review identified 4 additional states that have passed legislation mandating some form of maternal mental health screening,³ although much variation exists. Two states, Nevada and Washington, wrote their mandates for Medicaid enrollees only, tying screening to the insurance benefit rather than to the birth itself. These 2 states are also the only ones whose statutes contain explicit language requiring coverage or payment for screening or for the services that follow a positive screen.

Mandates also vary in when and where screening occurs. For instance, 4 states direct screening into pediatric settings by attaching it to infant well-child visits, a pathway endorsed by the American Academy of Pediatrics precisely because mothers who miss their own postpartum appointments reliably bring their infants to the pediatrician.⁴ Louisiana requires maternal screening during the first 6 months of an infant's life, while Nevada and Washington require that Medicaid-covered postpartum care include depression screening, including at well-child visits during the infant's first 6 months. Massachusetts not only requires screening at pediatric visits throughout the first 12 months of infants' lives, but also stands alone in extending screening to parents who have lost pregnancies to

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miscarriage, medical termination, or stillbirth, and to any biological, adoptive, or foster parent who has assumed custodial care of a child within the preceding 12 months.⁵ Most consequentially, states differ in what they require after a positive screen. For instance, Massachusetts mandates that health care professionals must discuss available treatments with and provide referrals to those who screen positive. Conversely, Arkansas' law contains no explicit language about what must happen when a mother screens positive.³

Herein lies the crux. Screening mandates are inherently identification policies, not treatment policies. But screening is only effective if there are clear next steps after a positive screen occurs and the financial infrastructure to ensure those steps are sustainable. These next steps thus depend entirely on whether health systems possess the workforce, referral pathways, reimbursement, and accountability to convert a positive screen into timely, effective mental health care. New Jersey's own experience is cautionary. In 2011, Kozhimannil and colleagues⁶ published an evaluation of the state's screening mandate among Medicaid-enrolled mothers, examining both population-level trends in monthly rates of depression treatment initiation and patient-level probabilities of initiating, following up on, and continuing care. Fewer than 7% of women initiated mental health care within 6 months of delivery both before and after the law took effect, and their analyses did not detect any association between the mandate and treatment. Those findings predate Medicaid postpartum coverage extensions, telehealth expansion, and newer postpartum depression treatments, but the underlying question remains urgent amid the continuing public health crisis of postpartum depression: does screening lead to better care and better outcomes? Fewer than half of US women with postpartum depressive symptoms receive a diagnosis, and, in settings without targeted interventions, fewer than one quarter of those diagnosed receive treatment; substantial racial and ethnic inequities in both diagnosis and care persist.⁷ A positive screen without a warm handoff to a clinician available to receive referrals and coverage for such services creates a dangerous cliff for women.

Woofter and colleagues² raise the stakes of that cliff. If depressive symptoms in the first days after birth mark nearly 3-fold higher infant mortality risk across causes ranging from prematurity-related conditions to sudden infant death syndrome, then the gap between identification and treatment of postpartum depression is not only a maternal health failure but potentially an infant one as well. Whether treating maternal depression reduces infant mortality remains unknown, and the authors are appropriately circumspect about causality. Potential pathways may involve physiology, caregiving practices, social drivers of health, or reverse causation related to infant illness.

However, uncertainty about mechanism is not an argument for inaction on treatment access. Screening mandates without treatment follow-up and sustainable financing for the care cascade risk screening programs living on the books while changing little in practice, the very pattern Kozhimannil and colleagues documented in New Jersey.⁶ The next generation of policy must legislate the "what next": required response protocols for the entities performing screening, reimbursement for both the screening and the services a positive screen triggers, investment in the perinatal mental health workforce, and accountability metrics that extend beyond screening completion. Paired with rigorous policy research, such policies could improve not only screening rates but also the necessary care delivery to ultimately impact maternal and infant outcomes. That is the promise of evidence-based health policy.

ARTICLE INFORMATION

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