APS European Society for Paediatric Research spr Society for Pediatric Research

www.nature.com/pr

COMMENT OPEN

Prioritizing caregiver mental health to promote child health

Kristine Schmitz[1✉], Mona Patel[2], Maya I. Ragavan[3] and Christina R. Rojas[4]

© The Author(s) 2024

Pediatric Research; https://doi.org/10.1038/s41390-024-03787-z

Stress and mental health disorders among parents and caregivers (hereafter called caregivers) in the U.S. have been rising at an alarming rate. The COVID-19 pandemic underscored the pressing mental health needs of caregivers, who faced heightened financial and childcare pressures, and revealed deep-seated inequities in access to healthcare, disproportionately affecting racial, ethnic, and economically marginalized groups due to structural racism and discrimination. This compounded the existing disparities in caregiver stress faced by marginalized and under-resourced communities. Caregiver stress and mental health disorders have profound effects on children's health, socioemotional development, and represent an important adverse childhood experience.[1] Recently, the U.S. Surgeon General released a report highlighting the critical need to address stress in caregivers and to support caregiver well-being.[2] Significant work remains to ensure comprehensive mental health support for caregivers in the prenatal and postnatal periods.

MATERNAL MENTAL HEALTH HAS PROFOUND EFFECTS ON CHILDREN

Supporting caregivers with mental health challenges is essential to fostering healthy, positive childhood experiences and promoting long-term well-being for children.[3] Maternal mental health is closely tied to child developmental and behavioral outcomes, including social skills,[4] mental health,[5] and academic success.[6] Caregivers with better mental health are more likely to engage in positive parenting practices that promote optimal development.[7] We have an urgent responsibility to support caregivers and provide multigenerational solutions to ensure optimal caregiver mental health & stress management.

Less is known about the impact of maternal mental health on children's physical health. In the article by Geiger et al.[8] the authors sought to evaluate associations between maternal psychosocial stress in the pre-and postnatal periods and child sleep problems and disturbances. The authors utilized data from a national cohort of biological mother-child dyads in the United States, in which maternal stress and child sleep were evaluated via validated measures. Their results demonstrate that maternal prenatal stress is associated with increases in child disturbances and, further, that postnatal maternal stress is a key mediator. These novel findings underscore the impact that caregiver mental health can have on child health and well-being throughout a child's lifespan, even in the prenatal period. These results also emphasize the importance of promoting policies and programs that support maternal mental health in the perinatal period and beyond.

SUPPORTING FATHERS AND OTHER CAREGIVERS IS CRITICAL

While much of the emphasis on caregiver mental health has centered on mothers, the mental health of fathers and other caregivers is equally vital for child well-being. Geiger et al.'s study[8] does not account for stress among other caregivers, which is an important limitation. Like mothers, fathers and other caregivers with greater stress and mental health needs may encounter obstacles in fostering positive socioemotional outcomes in children.[9,10] Caregivers, including grandparents and kinship foster parents, often face unique social and emotional demands and benefit from additional community resources and support.[11] Addressing the mental health of all caregivers proactively can enhance parenting or co-parenting dynamics and contribute to a nurturing, resilient family environment.

DISPARITIES IN CAREGIVER STRESS

Significant disparity exists in the experience of caregiver stress and mental health. Families who have experienced racial, ethnic, and economic marginalization face structural inequities that increase toxic stress for caregivers and children and contribute to social and environmental influences of health. While the study by Geiger et al.[8] includes a racially and ethnically diverse cohort, it is not educationally diverse, as more than 83% of participants reported having some college education. Educational attainment is linked to economic and health outcomes; by under-representing people with lower educational attainment, it may miss other poverty-related stressors. Relatedly, many factors can contribute to maternal stress in the perinatal period, including the mother's life condition, which could magnify the child's stress, impacting sleep. Social and environmental factors often play an intensified role for communities affected by racial, ethnic, economic, and LGBTQ+ inequities. Both appreciation of these inequities and integration of active approaches to address them and the downstream effects should be foundational to supporting caregiver mental health.

The study by Geiger et al.[8] highlights the associations of psychosocial stress in the prenatal period with child sleep problems, with postnatal stress acting as an important mediator; these results highlight the need for caregiver mental health support both during the perinatal period and throughout

[1]Department of Pediatrics, Robert Wood Johnson Medical School, Rutgers University, New Brunswick, NJ, USA. [2]Children's Hospital Los Angeles, Keck School of Medicine at the University of Southern California, Los Angeles, CA, USA. [3]Department of Pediatrics; University of Pittsburgh, Pittsburgh, PA, USA. [4]Division of Emergency Medicine, Ann & Robert H. Lurie Children's Hospital of Chicago, Chicago, IL, USA. ✉email: ks1692@rwjms.rutgers.edu

Received: 20 November 2024 Accepted: 24 November 2024
Published online: 17 December 2024

Table 1. Examples of Models for Supporting Caregiver Mental Health in Pediatrics.

Model	Description	Ages	Source(s)
Child First	-mental health services to parents -partners with nurse-family partnership programs	Prenatal-5 years	https://www.childfirst.org
Healthy Start	-care coordination for social determinants of health and mental health services for parents	Prenatal-18 months	https://mchb.hrsa.gov/programs-impact/healthy-start
Nurse-Community Health Worker (CHW) Team Intervention	-nurse-CHW partnership to offer home visitation and relational social support in the perinatal period	Prenatal-1 year	Roman LA, Gardiner JC, Lindsay JK, et al. Alleviating perinatal depressive symptoms and stress: a nurse-community health worker randomized trial. Arch Womens Ment Health 2009;12:379–91.
Doulas	-physical, emotional, and informational support during the prenatal, birthing, and postpartum period. -Some doulas can also provide support around infertility and pregnancy loss	Prenatal-1 year	https://www.dona.org/ https://healthlaw.org/doulamedicaidproject/
HealthySteps	-behavioral health specialist integrated into the pediatric primary care team -mental health screening, referral, and integrated therapeutic services in a tiered model	0–3 years	https://www.healthysteps.org/
Child-Parent Psychotherapy	-dyadic psychotherapy for parents and children who have experienced trauma	0–5 years	https://childparentpsychotherapy.com
ECIN[a] Family Wellbeing Program	-mental health support embedded in early childcare settings -peer support, parent training, and clinical mental health services for parents and children	0–5 years	https://www.ecin.org/
Community Health Workers	-social support, mental health education, and linkages to community resources and mental health services	all	https://nachw.org/

[a]ECIN-The Early Childhood Innovation Network's.

childhood. The American Academy of Pediatrics recommends routine screening and referrals for postpartum depression among mothers during infant preventive care visits,[12] yet many mothers are not screened.[13] And, there are few structured and evidence-based practices for screening caregivers outside of the perinatal period.[14] To increase impact, we must not only improve identification, but also shift beyond simply screening for caregiver mental health to a broad-based, integrated, and multidisciplinary approach. These efforts should extend beyond the perinatal period to support caregivers of children of all ages.

MODELS TO SUPPORT CAREGIVER MENTAL HEALTH

Pediatric clinicians are well poised to offer integrated resources for caregiver mental health, given their frequent contact with families through recommended well visits and opportunities to build trusted relationships.[15] Several existing models provide integrated mental health services and social support for both caregivers and children (Table 1). Additionally, there is growing momentum toward implementing caregiver mental health services, particularly for maternal postpartum depression, in emergency departments and inpatient hospital settings. These efforts are laudable but can lack universal access; they often focus on screening with referrals or targeted treatment of families who are selected based on income level or other tiered risk assessment.

One potential solution for improving caregiver support in pediatric settings is universal education, empowerment, and resource provision. Unlike the traditional "screen and refer" approach, where only caregivers screening positive for mental health concerns receive resources, universal empowerment recognizes that caregiver depression and parenting stress are common, and there may be reasons caregivers do not wish to disclose during pediatric visits. In a universal empowerment approach, all caregivers are provided brief strengths-based information about caregiver mental health and resources, regardless of disclosure. This approach has been used successfully in violence prevention interventions in healthcare settings and is recommended by the American Academy of Pediatrics as the way to support caregiver survivors of partner violence.[16] Future work should develop and test universal empowerment approaches in pediatric settings to support families with mental health concerns and stressors. These approaches should be co-created with families to ensure they are optimally meeting the needs of caregivers and connecting them with resources. Payors must also find ways to reimburse for caregiver mental health universal empowerment, rather than only for screening.

PAYMENT MODELS FOR CAREGIVER MENTAL HEALTH IN PEDIATRIC CARE ARE NEEDED

The National Academies of Science, Engineering, and Medicine (NASEM) recently released a consensus report on promoting lifelong health by improving healthcare for children, youth, and families.[17] The report recommends reforming payment models to

support and reimburse clinicians working with families and communities, particularly in relation to integrated mental health screening and empowerment. Dyadic care represents an opportunity for pediatric clinicians to provide services to both children and caregivers simultaneously, a practical approach that can reduce barriers to services.[18] However, current payment structures vary greatly on a state-by-state basis; for example, there are only 32 states that provide Medicaid reimbursement for maternal depression screening during pediatric visits.[19,20] While 42 states report Medicaid payment for dyadic services, few states allow for reimbursement based on the caregiver's needs or diagnoses, such as for postpartum depression. Thus, programs providing dyadic care specifically in relation to caregiver mental health are often reliant on philanthropic funding that cannot sustain services in a consistent and long-term manner. Reforming payment models to support the mental health of caregivers – and thus support the health of children – is critically needed.

CALL TO ACTION

Supporting family mental health positively impacts children's physical and emotional well-being. Expanding services for family mental health requires prioritizing the development, implementation, and sustainability of effective programs. To do this, we must conduct research on best practices and refine implementation strategies that consider the social and environmental influences on the health of the community they serve. To deepen our understanding of caregiver stress and mental health, we must use mixed-method approaches to contextualize caregivers' experiences and co-create targeted, caregiver-focused tools and interventions alongside caregiver stakeholders. These interventions should be practical, validated for all caregivers, inclusive of historically marginalized groups and the inequities faced, and available in multiple languages. Interventions must be agile and tailored to the particular setting. Lastly, sustainable service provision depends on developing effective and lasting payment models.

REFERENCES

1. Felitti, V. J. et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *Am. J. Prev. Med.* **14**, 245–258 (1998).
2. Office of the Surgeon General. *Parents Under Pressure: the U.S. Surgeon General Advisory on the Mental Health and Well-being of Parents* [Internet]. Parental Mental Health & Well-Being. [cited 2024 Oct 30];Available from: https://www.hhs.gov/surgeongeneral/priorities/parents/index.html (2024).
3. Weissman, M. M. et al. Offspring of depressed parents: 30 years later. *Am. J. Psychiatry* **173**, 1024–1032 (2016).
4. Cummings, E. M., Keller, P. S. & Davies, P. T. Towards a family process model of maternal and paternal depressive symptoms: exploring multiple relations with child and family functioning. *J. Child Psychol. Psychiatry* **46**, 479–489 (2005).
5. Goodman, S. H. Intergenerational Transmission of Depression. *Annu. Rev. Clin. Psychol.* **16**, 213–238 (2020).
6. Claessens, A., Engel, M. & Chris Curran, F. The effects of maternal depression on child outcomes during the first years of formal schooling. *Early Child. Res. Q.* **32**, 80–93 (2015).
7. Kuckertz, J. M., Mitchell, C. & Wiggins, J. L. Parenting mediates the impact of maternal depression on child internalizing symptoms. *Depress. Anxiety* **35**, 89–97 (2018).
8. Geiger S. D., et al. Association between maternal stress and child sleep quality: a nationwide ECHO prospective cohort study. *Pediatr. Res*. (2025), in press.
9. Sweeney, S. & MacBeth, A. The effects of paternal depression on child and adolescent outcomes: A systematic review. *J. Affect. Disord.* **205**, 44–59 (2016).
10. Xu, Y., Wu, Q., Jedwab, M. & Levkoff, S. E. Understanding the relationships between parenting stress and mental health with grandparent kinship caregivers' risky parenting behaviors in the time of COVID-19. *J. Fam. Violence;* **37**, 847–859 (2022).
11. Fergeus, J., Humphreys, C., Harvey, C. & Herrman, H. Supporting foster and kinship carers to promote the mental health of children. *Child Fam. Soc. Work* **24**, 77–83 (2019).
12. Earls, M. F., Yogman, M. W. & Mattson, G. Incorporating recognition and management of perinatal depression into pediatric practice. *Pediatrics* **143**, 9 (2019).
13. Kerker, B. D. et al. Identifying maternal depression in pediatric primary care: changes over a decade. *Behav. Pediatr.* **37**, 2 (2016).
14. Hunt, A. M., Uthirasamy, N., Porter, S. & Jimenez, M. E. Parental depression screening in pediatric health care settings: a scoping review. *Pediatrics* **150**, e2021055804 (2022).
15. Hagan J. F., Shaw J. S., Duncan P. M., editors. *Bright futures: guidelines for health supervision of infants, children, and adolescents*. Fourth edn. (Bright Futures/American Academy of Pediatrics, Elk Grove Village, IL, 2017.
16. Thackeray, J. et al. Intimate partner violence: role of the pediatrician. *Pediatrics* **152**, e2023062509 (2023).
17. National Academies of Sciences, Engineering, and Medicine. 2024. *Launching Lifelong Health by Improving Health Care for Children, Youth, and Families*. Washington, DC: The National Academies Press. [cited 2024 Nov 11]. Available from: https://nap.nationalacademies.org/catalog/27835 (2024).
18. Gregory, E. F., Passarella, M., Levine, L. D., Fiks, A. G. & Lorch, S. A. Preventive health care utilization among mother-infant dyads with medicaid insurance in the year following birth. *Med. Care* **58**, 519–525 (2020).
19. PolicyLab. *Addressing postpartum depression in pediatric settings: investing in innovative care delivery and payment policy* [Internet]. Children's Hospital of Philadelphia PolicyLab; [cited 2024 Nov 11]. Available from: https://policylab.chop.edu/sites/default/files/pdf/publications/PolicyLab-Policy-Brief-Addressing-Postpartum-Depression-Pediatric-Settings.pdf (2021).
20. Smith S., Granja M. R., Nguyen U. S., Rajani K. *How States Use Medicaid to Cover Key Infant and Early Childhood Mental Health Services: Results from a 50-State Survey* [Internet]. National Center for Children in Poverty, Mailman School of Public Health, Columbia University. [cited 2024 Nov 11]. Available from: https://www.nccp.org/wp-content/uploads/2018/11/text_1211.pdf (2018).

ACKNOWLEDGEMENTS

We would like to acknowledge the critical review and feedback provided by the Pediatric Policy Council: Shetal Shah (Chair), Mona Patel (Academic Pediatric Association), Maya Ragavan (Academic Pediatric Association), Scott Lorch (American Pediatric Society), Lisa Chamberlain (American Pediatric Society), Tina Cheng (Association of Medical School Pediatric Department Chairs), Ann Reed (Association of Medical School Pediatric Department Chairs), Joyce Javier (Society for Pediatric Research) & Ashwini Lakshmanan (Society for Pediatric Research). Dr. Schmitz is supported by the National Center for Advancing Translational Sciences, a component of the National Institutes of Health under award number K12TR004788, and the Robert Wood Johnson Foundation through its support of the Child Health Institute of New Jersey (Grants 78701). Dr. Ragavan is partially funded by a K23 from NICHD (K23104925). The funders/sponsors did not participate in the work and the content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or the Robert Wood Johnson Foundation.

AUTHOR CONTRIBUTIONS

Drs. Schmitz, Patel, Ragavan, and Rojas contributed to the study's conception and design; drafted and/or critically revised the manuscript; and approved the final version for publication.

COMPETING INTERESTS

The authors declare no competing interests.

ADDITIONAL INFORMATION

Correspondence and requests for materials should be addressed to Kristine Schmitz.

Reprints and permission information is available at http://www.nature.com/reprints

Publisher's note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Open Access This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/.

© The Author(s) 2024