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# Implementing the USPSTF Recommendations on Prevention of Perinatal Depression–Opportunities and Challenges

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**In this issue of *JAMA*,** the United States Preventive Services Task Force (USPSTF) recommends that clinicians refer pregnant and postpartum (ie, perinatal) persons who are at increased risk for depression to counseling interventions (B recommendation).[1] Based on a systematic review of 50 studies,[2] the USPSTF "concludes with moderate certainty that providing or referring pregnant or postpartum women at increased risk to counseling interventions has a moderate net benefit in preventing perinatal depression."[1] Women have frequent contact with clinicians during the perinatal period, rendering this a particularly opportune time to identify and treat those at risk for depression. Furthermore, perinatal women may be highly motivated to engage in behaviors that promote both their own and their infants' well-being. The most important take-home message from the USPSTF recommendation is that perinatal depression is preventable.

## Burden of Perinatal Depression

Approximately 14% of perinatal women experience depression, making it one of the most common complications of childbirth.[3] The adverse correlates and consequences of perinatal depression are well established and include increased risk of preterm birth, less positive and more negative parenting behaviors, emotional and behavioral problems among offspring, and higher health care costs.[4] Treating women at risk for perinatal depression may avert the long reach of negative consequences on maternal and child health and well-being.

## Identification and Prevention of Perinatal Depression

Clinical and sociodemographic risk factors for perinatal depression include lack of social support, history of abuse or domestic violence, unplanned or unwanted pregnancy, and low socioeconomic status.[5] The majority of preventive interventions have been studied among perinatal women with (1) elevated depressive symptoms or (2) a history of depression. Therefore, given limited time within medical appointments, it would be prudent for clinicians to prioritize screening for these 2 risk factors using brief patient-report measures (Table).[6–10] To screen for other perinatal depression risk factors, clinicians can find helpful

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language in the Antenatal Risk Questionnaire or Postpartum Depression Predictors Inventory.[10,11]

Clinicians do not need to wait until depressive symptoms emerge at clinically significant levels to recommend interventions. Counseling interventions are associated with a 39% reduction in the likelihood of perinatal depression, corresponding to a number needed to treat of 13.5 perinatal women.[2] The most widely studied counseling interventions for preventing perinatal depression are cognitive behavior therapy[12] and interpersonal psychotherapy.[13]

## Translating Evidence to Practice

Concerns may rightly be sounded that counseling, despite its efficacy in preventing perinatal depression, is far from universally accessible. Cognitive behavior therapy and interpersonal psychotherapy are conventionally offered by a licensed clinical psychologist during in-person appointments, and there are online resources for locating psychologists with relevant expertise (eg,http://www.postpartum.net/get-help/locations/united-states/and http://www.findcbt.org/xFAT/). However, the need for preventive interventions outnumbers the availability of psychologists. Although researchers have investigated a variety of alternative delivery formats, including by phone, during home visits, and via digital platforms, these adaptations currently have limited availability to the public. Moreover, the efficacy of many of the preventive interventions cited in USPSTF's systematic review was established in tightly controlled studies under ideal circumstances. It is vital that researchers investigate effectiveness in real-world settings and disseminate effective interventions into practice.

## Need for Infrastructural Changes

Gestational diabetes mellitus (<10% prevalence[14]) may provide an apt model for health systems and policymakers charged with designing perinatal depression screening and prevention programs. Universal screening for and management of gestational diabetes mellitus is now standard practice in prenatal care,[15] and the American College of Obstetricians and Gynecologists recommends early screening for those at risk for gestational diabetes.[16] For women diagnosed with gestational diabetes mellitus, referral to a dietician who can provide nutrition and exercise counseling is often the first step. In settings where a dietician is not available, prenatal care clinicians may provide such recommendations.[16] Analogous efforts to integrate perinatal depression care into obstetric, pediatric, and primary care clinics will enable more comprehensive and holistic care. The Massachusetts Child Psychiatry Access Program for Moms model offers a helpful framework.[17] In this program, which is funded by the Department of Mental Health, perinatal psychiatrists provide consultation, resources, and referrals to help clinicians identify, prevent, and manage mental health concerns among perinatal women. Additionally, legislation like California Assembly Bill 2193,[18] which mandates perinatal depression screening and requires private and public insurers to create maternal mental health programs, is an important step in the right direction. A hopeful outcome of the USPSTF recommendation is that it may galvanize efforts to enact the policy and health system changes that are needed to prevent perinatal depression.

## Conclusions

Perinatal depression is common, consequential, and costly. Fortunately, there are evidence-based interventions shown to prevent perinatal depression among women who are at risk. As a start, clinicians should screen for elevated depressive symptoms and history of depression and refer women who screen positive to a counseling intervention, such as cognitive behavior therapy or interpersonal psychotherapy. The screening and referral process should be individualized based on patient preferences, clinic setting, and intervention accessibility. It is essential that clinical efforts to prevent perinatal depression are matched by the infrastructural and policy changes needed to maximize their likelihood of success.

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**Table.**

Suggested Measures for Assessing Perinatal Depression Risk Factors

| Risk Factor | Brief Patient-Report Measure | No. of Items | Helpful References |
|---|---|---|---|
| Elevated depressive symptom severity | Edinburgh Postnatal Depression Scale | 10 | Cox et al,[6] 1987 |
| | Patient Health Questionnaire | 9 | Kroenke et al,[7] 2001; Yawn et al,[8] 2009 |
| History of depression | "Before this pregnancy, did you ever have a period of 2 weeks or more when you felt particularly miserable or depressed?"<br>"If so, did being depressed interfere with your abilityto get things done or your relationships with friends and family or did it lead you to seek professional help?" | 2 | Austin et al,[9] 2008; Austin et al,[10] 2013 |