Do ask, but don't screen: identifying peripartum depression in primary care

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In updated guidance, the Canadian Task Force on Preventive Health Care has again recommended that physicians in Canada should not routinely screen people without a personal history of mental disorder for depression in pregnancy and the postpartum period using dedicated instruments.[1] The key message is "Do ask, but don't screen."

High-quality evidence to support the clinical effectiveness of instrument-based depression screening in the peripartum period in a primary care setting is exceedingly limited. The guideline authors emphasize, however, that asking about mental well-being during this period is important and should remain part of standard antenatal and postnatal care, and that people who show symptoms and signs of depression should receive appropriate diagnostic and follow-up care.

The task force conducted a comprehensive search for studies that compared instrument-based depression screening in pregnant and postpartum people in primary care settings and measured important clinical and developmental outcomes for either parent or offspring. They found only 1 randomized trial of moderate size eligible to inform the current guideline. That, in itself, is telling. Screening for depression in the peripartum is recommended by guidelines from many other bodies, and such screening — using instruments such as the Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire (PHQ)-2 or PHQ-9 — continues in many jurisdictions across Canada.[1] A recent systematic review and individual patient data meta-analysis seeking to establish the accuracy of the EPDS in identifying people with depression found 121 studies from across the world that had compared the EPDS with a diagnostic interview.[2] Yet, studies looking at whether such screening is either clinically effective or harmful are essentially lacking.

Consolidated principles for screening hold that screening tests or programs should fulfill criteria in 3 domains: condition-related, test-related and system-related.[3] The condition being screened for should be common, the test should be valid and postscreening steps for definitive diagnosis and appropriate care should be clear, with adequate infrastructure to support the screening program. Any program of screening should be ethically acceptable, cost effective and explicitly linked to program planning, monitoring, evaluating and reporting.[3]

Depression of any severity in pregnancy and the postpartum period is relatively common, with some variation across populations.[4] The authors of the related guideline thoroughly explain the serious potential consequences of untreated peripartum depression for both the depressed parent and their offspring, identified by good observational studies.[1] Commonly used screening instruments have been shown to be reasonably good at detecting and ruling out depression.[2] However, the systematic review that underpinned the new guideline has made it clear that the effect of routine screening for depression in the peripartum period on important outcomes is poorly understood; moreover, the harms of routine screening and its cost-effectiveness are not known.[1] Furthermore, and crucially, routine screening for peripartum depression in Canada is not supported by system-wide dedicated infrastructure to facilitate evidence-based treatment and supports for people who screen positive, according to criteria for screening.[3] Until such time as better evidence and better infrastructure support exist, a recommendation to screen would seem indefensible.

Any illness that is reasonably common, and for which the natural history is understood to be associated with poor outcomes that can be prevented with evidence-based treatment, should be detected early, diagnosed and have treatment initiated by primary health care practitioners. Peripartum depression should be no exception. To facilitate this, practitioners should be aware of the known risk factors and typical symptoms and should ask patients about these routinely. Good observational evidence suggests that people who have a history of mental disorders, those who are experiencing interpersonal violence, those living with substantial life stress or experiencing a major or negative life event, and people of low socioeconomic status are at higher risk of developing depression in pregnancy or the postpartum period.[4] Some studies have also identified poor social support, Indigenous identity, recent immigrant status, traumatic birth experience and very young age to be risk factors.[4–6]

Here's where we run into difficulty. Some of the risk factors for peripartum depression are also associated with barriers to accessing primary care and routine antenatal care. In an ideal Canada, all pregnant people would be cared for by a practitioner with whom they have established rapport, a provider who knows their history well enough to be able to spot telling signs and ask appropriate questions about mood and life circumstances, as the authors of the new guideline hold to be best practice. This ideal is not a reality for many people who become pregnant, however — especially those with the aforementioned risk factors. Although whole-population instrument-based screening may not be evidence based or justified, screening instruments may serve as useful tools to assist practitioners with case-finding in certain circumstances. For example, the EPDS has been translated into many languages other than the original English[7] and validated for use for speakers of these languages; use of a translated tool may serve as a way to question a patient about their mood if language discordance is a barrier.

Ticking a screening box does not constitute "doing something" at either an individual practitioner or a health system level. As the authors of the new guideline take care to emphasize, abandoning screening doesn't mean primary care practitioners shouldn't ask patients about their mental health with a view to finding cases of treatable depression. They should. Moreover, they should bear in mind that those most likely to become cases may be the hardest to find. However, to support practitioners to do their job well, health systems will need to improve access to the primary care, mental health and social resources that can support better care for peripartum mental illness.

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Competing interests: www.cmaj.ca/staff

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