MEDWIN PUBLISHERS
Committed to Create Value for Researchers

Journal of Quality in Health care & Economics
ISSN: 2642-6250

A Review of Post-Partum Depression-Why is the Mom Sad!

Tiwana M*

University of Cincinnati, USA

***Corresponding author:** Maida Tiwana, University Of Cincinnati, 160 Panzeca way Cincinnati, Ohio, 45267, USA, Tel: 2158289006l; Email: tiwanama@mail.uc.edu

Investigation Paper

Volume 5 Issue 3

Received Date: April 18, 2022

Published Date: May 30, 2022

DOI: 10.23880/jqhe-16000277

Abstract

Pregnancy is a harbinger of life. It is a phase of life where a new life is stemming from a mother's womb. This journey is full of surprises and ups and downs but nonetheless it is filled with hope, dreams and happiness for an offspring that will be known as your "child". For some mothers this journey brings its own set of struggles and hardships. One of that being the postpartum depression and an extreme version called Psychosis. Sometimes, even in early pregnancy the bouts of sadness become so intense that the mother to be is full of guilt and feels overwhelmed to the point of causing harm to herself. Many women in the world suffer from perinatal and postpartum depression. The world needs to engage in more research on ways to protect the mental health of a new mom. The policy to devise methods and ways to ensure there is enough support for new moms is not a new area of interest but there is no new approach to the same old problems. This article explores the history of postpartum depression and how it became a matter of policy. The legislation and more means needed to bring relief to mothers who do not have a support network are indeed needed.

Keywords: Postpartum Depression; New Mom; Pregnant Woman

Abbreviations: PPD: Post-Partum Depression; EPDS: Edinburgh Post Natal Depression Scale; NIH: National Institute of Health; FDA: Food and Drug Administration; NICHD: National Institute for Child Health and Human Development; CDC: Center for Disease Control; NIMH: National Institute of Mental Health ; ACA: Affordable Care Act; ACOG: American college of Obstetricians and Gynecologists; EEOC: Equal Employment Opportunity Commission; ADA: Americans with Disabilities Act; PMD: Postnatal Mood Disorder; EPSDT: Early and Periodic Screening, Diagnostic and Treatment Service; C&TC"s: Child & Teen Checkups.

Introduction

A Journey of Improving Health Care Quality

Pregnancy is a harbinger of new life. It is a phase of life that is full of happiness, hopes and dreams for another human being who would be known by the rest of the world as your child. For some mothers this is not true and they end up suffering. Sometimes even in early pregnancy the bouts of sadness and tearfulness are so intense that the pregnant woman starts feeling guilty and feels its her fault that she is not happy. While being emotionally overwhelmed is very much normal and not a cause of concern, it certainly needs to be evaluated, if the pregnant woman is not able to handle the things herself and thinks that situation is getting worse. Many women have an emotionally debilitating experience "after" having the baby. When the symptoms of depression manifest after the delivery they are categorized as Post Partum Blues. Postpartum blues have been reported to occur in 15-85% of women within the first 10 days after giving birth, with a peak incidence at the fifth day. Common symptoms include mood swings, mild elation, irritability, tearfulness, fatigue, and confusion [1].

Post-partum depression (PPD) is a non-psychotic depressive illness that is moderately severe in symptomatology and similar to depression at other times in life. Onset is often four to six weeks postpartum, but can occur anytime within the first trimester. An estimated 10–15% of women experience PPD11 and it has been found to be much higher in low-income populations, at between 23 and 52%. Women at highest risk for PPD are those who have a history of depression, experience depression during pregnancy and have had one episode of major depression following childbirth. Women with a previous diagnosis of PPD have a risk of recurrence of about 25% [2]. Depression is often accompanied by a slower rate of speech and reduced eye contact, as well as decreased emotional expressiveness and responsiveness [3].

Parent–infant synchrony is impacted in that depressed mothers tend to be slower to respond to infant stress or social signals, look at and vocalize less often to their children and engage in less rhythmic imitation and joint activity. Further, mothers with depression demonstrate speech that is less focused on the actions and abilities of the infant have more difficulty providing Optimal levels of stimulation provide less touch to their babies, and their touch is more functional and less affectionate. Interactions between depressed mothers and their infants become impaired with a longer course of depression, with depressed mothers being less positive in face-to-face interactions and in play with toys and less competent in feeding at six months post-partum. The non-contingent and self-preoccupied nature of behavior in depressed mothers appears to promote insecure attachment in infants, toddlers and preschoolers. When a caregiver responds by being unavailable, unpredictable, insensitive or rejecting, the infant will learn to not seek out the caregiver when distressed or will do so in an ambivalent manner. These infants learn to see others as untrustworthy and potentially rejecting, and view themselves as unworthy. Maternal depression is associated with a range of difficulties in infants and toddlers including emotional lability, lower frustration tolerance, and higher rates of non-compliant behavior and decreased positive affect and ability to self-sooth. “This is an illness that takes away a women’s ability to access joy… right at the time she needs it most.”

Post-Partum Depression: History

The issue of post-partum depression is not a new one or a phenomenon observed in recent times. The history of postpartum depression (PPD) dates back far as the writings of Hippocrates, however, the symptoms of PPD were not recognized as a medical disorder until the 19th century. During the 19th century when women experienced depression, many did not divulge their symptoms and those who did were often diagnosed as “neurotic.” Women who sought help for their symptoms were often subjected to a variety of unusual treatments.

During the 1950s electroshock therapy was often the recommended treatment for a “neurotic” woman or they were occasional prescribed Valium. Women did not recognize their symptoms as those of depression, nor did they discuss their thoughts and fears regarding their symptoms. Their silence was most likely out of shame that others would think they were “neurotic” or insane.

PPD is significantly undertreated. Many women feel that sadness at what “ought” to be a joyful and a beautiful time is shameful. In order to confirm to the standards of society they put a lid on their feelings and suffer internally. Some women are influenced by society’s general stigma concerning mental health care. In addition, those women who do seek treatment often hesitate to take psychotropic medications when breastfeeding, despite substantial evidence of their relative safety [4]. In efforts to bring this issue to light many countries have had extensive health policy changes and many researchers in collaboration with primary care physicians have tried to find a clue to PPD [5]. Many health policies that adversely affect the woman’s health are to be held responsible for a lack of interest in PPD by many people who have the power to change the current scenario [6].

Post-Partum Depression and Maternal Care in US

In the United States, studies conducted by the CDC show that about 11-20% of women experience the symptoms of postnatal depression. This means that of the 4 million live births that occur every year, 600,000 of them develop postpartum depression. This is much more than the number of women diagnosed with breast cancer, cervical cancer, and stroke combined. When the studies are narrowed down to specific states, the rates even go higher [7].

A more recent report filed in the Morbidity and Mortality Weekly Report gave a more specific report in specific states. It showed that the overall prevalence rate is currently at 11.56%. There are huge disparities among states with some like Illinois having 8% and 20% for Arkansas [8].

Given the public health relevance of PPD, its well–characterized psychological risk factors, and the substantial barriers to care once women become ill, a focus on the prevention of PPD holds tremendous potential for clinical efficacy. In particular, prospective mothers are especially motivated for self-care [9] postpartum maternal health care is a neglected aspect of women’s health care. Missed

opportunities for enhancing the health care of postpartum women are a routine in primary health care clinics. Differing perceptions of maternal needs between nurses and new mothers also contribute to inadequate health care.

There are nearly 4 million live births every year in the United States. Nearly, 20% of these mothers will experience symptoms of major or minor depression during the first 3 months after delivery [10]. This makes depression the most common complication seen in the post-partum period surpassing both gestational diabetes (3-8)% and preterm birth (12.3%). There is huge lack of data and interest in maternal care and parameters that define how healthy a mother is after the childbirth. Therefore, collecting national data on postpartum maternal morbidity, reforming postpartum care policies, providing holistic and flexible maternal health care, encouraging family support and involvement in support groups, and initiating educational programs are recommended [11].

When we look at the post partum maternal care being given to mother in other countries we can see that USA is far behind and there is huge gap in the care. The national goals, surveillance and programs responding effectively to the health needs of postpartum women require relevant national health goals, surveillance systems, and programs of care. With regard to U.S. health goals, Healthy People 2010 objectives associated with maternity care focus on pregnancy and its immediate outcomes (U.S. Department of Health and Human Services, 2000a). Healthy People 2010 contains 467 objectives designed to serve as a framework for improving the health of all people in the United States during the first decade of the 21st century [12]. Although postpartum complications may be considered important, only postpartum depression was mentioned in Healthy People 2010, and its national goal was not established [13].

Public policy erects two barriers to adequate prevention and treatment of postpartum depression (PPD) in the United States:

(1) The lack of parity between insurance coverage for mental and physical illness decreases access to care.

(2) The current model of postpartum care fails to incorporate screening and follow-up. Treatment for PPD falls into the insurance category of mental health. But many insurance companies either do not cover mental illness at all or provide coverage that is far below that for physical ailments. Because cost-benefit analyses have shown the benefits of parity laws, legislation to achieve parity between mental and physical health insurance is crucial in addressing this problem [14].

Post-Partum Maternal Care in Other Countries

In the Netherlands, women with normal pregnancies can give birth at home or birth rooms, which are operated by midwives or general practitioners in a hospital. A continuous 1-week home care to mothers covered by insurance for normal birth is provided by kraamverzorgsters, who receive a 3-year training [11]. This postpartum home care includes care for children and mothers and housework services.

Despite home visits, mothers can also choose to stay in maternity centers for postpartum care. In Norway, maternity centers established near hospitals are hotel-like environments where new mothers, newborns, and their families can stay together for postpartum care. Likewise, in Taiwan, new mothers can choose to stay in private maternity centers where mothers and newborns are taken care of by nurses. A majority of Chinese mothers who choose to stay at home are cared for by their family members for about 1 month to prevent diseases and promote health. Parental leave is another policy that facilitates maternal and children's health. In Sweden, new parents can take, at most, a 1-year leave at 80% of their salary. In Finland, women have the chance to take a 1-year maternal leave supported by a state grant.

Whether provided at home or a facility, postpartum care helps new mothers to recover from physical changes of pregnancy and to learn child-care skills [11]. The U.S. model of post-partum care should follow the example of care provided in the United Kingdom where nurse-midwives visit new mothers at home to check on their physical and emotional status. In one program that produced positive psychological health outcomes, midwifery visits were tailored to individual needs and extended to 10-12 weeks postpartum. Encouraging developments in the United States include:

- An effective program that screens new mothers with signs of PPD and provides telephone follow-up and rapid treatment referral
- proposed legislation to fund organizations working to reduce the incidence of PPD [14].

Contributing Factors and Their Assessment

Researchers are only at the beginning stages of discovering biological factors that may contribute to the etiology of postpartum depression, but there are numerous known psychological and social risk factors. Previous meta-analyses have identified fifteen:
(1) lower social class, (2) life stressors during pregnancy, (3) complicated pregnancy/birth, (4) difficult relationship

with family or partner, (5) lack of support from family or friends, (6) prior history of psychopathology (depression, anxiety), (7) chronic stressors postpartum (this can include problems with child care and difficult infant temperament), (8) unemployment/instability, (9) unplanned pregnancy, (10) ambivalence over becoming a pregnant, (11) poor relationship with own mother, (12) history of sexual abuse, (13) lack of a confidante, (14) bottle feeding, and (15) depression during pregnancy, with the last generally acknowledged to be the strongest predictor of PPD [9].

Young mothers who are looking for support usually fall behind schedule and are the most vulnerable. There can be many ways in which we can evaluate each of these factors and more research can be done on these to know the cause and effect [15]. Women who are not working, or those with lower occupational status are at greater risk for depression. Recent immigrants, particularly those who were not working or who had given birth to a second child, were also at higher risk Zelkowitz, et al. [16] Health system barriers included normalizing of symptoms, offering of unacceptable interventions, and disconnected care pathways [17].

These factors if studied individually can be of great help. If we can evaluate these one by one and the government works with women centered clinics to follow up on these issues we can be sure that we can handle PPD. Implementation of some ground rules and providing effective support to such centers is of vital importance. A mechanism of early detection linked to appropriate treatment and follow-up would be beneficial for the depressed woman, her family, and her infant. New strategies are required to identify women at highest risk or already suffering from depression Mandl KD, et al. [18] primary care providers should observe the mothers with a very keen eye if they are bringing a small baby frequently. It could be a mom's cry for help. Although it is tempting to attribute postpartum depression to hormonal decline, several other factors may predispose women to this condition. Stressful life events, past episodes of depression (not necessarily related to childbearing), and a family history of mood disorders all recognized predictors of major depression in women, are also predictors of postpartum depression. The likelihood of postpartum depression does not appear to be related to a woman's educational level, the sex of her infant, whether or not she breast-feeds, the mode of delivery, or whether or not the pregnancy was planned [19].

The pediatrician who finds a mother bringing in her infant for frequent visits to the emergency department or to the office should closely examine the motivation for the visits, and consider screening for depressive symptoms. Specific evaluation of mothers by health care providers who recognize these signature patterns of service use may reduce unnecessary health care use and facilitate early diagnosis and treatment of postpartum depression, improving outcomes for women and their families Mandl KD, et al. [18] Apart from questions about psychiatric history, a psychosocial history in early pregnancy including stressful life events, native language and employment status could help the health professionals to identify women at risk for recurrent or sustained depression during pregnancy and the year after giving birth [20].

The Edinburgh Post Natal Depression Scale (EPDS) is a very useful tool. This questionnaire is a very complete guide to ask mothers the relevant questions and in a short duration a primary care provider can assess the mental wellbeing of the mother. Using this we can examine the effects of the mother's sense of well-being on the child's growth and development and explore risk factors for low spirits in the post-partum period [21]. The EPDS was found to have satisfactory sensitivity and specificity, and was also sensitive to change in the severity of depression over time. The scale can be completed in about 5 minutes and has a simple method of scoring [22].

Strategies to Address the Issue

One of the feasible options to reduce the number of women who are faced by the dilemma of PPD would be a good support system [23]. Other activities that a mother can include in her life would be stress management and increasing activity levels to prevent or lessen depressive symptoms [24]. The family support is very much needed and can help with stress management.

Apart from the families and friends a good working environment where a preference is given to handle the issues of the employees is also a much needed change. The work culture of US does not give a lot of leverage to women who have just delivered. The official paid maternity leave is only 6 weeks. It is the least amount of time compared to all developed countries like European countries**.** It is also important that new mothers receive work-related support. Length of maternity leave and number of work hours are both significantly related to new mothers' postpartum mental health [25]. It appears that taking a longer maternity leave and limiting work hours during the postpartum period may have positive health consequences for mothers with infants.

Job-related stress indicates a need for work policies and benefits that provide flexibility and support for employed women who give birth. With more than one half of women returning to the work force after having a baby, the development of work-related support systems is especially critical. Considerable associations between early returns to work and children's outcomes are found suggesting causal

relationships between early returns to work and reductions in breastfeeding and immunizations, as well as increases in externalizing behavior (mental health problems that include depression and psychosis) problems. There is a strong chance for mothers who return to work full-time within 12 weeks of giving birth to have the negative symptoms [26].

Time for a Work Culture Change

Rapid changes in the modern work environment, including the proliferation of computer technology and the United States transitioning from a manufacturing-based economy to a service-based one, have led to longer work hours, more shift work, and greater job complexity. Modifications that help mothers feel less stressed about keeping pace with workload demands and maintain better work–life balance bode well for recovery. For instance, allowing new mothers to work day shifts rather than night shifts helps them establish regular feeding and sleep–wake routines with newborns and optimize their own sleeping patterns as well. Also, many child care programs will not enroll children who are not toilet trained—meaning that women with infants have fewer options for child care, especially if they lack a partner or family members to help provide support. Permitting flexible schedules or teleworking can be especially helpful in such situations. Only 12% of U.S. private companies offer paid parental leave, and there is a misperception that only large tech outfits and Fortune 500 companies can afford to do so. However, many businesses may be able to extend this privilege without breaking their bottom line. A recent analysis of the state-mandated paid leave programs in New Jersey and California found that paid leave financed by payroll deductions are relatively inexpensive, costing individual employees approximately $30 a year-less than $1 a week. The states have also reported that the programs tended to have either a positive effect or no impact whatsoever on outcomes such as profitability, performance, productivity, turnover, and employee morale. Despite any lingering reluctance, some businesses may be forced to contemplate paid maternity leave in the near future: although only four states currently have such legislation (California, New Jersey, Rhode Island, and New York), 18 are reviewing their laws in consideration of adopting similar mandates.

Actions Taken by the Government

The main problem arises when we do not give enough importance to a very sensitive issue. We know the stakeholders in this issue, we know what are the probable implications and consequences and yet we are not doing enough in this regard??.

The constellation of health policy hierarchy is different in every country; however there is usually a "top of the pyramid." If policy is mandated from that peak, be it the legislature or the executive branch, the likelihood increases that the largest number of citizens will benefit. We can examine the progress of the government of United States as the following yearly steps taken in the right direction.

Year 1999

A Congressional resolution, "Expressing the sense of the House of Representatives with respect to postpartum depression", passed on May 6, 1999. There solution encourages screening, training of health professionals, and the establishment of a coordinated system of registries to collect data on mental dis-orders in the new mother. The Resolution also encourages the National Institutes of Health (NIH) to undertake additional research on postpartum psychiatric conditions. In addition, several meetings have focused on psychopharmacological and psycho-social treatment of pregnant and postpartum women. "Clinical pharmacology during pregnancy: Addressing clinical needs through science" Henney JE, et al. [27] (December 2000; co-sponsored by the Food and Drug Administration (FDA) and National Institute for Child Health and Human Development [NICHD]) highlighted the need for research and collaboration for pharmacology in pregnancy [28]. Similarly, the "Summit on women and depression meeting" (October 2000; cosponsored by American Psychological Association and NIMH) identified a public health need to focus on depression in childbearing age women.

Year 2000

Finally, in November 2000, the Center for Disease Control (CDC), FDA and NIH sponsored a meeting "Concepts and strategies to actively monitor the risk of medications in pregnancy: Enhancing post marketing surveillance that focused on the various strategies and infrastructure needs for investigating fetal and child outcomes and the safety of drugs that women take during pregnancy. Altogether, there are several federal initiatives that can promote significant benefits for the field [28].

Year 2001-2007

The "MOTHERS ACT" was introduced in the U.S. Senate to ensure education, screening and services relating to PPD, and in October, 2007 the House of Representatives passed the Melanie Blocker Stokes Postpartum Depression Research and Care Act by a vote of 382-3 [29].

This bill was first introduced in 2001 after the tragic death of Chicagoan, Melanie Blocker Stokes. Melanie was a 40-year-old, African American woman who died by suicide after a long, much-publicized battle with this most severe

form of the mental illness—postpartum psychosis. She left behind a daughter, Summer Skky and her husband, Dr. Sam Stokes. Cases like these and many more need to be heard and discussed to bring about a change. The change does not come over night. We need the health care providers, the health policy makers, Women centered clinics and hospitals to come together and analyze how far we need to go in order to address this issue.

Mothers Act and the ACA – What has Happened Since 2010?

When the U.S. Patient Protection and Affordable Care Act passed in 2010, the MOTHERS Act was included in the text of the bill. The adoption of the Patient Protection and Affordable Care Act (ACA), Section 2952: Support, Education, and Research for Postpartum Depression mandated ongoing research to better understand the frequency and course of postpartum depression, address differences in treatment needs among racial and ethnic groups, and develop culturally competent evidence-based treatment approaches (U.S. Department of Labor, 2012). However, Congress has not appropriated funds to carry out the activities authorized in these provisions.

Year 2015

In November 2015, Congresswoman Katherine Clark of Massachusetts and Congressman Mr. Costello of Pennsylvania have introduced the following bill; Bringing Postpartum Depression Out of the Shadows Act of 2015 [H.R. 3235] (Bringing Postpartum Depression Out of the Shadows Act of 2015) This bill would amend the Public Health Service Act to authorize the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, to make grants to States for screening and treatment for maternal depression. The Bringing Postpartum Depression Out of the Shadows Act would build upon existing state and local efforts by providing targeted federal grants to assist states in developing programs to better screen and treat maternal depression. A companion bill, S. 2311, was introduced in the U.S. Senate by Senators Dean Heller (R-NV), Kirsten Gillibrand (D-NY), Kelly Ayotte (R-NH) and Ed Markey (D-MA)].

Step in the Right Direction

The Mothers Act was historically significant, introducing language of postpartum depression into the federal legislative record, and it garnered support and interest across the US and across political parties. However, none of the provisions of the Act were activated with funding. Subsequent legislative action has been state-based, until the introduction of the Bringing Depression Out of the Shadows Act in 2015. Although there are no US federal policies that require screening of new mothers for postpartum depression, at least 12 states have adopted either state legislation, developed awareness campaigns, or convened tasks forces. States that require screening include New Jersey (Findings, Declarations Relative to Postpartum Depression, 2006), Illinois (Perinatal Mental Health Disorders Prevention and Treatment Act, 2008), and West Virginia (Uniform Maternal Screening Act, 2009). Other states require education about postpartum depression including Texas (Relating to Information Provided to Parents of Newborn Children, 2005), Virginia (Certain Information Required for Maternity Patients, 2003), Minnesota (Postpartum Depression Education and Information, 2015), and Oregon (Relating to Perinatal Mental Health Disorders and Declaring an Emergency, 2011). Washington has passed statewide awareness campaigns, and California, Michigan, and Oregon have postpartum depression awareness months. Maine, Maryland, Massachusetts, and Oregon have appointed perinatal depression task forces [30].

Guidelines by American College of Obstetricians and Gynecologists

According to the guidelines laid down by the American college of Obstetricians and Gynecologists (ACOG) there are a number of things that can be ensured to keep a mother safe and emotionally healthy during the post-partum period. In 2018, the ACOG said "In redefining the Postpartum health care program, a post-partum Visit Task Force revised the American College of Obstetricians and Gynecologists' Committee Opinion on postpartum care (Committee Opinion No. 732, Optimizing Postpartum Care) to reflect the importance of the "fourth trimester" period. Instead of a single visit, the new Committee Opinion recommends that services and support should be tailored to each woman's individual needs. It is recommended that all women have contact with their health care providers within the first 3 weeks of the postpartum period. This initial assessment should be followed up with individualized ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth. The Committee Opinion also highlights the importance of health care providers counseling women who have experienced pregnancy complications, as well as women who may have chronic conditions, to receive timely follow-up care with their obstetrician–gynecologists or primary care providers."

Make Sure Employees Know their Rights

Not all working mothers are aware of the rights afforded them by the U.S. Equal Employment Opportunity Commission (EEOC). According to the EEOC (2008), companies with more than 15 employees are required to comply with the

1978 Pregnancy Discrimination Act and the Americans with Disabilities Act (ADA). Under these, employers must make the same allowances, such as extended unpaid leave or workplace accommodations, to women with pregnancy-related disabilities as they do to employees with other ADA-covered disabilities. Reassure working mothers that they cannot be terminated, demoted, or denied promotion for experiencing a peripartum or postpartum mental illness (EEOC v. The Lash Group, Inc., 2014). Education about the terms of the Family Medical Leave Act should extend to all employees, not just pregnant women, and should include the length of time covered (up to 12 weeks unpaid) and eligibility (i.e., an employee must have worked for the company for 1 year and at least 1,250 hours within a year).

Comparisons and Conclusions

In conclusion to the discussion, it can be stated that to achieve all our health goals we need to give importance to the women's health. When we say women's health we are talking about all aspects of health that include the physical as well as mental health specially in vulnerable times of a woman's life. Public health for 2020 (HEALTHY PEOPLE 2020) and beyond should continue to stretch beyond traditional health sectors. Doing so will require reinvigorated public health leadership that engages nontraditional partners to create healthier choices that are easier for all people to make and adapt their lives according to the goals [31].

This clearly shows the need to assess for both depression and anxiety in new and expectant parents, and the term 'postnatal mood disorder' (PMD), accurately reflects significant adjustment disorders for the new parents specifically the new mother. More research is required to understand the problem but in the meantime the health systems should be improved to give support to mothers suffering from PPD [19].

Results from clinical trials on depressed new mothers found that both psychosocial (e.g., peer support, non-directive counseling) and psychological (e.g., cognitive behavioral therapy and interpersonal psychotherapy) interventions appear to be effective in reducing symptoms of postpartum depression [32]. Studies have shown that counseling done by health visitors through a systematic program has ample benefits for pregnant women who are anxious or mothers who are showing symptoms of non- psychotic depression [33]. More funds should be allocated to achieve these goals and priority should be given in finding a way to help women suffering from this debilitating condition.

Another important practical example comes from the state of Minnesota. The states establish and administer their own Medicaid programs and determine the type, duration, amount and scope of services. A mandatory benefit under Medicaid is Early and Periodic Screening, Diagnostic and Treatment Service (EPSDT), which covers visits commonly, referred to as well child checks. This program also includes Child & Teen checkups (C&TC"s). In 2010, the staff within the Minnesota Health Department began including maternal depression screening as a recommended but not required screening for visits from birth till 12 months [34]. The providers who actually performed this screening said that this practice actually made it easier for them to look for mothers with post-partum depression and utilize the time available in clinic in talking about the treatment. If we can implement this model to our health care programs all over US we can actually see a change. Many health models from the European countries also suggest that home visits by the health workers and nurses might actually help in helping a woman with non-psychotic post-partum depression. Women who are pregnant or have given birth should be given maternity leaves that are paid beyond the regular 6 weeks leave. Research has found an association between longer maternity leave and a lowered risk of PPD, with women taking less than 6 months of leave being at an increased risk for the disorder [35]. Findings suggest employed women experience problems in wellbeing at approximately seven months postpartum. Variables associated with improved health include: longer maternity leaves, fewer prenatal mental health symptoms, fewer concurrent physical symptoms, more sleep, increased social support, increased job satisfaction, less physical exertion on the job, fewer infant symptoms, and less difficulty arranging child care [36]. Work places should have child friendly areas with nursing stations and in house day care centers so that women feel stress free. State and the Government should give more funds to research centers and women centered clinics. In the end, we can sum up our discussion with a hope for a better future and a good health care system.

"Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a healthcare system that delivers better care, spends healthcare dollars more wisely and results in healthier people. Today's announcement is about improving the quality of care we receive when we are sick, while at the same time spending our healthcare dollars more wisely." HHS Secretary Sylvia Burwell on the organization's goal to shift 50 percent of payments to value-based models by 2018.

References

1. Pearlstein T, Howard M, Salisbury A, Zlotnick C (2009) Postpartum depression. Am J Obstet Gynecol 200(4): 357-364.

2. Thompson KS, Fox JE (2010) Post-partum depression: A

comprehensive approach to evaluation and treatment. Ment Health Fam Med 7(4): 249-257.

3. Ohara MW, Swain AM (1996) Rates and risk of postpartum depression-a meta-analysis. International Review of Psychiatry 8(1): 37-54.

4. Beck CT (1996) A Meta-Analysis of Predictors of Postpartum Depression. Nurs Res 45(5): 297-303.

5. Wisner KL, Chambers C, Sit KYD (2006) Postpartum depression: A major public health problem. JAMA 296(21): 2616-2618.

6. Howell EA, Padrón NA, Beane SJ, Stone J, Walther V, et al. (2017) Delivery and Payment Redesign to Reduce Disparities in High Risk Postpartum Care. Matern Child Health J 21(3): 432-438.

7. Gross KH, Wells CS, Garcia AR, Dietz PM (2002) Correlates of self-reports of being very depressed in the months after delivery: results from the Pregnancy Risk Assessment Monitoring System. Matern Child Health J 6(4): 247-253.

8. Pooler J, Perry DF, Ghandour RM (2013) Prevalence and risk factors for postpartum depressive symptoms among women enrolled in WIC. Matern Child Health J 17(10): 1969-1980.

9. Exavery A, Kanté AM, Njozi M, Tani K, Doctor HV, et al. (2014) Predictors of mistimed, and unwanted pregnancies among women of childbearing age in Rufiji, Kilombero, and Ulanga districts of Tanzania. Reproductive Health 11(1): 63.

10. Werner E, Miller M, Osborne LM, Kuzava S, Monk C (2015) Preventing postpartum depression: review and recommendations. Arch Womens Ment Health 18(1): 41-60.

11. Cheng CY, Fowles ER, Walker LO (2006) Continuing education module: postpartum maternal health care in the United States: a critical review. J Perinat Educ 15(3): 34-42.

12. Sondik EJ, Huang DT, Klein RJ, Satcher D (2010) Progress toward the Healthy People 2010 Goals and Objectives. Annu Rev Public Health 31(1): 271-281.

13. Suellentrop K, Morrow B, Williams L, D'Angelo D (2006) Monitoring progress toward achieving Maternal and Infant Healthy People 2010 objectives--19 states, Pregnancy Risk Assessment Monitoring System (PRAMS), 2000-2003. MMWR Surveill Summ 55(9): 1-11.

14. Sobey WS (2002) Barriers to Postpartum Depression Prevention and Treatment: A Policy Analysis. J Midwifery Womens Health 47(5): 331-336.

15. Health policy (2020).

16. Zelkowitz P, Milet TH (1995) Screening for Post-Partum Depression in a Community Sample. Can J Psychiatry 40(2): 80-86.

17. Sword W, Busser D, Ganann R, McMillan T, Swinton M (2008) Women's Care-Seeking Experiences After Referral for Postpartum Depression. Qual Health Res 18(9): 1161-1173.

18. Mandl KD, Tronick EZ, Brennan TA, Alpert HR, Homer CJ (1999) Infant health care use and maternal depression. Arch Pediatr Adolesc Med 153(8): 808-813.

19. Wisner KL, Parry BL, Piontek CM (2002) Clinical practice. Postpartum depression. N Engl J Med 347(3): 194-199.

20. Rubertsson C, Wickberg B, Gustavsson P, Radestad I (2005) Depressive symptoms in early pregnancy, two months and one year postpartum-prevalence and psychosocial risk factors in a national Swedish sample. Arch Womens Ment Health 8(2): 97-104.

21. Inskip HM, Godfrey KM, Robinson SM, Law CM, Barker DJP, et al. (2006) Cohort profile: The Southampton Women's Survey. Int J Epidemiol 35(1): 42-48.

22. Cox JL, Holden JM, Sagovsky R (1987) Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry 150(6): 782-786.

23. Ni PK, Lin SKS (2011) The role of family and friends in providing social support towards enhancing the wellbeing of postpartum women: a comprehensive systematic review. JBI Libr Syst Rev 9(10): 313-370.

24. Boury JM, Larkin KT, Krummel DA (2004) Factors related to postpartum depressive symptoms in low-income women. Women Health 39(3): 19-34.

25. Gjerdingen DK, Chaloner KM (1994) The relationship of women's postpartum mental health to employment, childbirth, and social support. J Fam Pract 38(5): 465-472.

26. Berger LM, Hill J, Waldfogel J (2005) Maternity leave, early maternal employment and child health and development in the US. The Economic Journal 115(501): F29-F47.

27. Henney JE, FDA/NICHD Conference (2000) Clinical

Pharmacology during Pregnancy: Addressing Clinical Needs through Science.

28. Boyd RC, Pearson JL, Blehar M (2002) Prevention and treatment of depression in pregnancy and the postpartum period–summary of a maternal depression roundtable: a US perspective. Archives of Women's Mental Health 4(3): 79-82.

29. Glasser S (2010) Postpartum depression: A chronicle of health policy development. Isr J Psychiatry Relat Sci 47(4): 254-259.

30. Rhodes AM, Segre LS (2013) Perinatal depression: A review of US legislation and law. Arch Womens Ment Health 16(4): 259-270.

31. Koh HK (2010) A 2020 Vision for Healthy People. N Engl J Med 362(18): 1653-1656.

32. Dennis CL, Hodnett ED (2007) Psychosocial and psychological interventions for treating postpartum depression. Cochrane Database Syst Rev 4: CD006116.

33. Holden JM, Sagovsky R, Cox JL (1989) Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. BMJ 298(6668): 223-226.

34. Chaudron LH, Szilagyi PG, Kitzman HJ, Wadkins HIM, Conwell Y (2004) Detection of Postpartum Depressive Symptoms by Screening at Well-Child Visits. Pediatrics 113(3): 551-558.

35. Dagher RK, McGovern PM, Dowd BE (2014) Maternity leave duration and postpartum mental and physical health: implications for leave policies. J Health Polit Policy Law 39(2): 369-416.

36. McGovern P, Dowd B, Gjerdingen D, Moscovice I, Kochevar L, et al. (1997) Time off work and the postpartum health of employed women. Med Care 35(5): 507-521.